Quality, Safety and Experience Committee - 16 February 2021

Tue 16 February 2021, 09:00 - 11:00

Agenda

09:00 - 09:00
0 min

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the Committee Meeting held on 15th December 2020

Susan Elsmore

1.4 Unconfirmed Minutes 15.12.20 SR.pdf (15 pages)

1.5. Action Log – 15th December 2020

Susan Elsmore

1.5 Action Log.pdf (3 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

09:00 - 09:00
0 min

2. Items for Review & Assurance

2.1. Specialist Clinical Board Assurance Report

Guy Blackshaw / Catherine Wood / Claire Main

2.1 Specialist Clinical Board Assurance Report.pdf (33 pages)

2.2. Quality Indicators Report

Carol Evans

2.2 Quality Indicators Report.pdf (11 pages)

2.3. Exception Reports & Impact of Covid-19 on Patient Safety

Ruth Walker / Stuart Walker

Verbal Update

2.4. Progress on Mass Vaccination

Lisa Dunsford / Tracy Meredith

2.5. Board Assurance Framework – Patient Safety

Nicola Foreman

- 2.5 Board Assurance Framework Covering Report.pdf (2 pages)
- 2.5 Patient Safety BAF Risk.pdf (3 pages)

2.6. HIW Activity and Reports Update

Carol Evans

- 2.6 HIW Activity and Reports Update.pdf (5 pages)

2.7. Health Care Standards Self-Assessment Plan and Progress

Carol Evans

- 2.7 Health and Care Standards Self-Assessment Plan & Progress.pdf (6 pages)

09:00 - 09:00
0 min

3. Items for Approval / Ratification

3.1. Terms of Reference

Nicola Foreman

- 3.1 Terms of Reference.pdf (2 pages)
- 3.1 Quality Committee ToR - Feb 2021v2.pdf (9 pages)

3.2. Work Plan

Nicola Foreman

- 3.2 Work Plan.pdf (2 pages)
- 3.2 QSE workplan v2 21.22.pdf (1 pages)

3.3. Committee Annual Report

Nicola Foreman

- 3.3 Committee Annual Report.pdf (2 pages)
- 3.3 Draft QSE Committee Annual Report.pdf (8 pages)

3.4. Policies & Procedures

Nicola Foreman

- 3.4 Policies and Procedures.pdf (2 pages)

09:00 - 09:00
0 min

4. Items for Noting & Information

4.1. Board of Community Health Councils in Wales Report - Feeling forgotten? Hearing from people waiting for NHS care and treatment during the Coronavirus pandemic

Angela Hughes

- 4.1 Board of CHCs in Wales Report.pdf (4 pages)

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

Carol Evans

a) Children & Women's Clinical Board Minutes - 24/11/20
b) Specialist Clinical Board Minutes - 30/10/20
c) CD&T Clinical Board Minutes - 11/11/20
d) Surgery Clinical Board Minutes - 17/11/20
e) Mental Health Clinical Board Minutes - Not received
f) Medicine Clinical Board Minutes - Not received
g) PCIC minutes - Not received

- 4.2a Att 1 - C&W QSPE Minutes 24.11.20.pdf (6 pages)
- 4.2c Att 1 - Minutes 11.11.20.pdf (11 pages)
- 4.2d SCB Minutes Q&S 17.11.20 (1).pdf (12 pages)
- 4.2b QS Minutes 30.10.20 CM.pdf (7 pages)

09:00 - 09:00
0 min

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

Susan Elsmore

09:00 - 09:00
0 min

6. Any Other Business

Susan Elsmore

09:00 - 09:00
0 min

7. Review of the Meeting

Susan Elsmore

09:00 - 09:00
0 min

8. Date & Time of Next Meeting:

Tuesday, 13 April 2021

9am

MS Teams

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 15th December 2020 at 09.00am
Via MS Teams

Present		
Susan Elsmore	SE	Independent Member – Local Authority
Michael Imperato	MI	Independent Member – Legal
Gary Baxter	GB	Independent Member – University
Dawn Ward	DW	Independent Member – Trade Union
In Attendance		
Stuart Walker	SW	Executive Medical Director
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Christopher Lewis	CL	Interim Executive Director of Finance
Angela Hughes	AH	Assistant Director of Patient Experience
Ruth Walker	RW	Executive Nurse Director
Nicola Foreman	NF	Director of Corporate Governance
Richard Hughes	RH	
Joy Whitlock	JW	Head of Quality and Safety
Andrew Carson-Stevens	AC	Patient Safety Researcher
Clare Wade	CW	Director of Nursing Surgery
Mike Bond	MB	Director of Operations Surgery
Alun Tomkinson	AT	Clinical Board Director Surgery
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Matthew McCarthy	MM	Patient Safety Facilitator
Observer		
Emily Howell	EH	Audit Wales
Maureen Edgar	ME	Research Governance Coordinator
Kerry Ashmore	KA	Information Liaison Manager
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health

QSE 20/12/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the final QSE Committee Meeting of 2020. The CC acknowledged that this was the last QSE meeting of the Independent Member – Trade Union.	**Action**
QSE 20/12/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 20/12/003	**Declarations of Interest** The Independent Member – Legal (IML) declared an interest in agenda item 4.6 - Blood Inquiry Update.	
QSE 20/12/004	**Minutes of the Committee Meeting held on 8th September 2020** The minutes of the meeting held on 8th September 2020 were reviewed.	

	Resolved that: a) The minutes of the meeting held on 8th September be approved as a true and accurate record.	
QSE 20/12/005	**Action Log following the Meeting held on 8th September 2020** The CC noted that action QSE 19/09/011 The Gosport Review was marked as "To come to a future meeting" and asked that a date be set. The Assistant Director of Patient Safety and Quality (ADPSQ) responded that a report had been brought to the Committee previously but noted that there was an outstanding action which would be picked up via a national audit on end of life care. That was delayed due to COVID-19. The Executive Nurse Director (END) updated in respect of action QSE 20/02/009 that the entire layout of the Assessment Unit had changed and discussed in October's Board Meeting. The END recommended therefore that the action be marked as complete.	
QSE 20/12/006	**Chair's Action taken since last meeting** None taken.	
QSE 20/12/007	**Advancing Applied Analytics Health Foundation Project Presentation** The Assistant Medical Director - Patient Safety and Clinical Governance (AMD) and Patient Safety Researcher (PSR) presented to the Committee. The PSR noted that often there was a narrow and restricted view of the problem. At one end of the scale there was Incident Reporting and at the other end in-depth investigations and somewhere in between, other various data sources such as patient stories, Coroner's reports, audits of clinical care and culture surveys amongst others. The PSR advised the Committee that data sources offered a window into the healthcare system and posed how opportunities could be maximised by using the data to identify the patient safety priorities. The PSR advised the Committee that Healthcare was often criticised for collecting too much data and doing too little with it. Also the apparent lack of demonstrable progress deterred reporting, as few staff could see the rewards of their conscientiousness in trying to protect patients, and not closing the feedback loop to incident reporters had in some cases led to frustration. The PSR advised the Committee that he had been working with the World Health Organisation (WHO) and exploring what slowed down the data driven patient safety improvement agenda and culture. From observations from multiple countries it could be realised that the range and utility of the patient safety data we already had was key. The PSR commented that not all data sources could provide essential information and presented to the Committee the WHO Classification for Patient Safety model which looked at other sources. The PSR asked the Committee if the UHB knew where the gaps were in data required to understand patient safety in order to be clear on whether further data gathering was required.	

The PSR advised the Committee that this would become the premise for the Health Foundation Advancing Analytics Award that it had worked hard to progress over the last 15 months. The Health Foundation funded:

1. The exploration of how to build the capability of the administrative informatics team members to generate learning from patient safety data.
2. How to support patient safety risk managers to regularly learn from patient safety data to inform their work
3. Build will amongst the staff reporting patient safety incidents.

The Patient Safety Facilitator (PSF) presented to the Committee what had been done and what had been learnt by the Patient Safety Team.

The PSF advised the Committee that when the team set out on the project, they knew that UHB staff from a range of professions wanted to undertake Quality Improvement (QI) projects however the selection of topics that could be used for the projects was not targeted.

The PSF advised the Committee that there were a lot of Patient Safety Incident reports within the UHB that could tell how, when and where the patients were being harmed.

The PSF advised the Committee that at the beginning of the project a workshop was held with Clinicians from the Acute Child Health Directorate and the data available explored to assess how it could be used to inform quality improvement within the directorate.

The PSF advised the Committee that there had been some really great discussions at the workshop and the following key messages:

- It was difficult to get data
- Not clear on the pros and cons of the data source
- More than one data source was needed to fully understand an issue.

The PSF advised the Committee that as a project team, it needed to test how clinical staff could be supported to use and analyse patient safety data to inform their QI projects. They asked staff from the Acute Child Health Directorate to join and undertake a pilot project which was named Quality Improvement using Data in Child Health (QIDICH).

The PSF advised the Committee that working with the QIDICH team, they were able to extract 2 years' worth of Acute Child Health Patient Safety Incident Reports from the UHB Datix system and it was identified that there were themes within that data.

The most frequent data was that of Medication and communication related incidents. The Team realised that combining data sources would give important new knowledge that would not have been identified with one source.

The PSF advised the Committee that with funding from the Health Foundation they had been able to work intensively with Acute Child Health over the past 15 months.

	Extracting and exploring data from the incident reporting system was labour intensive and time consuming so to roll that data project across the UHB, a dashboard was developed by the Business Intelligence team. They were looking at developing this dashboard further to make it more powerful by using statistical tools. The PSF advised the Committee that to improve consistency, the team removed paper forms and developed an electronic form. The PSF concluded that patient safety data could inform the UHB where areas could be improved but only if it was looked at, analysed and understood. The AMD advised the Committee that as part of the project a self-evaluation was performed to see where they were and where they could be better. Also the project would be able to give staff the skillset to look at raw data which would motivate staff to create reports. The AMD advised the Committee that they were moving into the next phase of the project which would be to roll it out across the health board and that this would be known as CAVQi and that it proposed a unifying ambition to make sure there were meaningful and bespoke QI projects being done. The AMD advised the Committee that they had won a PhD studentship with the economic and social research council to look into more of the patient safety within the UHB.	
QSE 20/12/008	**Quality Indicators Report** The END advised the Committee that she, the Director of Corporate Governance (DCG) and the Executive Medical Director (EMD) had been working on what could be reported into each Committee and that this was the first attempt at doing this. The END highlighted a number of areas within the report and advised the Committee that the number of Serious Incidents (SI) reported had reduced significantly over the last two years. The END advised the Committee that SI forms were put to WG and this was to try and prevent these types of incidents from happening again. The number of SI closure forms submitted to WG had dropped during Q1 and Q2 of 2020/2021 which was of no surprise due to the pandemic. The END advised the Committee that pressure damage had gone up in the last 2 months which was being looked at by the pressure ulcer group. The END advised the Committee that the compliance for patients admitted to the stroke ward was worrying because patients were not getting to the places where they should be and that was being looked at by the effectiveness committee. The END advised the Committee that there were some mortality indicators and 2 new groups had been set up by the EMD.	

	The CC advised the Committee that it was good to see these sub Committees that would feed in and be able to report back and the sense of the Governance framework being much tighter around QSE. The CC asked Committee if there were any questions. The IML responded that the pressure ulcer issue was always on the agenda and asked whether it would be beneficial for someone to get a better understanding of the Pressure Ulcer group. The END responded that she would be happy to bring a report about it and the functionality and aims and noted that the Director of Nursing Surgery led on that. The IMTU asked about the stroke patient figures and whether it was because the numbers presenting had gone up or because there were less staff. The END responded that the challenge was the availability of beds and getting people through the system. Testing patients in the department and the ability get them to the right place the first time was challenging. Operation teams were focused on it at the moment and this would be discussed in regards to the Lakeside Wing. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of the Quality Indicators report and the actions being taken forward to address areas for improvement.	**CW** **RW**
QSE 20/12/009	**Exception Reports** Verbal update was provided by the END. The END advised the Committee that as of 1pm yesterday there were 14 wards that had been classified as “outbreak”, of which 46 patients had hospital acquired COVID-19 and that 73 staff were COVID positive however at that stage it was not known if it was hospital or community acquired for staff. The END advised the Committee that the number of beds available was 92 but 53 were being admitted based on risk assessment. Some patients were testing negative at the front door but when they were here for 24/48 hours they were then presenting positive. The END advised the Committee that the culmination of patients affected in their clinical environments was 122. The IMTU asked whether reporting of staff testing positive was done via DATIX and Riddor. The END responded that it was not but that recording was done if 2 or more staff members were positive as that was classed as an outbreak and would be reported via the DATIX system.	
QSE 20/12/010	**Impact of COVID-19 on Patient Safety** The END advised the Committee that this paper was more for noting however from a Governance perspective, it would be good to note the information around COVID related incident reporting and reporting in to Public Health Wales (PHW) particularly around deaths. Also how PPE has been managed, IPC and issues around handover at front door.	

	The END advised the Committee that with the issues around handover at the front door, they were working closely with WAST colleagues to ensure they could get back out to collect patients in the community. The CC noted that the paper promised a full brief on these issues at the forthcoming Committee meeting. The EMD responded that at the time of completing the paper it was not known where we would be in the course of the pandemic. He added that we were now at the most concerning point subsequent to the original peak earlier in the pandemic, and that it was well recognised that in the community instance the number of COVID positive cases were going up and up. The EMD advised the Committee that the age profile of the infected was shifting into an older cohort which was now manifesting in the number of patients coming in to the UHB. He noted that there was a significant increase in patients on critical care. The EMD advised the Committee that we were at a crucial point in the second peak and as a group of Critical Care Clinicians in Wales they had written to the Health Minister to ask him to invoke a lockdown sooner than December 28th and as a group of Executive Medical Directors they had written to the Chief Medical Officer supporting any decision he would want to make to implement an earlier lockdown. The EMD advised that a 13 day wait for the 28th December lockdown could result in 4 times as many cases. The EMD advised that the biggest constraint and concern was the workforce and the ability to deliver care; there was sufficient bed capacity but not the amount of nurses. The EMD advised that we were at the point at which a decision would need to be made about whether we discontinued certain services and surgery. The EMD advised that the signing off rotas for the Lakeside Wing had begun and that had a direct consequence on where staff were being redistributed from and staff wellbeing. The END advised that she wanted to reiterate the EMD's comments and that staffing was the biggest challenge. The END advised the Committee that had the Executive Director of Public Health Wales been in the meeting she would have reminded everybody that vaccinating had started and that a lot of staff had tested positive in the Splott vaccination centre and that they were revisiting that as an outbreak. The END advised that Track and Trace worked very well but again had an impact on the staff available to us as did the closure of schools. The Interim Executive Director of Finance (IEDF) asked the Committee to note that where we were experiencing a very difficult operational situation, finance was not a constraint and financial support was being provided but the key concern was the availability of staff.	

	The EMD advised that there was a concern regarding waiting list numbers and he considered that the commencement of level 3 or above surgery should not go ahead after Christmas. The EMD noted that a service still needed to be provided to cover urgent patients and that there was a real balance required. He advised that everything possible needed to be done to ensure the wellbeing of staff. The IMTU asked whether there would be COVID testing for all staff. The EMD responded that lateral flow tests and POC testing was being rolled out to some degree and that ultimately it would be available for all staff but there were 168,000 patient facing staff that required testing twice a week resulting in over 300,000 tests which was a large logistical task. **Resolved that:** a) The Quality, Safety and Experience Committee noted the content of the report.	
QSE 20/12/011	**Public Services Ombudsman for Wales Annual Letter** The END advised the Committee that this was a statement of fact on where we were as an organisation and that the UHB Chair had asked for the letter to be brought to the Committee. The END advised that it demonstrated that as a health board, there were no major concerns. **Resolved that:** a) The Committee noted the findings of the Ombudsman's Annual Letter 2019/2020 and the actions being taken.	
QSE 20/12/012	**Clinical Board Assurance Reports:** 1) Surgery Clinical Board The Clinical Board Director of Surgery (CBDS) presented to the Committee. He explained how the surgical board responded to the COVID-19 pandemic and what the challenges were. The CBDS advised that a number of principles, aims and objectives were used to ensure that patients were made as safe as they could be. The Clinical Board Director of Nursing Surgery (CBDNS) added that the advice from Welsh Government (WG) at the start of the pandemic was to stop all non-urgent surgical treatment. The surgical clinical board (CB) started to log the clinical risk of each of their patients and a lot of data had been collected. The UHB was one of the only health boards in Wales to have collected post-operative outcomes. The CBDNS noted to the Committee a reduction in referrals at the start of the pandemic and this impacted the whole pathway of a patient. The CBDNS advised the Committee that there had been a lot of logistics that they had had to deal with including PPE guidance changing rapidly and differing information from some professional organisations surrounding PPE and the differing advice given to Public Health Wales.	

	The CBDNS advised the Committee that communication had been important during the pandemic, not just with patients but with their teams. The CBDNS advised the Committee that they needed governance controls around the response to the pandemic and this was thought about when discussing changed to the service to fit the needs of the patients. The CBDNS advised the Committee that immediately they met as a senior team within service groups – twice daily and then once a day as the pandemic continued. This meeting was now held 3 times a week to see where they were, what needed to be done and how to plan future treatment and how the service would be shaped. The CBDNS advised the Committee that they had started a journey in December 2019/January 2020 and had started looking at how they could utilise their bed base much easier which they had named “Right Bed, First Time” and that was the ethos they would use throughout the pandemic. The CBDNS advised the Committee that Lightfoot had collected data for them in 2019 which they had been able to use to tell them what they needed to do and how they could model their services moving forward. The CBDNS advised the Committee that they had used their own frontline staff to drive the changes and to develop what the services needed to look like through the COVID-19 pandemic The CBDNS advised the Committee that the CB had linked in quickly with Infection, Prevention & Control (IP&C) colleagues and had built up good relationships and that without them the CB would not have progressed. The CBDNS advised the Committee that they had followed the evidence provided by Lightfoot and wanted to ensure that everything was patient centred. The CBDNS advised the Committee of 3 areas and how they had wanted to create safe and ring-fenced capacity: 1) Green – COVID-19 secure 2) Amber – For Patients that they are unsure of their COVID status and are tested on admission. 3) Red – COVID-19 positive patients. The CBDNS advised the Committee they wanted to create green ring-fenced capacity across the UHB to maintain their core services of urgent cases and cancer treatment. The CBDNS advised the Committee that the CB wanted the population of Cardiff and Vale to feel safe if they had to attend the green zones. The Director of Operations for Surgery (DOS) advised the Committee of the changes that had been made by the CB and expressed his amazement at how agile, responsive and creative the UHB had been as a whole.	

	The DOS advised the Committee that the UHB had moved with the CB and had helped development and that very quickly, over a weekend, they had moved all Ambulant and Frail trauma to the University Hospital Llandough (UHL) and this had proved a success. The DOS advised the Committee that had supported the cardio thoracic move to UHL and that this had gone very well. They had redesigned theatres and wards across University Hospital Wales (UHW) and UHL and had created the green zones. They had partnered with the private sector and thanked the Corporate team for the organisation of that which had created a huge amount of green capacity in Spire Hospital where over 2000 operations had been undertaken. They had increased emergency theatres which was important because when splitting services, assurance was needed that the workforce was in the right place. The DOS advised the Committee that they had revised all staffing rotas as COVID increased, supported the wider organisation and were currently running a COVID ward which was working reasonably well. The DOS presented the risks involved: • Fearful staff and patients. • Lack of understanding around what the CB had tried to do, internally and externally. • "Old habits die hard" – Working around people or try and work with them. • Anecdotes not evidence • Mental Fatigue – Staff have worked tirelessly. • Responsive, agile change in crisis wears thin. The DOS summarised what had been achieved from April 2020 until November 2020: • The CB had managed to undertake 7308 elective operations. • 5946 emergency operations. • Total redesign of surgical footprint to support the UHB and patients. • Flexible and responsive workforce. • Clinically lead models of care • One eye on the future • Clinical publication of the CB audit • "Stars are born" – Staff who have shown their true methods. The DOS advised that the CB could not return to the way it was pre pandemic and that it would be a "rocky road" going forward due to the waiting lists. He commented that the staff were the greatest asset. The CBDS advised of 2 problems faced by the CB: 1) Large backlog of undifferentiated patients 2) COVID-19 was ongoing. The CBDS advised the Committee that at this point success needed to be celebrated and the momentum needed to continue.	

	The CBDS presented its patient story. The patient had attended one of the CB green zones. She had originally presented to Cwm Taf UHB and had been diagnosed with head and neck cancer. She was pre-assessed and advised to self-isolate for 14 days and had a COVID swab 72 hours pre admission. She was admitted on the morning of her surgery and met with the anaesthetist and surgeons. She underwent the operation which took 4 hours and was cared for post operatively by ENT trained nurses on Ward A2 and discharged 4 days later. The CBDS advised that A2 was a ward that had been designed to look after a multitude of complex patients and that one of the primary concerns that Surgeons had had when creating green zones was the loss of their specific ward. The newly designed A2 was staffed with well experienced Senior Nurses and that proved a huge success with all staff. The CC noted the leadership shown by the Surgical Clinical Board had been phenomenal and that they had tackled difficult problems; their sensitivity and drive was remarkable. She enquired what staff morale was like. The CBDNS responded that the uncertainty around COVID-19 was still proving difficult but noted that Nurses and others had gone over and beyond. Staff had been very flexible and it was amazing how teams had come together during hardship. The Independent Member – University (IMU) asked about the future and how the momentum for change could be maintained. The DOS responded that traditional services needed to change and the CB were already looking at how that could look with for example virtual clinics and a complete redesign of job plans. “Right Bed, First Time” was key and the CB would think very differently and design a service fit for purpose. The DOS advised the Committee that based on Lightfoot data, issues could continue until 2027 to 2030 if the change was not maintained. The CBDS noted that every patient was guaranteed a bed during this time because of the green zone changes and that the UHB had never had a time where surgery was guaranteed. To go backwards was not an option. The Independent Member – Legal (IML) commented that if there were going to be things that looked permanently different, had the UHB considered how they would engage with stakeholders to avoid criticism. The DOS responded that they had engaged with the CHC. Richard Hughes (RH) commented that the pandemic had brought lots of challenges to Pre-op assessment and changes as a result of the pandemic would be central to the way forward. The short stay had been a godsend through the pandemic and having theatres right next to ward areas was superb. He would like to see surgical Nurses kept within surgical areas to use their expertise. The END commented that the presentation had been a very impressive example of leadership, certainly around values and behaviours and the engagement of staff.	

	The Executive Medical Director (EMD) advised that staff redistribution was a difficult problem and that some of the aspirations had to take a back seat as we delivered our COVID response. **Resolved that:** a) The Quality Safety and Experience Committee noted the progress made by the Clinical Board to date. b) The Quality Safety and Experience Committee approved the content of the report and the assurance given by the Surgery Clinical Board.	
QSE 20/12/013	**Health Care Standards Self-Assessment Plan and Progress Update** The Assistant Director of Patient Safety and Quality (ADPSQ) advised that work had been undertaken with specialist leads in the UHB to make sure their improvement plans had been implemented. The ADPSQ advised that they were currently thinking through how processes could be put in place next year without it being too onerous for Clinical Boards. The ADPSQ advised that further information would be brought back to Committee in the February meeting. The END advised that another of the red items in the paper related to the Clinical Board rolling programme of maintenance which was something looked at regularly by the Committee. The ADPSQ advised that they were looking across the small central Clinical Audit team and that there were 38 national mandated audits and the UHB were signed up to 35 of these. At the moment there was no dedicated resource to pick national audits up and they were working through with the Clinical Boards how the national audits could be delivered. The CC asked the ADPSQ for an update on this at a future meeting. The END closed that the final area reported on the 36 week elective treatment and 8 weeks diagnostics which was a report that went regularly to Board and was actively monitored. **Resolved that:** a) The Quality Safety and Experience Committee noted the progress made against the actions identified for each of the Health and Care Standards.	**CE**
QSE 20/12/014	**Board Assurance Framework – Patient Safety** The DCG advised Committee of work with the Board Assurance Framework (BAF) and how each risk was allocated to a Committee and reports had gone to the Strategy and Delivery Committee for some time. The DCG advised that this was the only risk on the BAF linked to this Committee. The covering report highlighted a number of ways patient safety could be compromised within the organisation as referred to in today's meeting. The DCG advised that this was brought to Committee to provide an extra level of assurance and to open it up for check and challenge before going	

	back to the Board. The DCG asked the Committee if it was happy with the risk net score of 15 currently based upon discussions had in the meeting. The EMD responded that 15 was the right score at the moment and the END agreed. The IMU noted that there was reference in the supporting document table to the use of capacity within the Spire hospital and asked how the UHB mitigated any risk by that private provider. The END responded that in its role as commissioner, the UHB had contracts with them which included quality indicators and they had a duty to report to the UHB any incidents or concerns. **Resolved that:** a) The Quality, Safety and Experience Committee reviewed the attached risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 20/12/015	**Quality, Safety & Experience Workshop – Feedback & Action Plan** The EMD advised the Committee that it had been a great workshop and great to see some of the Independent Members had joined. Staff across the whole of the UHB had contributed and there had been a further feedback session on 13th November to ensure all of the learning had been taken from the event. The EMD advised that the plan moving forward was to convert the discussions had and create a proposal to take to Board Development in terms of next steps for some of the structural pieces. The EMD advised that they had been asked to work with the National Audit Team to undertake a Quality Governance review as an organisation. It was confirmed that there was ongoing work to ensure the right information reached the right places and at the right time as well as ensuring not to duplicate information. Meetings were also taking place to look at Learning, Education and Development and Medical Education to ensure the right approach and governance around the Learning Committee. **Resolved that:** a) The Quality, Safety and Experience Committee noted the feedback from the QSE workshop and agreed the next steps.	

QSE 20/12/016	**Minutes from Clinical Board QSE Sub Committees – Exceptional Items to be raised by Assistant Director, Patient Safety & Quality** The ADPSQ advised the Committee that the main observation was that it was good to see the Clinical Boards (CB) had managed to keep their Quality and Safety meetings wholly in place throughout COVID-19. The ADPSQ noted that there were no minutes received from the Mental Health CB. The ADPSQ also highlighted that CD&T had a huge radiology backlog with over 7000 patients waiting greater than 8 weeks against their RTT. This would need regular updates. The ADPSQ advised that PCIC had been rolling out news in the prison and the Director of Nursing had a very good plan to audit this in January. The IMTU asked where we might pick up operational services and estates and facilities issues given that they were not a Clinical Board. The ADPSQ responded that we worked very closely with them especially around the environment and how it impacted on patients but acknowledged there was a gap to explore.	
QSE 20/12/017	**Self-assessment of Committee Effectiveness and Forward Action Plan** The DCG advised that she had extended the action plan after discussion with the CC. The END commented that she had been disappointed with the results, noting a deterioration to where we had been in the past, and was keen that the improvement plan delivered. She added that QSE was a challenging Committee with a lot of information brought to it and that the Independent Members needed to be assured by what was presented to them. **Resolved that:** a) The Quality, Safety and Experience Committee noted the results of the Committee's self-assessment Effectiveness Review for 2019-20. b) Approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which would feed into the 2020-21 Annual Governance Statement.	
QSE 20/12/018	**HIW Activity Overview** The ADPSQ advised that HIW did step down its normal approach to inspections during the first wave of the pandemic and that they had introduced some quality checks to do offsite virtual inspections. The ADPSQ commented that the published reports had been very positive and that the focus was on COVID preparedness. The ADPSQ advised that this would be brought back to the Committee in February. The CC commented that there were clearly improvements needed in particular Clinical Boards.	**CE**

	Resolved that: a) The Quality, Safety and Experience Committee noted the level of HIW activity across a broad range of services. b) Agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 20/12/019	**HIW Primary Care Contractor Report** The ADPSQ advised that the amount of activity seen by HIW in Primary care had significantly reduced to what we would normally expect. HIW did an onsite inspection of Birchgrove dental surgery around COVID precautions due to an anonymous concern being raised. The ADPSQ advised that Primary Care had provided assurance that necessary mitigations were in place. The END advised that it was helpful to put everything into context against an all Wales picture and that feedback given by HIW was that we seemed to be getting positive reports to date from Primacy Care and inpatient whereas some colleagues across Wales were not. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors. b) The Quality, Safety and Experience Committee were assured that appropriate remedial actions were being taken by practices in relation to immediate assurance notifications. c) The Quality, Safety and Experience Committee noted that there was 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.	
QSE 20/12/020	**Blood Inquiry Update** The IML left the meeting. The DCG advised the Committee that the report was for information and to keep the Committee updated on progress. The DCG advised that outcomes would continue to be reported and any significant issues raised in the private domain when appropriate. The DCG advised that a full communications plan was in place if needed. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of the report and links to inquiry resources.	
QSE 20/12/021	**Items to bring to the attention of the Board / Committee** The END advised that she had picked up on the point made by the IMU about data, its availability and interpretation and that this would be followed through at Board and Board Development.	
QSE 20/12/022	**Any Other Business** The CC thanked the IMTU and Vice Chair for her attendance, this being her last QSE Committee meeting. The END also noted her thanks to the IMTU for her support.	

	The IMTU thanked the Committee for their generous comments.	
QSE 20/12/023	**Review of the Meeting** The CC commented that the meeting had run well. The END added that it had been a heavy agenda but it was good to see the Committee moving forward on some of the bigger issues. The IMU commented that no matter the size of the agenda, it was important to always make space to hear the messages coming from Clinical Boards and others working within the Organisation in order to have assurance. The DCG responded that the Executive team could be smarter in using the covering report appropriately to pull out key areas for IMs to focus on which would enable more time to be spent on strategic issues.	
QSE 20/12/024	**Date & Time of Next Meeting:** Tuesday 16th February 2021 at 9am. Via MS Teams	

Action Log

Quality, Safety & Experience Committee

Following the meeting held on 15th December 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 20/12/021	Data	The availability of data and how to interpret that data.	To be agreed	Ruth Walker	**COMPLETE** The END responded that it would be picked up at Board and Board Development. Was picked up at Board Dev
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	**COMPLETE** To be picked up in review of quality governance. Would not include the IMTP
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	**COMPLETE** On December agenda, item 2.6.
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	**COMPLETE** On December agenda, item 4.5
QSE 19/12/016	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.	16.02.21	Fiona Kinghorn	**COMPLETE** Taken to Strategy & Delivery Committee

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
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	**COMPLETE (Committee Secretariat checked with Stephen Allen of CHC that this is completed).** Agreed at the meeting held on 14.04.2020 this would be brought after the COVID-19 pandemic.
Actions In Progress					
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	App would not be developed and the perfect ward would be added to the work plan
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.	16.02.21	N Foreman	On February Agenda items 3.1 & 3.2
QSE 19/09/011	Gosport Review	An audit in relation to anticipatory prescribing will be carried out to provide assurance that necessary standards are being adhered with	13.04.21	Carol Evans	To come to a future meeting. This will be included as part of the National End of Life Care audit. – On April Agenda
QSE 20/12/008	Quality Indicators Report	Report about the functionality and aims of the Pressure Ulcer Group	To be agreed	Ruth Walker / Clare Wade	On February Agenda: Item 2.2
QSE 20/12/013	Health Care Standards Self-Assessment Plan and Progress	Provide an update on Health Care Standards Self-Assessment Plan and Progress	16.02.21	Carol Evans	On February Agenda: Item 2.7
QSE 20/12/018	HIW Activity Overview	Provide an update on HIW Activity and reports	16.02.21	Carol Evans	On February Agenda: Item 2.6
Actions referred to Board / Committees					
QSE 20/09/019	Exception Reports – IP&C Position	END mentioned that the Chair had asked for the exception report for	13.04.21	Ruth Walker	Add to April Agenda – IP&C position.

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		the IP&C Position back into the Open Board sessions			

Report Title:	**Specialist Services Clinical Board Assurance Paper**						
Meeting:	**Quality, Safety and Patient Experience committee**				**Meeting Date:**	16th February 2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Claire Main , Interim Director of Nursing** **Catherine Wood Interim Director of Operations**						

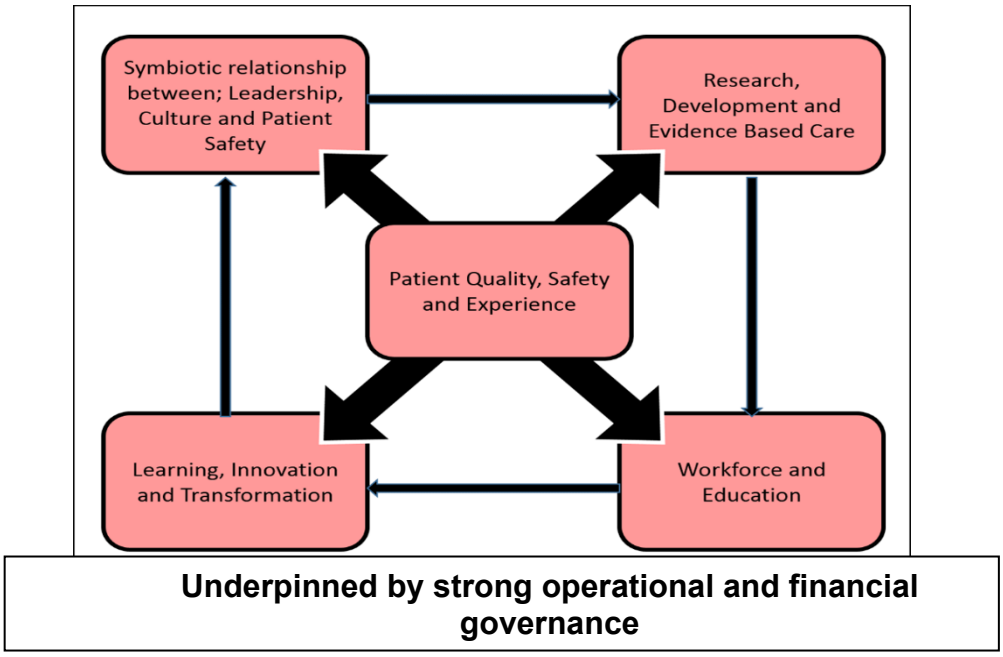
SITUATION

This report provides details of the arrangements, progress and outcomes within the Specialist Services Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It highlights the achievements, innovation and transformational work undertaken to date, and describes key residual risks and their mitigating actions that carry forward into 2021/22.

Quality and Safety and patient experience is at the core of all that we do within Specialist Services, and our operating framework is described below.

Whilst the linkages between Quality, Safety and Experience, and the four quadrants below are often assumed, we have worked hard this year to change the culture within the Board, to make these links explicit.

We have refocussed both our operational delivery, and performance management to focus on the link between the quadrants, whilst reframing the Clinical Boards approach to be more open to risk, innovation and transformation where clear links to improving patient quality safety and experience can be evidenced.



BACKGROUND

During the financial year 2020/21, the Specialist Services Clinical Board comprised six clinical Directorates with associated clinical services and sub-specialties. The Clinical Board delivers a number of highly specialised services serving both the South East region and wider all Wales population as well as providing secondary care services to the local Cardiff and Vale population. The Clinical Board has a budget of £180m and an establishment of 1,820 WTE staff.

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

- Cardiothoracic Services
- Critical Care and Major Trauma
- Haematology & Clinical Immunology
- Nephrology & Transplant
- Neurosciences
- Artificial Limb & Appliance Service (ALAS)

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

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

ASSESSMENT AND ASSURANCE

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

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

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

- Ensure that there is a continuous review of the quality and safety risks and take action to mitigate these on an ongoing basis.
- Proactively support clinically led and managerially enabled transformation that is evidence based and results in improvements in quality, safety and patient experience throughout the Clinical Board.

ASSESSMENT

Governance, Leadership and Accountability

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

The Specialist Services Clinical Board has a well-established formal Quality, Safety and Patient Experience Committee (QSPE) that meets every 3 weeks which is co-chaired by the Director of Nursing for Specialist Services Clinical Board and the Medical Lead for Quality and Safety who is a Consultant Intensivist.

This structure is formally replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; a Health and Safety group and Infection Prevention and Control (IP+C) group. The Health and Safety group meets quarterly and the Infection Prevention and Control group meets bi-monthly. They have formal terms of reference, are formally minuted and have a range of stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda.

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

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

The IP+C meetings have been refocused with updated terms of reference and reviewed attendance. The purpose of these meetings is to assimilate the data obtained from each directorate, evidence based practice and IP+C standards to address key areas of concern within specialist services. This allows targeted areas of quality of improvement with measurable changes, underpinned by fundamental IP+C practices.

The formal governance processes above have been extended within Specialist Services such that we also use them as a mechanism through the performance arena to progress at pace our commitment to an improvement and transformation, supporting the Patient quality, safety and experience agenda.

Improvements have been made to the Performance Management arrangements within the clinical board this year, such that in addition to the traditional metrics, our focus is on key service risks, mitigation and transformation of services. These lenses are applied at every performance review and associated actions agreed and implemented.

Leadership, Culture and Patient Safety

Specific attention has been paid this year to the symbiotic relationship between a visible, transparent and progressive leadership culture and patient safety. The Clinical Board was the first to host a Covid 19 innovation and improvement event to share learning from the pandemic across services in May

2020.

The Clinical Board Team have undertaken a piece of Organisational Development work together with each of the Directorates using the NHS Risk appetite Framework. The learning from this has led the Clinical Board Team to develop a servant leadership model, central to our revised lens on performance. The model is based on the board making a shift from management to leadership, allowing clinical leaders to own and implement decisions, reducing bureaucracy and progress at pace.

The Lightfoot data suggests a seismic transformation of services will be required in order to safely and effectively deliver services post pandemic. An acute focus on the culture described above is essential in delivering this agenda moving forwards.

Whilst our assessment against the Risk Appetite Framework has suggested over the past year the Board has progressed from a "Minimal" acceptance of risk (ie a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential" To an "Open" culture that is willing to consider all potential delivery options while also providing an acceptable level of reward (an example of which is the move of cardiac surgery to UHL). There is a way to go towards reaching "Maturity" and thus six monthly temperature tests of our leadership approach against the Framework will continue into 2021/22.

Risk Register

The Clinical Board receives local updates from Directorates to inform the Clinical Board Risk Register as well as receiving information from commissioners (WHSSC) which may identify risks around service sustainability and offer mitigation in terms of addressing known risks through the annual planning process. The top 5 risks on the Clinical Board risk register in February 2021 are:

Risks	Risk Score	Actions to Manage or Mitigate
Critical Care - Clinical Environment There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and	25	The pandemic has provided both opportunity and threats in addressing these risks The department has expanded across the third floor such that it now has a footprint of in excess of 50 beds. The infrastructure however is not fit for purpose and the lack of isolation facilities is a significant risk. Work is currently underway to create additional storage and staff changing and break facilities within the Peter Grey area adjacent to Critical Care.

also compromises the care of patients where temperature is a critical concern. The well-being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dehydration. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, pharmaceutical storage, device storage and management hubs areas.		
Haematology and Immunology - Clinical Environment There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	25	There is an urgent need for a capital investment program and business case developed to address this need, to support a revised model of care that will span Velindre, Medicine and Specialist Services Clinical Board.
Critical Care - Nursing Workforce There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due to Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	25	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.
Haematology, Immunology and		Access to VCC chemo care on TCTU. Treatment

Metabolic Medicine - TYA Oncology Services TYA cancer patients may elect to have their treatment on the designated TYA cancer unit hosted in UHW. Chemotherapy plans are determined by the site specific MDT/Consultant and facilitated by the TYA cancer Team on the unit. Chemotherapy is currently prescribed by the Consultant or TYA Staff Grade. Chemotherapy may be prescribed in 4 different ways. As a result, there are risks around: -Transcribing of chemotherapy - Lack of oversight of chemotherapy being prescribed by oncology clinician for their TYA patients -Variation in practices between UHW and VCC Overreliance on individuals to make the TYA oncology cancer delivery work, including patients and families to provide history.		plan proforma to be utilised by all TYA cancer patients. TYA team to access and use Canisc.
Cardiothoracic - Clinical Area Relocations and Reduced Footprints Multiple relocations of the level 2 CCU Unit, Pacing theatre, PCI Service and acute cardiology beds have resulted in a number of issues being identified: **1) No of line of sight of patients:** increased risks of unwitnessed patient deterioration & cardiac arrest, unwitnessed falls and inadequate staffing levels for the acuity of patients. **2) Reduced size bed spaces:** restricted use of clinical equipment, patient access and staff activity during emergency procedures. **3) A reduced departmental footprint and increased patient flow:** insufficient space in general & utility areas leading to increased fire hazard, increased IP&C risks, social distancing issues, reduced bed capacity, insufficient consumables & equipment storage, patient care delays and rediced continuity, increased risk of patient complaints, increased pressure on staff resources, restricted flow of staff and patients, limited space to perform tasks, increased noise, communication issues, patient dignity issues (mixed gender unit) and reduced isolation facilities for palliative care, shielding, aerosol generating	15	Staffing establishment increased each shift. Review daily. •Experienced Cardiac nurse in charge of each shift •Increase cardiac monitoring •Nurses to be stationed in each bay to observe patients •Portable monitor for arterial /CVP lines •Limit equipment around bed area •Use storage off ward area (limited) •Privacy : Appropriate use of curtains; explanations to patients •Computer space limited. Staff to use computer in end bay and at reception desk •Pacing theatre: appropriate nurse staffing levels; use of CCU as backup for patients that need post/peri arrest care. •Close communication with bed managers, MDT and senior nurse management •Advice of infection control has been sought for transporting amber patients through Blue zone. •Escalation of critical care services •Reallocation of services

procedures. **4) Compromised service pathways, patient flow & reduced access to other departments:** additional patient ward movements, increased escalation to critical care, reduced emergency support, Amber patients transit via critical care Blue zone, compromised access to the shielding area, compromised 'Treat & repatriate service' and reduced day case activity.		

Other Significant Quality and Safety Challenges

- Lack of isolation facilities – ICU, Haematology
- Lack of en-suite facilities in Bone Marrow Transplant cubicles.
- Deaths on cardiac services waiting lists
- Lack of suitable accommodation to hold Regional MDTs in Neurosciences and MTC
- Ongoing leaks on B1/T4/B3 due to pipe erosion.
- Ongoing nosocomial transmission of covid 19 across Specialist Services

Healthy (Theme 1)
Specialist Services Clinical Board positively promotes the health of our staff and the wellbeing of our patients by proactively encouraging staff to take up the seasonal flu vaccine. As of the 1st of February 2021 we had vaccinated 70 % (an improvement on 63% previous year) of our staff. There is a proactive approach to encourage long stay patients to receive the flu vaccine in both Rookwood and Haematology.

Specialist Services have positively promoted the health of our staff and the wellbeing of our patients by proactively encouraging staff in line with public health guidance to take up COVID Vaccines

Support mechanisms are in place for Staff and Patient Well-being during COVID pandemic, published widely the resources available from EWS, Occupational Health and HR workshops. Bespoke support given by Occupational Health for individual areas (Critical Care, B5)

Due to the impact of the pandemic and working through a significant and prolonged period of stress in critical care the staff, with the support of the psychologist, have begun a programme of peer support. This is facilitated by a group of staff who have undergone additional training and clinical supervision to provide support to colleagues. If well received we will look to implement a similar approach in a number of other clinical areas. The Renal Team have successfully implemented psycho-social virtual peer support groups for renal patients through 2020 supported by the social worker; youth worker and psychology teams. This has included focused support groups for mental health including craft and anxiety groups. Electronic devices have been shared with vulnerable patients to support participation and engagement

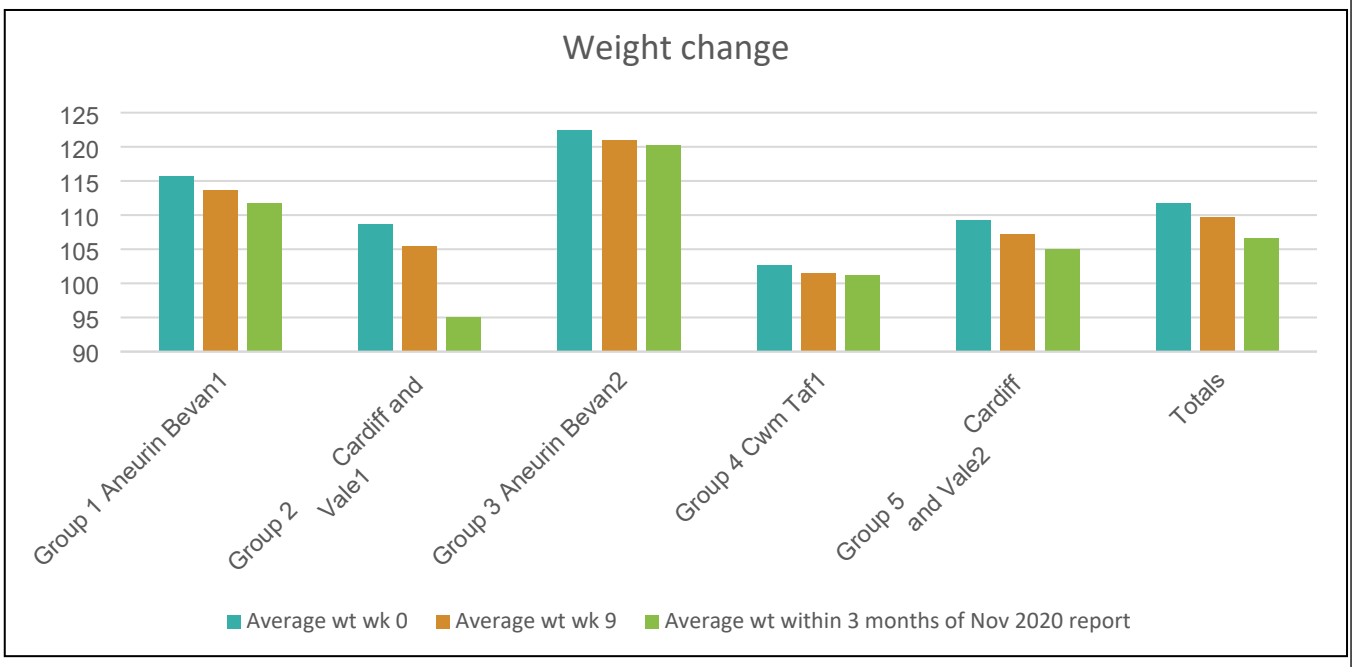
All patients who attend a pre-operative assessment within Specialist Services are if required given advice on smoking cessation, safe alcohol limits and healthy weight management. The ERAS programme has embedded into practice well on Thoracic Surgery This has continued despite the move of Cardiothoracic surgery to UHL. The implementation of the ERAS principles have been successfully implemented in Thoracic surgery by a cohesive multidisciplinary approach to ensure that the :

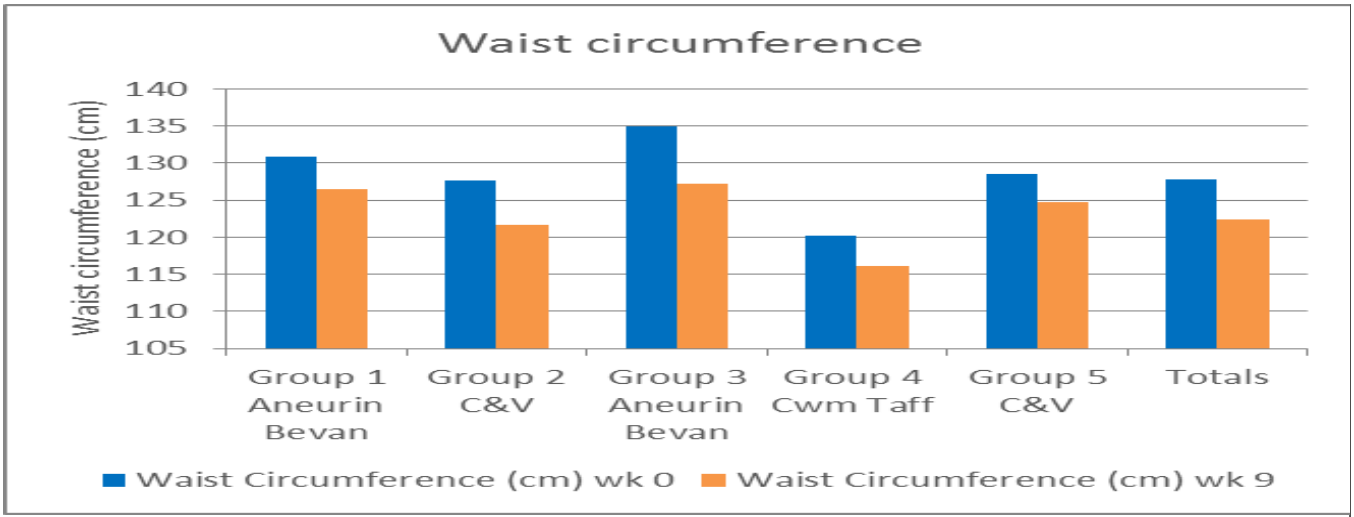
- The patient is in the best possible condition for surgery.

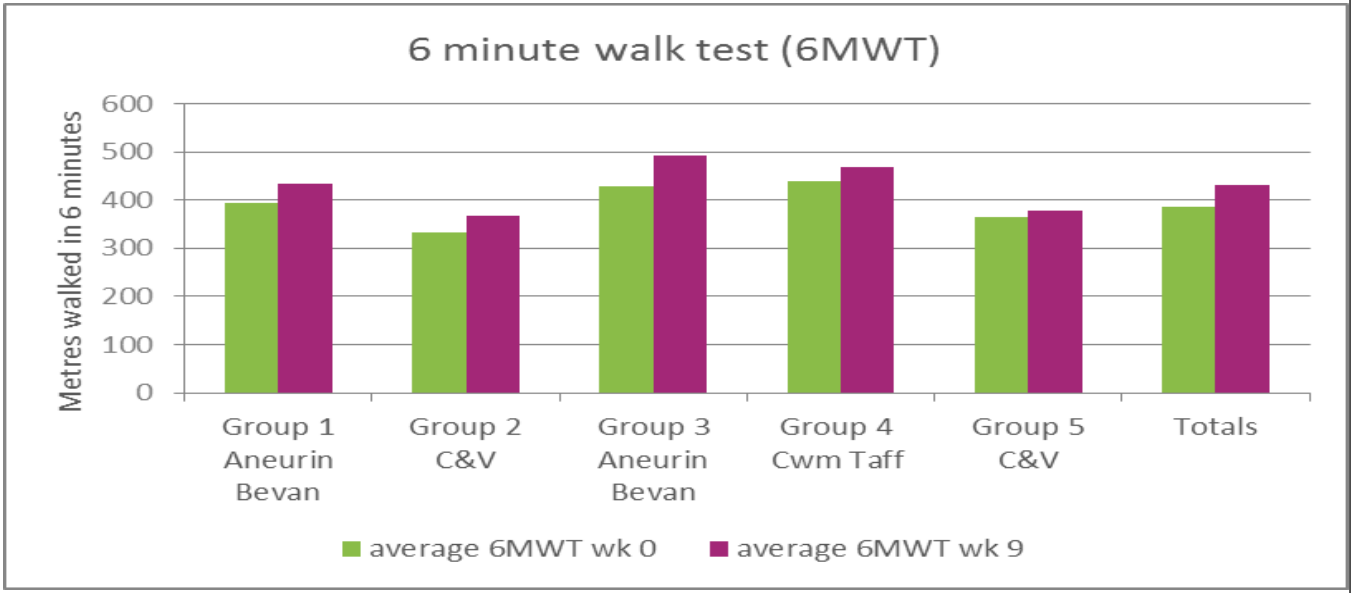
- The patient has the best possible management during and after his/her operation.
- Ensuring the patient experiences the best possible rehabilitation, enabling early recovery and discharge from hospital, allowing them to return to their normal activities quicker.

The next stage is to implement day of surgery admission for appropriate Thoracic surgical patients to improve patient experience and further reduce length of stay. This has currently been postponed due to COVID pandemic

Implementation of a BALANCE Lifestyle Management Programme for pre and post kidney transplant donors and recipients. The aim of the 9 week programme is to promote the best chance of successful kidney transplant / donation surgery and long-term health by improving lifestyle through diet, exercise and behaviour change. This programme has had the following outcomes:







The Balance Programme has enabled 10 patients who would not previously been eligible for transplantation to be added to the transplant waiting list – 3 of which have now been transplanted

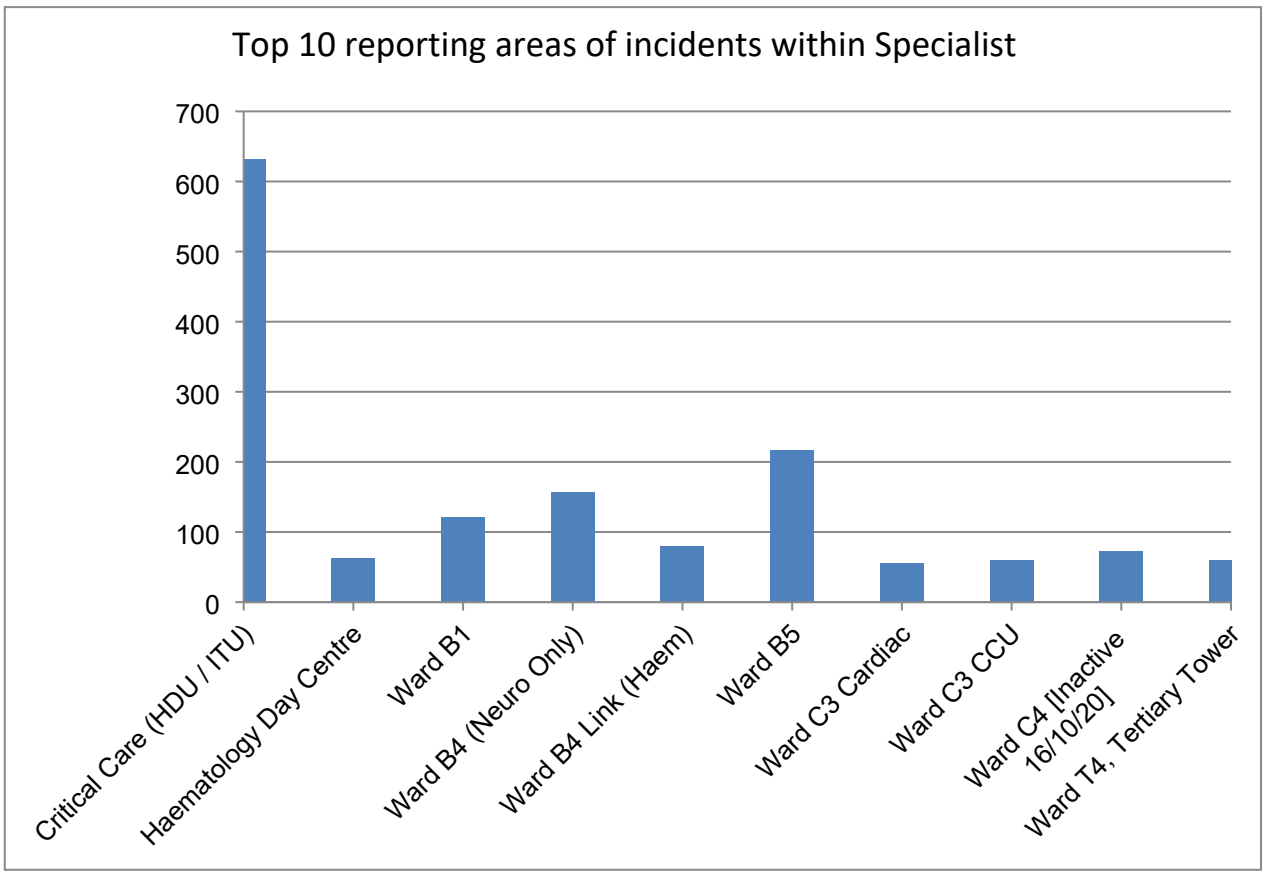
The Specialist Services Clinical Board has proactively driven the dementia agenda over the last 3 years. ‘‘Read about Me’ originated from a group of proactive staff from within the Cardiothoracic Directorate following implementation of a LIPS project. Specialist Services Clinical Board has a dementia care plan and has some very proactive staff who embrace this important agenda.

Safe Care (Theme 2)

Patient Safety Reported Incidents.

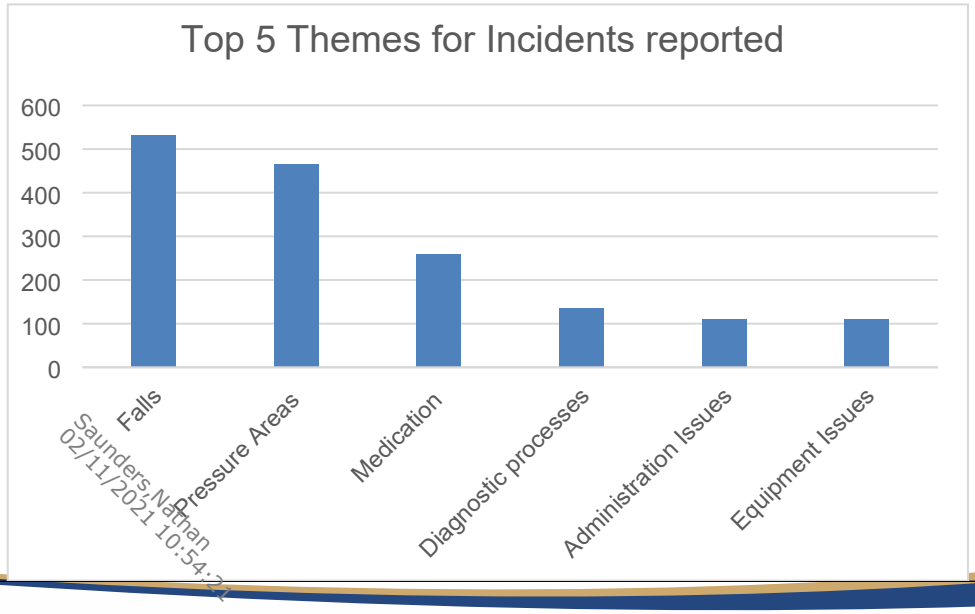
The clinical board had a total of 1838 incidents reported through the Datix management system from April 2019 to March 2020.

On review of these incidents it is clear to see that a significant proportion of these occur within the critical care environment.



With such large numbers of incidents the directorates are taking a structured approach to targeting specific areas through a quality improvement change management process.

There are clear themes detailed within the incidents reported and patterns emerging. The drive for the next 12 months is to not only manage the volume of incidents but to improve the quality of actions taken. This will allow real time reactions to incidents to drive meaningful changes in practices. It is also key to involve the frontline staff in all of these processes so that they have meaningful results from the incidents reported and drive the change from learning from their practice.



Pressure Damage

Pressure damage is an area of significant concern for the clinical board, and there is a plan for a targeted approach in two of the most affected clinical areas, renal and Critical care. Over 300 of these reported are grade 2.

The first part of this is to review these incident areas for themes within the incident reports.
A targeted action plan will then be devised and delivered using PDSA methodology supported by link roles within the clinical areas and supported by the clinical board patient safety facilitator.

This targeted approach in approach has been implemented for an issue that presented as a result of the pandemic. It was identified early in the pandemic that patients were getting device related pressure ulcers from oxygen masks. The team implemented an updated approach to monitor and recording to include checking and observation of ears, with education and reminders through safety briefings. This has resulted in a reduction in pressure ulcers

Falls

Falls Prevention and Reduction
There were 300 falls reported between 1/4/19and 31/3/20 where the level of harm was recorded as minor or greater. Injurious falls reviews have not identified any particular themes for the falls however they have given assurance that UHB policies, protocols and guidelines are being used in Directorates. The Clinical Board 'Falls' Lead is working with the UHB team and has initiated scenario based falls training which is being rolled out across the Clinical Board.

Medical Devices and Equipment

An End of Life Notice was served in September 2020 for Catheter Lab A at UHW active from 31 December 2021. A total replacement of equipment will be required with an estimated capital expenditure of circa £750K. Notification has been escalated to the Capital Management Group. Refurbishment of the lab is critical to enable safe patient care, this will be progressed as a priority across 2021/2.
Sporadic electricity supply issues have been experienced within the catheter labs and outpatient department (T1) at UHW impacting on patient care and safety. The Estates department are investigating cause and possible solutions.

Relocation to Green pathway for TAVI service

Work undertaken by Cardiothoracic team in collaboration with Surgery Clinical board to relocate delivery of the TAVI service following poor outcomes to patient with post-operative COVID. To establish 2 beds in SSSU to deliver pathway. Due to commence 8th February

Serious Incidents and No Surprise Incidents reported to Welsh Government

Between 1/4/2019 and 30/3/2020 there were no 'no surprise' incidents reported.

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

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

Administrative processes	1
Medication	1
Medical Devices	2
Diagnostic processes/procedures	1
Infection control incident	1
Patient accidents/falls	2
Pressure ulcers	4
Therapeutic processes/procedures	3
Total	**15**

Individual Care

- Service informed by service user feedback, comments, concerns, User Group. Integral to ALAS Business Management System ISO9001:2015 accreditation
- ALAS provides services in line with the Social Model of Disability
- Accredited Deaf Awareness and BSL training December 2019
- Introduction of Text messaging from June 2020.
- Use of Video conferencing with captioning from March 2020
- Representation on UHB Sensory Loss Group

HM Coroner's Inquests and Regulation 28 Reports
The Clinical Board has been involved in 67 inquests between 1/4/19 and 31/3/20 (where Specialist Services was the managing Clinical Board). No regulation 28 reports were issued as a result of these.

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

HCAI – Reduction across all incidences as compared to last year

The information below provides an overview of the Clinical Board position from 1/4/2019 and 31/3/2020 together with a summary of the key actions being taken to improve the position.

Clostridium difficile

There were 24cases reported which was a drop from 26 in the previous year and below the target of 28. The cases were spread through a number of areas with small numbers in each.
From April 2020 to December 2020 we currently have only reported 16 cases.

One area that has seen a significant improvement is B5, so the learning from this will be shared.

- **Through effective IP+C measures and ongoing focus from the clinical team, B5 has gone 348 days (and counting) without a hospital acquired Clostridium Difficile case**

Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia

There was 1 case reported and again an improvement from 3 the previous year and below the target

of 3 cases.

Methicillin Susceptible Staphylococcus Aureus (MSSA) bacteraemia

MSSA was improved at to 21 this year, almost half of the previous year. This was just below the target of 23 for 12 months. From April 2020 to December 2020 so far only 13 cases have been reported.

The reduction for MRSA and MSSA has been due to a targeted approach following extensive work to understand the themes developing through the reports of these.

- Strong focus on line related infections across the Clinical Board with a recent dedicated Clinical Board Quality & Safety meeting to agree the approach.
- Revised protocol for non-tunnelled dialysis CVC and tunnelled dialysis CVC following NatSSIPs, improving the governance of these procedures and safety and experience for patients
- Vascular access nursing team have implemented the British Renal Association guidelines for needling assessment to support best practice effective and safe care for dialysis patients. This also aids with early recognition for infection and flow issues with a patient's dialysis access so these can be addressed in a planned way rather than requiring a hospital admission
- Following an increase in MSSA infections, daily Chlorhexidine washes and bi-weekly hair washing with a chlorhexidine shampoo cap were instigated within Critical Care.
- Multidisciplinary approach to implement robust action plan to improve compliance and prevent infections.

Escherichia Coli (E. Coli) bacteraemia

There were 25 cases reported which was a reduction on the previous year of 39 cases and also below the target of 32. From April 2020 to December 2020 we have seen a further 25 cases reported.

P. aeruginosa

8 cases reported for this period. Currently 4 cases are reported from April 2020 to December 2020

Klebsiella. Spp

15 cases reported for this time period. Currently 4 cases have been reported from April 2020 to December 2020.

Effective care (Theme 3)

Improvement, Innovation and clinical transformation

Opening of The Major Trauma Centre (MTC)

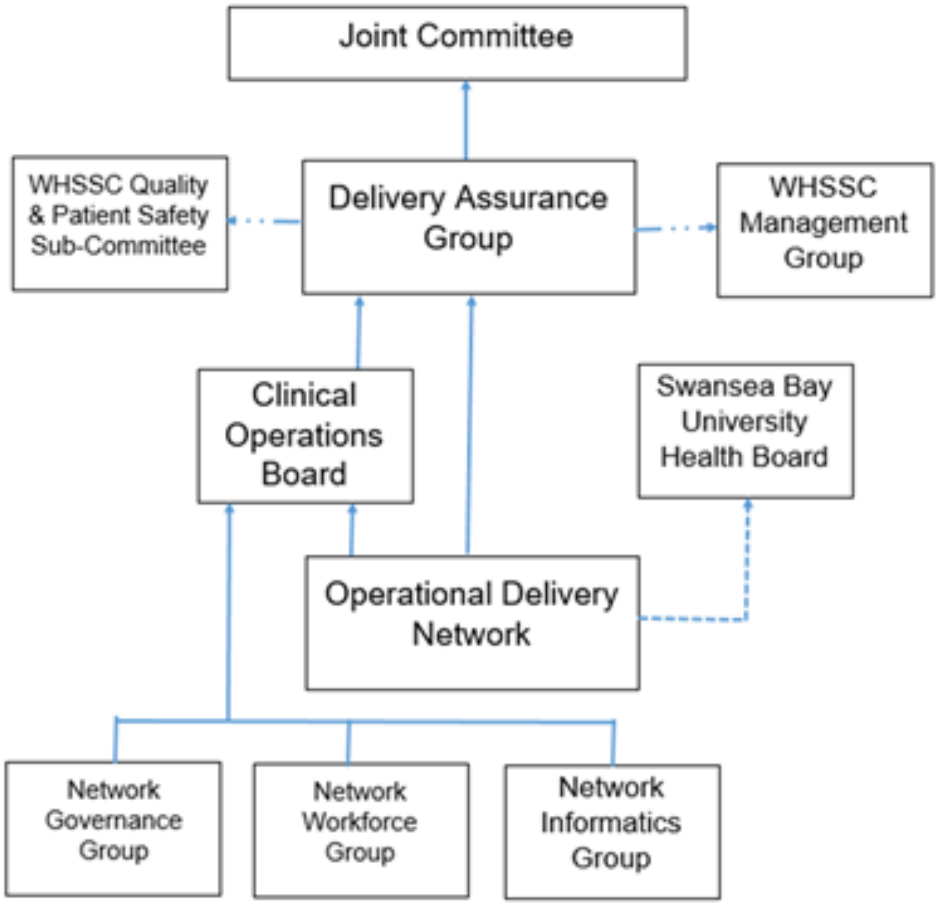
The MTC forms the central component of a Regional Major Trauma Network for South Wales and Powys, and is hosted by Specialist Services Clinical Board. The MTC provides highly specialised services for both adults and children across the regions, in line with the NHS England national service specification for major trauma. This is a material change to patient pathways and is a significant development in improving patient safety and outcomes across the region. The development of the MTC has required recruitment of 180 staff, and significant infrastructure changes, and to successfully launch this service within the context of the pandemic is a remarkable achievement.

The MTC provides early/hyper acute rehabilitation as well as a managed transition to rehabilitation

and the community. In addition to acute care clinicians the service is supported by roles such as the rehabilitation consultant, Consultant AHP, lead therapist and nurse for Major Trauma as well as Psychologist.

MTC – the service recognises the importance of embedding rehabilitation early in the clinical pathway, both in terms of patient outcomes and also to facilitate flow from the MTC back to the local Trauma Units and care closer to home.

MTC - Clinical governance is supported by the South Wales Trauma Network and via the Major Trauma Directorate (MTD), which sits within Specialist Services Clinical Board (SSCB). The Governance structure for the SWTN is illustrated below.



The service runs from a bespoke 16 bedded Poly Trauma Unit (PTU), comprising of 10 ward level beds as well as 6 Level 1 High Care beds. In addition, an outreach pathway is provided to Major Trauma Patients with a single system injury, such as to Neurosciences, Orthopedics, and General Surgery etc., to ensure these patients also benefit from the MTCs acute rehabilitation model.

Admissions to the PTU:

UHB	Average LOS (END OF DEC)	Number of PTU admissions (14 Sept - 31 Dec)
AB	16	21
CAV	14	31
HDDA	53	7
SB	23	8
CTM	18	20
England	20	6
Other	25	2
Total	24	95

MTC - There are nationally agreed quality indicators for an MTC service. There are 52 adult standards and 46 Children's standards in total. An analysis has been undertaken reviewing current CAV UHB services against the agreed national quality indicators. The vast majority were met at the point of MTC launch and plans are in place to ensure the indicators are met over the first 2/3 years of MTC launch.

Local clinical audit lead in post to progress the governance and audit agenda. TARN audit data will be used to support a National Peer Review against the Quality Indicators in September 2021

Continuous review of MT pathway in conjunction with the network. TRID process is the established mechanism to nonconformities.

Key achievements :

- MDT model of care enable to the service to deliver timely, comprehensive holistic care to patients.
- Rib fracture pathway – improved patient experience
- Theatres – consistently timely delivery of MTC CEPOD and urgent theatre access in spite of reduced theatre capacity as a result of COVID
- Repatriation Policy – vast majority of MTC cases have been repatriated in line with the policy in spite of COVID related constraints
- Discharge to home profile exceed anticipated performance, only 23% repatriated to TUs, 40% had been forecasted.

Key challenges :

- T16-2B-107 – CT reporting – time delays. Not delivering within the hot report timescales. COVID compromise the 'direct to CT' protocol.
- 16-2C-121/218 - Patient Experience - TARN PROMS and PREMS. TARN performance variable and sustainability issues within the audit team.
- T16-2B-118/216 - 24/7 Specialist Acute Pain Service – this service does not current cover all Major Trauma patients
- Clinical frailty score – no geriatric input into the PTU. Inequitable care across CAV.

Local clinical audit lead in post to progress the governance and audit agenda.

Continuous review of MT pathway in conjunction with the network. TRID process is the established

mechanism to nonconformities.

Clinical Innovations

Significant changes in practice – TTM Trial results changed the European Resuscitation Guidelines on post cardiac arrest treatment – TTM2 due to be published and presented in March. Sedation studies – SPICE III and A2B have changed sedation practices. SUP-ICU has changed stress ulcer prophylaxis treatment. HOT-ICU was published this month and will influence the use of oxygen in critically ill patients.

- During the Covid-19 pandemic Critical Care has been one of the consistently highest recruiters nationally for Covid-19 specific studies. 95% of Covid-19 positive patients have been enrolled into a clinical trial. These trials have been the first worldwide to show effective treatments for Covid-19 including the **RECOVERY Trial** (Identified Dexamethasone as an effective treatment)
- Critical Care ran two compassionate use programmes, one for the antiviral drug **Remdesivir** which helped inform practice on how best to use this drug in the treatment of Covid-19, and the second for a novel biological agent LFG316. The LFG316 treated patients were the first CoVID-19 patients in the world to receive this agent and several made full recoveries and went home
- **Hepatitis C Transplantation.** In 2019 the Cardiff Transplant team achieved the status of the first team in the UK to successfully implement a change in policy on the use of Hepatitis C viraemic organs into Hepatitis C negative recipients.

Traditionally, these organs could not be used for transplant. The availability of direct acting antivirals (DAA) with very high cure rates potentially made these organs available for use.

Established relationships and collaborative effort between the transplant team, infectious diseases, virology, pharmacy, our patients, Welsh Government and NHSBT enabled this change to take place.

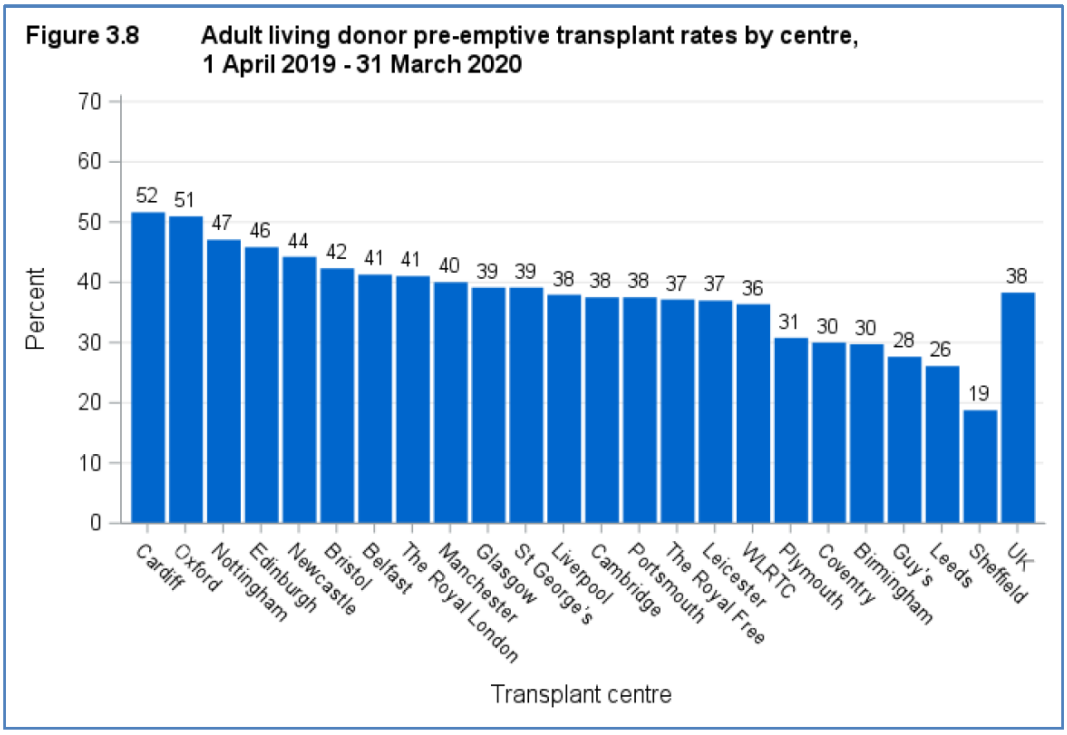
On the 26th May 2019 Cardiff Transplant Unit performed the first 2 transplants from confirmed HCV positive donor into 2 suitably consented recipients who did not have hepatitis C themselves.

These were the first transplants of this kind in the United Kingdom. Within the first 8 months of the programme 9 transplants had been performed.

Following this success the programme now includes those patients waiting for a pancreas transplant as well. This should increase the amount of transplants performed within our unit.

- **NORS (National Organ Retrieval Service)** team have been trained and implemented the governance processes to enable them to undertake Normothermic Regional Perfusion retrievals. This has been supported and endorsed by Welsh Government and NHS BT. There are only 2 other centres that provide this across the UK and will enable the team to build a further strong profile in the future of NORS provision

- The below data was highlighted on 27th January 2021 at the national renal services meeting demonstrating Cardiff as top unit in the UK for the gold standard of pre-emptive transplantation



- UK Renal Registry Audit report most recent publication places Cardiff as 4th in the UK for the percentage of adult patients incident to dialysis in 2018 who started dialysis using either an arteriovenous fistula (AVF) or an arteriovenous graft (AVG)

- **The implementation of CAR-T therapy**
  Advanced cellular therapies are new and emerging medicines offering potentially curative options for patients with chronic conditions, including cancer, where standard therapies have effectively 'run out'. Unlike conventional medicines, these therapies aim to selectively remove, replace and re-engineer a patient's own cells/ genes to allow restoration of normal function / elimination of disease.

- CAR-T cell therapies are amongst the first in the pipeline of cell therapies transitioning from 'bench to bedside' for both malignant and non-malignant diseases. They are considered to be highly innovative personalised treatments offering potentially effective therapy with severe but manageable adverse events (AEs) which require specialised monitoring and management

- Haematology Directorate now host an Extracorporeal Photopheresis (ECP) service for patients with chronic GvHD (2020)

- The Blood and Marrow Transplant team now have access to ECP services for their patients on-site. The On-site services ensures that patients from South Wales have local access to treatment and negate the need for them to travel to Bristol. Often patients were too sick to travel which precluded them from accessing this treatment.

- NHSBT are supportive of the change in service aspect. The service is now provided as a 'spoke' site from the Bristol NHSBT hub unit with NHSBT offering regular outpatient services . Patients have been massively appreciative of the change in service model which allows them to receive treatment closer to home.

- NICE have recently approved several other indications for CAR-T therapy, and thus an extension of this service, within an appropriate, fit for purpose clinical environment (as well as its links with the Acute Oncology Service, and Bone Marrow Transplantation) is a key priority for the Board in2021/22

Patient at Risk Team (PART)

The Royal College of Anaesthetists (RCoA) undertook an external review of intensive care services in the UHB (Published April 2019).

Under '*immediate actions'* it was recommended that the UHB adopt a single critical care outreach model across all acute clinical settings.

In order to fulfil this recommendation the implementation of a Patient At Risk Team (PART) has been agreed. This is a significant investment in patient safety by the Health Board of 2 million pounds in revenue to support this exciting development. Recruitment to the keys roles to start the roll out of this project is underway. Once operational the benefits of the PART team are significant and are described below

Patient care:

- Delivers timely escalation of care to those patients who are most likely to benefit from intensive care admission. This is likely to improve critical care outcomes by reducing delays to definitive treatment.
- Improves access to palliative care ensuring that those patients destined to die do so with dignity and comfort.

Provide Equity of care at UHL

- Support the treat and transfer model at UHL – improving safety of acute specialties
- Support Rookwood when the service moves there in April 2021
- Provides support for Hafan y Coed

Service/System benefits

- Releases Anaesthetic time – enables improvement in time to theatre for emergency cases
- Releases Anaesthetic time to Support MTC
- Improves flow through EU
- Improves timely access to ICU and decrease in length of stay
- Supports Hospital at Night Junior Drs –particularly in the context of zoned wards
- Enhances training opportunities for ward staff in the recognition and management of acutely ill patients

Key Quality Improvement Projects

Introduction of a Full Blood Count analyser in the Day Centre – patient and service benefit

Up to 40 patients per day typically attend the Haematology Day Centre (HDC) who all require blood samples to be taken and analysed before treatment (including chemotherapy) can be delivered, and historically these samples have been processed via the main Biochemistry Lab at UHW with a typical turnaround time of at least 2 hours, but this can be much longer. This delay often resulted in a poor patient experience and clinician frustration as treatments were being delayed which also had a detrimental impact on the efficiency of the HDC. For many years the directorate has been aware of the potential benefits to utilising an FBC analyser at the point of care in the HDC which has a turnaround time of a few minutes.

The majority of the patients attending the HDC for treatment have a cancer diagnosis and will be receiving chemotherapy or palliative care. Numerous patient satisfaction surveys have indicated that a major source of concern and a potential area for improvement is the timely receipt of blood sample results as patients are unable to proceed with their treatment without these results being available to the clinical teams. Patients understandably do not want to be in the HDC for longer than they need to be, and the clinical teams want to deliver treatment to patients in a timely manner. At the start of the Covid pandemic the team were given the opportunity to utilise an FBC blood analyser on a trial basis which has now been in place for approximately six months. This analyser has proven to be very successful in reducing waiting times for treatments, improving the patient experience and the efficiency of the service provided.

It is hypothesised that the pilot will demonstrate

- Improved efficiency of the service
- Improved patient satisfaction
- Reduced waiting times for treatments
- Clinician satisfaction
- Timely delivery of treatment for patients

Pilot of a catheter-directed therapies programme for the treatment of large-volume pulmonary embolism at UHW

Pulmonary embolism (PE) is responsible for hundreds of thousands of deaths in Europe every year. It is the third commonest cause of cardiovascular death and a major cause of in-hospital morbidity and mortality.
Current treatment strategies are based around a simple assessment of blood pressure. If systolic blood pressure is less than 90mmHg, the patient should receive systemic thrombolysis. If not, they should receive simple anticoagulation. This leaves a substantial number of patients in an intermediate risk group, some of whom have a risk of death or haemodynamic collapse of up to 20% in the first seven days from the recommended strategy of simple anticoagulation. These patients require new and better treatments than waiting to see if 1 in 5 of them will come to serious harm through standard of care. Additionally, many patients with low blood pressure due to PE cannot receive systemic thrombolysis as the bleeding risk is too great (post-operative patients for example)
Professor Sharp, Consultant Cardiologist at UHW, runs a clinical and research programme looking at catheter laboratory treatments designed to remove or degrade the clot within the lungs that causes destabilisation of the patient and death. These treatments are now available and in demand from multiple divisions across UHW, particularly given the increased rates of thrombotic complications associated with CoVid-19. A service evaluation pilot of the impact and efficacy of these treatments is currently underway. The data is being collected with the ambition of establishing catheter-directed treatments for PE as a routine clinical service at UHW, which will also build a foundation for a ground-

breaking research programme.

STEP UP PROJECT - Effectiveness of a high intensity rehabilitation area for post critical care rehabilitation versus standard care: A pilot randomised control trial

- This project builds on a small scale test of change that implemented an enhanced therapy model for ICU patients that resulted in an 8 day reduction in length of stay on the ward. It is clinically designed and managerially enabled and Multi-disciplinary, Cross board collaboration from Specialist Services, Clinical Diagnostics and Therapies and Medicine
- Aligns to: Outcomes that matter to people
- Quicker return to home Improved functional outcome

Primary aim: To compare length of stay from point of decision to discharge from critical care until discharge from hospital for those admitted to the high intensity rehabilitation area compared to standard discharge practice

Secondary Aims :

To compare each of the following for those admitted to the high intensity rehabilitation area compared to standard care

Ward length of stay (after discharge from critical care)

Delays in transfer of care from critical care to ward

Re-admission rates to critical care

Physical and psychological function on hospital discharge

Support required on discharge

Return to work at 3 months post discharge

Patient satisfaction

Staff satisfaction

Staff resource requirements

Health economics analysis

Research and Development

- One of the highest recruitment rates for critical care research in the UK and Europe
- Innovative 24/7 recruitment model – only ICU in UK who do this
- Over 2000 patients recruited into clinical trials in the last 5 years
- First ICU in UK to use a 'cluster guardian consent model' for a trial – RGNOSIS
- >70 original research publications in the last 5 years – > 40 with an impact factor >5. Authors are doctors, nurses, AHP's
- Publications in the highest ranked medical journals worldwide –

4 NEJM publications (will hopefully be 5 by next month), 1 in JAMA.

This is the highest number of NEJM publications for a department in Wales.

PREMS and PROMS

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

This has already resulted in a publication in British Medical Journal with more to follow as the study evolves.

- Participation in the UK Kidney Patient Reported Experience Measure collected from October through to November, high response rate across all areas (approx. 500 responses awaiting final numbers). Results due in April 2021, but indications have been given that Cardiff has moved from the lower range of reporting into the top 10% of units within a twelve month time frame.
- As a result of this the Renal Registry is currently exploring with KQuiP to write a case study with Cardiff on engagement with patients and carers across all aspects of renal pathway.

PREMS and PROMS work embedded in Heart Failure patients within Cardiothoracic Services.

Supportive Care Programme

In 2016 a pilot project started between Palliative care team and the Heart Failure team developing Supportive Care for Heart Failure patients. This seminal work has driven a service that listens to this patient group, enables them to make an informed decision and allow them to design the pathway of their care and ensure they can spend their last days in their place of choice. This is now an integral part of the cardiac service

Following on from this a very similar group of patients has been identified within the renal service and work is underway to scope out the service for patients with end stage renal failure who choose to have conservative management and now will have the option of a formal supportive care programme.

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

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

Dignified Care (Theme 4)

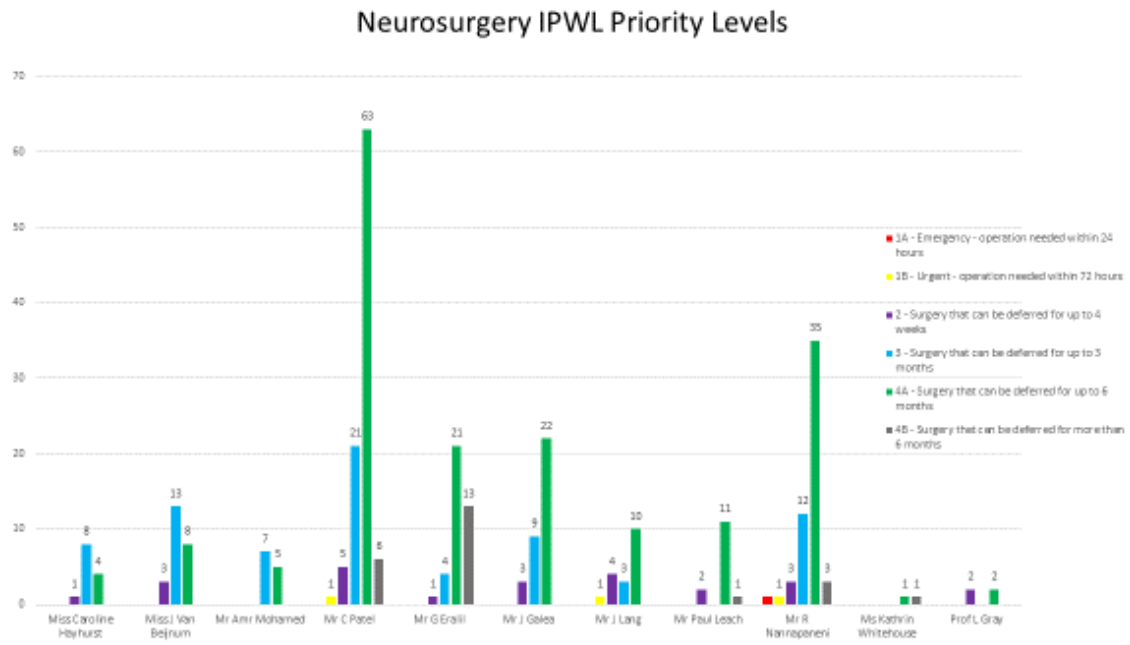
Dignified care Inspections and CHC Inspections carried out in 2019-2020 have not identified any areas of significant concern.

Timely Care (Theme 5)

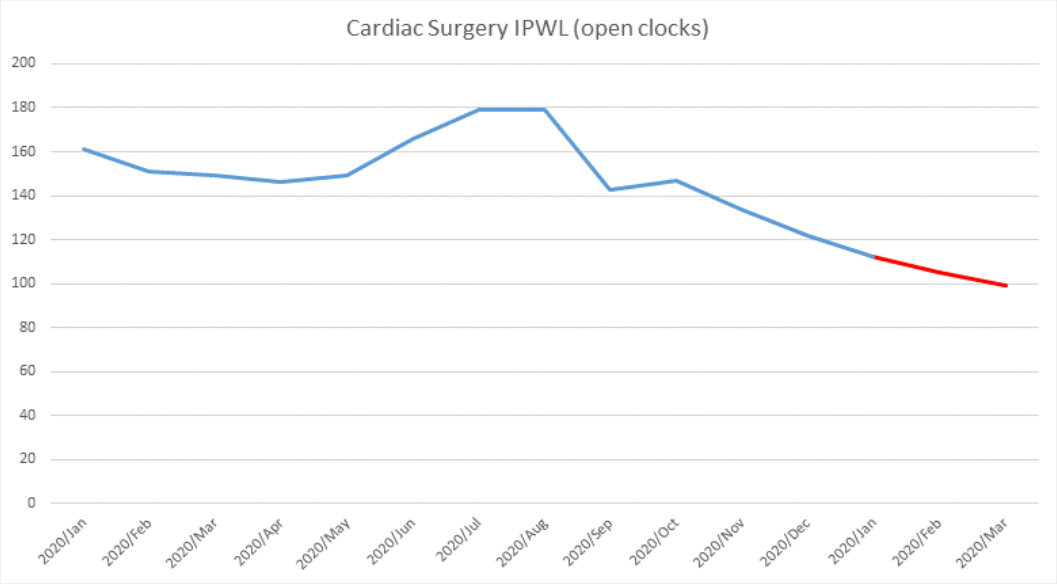
The impact of the requirement to step down or reconfigure services as a consequence of the pandemic has had a significant impact on access to care. All of our inpatient and outpatient waiting lists are regularly reviewed by the clinical teams, and patients treated in order of their clinical risk in contrast to the traditional RTT approach.

This has led to significant changes in shape and volume of our waiting lists, with particular impacts seen across Cardiac surgery, neurosurgery, cardiology and neurology outpatients. Haematology and Neurology have remained stable

A break down of the patients waiting by RCS category for Neuro Surgery may be seen below.



Timely access to cardiac surgery has been one of the highest Clinical Risks (RR 25) for the Clinical Board for several years. At its peak there were 180 patients waiting for cardiac surgery, with significant numbers waiting over 36 weeks, and unfortunately several instances of deaths on the waiting list. A piece of clinically led transformation has been undertaken this year to create a "green" pathway for cardiac surgery patients, which has seen the service move from UHW to bespoke, ring fenced facilities at UHL. The move has had a significant impact on the number of patients waiting, with a 50% reduction anticipated by the end of March, the improvement trajectory is outlined below.



Cardiology Treat & Repatriate Service

Continued success even during the COVID pandemic of the South East Wales Regional NSTEACS service has supported delivery of coronary angiography and PCI to 80% patients within 72 hours as per national guidelines. Positive impact on patients length of stay following implementation of service which now includes UHL reducing the average bed stay from 8 days to 3 days.

- Successful management of COVID positive patients across the dialysis units to maintain the community –based model of care and ensure that patients had access to three-times a week treatment through the pandemic. This approach has meant that we have not overwhelmed the inpatient ward capacity. Approach taken has been a partnership proactive approach with both ISPs and WAST, and includes a weekly review and planning approach for dialysis care.

- Adapted transplant programme and implemented clear pathways to enable the safe re-opening of the programme in June 2020. This has included a system to regularly screen the patients on the waiting list. Programme has undertaken 40 transplants until December 2020 – 8 of which have been live donors.

- Home haemodialysis patients take their own bloods from their dialysis machine to return to GPs to enable virtual review and reduce the need to attend outpatients or a GP to have bloods taken

- New pathway work through the David Thomas Dialysis unit for patients to be treated through ambulatory emergency pathways instead of requiring inpatient admission. This has included access to Interventional radiology that would previously would have involved an inpatient admission and potential wait for access

- UK Renal Registry Audit report most recent publication places Cardiff as 4th in the UK for the percentage of adult patients incident to dialysis in 2018 who started dialysis using either

an arteriovenous fistula (AVF) or an arteriovenous graft (AVG)

Critical Care
Demand and capacity modelling undertaken in 2014 indicated that 50 Critical Care beds were required to meet the needs of the population. Critical Care has consistently fallen short of this number, but the advent of the pandemic saw the physical footprint of the unit expand across the third floor to a unit with fifty plus physical bed spaces. The geography and infrastructure of the unit poses particular challenges to the running of a modern ICU service, shortage of isolation spaces, storage, IT etc. However, these issues are currently being addressed with the opening of additional staff rest areas and storage facilities planned for the 8th of February. Work to modernize the infrastructure will be ongoing throughout 2021/2, a key enabler for which is anticipated to be the relocation of the Coronary Care Unit. Recruiting and retaining a suitably qualified and experienced workforce to keep pace with the physical expansion will also pose a challenge in 201/22, and new ways or working and extended and modernised roles supported by education are currently being explored.

<u>Individual Care (Theme 6)</u>

Concerns, Compliments and Claims

This is an area of significant progress for the Specialist Services Clinical Board in terms of providing timely and effective responses to patients, relatives and carers. Between and 01/04/2019 and 30/3/2020 the Clinical Board received a total of 380 concerns:

Formal concerns

88% were responded to within the 30 day target. The Clinical Board has a robust process in place for tracking concern responses and the Clinical Board benefits from good clinical engagement from the multi-professional teams in undertaking notes reviews and providing statements.

Informal concerns

102 of these concerns were managed through an informal response route and closed with no further action needed.

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

Compliments
The Clinical Board has received 25 compliments which have been logged formally. The main focus of compliments have been to highlight the care received by staff and compassion shown during end of life care. These are shared with staff appropriately.

Claims
The Clinical Board has had 17 clinical negligence claims opened between 1/4/2019 and 31/3/2020 which are split between the following Directorates:

Critical Care (3)
Neurosciences (8)
Nephrology & Transplant (2)
Cardiothoracic (4)

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

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

Critical Care follow up clinics learning from patient experience

In September 2020 Critical care began a supportive clinic to follow up patients discharged from critical care. This was a true multidisciplinary approach to reviewing patients, with medical, physiotherapy and psychology disciplines involved to tailor a support programme for these patients. Many of the initial patients into this service are Covid survivors so this has led to close working relationship with the respiratory team to deliver appropriate follow up care.
Although this work is in its infancy, listening to the patients experience is not only helping them process what has happened, but also for the team to understand first hand from the patients what is needed from the service. Early indications are showing there is a need to standardise some medication pathways to manage on discharge, the importance of the environment, especially noise and time for patients and the types of interactions that patients can remember. The plan is that this will be reviewed for trends as the clinics continue and also to share patient stories with staff to help them to process what is achieved for these patients, thanks to their time in critical care.

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

Staff and Resources (Theme 7)

Finance -

The Clinical Board had prepared for 2020/21, with a solid foundation of successive years of maintaining a small underspend against its budget of £180m and a full programme of saving schemes to achieve an efficiency target of 3.5%. However, the need to respond to the COVID pandemic has had a significant impact on how the clinical board has reorganised itself and this is reflected in its financial performance.

The following table details the Clinical Board's financial performance against its budget for the 9 months to 31 December 2020 and analyses the budget variance in the context of responding to Covid 19.

	Budget (£000)	Actual (£000)	Variance (£000)		Operational variance (£000)	Additional expenditure (£000)	Savings not achieved (£000)	Reduced planned exp. (£000)	Total variance (£000)
Income	(2,877)	(2,572)	305		(30)	335	0	0	305
Pay	73,292	73,062	(230)		(1,598)	2,243	0	(875)	(230)
Non-Pay	62,773	65,443	2,670		1,151	1,408	2,458	(2,347)	2,670
TOTAL	**133,187**	**135,932**	**2,745**		**(477)**	**3,986**	**2,458**	**(3,222)**	**2,745**

The table shows that the clinical board has a budgetary overspend of £2.7m. This can be explained as:

- a small operational overspend of £0.5m;
- additional expenditure of £4.0m to respond to the pandemic, especially in critical care where staff have worked tirelessly and additional drugs and other clinical supplies have been needed;
- Many of the planned savings have had to be put on hold causing a variance of £2.5m. The saving schemes will be revisited in the next financial year. Our working assumption is that at some stage during 2021/22 many of these will be able to be implemented; and
- there are areas, especially within surgical specialties, where planned expenditure has not occurred. This is a £3.2m reduction.

It is emphasised that these significant budgetary variances to the clinical board's financial plan, illustrate the extent to which services have been reorganised and staff have been redeployed to support the COVID response.

Despite the pandemic, during 2020/21 a number of service developments and significant investments have been implemented, which will have benefitted a range of patients, not only for the population of Cardiff and the Vale of Glamorgan, but also in communities across south and west wales. Examples are:

- The establishment of a major trauma network with a major trauma centre at UHW. The establishment of an MTC has been a huge undertaking requiring investment of £11m and recruitment to over 200 posts.
- Expansion of a network for patients from across Wales with inherited bleeding disorders and investment in a sustainable service for patients with hereditary anaemias, such as sickle cell anaemia, which have a greater prevalence amongst some BAME communities.
- Significant recruitment across all disciplines to support Critical Care

Unfortunately, the pandemic has meant that some planned developments have not progressed as intended. For example, the planned establishment of a 6 bed long term ventilation unit for patients across south wales has had to be put on hold and the monies have been returned to WHSSC. This implementation will be resumed in 2021/22.

Workforce Achievements during 2020/21

The past year has not been a typical year and has been very challenging for the UHB due to the impact of Covid 19. The Clinical Board however has risen to the challenge and supported the UHB's service pressures by deploying its staff to where they were needed most and ensuring safe patient care is not

compromised. Critical Care faced significant burdens on their service as patient numbers increased from their usual capacity of 32 beds to 54 beds. This put significant pressures on the staff and as a result a number of wellbeing initiatives were implemented to offer support.

Some of the key workforce achievements for the past year include:

- Delivery and implementation of a workforce strategy for the Major Trauma Centre which involved the recruitment of 178WTE over multiple professions. By September 2020, 83% of these posts were recruited to and the service could commence.

- Successful recruitment within Critical Care, heralding a full Consultant establishment for the first time in a decade.
- Pre-covid Critical Care Turnover had reduced from 19% to 16% - against a National average of 24%

- Working in partnership with the Trade Unions and staff to prepare for the transfer of the services at Rookwood Hospital to UHL. This included regular staff meetings, Q&A updates and individual support for staff

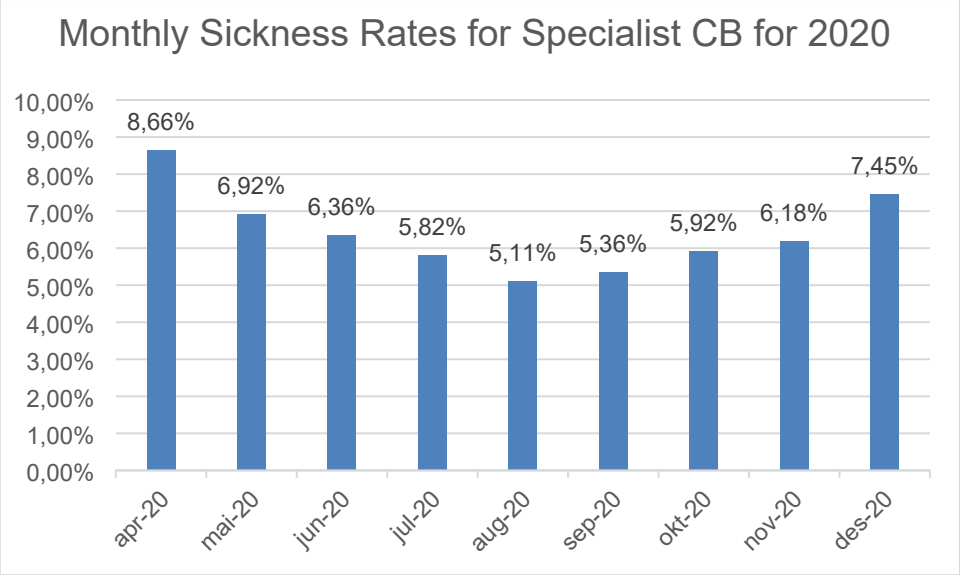
- Reinforcement of values and behaviours – any incidents reported were dealt with swiftly with meetings with the individuals concerned and followed up in writing.

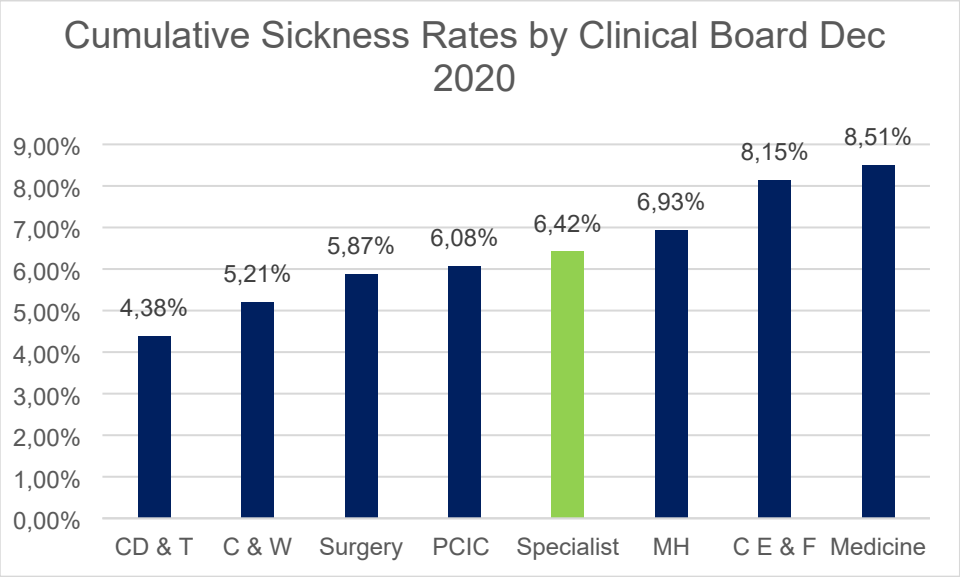
- Undertaken a number of pulse surveys in a number of departments and wards with staff to identify job satisfaction and morale. This was followed up with facilitated sessions to develop action improvement plans. These will be evaluated over 201/22.

- There have been 8 secondment opportunities for managers and professional leads within the Clinical Board to progress to more senior roles which has been a positive move for the Board's succession planning

- Agile working took a major step forward due to the need to be able to work from home as a result of the Covid 19 restrictions. Undertaking the majority of meetings via MS Teams has had a major impact on saving time and travel. This way of working has also provided additional flexibility for staff to optimise worklife balance.

Sickness Absence
Sickness absence with the Clinical Board mirrored both the first and second waves of Covid 19 where peaks were experienced during April and December. Although Specialist Services generally has the lowest rates of sickness within the UHB, the past year has been an exception.





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

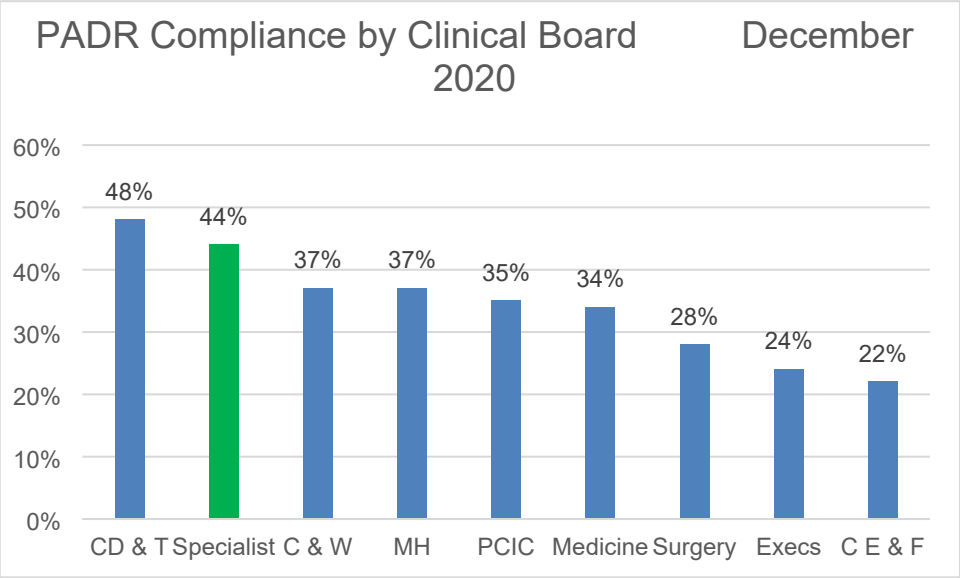
- Support for managers with both short and long term absence
- Bespoke training by the Workforce & OD Team
- Sickness Absence surgeries with Line Managers, to discuss individual cases
- Audit programme, focussing on hot spot areas to check
- Health & Wellbeing Promotion via sickness surgeries and training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

Employee Wellbeing

Support mechanisms in place for Staff Well-being during COVID pandemic, published widely the resources available from EWS, Occ Health and HR workshops. Support given by Occ Health for individual areas

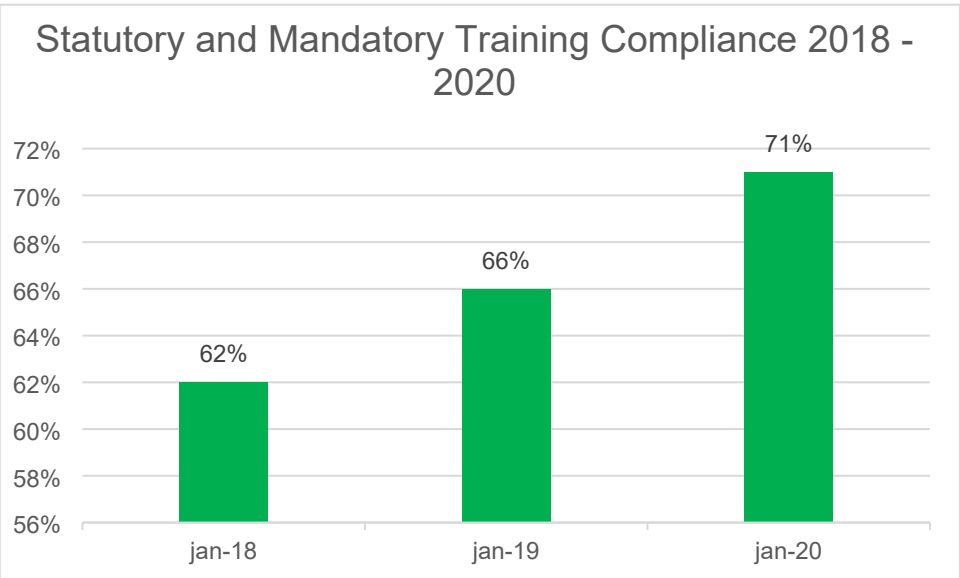
Performance Appraisals

The Clinical Board is currently holding second position within the UHB with regard to PADRs. The rate has dropped significantly from last year however this is as a result of services having to react to the pressures of the Covid 19 Pandemic which has had a big impact on management capacity to undertake PADRs. This will be addressed during 21/22 to improve on the current performance.



Robust performance management arrangements to improve PADR compliance will be instituted as "Business as Usual" returns over the course of 2021/2

There has been an ongoing improvement with regard the statutory and mandatory training compliance over the last 3 years. The current rate is at 71% which is the highest achieved to date.

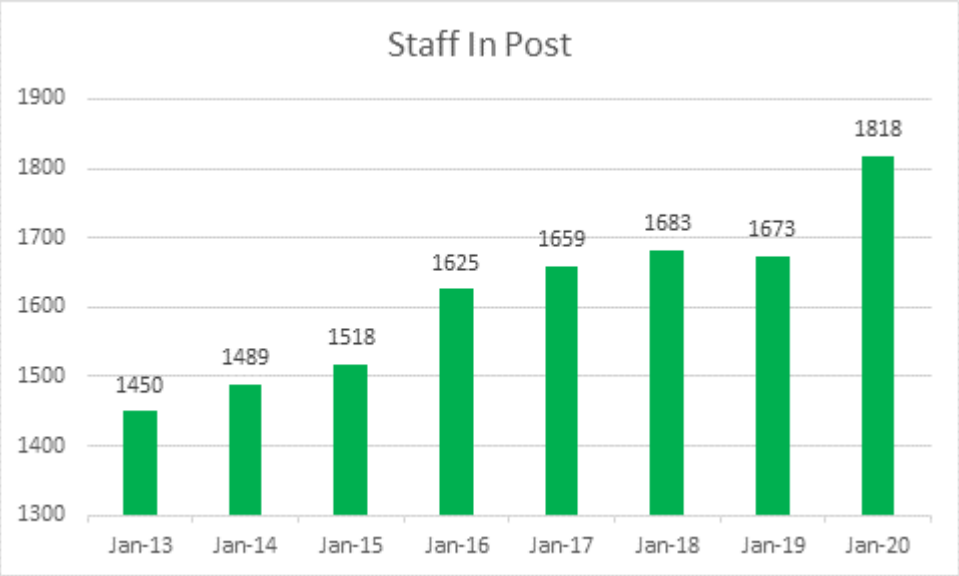


Newly Created roles – modernising the workforce

- Nurses taking on the role of PI. Lead Research Nurse was PI for HOT-ICU Trial. Largest trial of oxygen targets in the ICU ever conducted. Published in NEJM this month
- First Critical Care Research Team Lead Nurse post in Wales created and appointed into

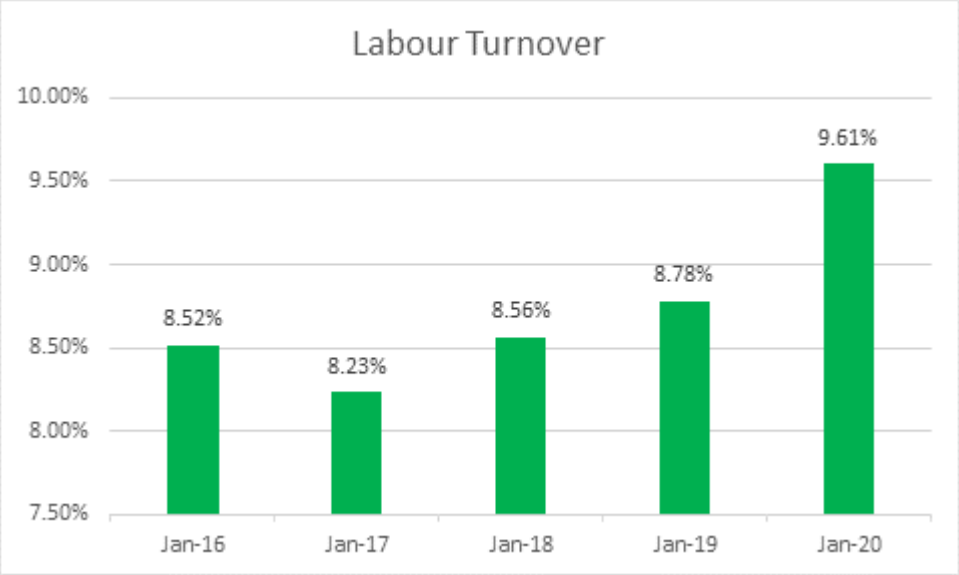
- First nurse prescriber for critical care research trials
- Nurse Consultant in Immunology appointed

Recruitment



- The Clinical Board has had a very successful year with regard to recruitment as 65 nurses were recruited from Student Streamlining. Critical Care has been very effective in attracting new recruits with 20 overseas nurses and 27 nurses as a result of general advertising
- Dedicated supported 4-6 week supernumerary time for all new registered staff joining a ward.
- Keeping in touch days where UHB staff contact staff those who have been appointed but may not be commencing employment for a few months. Specialist Services invite them into the workplace to talk to them about new initiatives and give them opportunity to meet with staff in the team they will be joining.
- Student Streamlining awareness events in CVUHB, at local Universities and recruitment events.
- Student Streamlining social media campaign.
- Social media recruitment videos.
- Recruitment events, both local and national in the U.K.

Retention



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

Staff engagement

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

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

Awards and Recognition

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

Awards won in past 12 months

- 2020 – Jade Cole. Queen's Birthday Honours List. BEM for services to the NHS and

Critical Care Research

- 2020 – Dr Matt Morgan. Faculty of Intensive Care Medicine (FICM) NIHR Clinical Research Network Consultant Award
- Ward Deputies (B5) being awarded the Liz Baker Award.
- Tracey Roberts (Ward Manager0) highly commended of commitment to patient care (Renal Network)
- 2 Nurses in Haematology nominated for RCN Nurse of the Year – Winner for advanced and specialist nursing and (2019)
- The Immunology & Allergy Team won an award for World Patient Safety Day (2020) - they won the award for their work to train as many patients as possible to undertake subcutaneous immunoglobulin (SCIG) treatment.
- 2020 Claire Main awarded Jane McDonald Leadership Award for Outstanding Leadership in the renal community

Key Priorities for2021/22

Development of the Haematology Oncology Service in collaboration with the Acute Oncology Service and Velindre

Build on progress re ICU infrastructure and workforce

Embed the use of Lightfoot Data and methodology to inform how we reconfigure our services post – pandemic. Extend and progress the cultural change within the Board that focuses on clinically led managerially enabled change informed by data. Both elements are vital in delivering the scale and pace of transformation required over the next 12 months to recalibrate services post covid.

Recalibrate cardio thoracic services - return from UHL with no deleterious impact to activity, reconfigure to a fit for purpose location for Coronary Care Unit

Implement remedial strategies to return to a balanced financial position

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

improve quality, safety and patient experience

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the progress made by the Clinical Board to date
- **NOTE** the approach being taken by the Clinical Board
- **APPROVE** the content of this report and the assurance given by the Specialist Services Clinical Board.

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

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Quality Indicators – progress report**						
Meeting:	Quality, Safety and Experience (QSE)				**Meeting Date:**	16/02/2021	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Excutive 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.

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 was returning to pre-covid rates. Welsh Government have however put in place again in January 2021, a more limited reporting requirement for Serious Incidents due to the on-going workforce challenges of the pandemic.

The number of SI closure forms submitted to WG improved during Q3 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 95 open SIs, which is an improvement when compared to the numbers open in December 2020.

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. Considerable work has been undertaken in the organisation to improve the rate and quality of reported pressure damage; nevertheless this is a trend which will require monitoring.

Never events - There has been a total of 6 never events since May 2020. Based on our usual annual numbers this is higher than normal. Two relate to wrong tooth extraction and two are in Trauma and Orthopaedic theatre settings. The remaining two relate to a retained instrument in an obstetric setting and a wrong route drug administration error. A detailed thematic review of Never events will be presented to the April 2021 Quality, Safety and Experience Committee.

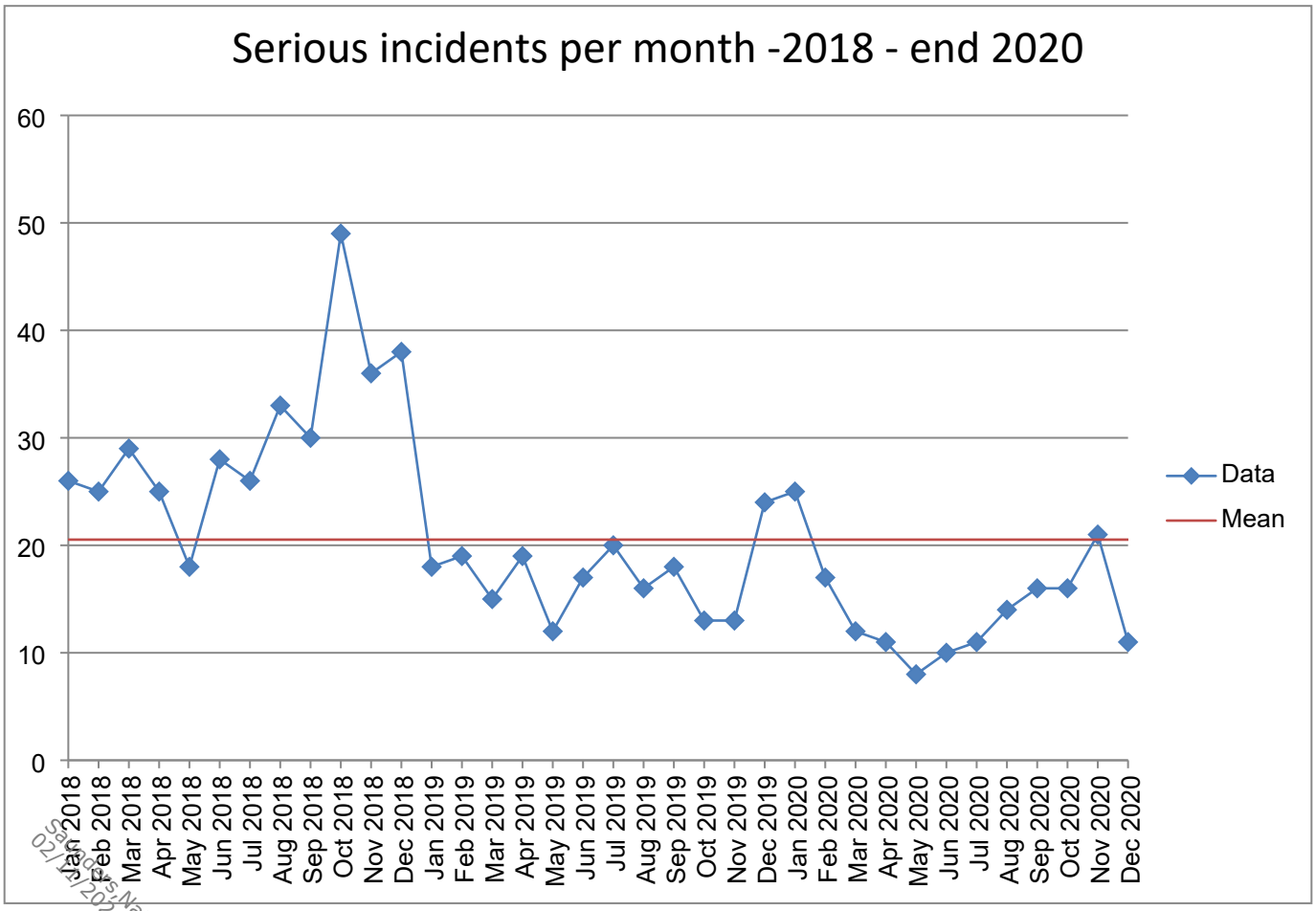
There has been a continued reduction in the % compliance of patients who are admitted to the stroke ward within 4 hours of presentation to the Emergency Unit. In the last report to Committee in December 2020, we reported that in the last published national SSNAP audit the national average is that 58.9% are admitted to a stroke unit within 4 hours of arrival at hospital. UHB performance in the last report was 52.1% of patient go directly to a stroke unit within 4 hours. This has deteriorated further to 17%. There has however been a significant improvement with 100 % compliance of patients seen by a stroke consultant within 24 hours. This issue will be discussed in detail in the February 2021 Clinical Effectiveness Committee.

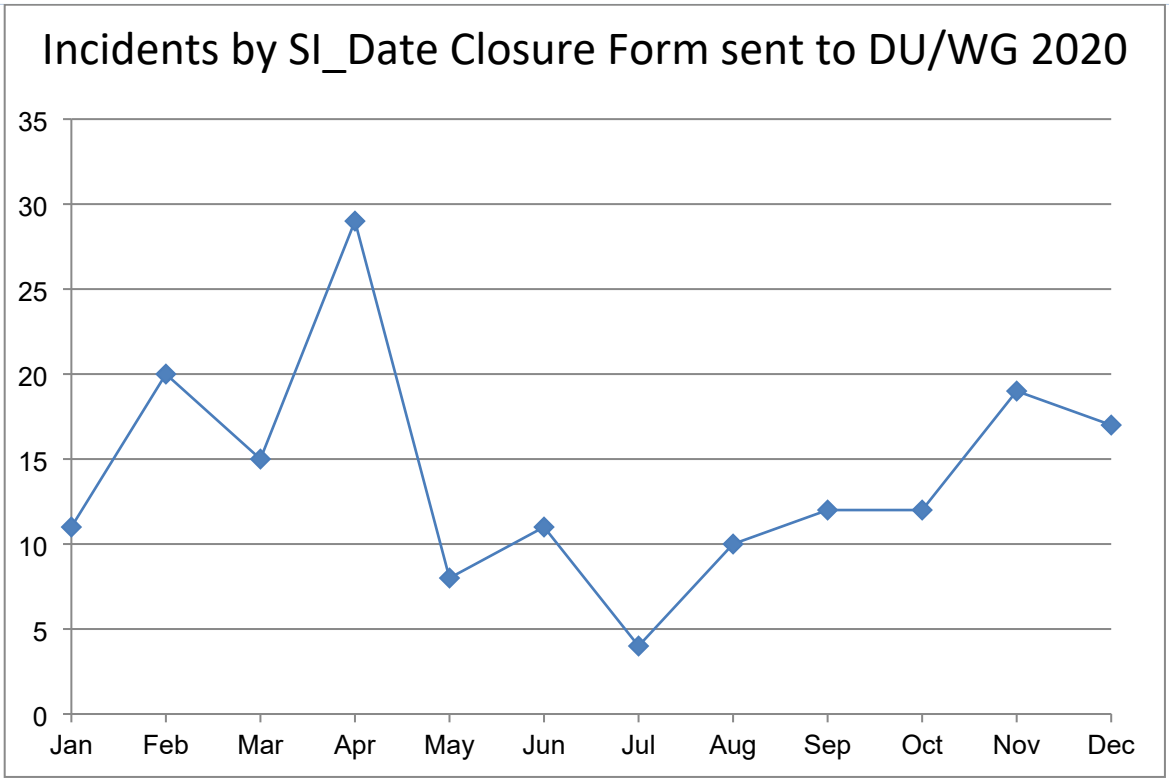
Mortality – data for compliance with Level 1 mortality reviews is incomplete for January 2021 (due to a lag in data input). There is however, overall improving compliance and this is being driven and overseen by the Mortality Review Group which is chaired by the Assistant Medical Director for Patient Safety.

Infection, prevention and control - The UHB continues to make good progress against all WG identified targets, with performance against all (with the exception of Klebsiella) showing an improvement in cumulative numbers when compared with 2019/2020.

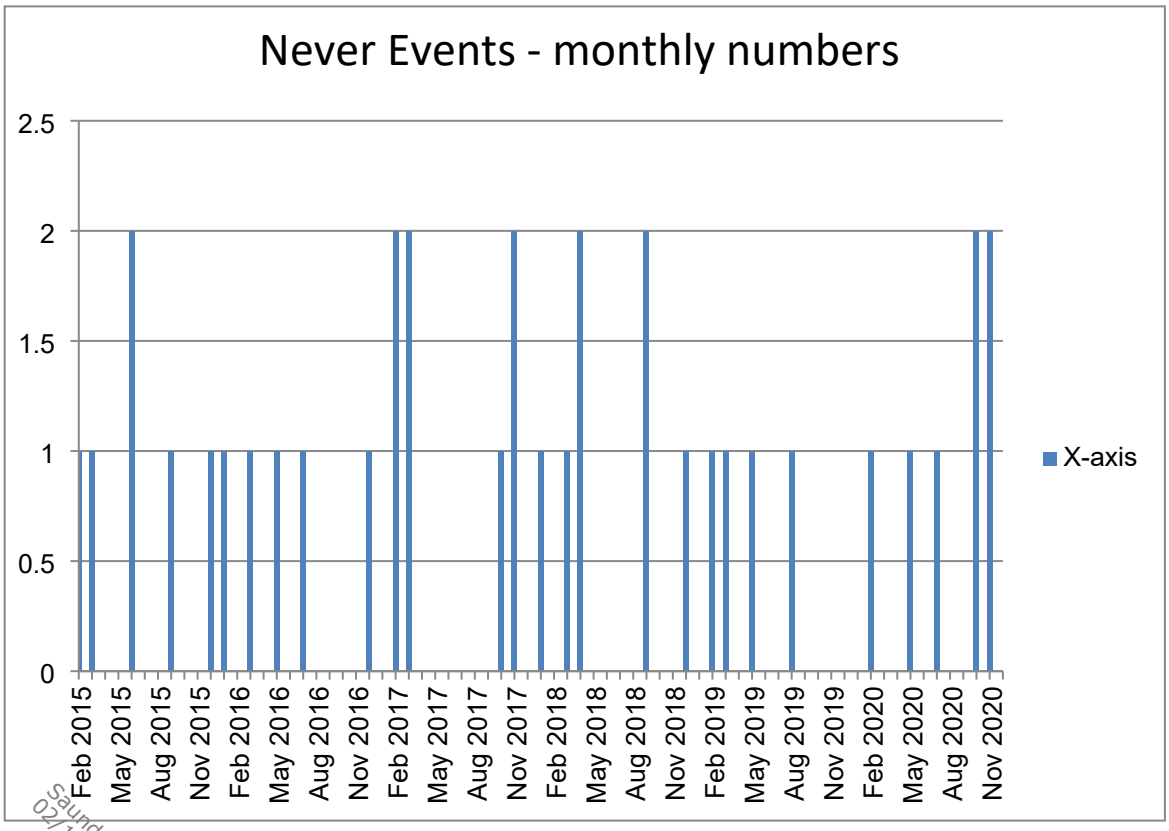
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Serious Incidents

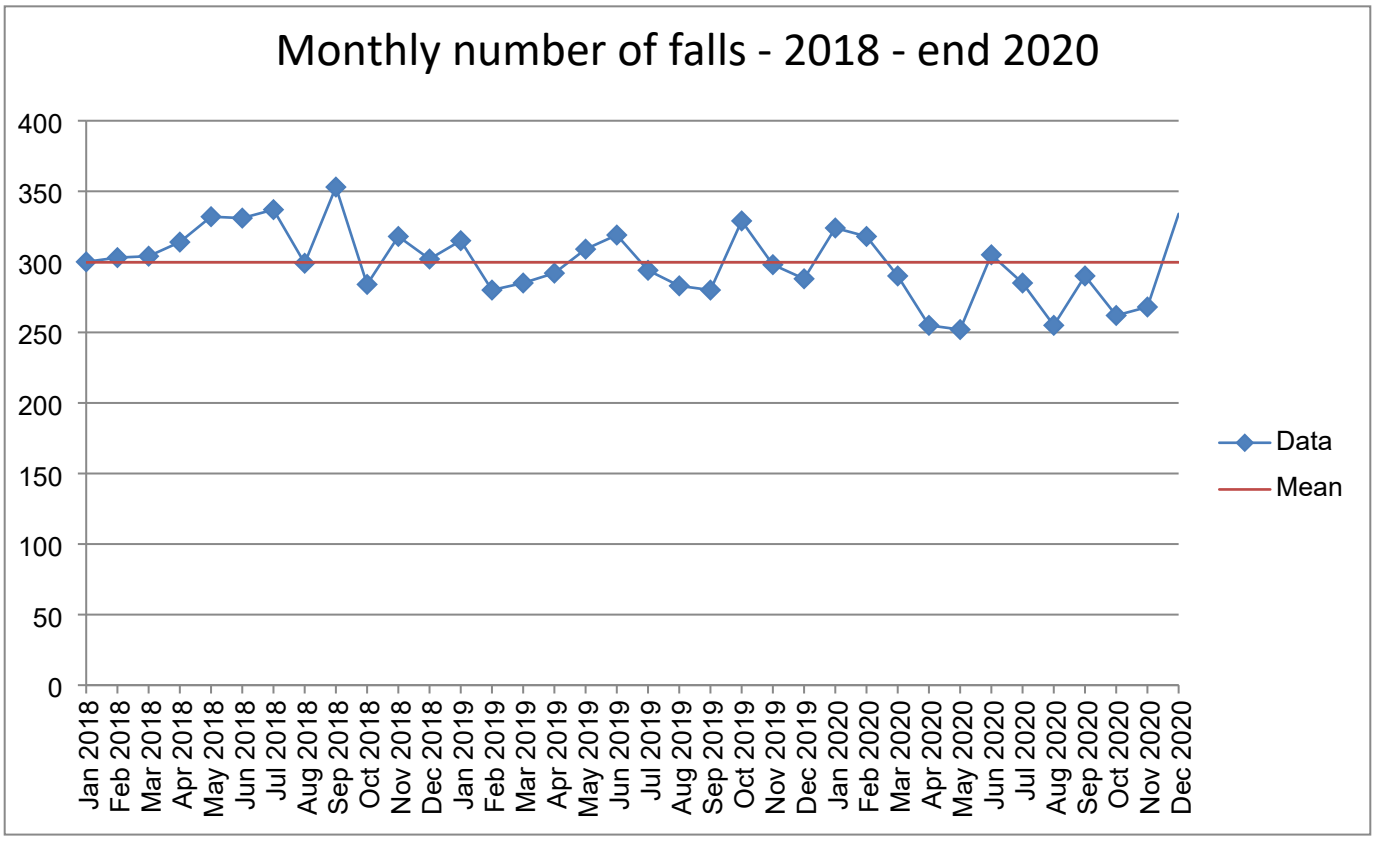


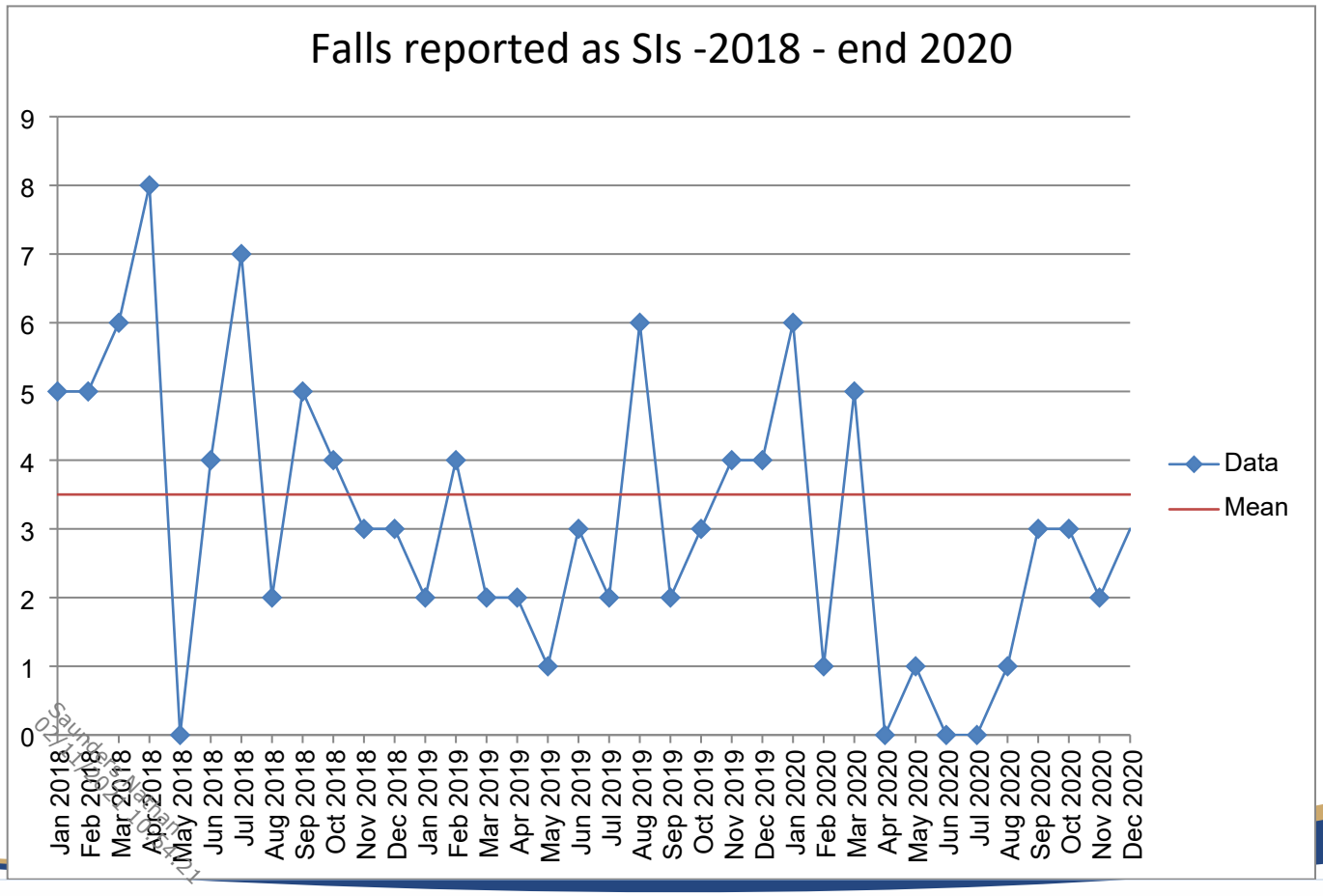


Never events

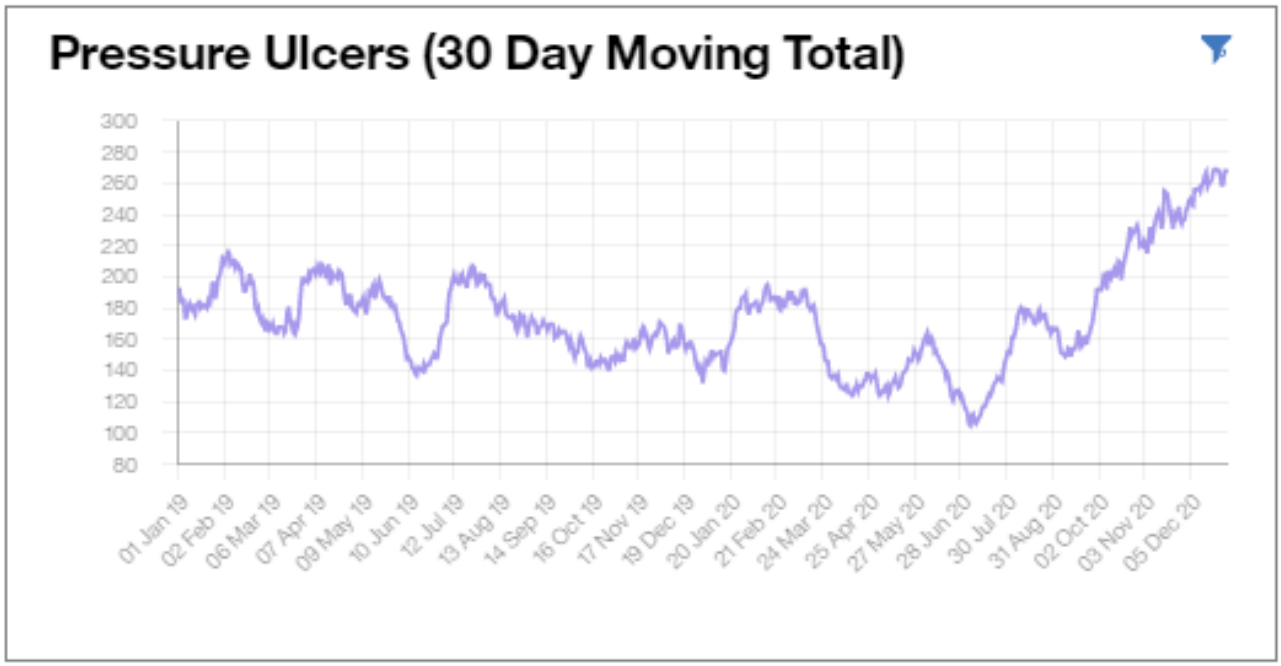


In-patient falls

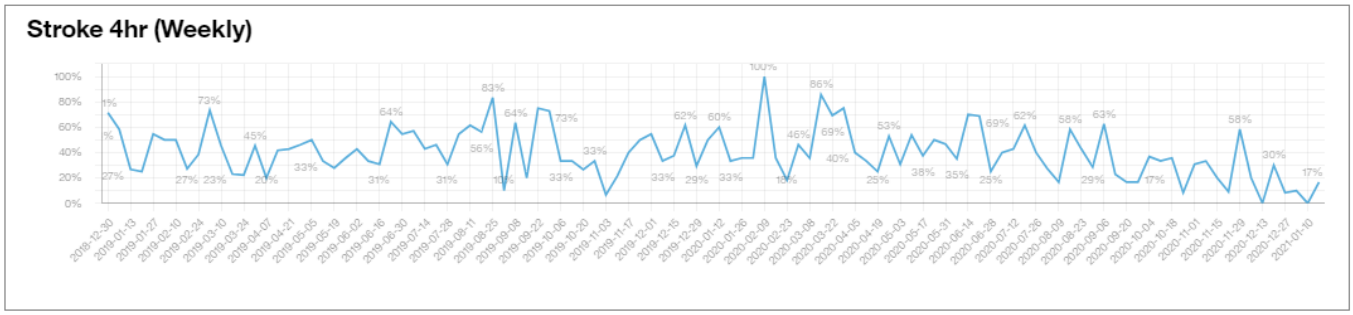


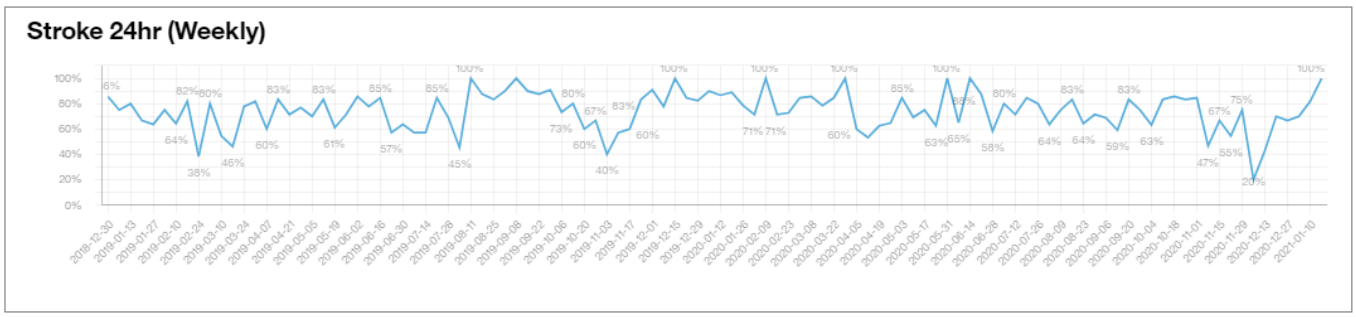


Pressure ulcers



Stroke indicators





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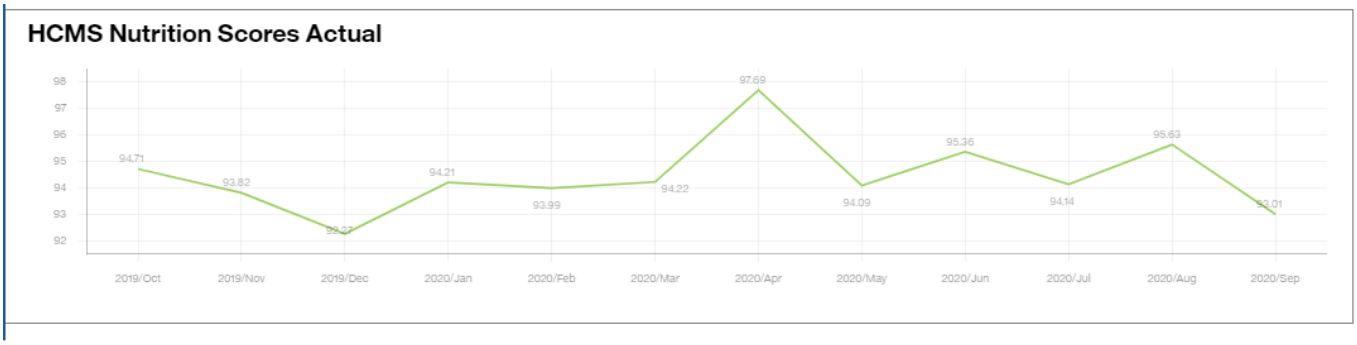
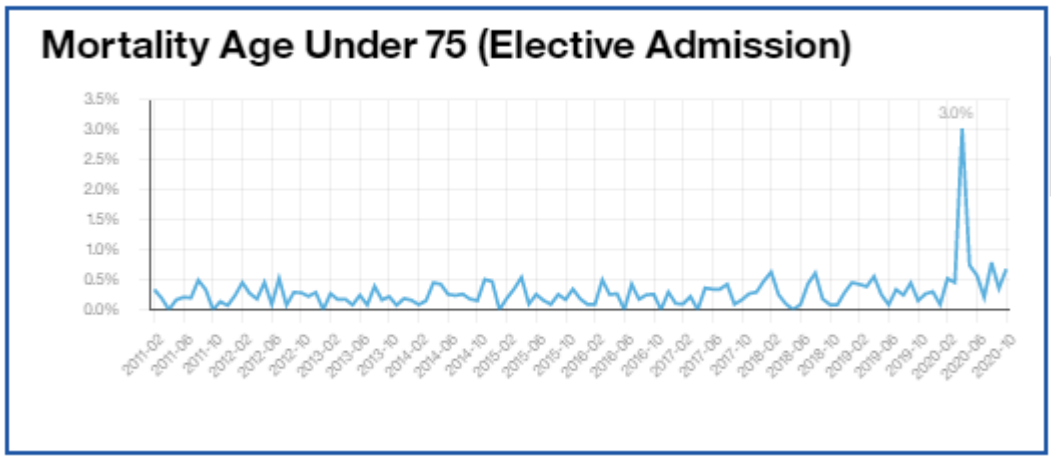
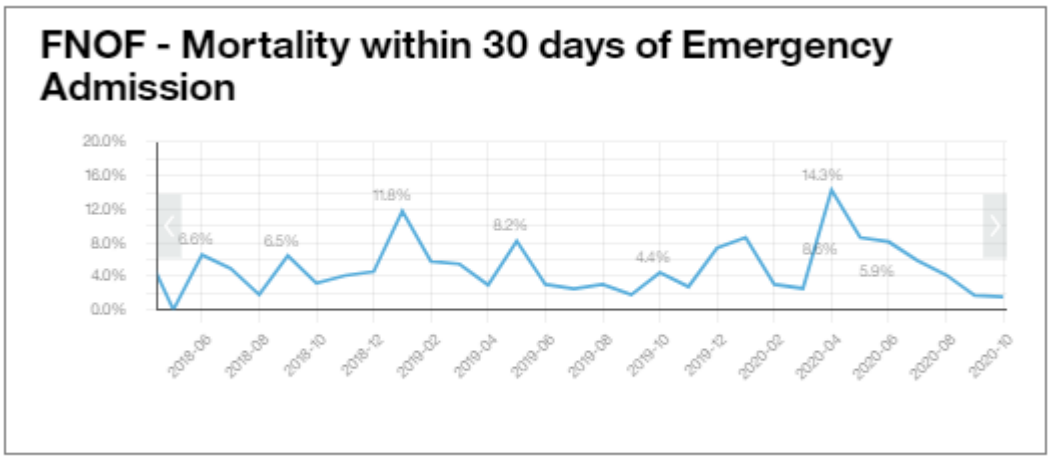
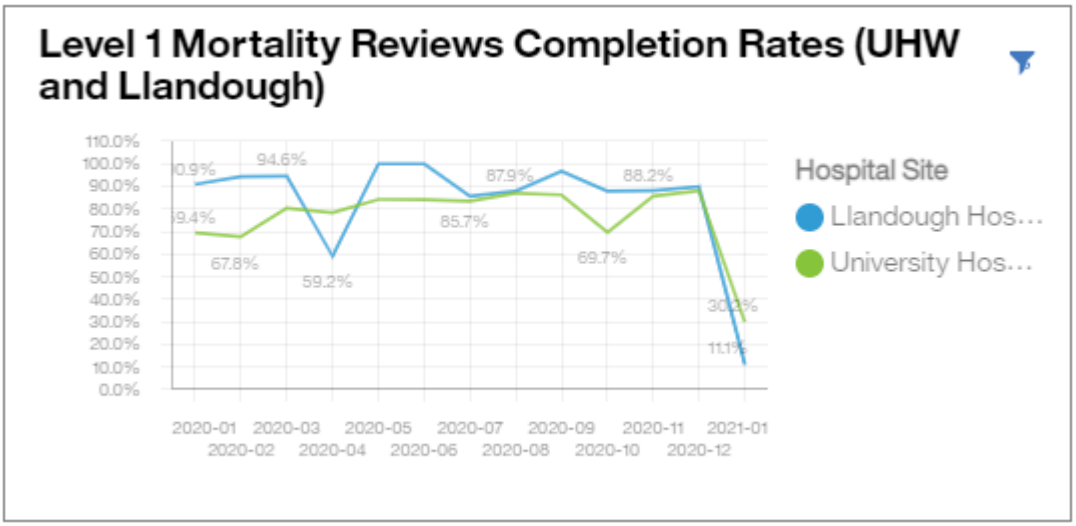
Nutritional assessment scores



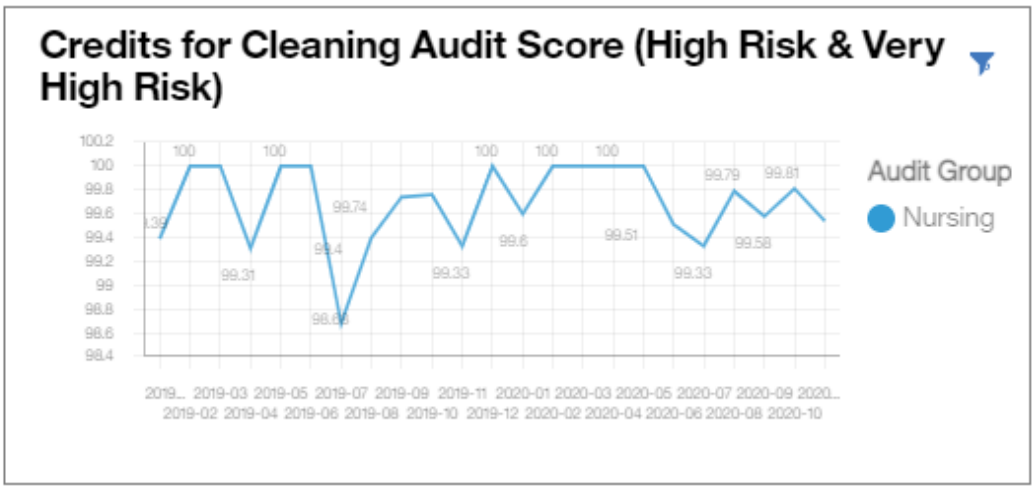
Mortality

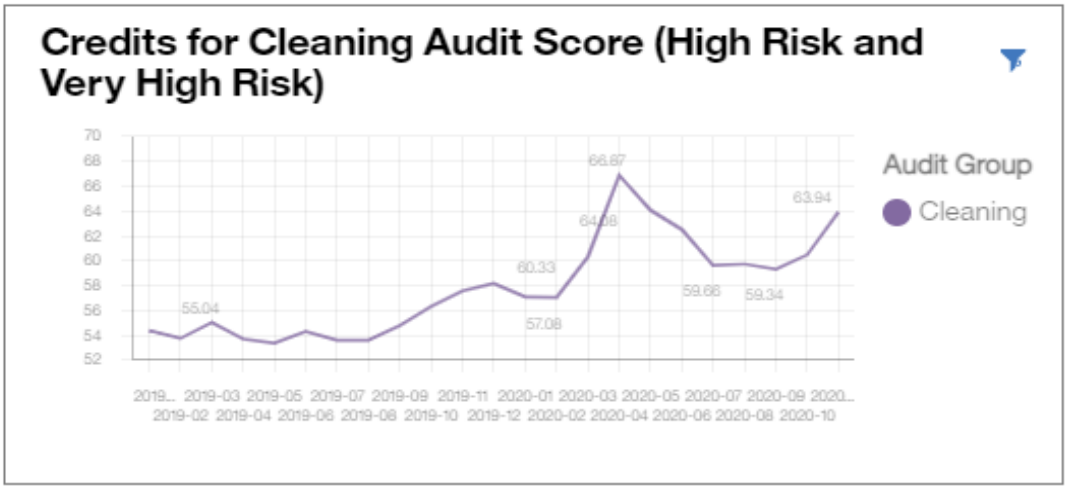






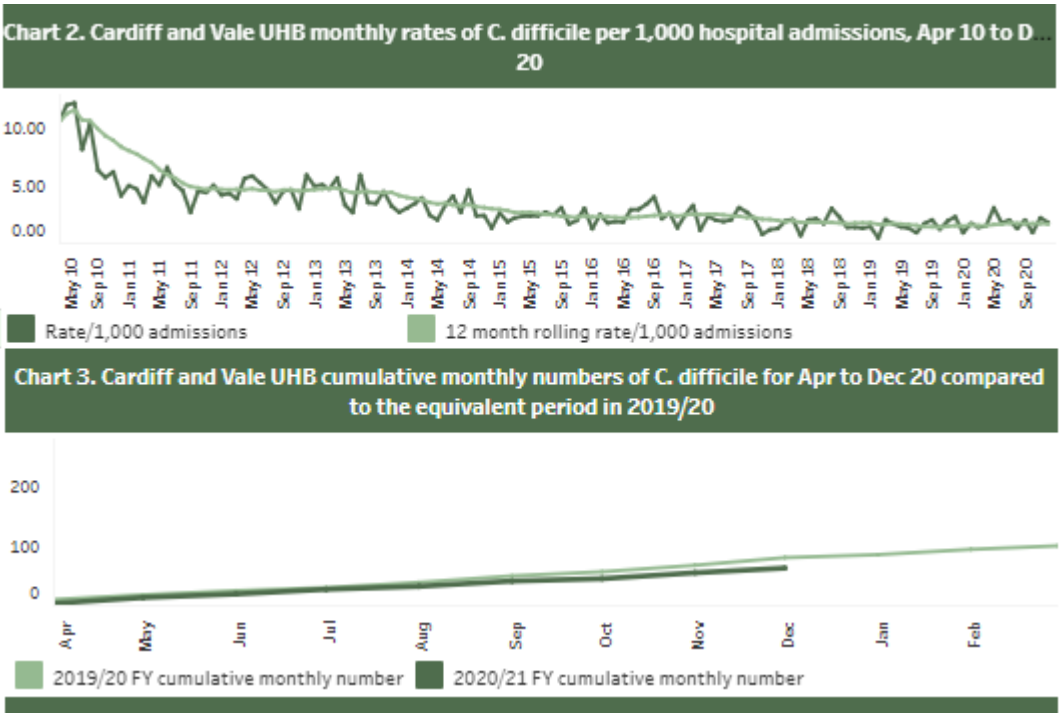
Cleaning scores



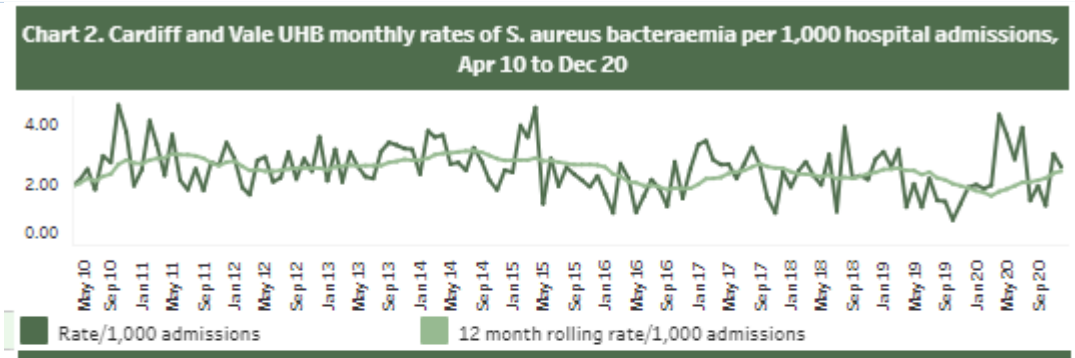


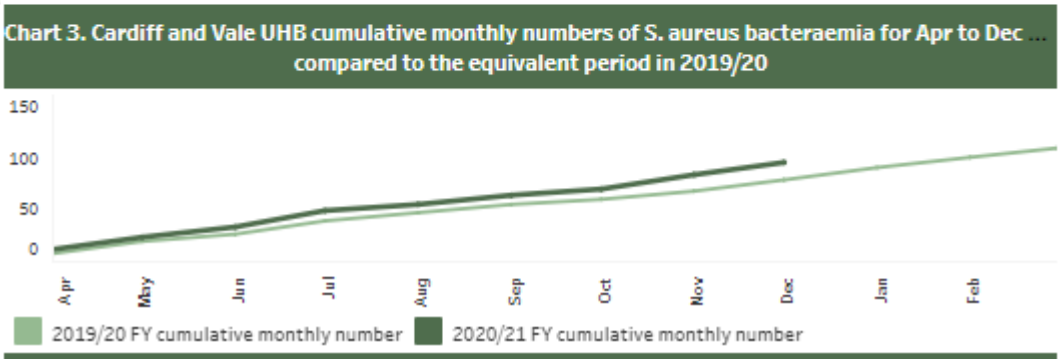
Infection prevention and control

C Difficile



Staph Aureus





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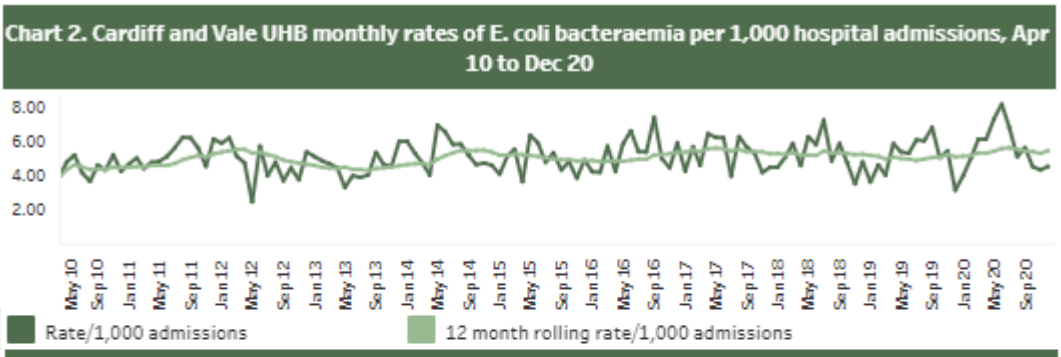
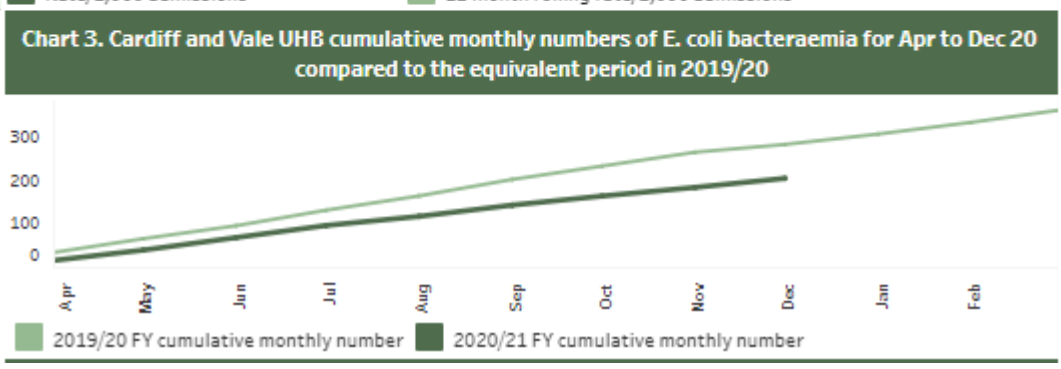
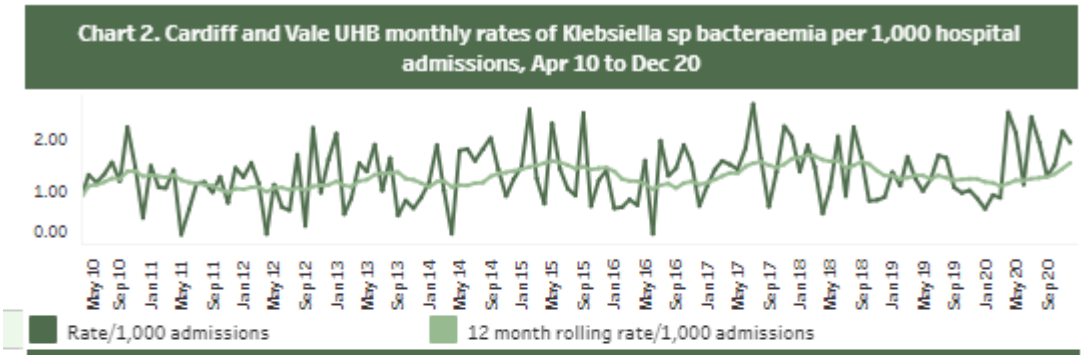
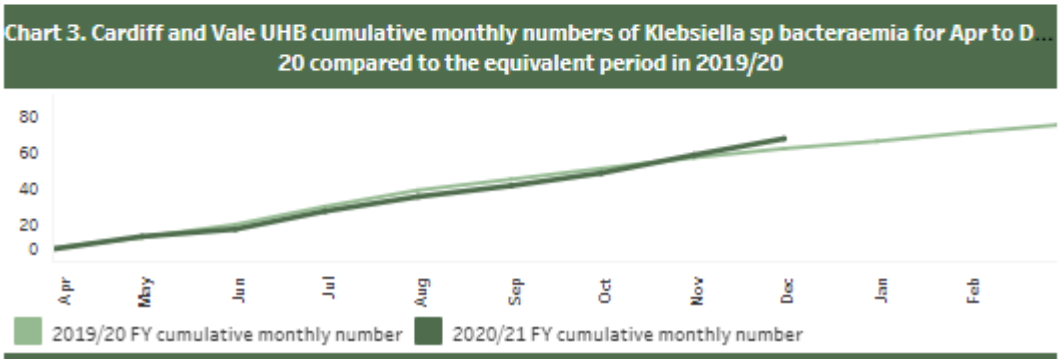


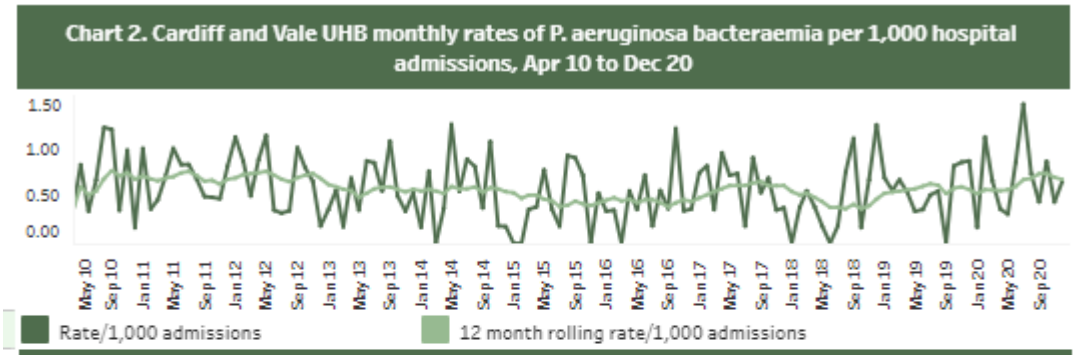


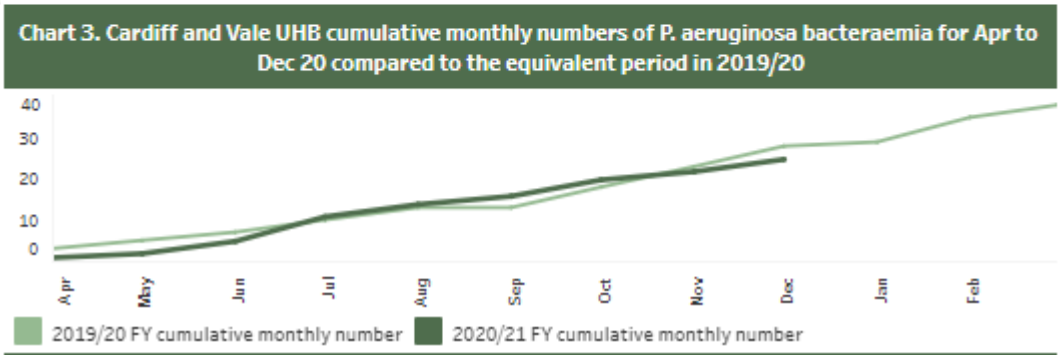
Klebsiella



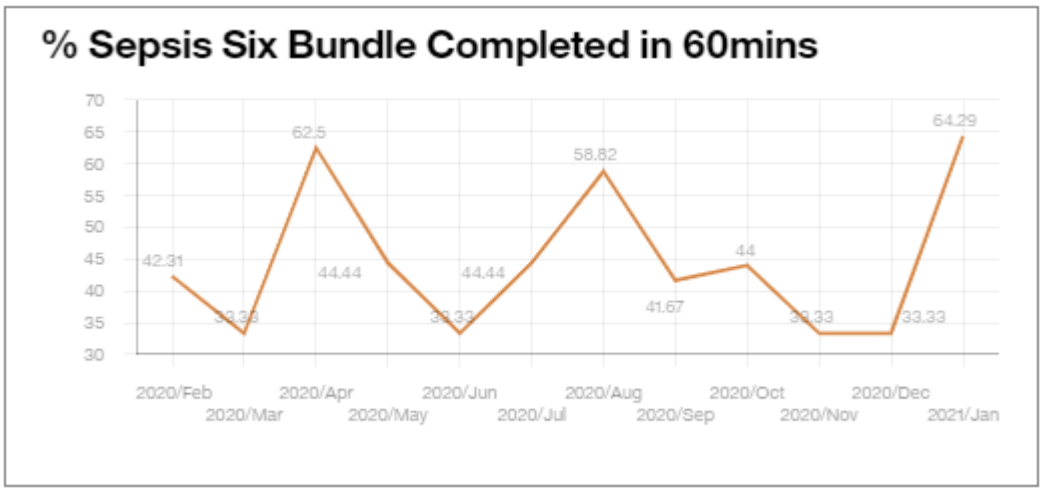


Pseudomonas





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:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Board Assurance Framework – Patient Safety**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	16th February 2021	
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 (last considered by the Board in January 2021) is considered to be a key risk to the achievement of the organisation's Strategic Objectives. At the January Meeting of the Board the risk had increased from a 15 to a 20 due to the increased risk to patients associated with COVID 19.

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 in January 2021, 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 Executives 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		
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: 4**	**Net Risk Score:**	**20**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	**Lead**	**By when**	**Update since November 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	Complete and embedded in improvement plans for each outbreak

5. Genotype testing which shows whether outbreaks are linked and core case		Ruth Walker	From mid October	Requests now in place being delivered as capacity allows
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

Report Title:	**HIW ACTIVITY UPDATE**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**16.02.2021**	
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 December 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. On October 20th HIW informed the health board of a planned programme of Quality Checks from November 2020 to January 2021. Since the last HIW activity report in December 2020, there has been one Quality Check undertaken.

On the 18th of December HIW notified the health boards that given the continued and significant pressures that NHS services face as a result of the pandemic, the decision was made to pause routine Quality Checks and Inspections in the NHS from 24th December until at least the end of January 2021. However, where there is a very high, imminent risk to patient safety it may still be necessary to carry out inspection activity.

On the 13th of January HIW informed the health board that the second phase of the maternity review will be delayed by around six months, again due to the effects of the COVID pandemic.

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. A pilot of this new approach was undertaken from August to October 2020 which allowed HIW to deploy their workforce in a more agile way, responding to risks and issues while taking account of revised operating models during the pandemic. Following the pilot phase feedback was sought which reflected positively on the tiered approach and following some fine tuning a further planned programme of Quality Checks was announced in October 2020.

A key feature of the new approach is 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 have published a Quality Insight bulletin – COVID 19, which has captured the positive themes, good practice and emerging risks and is available on link below.
https://hiw.org.uk/quality-insight-bulletin-covid-19?_ga=2.19908280.1648384767.1610967625-75638883.1566898668

Medical Emergency Admissions Unit (MEAU) Llandough Hospital - 8th of December 2020

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Medical Emergency Assessment Unit (MEAU) at the University Hospital Llandough. The focus of key lines of enquires were around the environment, Infection control, Governance and Patient flow.

Environment

During the quality check, HIW considered how the service has responded to the challenges presented by COVID-19 and considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.
HIW shared in the report that the information that was given demonstrated that the MEAU was confident in applying a range of environment measures to reduce the risk of COVID-19.

The report reflected positively that visitors were permitted in exceptional circumstances such as end of life care or specific needs such as learning disabilities and end of life care, and that arrangements were in place to ensure regular communication with patients' relatives, which included designating one family member to be called by staff. Staff also provided patients with tablets and cordless telephones to contact relatives

Improvements were identified with compliance with falls and pressure area audits which were 75% compliant, there were suggestions that this was due to documentation issues and learning would be shared with staff in staff briefings, HIW advised that a process should be developed that would evidence sharing of any learning with staff to ensure future learning on required standards particularly around documentation. HIW were also keen that learning form HIW inspections would be shared across the Health board.

The MEAU were unable to provide evidence of a full up to date environmental risk assessment and requested that this be undertaken as soon as possible, HIW felt that this was a missed opportunity to identify issues with the environment that would pose a risk to staff and patients.

Infection prevention.

HIW considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. HIW reviewed key systems including the use of PPE.

Overall this aspect of the report was very positive, patients that were nursed on ambulatory chairs, trolleys or beds were all screened off with curtains and provided with call bells. All patients were risk assessed on admission which was audited monthly. Patient's nutrition and hydration needs were met by a dedicated catering throughout the day.
It was demonstrated that appropriate triage of patients for any infectious symptoms was undertaken and the unit was compliant with hand hygiene and the correct use of PPE with compliance being monitored by monthly audits.

The facilities on the Enhanced Care Unit (ECU) was also viewed positively, with its access to computerised tomography scanning and facilities that were available for specialised interventions, such as thrombolysis which could be provided if needed in a time critical way.

The Health Board system of sharing updates for COVID-10 was also featured as a positive

aspect in the report, including the daily CEO updates, a dedicated COVID 19 page on the intranet and links to access the National Infection Prevention Manual, the Public Health Wales and NICE websites which allows staff to access the most up to date guidance.

There were some areas identified for improvement. When HIW accessed the health board intranet pages they selected two IP&C guidance to view, one of which appeared out of date since 2019. An explanation was provided regarding the process of reviewing guidelines and that guidance was still valid, it had already been formally reviewed at the point of inspection and would be on the intranet imminently

Governance

HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care. They reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

This aspect of the inspection was very positive and there were no recommendations for improvement

Patient flow

HIW felt it was important to explore the flow of patients through the department. The aim of this is to make sure patients are being assessed, admitted and discharged in a timely way.

This aspect of the report was overall very positive, There was one action identified for improvement. Whilst it was recognised that patients would not normally stay on the unit for more than 48 hours, this did occur on occasions, it was identified that there was no process in place to monitor how often this happened or how long patients would wait to be seen by a health professional. This was viewed as a missed opportunity to identify themes and trends, HIW recommended that the health board should consider introducing targets to monitor patient waiting times and how long patients spent on the unit.

Full report and improvement plan can be seen on the link below
file:///C:/Users/an094795/AppData/Local/Microsoft/Windows/INetCache/IE/BL8QWXL7/20200113UniversityHospitalLlandoughEN.pdf

Update on thematic reviews:

HIW have announced their intention to carry out a National Review Of Mental Health Crisis Prevention in the Community. It is anticipated that the review will be completed and published by Autumn 2021. The Terms of Reference can be found here

Recommendation:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.

AGREE that the appropriate processes are in place to address and monitor the recommendations.

Shaping our Future Wellbeing Strategic Objectives *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 *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Health and Care Standards Self-Assessment 2021 Process**								
Meeting:	Quality Safety and Experience (QSE) Committee						**Meeting Date:**	16 Feb 2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	Executive Nurse Director								
Report Author (Title):	Assistant Director Patient Safety and Quality								

Background and current situation:

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

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

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

Since 2016 there has been a programme of alignment of Health and Care Standards to existing groups and committees within the health board, the aim of this approach was to reduce variation and to support ongoing monitoring and quality improvement. A corporate assessment of each standard that has been aligned to a group or committee is undertaken annually to give assurance about the UHB performance against that standard and to develop a set of actions to address requisite improvements. Currently 16/22 standards have been aligned with a group and where an appropriate group or committee has not been identified the Clinical Boards have undertaken 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.

In 2020, the Health and Care Standards self- assessment was not undertaken due to the challenges of the evolving pandemic. An update paper on the current improvement plan was presented to the December 2020 QSE Committee. For 2021, it is proposed that the identified organizational leads/Groups for the 16 Standards, are asked to submit a short, structured SBAR assessment of their current position and an outline of the main improvements planned/required for 2021/2022.

Corporate Leads will seek Executive sign off of each of the 16 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

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

It is proposed that a more limited self-assessment is undertaken during 2021 of 17/22 Standards which are aligned with established UHB Groups. This will reduce the burden on Clinical Boards during the pandemic, but also provide a level of assurance across the specialist standards, which are overseen by established groups in the UHB.

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

ASSESSMENT

The overall approach and timescales for the 2021 self-assessment is::

Timescale		Activity	Lead
Start	End		
February 2021	End April 2021	Assessment of compliance against standards 1.1 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 3.2 3.4 5.1 6.1 6.2 7.1	Corporate Leads Related Group/committee
	May 2021	Executive member Sign Off	Executive Leads
	May 2021	Independent Member Sign Off	Independent Leads
	June 2021	Paper to QSE	Patient Safety and Quality Assurance Manager
	Dec 2021	Update paper to QSE outlining progress with actions	Patient Safety and Quality Assurance Manager

Recommendation:

The QSE Committee is asked to **NOTE** and **AGREE** the proposed approach to the 2021 Health and Care Standards self-assessment**.**

Shaping our Future Wellbeing Strategic Objectives

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

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√
Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

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	Deputy Nurse Director 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/medical Director	Assistant Director Patient Safety & Quality Assistant medical Director	Quality Safety and Experience Committee Chair	Clinical Board Self Assessment

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

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

Report Title:	**Terms of Reference – Quality, Safety and Experience Committee**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	16.02.21	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

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

The Terms of Reference for the Quality, Safety and Experience Committee were last reviewed in February 2019. At the Quality, Safety and Experience Committee in February 2020 it was agreed that a review of the Terms of Reference would wait this was due to:

- An audit review was due to be undertaken by Audit Wales across all Health Boards in Wales the output of which may of impacted upon the Terms of Reference;
- The Health and Social Care (Quality and Engagement) (Wales) Act 2020 which became law on 1st June 2020;
- The Quality, Safety and Experience Committee sub structure was undergoing significant review.

Due to Covid 19 the above has been delayed however, the attached Terms of Reference have been reviewed and allow for the above to be incorporated as and when required and when the Committee Sub Structures have been finalised.

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

The attached Terms of Reference have been reviewed with input from the Executive Medical Director, the Executive Nurse Director and the Assistant Director of Patient Safety and Quality.

It should be noted that they are fit for purpose but may require further updating as the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 are implemented by Welsh Government and the Committee Sub Structure is confirmed.

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

There is no risk associated with the Committee recommending approval of the attached Terms of Reference to the Board for approval. The limited number of changes which have been made allow for flexiblity moving forward and reporting requirements which may be required under the Act.

Recommendation:

For Members of the Quality, Safety and Experience Committee to approve the Terms of Reference and recommend them for approval to the Board on 25th March 2021.

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

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

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Quality, Safety and Experience Committee

Terms of Reference

Reviewed by Quality Safety and Experience Committee:

16th February 2021

Approved by Board : 25th March 2021

Updated NF 05.02.21

1. INTRODUCTION

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

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

2. PURPOSE

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

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

- ***assurance*** to the Board on the setting of local organisational Quality and Safety standards and supporting an organisational safety culture.

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

- oversee the initial development of the UHB plans for the development and delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;
- consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board;
- consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;
- consider the outcomes for patient feedback methodologies in line with the National Service User Framework
- review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements;
- consider and approve policies as determined by the Board.
- Approve and monitor implementation of the Quality, Safety and ~~Improvement~~ Experience ~~(QSI)~~ Framework and oversee the necessary developments to deliver the seven identified workstreams:
  - 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
  - Professionalism of patient safety, quality and experience

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

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

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;
- the organization, at all levels has a citizen centred approach, putting citizens, patients and carers, patient safety and safeguarding above all other considerations;
- the care planned or provided across the breadth of the organization's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the organization, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient, effective, timely and safe services;
- the organization has effective systems and processes to meet the Health and Care Standards;
- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory arrangements, professional standards and registration/revalidation requirements are maintained;

- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organization;
- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;
- risks are actively identified and robustly managed at all levels of the organization;
- decisions are based upon valid, accurate, complete and timely data and information;
- there is continuous improvement in the standard of quality and safety across the whole organization – continuously monitored through the Health and Care Standards in Wales;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:

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

    - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
    - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as 'concerns', (noting that concerns information is routinely included in the standing item on the Board agenda (Patient Safety Quality and Experience Report) and will not be duplicated in Committee)

3.4 The Committee will advise the Board on the adoption of a set of key indicators of safety, quality and patient and citizen experience against which the UHB performance will be regularly assessed and reported on through the Annual Quality Statement.

Authority

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

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

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

Access

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

Sub Committees and Groups

3.8 The Board has approved the following sub-Committees shall report into the Quality, Safety and Experience Committee:

- ~~8~~ 7 Clinical Board Quality and Safety sub-Committees
- Clinical Effectiveness Committee
- Mortality Group
- Organ Donation Committee
- Learning Committee (once established)

These Committees will report in the Quality, Safety and Experience Committee on a rolling programme as set out in the Annual Work Plan of the Committee and after each of their respective meetings.

3.9 Other Quality, Safety and Experience Committee related Groups will also report into the Committee, once established, and as and when required.

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

4. MEMBERSHIP

Members

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

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

Attendees

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

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

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

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

4.3. By invitation:

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

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

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for Committee members in conjunction with the Director of Workforce and Organizational Development.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of the Annual Quality Statement.
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

9. REVIEW

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

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

Updated NF 05.02.21

Report Title:	**Work Plan 2021/22 – Quality, Safety and Experience Committee**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	16.02.21	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
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 Quality, Safety and Experience Committee Work Plan 2021/22 prior to presentation to the Board for approval.

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

The Work Plan for the Quality, Safety and Experience Committee was last reviewed in February 2019. At the Quality, Safety and Experience Committee in February 2020 it was agreed that a review of the Work Plan would wait this was due to:

- An audit review was due to be undertaken by Audit Wales across all Health Boards in Wales the output of which may of impacted upon the Terms of Reference;
- The Health and Social Care (Quality and Engagement) (Wales) Act 2020 which became law on 1st June 2020;
- The Quality, Safety and Experience Committee sub structure was undergoing significant review.

Due to Covid 19 the above has been delayed however, the attached Work Plan has been reviewed and allows for the above to be incorporated as and when required and when the Committee Sub Structures have been finalised.

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

The work plan for the Quality, Safety and Experience Committee 2021/22 has been based on the requirements set out within Quality, Safety and Experience Committee Terms of Reference which requires the Committee to meet six times a year in addition to a 'special' meeting in October.

The Work Plan should be kept under review to ensure appropriate reporting requirements are met and it should be noted that it may require further updating as the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 are implemented by Welsh Government and the Committee Sub Structure is confirmed.

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

The Work Plan provides a structure for reporting to ensure that the requirements set out within the Terms of Reference are met. It will be kept under review due to the changes which are likely to implemented during the year.

Recommendation:

For Members of the Quality, Safety and Experience Committee to review and approve the Committee Work Plan for 2021/22 and recommend approval to the Board on 25th March 2021.

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

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

Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Quality Safety and Experience Committee Work Plan 2021 - 22								
A -Approval D- discussion I - Information	**Exec Lead**	**13-apr.**	**15-jun.**	**28-sep.**	**26-okt.**	**14-des.**	**22-feb.**	**12-apr.**
Agenda Item					Special			
Standing Items								
Quality Indicators	RW/SW	D	D	D		D	D	D
Sub Committee Assurance Reports from Clinical Boards	SC	D	D	D			D	D
Sub Groups to Quality, Safety and Experience Committee (to be confirmed): - **Clinical Effectiveness Committee** (consent MCA, DoLS, National Clinical Audit, NICE, NCEPOD, Patient Information, EOL Care, Dementia and delirium, Transition,Organ Donation, Peer Reviews.) - **Learning Committee (when established)** **- Concerns Group** (concerns and complaints, incident reporting, Duty of candour, patient/user experience and feedback, claims, datix system.) - **Operational Groups** (IP&C, Cleanliness, Decontamination, Medicines Management, Safeguarding, Research, Patient Safety Solutions, Medical Devices, Nutrition and hydration, Falls, Health Records, Blood Transfusion, Resus, VTE, Pressure damante, Mortality, Sudicide Prevention, Point of Care Testing)	RW/SW	D	D	D			D	D
Patient Story	RW	Children and Women; Mental Health	CD&T	Medicine		PCIC	Surgery	Specialist
Quality Governance								
Quality, Safety and Experience Framework	RW/SW	A						
Health Care Standards Strategy and Action Plan	RW/SW		A				A	
Policies	RW/SW	A	A	A		A	A	A
Health and Social Care (Quality and Engagement) (Wales) Act 2020- Annual Compliance	RW/SW							
Key External Reports from CHC, Internal Audit, Audit Wales	RW/SW	D	D	D		D	D	D
HIW Activity Overview	RW	A	A	A		A	A	A
HIW Primary Care Contractors	RW		A			A		
Health Promotion Protection and Improvement								
Public Health Promotion activities	FK	D						
Quality, Safety and Experience of Public Health Services	FK					D		
Quality, Safety and Experience Committee Governance								
Chairs Action	SE	I	I	I			I	I
Annual Work Plan	NF						A	
Review of Meeting	NF	D	D	D		D	D	D
Self assessment of effectiveness	NF	D						
Review Terms of Reference	NF						A	
Produce Committee Annual Report	NF						A	
Minutes of Quality, Safety & Experience Committee Meeting	NF	A	A	A		A	A	A
Action log of Quality, Safety and Experience Committee Meeting	NF	D	D	D		D	D	D

Report Title:	Committee Annual Report 2020/21						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	16.02.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Background and current situation:

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

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

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

The Committee has achieved an overall attendance rate of 73% and has met on six occassions during the year.

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

The attached Annual Report 2020/21 of the Quality, Safety and Experience Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

REVIEW the draft Annual Report 2020/21 of the Quality, Safety and Experience Committee.
RECOMMEND the Annual Report to the Board for approval.

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

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of the Quality, Safety and Experience Committee 2020/21

1.0 INTRODUCTION

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

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members one whom must be a member of the Audit and Assurance Committee. During the financial year 2020/21 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Executive Nurse Director (Executive Lead for the Committee) and the Director of Corporate Governance. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS AND ATTENDANCE

The Committee met six times during the period 1 April 2020 to 31 March 2021 one of which (October 2020) was a special meeting. This is in line with its Terms of Reference.

The Quality, Safety and Experience Committee achieved an attendance rate of 73.3% (80% is considered to be an acceptable attendance rate) during the period 1st April 2020 to 31st March 2021 as set out below:

	14.04.20	16.06.20	08.09.20	13.10.20	15.12.20	16.02.21	Attendance
Gary Baxter	X	X	X	✓	✓	✓	50%
Susan Elsmore	✓	X	✓	✓	✓	✓	83%
Akmal Hanuk	X	✓	✓	X	X	✓	50%
Michael Imperato	✓	✓	✓	✓	✓	✓	100%
Dawn Ward	✓	✓	✓	✓	✓	*	83%
Total	**60%**	**60%**	**80%**	**80%**	**80%**	**100%**	**73%**

*In January 2021, Independent Member Dawn Ward left her role and did not attend February's meeting.

4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 16th February 2020 and are to be approved by the Board on 25th March 2021.

5.0 WORK UNDERTAKEN

During the financial year 2020/21 the Quality, Safety and Experience Committee reviewed the following key items at its meetings:

1. Mortality Review – Learning from Deaths
2. Ophthalmology waiting times and the management of Patient risk

3. End of Year Position on Quality Indicators
4. Quality, Safety and Experience Themes and Trends 2019-2020
5. Safeguarding Annual Report
6. Systemic Anti-Cancer Therapy Peer Review
7. Neonatal Peer Review

PRIVATE QUALITY, SAFETY AND EXPERIENCE COMMITTEE

APRIL, JUNE, SEPTEMBER, OCTOBER, DECEMBER 2020 AND FEBRUARY 2021

1. Safeguarding report
2. Abduction Policy
3. Key Issues – Cardiac Surgery
4. UHB Mortality Review Group Terms of Reference
5. Any Urgent / Emerging Themes
6. Covid Outbreaks
7. Paediatric surgery
8. Corporate Risk Register
9. Pandemic Update & Any Urgent/Emerging Themes
10. Corporate Risk Register
11. Review into working practices of CMHT's in C&V UHB

PUBLIC QUALITY, SAFETY AND EXPERIENCE COMMITTEE – SET AGENDA ITEMS

April 2020 - March 2021

Clinical Board Assurance Reports

The reports provided detail of the clinical governance arrangements within the Clinical Boards in relation to Quality, Safety and Patient Experience (QSPE). The reports identified the achievements, progress and planned actions to maintain the priority of QSPE. This is aligned to the UHB's Shaping Our Future Well Being Strategy 2015 – 2025, underpinning the development of the services by working collaboratively with the UHB workforce.

Exception Reports

The Committee received three Exception Reports:

1. Exception Reports – Key Issues
2. Exception Reports – IP&C Position
3. Exception Reports – COVID reporting

COVID-19

At each meeting, reports were provided to detail:

1. COVID-19 related incident reporting
2. COVID-19 Patient Experience Response

3. COVID-19 Assurance on reporting of deaths
4. Impact of COVID-19 on Patient Safety
5. Progress on COVID-19 Mass Vaccination

A Special Meeting of the Quality, Safety and Experience Committee 13th October 2020

This meeting is held each year to focus on Serious Incidents and provide a deep dive into particular issues. The following items were presented:

1. Hot Topics
2. Quality, Safety and Experience Themes and Trends 2019-2020
3. Analysis of Themes and Trends in Deaths of Patients with Mental Illness - learning, action taken and improvement since last year

Policies and Procedures

A number of policies and procedures were discussed & approved at the Committee as follows:

1. Revised Guidance/Regulations Issued in Response to the COVID-19 Pandemic
2. Use of Antimicrobial Agents Policy
3. Health & Social Care (Quality & Engagement) (Wales) Act
4. Abduction Policy (Private Agenda)

Inspections, Peer Reviews and Other Reviews

11 Inspections, Peer Reviews and Other Reviews were received and approved over the course of the year and is as follows:

1. Mortality Review – Learning from Deaths (April 2020)
2. Healthcare Inspectorate Wales Update Review
3. Mortality Review (September 2020)
4. Systemic Anti-Cancer Therapy Peer Review
5. Neonatal Peer Review
6. Feedback from Effectiveness Review
7. Internal Inspections
8. Health Inspectorate Wales Activity Overview
9. Health Inspectorate Wales Primary Care Contractors
10. Health Inspectorate Wales Assessment Unit Update Report
11. Terms of Reference Annual Review

Risk and Assessments

The Committee received four reports:

1. UHB self-assessment and improvement plan against the Cwm Taf HIW/WAO governance review
2. Self-assessment of Committee Effectiveness & Forward Action Plan
3. Healthcare Self-Assessment Plan and Progress Update
4. Ophthalmology waiting times and the management of Patient risk

Plans

Three plans were presented to the committee and are as follows:

1. Clinical Audit Plan – Local and National - The AD-PSQ advised the Committee that the National Clinical Audit Plan had been stood down by Welsh Government, however, the team would keep in touch with the Clinical Audit Teams to ensure that data is still inputted, although it is not a priority
2. Quality, Safety & Experience Workshop – Feedback & Action Plan
3. Annual Committee Workplan

Other Reports

Over the course of the year 12 other reports were presented to the Committee. The following was highlighted:

1. Maintaining Quality and Safety in Non-COVID Essential Services

The Deputy Chief Operating Officer summarised the position of the UHB in maintaining Quality and Safety in Non-COVID essential services and 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.

2. Controlled Drugs Local Intelligence Network

The report summarised the activities of the CDLIN over the past 12 months under the relevant headings of the Regulations:

Regulation 4: Accountable Officer

Regulation 7: Funds and other resources available

Regulation 10: Adequate destruction and Disposal arrangements for controlled drugs

Regulation 11: Monitoring and audit of the use of controlled drugs

Regulation 12: Declarations and self-assessments

Regulation 13: Appropriate training of relevant individuals

Regulation 15/16/17. Regulation 29 Records of concerns, assess, investigate and take action in relation to concerns. Occurrence reports

Regulation 18. Establish arrangements for information sharing

3. Concerns and Claims Report

The Executive Nurse Director advised the Committee there had been a 10% increase in concerns raised to the UHB. The number of concerns closed had increased by 15% and performance was above Welsh Government targets at 82%. The Committee were informed there was no particular change with themes and the team expected to receive PI claims going forward, along with clinical negligence claims due to COVID-19.

4. Safeguarding Annual Report

The END advised the Committee that an increase in activity 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.

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

The Assistant Director of Patient Safety and Quality (ADPSQ) advised the Committee that work had been undertaken with specialist leads in the UHB and making sure their improvement plans had been implemented.

The ADPSQ advised the Committee that they were looking across the small central Clinical Audit team and that there were 38 national mandated audits and that the UHB are signed up to 35 of these.

6. Board Assurance Framework – Patient Safety

The Director of Corporate Governance advised the Committee that each of the risks are allocated to a Committee.

The DCG noted to the Committee that the reason for bringing Patient Safety Risks to the Committee is to provide an extra level of assurance and to open it up for check and challenge before going back to the board.

7. Annual Quality Statement

NHS bodies are required to publish Annual Report and Accounts, an important element of this will be the publication of the Annual Quality Statement. The AQS is intended to provide an opportunity for the Health Board to inform the public about the quality and safety of the services that it provides, including how it is making better use of resources to deliver safe, effective and patient centred services and how it provides care that is dignified and compassionate.

8. Patient Safety Solutions

The UHB regularly receives alerts and notices from Welsh Government. These cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according

to the complexity of the actions required. By the specified deadline, the UHB must report a position of compliance, non-compliance or not applicable.

9. Patient Falls

Falls and falls-related injuries are a major public health concern, and are a one of the biggest causes of morbidity and mortality for older people in the home, community and in hospital settings.

The Committee was briefed on the significant amount of work that has been done to date and to describe the proposed approach to falls prevention in Cardiff and the Vale of Glamorgan.

The Committee was advised that the falls delivery group continue to meet and excellent community work is underway and much of this work was started by Oliver Williams, a physiotherapist working with the patient safety team and led on falls.

10. Infected Blood Inquiry Update

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

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

11. Ophthalmology Report

The Committee was informed that a plan for Ophthalmology had been developed as the volume of individuals requiring access to the service was a problem across Wales. It was advised that there was a high level of risk associated with long waits as an individual's eyesight could deteriorate quickly. The Ophthalmology team had developed and tested a virtual service which was successful. An update was provided on progress against the priorities set out in the Ophthalmology Plan.

12. Ombudsman Annual Letter and Report

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

13. Advancing Applied Analytics Health Foundation Project Presentation

A report was presented to the Committee around Patient Safety and applied analytics around that and how to achieve a complete view of Patient Safety.

A Patient Safety Facilitator advised the Committee that extracting and exploring data from the incident reporting system was labour intensive and time consuming so to roll that data project across the UHB, a dashboard was developed by the Business Intelligence team.

6.0 REPORTING RESPONSIBILITIES

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

7.0 OPINION

The Committee is of the opinion that the draft Quality, Safety and Experience Committee Report 2020/21 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

SUSAN ELSMORE
Committee Chair

Report Title:	**Policies and Procedures**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	16th Feb 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Goverance**								
Report Author (Title):	**Head of Corporate Governance**								

Background and current situation:

UHB policies and procedures ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. Furthermore it is important that existing policies and procedures are regularly reviewed and updated to reflect current guidance, best practice and measures set out by Welsh Government.

The purpose of the report is to provide members with an update as to UHB policies/procedures, allocated specifically to this Committee, which have been recently reviewed and updated. These documents are listed in the below table and detail provided of the UHB groups that have approved the same.

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

The corporate management of UHB policies/procedures sits with the department of Corporate Governance. Each document has an Executive Lead and is aligned to a sub-committee of the Board for ultimate sign-off.

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

Consultation has taken place as appropriate to ensure that the policies/procedures meet the needs of our stakeholders and the UHB and where appropriate comments are taken on board and incorporated within the document. The consultation undertaken includes:

- Adding the document to the Policy Consultation pages on the intranet for a period of 28 days;
- Sharing of the document with relevant groups and service leads and
- Inviting comments via e-mail from key individuals.

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

Compliance with these documents will be monitored by the relevant group as identified in the policy/procedure.

All documents and accompanying EHIAs can be provided to members by the Corporate Governance Team for inspection.

Policy/Procedure	Approving	Date	Executive Lead

	Group		
Ultrasound Risk Management Policy and Procedure (Updated)	Ultrasound Clinical Governance Group	20.07.2020	Executive Director of Therapies & Health Sciences
Use of Antimicrobial Agents Policy (Updated)	Medicines Management Group	06.08.2020	Executive Medical Director
Blood Component Transfusion Policy and Procedure (Updated)	Blood Transfusion Group	09.10.2020	Executive Medical Director
New Procedure Policy (Updated)	Clinical Effectiveness Group	01.12.2020	Executive Medical Director

Recommendation:

The Quality, Safety and Experience Committee is asked to ratify the Policies/Procedures listed following their approval by appropriate quality and safety sub groups of the UHB.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	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	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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:	EHIAs completed as appropriate as part of the policy review process.

Report Title:	Board of Community Health Councils in Wales Report - Feeling forgotten? Hearing from people waiting for NHS care and treatment during the coronavirus pandemic						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	16/02/2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executuve Nurse Director						
Report Author (Title):	**Assistant Director of Patient Experience**						

Background and current situation:

Report

Community Health Councils are an independent watchdog of NHS services within Wales. They encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities. They undertook

Throughout the coronavirus pandemic CHCs have heard about the heart-breaking impact on many people whose care and treatment has been delayed because of the pandemic. CHCs also heard the worries people have about becoming ill in the future because vital early detection has not always been possible while many NHS services were suspended.

The recently published Welsh Government figures showing people waiting for treatment in Wales reveals the impact of the coronavirus pandemic on waiting times. The stories people shared with CHCs show the devastating impact this is having on peoples' lives. The report concluded that more needs to be done so that the NHS keeps in regular touch with people waiting for treatment so that they feel properly informed and involved. People must get the advice and support they need to help them manage the impact of waiting longer for treatment on their everyday lives.

The Board of CHCs represents the collective voice of the 7 CHCs in Wales.

The report was based upon feedback from 1,150 people through national surveys. Over 95% shared their views and experiences in English Over three quarters were women, and over 95% were cisgender (*Cisgender is a term for people whose gender identity matches their sex assigned at birth)* The youngest person was 21 and the oldest was 77. Around 85% identified as heterosexual, 90% were White (Welsh, English, Scottish, Northern Irish, British) Almost 40% were carers. Almost a quarter of respondents had a disability or long term health condition

The report raised several recommendations

NHS bodies in Wales need to respond to the worries people have shared with us by making sure:

1. Healthcare staff keep in regular touch with people waiting for care and treatment. This will help them know what is happening, how long they might need to wait, the reasons for the

delay and what the delay might mean for them in the longer term

2. People waiting for care and treatment know how to get advice and support while they are waiting

3. Healthcare staff involve people in discussions about the benefits and risks of treatment during the pandemic. This will help people feel involved in the decisions being made and that they have control over their own lives through shared decision making
4. they explain clearly and simply when changes need to be made to the way services are provided during the pandemic, and what this means for people attending for care and treatment

5. They provide up to date, clear and simple information about how local NHS services have changed during the pandemic, and what the plans are to reintroduce services

6. They reach more people who may not be able to find things out by looking on-line. Not everyone has or is able to use a smartphone, tablet or computer. Accessible, up to date information should also be shared in other ways through community networks and groups

Health Board response

One of the key messages from the CHC report is the need to communicate with people on waiting lists we have undertaken a p**re-habilitation process which has been endorsed by the Delivery Unit for use across Wales**

Using an Innovative Behavioral Change Approach to deliver health messages and prehabilitation style advice for patients on the inpatient waiting list.

An initiative led by Cardiff and Vale UHB, with a view to be spread and scale across NHS Wales.

Project Lead: Dr Rachael Barlow, Clinical Lead Prehab2Rehab

This project was conceived at the break of the Covid-19 crisis, when it was anticipated that planned elective surgery was to be significantly disrupted. Concerns were raised for those patients on the inpatient waiting list and how we could be of support to them during this crisis.

Aim

To provide robust self-management advice to educate, support and inform patients about prehabilitation style advice (general health and well-being) whilst they wait (and prepare) for their elective operation. The approach will also be used to inform patients about other important health messages to help them during this time.

Secondary purpose

To exploit the opportunity of this initiative to collect Patient Reported Outcome Measures and/or Patient Reported Experience Measures to gather an evidence base for a potential new model of working with adding value in mind.

Methods

We use a novel approach ('Nudge Theory' (1) for this initiative, one that to our knowledge has not been used before. A report by the Health Foundation in 2015 (2) suggests that nudge type interventions have the potential for changing behaviors, increasing efficiency and reducing waste in health care (3).

We propose that by using this 'nudge approach' we can communicate directly with often hard to reach populations (inpatient waiting list) improving their recovery and rehabilitation following surgery but also potentially giving them the opportunity to contemplate longer-term health changes for them and their loved ones.
All adult patients on the inpatient waiting list will have prehab style content sent to them either digitally via SMS messaging or via the post. Simple health message alerts will be sent to the patient asking them to divert to the UHB website. A series of podcasts, videos and cartoons will be produced to support this initiative.

Evaluation and Impact

An evaluation plan has been developed in conjunction with value based healthcare team, patient experience team and communication and engagement team.

Pre-hab survey

A follow up to the Prehab work has been carried out with the evaluation of the 'nudge' information sent out to patients awaiting their surgical procedure. To date the team has sent out information nudges on 'Healthy Eating' and 'Mindfulness' and the feedback received from those responding to an evaluation survey on each, has been very positive. For example, **90%** (Healthy Eating) and **84%** (Mindfulness) of respondents found the information helpful. In relation to the 'Mindfulness' information evaluation, the breakdown of responses was as follows:

Positive comments received included:

- *This was excellent however I would find it more reassuring if it came more often perhaps in smaller sections.*
- *I think the texts are really helpful.*

However, we did received a number of comments asking when their surgery was taking place:

- *When is my cancelled operation going to take place?*
- *Time scale on my operation?*

The information provided to all people on the waiting lists included contact details for the Concerns Team 7 day enquiry line so than any queries could be addressed. The queries from many who called us was assurance that they remained on the waiting list and information

regarding when their procedure was likely to take place.

As an organization we are pleased to have regular engagement with the CHC and to work together to support people in these difficult times.

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

The work being undertaken in Cardiff and the Vale UHB

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

Risk of monitoring and mataning patients safely on lists

Recommendation: Contiuned commitemnt for on going communication with people regarding services.

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

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Saunders,Nathan 02/11/2021 10:35:21

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 24th November 2020, 8.30am via Microsoft Teams

Preliminaries		Lead
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Angela Jones, Senior Nurse, Resuscitation Service Louise Young, Quality & Safety Manager, Children, Young People & Family Health Services Paula Davies, Lead Nurse, Children Young People & Family Health Services Sarah Davies, Risk Manager, Obstetrics & Gynaecology Matt McCarthy, Patient Safety Lead Rhodri John, Directorate Manager, Obstetrics & Gynaecology Becci Ingram, General Manager, Children's Hospital for Wales Services Mary Glover, Lead Nurse, Children's Hospital for Wales Services Sarah Spencer, Deputy Head of Midwifery, Obstetrics & Gynaecology Anthony Lewis, Clinical Board Pharmacist Suzanne Hardacre, Head of Midwifery/Directorate Lead Nurse Obstetrics & Gynaecology **In Attendance** Kirsty Hook, Board Secretary Amelia Huff, Midwife (shadowing Suzanne Hardacre) Kate Bordeaux, Paediatric Continence CNS (Item 2.1 only)	
1.2	**Apologies for absence** Clare Rowntree, Alyn Coles, Jane Jones, Nia John, Helen Francis	
1.4	**To note the Minutes of the previous Q&S meeting held on 27th October 2020** The minutes of the meeting were agreed to be an accurate record.	
1.5	**To note and update the action log of the meeting of 27th October 2020** The action log was updated, with the following noted as further actions: **RCA LC** CH to request if JE can present at the resus committee to share lessons learnt. **PEWS Chart** Still awaited. MG to provide further update on roll out for pilot. **Children's Rights Charter** Further discussions to take place outside of the meeting and feedback at the next meeting.	 CH MG CH/PD/MG
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – Continence Service** Kate Bordeaux, Paediatric Continence CNS was welcomed to the group and provided the background to the patient story and the treatment that has been provided. It was noted that whilst constipation is common and is treatable, however this has had a significant effect on the patient.	

	Significant work is being undertaken on timely referral and pathways in order to ensure that the optimal treatment and care plans can be provided to patients. The clinical benefits of an integrated community continence service includes: • Suboptimal and optimal journey cost implications • Reduce physical / social impact • Effective Community Services reduce inappropriate acute Services costs • Increases NHS value • Improves quality of Service: Positive outcomes It was noted that this patient journey represents a good news story of the positive outcomes that can be achieved for patients. Discussion ensued as to how support can be provided via Paediatricians and GP's in order to better support the patients prior to referrals to continence service. It was noted that training and guidance is being developed collaboratively with PCIC in order to provide a cohesive MDT approach in order to help support this service going forward. It was felt that geographical data can be sought in order to understand where these patients are currently sitting in order to better understand where these patients are in the system and where is best placed for them to be treated effectively. CH and PD agreed to discuss further outside of the meeting in order to review options to better support the service going forward.	CH/PD
2.3	Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues) CYPFHS Directorate • Staff Flu update is currently at 63.9% and work is ongoing in order to achieve the 75% target. Flu Champions support to COVID administration has been requested and detail will be shared when the impact/risk of this is received. • New IT risks identified within the Health Visiting Service with regards to Attend Anywhere • Admission for 16-18yr old at Hafan Y Coed pathways are being reviewed in conjunction with Adult Mental Health in order to improve the current pathways and processes in place. • Capacity within CAMHS team is pressured and recruitment is ongoing. • Meeting statutory requirements for CCNS care packages is difficult due to current pressures in the service and work is underway to see how this can be resolved. • Safeguarding case review is being taken forward within the community and RCA being taken forward following administration of Hep A. It was noted that once complete, the lessons learnt will be shared as part of the Q&S agenda. • Continence service pressures are increasing and it was agreed that a review should be undertaken as soon as possible in order to review how this increase in demand can be managed going forwards. • Increase in pressure ulcers in children have been noted and development of a pathway is progressing across a multiagency approach. • Medicines management work continues and draft medication policy is developed which will be shared formally when complete. Single checking is also being developed. • Safeguarding cases are escalating which is significantly impacting on health visiting and school nursing time. • Formal safeguarding supervision was being taken forward for the CCNS team and ongoing discussions are taking place in order to reinstate this provision. • Healthy Child Programme • Communication between midwives and health visitors • Recruitment is ongoing with some pressures within Health Visiting (both generic and flying start) at present, and work is also progressing with regards to support for adult nursing for COVID 19.	PD

	• RCA relating to fracture in child with complex needs is almost complete and it was agreed that this would be shared at CB Q&S when finalised to share lessons learnt. CHFW Directorate • Staff flu champions is continuing to be encouraged across all areas, uptake to date has been excellent. • All outstanding RCA's are now complete, one on the agenda and the other will be shared at the next meeting. • Cubicle for PICU has been put on hold due to concerns from IP&C given the current winter pressures. Work will be undertaken in the Spring. • Roll out of single nurse checking is scheduled for January 2021 • Internal safety notices have been shared widely across the directorate • Research trials have now recommenced following the postponement due to COVID 19. • All newly qualified nurses are in place and further recruitment continues. O&G Directorate • Flu vaccination programme continues, uptake to date has been excellent. • Access to rapid tests is being reviewed and all women are now being tested on admission. • 13 ongoing RCA's at present. 5 of which are SI's and work is progressing to complete these • No recorded pressure damage across Gynaecology or Maternity in month. • IP&C Walkabout to explore safe management of cohort areas for green / amber due to the complex pathways women follow within the maternity setting has been undertaken and no changes have been requested. Risk assessments are undertaken for patients where necessary • Access to patient homes concerns have been highlighted and an SOP has been developed • Medication error 325106: Bolus of Oxytocin now being investigated as an SI. Mum and baby are both fine and the investigation is being completed. • 2 ABL 90 gas analysers for Del Suite: not in use training underway. Bid for 3rd machine for 1st floor for accurate measurement of baby blood glucose (ATAIN). • Guidelines are available on teams and provides more access for staff for information sharing • FOI request has been received, and is being progressed. • Attend Anywhere has been rolled out across a number of areas within the Directorates • Themes for concerns relate specifically to Visiting & Appointment cancellations/Waiting for surgery dates across Obstetrics & Gynaecology, Attitude and Behaviour, Issues with Community Midwives and communication of appointments/being able to get in contact with them. • Caring for you action plan is being progressed. • Recruitment is ongoing across a number of areas.	PD MG
2.4	Exception Reporting / New Risks to be considered for the Clinical Board Risk Register No specific items to note for this meeting.	
2.5	Long Waiting Patients Update CYPFHS Directorate • ND waiting times continue to be an issue both in eDatix reporting and Concerns. Fortnightly performance monitoring meetings are in place to continue to review and work towards resolution. • Continence service issues continue –number of eDatix submitted –all reviewed – 103 week WL. • Difficulties in accessing a Tier 4 bed. WHSSC and inpatient team gatekeeping referrals and monitoring. Continual monitoring of all waiting times are robustly undertaken to ensure that there is no harm coming to patients and all that can be done is being taken forward in a timely manner as is possible. CHFW Directorate	

	Continue to treat by clinical priority and work is ongoing with Surgery CB with regards to increasing elective capacity within Paediatric Surgery. This has significantly impacted on the waiting times for inpatients. Within Outpatients, this has also seen a significant impact on the waiting times for patients as a result of COVID 19 and work is ongoing in order to review what can be done to increase activity within outpatients going forward. Obstetrics & Gynaecology 18 beds opened on C1 to support surgery. • All gynaecologists are reviewing outpatient waiting list data in respect of their specialities. • Patients on the inpatient waiting list (26+ weeks wait) and outpatient waiting lists (19+weeks wait) have been written to informing them of the increased waiting times due to the pandemic, asking if they wish to remain on the waiting list and if no response they will be removed from the waiting list. • Theatre capacity: 1 x benign all-day Gynae Spire theatre per week. 1 x all day SSSU theatre every week (Urgency level 2/3 priority patients). As an addition we will have an all-day UHL theatre alternate weeks for benign Gynae from 26th November 2020.	
2.6	Business Continuity Update There were no exceptions to note for this meeting.	
SAFE CARE		
3.1	Update on Serious Incidents The report was shared for information. The Clinical Board currently has 10 open SI's at present however it was noted that significant work has been undertaken in order to progress these investigations to closure. Incident reporting has returned more to business as usual and it was encouraged to ensure that any incidents are reviewed in a timely manner.	ALL
3.2	SI's/RCA's/Closure Forms for noting RCA & Improvement Plan - Patient RB (Datix Ref – 317172) The case involves patient who was treated by the Oncology department for his spinal glioma since Oct 2019. He was also suffering from chronic pain as a complication of his condition and was actively managed by the Paediatric Neurology and Palliative Care pain team. He had decreased mobility, continence, pain and gait disturbance for several months prior to this incident. As part of this treatment process, he had an MRI of his spine under general anaesthesia on 11 June 2020. He was discharged home on the same day and it was reported that the patient had deteriorated at home with loss of function of his legs. This has now resulted in wheel chair use and catheterisation of his bladder. The RCA investigation was completed where it was noted that due to the patients chronic pain needs, that were inadequately treated despite pain team and neurology input, prior to the MRI, it is not clear if this had any relevance to his subsequent spinal injury as it is surmised that his spinal injury was due to a vascular insult from his tumour. There were no indications of any unusual manipulations during the process other than laying him supine for the MRI. It is not clear if laying him in a different position for the MRI would alter this risk as that was the primary purpose for the scanning that day. It is normal practise to be laid supine for MRI scanning. It is therefore unclear of the relevance to the spinal tumour and whether this would have altered to the risk. Recommendations Pain Management discussion to take place with Anaesthetists prior to anaesthesia Storing of pain management in MRI Suite	

	Discussions are taking place with both Surgery and CD&T Clinical Boards with regards to the recommendations. A formal concern has been received and it was noted that this report will be shared with Anaesthetics for noting and will then be shared with the parents. RCA & Improvement Plan – Patient Baby B (Datix Ref The RCA has now been finalised and the closure plan will now need to be completed for submission to Welsh Government. Baby was born in very poor condition and unfortunately could not be resuscitated. Birth asphyxia was noted to be the outcome of the post mortem findings. Learning points have been noted with regards to communication and it was noted that an action plan has been developed in order to address the recommendations and learning points highlighted within the report. It was agreed that the report can now be shared with the family and progressed for closure. SD agreed to share the final report with AJ for onward sharing of learning points. Closure Form– In100603 Noted for information. Case has been submitted to Welsh Government for closure. This case relates to a pregnant patient attended the Obstetric Assessment Unit (OAU) with reduced fetal movements and abdominal pain. An ultrasound scan sadly showed the absence of a fetal heartbeat, with evidence of placental abruption. Following induction of labour, the patient gave birth to a stillborn female. Incidental learning was identified relating to the completion of a risk factor sticker for growth assessment, documentation on a MEWS chart and documentation of the reason for a call to the OAU. All action identified within the investigation have been completed and learning shared across Directorate and Clinical Board Q&S agendas.	SD
3.3	Infection Prevention Control Update PPE Audits Noted for information.	
3.4	Safeguarding No specific items to note for this meeting that have not been noted as part of the Directorate reports.	
3.5	Patient Safety Alerts (internal/external)/Welsh Health Circulars • ISN 2020 010 – Wrong Route Administration • ISN 2019 003 – Resuscitation Trolley Checks • Patient Safety Notice 056 - Foreign body aspiration during intubation, advanced airway management or ventilation • Patient Safety Notice 055 - The safe storage of medicines: Cupboards All alerts have been shared widely across all areas of the Clinical Board. There were no exceptions to note.	
3.6	HIW Maternity Services Review The report was shared for information. Phase 2 will be undertaken in the Spring and this will include community services. The action plan will now be progressed and outlines a number of recommendations. The overall findings were positive and work is progressing. It was agreed that the improvement plan would be shared at the next meeting. The recommendations with regards to the fridges have been progressed and spot check audits are regularly being undertaken within the service.	SH

TIMELY CARE		
4.1	Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes No specific items to note that were not covered as part of main agenda.	
INDIVIDUAL CARE		
5.1	Update on latest 2 minutes of your Time feedback No exceptions to note. Feedback continues to be collated and shared appropriately.	
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 22nd October 2020** Noted for information. It was acknowledged that these meetings are having a positive impact and it was agreed that these meetings will continue.	
6.2	**NBS Performance Report – September 2020** Noted for information. Error rates for NICU were noted and it was noted that this is being progressed and technique is reviewed. It was agreed that the NICU improvement plan would be shared for information.	MG
6.3	**Medicines Safety Briefing – November 2020** Noted for information. It was acknowledged that positive work is being taken forward on Medication Errors and Medicines safety within the Clinical Board. Discussion ensued with regards to tenfold errors and it was noted that there has been a decrease and work is being taken forward with regards to potential to implement electronic prescribing processes across the Health Board. Further update will be provided as this work progresses.	AL
ANY OTHER BUSINESS		
7.1	**ALPS Course** Thanks expressed to Martin Edwards for his support.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 22nd December (H&S Focus), 8.30am via Microsoft Teams**

2021 Meeting Dates

The meetings for 2021 will follow the same pattern as this year and take place on the **4th Tuesday of each month between 8.30 – 10am**. All meetings will be held via Microsoft Teams – links will be circulated.

26th January
23rd February
23rd March (H&S Focus)
27th April
25th May
22nd June (H&S Focus)
27th July
24th August
28th September (H&S Focus)
26th October
23rd November
21st December

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

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

MINUTES OF THE MEETING HELD ON 11TH NOVEMBER 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Meriel Jenney	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Alun Roderick	Laboratory Service Manager, Haematology
Alicia Christopher	Operational Support Service Manager
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Jacqueline Sharp	Physiotherapy (for Emma Cooke)
Jo Fleming	Quality and Safety Lead, Radiology
Rhiannon Williams	Dietetics (for Judyth Jenkins)
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
Jane James	Phlebotomy Support Service Manager
Paul Williams	Clinical Scientist, Medical Physics
Timothy Banner	Head of Patient Services, Pharmacy
Julie Mears	Head of Occupational Therapy

Apologies:

Scott Gable	Laboratory Service Manager, Cellular Pathology
Bolette Jones	Head of Media Resources
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
Judyth Jenkins	Head of Dietetics

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/373 Welcome and Introductions

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

CDTQSE 20/374 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/375 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 14th October 2020 were **APPROVED.**

CDTQSE 20/376 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 with the Clinical Board Health and Safety Adviser when he is back in post, the issues raised relating to the Contractors Policy.

Action: Sue Bailey

CDTQSE 20/137 Risk Registers

There are 3 departments that have not yet submitted their risk registers.

Action: Alun Roderick/Nia Came/ Tim Banner

CDTQSE 20/335 Consent Issues/Review of Diagnostic Images Outside of Radiology

Matt Temby, Sue Bailey and Meriel Jenney to discuss these issues.

Action: Matt Temby/Sue Bailey/Meriel Jenney

Sue Bailey noted that she attended a webinar and learnt a lot of information around consent issues. She will share the web link.

Action: Sue Bailey

CDTQSE 20/339 Podiatry Rooms in the Vale

Mathew King contacted PCIC Clinical Board to reach a compromise on the use of the rooms however the issue is still not resolved. He noted that he is receiving requests from the CHC asking when these rooms will be reopened to Podiatry. Matt Temby and Mathew King to discuss outside of the meeting.

Action: Matt Temby/Mathew King

CDTQSE 20/352 Stocks of Visors on Wards at UHL

Matt Temby has asked all wards at UHL to ensure they have stocks of PPE for peripatetic staff as well as ward based staff.

CDTQSE 20/376 Patient Safety Intranet Site

Suzie Cheesman to send the link to the to the patient safety intranet site that contains useful information on the World Patient Safety Day.

Action: Suzie Cheesman

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/377 Patient Story

Sue Bailey will reinstate a rolling programme for directorates to present patient stories to this group.

Action: Sue Bailey

CDTQSE 20/378 Feedback from UHB QSE Committee

The minutes of the meeting held on 12th October 2020 are not yet available.

CDTQSE 20/379 Health and Care Standards

The self-assessment process is currently stood down.

CDTQSE 20/380 Risk Register

A new risk within Radiology was escalated regarding lack of MR safety experts available to the Health Board. This is an All Wales issue. To mitigate risk the directorate needs to look at outsourcing or employing an external individual. The directorate is awaiting quotes.

An outstanding risk was raised at the Haematology Quality Meeting yesterday relating to exhaust fumes from the generator. The department is seeking advice on how to mitigate this risk. Incident forms have been submitted to Health and Safety. The department has taken the decision that the generator would not be run in normal working hours, however should it be needed the impact this would have on staff is not known. Alun Roderick to escalate the risk in writing to Sue Bailey.

Action: Alun Roderick

Robert Bracchi reported a potential risk relating to software utilised in AWTTC that allows the safe sharing of data across Wales. Public Health Wales is reviewing their contract and there is a risk to the work being undertaken in AWTTC if this contract is removed.

CDTQSE 20/381 Exception Report

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/382 Initiatives to Promote Health and Wellbeing of Patients and Staff

Mental Health First Aid Training sessions were arranged for Clinical Board staff earlier in the year but cancelled due to the first phase of Covid. Sue Bailey will discuss with Sian Jones on the optimal time to reinstate this training and consider how this training can be delivered in a way that is effective for staff.

Action: Sue Bailey/Sian Jones

SAFE CARE

CDT QSE 20/383 Concerns and Compliments Report

In October 2020 the Clinical Board reported a Red status. 18 concerns were received and there were 2 breaches in response times. 35% of the formal concerns were resolved by early resolution and 6 compliments were received.

The areas of concern are Outpatients/Patient Administration which received 2 concerns and reported 1 breach against response times.

Physiotherapy reported 6 concerns and 1 breach in response times. However it resolved 50% of the concerns within early resolution timeframes and received 3 compliments.

Departments reporting good concerns management are:

Speech and Language Therapy which received 1 compliment.

Laboratory Medicine which received 2 concerns and dealt with 50% by early resolution.

Radiology received 5 concerns and resolves 20% by early resolution and it received 2 compliments.

Pharmacy received 1 concern and this was resolved within early resolution timeframes.

CDTQSE 20/384 Ombudsman Reports

Nothing to report.

CDTQSE 20/385 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/386 Patient Safety Incidents

SI Report

The Clinical Board is currently reporting 2 open SIs which are under investigation.

In122136 - Cardiac theatre case investigation underway.

In82274 Speech and Language Therapy incident investigation due for completion this week.

2 closure forms are with Welsh Government.

SIs are now being reported to the Delivery Unit therefore the patient safety team are following up the closure forms that are outstanding with Welsh Government to request closure. The Delivery Unit is the performance arm of Welsh Government and this unit will be reviewing closure forms.

CDTQSE 20/387 New SI's

There are no new SIs to report.

CDTQSE 20/388 RCA/Improvement Plans

Nothing to report.

CDTQSE 20/389 WG Closure Forms – Sign Off

Nothing to report**.**

CDTQSE 20/390 Regulation 28 Reports

Nothing to report.

CDTQSE 20/391 Patient Safety Alerts

PSN 055 Safe storage of Medicines: Cupboards

This replaces the Safety Notice from 2016. Tim Banner reported the challenges in relation to the notice particularly for the new Lakeside Wing and for new areas opening across the Health Board as there are clinical areas that do not meet the specification. Where areas are non-compliant there is a requirement for a risk assessment to be completed and Medicines Management Team are supporting this.

PSN 056 Foreign Body Aspiration during Intubation, Advanced Airway Management or Ventilation

Jo Fleming reported that this has been circulated to Radiology staff and they are monitoring this. She will check that the Procurement department has received the notice.

Action: Jo Fleming

CDTQSE 20/392 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/393 Medical Device Risks/Equipment and Diagnostic Systems

A Capital request was **RECEIVED** relating to replacement of Medrad pump injector in Cavoc for MRI which is over 10 years old and has a maintenance only contract on this device and any replacement parts will not be covered under the contract. This risk is on the Radiology risk register and the scoring has reduced due to controls put in place. It was agreed that a copy of the capital request should be submitted to Clive Morgan should any discretionary capital become available.

Action: Lesley Harris

An SBAR document relating to a T34 syringe driver was **RECEIVED.** It is predicted that an increase in Covi-19 cases is likely to increase demand for T34s. However notification has been received that there are ongoing issues with the pumps in particular with regards to battery life. Clinical Engineering will introduce measures to improve turnaround times of T34's to minimise time out of clinical use and Version 3s are available to be put in use. A risk assessment has been completed and Jo Fleming to check that this is recorded on the directorate's risk register.

Action: Jo Fleming

CDTQSE 20/394 IP&C/Decontamination Issues

A Clinical Board meeting was held last week with all directorates concerning risk assessments and actions to be taken in an outbreak. Directorates were asked to submit their risk assessments and actions to the Clinical Board.

A discussion was held whether the Clinical Board should set a trigger point for an outbreak ward that would then enact a restriction on movement of peripatetic staff needing to work on outbreak wards.

The advice from IPC Team is that it would be acceptable practice for staff wearing the appropriate PPE to visit an Outbreak ward as their last point of call in their working day. However there is a set of circumstances where even this creates risk.

Jo Fleming commented that this would be a challenge to overnight staff in Radiology who are providing cover for all portable radiology equipment and there is a potential need to enter all zones.

In the event of an outbreak, multiple phlebotomists have been entering a ward at the same time and this is a risk that can be mitigated by reducing the numbers of phlebotomists to 1 or even not entering the ward. The clinical team would need to determine if it is essential whether a patient needs a blood test.

The risk needs to be balanced against the benefit/need of a procedure to be undertaken on the patient. Decisions that are taken need to be clearly documented in the patient notes and there needs to be communication with the staff involved with the patient.

Alun Roderick reported that the same levels of PPE are being worn in red zones and outbreak wards, yet staff are being restricted in outbreak areas. He asked what will determine the trigger point. It was noted that a deep dive is being undertaken on the impact of an outbreak ward on the different services and Sue Bailey will aim to complete this by next week. A consensus on a trigger point needs to be agreed by the IPC Team.

Action: Sue Bailey

A staff investigation document has been circulated. Going forward where staff contract Covid-19 as a result of their employ then this should be recorded on Datix as it is a notifiable disease.

Sue Bailey was pleased to note that this Clinical Board is reporting the highest uptake of the flu vaccination by frontline staff to date, with 67.6% having been vaccinated. She thanked Maria Jones and the Flu Champions for all their efforts.

CDTQSE 20/395 Point of Care Testing

Nothing to report.

CDTQSE 20/396 Key Patient Safety Risks

Safeguarding

Nothing to report.

Mental Capacity Act

Nothing to report.

CDTQSE 20/397 Health and Safety Issues

Nothing to report.

CDTQSE 20/398 Regulatory Compliance and Accreditation

Nothing to report.

CDTQSE 20/399 Policies, Procedures and Guidance

The Transfusion Policy and Audit and Research Policy are both out to consultation.

EFFECTIVE CARE

CDTQSE 20/400 Clinical Audit

The Clinical Board has been asked to provide its clinical audit plan for the year. This is an area where assurance is required from directorates that audit is taking place. Directorates are asked to submit a list of audits being undertaken in their areas to Sue Bailey and highlight the 3 most important audits that have resulted in service improvement or made a difference.

Action: All

Seetal Sall reported that the Point of Care Testing Team participate in technical audits rather than clinical audits. It was noted that the Clinical Board is interested in understanding what audits are taking place and any learning.

Sue Bailey reported that Estates are engaging with Clinical Boards on their environmental impact and the Clinical Board has committed to supporting 4 audits looking at energy, waste and use of resources. Sue Bailey asked for 4 departments to volunteer to assist in this audit. She noted that no work is involved, Estates just need support from departments to answer questions.

Action: Directorates

CDTQSE 20/401 Research and Development

Clinical Board level R&D Performance meetings have been held with the Medical Director and UHB R&D Lead. Following these meetings the Clinical Board met with its directorate R&D leads this month and agreed how to move forward with R&D. Each directorate has agreed to look at its current position against PIs and how this can be taken further. Also to consider where support provided to others undertaking R&D can be improved and what metrics can be developed to demonstrate the support being provided.

Meriel Jenney and Matt Temby will finalise the job description for the Clinical Board R&D Lead which will then be circulated for expressions of interest.

Action: Matt Temby/Meriel Jenney

CDTQSE 20/402 Service Improvement Initiatives

An Outpatients Transformation Programme has been implemented. This involves 3 streams:

- Prioritisation for services
- Adaptive ways of working.
- Configuration/space i.e. how outpatient areas are currently being utilised.

The aim is to make best use of capacity and maximise throughput whilst minimising risks to patients.

Work is underway around taking forward virtual appointments i.e. Attend Anywhere. Equipment is being released to areas that have made requests to implement this. There is ongoing learning around supporting clinicians and patients in virtual clinics and staff are being trained to support virtual receptions.

CDTQSE 20/403 NICE Guidance

Nothing to report.

CDTQSE 20/404 Information Governance/Data Quality

Sion O'Keefe reported that the ICO are providing more resources and there are more requirements to feedback on data breaches.

Paul Williams raised the issue of whether there are information governance concerns around hand held ultrasound devices where images are stored in the cloud. Sion O'Keefe advised that there is a cloud assessment form to be completed and will send him a copy.

Action: Sion O'Keefe

DIGNIFIED CARE

CDTQSE 20/405 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/406 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 20/407 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/408 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 20/409 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/410 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

It was noted that at the end of September there are 5754 patients waiting 8 weeks or over week in Radiology and Medical Physics.

There are 49 waiters at 14 weeks and over in Therapies. Of particular note is Podiatry which through creative thinking on how to manage patients differently are reporting 4 patients waiting 14 weeks or over.

Whilst figures are higher than they traditionally are, this is a significant achievement. In many instances there are services that are now exceeding pre-Covid activity.

There has been a lot of planning for winter surge and what capacity can be opened. There have been hospital outbreaks and the number of patients with Covid are steadily increasing. Every Clinical Board has been asked to provide nursing resource. These staff would be at 48 hours' notice asked to support ward areas within the organisation. Maria Jones is coordinating this for this Clinical Board. Any nursing support provided will be proportionate to the number of nurses in the Clinical Board. There will be discussions how this will affect services and what training requirements are needed. If the Clinical Board has to provide more support for the surge areas there will be recognition that services cannot fully run. The Clinical Board will be unable to provide support from nurses based within areas that are deemed as essential services.

CDTQSE 20/411 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/412 National User Experience Framework

Patent Experience data is currently not being collated.

STAFF AND RESOURCES

CDTQSE 20/413 Staff Awards and Recognition

Nothing to report.

CDTQSE 20/414 Monitoring of Mandatory Training and PADRs

No issues to report.

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

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

ANY OTHER BUSINESS

Jo Fleming reported that Radiology have reminded staff that they should be wearing a mask outside if they are less than 2 meters apart. This has to be a surgical mask and not a face covering.

Seetal Sall reported a major concern in point of care testing around the inability to link clinical equipment to the network in newly created and ward moves. The risk is users are not be able to perform tests and cannot download key reagents. A risk assessment is being produced.

An incident occurred at UHL this week with a device not connecting to the network. Seetal Sall to report the risk on Datix and provide Matt Temby with the details of the incident and he will escalate to the LCCs.

Action: Seetal Sall/Matt Temby

DATE AND TIME OF NEXT MEETING

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

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 17th November 2020, 08:00-10:30 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Abraham Theron	Consultant Anaesthetist, Anaesthetics
Adrian Turk	Pharmacist
Andy Jones	Lead Nurse, Surgery, Urology, Ophth & ENT
Angela Jones	Senior Nurse, Resuscitation Service
Adrian Turk	Pharmacist, Pharmacy
Barbara Jones	Educational Lead, Perioperative Care Directorate
Becca Jos	General Manager, Trauma & Orthopaedics
Ceri Chinn	Lead Nurse Peri-operative Care, Peri-op Care
Carol Evans	Asst Director Pt Safety And Qu, Nursing
Catherine Evans	Patient Safety Team
Mark Bennion	Quality & Safety Lead, Perioperative Care
Rafal Baraz	Consultant Anaesthetist, Anaesthetics
Susan Mogford	Senior Nurse, Perioperative Care
Terry Stephens	Procurement Nurse, Procurement
Tracy Johnson	Practice Development Nurse, Trauma/Ortho
Vince Saunders	Infection Prevent and Control Nurse, Infec Control

In attendance:

Dr Mark Foster	Clinical Lead/Knee Surgeon
Catherine Doyle	Anaes Consult and Diabetic Pre Op Ass Lead
Rhiannon Smith	Acute Learning Disability Liaison Nurse
Zoe Brooks	Surgery Clinical Board Secretary

PRELIMINARIES *(Chair)*		
SCB/QS: 20/190	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS: 20/191	**Apologies for Absence** Helen Luton — Interim Lead Nurse, Trauma & Orthopaedics Chris Williams — Consultant Ophthalmologist , Ophthalmology Yvonne Hyde — Cns In Infection Prevention And Control	
SCB/QS: 20/192	**Minutes of meeting held 22nd Sept 2020** The Group approved the minutes of the previous meeting.	

SCB/QS: 20/193	**Matters Arising:** No matters arising	
SCB/QS: 20/194	**Presentation Mandatory safeguarding compliance** Deferred to the next meeting in January 2021	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS: 20/195	**Patient Story –** **Trauma – Plaster Cast Saw** Procurement Nurse – TS reported on a plaster cast saw incident which involved a young patient who sustained a fracture as a result of falling off her bike in June. It was noted that the patient was seen in Paediatric A&E where a cast was applied. TS highlighted that the following day the patient returned due to swelling and tingling of her fingers. The Group were informed that on arrival to Paediatric Unit, the patient was seen by a Senior Clinical fellow and due to clinical indication it was decided that the cast was to be removed. It was reported that no cast saw was available in Paediatric Unit and a saw was obtained from another area; it was not apparent were it came from. It was noted that during the removal of the cast the patient become distressed and complaining of pain. Following a report from the Senior Clinical Fellow, it was suggested that the Clinical fellow felt that the patient was complaining of pain from the fractured site and continued to appease the patient and remove the cast. TS reported that on the 17th June the patient returned for an X-ray and another cast was applied; a further three weeks passed and on arrival at Trauma Clinic for removal, it was noted that old scars were visible, the length of her arm. The Group were informed that as a result, medical photography was carried out which highlighted that the scars were as a result of the saw. It was noted that due to these findings a check was carried out on all saws within Paediatrics, Trauma Clinic and Main A&E by Clinical Engineering, who reported no issues. TS highlighted that due to concerns around the saws, a number of measures had been put in place, such as ensuring that new doctors are competent in the use of the saws and assessed; the Senior Clinical Fellow received further training and sent an apology letter to the patient's family. The Chair thanked TS and welcomed any questions from the Group. Catherine Evans gave an update on the patient, reporting that the young girl has since been seen by a plastic surgeon and it is thought that there would be no long term scaring.	

SCB/QS: 20/196	**QSE bring forward action log:** **18/105 Orthopaedic Thromboprophylaxis regimes** CW agreed to discuss with AT outside of the meeting. To remain on Action log **19/106 Hydrochloroquine retinal monitoring** Awaiting business case to be prepared for additional resource for Opthamology. Lead Nurse, Surgery, Urology, Ophthalmology & ENT – AJ agreed to link in with Director of Nursing- CW to progress. To remain on Action Log **10/34.11 Pertussus vaccination** Consultant Anaesthetist – RB reported that a response from the Senior Occupational Health Nurse had been received, stating that priority had been categorised into groups. It was noted that Maternity was targeted back in August and continues to be rolled out. Item Closed **20/1/01 Teicoplanin in orthopaedics** The Chair reported that information had been received and liaison with allergy experts had taken place, with the aim to establish recommendations for the team on how to administrate Teicoplanin. To remain on Action Log **20/01/02 Nice Guidance** Director of Nursing - CW asked that this item be closed due to lack of reference. **14/194 Q&S session plans** Quality & Safety Lead - MB reported that Q&A sessions had not started back up and was waiting on a date when they will re-commence. Director of Nursing -CW reported that information had been received stating that sessions will re-commence in January. MB highlighted that the issues around the stop before you block, was in relation to whether anaesthetists should mark their own block. It was noted that discussions had taken place and a paper was due to be published in November. To be progressed following submission of the paper and recommendations. To remain on Action Log **14/195 Patient Story In110925** Concerns raised around newly qualified member of staff working outside of policy. Quality & Safety Lead -MB reported that information had been circulated highlighting the requirements of the policy. Item Closed **14/200 Updated Patient Safety Alerts** Director of Nursing -CW reported that minutes of the Bed Management Group had been received. **14/202 Monitoring of CB Clinical Audit plan** It was suggested that Consultant Urologist- HK to be invited to the meeting early next year for update. **14/203 Meetings of Dementia Sensory loss Learning Disabilities initiatives.**	

	Agenda Item	
SCB/QS: 20/197	**Feedback from UHB QSE Committee:** Director of Nursing - CW reported that October's QSE papers had not yet been received, however noted some of the agenda items, such as SI reported and concerns and complaints over the Covid period. Asst Director Pt Safety And Qu, Nursing - CE suggested that the presentation taken to the last QSE Committee is shared with the Group. Action CW/CE The Group were informed that the Surgery Clinical Board would be attending the QSE Committee on the 14th December to present a paper on the review of the last year. It was also noted that there will be a further presentation at this meeting around the work carried out within the Green zones and PESU.	
SCB/QS: 20/198	**Health and Care Standards – sign of self-assessment/ ongoing review of implementation/ improvement plan:** Director of Nursing - CW re-iterated that due to Covid the Health Care standards had not been completed this year and as a result a review against the improvement plan would not be completed.	
SCB/QS: 20/199	**Regulatory compliance and external accreditation (where relevant):** **QUAD audit feedback** A report was received and noted by the Group. The Group were informed that an Internal QUAD Audit was carried out in September 2020 for both sites. Educational Lead – BJ was pleased to report that all Theatres audited were compliant with all aspects of the QUAD Audit standards. It was also noted that an additional retrospective audit was carried out around the same time across all areas and sites. Concerns were raised with regards to the care plans audited in Main Theatres, where there were no sign out and documentation not completed correctly. It was reported that at the beginning of the year stickers were added to the checklist for the timeout section, however the care plans in distribution did not have these stickers on them; as a result additional stickers were produced. BJ reported that similar issues were raised in Green areas in Main Theatres and SSSU; a detailed action plan had been received for these areas. It was noted that full details could be found in the report; overall findings demonstrated that a significant number of areas were complaint with the QUAD standards.	

SCB/QS: 20/200	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities:** • Directorates Lead Nurse, Surgery, Urology, Ophthalmology & ENT - AJ reported that there had been a number of IP&C outbreaks on B2; which are being managed. AJ also raised concerns around staffing risks in C7; which is a red ward for winter pressures. Quality & Safety Lead - MB informed the Group that there were consent audits underway throughout the departments. MB also reported on an incident that occurred within Main Theatres where a patient sustained skin damage to lower back, following surgery. It was noted that a RCA was underway; a Clinical Engineering report identified a fault with the mattress. MB reported on a new never event in Main Theatres; the patient was due back to Theatres to confirm if there was a retained swab following recent surgery. It was noted that if a swab is confirmed then this was to be escalated. MB gave a further brief update on the following:- • SSSU Theatre 8 failed a laser inspection check, all actions underway to ensure all laser safety is in place. • UHL Theatres second phase of green zone went live on the 9th November, will see an increase of more orthopaedic sessions and breast lists. • Risk raised in the radiology department regarding the provision of intraoperative X-Rays due to staffing constraints and equipment; weekly meetings established to alleviate these risks. • Never event in DSU in UHL report of a patient had an incision made in the incorrect site; this had been escalated and a meeting was scheduled for the 18th November 2020. Consultant Anaesthetist - RB highlighted that a number of incident forms had been submitted over the past few months, one relating to Cardiac Unit in UHL where RCA involvement was required; due to an X-Ray machine overheating. The Group were informed of a serious incident that occurred in September at UHL, where a patient required a front of neck access, it was noted that this was appropriately managed and the patient was later taken to ICU at UHW; patient did not sustain any long term nerve damage and fully recovered.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 20/201	**Initiatives to promote health and wellbeing of Patients and Staff:** **Presentation on what the National standards are for Perioperative Diabetic care and what we are currently doing at C&V.**	

	The Chair introduced Catherine Doyle – Anaesthetic Consultant and Diabetic pre Op Assessment Clinical lead. CD opened up the presentation with some background information, it was reported that although Cardiff and Vale had implemented a number of projects within Diabetics, this was not the case nationally. It was reported that the purpose of the presentation was to demonstrate the Health Board's current position and were it need to be. The Group were informed of the background Information:- • 1 in 6 hospital beds occupied by someone with diabetes Problems: • 1) Higher infection rates • 2) Increase LOS 1 to 3 days • 3) Increase Mortality – 6.4% higher • NaDIA (National Diabetes Inpatient Audit)- 18% of inpatients have Diabetes CD reported that an audit was completed in 2016 to identify if the Health Board had the services of a dedicated Diabetic Inpatient Specialist nurse and what the percentage of people with diabetes who are listed for whom a perioperative diabetes management plan is created at POAC? Standard 100%; the outcome was that there was no dedicated Diabetic Nurse Specialist for C&V Surgical Directorate and C&V diabetic audit 2019 highlighted a compliance of 72%. Key finding reported:- • 19.4 % (42/439) of patients were not prioritized appropriately – prolonged fasting • 35.8% (182/509) room for improvement in clinical care • 21.2% (86/406) of patients did not have their blood glucose managed appropriately in the post op period (opinion of case reviewers) • In 16.6% Diabetes was not managed by all appropriate staff - EARLY involvement of a Diabetes Nurse Specialist would have been beneficial Recommendations reported:- • Ensure diabetes management is optimised for surgery • Ensure patients with diabetes are prioritised on the operating list, including the co-ordination of emergency surgery • Identify when involvement of the diabetes multidisciplinary team, including diabetes specialist nurse, is required CD was thanked for her presentation and comments were welcomed. **Meeting Update** • SCB H&S/IPC meeting update	
20/201.1		

	Director of Nursing- CW reported that the above meetings had been merged and met on the 19th October; focused on Patient and Staff Covid related issues. • Decontamination group update Meeting had not taken place during the period. • Water safety Group Update Scheduled for the 9th December.	
SCB/QS: 20/202	**Bring forward –progress on relevant improvement plans (previously approved/discussed):** **B2 improvement plan** Action Plan received and noted by the Group. Group were advised that the Action Plan was established following an incidence of possible hospital acquired transmission of Covid-19 within a staff group on Ward B2 UHW. AJ reported that it was believed that this outbreak started from a patient that was transferred from Prince Charles's Hospital. AJ gave an overview of the report highlighting that a plan for B2 North had been established to determine if additional capacity could be created. It was reported that discussions had taken place with IPC regarding moving patients out of 9 bedder into 4 bedder and 1 X positive patient into the cubicle and plan had been supported. In respect of B2 South, AJ reported that there were eleven patient in total that had tested positive, however a number of patents had turned Covid-Blue and had since been discharged. It was also noted that three members of staff were effected. It was noted that the outbreak was being well contained and was an improving situation. Director of Nursing – CW praised the staff of B2 on how well managed this was. CW also reported that there was a similar situation on A5.	
PART 3: SAFE CARE		
SCB/QS: 20/203	**Implementation of relevant care bundles and changes to patient pathways** **The National Joint Registry 17th Annual Report** Mark Foster – Clinical Lead/Knee Surgeon presented on National Joint Registry, outlining the purpose and process. It was highlighted that a K1 form is completed at the time of surgery, which is then transferred onto a national database; a k2 form is then completed on revision and an Annual Report is generated.	

	It was noted that in 2013 findings identified that the knee revision rate was higher than average and that the Health Board was unit outliers. The Group were informed that following a letter from the NRJ, the following actions were agreed:- • Review all the surgeon level reports • Review all outlier 1st linked revisions. MR reported that following these agreed actions the following was identified:- • No further surgeon's outliers, however two surgeons were close. • Implant issues – MB PS PFC – 7.1% revision rate at 9 years and Deuce – 15-40% revision rate. It was noted that due to these concerns a number of measures had been put in place and continually monitored each year. Full presentation identifying key issues and measures put in place as well as statistics, is available on request. MR was thanked for his time and the Group found the presentation interesting and useful. Asst Director Pt Safety And Qu, Nursing - CE reported that a clinical effectiveness Committee was being establishing, which was scheduled to meet for the first time in December and asked if MR would attend one of these meeting to present this to that Committee. MR was happy to attend.	
SCB/QS: 20/204	**Patient Safety Incidents** Patient Safety - CE informed the Group that during the period an additional five Serious incidents had been reported. The group were also informed that a new process had been established were these incidents were to be reported to the Delivery Unit, rather than Welsh Government, however it was noted that there were no changes to the internal process for the Clinical Boards. CE highlighted that only one closure form was sent for the previous month, relating to the plaster saw incident. In relation to inquests, it was reported that there were a number of complexed inquests to be progressed next year. The Chair re-iterated the importance of the management of these incidents.	
SCB/QS: 20/205	**Patient Safety Alerts (internal/external)** The Group received and noted the Patient Safety Alert reports. Director of Nursing – CW reported that a number of Patient Safety Alerts had been received, the Group received an overview of the following:- • **ISN 2020 009 - Expired blood tubes** The Chair asked that OPD's are encouraged to check the various places and check the expiry date on the bottles. MB Agreed to feedback to the OPD's with this request.	MB

	• **PN056 - Foreign body aspiration** • **PN055 - The Safe Storage of Medicines - Cupboards** It was noted that further alerts had been received since the agenda had been submitted and would be brought to the next meeting.	
SCB/QS: 20/206	**Health Care Associated Infections** HCAI rate – October data Infection Prevent and Control Nurse - VS gave an overview of the data report highlighting that Surgery Clinical Board was doing well. Key findings for reporting period April 2020 to date:- • 2 cases of C. difficile • 0 MRSA • 4 MSSA • 8 E.coli • 3 P.aeruginosa • 3 Klebsiella spp Full details can be found within the report. VS reported that although MMSA is being well managed within Surgery, as a Health Board, it was likely that the target would not be met as other Clinical Boards were seeing an increase.	
SCB/QS: 20/207	**Any key patient safety risks:** **Q&S performance data** Report received by the Group. Director of Nursing – CW gave a summary of the Q&S performance data report that included Serious incidents, DATIX management and other performance statistics. It was highlighted that DATIX management continues to be discussed to ensure managers are reviewing incidents. It was noted that there had been a reduction in reporting during the first wave of Covid. CW reported positive progress with regards to mortality reviews, where a 100% was achieved in October. The Group were informed that the reporting of avoidable pressure damage was again being reported to the Welsh Government; this was stopped during the first wave of Covid. With regards to medication data, October's figures was not available, however it was noted that Septembers data was positive with 99% of patients reported to have been prescribed appropriately.	

	The Chair queried whether Health Care workers should be completing DATIX form if there is a confirmed hospital acquired Covid. The Director of Nursing CW confirmed that and Health Care acquired Covid, whether staff or patient requires a DATIX form to be completed. It was suggested that the process for investigation was being reviewed to be simplified. It was noted that the minutes of the Corporate Beds management Group was available for information. Lead Nurse, Surgery, Urology, Ophthalmology & ENT – AJ reported that the Safeguarding Group had not met, however highlighted that it was White Ribbon Day shortly in recognition of domestic abuse and violence against women. AJ informed the Group that two learning and disability liaison nurses had been recruited in April/May and highlighted the benefits of having them in post. It was noted that due to covid, the training aspect had been difficult, however the learning and disability liaison nurses had managed to visit wards and ensure that patients with learning disabilities are getting the right care. AJ highlighted that Rhiannon Smith - Acute Learning Disability Liaison Nurse was present at this meeting. The Chair welcomed RS and asked if there was anything she would like to add. RS gave a brief overview of the role highlighting the following:- • Coordination of care when patients are admitted to hospital, including safe discharge. • Support/Advise acute staff regarding personalised care. • Work with agencies • To promote positive experiences within the hospital • Training of the learning disability champions. Medical devices Group – the Chair reported that a meeting had taken place where recent work in Dental was discussed around the ventilation system. It was noted that this was working very well. The Chair reported that there would possibly be monies available for medical equipment for the Health Board and encouraged areas to submit bids. Director of Nursing – CW reported that the Q&S Workplan 2020 was circulated for information and highlighted that 2021 plan was being updated and would be circulated.	
SCB/QS: 20/208	**Mortality data analysis** The Chair reported on the newly established Mortality review Group. It was noted that the main purpose of this group was to work on the implementation of the new medical examiners that are in situ; ten around the whole of Wales who will be looking to review every death, where a decision within 48 hours will establish is a level 2 mortality is needed.	

	It was highlighted that a Health Board in Wales who has access to electronic records would be the first to implement this and would then be rolling out to all other Health Boards in Wales.	
PART 4: EFFECTIVE CARE		
SCB/QS: 20/209	**Monitoring of CB Clinical Audit plan** The Director of Nursing – CW reported that a review against the previous year was being carried out and all Audit leads had been approached to submit information; feedback received.	
SCB/QS: 20/210	**Implementation of key NICE Guidance** No Update	
SCB/QS: 20/211	**Research and development update** No Update	
PART 5: DIGNIFIED CARE		
SCB/QS: 20/212	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** Overview report from HIW for 2019/20 circulated for information.	
SCB/QS: 20/213	**Initiatives to improve services for people with:** **Dementia** **Sensory loss** **Learning Disabilities** Covered in other agenda items above.	
SCB/QS: 20/214	**Any initiatives specifically related to the promotion of dignity** No Update	
PART 6: TIMELY CARE		
SCB/QS: 20/215	**Initiatives to improve access to services/ management of risk** The Director of Nursing – CW reported that a robust plan had been initiated in relation to improving activity under the current pressures and referenced the opening of the orthopaedic and Breast green area. It was noted the activity in Spire would reduce and with the predicted demand on amber areas in the coming weeks, the plan was to keep all Green activity running throughout the winter; this was subject to review based off demands and pressures, and as a result priorities may change.	
SCB/QS: 20/217	**Performance with follow up arrangements** It was noted that RTT was not currently being monitored, however follow ups were being conducted virtually. The Director of Nursing.	
PART 7: INDIVIDUAL CARE		
SCB/QS: 20/218	**Feedback from surveys – relevant improvement plans** - **Compliments**	

	It was reported that a number of complements had been received and was noted with the Patient experience department. - **Complaints (include reference number for specific complaints)** It was highlighted that a significant number of complaints had been received; where a high proportion related to patients querying their operation date.	
PART 8: Staff and Resources		
SCB/QS: 20/219	**Staff awards and recognition** The Director of Nursing – CW reported that shortlisting for Surgery stars had been completed and was preparing for the next stage of informing the winners and presenting them with their prizes. CW highlighted that there was a significant number of staff nominated and very it was humbling to read the reasons why.	
SCB/QS: 20/220	**Staffing levels** It was reported that safer staffing levels had been signed off and agreed last week with Nurse Director - Ruth Walker for Surgery Clinical Board, to capture recent changes due to Covid. The Director of Nursing – CW informed the Group that there had been ward changes since the sign off with new wards also open for winter pressures such as C7 (Red Area); that was being managed by Surgery.	
SCB/QS: 20/221	**Staff surveys** The Chair highlighted that the deadline of all wales staff survey was soon approaching and encouraged staff to complete.	
SCB/QS: 20/222	**Monitoring of attendance at relevant training e.g IP+C, Safeguarding, MCA, DoLs pressure damage, falls prevention.** It was noted that the release of staff for training under these current pressures was problematic and this had been highlighted to the Learning, Education and Development team. Senior Nurse, Resuscitation Service - AJ highlighted the substantial amount of support that Surgery Clinical Board has given for attendance around deteriorating patients, in particular Health Care Support workers attending the Beach Course. It was noted that feedback had been positive.	
DATES OF NEXT MEETING 19th January 2021 – 8-10PM – Ms Teams		
ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 30th October 2020
Skype Meeting

Minutes

Attendees:
Claire Main (CM), Interim Director of Nursing (Chair)
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Kevin Nichols (KN), Service Manager, Cardiothoracics
Maurice Wentworth (MW), REU/ALAS
Nick Gidman (NG), Directorate Manager, Cardiothoracic
Claire Mahoney (CMah), IP&C Lead
Steve Gage (SG), Pharmacy Lead
Richard Parry (RP), Q&S Facilitator
Judith Burnett (JB), Senior Nurse, Critical Care
Rachel Barry (RB), Lead Nurse, Neurosciences
Mary Harness (MH), Senior Nurse, Haematology
Mathew Price (MP), Service Manager, Neurology
Carol Evans (CE), Assistant Director, Patient Safety and Quality
Rafael Chavez (RC), Consultant, N&T
Dan Jones (DJ), Deputy General Manager, Critical Care and MT

Present:
Gemma Williams (GW), PA for the Specialist Clinical Board (Note taker)
Anne Owen (AO), Business Analyst**,** Digital & Health Intelligence

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions CP chaired the beginning of the meeting on behalf of CM due to IT issues. There were some IT issues throughout the meeting.	
1.2	Apologies for absence Received from; Sarah Matthews, Angela Jones, Gareth Jenkins, Jonathan Davies, Colin Gibson, Catherine Wood, Guy Blackshaw, Suzie Cheesman and Keith Wilson.	
1.3	To review the Minutes of the previous meeting 25th September 2020 The minutes were an accurate record, subject to; RP noted that on page 2 the back log of RCAs specifically relates to the IP&C RCAs and not the RCAs in general – GW to amend. Matters Arising Item 1.3 • GW has made the typo amendments required on the previous minutes from 17th July. • Risk Registers – RP noted that there has been an issue getting the Major Trauma Risk Register completed for the first time. RP encouraged	**GW**

	Directorates to let him know if there were any issues and he could help to support. CP noted that they need re-assurance that the Board is aware of all of the top risks and reiterated the need for Directorates to respond to RP with their regular update even if there are no further updates on risks. • HCAI – CM to circulate the Clinical Board HCAI action plan. The Clinical Board is looking to set up IP&C meetings again – CM is leading on this. • No pharmacist on the Polytrauma Unit – SG updated that they are still trying to fill the gap – waiting on some action from someone they have recruited. Ongoing. • Open Serious Incidents – will be picked up as part of the main agenda. • HCAI – reinstating the Clinical Board HCAI meetings as stated above. • Feedback from UHB QSE Committee – April minutes to be circulated when received. Item 2.1 • Open Serious Incidents - to be picked up as part of main agenda. • Open Inquests – to be picked up as part of the main agenda. Item 2.2 • MDA/2020/019 – on the agenda to be discussed by Nick Gidman. Item 2.3 • HCAI – suggestion to change routine screening in renal so a meeting with microbiology was arranged. To be discussed at the next meeting. • Critical Care MSSA – increased bacteraemia infections. There are still ongoing environment issues. Work sat with Estates. BO was going to send the list of repairs required to CP to link in with Estates. Item 3.1 • Documentation audit – CP noted that the results discussed in the last meeting were really positive overall. One of the actions was that Directorates share their action plans for shared learning. Directorates to provide a short summary of findings and actions. GW will email out to Directorates to follow this up. • Documentation audit to take place every 3 months. Item 3.2 • Feedback from UHB QSE Committee – SC to send GW the June minutes to circulate. CM thanked CP for all her support and hard work over the last few months whilst undertaking the Interim Director of Nursing role.	**Claire Main** **SC/GW** **GW** **CP** **GW** **SC/GW**
1.4	<u>Attend anywhere presentation</u> CM noted that most people have adopted "Attend Anywhere" within their Directorates but that Anne Owen, Business Analyst, Digital and Health Intelligence, would be providing an update for the group. Anne noted that her team had been going around all of the Clinical Boards providing updates on where they are and how the roll out has been going. Anne works in the Digital Health Team and part of her role is the roll out of attend anywhere which is the video platform of choice. Since its roll out in April in response to the Covid-19 lockdown, the roll out has been very successful. The attend anywhere report shows that 492 clinicians have participated in the consultations, 810 staff trained, 88 waiting rooms used for consultations, and there has been 8,141 consultations.	

	Specialist have carried out 654 video consultations, trained 160 staff members, have set up 8 waiting rooms with 6 being used. There are a team of implementation leads and Paul Rogers, Directorate Manager, ALAS is the implementation lead for Specialist. All of the guidance documents are up to date on the intranet. Good feedback around patient empowerment – with patients taking on clinical advice more readily in their home environment. Anne asked that Directorates encourage more services within the Clinical Board to use attend anywhere where possible. Anne is happy to provide support to any areas that need it. It would be useful to share any good news stories or challenges in Directorate meetings. SL asked if there were any plans to formally evaluate the project. Anne noted that at the end of the video consultation call there are 2 surveys and these are actively being evaluated. Anne will let GW know who the Evaluation lead is (national level) and circulate it to the group. The aim is that all services will be offering video consultations. Contact Paul Rogers initially and he will inform the person/team of what needs to be done to be set up and training etc. The presentation was embedded in the agenda and circulated to the group.	**Anne/ GW**
PART 2: SAFE CARE		
2.1	<u>Open Inquests</u> RP updated the group in Suzie's absence. A number of inquests open but already in process. Nothing specific to add. CE noted that the inquests are being booked up to 12 months ahead at the moment. <u>Serious Incidents</u> • In106895 SW - Open SI in Neurosciences – RB noted that there was a delay in finalising the action plan but that she had sent it late yesterday to RP. Hopefully now at the point where it can be closed fairly quickly. RP noted that he did manage to send the closure form out last night to the group (which was then closed after review by Carol Evans). • In103961 LP – Coroner inquest into patient death following complex TAVI which involved equipment failure and haematoma that may have contributed to the patient's death. RCA completed but not fully approved as yet. CE will try to expedite this so that it can be reviewed at the next QSE meeting. • In101282 MB – Cardiac Waiting List Death. Closure form completed and for review at this QSE. Due to the significance of this case the closure form will require further review after the QSE which is to be coordinated between CE and CM. • In103031 PO - Cardiac arrest on Critical Care possibly related to blood loss from haemofiltration blood lines and IV noradrenaline administration. Closure form completed and for review at this QSE • In108123 PJ - Cardiac waiting list death - RCA in progress. RP is supporting Lisa Evans and drafting the closure form next week. • In116055 - Covid19 outbreak involving 5 patient deaths following admission for cardiac surgery. • In122276 RH –Patient fall on B1 - Closure form completed and for review at this QSE. • New SI In124739 FS - the young boy was on the MT pathway and experienced difficulties in getting vascular surgery – RCA just underway. CE noted that she will be looking to review the closure forms she has	**CE/CM**

	received later on today.	
2.2	Alerts/Patient Safety Notices MDA/2020/019 - Abbott Trifecta / Trifecta GT bioprosthetic aortic heart valves: cases of structural valve deterioration (SVD). The MDA states the need to identify those patients implanted with a 1st generation Trifecta valve and consider implementing enhanced follow-up. NG updated the group. Of the valves implemented to date, 65 cases presented to MHRA and 60 relate to the 1st generation valve and 5 to the second generation. In Cardiothoracics they have contacted the company and now have a list of transplanted valves between 2010 and 2017 132 valves transplanted and they have managed to cross reference with the surgical database and now have all of the names of the patients that had valves transplanted. There isn't any advice regarding a surveillance plan in the MDA however last week the British Cardiology society released guidance to say out patients should be followed up annually and have an annual echo. Currently working through the list to identify those patients – the age profile is elderly so a significant number are in their 80s and 90s. NG noted that they will be checking the clinical portal and will be getting these patients in for their out-patient appointment and check their valve. Working as a DMT and this will be discussed further at a meeting on Monday.	
2.3	Closure Forms • IN101282 – closure form and improvement plan KN updated the group. This case relates to a gentlemen seen within Cardiothoracics – who had a cardiology history dated back to February 2011. The patient came through the emergency stream in Cwm Taf and had a PCI and was diagnosed with mild aortic stenosis. In October 2018 the gentleman's symptoms were getting serious and he was suffering from shortness of breath so was referred for cardiac surgery and was seen in out patients. He was placed on the waiting list with view to losing weight but he then became critical so the plan was to proceed to surgery. Unfortunately the patients planned surgery in June, July, August and September was cancelled because of the high number of cases and reduced capacity. The gentlemen sadly passed away - believed to be from a heart attack. The action plan notes the need to monitor patients on the waiting list and details how to recover activity. The Cardiac case managers and Directorate management team are tracking patients who have their surgery postponed. There is a red flag system that means that if a patient comes to us even from another speciality they will be red flagged. All patients on the cardiac surgery waiting list are now given a letter that informs them if they become more symptomatic and ill what they need to do. All patients on the waiting list are being reviewed every 3 months by the referring cardiologist. More challenging during covid but the move to UHL has helped. Working with UHL and surgery to maximise activity there. Delayed with some works but getting towards full capacity and will hopefully recover weekend operating to tackle the waiting list. CM acknowledged the huge amount of work taken place. The closure form was held for further review. NG raised concern that the covid situation has significantly impacted on the cardiac waiting list and that it has been well acknowledged that there are 170 patients on the in-patient waiting list and many have been waiting over 12 months and have a critical aortic synosis so are a significant risk. NG noted that as it stands it is highly likely that there will be further incidents because of the pandemic. This has been fully communicated through the appropriate channels and the Directorate is working to mitigate this risk.	

	• In122276 Closure Form – CP updated the group. This case relates to a cardiology fall. A gentlemen was admitted to ward B1 in July via A&E with acute pulmonary oedema requiring continual positive airway pressure (CPAP) due to ischaemic cause and hypertensive cardiomyopathy. The patient fell in the bathroom and suffered a fracture to the right neck of femur. The review showed that full assessments were carried out in terms of mobility and there was regular physio engagement. The gentlemen's mobility was poor and he had walked by himself to the bathroom even though it had been recommended to him to walk with a member of staff. In terms of actions, sitting and standing blood pressure processes have been shared with the teams, and practice educators are carrying out spot checks of patient records, one set of lying and standing observations must be taken. This will be discussed as well at the next Sisters Forum next week. Also, lying and standing observations will be added into the perfect ward pilot which B1 will participate in. Each Directorate to take this back to their areas regarding the need to do sitting and standing observations as this is relevant to all areas. SW is the falls lead if anyone needs help/support around this. The closure form was signed off. • Improvement Plan IN103031 (no closure form was sent out) – JB gave an overview of the incident that took place in Critical Care. This relates to a lady who was extremely sick and had an emergency triple A repair carried out. 2 days into her stay she had a cardiac arrest. During the course of the arrest the haemofilter machine disconnected from the femoral line. Days later the lady passed away. This is a complex SI and it can't be proven that the disconnection impacted on her death as she was extremely unwell but it shouldn't have happened. There are a number of recommendations in the SI. They have developed an SOP in relation to managing the lines and are raising awareness amongst staff dealing with femoral lines. CM will pick this up afterwards with JB as it happened some time ago. JB noted that the recommendations had been sent through to Suzie Cheesman this week but that she was aware that Suzie was on leave this week. This one was to be reviewed by Carol Evans due to the timeframes involved.	**Dirs**
2.4	Healthcare Associated Infections Outbreak on B1 CMah provided an update to the group. B1 is currently closed as they had 9 patients tested positive for covid. On Tuesday night they had 4 patients testing positive and the ward was closed and they cohorted the positive patients - there are now 9 positive patients (8 of which remain on B1). One member of staff had symptoms and has had a covid test but the results are not yet available. A second staff member has had a cough recently and was treated for a chest infection and she is now off isolating and also a HCSW bank staff tested positive that worked on B1. The first out-break meeting was yesterday and this is being followed up early next week with another meeting. CP noted that she attended the outbreak meeting yesterday and there are clear measures in place around segregating staff when rostering and the cohort of patients are now in the end of the South side so the communal space is cleared as best they can. Working closely with CMah and the IP&C team. B1 also used the north side for the 4 trolley bay service for acute coronary patients. There was concern around the tertiary service as they had to suspend this service for 2 days Wednesday and Thursday but after yesterday it was advised that it was critical that patients aren't delayed. The follow up outbreak meeting is on Monday. NG raised concern that they have lost a significant number of cardiac beds due to covid and that if we continue to lose this capacity it will mean further significant pressure managing the cardiac conditions. The B1 ward needs to be protected in order to be able to appropriately manage acute cardiac conditions. CM will take this to the	

	site meeting today so it's formally noted there. CP will look at a clear plan for the weekend and link in with CM. Pseudomonas Increase– Haematology CMah updated the group on the pseudomonas increase in haematology. Water testing was carried out on B4 haem and the showers tested positive for pseudomonas. Some typing was undertaken of water samples and there were some patient matches. A repeat sample was carried out and this still showed high counts again in showers in B4 haem and in the hand wash basins. An IP&C meeting was held to discuss the plan for the more remedial actions (as patients have travelled). The water on the TCT unit is also being tested and the investigation is ongoing. The audits were completed this week. Need to make sure there are specific SOPs in place. MH noted that only 1 patient has been contacted who has a rare type of pseudomonas and that they have taken the news well. Work ongoing. VRE Bacteraemia - Haematology It was noted that there is also a cluster of VRE bacteraemia cases in haematology. There was a PII meeting held and it is likely that the cases are not linked. This will be picked up in the Haem HCAI meeting. HCAI Report CMah summarised the position on her HCAI report noting that the Board is only down slightly in e-coli and klebsiella and that everything else is showing as an increase. Clinical Boards HCAI Meetings CM noted that MH has offered to support the Clinical Board HCAI meetings going forward (which have been on hold due to the pandemic). CM thanked everyone for their hard work with regards to the HCAI issues.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1		
3.2	Feedback from UHB QSE Committee No meeting since last QSE Committee.	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Cardiac CP re-iterated the importance of keeping the B1 beds free (as mentioned above by Nick Gidman). Critical Care JB raised concern regarding the lack of facilities and space in Critical Care and the need for support for staff.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR IFNORMATION BY THE COMMITTEE		
4.1	Alerts/MDAs for information /noting (previously circulated): For noting/action where required. • Internal Safety Notice ref 2020/Sept/008 • Extension Sets • Internal Safety Notice ref 2020/Oct/009 • Internal Safety Notice ref 2020/Sept/007	008 Plaster saw Final.pptx Extension Set.docx

		ISN 2020 009 - Expired blood tubes ISN T34 Batteries Aug 2020 v4 007.ppt
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Flu MH flagged the issue of problems obtaining the flu vaccines – only 100 left so prioritizing front line staff. More vaccine should be coming in the next few weeks. MH noted that the flu champions are still carrying on immunizing as and when they can. Pharmacy Issue SG noted that there is work ongoing around medicines procurement with the no-deal Brexit still ongoing nationally (Wales and UK). SG will keep everyone informed. Infection Prevention Measures CM reminded the group of the importance of being mindful of the infection prevention measures in light of the recent increases. Maria Roberts – Secondment CE informed the group that Maria Roberts, Patient Safety, has recently secured a secondment to Welsh Government for 18 months to lead on the Duty of Quality. Therefore Maria's post here in the Patient Safety team will be out to advert soon – if anyone is interested please contact Carol Evans.	
PART 6: DATE OF NEXT MEETING		
6.1	Fri 20th November 2020, 8-9am, Venue to be confirmed.	