Quality, Safety and Experience Committee - 13th April 2021

Tue 13 April 2021, 09:00 - 11:00

Agenda

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the Committee Meeting held on 16th February 2021

Susan Elsmore

1.4 PUBLIC DRAFT Minutes QSE 16-02-2021 - AF.NF.pdf (16 pages)

1.5. Action Log – 16th February 2021

Susan Elsmore

1.5 Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

2. Items for Review & Assurance

2.1. Children & Women's Clinical Board Assurance Report

Cath Heath / Scott Mclean / Clare Rowntree / Suzanne Hardacre

2.1 Children and Women's CB Assurance report April 2021 (004).pdf (31 pages)

2.2. Quality Indicators Report

Ruth Walker

2.2 Quality Indicators - April QSE 2021 V4.pdf (14 pages)

2.3. Exception Reports – IP&C Position (Presentation)

Ruth Walker

2.4. Impact of Covid-19 on Patient Safety (Verbal)

Ruth Walker / Stuart Walker

2.5. HIW – Activity Update and Primary Care Update

Carol Evans

- 2.5a HIW update on activity_QSE April 2021 V1 (1).pdf (7 pages)
- 2.5b HIW Primary Care Contractor SBAR Report March 2021.pdf (4 pages)
- 2.5c HIW Primary Care Contractor March 2021 Appendix 1 GDS.pdf (5 pages)

2.6. Themes and Trends in Never Events

Carol Evans

- 2.6 Never Events - V2.pdf (8 pages)

2.7. Gosport Review (Verbal)

Carol Evans

Verbal

2.8. Draft Quality, Safety and Experience Framework (Presentation)

Carol Evans / Angela Hughes

- 2.8 - Cardiff UHB - Health Foundation Project - LD Report.pdf (12 pages)

2.9. Board Assurance Framework – Patient Safety

- 2.9a BAF Covering Report.pdf (2 pages)
- 2.9b Patient Safety.pdf (2 pages)

3. Items for Approval / Ratification

3.1. Thromboprophylaxis Policy

Marilyn Rees

- 3 1 Template Report Policy Approval October 2020 MR.pdf (4 pages)
- 3.1 Thromboprophylaxis Policy 2020 Feb 21 u.pdf (10 pages)
- 3.1 EHIA Venous Thromboembolism (VTE)1 1.pdf (29 pages)

3.2. Swab, Instrument and Sharps Count Policy and Procedure

Stuart Walker

- 3.2 Swabs and Sharps Policy.pdf (3 pages)
- 3.2a Swab Instrument and Needle Count Policy and Procedure.pdf (25 pages)
- 3.2b Swab Instrument and Sharps Count EQIA.pdf (5 pages)

4. Items for Noting & Information

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

a) Children & Women's Clinical Board Minutes
b) Specialist Clinical Board Minutes
c) CD&T Clinical Board Minutes
d) Surgery Clinical Board Minutes
e) Mental Health Clinical Board Minutes
f) Medicine Clinical Board Minutes
g) PCIC Minutes

- 4.1a C&W QSE Minutes 26.01.21.pdf (9 pages)
- 4.1aa C&W QSE Minutes 23.02.21.pdf (8 pages)
- 4.1b Specialist QSE Minutes 20.11.20.pdf (7 pages)
- 4.1c CDT QSE Minutes 09.12.20.pdf (11 pages)
- 4.1c CDT QSE Minutes 10.02.21.pdf (10 pages)
- 4.1d Surgical QSE Minutes 19.01.21.pdf (9 pages)
- 4.1f Medicine QSE Minutes 22.10.20.pdf (6 pages)
- 4.1f Medicine QSE Minutes 25.02.21.pdf (5 pages)
- 4.1g PCIC QSE Minutes 10.03.21.pdf (10 pages)

4.2. Corporate Risk Register

Nicola Foreman

- 4.2a QSE - Corporate Risk Register Covering Report - April 2021.pdf (3 pages)
- 4.2b QSE Corporate Risk Register April 2021.pdf (4 pages)

4.3. Induction support for new Committee Members (Verbal)

Nicola Foreman

Verbal

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

Susan Elsmore

6. Any Other Business

Susan Elsmore

7. Review of the Meeting

Susan Elsmore

8. Date & Time of Next Meeting:

Tuesday 28th September 2021
9am

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 16th February 2021 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authority
Present:		
Gary Baxter	GB	Independent Member – University
Michael Imperato	MI	Independent Member – Legal
In Attendance		
Stephen Allen	SA	Chief Officer – Community Health Council
Guy Blackshaw	GB	Clinical Board Director - Specialist
Steve Curry	SC	Chief Operating Officer
Lisa Dunsford	LD	Director of Operations – PCIC
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Ann Jones	AJ	Patient Safety & Quality Assurance
Fiona Kinghorn	FK	Executive Director of Public Health
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Claire Main	CM	Interim Director of Nursing – Specialist Services
Hywel Pullen	HP	Assistant Director of Finance
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Joy Whitlock	JW	Head of Quality and Safety
Catherine Wood	CW	Interim Director of Operations – Specialist Services
Observer		
Annie Burrin	AB	Patient Safety Team
Emily Howell	EH	Audit Wales
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Abigail Harris	AH	Executive Director of Strategic Planning
Christopher Lewis	CL	Interim Executive Director of Finance
Tracey Meredith	TM	Vale Locality Integrated Manager

QSE 21/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the first QSE Committee meeting of 2021.	**Action**
QSE 21/02/002 Saunders,Nathan 04/12/2021 14:33:00	**Apologies for Absence** Apologies for absence were noted. The Chief Operating Officer (COO) advised the CC that he would need to leave the meeting at 10am to chair the COVID response meeting.	
QSE 21/02/003	**Declarations of Interest**	

	The Executive Director of Therapies & Health Science declared that she sits on board of Cwm Taf Morgannwg University Health Board.	
QSE 21/02/004	**Minutes of the Committee Meeting held on 15th December 2020** The minutes of the meeting held on 15th December 2020 were reviewed. **Resolved that:** a) The minutes of the meeting held on 15th December 2020 be approved as a true and accurate record.	
QSE 21/02/005	**Action Log following the Meeting held on 15th December 2020** The Executive Nurse Director (END) advised the Committee that item QSE 19/12/014 had been stood down because of work being started on the perfect ward. She noted that a report would be brought to September's meeting and the Action Log would be updated.	**NS**
QSE 21/02/006	**Chair's Action taken since last meeting** No chairs actions had been taken since the previous meeting.	
QSE 21/02/007	**Specialist Clinical Board Assurance Report** The Interim Director of Operations – Specialist Services (IDOSS) presented to the Committee. The presentation was intended to highlight how the team had delivered on the patient safety agenda and to show what the clinical board had been doing. The Specialist Clinical Board had taken a safe response to the pandemic and wanted to focus on what had been learnt, achieved and enabled despite COVID and not just in terms of what had been done to develop the patient safety agenda but also how it was done. She added that the Specialist Services clinical board had worked to key principles which were assumed in everyday practice but which they had made very clear and explicit. These were: 1) Symbiotic Relationship between leadership culture and patient safety. 2) Servant Leadership model. 3) Patient Experience. 4) Staff engagement –staff are the biggest asset. 5) Performance 6) Innovation – Clinically driven changes. The IDOSS advised the Committee that the team wanted to be become leaders in their field. Their work would be underpinned by financial integrity, the use of data to understand, demonstrate and prove change and to provide a focus on operational excellence. The IDOSS highlighted the following achievements. 1) Clinical innovation – This had enabled the UHB to become the second unit in the UK to undertake hepatitis C transplantation for	

both kidney and pancreas patients, the first unit in the UK to have undertaken Normothermic Perfusion, enabled the delivery of CAR-T therapy and the UHB was a pilot site for Catheter Directed Therapies.

2) Quality Improvement – They had implemented a Blood Count Analyser in the Haematology Day Unit, implemented a support care programme, started work on a STEP UP programme and had started work on a Patient at Risk Team (PART)

3) They had achieved a reduction in All Key HCA Metrics – reduced across the board using data to improve performance and sharing successes.

The Clinical Board Director – Specialist (CBDS) and the Interim Director of Nursing – Specialist Services (IDNSS) then shared operational examples of how the Specialist service were delivering on the principles mentioned as well some of the nascent actions in place that they wanted to implement over the following year.

The CBDS advised the Committee that Cardiac surgery were going through a journey and one of the headlines was that before COVID-19 hit, the service was carrying significant risk with long waiting times associated with high morbidity and mortality. He added that it was relatively clear from the onset of Covid UK that having major surgery and contracting COVID-19 perioperatively was a bad combination and that the mortality rate would have been approximately 50%.

The CBDS advised that it was important that changes made were Clinician led and that after much deliberation, the decision was made to move services to Llandough Hospital (UHL) where a green pathway was instigated. He noted that it had been a huge success and that the data spoke for itself.

He added that there had been no COVID-19 deaths via the green zone and that initially it was thought that the move to UHL was the “least worst” option but had realised that it was a successful move.

The CBDS advised the Committee that it had taken just 3 weeks between the decision to move to UHL and starting to deliver the service at UHL. He added that the waiting list had gone down by 50% and that by the end of March they were hopeful that there would be less than 100 patients on the list which Surgeons had deemed a stable waiting list.

The CBDS advised the Committee that a significant reduction in cancellations was noted and that the team appeared to be more stable and morale had increased.

He noted to the Committee that during the initial stages they had put as much work into one theatre at UHL as they had been in 2 theatres at UHW and productivity was excellent.

The CBDS advised the Committee that the Green Zone had been really positive which enabled the team to restore confidence in their own service and in the public.

The CBDS advised the Committee that with Cardiology being based at UHW, it made sense that at some point, the cardiac surgical services would need to be repatriated to UHW but hoped that it could be done with some of the changes implemented to make the service of the very best quality.

He added that with the expansion of ITU into C3 North and South, the cardiologists had noted that they did not want that space back and wanted everything to be on the first floor at UHW which made sense and what they hoped to achieve was to continue the good work undertaken to support cardiac surgical services, cardiology and ITU which would deliver the appropriate spaces.

The Interim Director of Nursing – Specialist Services (IDNSS) presented on the Major Trauma Service.

She advised the Committee that the service was designed to go live in April 2020 but due to COVID it was delayed. She added that during that time the polytrauma unit was repurposed as the Coronary Care Unit (CCU) and although they had pulled together a team ready to deliver the Major Trauma Service those staff members were kept in their existing employment or redeployed to support other units.

The IDNSS advised the Committee that a decision was then made for the Major Trauma Service to go live in September 2020 which brought a number of challenges.

She advised the Committee that the advantage of the Dragon's Heart Hospital was taken and a lot of simulation training was performed there through online platforms.

The IDNSS advised the Committee that all of the policies had to be revisited which involved cross collaboration with other Health Boards and other directorates within the UHB to make sure everybody would be aware of the impact of the service.

The IDNSS commented that the impact of going live was significant and was an unknown quantity in the context of what patients would come into the service given the public restrictions in place.

The IDNSS advised the Committee that 262 patients had gone through the service up until December 2020 of which 93 had been involved in serious vehicle incidents and a mixture of falls predominantly from Cardiff and Vale but also from Cwm Taf Morgannwg UHB and Aneurin Bevan UHB.

She added that they had tested all of the pathways that were implemented through the Major Trauma Service and brought together the Health Boards and repatriated the patients either back to their home (155 patients) or back to local specialist areas for rehabilitation and follow up care.

	The IDNSS advised the Committee that an important key focus was that they had kept the team together despite not having an initial base which proved beneficial in their Key Performance Metrics. The IDNSS advised the Committee that they had focussed on the MTC service and had worked closely with a specific MDT approach. She added that the important thing was to link with the community service to help support. The IDNSS advised the Committee that it had been a testament to starting a brand new service in a short space of time and that they were currently working on the 2nd phase of the business case which was driven by the team coming together and wanting to deliver this service. The IDNSS advised the Committee that Critical Care was a well-established service within Specialist Services and the information provided to the Committee had been worked to recognise that whilst there were 35 beds in the system the team had been working towards 50 level 3 beds for a number of years. The IDNSS advised the Committee that one of the most significant pieces of work within Critical Care was that the unit went from reporting zero Datix incident reports to being one of the highest reporters and had developed an open and trusting culture. The teams focus was on the patient at risk team recognising early on the patients who were deteriorating. The team were piloting a high intensity rehabilitation area where patients are stepped down from Critical Care to ensure that they could get the therapy they needed to reduce their length of stay and get them home. It had been identified that access to space and expansion was possible and that the team would need to focus on the important things within the MDT about driving critical services. The IDNSS advised the Committee that the Haematology Service was being looked at as a new project which included: 1) Accreditation of JACIE – The current service did not meet the clinical needs for accreditation. 2) Meeting the needs of the future population. 3) Collaboration with Medicine, Specialist Services and Velindre. 4) Planning and Capital Involvement. The IDOSS advised the Committee that clinically led services worked well and that they had adopted a mature risk based approach to performance management which had enabled progression and transformation in relation to the patient safety agenda. She added that they had asked one of the teams recently how they had felt after a performance review and their answer was that they felt excited which was a real demonstration in the team's belief. She noted that transformation was motivating and the team were keen to do more.	

	The CC complimented the team and noted that it was a comprehensive and coherent presentation which highlighted the team's ambition. The Executive Director of Therapies & Health Science (EDTHS) noted that she was really assured by the attention given to the presentation. The EDTHS noted that there had not been information provided around Artificial Limb and Appliance Service (ALAS) and wanted to advise the Committee that the Welsh Health Specialised Services Committee (WHSSC) would be funding micro-processor knees which would make a huge difference to the quality of care given to amputees. The EDTHS also advised the Committee that Paul Rogers had been appointed as one of her Assistant Director of Therapies & Health Science (ADTHS) and asked that the ADTHS would have a good link with Specialist Services. The Independent Member – University (IMU) asked: 1) In relation to the Critical Care environment, the IMU was unsure of the deficiency in bed numbers identified in 2014 and if it had been addressed. The IDNSS responded that they were still working in the surge capacity so were working with in excess of 50 beds. They were working closely with estates to get a more robust layout for the 50 beds. 2) The IMU noted that isolation facilities remained a significant risk. He asked what was being doing to address that risk. The IDNSS responded that they had been working alongside IP&C colleagues about how they would cohort and segregate patients. 3) What was the status of CAR-T therapy during COVID-19 and what were the plans for scale up of CAR-T therapy in post COVID-19 era? The IDOSS responded that CAR-T therapies had progressed as per pre-pandemic levels throughout all of 2020 and that they had developed a green pathway which enabled the safe delivery of the CAR-T programme. The IDOSS added that new NICE indications for increasing the scope of CAR-T therapies which were being planned which fitted in with the new haematology model presented. The CBDS advised the Committee that CAR-T was on the verge of an explosion and that the latest information he had received suggested that they were considering treatment of multiple myeloma which would be an enormous expansion. He added that within the new post anaesthetic care unit (PACU), where all green pathway surgical patients go, there had been talk of an area being established for CAR-T therapies.	

	The Assistant Director of Patient Safety and Quality (ADPSQ) advised the Committee that she could provide assurance that she would attend the QSE meetings with the specialist clinical board and that in April, she would be bringing the Quality and Safety framework for the next 5 years to the Committee. The END advised the Specialist Service Team that they should be proud of what they had been able to maintain during COVID-19 and how they had moved the service forward and decreased mortality which demonstrated really good learning. The END advised the Committee that she could not let the opportunity pass to commend the Specialist Service team for their work around IP&C and the improvements they had made. The END what advice the team would give to colleagues elsewhere in the UHB about improving incident reporting. The IDNSS responded that the reporting side more work was needed to get the information out. She added that what they had learnt was how to pull together themes from the reports and report those back. From that they could develop a quality improvement programme and take an MDT approach. The Independent Member – Legal (IML) advised the Committee that at every meeting there was talk of pressure damage and asked if there was a timeline to the Specialist approach to this and whether something could be reported to the QSE Committee to understand how to approach the problem. The END responded that the QSE Committee were due to have a paper on pressure damage at the next meeting. The IDNSS responded that within specialist services and critical care they were working through the understanding and the huge amount of data around pressure damage. She added that they would look back over the previous 12 months and would need to balance what had happened to get a full context of what was happening to patients and how to look at targeted interventions. The CC asked the Specialist Team how staff morale was. The IDOSS responded that staff were tired but morale was good. She added that there were specific wellbeing pieces in place and there was a strong sense of comradery within the team. **Resolved that:** a) The Committee noted the progress made by the Clinical Board to date. b) The Committee noted the approach being taken by the Clinical Board. c) The Committee approved the content of the report and the assurance given by the Specialist Services Clinical Board.	**CE** **NS**

QSE 21/02/008	**Quality Indicators Report** The Assistant Director of Patient Safety and Quality (ADPSQ) advised the Committee that the Quality Indicators Report was still a work in progress and noted that there was more to be done on the dashboards. The ADPSQ highlighted some of the key areas within the report, including: 1) The number of Serious Incidents had reduced 2) Clinical Board – Increased closures were noted 3) Pressure Ulcer damage 4) Never events – Since May 2020, there had been 6 which was higher than normal. The events were under investigation and a detailed view would be brought to the April meeting. The ADPSQ advised that there were some concerning trends around stroke data. She added that the data which provided most concern was patients getting to the stroke unit within 4 hours which had reduced to 17%. This would be discussed in detail at a future clinical effectiveness meeting. The ADPSQ advised the Committee that the Mortality Data for level 1 reviews compliance was improving and noted that there was a well-functioning mortality group chaired by Dr Krishnan. The ADPSQ advised the committee that in regards to IP&C, they were performing well. The EDTHS advised the Committee that she had an update on the stroke position. She noted that the UHB performed better than other Health Boards and that it needed to be recognised that the impact of COVID-19 had dictated the data and that the stroke team had been outreaching to other wards. The EDTHS advised the Committee that she was assured around the quality of care and that we were doing the very best we could during this time. The Chief Officer – Community Health Council (COCHC) noted to the ADPSQ that the graphs around inpatient falls appeared to be going up and asked if this was due to an increase in falls or was it the way the data was being presented. The ADPSQ responded that she needed to look closely at the data and would monitor that over time. She added that Annie Burrin had joined the Patient Safety Team recently who would be undertaking focused work to support falls prevention in the UHB. The COCHS asked the ADPSQ if the nutrition scores going down was a good thing. The ADPSQ responded that the scores should be as high as possible so the data would need to be looked at. The END added that if a patient assessment was undertaken on admission, the nutrition score would remain absent throughout the patient's stay so	

	during the COVID-19 period they probably would not have done as well on admission. The CC asked that in terms of the dental never events were there aspects of clinical supervision that the Committee needed to be concerned about. The ADPSQ responded that they had taken a thematic review of dental surgery and supervision was a recurring theme. She added that as part of the past work around never events, dental had linked up with centres of excellence from England and had agreed that when appropriate, somebody would come in and have a look at the processes in place in an external review process would be undertaken. The Executive Medical Director (EMD) responded that dental wrong tooth extraction was the biggest single never event in UK. He added that dental extraction was the only operation undertaken by students in health board so there was always a risk. The EMD advised the Committee that when there are complex dental issues it required attention to detail at every step which was way in excess of any other area. He noted that the key would be to take the learning from such events and utilise the external review process referred to by the ADPSQ. **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.	
QSE 21/02/009	**Exception Reports and Impact of Covid-19 on Patient Safety** A verbal update was provided by the END. The END advised the Committee that her time was focused on 4 main things. 1) Keeping going 2) Managing the ongoing COVID-19 pandemic 3) Ensuring we understand the demand for reopening activities such as surgery 4) The General Q&S agenda. The END advised the Committee that what was seen in COVID-19 was a general slow down into the summer of patients presenting with COVID-19, but gains in hospital acquired COVID. She advised that there had been a peak in hospital acquired COVID during January 2021, particularly at UHL. To address that concern teams had undertaken the following actions: • Increased lateral flow testing of staff.	

- Tested patients 3 days post admission in amber areas.
- Continued with point of care testing in EU
- Refreshed the communication plan across the UHB with a particular attention to staff behaviour.
- Asked Gwen Low, Consultant in Public Health, to provide a fresh look at the work they were currently undertaking.
- Increased focus on core IP&C and cleaning standards
- Maintained the good working between the IP&C team and the Local Command Centres.

The END advised the Committee that they knew the increase in hospital acquired infections related to geography and environment but it had was also been about patients testing negative on arrival and then positive during their stay.

The END advised the Committee that individual behaviours played a big part in this. She gave examples of car sharing, sitting together at lunch and not wearing masks.

The END advised the Committee that it was important from an assurance perspective to note that the team were looking at the things within the Health Board's own control such as staff behaviour.

The END advised the Committee that discussions had been had around lateral flow testing and the retesting of patients 3 days into their stay. It was agreed that this approach would be taken forward.

The END advised the Committee that colleagues had revisited the link between the operations meeting and the IP&C meeting and that the Executive Director of Public Health had also been invited to attend.

The CC noted that certain actions were within the control of the UHB and asked for an example of what was not in the control of the UHB.

The EMD responded on behalf of the END that that the key issue for the UHB was community incidents and that when talking about transmission in hospital by staff or visitors, the chance of those staff/visitors outside of work having COVID depended entirely on the community incident.

The EMD advised the Committee that as Community incidents drop so should the transmissions.

The EMD advised the Committee that the number of asymptomatic staff they had identified had been tiny.

The EMD advised the Committee that there had been good therapeutic advances in relation to COVID-19 which had a direct knock on effect of the number of patients who were escalated to AGPs and Critical Care.

The EMD advised the Committee that the clear ongoing issue was workforce wellbeing. He added that a new wellbeing survey would be shared at the operational meeting on Thursday 18th February.

Resolved that:

	a) The Quality, Safety and Experience Committee noted the verbal update on Exception Reports and the Impact of Covid-19 on Patient Safety.	
QSE 21/02/010	**Progress on Mass Vaccination** The Director of Operations – PCIC (DOP) gave the Committee an overview of the Mass Vaccination work. The DOP advised the Committee that the majority of vaccines were being delivered through 3 mass vaccination centres. 1) Splott, which had opened in December 2020 2) Penwyn Leisure Centre 3) Holm View in Barry She advised the Committee that in January hubs were established at UHW and UHL, and there had been mobile teams going out to care homes and more recently, to the patients who were housebound. The DOP shared the following figures with the Committee: Total vaccinations: 111,658 Total for groups 1-4: 96,503 (89%) Group 1: care home staff and residents: 81% Group 2: people 80+: 87% Group 2: frontline health and care staff: 98% Group 3: people 75-79: 88% Group 4: people 70-74: 90% Group 4: clinically extremely vulnerable: 74% The DOP advised the Committee that there were also a small number of people who had declined the vaccine or did not turn up to an appointment. The DOP advised the Committee that they had also been vaccinating patients in hospital and had patients in the lakeside wing, Barry Hospital, Rookwood Hospital and St. Davids Hospital had been vaccinated. The DOP advised the Committee that they had started some clinics at UHL for people who may have had allergic reactions. The DOP advised the Committee that there was a reduced vaccine that week and that teams would be focusing on 2nd doses. The DOP advised the Committee that the Patient experience team had undertaken a snapshot survey and received 68 responses. 97% were very satisfied and 3% satisfied with the work at the vaccination centres, which was a positive response. The DOP advised the Committee that in relation to incidents – there had been 16 to date. A small number of people had fainted and had adverse reactions.	

The DOP advised the Committee that there would be a formal review by (Health Inspectorate Wales) HIW and that they would be visiting 2 mass vaccination sites in March 2021. A self-evaluation report would be also be required which could be shared in the future.

The Executive Director of Public Health (EDPH) advised the Committee that some work had been undertaken around what could be done if there was a larger amount of the vaccine and whether Cardiff and Vale would be able to become a mass vaccination area. She added that the biggest challenge was the supply of vaccine and talks were ongoing with Welsh Government (WG) around this.

The EDPH advised the Committee than an analysis on the BAME community had started which was not complete as ethnicity data was only completed on 49% of those who had had the vaccine.

The CC noted to the Committee that the Imam's in various mosques had held meetings around the BAME community uptake on the vaccine.

The Assistant Director of Patient Experience advised the Committee that they had been looking at the seldom heard groups and were writing a strategy to take to the board. She added that they were working with local authorities around that and that it was a fast moving action.

The END advised the Committee that the focus would be on something that was bespoke for those communities and in regards to the traveller community, the vaccinations would have to travel to them.

The IMU asked about the sustainability of mass vaccination when looking forward to the prospect of a winter booster programme.

The DOP responded that in terms of workforce it was challenging. There had been a lot of offers for help but it had been challenging. She added that in an ideal world, longer shifts needed to be covered but staff had been reluctant to cover long shifts.

The DOP advised the Committee that in terms of planning for ongoing immunisation, they had been working on the 2 vaccines for priority groups and they could employ people on a more permanent basis if there was a booster programme.

The END added that the training programme was "quite something" and they would revisit that develop a more pragmatic approach.

The COCHC offered his help with communications within the community.

The EDPH responded to the COCHC and suggested that the Head of Communications could get involved in the discussions around communication and that there was a regional incident management team that met each week.

Resolved that:

	The Quality, Safety and Experience Committee noted the update on Mass Vaccination progress.	
QSE 21/02/011	**Board Assurance Framework – Patient Safety** The DCG advised the Committee that the report should be taken as read and reminded Committee members that the framework was shared for review before providing assurance to the board. **Resolved that:** a) The Quality, Safety and Experience Committee reviewed the Board Assurance Framework risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Framework was reviewed in its entirety at the March Board meeting.	
QSE 21/02/012	**HIW Activity and Reports Update** The ADPSQ advised the Committee that it was a short report and that the HIW had stepped down their activity during COVID-19. She added that since the last report, HIW had quality checked MEAU at UHL and an improvement plan had been submitted. The ADPSQ advised the Committee that they were still communicating with the HIW in terms of the maternity review and that an update would be brought to the next QSE Committee meeting. The ADPSQ advised the Committee that HIW would be attending the mass vaccination centres in March 2021 and they had also started a thematic review of mental health crisis prevention in the community. **Resolved that:** a) The Quality, Safety and Experience Committee noted the level of HIW activity across a broad range of services and agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 21/02/013	**Health Care Standards Self-Assessment Plan and Progress** The ADPSQ advised the Committee that every year a self-assessment was undertaken against Health Care Standards, however due to the pressures of 2020, a full assessment was not carried out. She advised the Committee that progress updates had been provided to the Committee on improvement plans. She advised the Committee that a self-assessment would be undertaken in 2021 against 17 of the standards. She suggested that, with permission of the Committee, she would work with the specialist groups until the end of April to submit SBARs and would bring a paper back to the June Committee.	

	Resolved that: a) The QSE Committee noted and agreed the proposed approach to the 2021 Health and Care Standards self-assessment**.**	
QSE 21/02/014	**Terms of Reference** The DCG advised the Committee that the Terms of Reference (ToR) feed into the end of year arrangements and are reported through to the annual report and she was keen to get them in this year as they were not in last year's report. The DCG advised the Committee that Audit Wales had delayed and slowed down their quality review due to ongoing pressures relating to Covid 19. The DCG advised the Committee that the ToR had been brought for the Committee approval. The EMD advised the Committee that he was unsure if the Organ Donor Committee would report to QSE but that the possibility had been left open in the ToR. He added that he did not think the Learning Committee would report to QSE and thought it was the outcomes that would be provided. The END advised the Committee that she agreed that the outcomes of the Learning Committee should be reported to QSE. **Resolved that:** a) The Quality, Safety and Experience Committee approved the Terms of Reference and recommended them for approval to the Board on 25th March 2021.	
QSE 21/02/015	**Work Plan** The DCG advised the Committee that the Work Plan had been drafted broadly and that it reflected what was in the ToR. **Resolved that:** a) The Committee reviewed and approved the Committee Work Plan for 2021/22 and recommended approval to the Board on 25th March 2021.	
QSE 21/02/016	**Committee Annual Report** The DCG advised the Committee that the Committee annual report provided a summary of all the work undertaken by the committee during the year. The CC commented that Committee Members should endeavour to improve their attendance figure of 73%. The DCG responded that work was being undertaken around who would sit on which Committee which would be taken to Board in March.	

	Resolved that: a) The Committee reviewed the draft Annual Report 2020/21 of the Quality, Safety and Experience Committee and recommended the Annual Report go to the Board for approval.	
QSE 21/02/017	**Policies and Procedures** The DCG advised the Committee that not all policies came to the Committee for approval. She added that at each meeting the Committee would be provided with a list of policies for ratification and that due diligence regarding prior approval of the documents would have been undertaken The DCG advised the Committee that ratification was needed for the following policies: 1) Ultrasound Risk Management Policy and Procedure. 2) Use of Antimicrobial Agents Policy. 3) Blood Component Transfusion Policy and Procedure. 4) New Procedure Policy. **Resolved that:** a) The Quality, Safety and Experience Committee ratified the Policies/Procedures listed following their approval by appropriate quality and safety sub groups of the UHB.	
QSE 21/02/018	**Board of Community Health Councils in Wales Report - Feeling forgotten? Hearing from people waiting for NHS care and treatment during the coronavirus pandemic** The COCHC advised the Committee that it would be helpful to have a discussion with somebody from the UHB around this. The END suggested that the Chief Operating Officer (COO) would be the best person to discuss this with. **Resolved that:** a) The Committee agreed to provide a continued commitment to ongoing communication with people regarding service delivery.	
QSE 21/02/019 Saunders.Nathan 04/12/2021 14:33:00	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality.** 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 f) Medicine Clinical Board Minutes – Unconfirmed	

	Resolved that: a) The minutes of each of the sub committees were noted approved as a true and accurate record.	
QSE 21/02/020	**Items to bring to the attention of the Board / Committee** No items were noted.	
QSE 21/02/022	**Any Other Business** No other business was noted	
QSE 21/02/023	**Review of the Meeting** The CC commented that she liked to give ample time to presenters as this provided the Committee with good quality presentations.	
QSE 21/02/024	**Date & Time of Next Meeting:** Tuesday 13th April 2021 at 9am. Via MS Teams	

Action Log

Quality, Safety & Experience Committee

Following the meeting held on 16th February 2021

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
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	**COMPLETE:** On February Agenda items 3.1 & 3.2
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	**COMPLETE:** 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	**COMPLETE**: 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	**COMPLETE**: On February Agenda: Item 2.6
QSE 20/12/018	HIW Activity Overview	Provide an update on HIW Activity and reports	16.02.21	Carol Evans	**COMPLETE:** On February Agenda: Item 2.6
Actions In Progress					
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	On April Agenda: Item 2.7
QSE 21/02/005	Perfect Ward Report	To share a report on the commencement of the “perfect ward”.	28.09.21	Ruth Walker	On September Agenda:
Actions referred to Board / Committees					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 20/09/019	Exception Reports – IP&C Position	END mentioned that the Chair had asked for the exception report for the IP&C Position back into the Open Board sessions	13.04.21	Ruth Walker	IP&C position on April Agenda: Item 2.3

Report Title:	**Children & Women's Clincal Board QSE Assurance report**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	13th April 2021	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Director of Nursing Children and Women Clinical Board Head of Midwifery, Directorate Lead Nurse.**						

Background and current situation:

The purpose of this report is to provide assurance to the Executive Committee that Quality, Safety and Patient Experience (QS&PE) is the driver for the shaping and delivery of services across the Clinical Board. The report will provide an overview of the patient safety and quality agenda over the preceeding 18 months and highlight the achievements, innovation and transformational work undertaken to date and describes key residual risks and their mitigating actions that carry forward into 2021/2022.

Quality, Safety and Patient Experience is at the core of all that we do within the Children & Women's Clinical Board

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

The Clinical Board wishes to update the Executive Board of the continued progress made regarding the Quality Safety and Patient Experience Agenda despite the significant challenges of the past year. We would like to highlight the considerable pressures we envisage as we approach a period of restoration and recovery. Of particular concern as we emerge from the second wave of the pandemic is the emotional well-being support that will be required for our children and young people.

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

ASSESSMENT

During the financial year 2020/2021, The Children and Women's Clinical Board comprises five clinical directorates with associated clinical services and specialties. The Clinical Board delivers a number of highly specialised services to both the South East region and wider all Wales population and has responsibility for universal services which support the health, well-being, education, development and Public Health amongst the population of children, young people, parents, families, women and their partners. This includes partnership and safeguarding priorities. The services also provide primary and secondary care services to the local Cardiff and Vale population. The Clinical Board has a budget of £102.646 m and a current workforce establishment of 1906 WTE.

Some of our services are Welsh Health Specialised Services Committee (WHSSC) commissioned and provide for the wider regional and Welsh Population Services are structured through the Directorates detailed below: -

- Obstetrics, Gynaecology and Sexual Assault Resource Centre (SARC)
- National Children's Hospital for Wales
- Children, Young People and Family Health Services (CYPFS)
- Specialist Child and Adolescent Mental Health Services (CAMHS)
- Cancer Services

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

The Children and Women's Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) Committee that meets monthly which is chaired by the Director of Nursing for the Children and Women Clinical Board with strong representation from Midwifery, Medical, Nursing and Allied Health Professional staff from both within and external to the Clinical Board.
Each directorate has its own QSPE forum which provides robust assurance to the Clinical Board Quality, Safety and Patient Experience Committee. Infection, Prevention and Control is a standing and high-profile agenda Item. There is also attendance from key stakeholders to ensure that there is wide engagement and challenge in the overarching quality and safety agenda.

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

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

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

Governance, Leadership and Accountability
Annual self-assessments against the Health and care standard across the University Health Board were not undertaken last year due to COVID restrictions and are not required this year.

The quality, safety and patient experience group led on the self-assessment against the Health and Care Standards. Key improvements identified for 2019-21 are: -

Health and Care Standard	Rating	Key Improvements
Health Promotion, Protection and	**AMBER** /Improving	• Maternity Safer Pregnancy Campaign has been embedded into practice with a notable

Improvement		reduction in stillbirth and perinatal mortality / morbidity • Standard operating procedures for COVID-19 vaccination programme developed for high risk pregnant women / frontline pregnant healthcare workers • Nursing staff rotated to support the mass immunisation and other Clinical Boards to support the COVID-19 effort and business continuity
Managing risk and promoting Health & Safety	Improving	• We have established multi-professional risk and governance meetings within the Directorates • Stillbirth review forum expanded to include neonatal deaths that do not leave the Delivery Suite. Compliance with Perinatal Mortality Review Tool • Multi professional skills and drills with PROMPT Wales has been implemented and progress against agreed standards monitored • The Clinical Board has held a series of workshops with the Corporate Risk and Governance team to support directorates with training and updating local risk registers.
People's Rights	Improving	• The Clinical Board continues to work in partnership with Cardiff Council and UNICEF to drive forward the Children's Rights approach. • The Clinical Board developed a Children's Charter in 2018 which is embedded within the Clinical Board and for 2021-2022 will work with other Clinical Boards in the UHB to spread this excellent work on a wider scale. • To continue to work with the CAVYB, to help inform the shaping of our services • Birth Choice clinics for women making decisions outside recommended guidance continue to ensure women make risk assessed, informed decisions about their birth • Patient stories are widely gathered and used for shared learning • Outdated signage being improved within the obstetrics and gynaecology directorate to ensure that language is inclusive • Maternity Services Liaison Committee due

		for relaunch in 2021 with a focus on reaching BAME / minority groups to help shape the service.
Timely Access	Improving	• Improvements this year demonstrate more women are booked by 10 completed weeks for their antenatal care • Restoration and Recovery plans underway post COVID-19

Each Directorate has a risk register which is based on robust risk assessment processes. In 2020 the Clinical Board held a risk assessment and governance workshop to analyse and review all risk assessment processes. This has triggered a targeted piece of work with each Directorate to review its risks and mitigating action.

Improvements have been made to the performance management arrangements within the Directorates in that in addition to the traditional metrics, the focus is on the key service risks and the required mitigation.

Each Directorate performs a monthly review of its clinical risk register which is then aligned to the Clinical Board Risk Register.

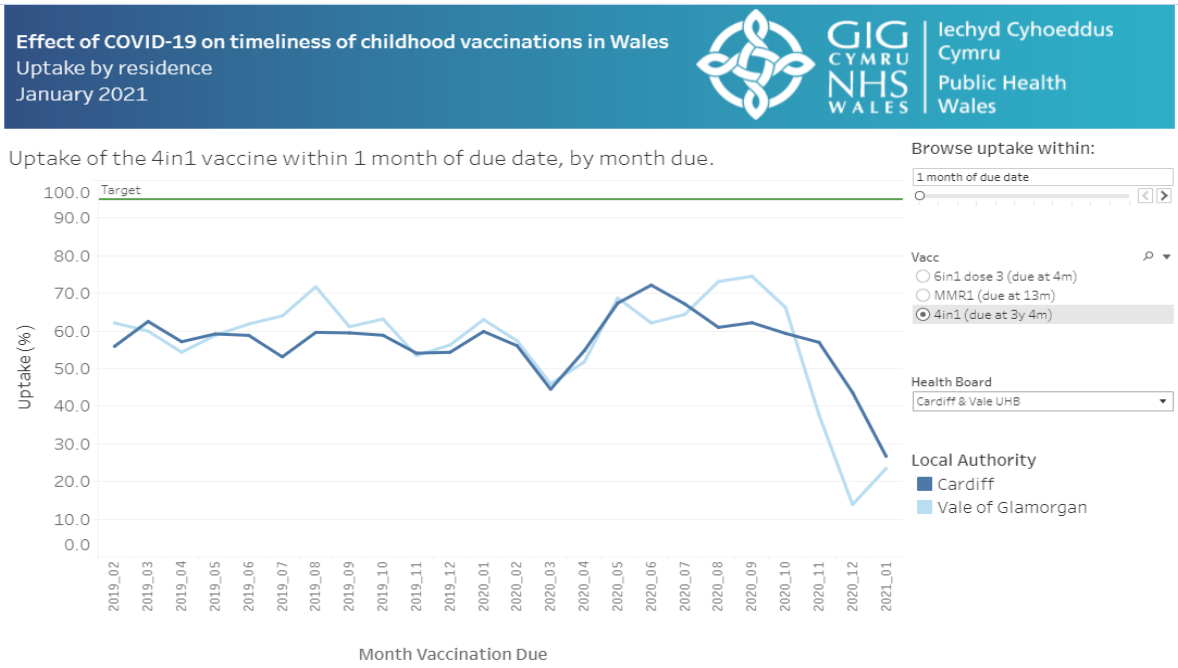
Currently the top 5 highest risks within the Clinical Board are detailed below: -

Risks	**Risk Score**	**Actions to Manage or Mitigate**
There is a risk of harm to women and babies from potential delays in treatment due to lifts in the women's unit being in a state of disrepair and regularly breaking down. On occasions all 3 lifts are out of order resulting in delays in transferring women in labour or to receive emergency treatment on the 2nd floor obstetric led unit	**16**	• A tertiary tower lift is available for emergency transfers (also C Block Lifts) • Lifts continue to breakdown on a daily basis. Continue to escalate to Health and Safety team and Executives for support in replacement/repairs. • Request regular updates from Capital Estates.
Risk of adverse clinical outcomes for CYP with Eating Disorders who require specialist assessment and intervention.	**16**	• Prioritising of the most urgent referrals based on clinical need and risk • Virtual ED team made up of Generic CAMHS clinicians, EDOS and SHED • Training has been secured to increase skills within the generic team to assess and deliver appropriate interventions • Some capacity within generic team has been freed up to provide input to young people with Eating Disorders from April. • Bid for additional posts through annual transformation monies
There is a risk of morbidity or mortality to patients waiting for longer periods of time on assessment or treatment waiting lists which have lengthened during and since the COVID-19 pandemic. The	**12**	• Monitoring of volume of patients waiting • Specific focus on patients waiting >36 weeks and >52 weeks • Clinical Review of patients waiting >52 weeks by a Consultant

main, but not exclusive groups of concern are in (adults) Benign Gynaecology, and (children) Neurodevelopmental, Continence, Primary Mental Health, Specialist CAMHS and Children Looked After services.		• Local negotiation with other Clinical Boards to increase Theatres, Anaesthetics, Clinic and Workforce capacity to allow increased activity • Submissions to central UHB bids for additional capacity/infrastructure • Influencing bespoke external stakeholders who may provide additional resources to increase capacity/infrastructure
There is a risk of adverse health outcomes for CYP requiring Community Paediatric Continence Service due to long waiting list. This is due to lack of adequate capacity and resource in the service.	**12**	• Reconfigured service with clear pathways • PARIS module developed to support admin and performance systems • Increase Nursing workforce • Increase in Tier 2 capacity • Staff trainer development • Agree process for containment product assessment / supply
Adverse outcomes for CYP with LD and challenging behaviour which could result in school exclusion, inappropriate hospital admission due to lack of emergency placement. There is a lack of capacity in Children's Intensive Support Service (Tier3)	**12**	• Cessation of acceptance of new referrals until CYP is discharged • FTC psychologist recruitment in process to CISS • Directorate T&F Group reviewing service needs across disciplines.

Staying Healthy (Theme 1)

Immunisation rates have dropped for our Children and Young People during COVID 19, due to parental reluctance to attend GP practices. To address this, champions have been identified in each health visiting base, training provided to CNNs and HV refresher sessions, cleansing of stats/ caseloads monthly and publishing in health briefing increase child health meetings.



In addition to the above, School Health nursing completed the Fluenz and HPV programmes and offered 'mop up sessions' in community venues. Fluenz uptake was improved on last year despite high absences in schools during the programme. With some funding released back from Public Health, the Directorate has recruited a full time Band 7 Immunisation lead to support improvement in uptake.

With regard to staff flu vaccine uptake, the Clinical Board achieved over 69% uptake, an improvement of 11% compared to the previous year.

The Clinical Board have positively promoted the health and well-being of our staff by proactively encouraging staff in line with public health guidance to take up COVID vaccines.

The 'Safer Pregnancy Campaign' continues to be a priority, with focused attention by community midwives and social media. The Obstetrics and Gynaecology Directorate continue to work closely with the Public Health Wales Healthy Child Wales agenda and midwifery staff are offered the Making Every Contact Count training to ensure public health messages are being given to women and their families at every opportunity.

In 2019 the Foodwise in Pregnancy course began to be offered to women, facilitated by the public health wales dietetics teams. Training for staff around healthy eating and lifestyle in pregnancy supports discussion with women around healthy lifestyle in pregnancy. The foodwise in pregnancy group has temporarily ceased due to the ongoing COVID-19-19 pandemic, however the team are developing an app as part of a Bevan Exemplar.

Healthy Pregnancy Clinic continues weekly, offering a 22-week appointment for women with a BMI over 35 to discuss healthy lifestyle and weight gain in pregnancy. Women are offered serial scans and glucose tolerance testing to identify any co morbidities in their pregnancy. Due to COVID-19 restrictions all women with a BMI over 35 are now offered a virtual appointment at 16-18 weeks gestation using video conferencing to discuss healthy eating and lifestyle in pregnancy. Women with no further co-morbidities and wishing to birth outside of the Obstetric led unit are offered a face to face birth choices appointment to discuss options for birth in line with RCOG and NICE guidance.

2019/2020 data

Measures	2019	2020
BMI over 30 at booking	21.7%	22%
Weighed at 36 weeks	95.2%	96.2%
Gained over 10kg in pregnancy	26%	24%

Actions are currently being implemented to support the obesity pathway for children with dietetic colleagues providing training to all school health nurses

Smoking

Women continue to be offered smoking cessation service via the local public health teams and 'help me quit' app.

Due to COVID-19 restrictions the appointments are now virtual. Until recently, the service did not receive feedback from smoking cessation services with the number of women successfully giving up smoking. In order to improve this service, the local Public Health Wales team supported the directorate to appoint a full-time maternity support worker (MSW). Based within the antenatal clinic, the MSW will provide public health messages to women who smoke, facilitate engagement to smoking cessation services and follow up referrals with women and their families. The RCOG 2020 COVID-19 guidance recommended that Carbon monoxide monitoring is stopped during COVID-19 due to an increase in risk of contamination of equipment and aerosol generation when using the machine.

2019/2020 data

Measures	2019	2020
(Pre-Pregnancy) Never smoked	72.15%	66.37%
Smoking at booking	10.9%	10.4%
Permission to contact smoking cessation	0.41%	0.50%
Gave up in pregnancy	3.50%	5.16%
CO monitoring at booking	92.1%	21.7% (stopped in March 20
Smoking at birth	0.018% of total births	0.131% of total births

Breastfeeding

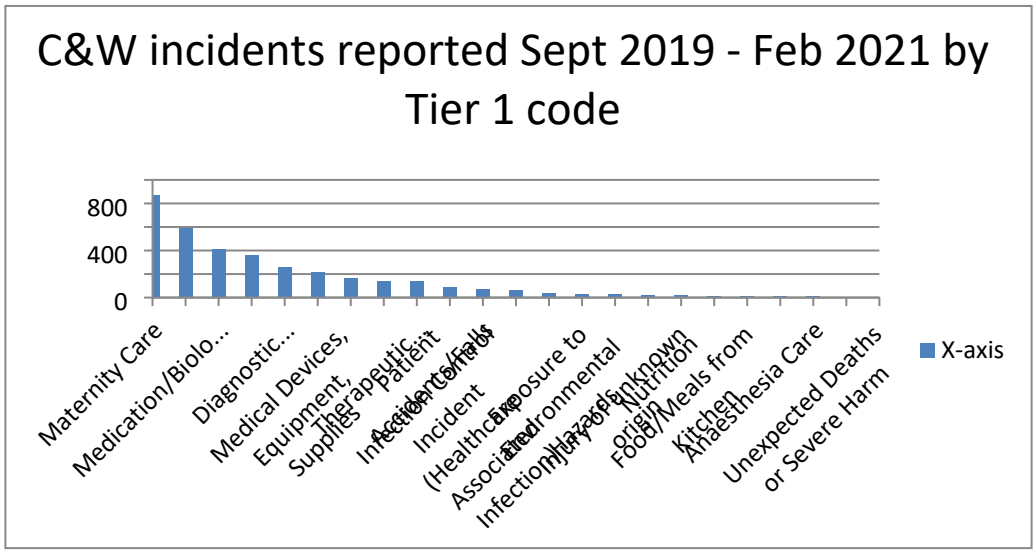
BFI assessment was due in March 2021 however due to COVID-19 restrictions this has been postponed until March 2022. Unintended consequences during COVID-19 has seen a rise in breastfeeding initiation rates to 72% this year with a sustained increase at both 10 days and six weeks. An infant feeding coordinator has been employed within Children, Young People and Family Health Services.

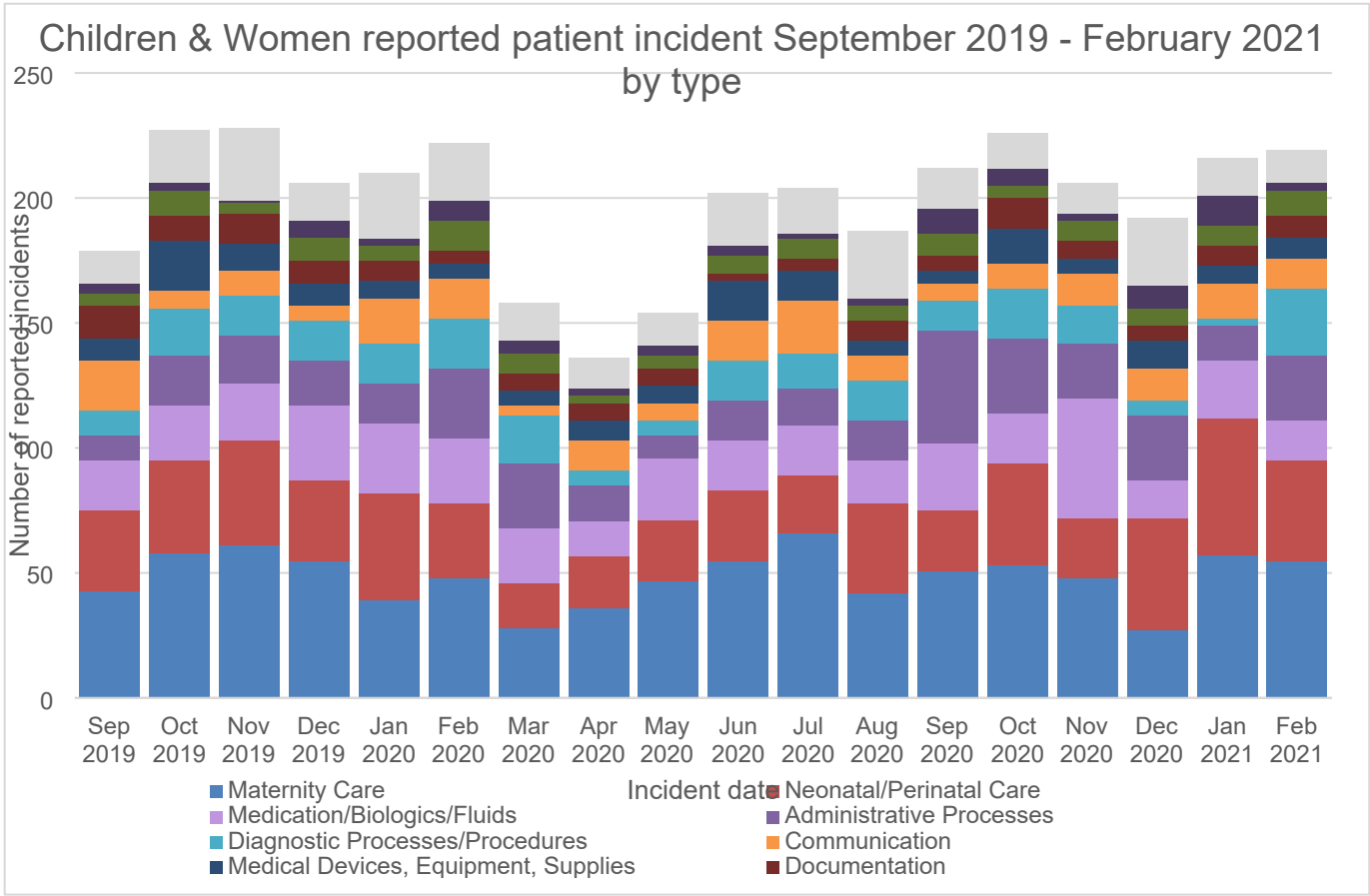
Safe Care (Theme 2)

Incident reporting

The Children and Women Clinical Board promotes a positive incident reporting culture. Between September 2019 and February 2021, there were 4952 incidents reported (3601 patient incidents, 942 organisational incidents, 386 staff incidents and 23 public/visitor incidents).

The most common incident types were maternity and neonatal care (both of which have trigger lists sitting under these codes), followed by medication incidents.





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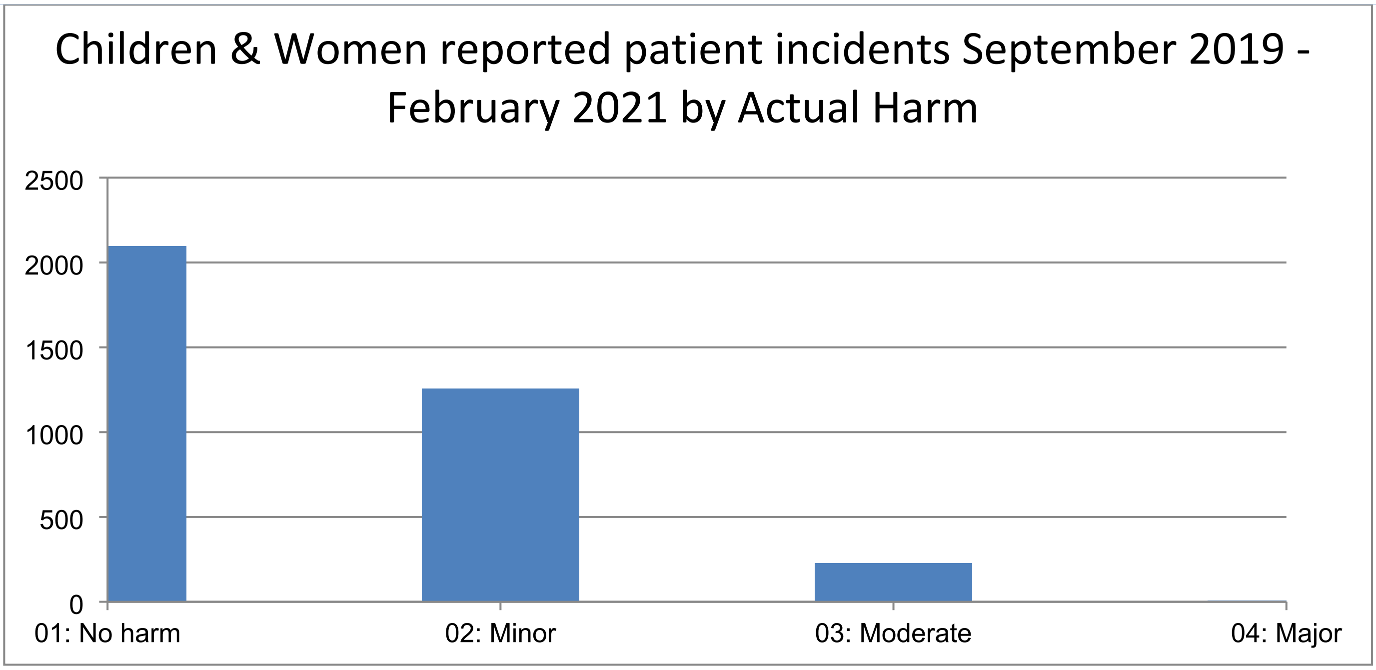


Several forums exist within the Clinical Board to monitor trends from incident reporting and share feedback and learning. All meetings are multi-professional. The Obstetrics and Gynaecology directorate host weekly incident review meetings, fortnightly clinical risk meeting and ATAIN forum, monthly stillbirth review forum (which includes neonatal deaths that do not leave delivery suite).

Learning is shared through professional governance forum, clinical audit, risk and governance newsletter. Learning from root cause analysis investigations are also used within PROMPT multi professional skills and drills, educational supervision for obstetric staff and clinical supervision for midwives. During COVID, the team have initiated a multi professional Patient Safety Investigation Group to review investigations and ensure that the investigation report has identified the root cause with SMART recommendations for learning. Improvement plans are reviewed by the obstetric risk and governance team and with the Clinical Board to ensure timely completion and monitoring.

The Clinical Board has a well-established Medicines Management Forum which is chaired by the Clinical Board lead pharmacist. The meetings are held monthly and medication errors are discussed in detail and themes and lessons learnt are widely shared. One particular high-profile patient safety review has been the investigation of paediatric 10-fold errors. Incidence has been reviewed on an all Wales basis. In a 12-month analysis across Wales there were 25 incidents reported of 10-fold errors.

The review highlighted that this was due to both system and human factor errors and what was needed was an all Wales standardised medication support system which would help to reduce errors. In the interim a number of measures to reduce incidence have been implemented within the Clinical Board.

Health Foundation Project

The Clinical Board has been actively involved in the Health Foundation project – Applied Analytics Awards Project. In collaboration with the Patient Safety Team, the Children's Hospital of Wales

Services mapped several aspects of quality improvement, specifically how the knowledge of key themes and trends in incident reporting can help identify topics for quality improvement. Throughout the course of the project, the power of combining multiple sources of data with incident report data has been strongly reinforced.

In addition to the above, we are working closely with Welsh Government, the Maternity and Neonatal Network and the Patient Safety Team to update the definition of a serious incident (focus within obstetric services).

RCOG triggers for clinical risk are discussed at multi professional risk management meetings and recommendations made for further reporting or investigation.

The Clinical Board is fully engaged with NATSSIPS, ANTT and SEPSIS

Serious Incidents:

During the preceding 18 months, 15 serious incidents were reported - 11 for Obstetrics and Gynaecology, 3 for Children, Young People and Family Health Services and 1 for the National Children's Hospital for Wales Services. In addition, 4 'no surprise' notifications for were submitted to Welsh Government, all were for National Children's Hospital for Wales Services. There were no similar themes identified within the incidents and within the same time period 16 closure forms have been submitted. Whilst there are no particular themes, incident types included

- Neonatal deaths/poor outcomes
- Issues with access to specialist CAMHS placements
- Self-harm of young people

At the time of writing the Clinical Board has 8 SIs open. There are now no Serious incidents open prior to May 2020. This is being proactively managed so that closure of the incidents which have been open the longest is prioritised.

Two Regulation 28 reports were received following Coroner Inquests involving children: -

- Case 1 – The case involved the collapse and cardiac arrest of a 12-year-old child in a GP Surgery form Addisonian Crisis the Coroner issued a Regulation 28 notice to WAST in relation to the delay in attending a 999 call to a GP Surgery but there were no recommendations for the Clinical Board

- Case 2 – This case highlighted the delay in diagnosing sepsis in a baby. There was an improvement plan developed which involved the Medicine Clinical Board and ourselves.

The Clinical Boards are working in partnership to embed the improvements required into practice.

Mortality reviews: -

Whilst Stage 1 Mortality reviews are carried out for adults over 18 who die in hospital, The Clinical Board has well established Mortality and Morbidity meetings in the Children's Hospital for Wales Services and Obstetrics and Gynaecology, all of which are monthly meetings. There is a paediatric wide M&M meeting which is chaired by a community paediatrician with representatives from the

Emergency Department, Community Paediatrics, Patient Safety Team and Clinical Teams from CHfWS and Paediatric Intensive Care Unit. Maternal, Neonatal and Child Deaths are formally reported through well-established UK wide systems. Unexpected Child deaths follow the PRUDIC process, Maternal and Neonatal deaths are reported through MBBRACE.

All neonatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT) which are then presented at monthly neonatal mortality review meetings which are held monthly. These meetings are attended by NICU Consultants, Senior nursing team, Maternity/Obstetric staff and Specialist teams are invited if they were involved in the care of an individual baby. There is also an external moderator in attendance (NICU Consultant from a neighbouring unit). All reviews are also fed into the Welsh Neonatal Network Mortality meetings.

Action/learning points from the last 3 months have included:

- Revamp of Resuscitation sheet to improve documentation
- Parallel planning for palliative care could have been helpful
- Improvement needed of Consultant to Consultant communication between Neonatal and Obstetrics teams
- Good communication noted between various teams involved in care of complex baby

Safety Alerts

With regard to the management of safety alerts, the Clinical Board has a robust management system in place for patient safety alerts working in conjunction with the Patient Safety Team. All patient safety alerts are disseminated widely and further discussed at Directorate and Clinical Board QS&PE meetings.

Within the past year the Clinical Board has received and circulated 50 safety alerts.

An example of this is evidenced from the minutes of our October 2020 QSPE committee: -

October 2020 • ISN Tracheostomy Ties • ISN Blood Transfusion Laboratory – Expired Blood Tubes • ISN Tissue Damage from Plaster Cast Saw • ISN T34 Syringe Driver	These were all circulated widely to all Directorates for information and action as appropriate. These were included as part of our Q&S Meeting, where there were no exceptions to note An update was provided with regards to the ISN-tracheostomy ties, significant work has been undertaken in order to change to the new ties following an incident within the community and compliance with the ISN. This will be revisited in cases where there has been found to be a preference to use the Velcro ties which are still available via the emergency boxes. Work is being undertaken in conjunction with Patient Safety in order to resolve this.

Safeguarding

- The Director of Nursing meets regularly with the Head of Safeguarding to keep updated with developments and discuss cases. Safeguarding within Health Visiting caseloads remain high, with clinical supervision in place for staff.

- Staff attend face to face mandatory level 2 updates as well as online training- our compliance is detailed below. This is below our usual compliance and is due largely to the effects of COVID. We will now be working with our staff to improve our uptake.

Org L4	Required	Achieved	Compliance %
001 All Wales Genomics Service	50	33	66.00%
001 Capital, Estates & Facilities	8	6	75.00%
001 Children & Women Clinical Board	1604	1211	75.50%
001 Clinical Diagnostics & Therapeutics Clinical Board	1160	792	68.28%
001 Corporate Executives	192	142	73.96%
001 Medicine Clinical Board	1122	636	56.68%
001 Mental Health Clinical Board	848	523	61.67%
001 Primary, Community Intermediate Care Clinical Board	617	386	62.56%
001 Specialist Services Clinical Board	1264	767	60.68%
001 Surgical Services Clinical Board	1378	734	53.27%
uHB	**8243**	**5230**	**63.45%**

All Staff working with vulnerable children and women will also undertake level 3 training.

- The Clinical Board is currently working with Cardiff Children's Services and Police to develop a protected pathway for professionals to escalate safeguarding concerns regarding Gypsy Traveller Children
- Routine Enquiry into Domestic Abuse is audited annually and there is sustained commitment across all directorates to ensure women are given opportunity to disclose and signposted appropriately to relevant services.

Routine Enquiry Asked:	Asked Once	Asked Twice
Midwifery Service	99%	90%
Health Visiting Service	95%	N/A

Falls Management

During this timeframe Patient Safety Alert PSA050 – "Assessment of babies who are accidentally dropped in hospital" was received. We were able to declare compliance with this in December 2019 due to the work that had been undertaken as part of 'Babies Don't Bounce'. Between Sept 19 and Feb 2021 there were 3 baby falls within the postnatal areas with all cases being reviewed through risk management processes compared to 12 baby falls in 2018. Audit and monitoring of baby falls continue within the postnatal wards and is received through the O&G Professional Governance Monthly Meetings

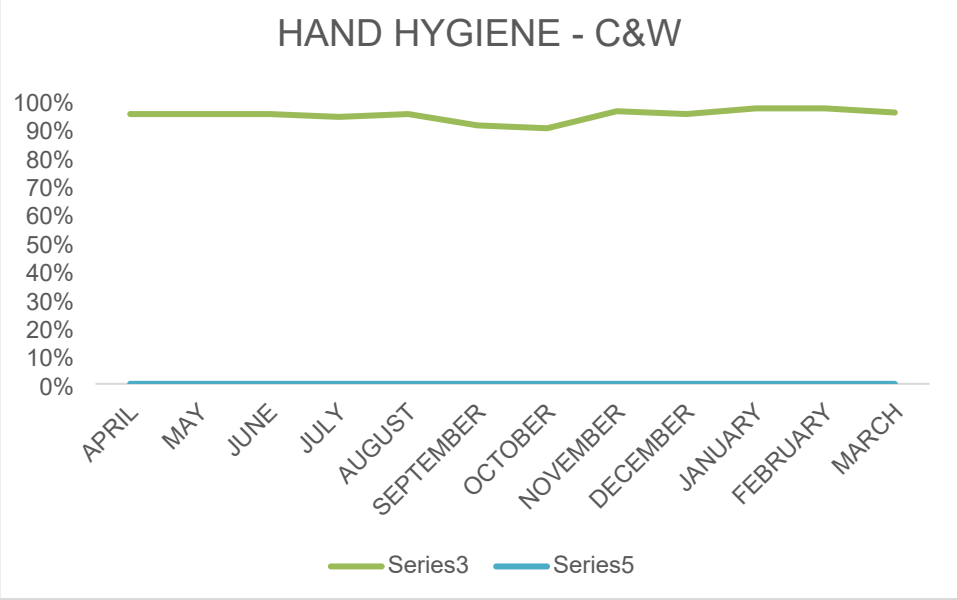
A falls prevention programme developed for children has recently been introduced to all areas within the National Children's Hospital for Wales

Infection Prevention and Control

Welsh Government's annual infection reduction goals were not set in 2020/21, but not all were achieved in 2019/21. The Clinical Board has made improvements on its incidents of Health Care Acquired Infection and continue to work closely with colleagues in microbiology to ensure that RCAs are completed in a timely manner.

	C. *difficile* *2019-20 GOAL 0*	MRSA bacteraemia *2019-20 GOAL 0*	MSSA bacteraemia *2019-20 GOAL 0*	*E. coli* bacteraemia *2019-20 GOAL No more than 1 case per month*	*P. aeruginosa* *2019-20 GOAL 0*	Klebsiella spp *2019-20 GOAL 0*
2019-2020	12	2	6	14	4	6
2020-2021	6	2	5	7	4	8

Hand Hygiene scores within the Clinical Board remain consistently high as demonstrated below.



Within the neonatal unit we have developed a multi-disciplinary task force to develop enhanced surveillance and initiatives to drive down incidence. This is a new approach and it is too early to

assess the impact of this.

The Clinical Board continues to monitor caesarean section site infection, however there has been no further reports published since 2018. Prior to the COVID-19 pandemic the obstetrics and gynaecology directorate had moved to electronic reporting and were working closely with Public Health Wales to ensure data collection was timely, robust and accurate. This work is due to recommence as part of COVID restoration and recovery of services.

During 2019-2020 the Clinical Board has had a number of External Reviews:

HIW:-

In November 2019, HIW began Phase 1 of the national review of maternity services in Wales and carried out an unannounced visit to University Hospital of Wales. Prior to the visit, the directorate had completed a self-assessment against the RCOG/RCM review of maternity services in Cwm Taf University Health Board which has been presented to the Board and monitored through Health Board QSE Committee.

HIW identified 4 immediate actions which were addressed at the time of the visit. The final report was received in February 2020 and all actions subsequently completed. Following the site inspections, a series of interviews with key staff within the Health Board was undertaken in March 2020 with the purpose of reviewing governance arrangements within the service. On completion, HIW subsequently published Phase 1 of its review of maternity services in Wales in November 2020. The Clinical Board has responded to the 32 recommendations and self-assessed where the directorate feels improvements or ongoing monitoring of existing arrangements could be made. These improvements are monitored through Directorate and Clinical Board QS&PE forums

Neonatal Peer Review: -

The peer review visit for Cardiff and Vale UHB took place in February 2020 and the report was received by the UHB in June 2020. The peer review feedback was extremely positive with acknowledgment of the implementation of QI projects which had resulted in a number of improvements. Particular credit was given for the level of care and support provided and the 'culture of openness' that was identified within the NICU.

Other positive findings were:

- High standard of informative notice boards targeting both parents and staff
- Evidence of regular MDT meetings, druggles and huddles.
- The clinical commitment to improve cot occupancy in addition to working towards increased psychology provision and neurodevelopmental in Neonatal care

There were no immediate risks identified during the peer review, however there were some recommendations made and an action plan to address these was promptly developed and implemented.

These include: -

- A deficit in ANP provision and lack of access to OT services
- Lack of 24 hour neonatal transport services.
- Funding for QIS modules.

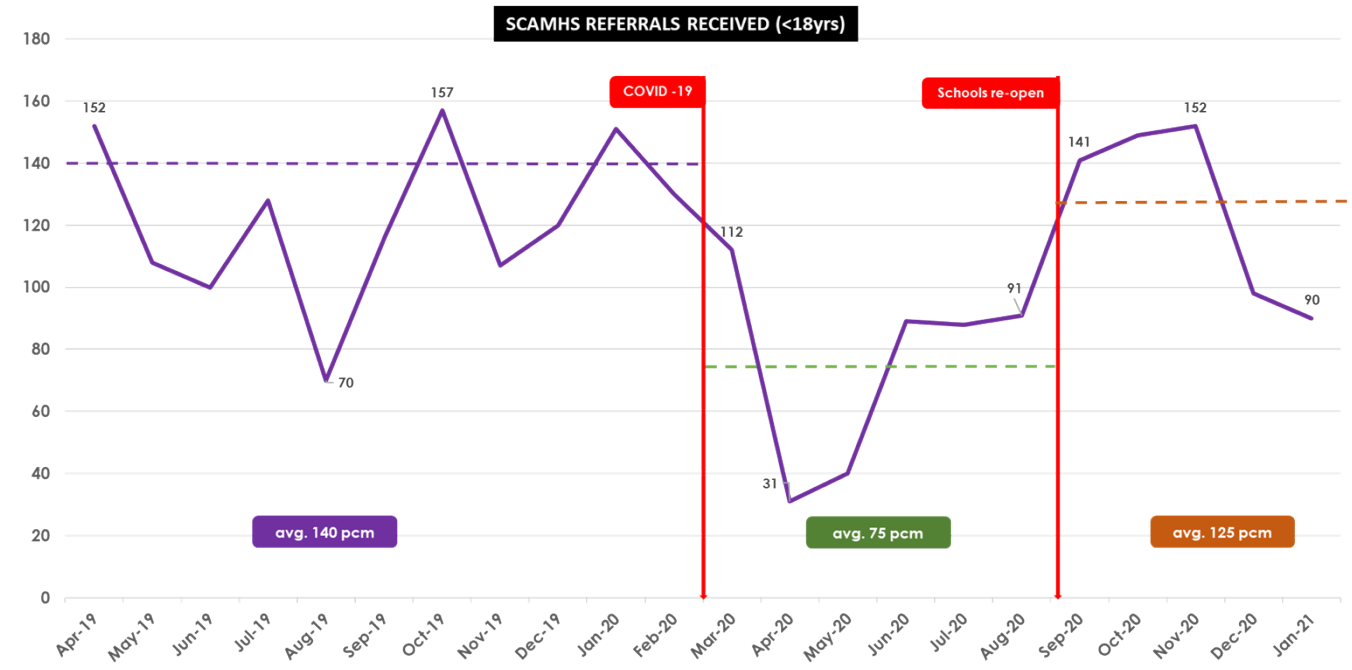
CAMHS Delivery Unit (DU) Report

The review of crisis and liaison CAMHS services in Cardiff and Vale University Health Board took place between August and September 2020.

The DU report has been recently published (December 2020) and recognised that the service is highly valued and valuable service that is operating at a time of significant rising demand and public expectation.

This can be evidenced in the graph below: -

Emotional Wellbeing & Mental Health Services – Specialist CAMHS (SCAMHS)



Within the report, there were a number of areas of concern.

The CAMHS service had already put an action plan in place following initial feedback and have achieved many of the actions, with some ongoing: -

- Training on record keeping delivered
- Staff capacity increased – waiting list initiative completed end of this month – marked impact – internal waiting list down from 366 at start to 62 to date. Agency staff employed have been closely supervised and using virtual platform.
- CRISIS Team expanding service until midnight (currently finish at 9pm). 3wte additional nurses currently being recruited.
- Appointment to new posts in Eating Disorder Service to improve pathway

- Service moved onto PARIS electronic records system which will address many of the issues raised regarding paper records along with the first action.

CAMHS access regular UHB safeguarding supervision sessions and the Head of Safeguarding reports that the team now contact UHB safeguarding more routinely to discuss concerns. The culture previously was to hold peer review and concerns were not always escalated in a timely manner with specialist advice being taken.

There has been development of bespoke training for Dialectical Behavioral Therapy, solution focused brief intervention, Maudsley and Eye Movement Desensitisation therapy.

Following recommendations in recent Children Services Inspection Wales review of Cardiff Youth Offending Services (YOS), a new pathway developed between CAMHS, school health nursing and YOS to provide a holistic approach to health assessment for Young people on the Youth Offending System. The appointment of a therapist, supplemented, by a CAMHS therapist with forensic expertise and a senior school health nurse with a focus on emotional wellbeing but who is also able to review general health needs will provide an improved model of care.

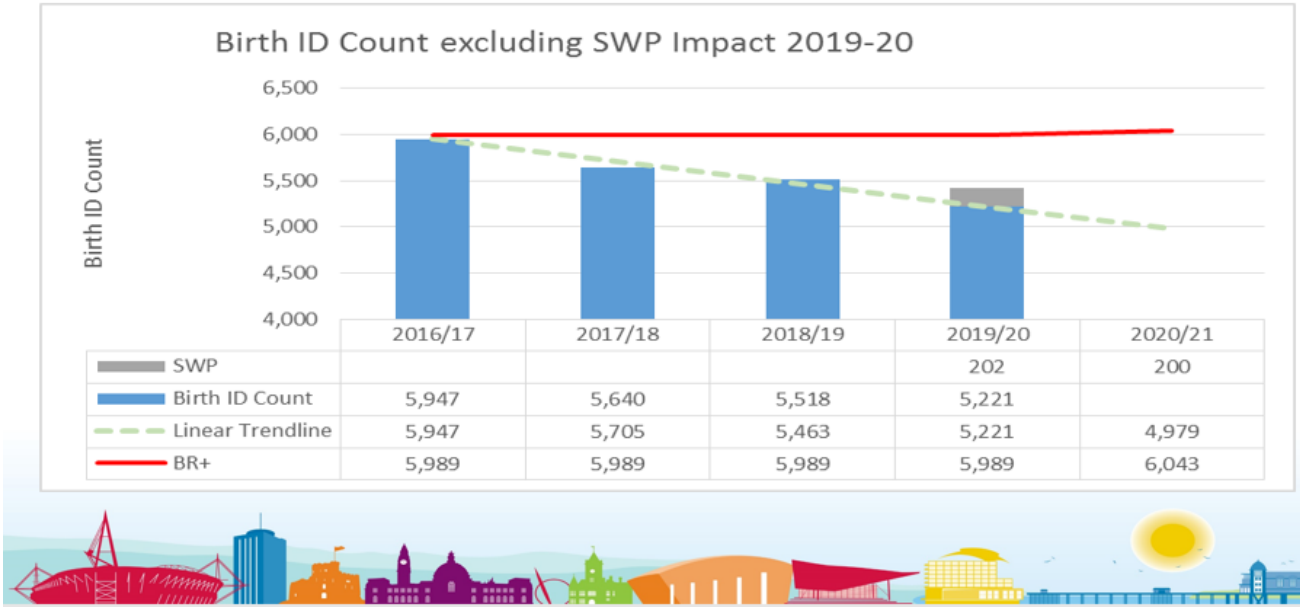
Effective Care (Theme 3)

Obstetrics & Gynaecology

Between September 2019 and February 2021, 8062 babies were born within Cardiff and Vale (@5500 pa). The current caesarean section rate is 25.4%, and has been steadily increasing in line with national trajectory. Instrumental deliveries are 13.1% and whilst the spontaneous vaginal delivery rates are 60.3% there has been a steady decline in births taking place within the alongside midwife led unit.

The graph below demonstrates this; however, it is important to note that although the Birth-rate is reducing the acuity of care is steadily increasing.

Birth Rate 2016/17 to 2019/20



	2016/17	2017/18	2018/19	2019/20	2020/21
SWP				202	200
Birth ID Count	5,947	5,640	5,518	5,221	
Linear Trendline	5,947	5,705	5,463	5,221	4,979
BR+	5,989	5,989	5,989	5,989	6,043

These reasons may be multi-faceted however a rising induction of labour rate may be contributory and is being explored by the clinical teams within obstetrics. A working group initiated to ensure that women receive safe, timely, informed, evidence-based care and a positive birth experience.

	Total births	**Induction of Labour**
2018	5596	Not routinely collected via Maternity Information System
2019-20	5423	(36.7%)
2020-21	4875 (til end Feb)	(41.6%)

In March 2019 the Saving Babies Lives Care Bundle Version Two (NHS England) published, supporting induction of labour (IOL) from 39 weeks onwards, finding IOL after 39 weeks of pregnancy was not associated with increased Caesarean section rates, instrumental birth rates, fetal morbidity or admissions to the neonatal unit (NNU). Whilst this is an English document the impact has been recognised in Wales with the rates of IOL increasing between 2019 and 2020. Coupled with the uncertainty of the COVID-19 pandemic women appear to be opting for IOL from 39 weeks of pregnancy.

In June 2020 the UHB introduced an outpatient induction of labour service, enabling women to return home for the first 24 hours of the IOL process. Evidence suggests women are more likely to establish into labour in their own home environment. The feedback from women has suggested this is a much-welcomed addition to our service as women are able to be with their family and home comfort during the process of IOL.

During the COVID-19 Pandemic there has been a 0.7% increase in home birth as a choice for women. Whilst this may be perceived as an unintended positive consequence, some women are

choosing to birth at home due to fear of coming into hospital and postnatal visiting restrictions choosing place of birth outside of recommended guidance. Place of birth / birth choice clinics have continued to support such requests throughout the pandemic and are facilitated by senior midwives and obstetrician to support informed decision making.

Home Birth Rates	
2018-19	61
2019-20	67
2020-21	98

Research & Development

The Clinical Board has a healthy portfolio of open research studies, funded studies set up with colleagues from Cardiff University and other HEI's studies in development or awaiting decisions on funded applications.

Details of current R&D activity by Directorate is detailed below:-

Obstetrics and Gynaecology:

Open Studies (up to and including 21 March 2021

Study	Target total until study close	Total Recruitment
Big Baby (portfolio)	60	75
EARS (portfolio)	40	42
WILL (portfolio)	15	4
CRAFT (portfolio)	120	24
Pan Covid (portfolio)	1	105
GEM3 (portfolio)	2	0
PROTECTOR (portfolio)	20	3
POOL (portfolio)	1950	1473
ROCKETS (portfolio)	150	143
ALDO (portfolio)	12	12
MSEP (portfolio)	200	84

Trials in Set Up

Study	Planned Start Date
Dilapan E Registry (commercial- contract signed)	March 2021
C Stich 2 (portfolio)	Awaiting Sponsor to recommence/with R&D
OASI (portfolio)	May 2021
NIPTY (portfolio)	January 2022
Optibreech (portfolio)	June 2021
Rainbow Clinic National Study (portfolio)	May 2021
OHANA (commercial)	May 2021
DAMET (commercial)	Awaiting sponsor to recommence
PROTECTOR (portfolio)	Awaiting sponsor to recommence

Children's Hospital for Wales Services: -

In addition to the above within the Children's Hospital for Wales, there are 9 commercial and 34 non-commercial trials and 5 new trials in set up.

Many non-COVID-19 related studies were temporarily halted during the ongoing pandemic and for some teams, a change of focus was required. The research team within the Children's Hospital were asked by Welsh Government to allocate resources to studies of Urgent Public Health (UPH) studies. A number of studies including ISARIC, ImmunoCOVID-19, RAPID-19, Clarity and RECOVERY were opened.

RAPID 19
(https://www.qub.ac.uk/News/Allnews/QueensUniversityawardedfundingtoconductCOVID-19-19rapidtestingtrial.html). Rapid 19 is being led by Queen University in Belfast with a four nations approach. Over 180 children have been recruited in Cardiff, all of whom are the children of staff who work at the UHB. The study includes taking blood from these children which is then tested for antibodies, parents and children are subsequently informed of the antibody status of the child. Parents and children were also asked about symptoms, from which the study team in Belfast were able to explore whether children are likely to show gastro symptoms if they have COVID-19 19. (https://noahsarkcharity.org/2020/09/03/rapid19/)

RECOVERY
The RECOVERY trial (https://www.recoverytrial.net/) is a national trial led by the University of Oxford. After the first reports in the UK in April 2020 of a new COVID-19 related condition in children called PIMS-TS the RECOVERY trial opened a paediatric arm of the study. The trial aims to identify beneficial treatments for children hospitalised with suspected or confirmed respiratory COVID-19 or PIMS-TS. Dr Jennifer Evans sits on the UK wide RECOVERY working group which supports decision making on which treatments to include in the paediatric study. The COVID-19 MDT, led at Cardiff and Vale University Health Board by Dr Siske Struik, has also supported numerous other sites in South Wales to recruit children in to RECOVERY. In November 2020 the National Children's Hospital for Wales recruited a child in to the convalescent plasma arm of RECOVERY, the only child in Wales to receive this treatment.

Non-COVID-19 research within the Children and Women Clinical Board was re-opened in September 2020, including Pool, MSep, MIRUM, and iHolds. The National Children's Hospital for Wales re-opened SKIPPER, VERTEX and PEACE studies.

Clinical Audit and Effectiveness

The Clinical Board has a robust clinical audit plan at both Tier 1 and Tier 2 within the Children's Hospital for Wales and the Obstetrics and Gynaecology Directorate.

Examples of Tier 1 and Tier 2 Audits include:

Tier 1

- National paediatric Diabetes Audit (Mandatory)
- Children and Young people Asthma Audit (Mandatory)
- Epilepsy 12 national Audit of Children and Young People
- Paediatric Intensive Care (PICanet)(Mandatory)
- BSGE National Audit of complex surgery outcomes and complications.

Tier 2 :

- Antibiotic usage in Gynaecology
- Review of Neonatal Term admissions
- Review of Necrotising Enterocolitis cases.

Despite the pressures of the pandemic, there were 9 new clinical audits registered in 2020 for CHFWS and 10 for O&G Directorate.

Progress against the clinical audit plan is regularly audited through Quality, Safety and Patient Experience arrangements. In addition to this, NCEPOD reports and NICE guidance is circulated widely throughout the Directorates and discussed at Directorate and Clinical Board QS&PE Committees.

Examples of our clinical assessment against the current evidence is demonstrated in the table below: -

Project Title	Standard	Audit lead
Recognition and Management of Paediatric Sepsis	NICE guidelines NG51.	Dr F Hussain
Current Provision of Community Paediatric Services for Primary School Children with Cerebral Palsy	NICE NG62 and CG145 and also NCEPOD recommendations	Dr C Peat
Screening and Treatment of Bacteriuria at the First Antenatal Appointment	NICE guidance CG62	Ms A Moorcroft
The Introduction of a New Obstetric Sepsis Clinical Pathway: Presentation, Management and Outcomes of Suspected or Confirmed Cases	Measure the clinical management compared with the standards set by the Sepsis Trust and NICE guidance	Dr R Collis
Management of category One and Two Caesareans	NICE guidelines NG132 .	Ms L Pilkington

The Clinical Board continue to work with colleagues within the Patient Safety Team and Welsh Government to further strengthen processes for the implementation and compliance with NICE guidance, to identify any gaps and action required to improve the quality of services and provide assurance to Welsh Government that NICE guidelines have been considered, if requested. The NICE implementation facilitator for Wales has met with some of the clinical teams to discuss their

role and how they can best support Directorates. A GAP analysis will be progressed as part of the Clinical Board's Restoration and Recovery plans in 2021.

Dignified Care (Theme 4)

Dignified care Inspections and CHC inspections carried out in 2019-2020 have not identified any areas of significant concern. Findings of inspections and peer review have been outlined previously in this report.

CYPFHS are working with Adult Mental Health to improve the pathway for adolescents requiring admission to Adult Mental Health (Hafan y Coed) for assessment. The pathway will improve patient experience for the young person, provide increased therapeutic support, continuity and structure during admission, increased support post discharge and potentially reduce LOS.

The introduction of SANDS template letters for bereaved parents which are signed by the Head of Midwifery and Clinical Director have been well –received. The letters include detail of the process and timeliness of any investigation and gives opportunity for the service to consider any questions the parents may have.

Signage to the Obstetrics and Gynaecology Directorate at University Hospital in Wales is currently being updated in response to feedback from previous Community Health Council and HIW visits. Outdated signage which displays 'women's unit' will be replaced by 'obstetrics and gynaecology' in response to feedback from members of the public.

New equipment to promote physiological birth and enhance the birth environment has been purchased for both the OU and the AMU, these have included mood lightly, imagery ceiling tiles, birth stools and birth systems to aid maternal comfort and positions for birth.

Timely Care (Theme 5)

It is of note that the Clinical Board position against the historical Referral-To-treatment time (RTT) standard in February 2020 was that <30 patients had breached and were on trajectory to zero RTT breaches by 31st March.

Clearly, like almost all UHB specialties this is no longer the case since the COVID-19 pandemic and we have significant concerns regarding waiting list volumes and the potential for clinical harm due to the prolonged length of time patients will be waiting for treatment.

Gynaecology Services

The Demand for outpatient services in benign and urgent/suspected Cancer (USC) Gynaecology fell significantly during March to May 2020. We managed to preserve pre-COVID levels of USC activity however benign activity significantly reduced.

June to December 2020 saw a return to normal referral demand patterns in benign and USC. Benign outpatient waiting lists have benefitted from active validation exercises and virtual working such that there are currently no greater queues for benign outpatient appointments than there was in March 2020.

However, Inpatient/surgical waiting times have significantly increased in benign gynaecology and are predicted to increase further. The Clinical Board recognises that measures to manage this escalation are urgently required. To address this the Clinical Board are working with the Surgical Clinical Board to secure additional theatre infrastructure to return us to pre-covid utilisation – at the time of writing the Gynae access to theatres is at 57% of what it was pre-COVID. We will continue to optimize our use of the private sector and review the use of methods not previously adopted such as physiotherapy interventions and smarter clinic working.

Children's Hospital for Wales Services

During 2019/20 the Children's Hospital for Wales was successful in significantly improving the delivery of the referral to treatment times, and was on target to ensure no child waited over 36 weeks. However, the impact of the requirement to step down or reconfigure our services in response to the pandemic has had a significant impact on access to care.

Through the course of 2020/21 waiting times have risen during this has resulted in significant number of children waiting over their target date for outpatients, diagnostics & surgery.

However, in the final quarter of 2020/21 the Children's Hospital has had improved access to theatres and have undertaken additional outpatient work. The impact being;

- A significant improvement in the waiting times for outpatients with a very small number of children waiting over 36 weeks. We continue to monitor this to ensure we improve and maintain this position to ensure all children have an outpatient appointment within 36 weeks

- Whilst we are now at 78% of our historical elective theatre capacity there continues to be a significant number of children waiting over 36 weeks and 52 weeks for a surgical procedure. Children's surgery is booked by clinical prioritisation rather than waiting times to ensure that the most clinically urgent patients are treated. To ensure we adhere to waiting time targets will require access to additional theatres

- We are satisfied that every child waiting >52 weeks for Paediatric Surgery has their case re-reviewed by a Consultant Surgeon

- We continue to have children waiting in excess of 8 weeks for a diagnostic endoscopy, with

an increased reliance on the use of emergency theatres for urgent diagnostics. To ensure we adhere to waiting time targets & reinstate routine surveillance endoscopies will require access to additional theatres. WHSSC have invested in Paediatric Gastroenterology which has identified the need for additional Endoscopy capacity

- We have undertaken a significant number of catch up clinics for echocardiography that were unable to be undertaken throughout the pandemic. We continue to work with WHSSC to ensure we make best use of the resource available to ensure we continue to reduce the number of children waiting for a Cardiology scan

- Due to reduced clinic capacity during COVID-19-19 a Drive-through HbA1c clinic was introduced at the University Hospital of Wales site to ensure children received timely care of their diabetes management

Cleft Lip Palate Surgery

On 6th March 2021, the first three cleft lip and palate surgeries took place at Children's Hospital for Wales. This was a historic moment both for the families involved and the staff on the many teams that worked together to make this possible.

Prior to this, all cleft lip and palate surgeries for South Wales had been undertaken at The Welsh Centre for Cleft Lip & Palate at Morriston Hospital, Swansea. However, the COVID-19 pandemic offered the opportunity for the Children's Hospital for Wales to collaborate with Morriston Hospital to improve access to these life-changing surgeries.

A decision to relocate some surgeries to Children's Hospital for Wales required a multi-disciplinary collaborative effort between Health Boards, Clinical Boards and staff.

Our team aim to carry out operations on three children each weekend, which will ensure no child has to wait longer than absolutely necessary for the surgery they need.

The adaptability and flexibility of our staff in taking this on has been a credit to all.

Children, Young People and Family Health Services (including CAMHS)

Prior to the COVID-19 pandemic there were existing concerns regarding timely access to Neurodevelopmental, Continence, Primary Mental Health, Specialist CAMHS and Children Looked After services. Many of these concerns had been present over several years, albeit Primary Mental Health Tier-1 target performance improved significantly over 2019/20.

In all 5 of these services concerns around timely access to services, and therefore concerns around potential morbidity while waiting, have grown, in some cases significantly.

2021/22 will see Neurodevelopmental and Continence waiting times continue to grow. There are a number of workstreams underway which attempt to mitigate this risk but at this stage the Clinical Board cannot provide definitive assurance that avoidable harm will be prevented in these cohorts.

Specialist CAMHS and Children Looked After services will be the focus of work over 2021/22 to better understand the quantum of risk presented by reduced timeliness of access.

Primary Mental Health Services have an improvement trajectory which aims to significantly improve timeliness of access in Q1 and Q2 2021/22 which will address concerns which arise when patients wait beyond the Tier-1 target threshold.

Individual Care (Theme 6)

Prior to COVID-19, the Clinical Board received national service user reports for both children and parents. The surveys were overall positive, with 'you said we did' actions demonstrated through information boards outside all clinical areas. For example, parents requested improvements for Welsh speaking families which has been addressed through increasing awareness and actively making sure that children and parents have opportunity to be cared for by Welsh speaking staff. Post COVID-19 plans are in place to work with the Youth Board and the patient experience team to develop a service user feedback questionnaire which is more applicable to children and their families.

Antenatal education has continued with classes and information being developed online and accessible through a number of social media platforms and community midwives.

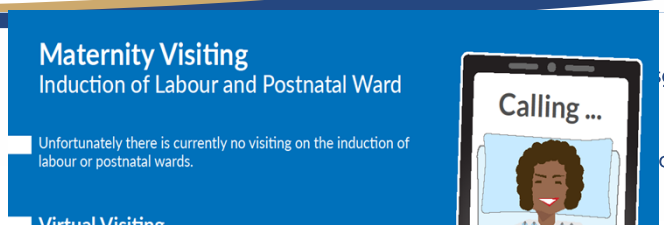
This has proven a positive step during COVID-19 as both an educational and support platform. Initially a Cardiff and Vale UHB initiative the team worked with colleagues across Wales to share good learning and practice including how to get to local hospitals, what to bring, changes in guidance and what to expect from staff wearing Personal Protective Equipment. CAV Midwives Instagram page has 1532 followers, Cardiff and Vale UHB Maternity Services Facebook page 4,026 followers and the All Wales Antenatal Education and Support Facebook Group 5,600.

The Birth Afterthoughts service continues to be a much utilised service offering women an opportunity to reflect on their birth experience. This service is offered to all women on discharge and appointments are offered from 8 weeks postpartum.

Maternity Services Liaison Committee - Learning from Women's Experiences

The maternity service has a well-developed maternity services liaison committee, the Chair being a service user. The Committee is made up of two thirds service user and supported by Health Board representatives and helps shape the future direction of the service by learning and listening to women's feedback. During the last twelve months, the MSLC has supported the service by gathering feedback from women about their experience of having a baby during the Pandemic. This work coincided with a national report received from the Community Health Council (2020) and service findings were very similar. 276 responses were received from women who completed an online survey in May 2020.

Women reported that they felt safe and supported by midwives and staff who were friendly and knowledgeable going above and beyond. There was a clear understanding of the pressures and uncertainty but that staff were doing their very best. Unsurprisingly women shared their disappointment at partners not being able to stay in hospital and not being able to attend routine antenatal appointments. The service adapted quickly to ever changing guidance and whilst the use of virtual technology vastly supported continuity of carer and service provision, women reported frustration at reduced continuity of carer and potentially missed face to face contact. A 'Talking Heads' presentation via You Tube for further information is provided via the link https://youtu.be/uufQrjCfqmY. A number of recommendations 'you said, we did' were progressed and communicated to women via social media and local engagement forums including clearer guidance for partners

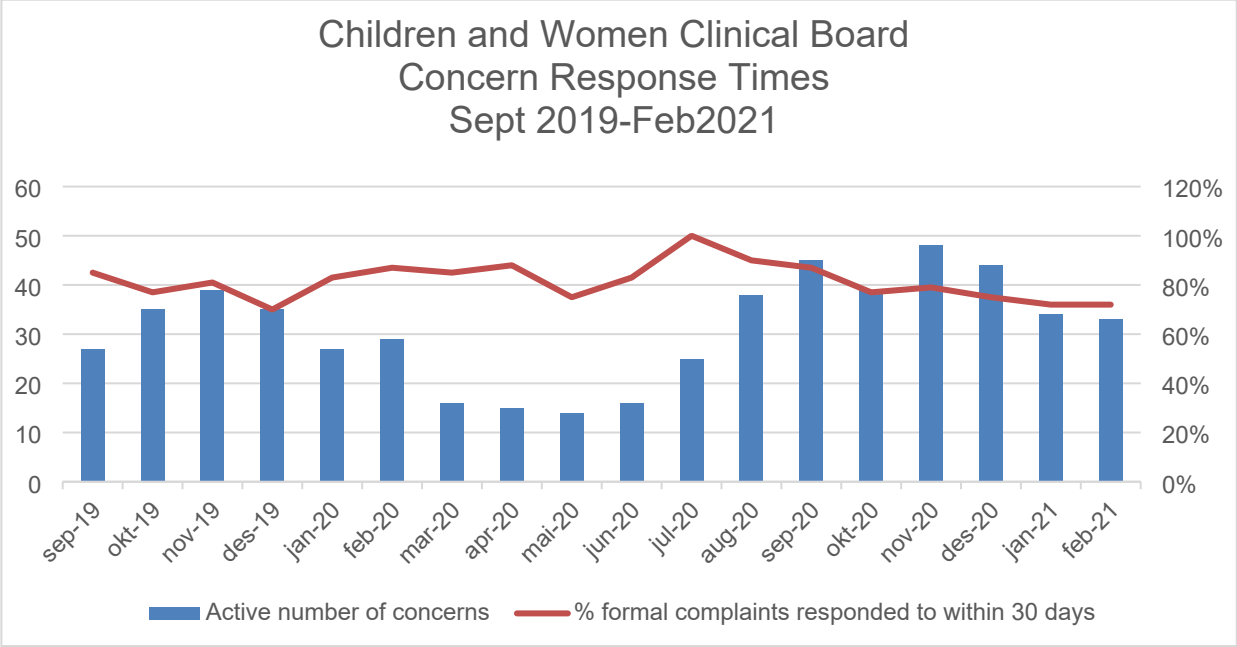


Concerns, Compliments and Claims

Prior to COVID, the Clinical Board continued to provide timely and effective responses to our women, their families and the children and young people who used our services. Whilst our responses compliance has reduced slightly during the pandemic, we have still achieved above the Welsh Government target for compliance of 75% response within 30 days.

The themes and trends of the concerns and the response compliance have been analysed and are detailed below:

1st September 2019- 28th February 2021	National Children's Hospital for Wales	Children, Young People and Family Health Services	Obstetrics, Gynaecology & SARC	Total
Access to Services	1	5	7	13
Admissions	6	0	11	17
Appointments	35	21	32	88
Attitude & Behaviour	11	8	12	31
Clinical Treatment / Assessment	80	52	140	272
Communication	19	24	43	86
Confidentiality	0	0	2	24
Discharge Issues	3	1	1	5
Equipment	1	0	0	1
Environment / Facilities	0	1	1	2
Infection Control	0	0	1	1
Medication	2	1	2	5
Monitoring / Observation Issues	0	1	0	1
Other	4	3	12	19
Patient Care	1	1	1	3
Record Keeping	1	0	2	3
Referral	2	6	2	10
Test Results	0	0	4	4
Total	**166**	**124**	**273**	**563**



Initially with the onset of the global COVID-19 Pandemic the number of formal concerns received across the Clinical Board dropped. However, as the pandemic continued, formal concerns began to increase which subsequently resulted in delayed response times due to ongoing service pressures, staff self-isolation and volume of both informal and formal concerns requiring response as demonstrated in the above graph.

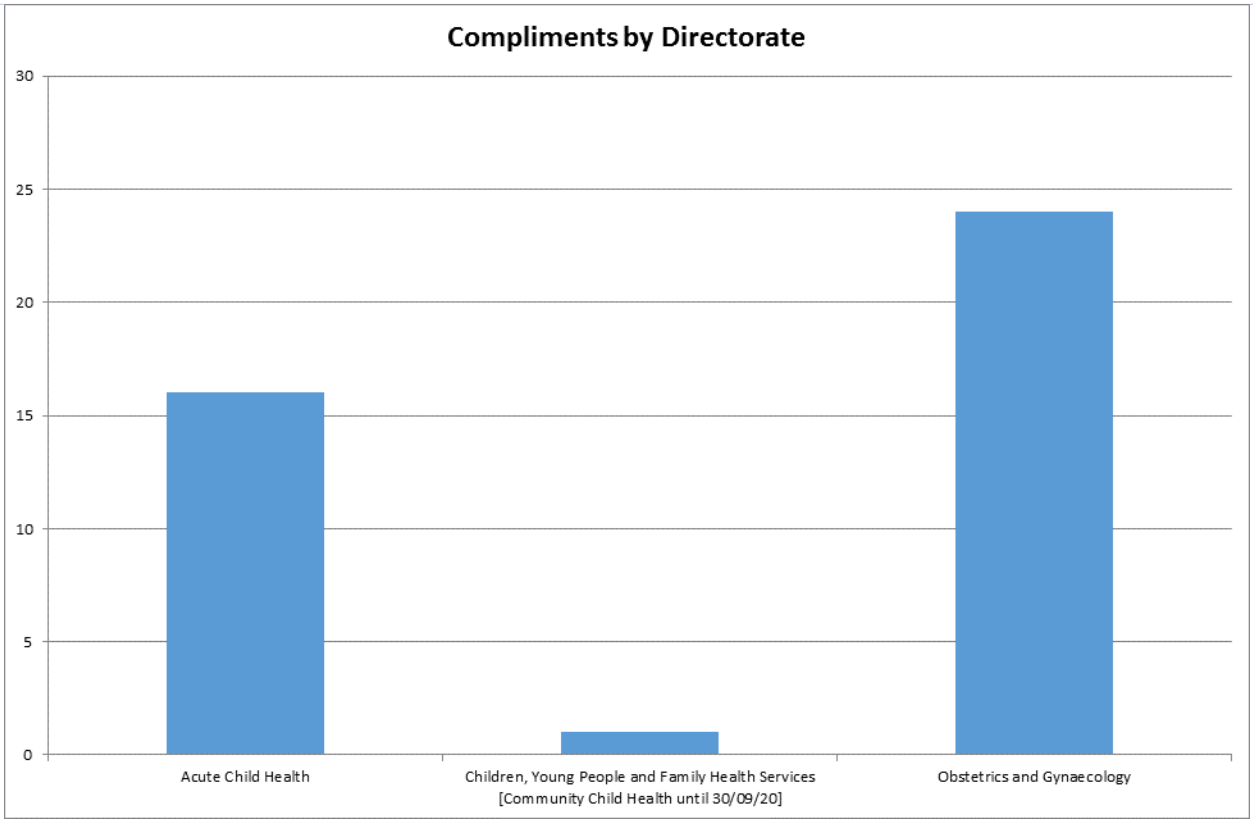
The main themes were delayed admission and care as routine surgery was cancelled due to COVID-19 pressures, particularly within Gynaecology services. COVID-19 visiting restrictions also accounted for a significant number of concerns within Obstetrics.

CYPFHS are experiencing a rise in concerns, particularly related to CAMHS and Neurodevelopment. Many are related to waiting list time. CAMHS concerns are often related to families requesting more input, at a time of crisis, wanting medication or hospital admission. Although attempts are made to try and resolve informally, there is a significant increase in referrals to the CRISIS team (20-30%) up on last year.

Informal concerns: -

The Clinical Board remains extremely committed to proactively contacting and meeting individuals who raise concerns at the informal stage in an attempt to achieve prompt resolution for our service users and their family and carers. CAMHS are currently offering drop in Clinics to service users to try and resolve informal concerns.

Within the same period the Clinical Board received a high number of formal written compliments:



These have been shared with the departments and staff responsible for the services provided.

The Clinical Board currently has 10 open negligence claims, all of which are in the O&G Directorate, details are outlined below.

Clinical Negligence Claims with sub categories
opened between September 2019 until February 2021

	GYN AE	OBS	Total
Delay in carrying out investigations	1	0	1
Delay in diagnosis	1	0	1
Failure to diagnose and treat	1	0	1
Wrong diagnosis and treatment	1	0	1
Inappropriate use/choice of	1	0	1
Inadequate/substandard care	1	0	1
Inadequate antenatal care or advice	0	2	2
Delay in effecting delivery	0	1	1
Perforation/damage to adjacent organ	1	0	1
Totals:	7	3	10

Staff and Resources (Theme 7)

Birthrate + Midwifery workforce assessment was completed in July 2020 in line with Welsh Government mandate and we are compliant.

The All Wales Nurse Staffing Act has now been extended to include paediatric wards and will come in to force on the 1st October 2021. As part of this extension there are a number of key milestones that have to be achieved which we are working towards. As the Children's Hospital for Wales, we have two key ward areas that the Act will affect.

As a UHB we continue to be represented on the All Wales Paediatric Nurse Staffing group which supports the extension of the Act and are in the process of writing an operational guidance document to support this.

The past year has not been a typical year and has been very challenging for the UHB and Clinical Board. The Clinical Board has risen to the challenge and supported the UHB's service pressures by deploying a large number of its staff to where they were needed most and ensuring patient care was not compromised.

A number of school health nurses have been deployed to mass vaccination centers during period of school closure. The Clinical Board are working to agree phased return of these key staff as schools start to re-open.

Sickness Absence

The in-month sickness rate for the Clinical Board currently stands at 4.93%. The 12-month cumulative rate is now at 5.45%. The sickness rate target for the clinical board is 4.18%.

Short Term sickness absence in month accounted for 1.65% of all absences whilst long term is 0.50%. the greatest number of cases sit between 4 and 6 months.

These are a number of actions that have been put in place to support managers with this agenda to include: _

- Support for managers with both short and long-term absence.
- Sickness Absence surgeries with Line managers.
- Consideration to undertake audits in the sickness hot spot areas.

PADR

Some progress has been made within the Clinical Board with staff trained to undertake Values Based Appraisals however this was halted due to the Pandemic. Staff will continue with this learning as soon as restrictions start to list. Overall PADR compliance is currently 39.36% which reflects many of the pressures felt within the Clinical Board over the past twelve months. The Clinical Board will ensure that this staff have an opportunity to have a meaningful appraisal and well-being discussion with their line manager as part of its restoration and recovery plans for 2021-22.

	Count	Completed	%
001 Children's Hospital for Wales	745	298	**40.00%**
001 Children, Young People and Family Health Services	672	245	**36.46%**
001 Obstetrics & Gynaecology	567	242	**42.68%**
001 Women & Children's MGMT	28	7	**25.00%**
Grand Total	**2,012**	**792**	**39.36%**

Medical Appraisal Rates

Rates for medical appraisal stood at 65.61% as at November 2020. Performance in Children, Young People and Family Health Services was highest at 90.48% followed by Children's Hospital for Wales 64.42% then O&G 53.13%.

Statutory and mandatory rates for all staff groups for November 2020 was reported at 73.55%.

Compliance against the statutory module is shown below:

Directorate	Assignment Count	Achieved	Compliance %
Children, Young People and Family Health Services	691	9036	81.44%
Children's Hospital for Wales	846	10428	69.93%
Obstetrics & Gynaecology	617	7553	70.44%

Recruitment/Vacancy/Turnover

November 2020 ESR data confirms that there are 1968.14 (wte) budgeted positions available within the clinical board, a total of 1844.44 (wte) are appointed to, leaving a vacancy factor of 6.28%.

Turnover rates for the clinical board stands at **11.43%**. This figure only includes those who have left the health board and includes Medical and Dental Staff.

The top two reasons provided for leaving in the last 12 months within the Clinical Board is due to relocation and retirement.

Staff Recognition Awards

The Children and Women Clinical Board are extremely proud of the achievements and efforts made by staff to support the health and well-being of children and young people in our care.

Winner of the Patient Care Award
Stacey Mcintyre Paediatric Diabetes, Specialist Nurse & Rhian Murphy Paediatric Diabetes Team

Winner of Patient Care & Engagement
Youth worker Rebecca Soundy Paediatric Diabetes team.

Winner of the Manager of the Year

Rebecca Williams Ward Sister Children's Assessment Unit.

Winner of the Equality, Diversity and Human Rights Award
Judith Cutter, Consultant Midwife Public Health and Vulnerable Women

Winner People's Choice Award
Julie Daly, Community Midwife

Community Midwife Wendy Ansell received an innovation award along with £5000 for equipment for asylum seekers and Vulnerable BAME groups from the Cardiff and Vale UHB Health Charity.

Publications & Other Achievements
The midwifery team were shortlisted in two categories again this year at the Royal College of Midwives national awards. Although the team were unable to travel to London to celebrate, they their achievement were acknowledged locally with a series of events coinciding with International Day of the Midwife including a visit by Wales Rugby Legend Jamie Roberts

- Marrianne Jenkins ANNP and Coral Rees ANNP
  RCN Clinical Guideline for, "Maximising nursing skills, caring for children and young people in the emergency care settings".
- Erica Thomas Paediatric Surgical Advanced Nurse Practitioner was a key stakeholder in developing the RCN Clinical guidelines for 'Day surgery for children and young people".
- Cutter,J (2020) Evaluation of a midwife-led postpartum family planning service. Midirs Midwifery Digest. Sept 2020, Volume 30, Issue 3. Page 367-372.
- Cutter, J (2021) Midwives play an important role in promoting public health. Nursing Practice, 6th Feb 20201, Winter 2021. Issue 118.

Dr S Zaher was nominated for National BAME health care award -ground breaking researcher**.**

NHS research time awards were awarded to S Zaher and S Jones

Recommendation:

The Quality and Safety Experience Committee is asked to :-

- **Note** the progress made by the Clinical Board to date
- **Note** the approach and strategies for improvement
- **Approve** the content of the report and the assurances provided by the Children and Women's Clinical Board.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Quality Indicators – Progress Report**						
Meeting:	Quality, Safety and Experience (QSE)				**Meeting Date:**	13/04/2021	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Executive Director of Nursing 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.

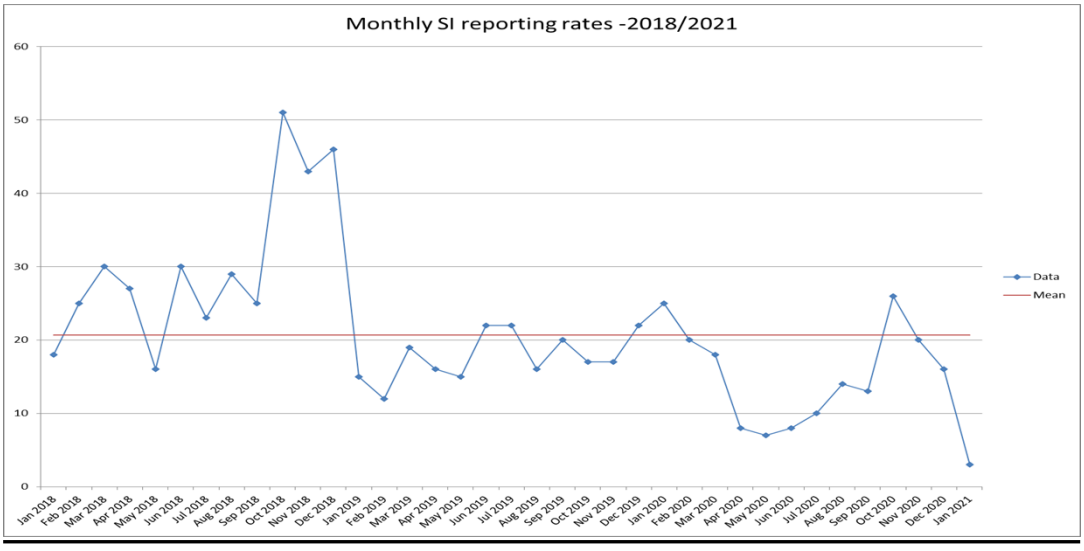
This paper provides an overview of current performance against those quality indicators that are available within the dashboard.

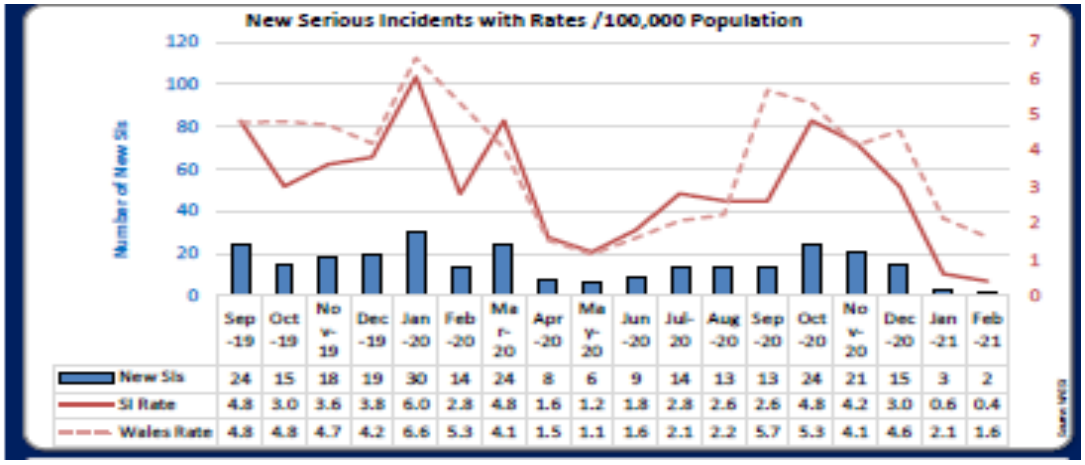
Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The QSE dashboard remains under development.
Actions to address any deteriorating positions are outlined within the paper.

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

Serious Incidents

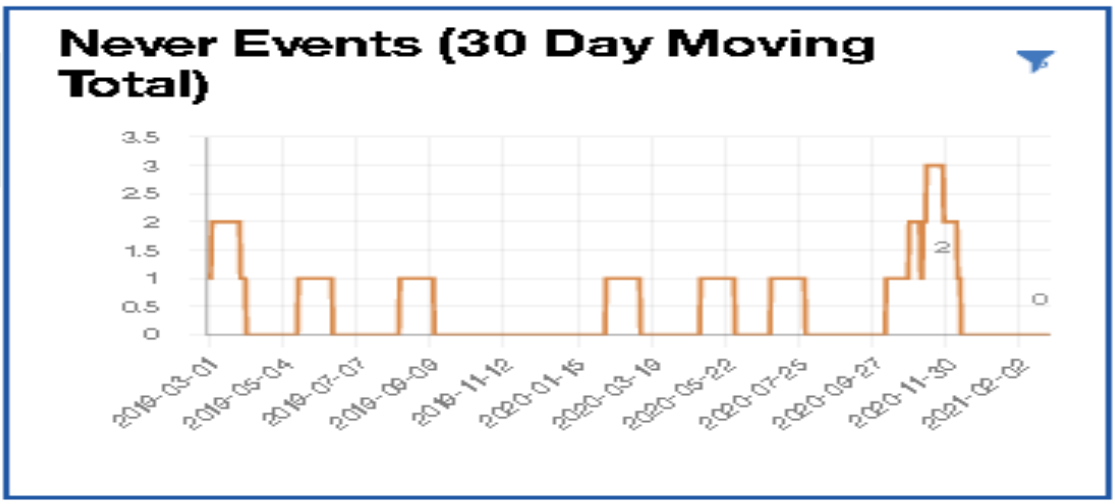




The number of Serious Incidents (SI) reported has reduced significantly over the last two years and this is a continuing trend. This is due mainly to the change in the requirement for reporting pressure damage and more recently changes to the SI reporting Framework in Wales. SI reporting reduced during 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 Patient Safety Team continues to monitor those incidents which would normally meet the SI reporting requirements and the usual investigation processes are in place.

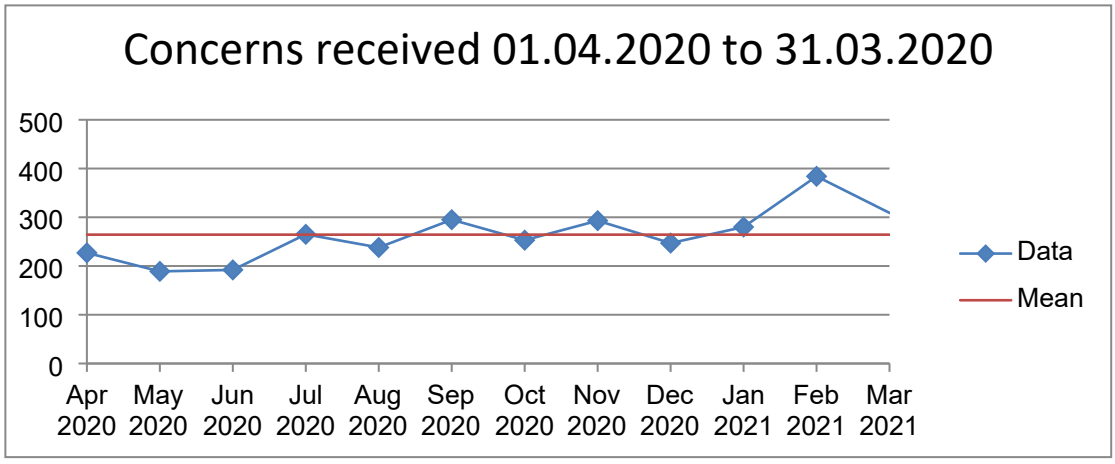
The number of SI closure forms submitted to WG improved during Q3 2020/2021. However this performance has not been maintained during the first two months of Q4. The Patient Safety Team are working closely with Clinical Boards to ensure timely investigation and closure of SIs, so that the UHB can achieve pre-Covid rates of SI closures. At the time of writing the UHB has 84 open SIs, which is an 11.5% improvement on the number open in the last report to the Committee in February 2021.

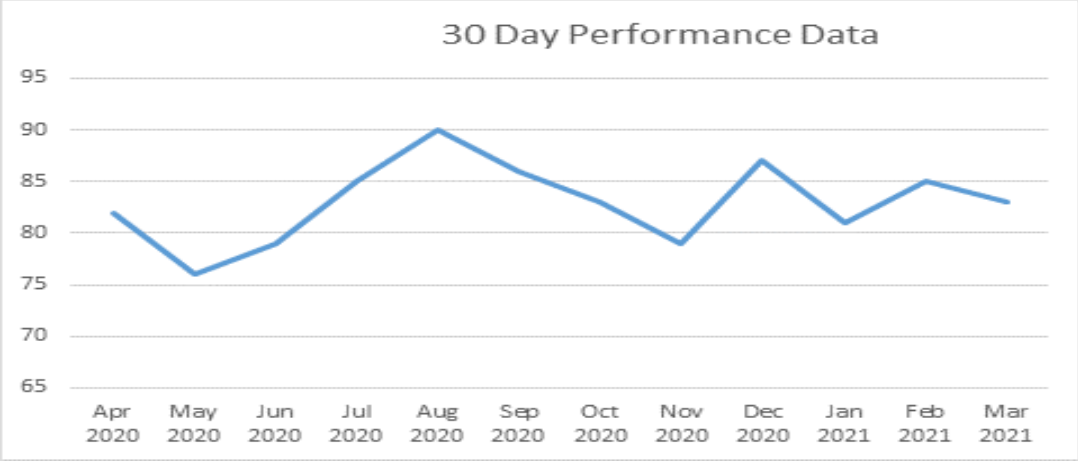
Never Events



A detailed thematic review of Never Events is presented as a separate paper to the April 2021 Quality, Safety and Experience Committee. The draft paper was discussed at the 26th March NaTSSIPs meeting – the group is putting in place a number of initiatives (including an awareness campaign, staff survey and observational audits) to support staff in reducing the number of Never Events. Development of a Human Factors Framework and Training Strategy will be an important element of our revised QSE Framework for the next five years. Embedding a Human Factors and Systems based approach to safety will support the reduction of Serious incidents and Never Events.

Complaints

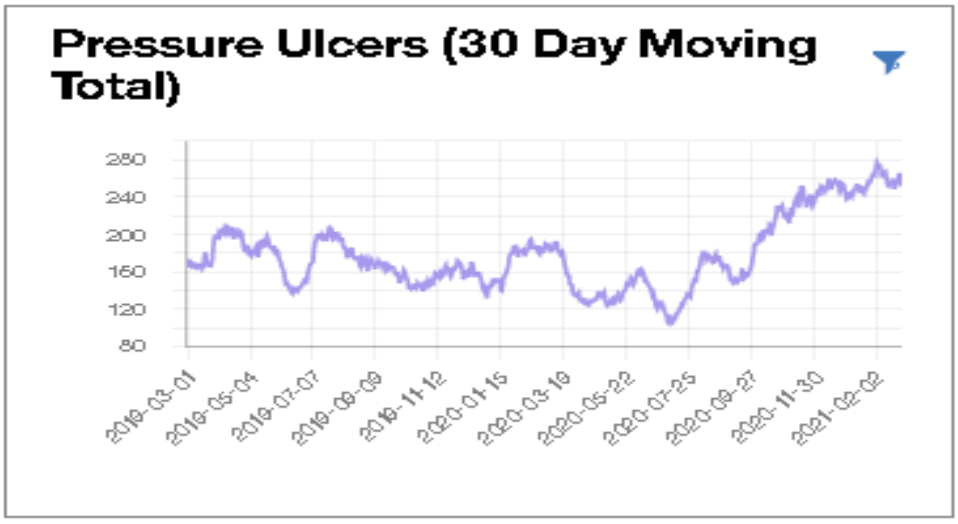




The number of complaints has increased significantly during February and March 2021 and this is due largely to concerns in relation to vaccination waiting times.

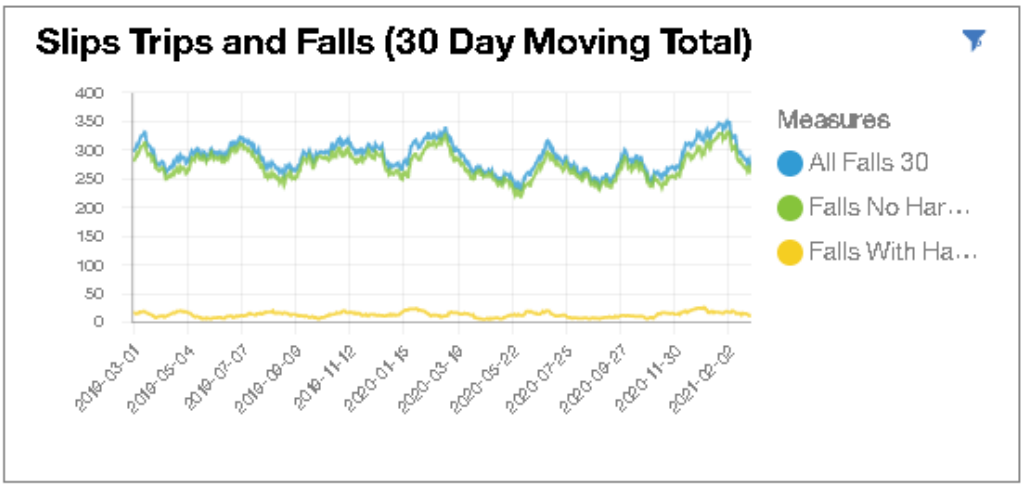
Despite the current challenges, compliance with the Welsh Government 30-day response time target remains consistently well above 75%.

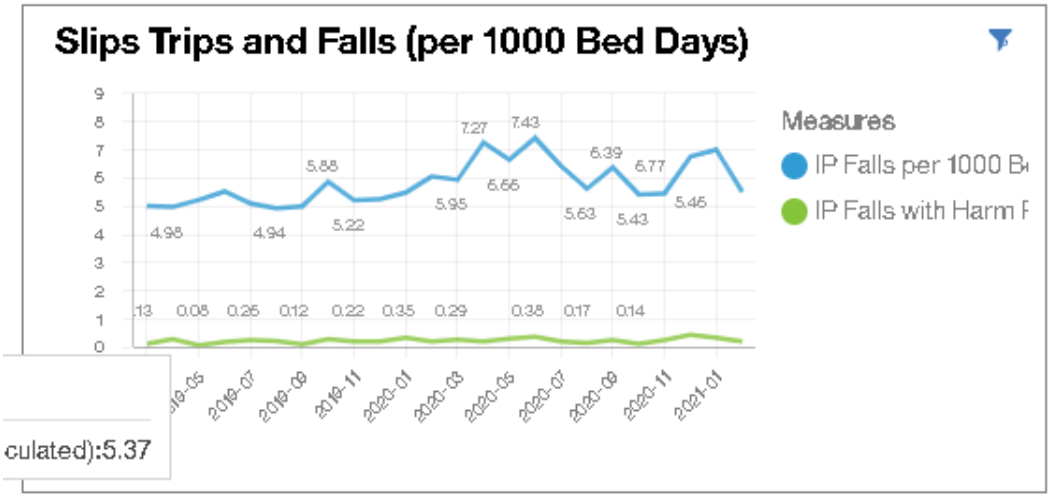
Pressure damage



The number of reported pressure ulcers has again 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 continued monitoring. The Director of Nursing for Surgery Clinical Board, who is the organisational lead for pressure damage prevention, is working with the Wound Healing Team to develop a project plan which will be presented to the June 2021 QSE Committee.

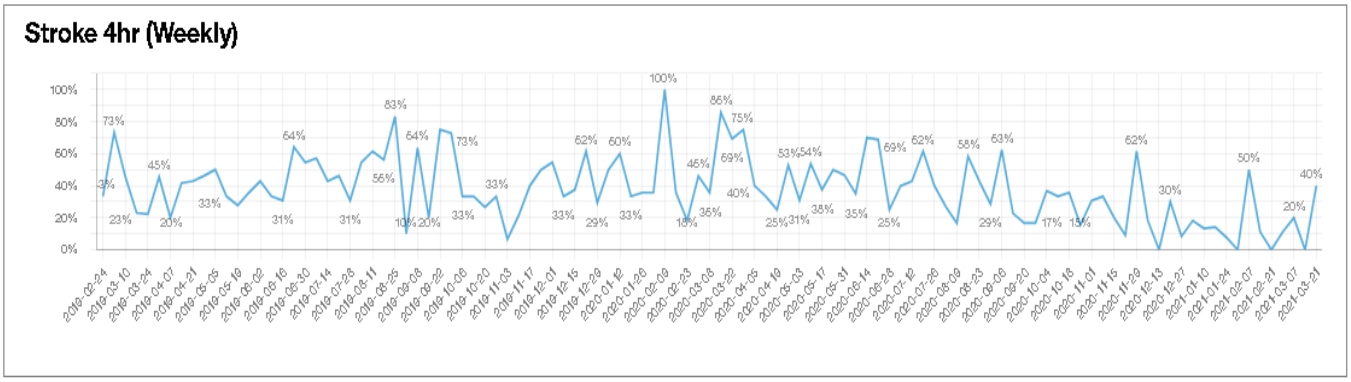
In-patient falls

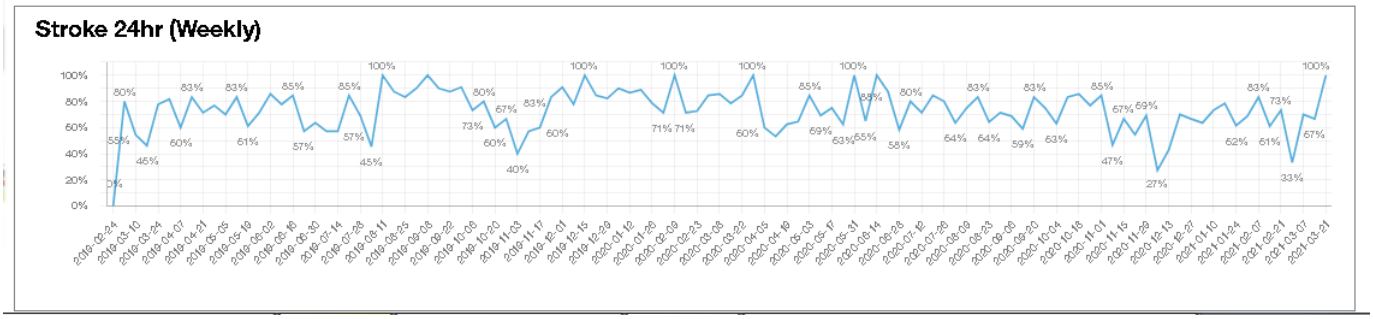




The Patient Safety Team has developed a detailed Falls dashboard which will be monitored routinely by the Falls Delivery Group. In-patient falls prevention work is now being undertaken by one of the Patient Safety and Quality Organisational Learning Managers (0.4 WTE) and a multidisciplinary Falls Review Panel has been established and will meet regularly to review the care of all patients who have had an injurious fall while an in-patient. A pilot of the Royal College of Physicians National Audit of In-patient Falls (NAIF) Hot debrief tool is currently being undertaken on a medical ward at University Hospital of Wales. This will help to inform a review of the current risk assessment and injurious falls investigation template.

Stroke indicators

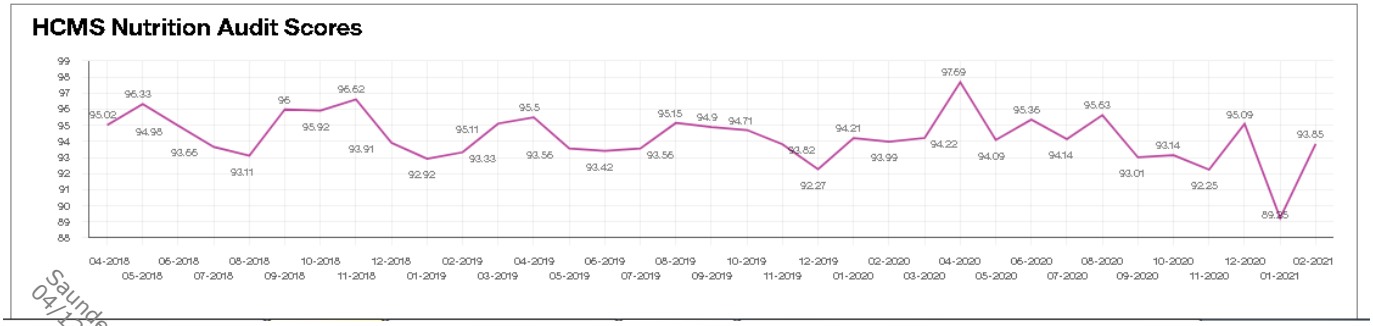




In the last report to Committee in February 2021, we reported that in the last published national SSNAP audit the national average is that 58.9% are admitted to a stroke unit within four hours of arrival at hospital. UHB performance in the last national report was that 52.1% of patient go directly to a Stroke Unit within four hours. This had deteriorated further to 17%. The latest performance has improved to 40 % compliance. The latest reported data demonstrates 100% compliance for patients seen by a Stroke Consultant within 24 hours. This issue will be discussed with the Clinical Board and Acute Stroke Team at the next Clinical Effectiveness Committee.

In future reports we will also include data on compliance with CT scanning and Thrombolysis targets.

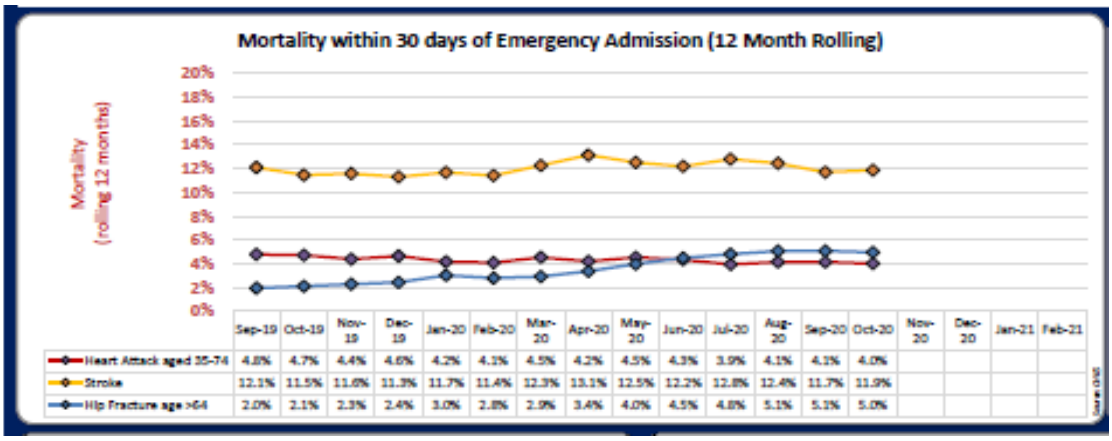
Nutritional assessment scores

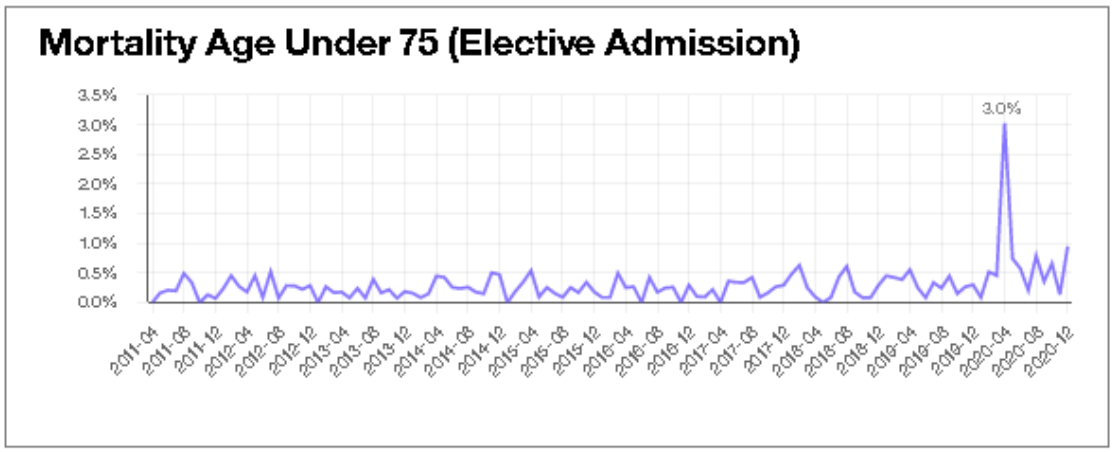


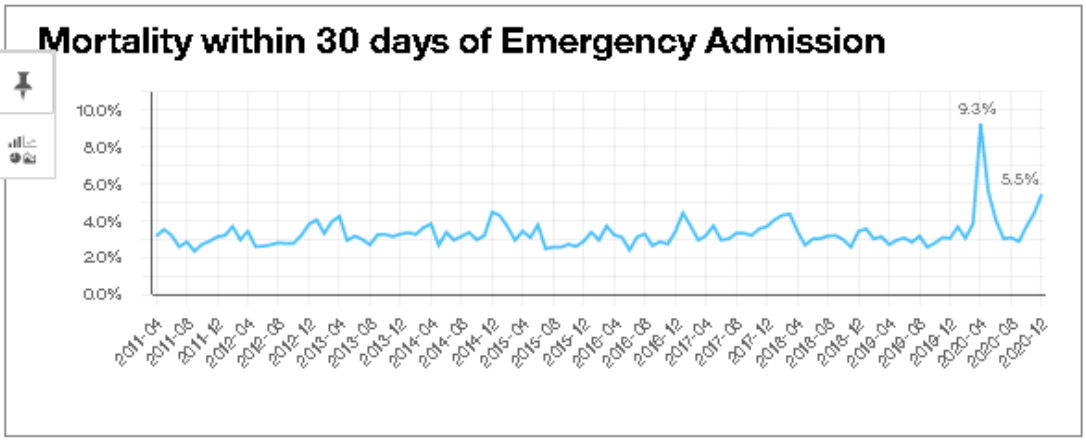
Following a decrease in compliance with nutritional assessment scores which was noted at the

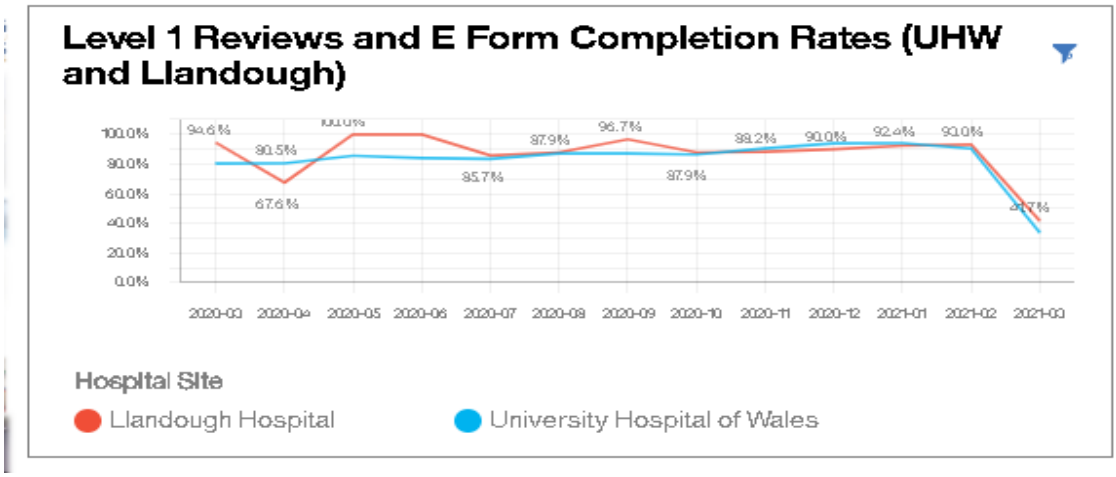
pervious Committee in February 2021, the Executive Director of Therapies and Health Sciences has asked the Nutrition and Catering Group to work with Clinical Boards to improve compliance with nutritional assessment on admission. There has been a subsequent improvement in performance which the UHB will continue to monitor.

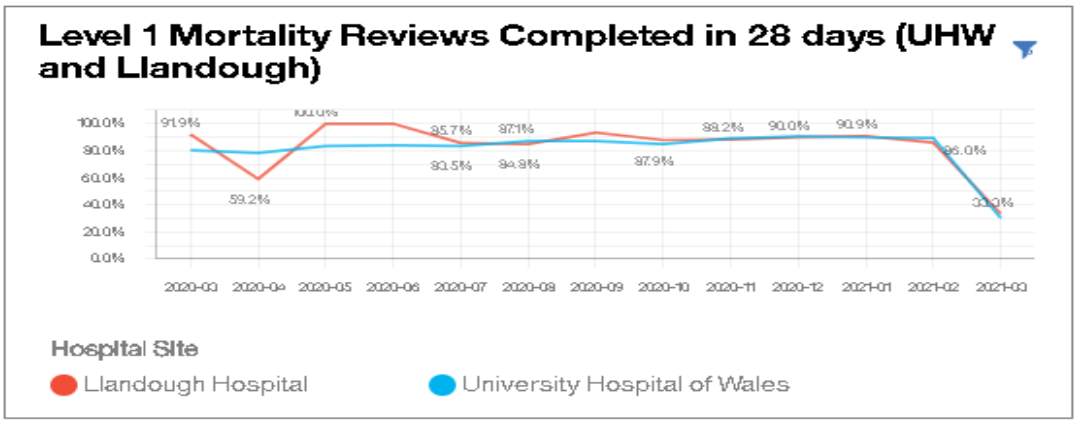
Mortality Indicators







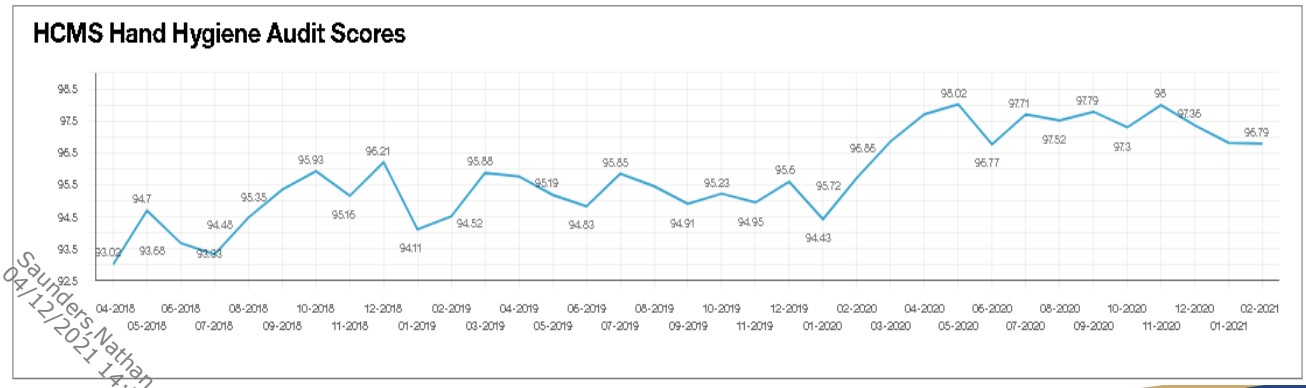




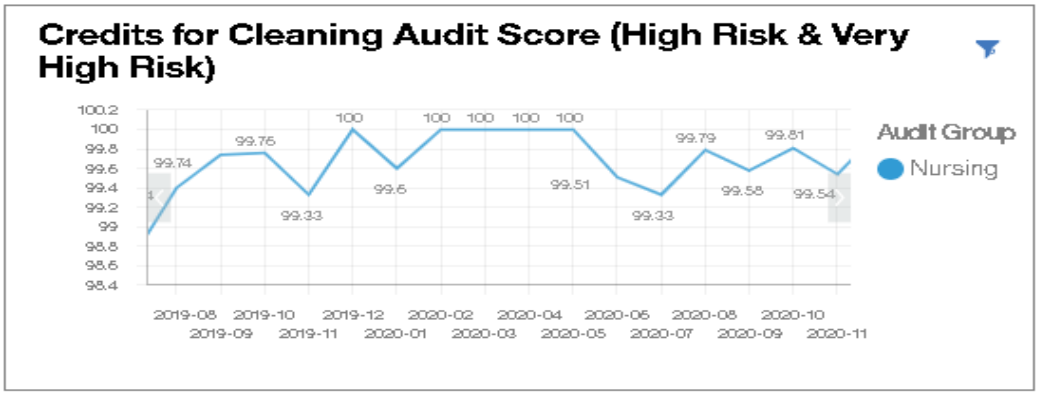
There was an increase in mortality within 30 days of an emergency admission, in December 2020. This is almost certainly linked to an increase in the number of patients with Covid–19, in line with the second wave, and will be discussed in more detail at the next meeting of the UHB Mortality Group.

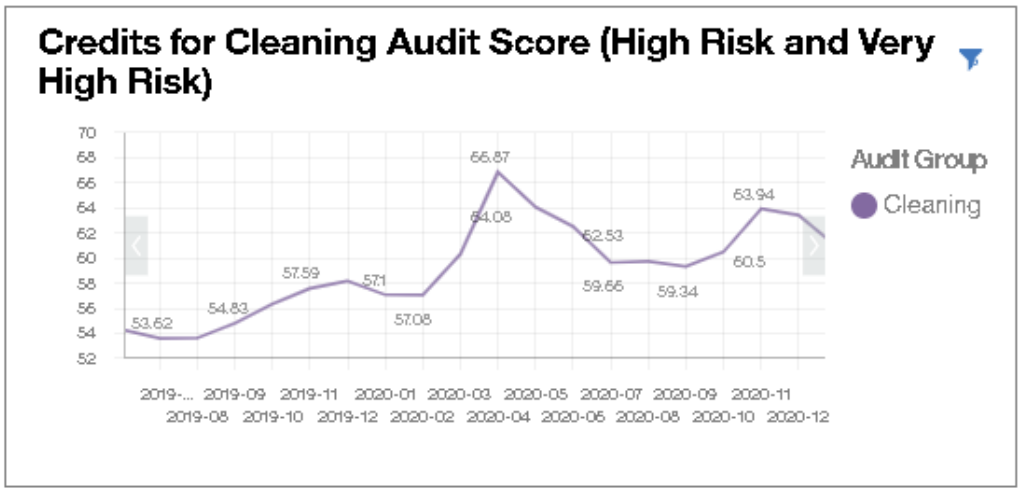
Data for March 2021 is incomplete due to the time of writing the report and the inevitable lag in data input due to the current system which is dependent on paper forms being in-putted centrally. Level 1 reviews will be replaced by the Medical Examiner scrutiny of deaths and from April 2021, a basic, electronic Level 2 Mortality form will be available as part of the Once for Wales Concerns Management System.

Hand Hygiene



Cleaning scores





Infection Prevention and Control

Wales 2020/21 HCAI mandatory surveillance summary, Apr 20 - Mar 21

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	137	25.32	9	1.66	132	24.40	141	26.06	269	49.72	105	19.41	22	4.07	396	73.20
Betsi Cadwaladr UHB	194	30.36	5	0.78	143	22.38	148	23.16	404	63.22	116	18.15	31	4.85	551	86.22
Cardiff and Vale UHB	89	19.59	11	2.42	107	23.56	118	25.98	252	55.48	89	19.59	29	6.38	370	81.45
Cwm Taf Morgannwg UHB	100	24.55	6	1.47	98	24.06	104	25.53	281	68.98	86	21.11	19	4.66	386	94.75
Hywel Dda UHB	124	35.14	10	2.83	76	21.54	86	24.37	271	76.80	59	16.72	21	5.95	351	99.47
Powys THB	6	4.95	0	0.00	1	0.83	1	0.83	4	3.30	2	1.65	1	0.83	7	5.78
Swansea Bay UHB	148	41.54	3	0.84	109	30.59	112	31.43	213	59.78	92	25.82	18	5.05	323	90.65
Velindre NHST	6		0	0.00	2		2		6		2		0		8	
Wales	804	25.62	44	1.40	668	21.28	712	22.69	1,700	54.16	551	17.56	141	4.49	2,392	76.21

Chart 2. University Hospital Of Wales monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Feb 21

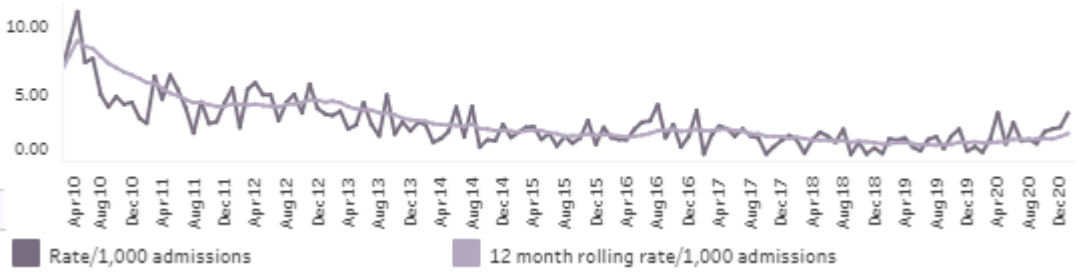


Chart 2. University Hospital Llandough monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Feb 21

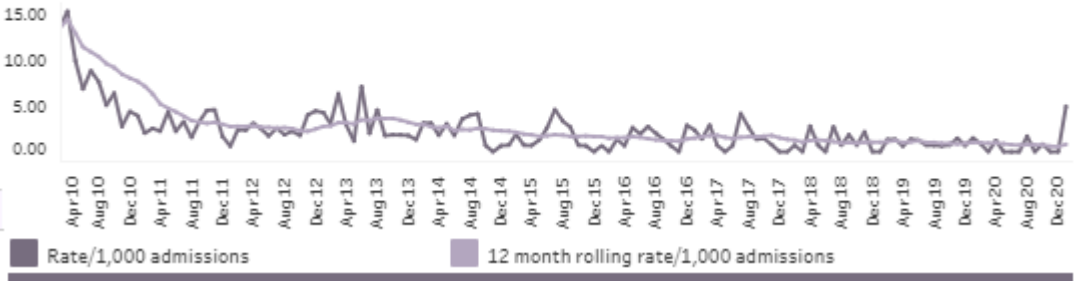


Chart 2. University Hospital Of Wales monthly rates of MRSA bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

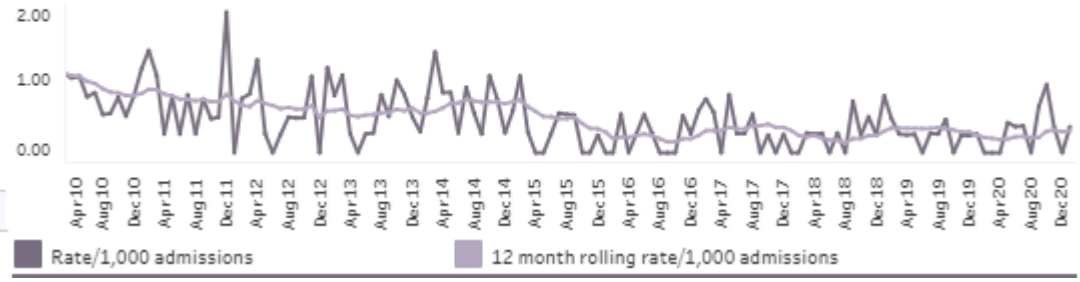


Chart 2. University Hospital Llandough monthly rates of MRSA bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

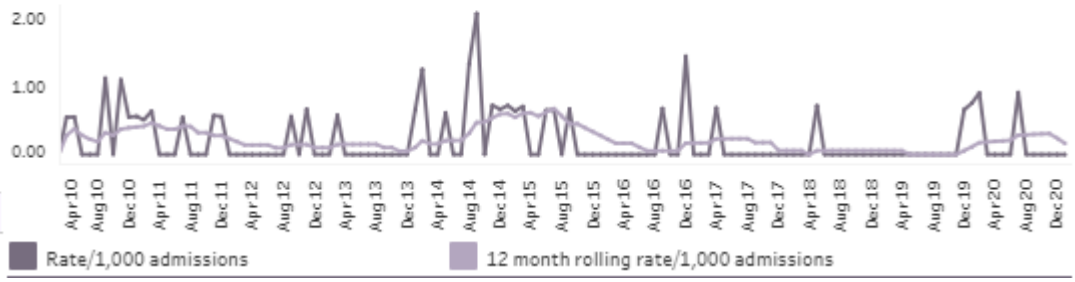


Chart 2. University Hospital Of Wales monthly rates of MSSA bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

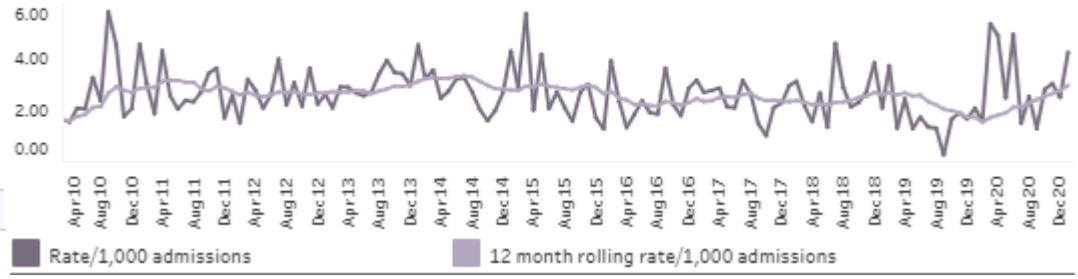


Chart 2. University Hospital Llandough monthly rates of MSSA bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

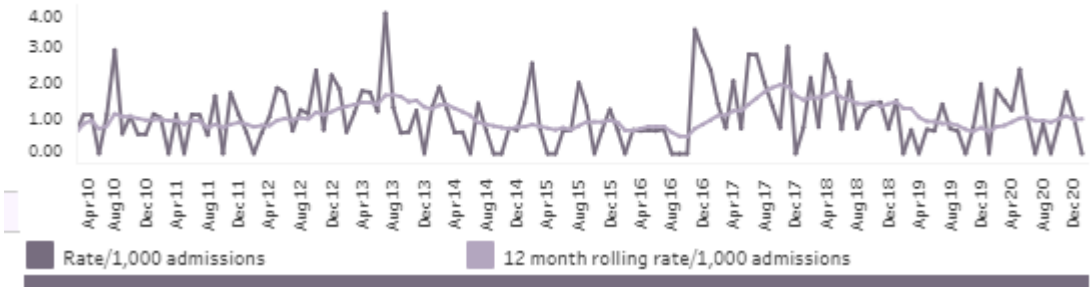


Chart 2. University Hospital Of Wales monthly rates of E. coli bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

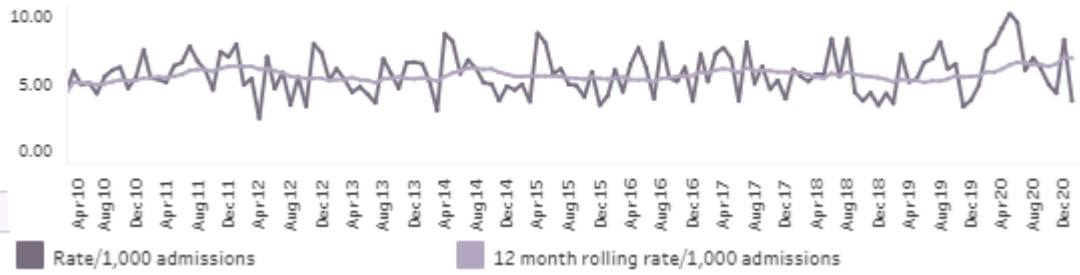


Chart 2. University Hospital Llandough monthly rates of E. coli bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

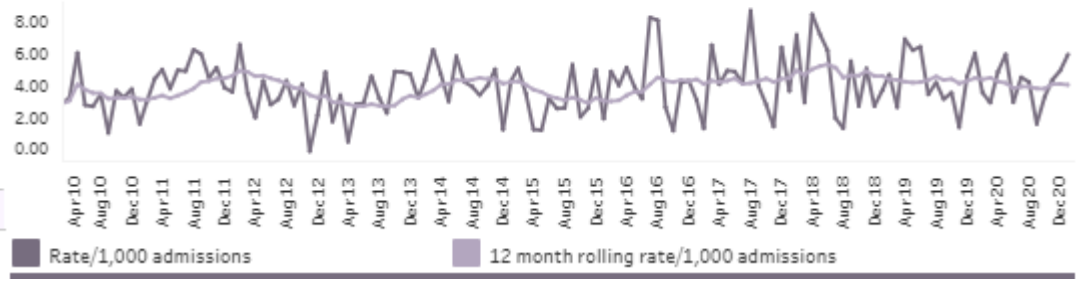


Chart 2. University Hospital Of Wales monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

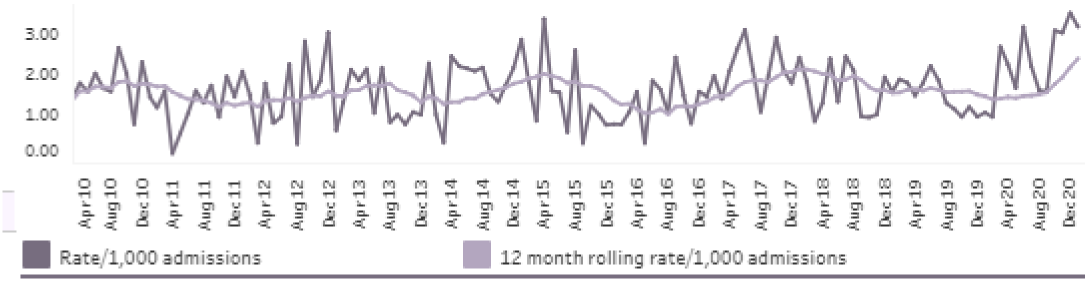


Chart 2. University Hospital Llandough monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

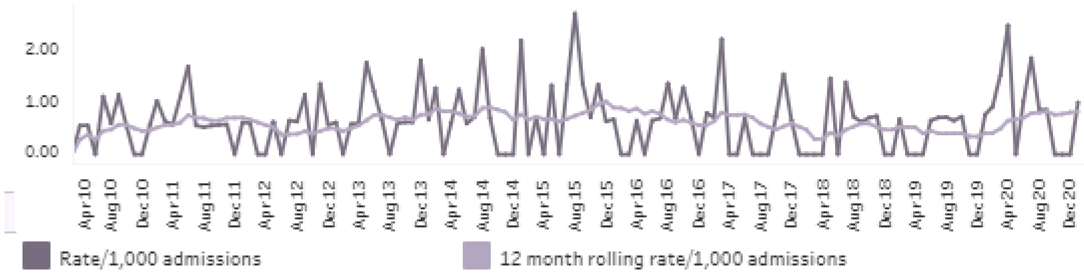


Chart 2. University Hospital Of Wales monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

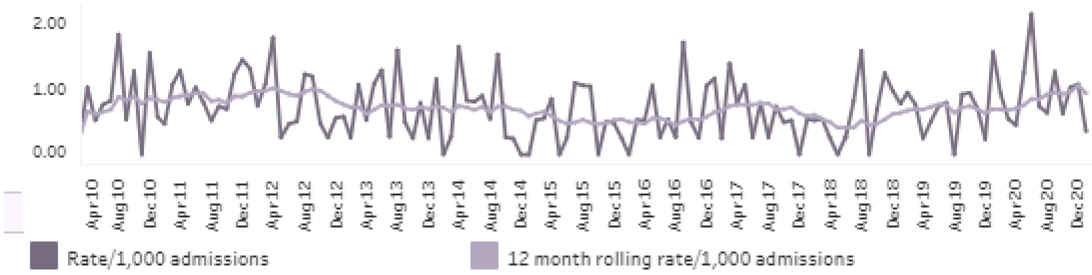
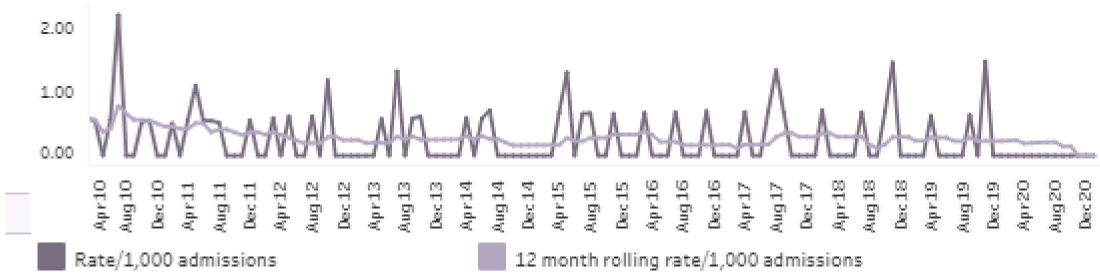


Chart 2. University Hospital Llandough monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to Feb 21

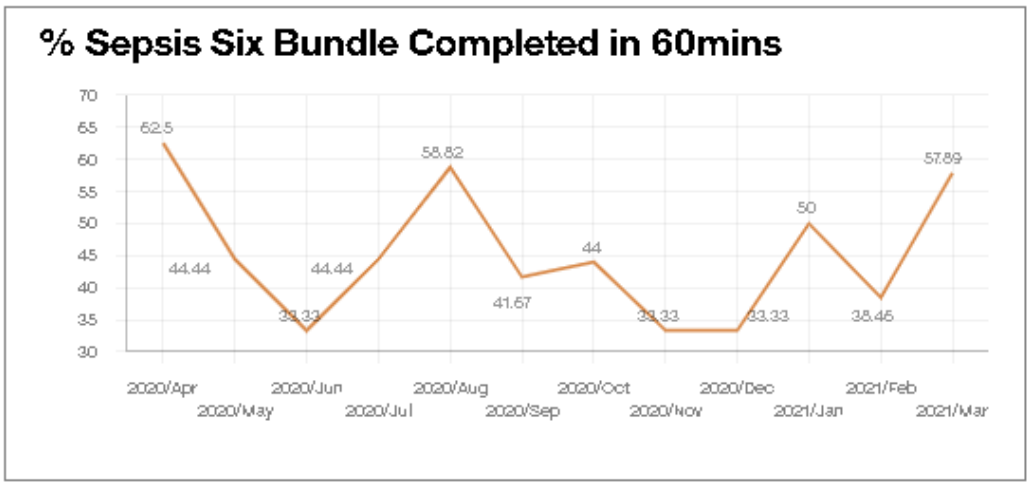


The UHB continues to make good progress and achieve a reduction in *C'diff*, *E.coli*, PAER and MRSA numbers compared to the same period last year, however there has been an increase in number of MSSA and Klebsiella sp. cases.

The IP&C Team are working with relevant Clinical Boards to identify possible areas for

improvement. Monitoring of compliance against WG targets is overseen by the well-established IP&C Group, chaired by the Executive Nurse Director.

Sepsis



The Sepsis dashboard collects data using the Sepsis Star from the Emergency Unit and Ward Clinical Workstation, or from the Sepsis button on the EU version. The figures for compliance are from UHW, with no data at present being collected from UHL or elsewhere. This is an issue that the UHB Sepsis Group are working hard to address.

Three are ongoing education programmes for sepsis, although these have been hampered by the impact of the pandemic. The UHB Sepsis Group met virtually on Teams in January 2021, with some useful developments underway, particularly the employment of antimicrobial pharmacists. The other development which will contribute to improvement in the treatment of Sepsis is the merger of the Critical Care Outreach Team and the Medical Rapid Response Team into the Patient At Risk Team (PART), who will be leading on the re-invigoration of sepsis education. Also, on the horizon is the prospect of getting an electronic observations system into the UHB, which would then enable the quicker detection of a high NEWS and alerts to encourage appropriate timely intervention. The Sepsis Group aims to celebrate World Sepsis Day on 13th September, which will provide fresh impetus to get the staff and the public thinking about sepsis and driving the compliance figures up and the morbidity and mortality down.

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:	**HEALTHCARE INSPECTORATE WALES ACTIVITY**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**13.4.21**	
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 February 2021, there has been one Focused Inspection at the Mass Vaccination Centers and Two Tier 1 Quality checks. The first Quality Check took place on East 12 (MHSOP) which is featured in this paper, and the second on Hazel Ward, Hafan y Coed. At the time of writing this report feedback had not been received. A Tier 1 Quality check is

planned to take place on the Teenage Cancer Trust on the 31st of March 2021.

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 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=2.19908280.1648384767.1610967625-756388831.1566898668

Mass Vaccination Centre – Focussed inspection.

HIW have undertook focussed inspections of Mass vaccination centres across Wales, The first inspection took place at the Splott MVC in Cardiff in March 2021. Following the inspection HIW issued a request for immediate action. An improvement plan was submitted with Immediate actions and accepted by HIW. The Improvement plan included the following:

Vaccination Processes

HIW were concerned that during their inspection it was not possible to confirm the length of time between drawing up of the vaccine and administration to the patient due to syringes not being labelled and no audits being undertaken to monitor. HIW were also concerned that at the point the vaccine was handed to the vaccinator by the runner that no safety check was undertaken at that point. HIW felt that the process was not in line with national protocol. Discussion were had between the inspections and senior management at the time, there appeared to be some ambiguity with national guidance in some areas and further clarification would be sought.

Since the HIW inspection amendments have been made, the pathway has been reviewed and time cards introduced by MVC Pharmacy leads across all sites to ensure that the time from drawing up the vaccine to administration is noted and the vaccine is delivered as efficiently as possible in time order ensuring that it is delivered, within a maximum time frame of 15 mins. The use of the Time card will be regularly audited to ensure compliance

The CAV vaccine SOP is in line with the National Protocol and the vaccine details i.e. brand, batch number and expiry date, are shared with all vaccinators via a notice in each pod at the start of each session

Audit Activities.

HIW identified that audit actives were not being undertaken at the sites inspected as vital part of governance to ensure compliance with required standards and to maintain patient safety.

In response a schedule of audits was developed with immediate effect on a weekly basis for IP&C, Environment, Resus Trolley and Citizen experience.

Security and Fire Hazard.

HIW were concerned that fire doors were wedged open causing a fire Hazzard and that staff were unfamiliar with the fire evacuation process. A further review of the risk assessments was undertaken by the UHB fire officers**,** fire awareness sessions have been introduced and run across all sites to ensure that all staff understand their personal responsibility should they be required to undertake fire evacuation should they be required.

Fire risk assessment and evacuation notices are available at each site. UHB Fire Officer is satisfied with the Fire evacuation plans being available on site and providing Fire awareness sessions.

At the time of the inspection HIW identified that the exit door of the Splott center was left unattended and open. HIW felt that there were inadequate security measures in place at all entry and exit points for all mass vaccination centres across the health board posing a risk to the security of staff, patients and vaccine stocks.

Immediate arrangements were put into place for military personnel to cover the Security guard breaks to ensure there is continuity whilst the contract for security staff was being renegotiated to include cover for staff breaks. The security firm confirmed that the security officer would be advised to face into the room to monitor the vaccine area as well as controlling egresses.

The Improvement plan and immediate actions taken were accepted by HIW.

Themes across Wales

A letter reived form Alun Jones Interim Chief Executive Healthcare Inspectorate Wales provided a summary of the issues identified during their inspections across Wales which required urgent remedial action to maintain patient safety, to share with internal networks in particular within the quality governance structures in place for vaccine delivery, the themes are listed below.

- Vaccines being left unsupervised and not checked between preparation and administration.
- No clinical or environmental audit activity
- Security, fire regulation compliance and emergency evacuation
- Checks of resuscitation equipment

<u>Tier 1 Quality Check for Mental Health Services for Older People (MHSOP) E12</u>

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of ward East 12, in the University Hospital Llandough as part of its programme of assurance work. The report has not yet been published, however a draft report of findings has been received by the UHB and was found to be overall very positive.

Environment

Recent risk assessments, incident reviews and use of restraint and seclusion were reviewed by HIW, they also considered the setting and the changes made to make sure patients continue to receive the care and treatment according to their needs.

Changes that had been made to the ward environment as a result of the pandemic were reflected upon positively. E12 reduced the number of beds to increase the number of single occupancy room to ensure that rooms are available for patients to self-isolate if needed, the dining area had been rearranged and notices were also in place in staff rooms with maximum numbers to ensure social distancing rules could be adhered to.

HIW were reassured by designated visitors pods being available to allows families to visit (when permitted by government guidance) whilst maintaining social distance measures. Changes to visiting times and patient leave were being monitored in multi-disciplinary team meetings to ensure risk and patient capacity/understanding is being checked. Alternative means of communication were also being utilised for patients to maintain contact with their family and friends. Video calls were also been facilitated by a newly established designated team called the Family Liaison Team.

HIW found that a formal environmental risk assessment had not been completed for East 12 since 2019. Despite measures undertaken at ward level to ensure the ward remains safe and fit for purpose, a formal risk assessment has been identified as an action for the UHB.

Infection Prevention and Control

During the quality check HIW were provided with evidence of IP&C procedures which included COVID -19 guidance. It was shared that the IP&C team regularly visit to the ward to support best practice. It was found that staff had increased cleaning throughout the hospital for all patient and staff areas alongside the implementation of PPE stations and temperature checking upon entering the ward. Hand washing facilities were available for patients and staff throughout the ward.

HIW were reassured that there were appropriate processes in place to identify any staff or patients at risk of developing COVID-19 in line with national guidance. Risk assessments were completed for staff and appropriate measures taken for symptomatic staff including COVID -19 testing and self-isolating. There was robust monitoring of IP&C procedures and use of PPE in place. The ward was identified as having no cases of clostridium Difficile, Norovirus.

HIW was reassured by local measures that were being taken in relation, however a formal IP&C inspections was out of date. A formal IP&C inspection was identified as an action to be undertaken as soon as possible.

Governance

HIW found that there were sufficient numbers of staff in post, and vacancies were being actively recruited into, figures were provided on staff attendance for mandatory study days which were overall positive, although there were some training requiring classroom attendance had been impacted on negatively on staff attendance due to the COVID pandemic, however HIW were reassured that his was under review.

Staff appeared to be adequately supported, monthly supervision had been introduced for all staff by the ward manager to ensure staff feel supported and can raise any concerns, and information was readily available for staff in relation to staff wellbeing services available in the UHB. The ward manager was very complimentary about the staff and the work that they had accomplished during the pandemic.

There were no areas identified for improvement.

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:	**HIW Primary Care Contractor Report**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**13.04.2021**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information** ✓
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	**Primary Care Support Manager – James Rugg**						

PURPOSE OF REPORT:

Please set out why this report is being provided to the meeting.

SITUATION:
The routine Welsh Government practice and performer inspection programme has been commissioned from Healthcare Inspectorate Wales (HIW) from August 2014. The UHB Primary Care Team is required to provide assurance to the PCIC Quality and Safety Group and Executive Team that Inspection Reports have been received, reviewed and acted upon.

REPORT:

Please provide your report in no more than 2 sides of A4 using the space provided and the headings below. Essential supporting documentation can be provided as an appendix.

BACKGROUND: All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections produce an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

HIW visits were suspended at the start of the Covid-19 pandemic. The Primary Care Team received a new Covid-19 "Quality Check" report for a GMS practice on the 12th of October. The following information was also provided:

"*HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.*

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focused on four key areas: COVID-19 arrangements; environment; infection

prevention and control; and governance"

The receipt of this new report lead to the restarting of this SBAR reporting process. However, since this report was received, no further Covid-19 "Quality Check" reports have been received.

ASSESSMENT:

HIW review each report and produce the action plan for the visit. Any responses from the practice which do not provide sufficient assurances are escalated within HIW and a more detailed response and actions requested from the practice. This communication is copied to the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity.

Actions contained within the HIW reports and immediate assurance letters are routinely followed up.

The Primary Care Team continue to report inconsistencies in the receipt of reports. The one new GDS report included in the appendix did not make its way to the Primary Care Team, and was instead discovered on the HIW website.

The review and summary of reports are attached **(GDS Appendix 1).**

General Medical Services:

Since the last SBAR report to the committee December 2020 there have been no HIW reports received by the Primary Care Team.

The committee can be assured that all previously reported actions have been followed up and resolved, and as there are no further actions or new reports there is no GMS appendix included with this paper.

The resolution of the Llanishen Court Surgery immediate assurance letter, which was presented in the last report, resulted in the sharing of the NHS Employers DBS eligibility tool with all GMS contractors. The letter raised concerns that not all staff had the relevant DBS check in place. The tool suggests appropriate levels of DBS check for each staff group and was circulated with all General Practice Managers to ensure the learning from this immediate assurance letter was shared.

General Dental Services:

Since the last SBAR report to the committee December 2020 there has been one HIW report received by the Primary Care Team.

The following report was received:

- Birchgrove Dental Practice

This HIW report has been reviewed by a Dental Practice Adviser (DPA), who advises the necessity of appropriate follow-up by the Primary Care Team. Outstanding actions from HIW visits highlighted in previous reports have been updated and included in Appendix 1.

Since the last report, two practices have been removed from Appendix 1, as their actions have been completed. These are as follows:

- Advanced Dental Care
- Llanedeyrn Dental Practice

Due to the actions of the practices, Penarth Dental, Owain Joynson, Restore Dental Whitchurch and Restore Dental St Mellons have been re-categorised from Amber to a Green.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- Note the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors
- Be assured that appropriate remedial actions are being taken by practices in relation to immediate assurance notifications
- Note that there is a robust process in place within the Primary Care Team to manage the receipt of inspection reports and ensure review and follow up by the practice

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information									
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.								

Saunders,Nathan
04/12/2021 14:33:00

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2020) - TABLE OF INSPECTIONS

Total 10	*Practice Name*	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
64	Birchgrove Dental Practice (Moorcastle Ltd)	02/10/2020 Non-compliance 07/10/2020 Final Report published 16/11/2020	• The service must ensure that the arrangements in place at the practice are in line with the 'Standard Operating Procedure for the Dental Management of Non-COVID-19 Patients in Wales' guidance document produced by the Chief Dental Officer		• Mick Allen (DPA) visited practive 07/10/2020, written response to HIW regarding visit findings	• DPA visit complete 07/10/2020. • HIW accepted practices non compliance response. • DPA's to keep in contact with practice to support.
62	Mount Pleasant Dental Practice (E Akbas)	05/11/2019 (Report found on website) Published 06/02/2020	A quality patient experience, with friendly and professional staff. Areas of improvement identified including notekeeping, compliance to practice policies and quality assurance including audit. • Sharps bins to be relocated to avoid contamination of clean areas which should be clearly designated • The practice must ensure complaints procedure (Putting things Right) is displayed, mechanism for feedback and display how feedback was acted upon. • Fire safety training and assessment to carried out • Clinical audit including smoking cessation. • Audit of note keeping to identify areas of improvement • Record of policy awareness updates by staff including whistleblowing		• DPA summary report complete. • DPA letter • Ongoing investigations into provider	Response from practice, ongoing correspondence.
61	Newport Dental Practice (321 Newport Road S Yeganeh)	02/10/19 Report published 03/01/2020 (Full report found on	The practice was found to be committed to a positive patient experience and rated excellent by patients. Areas of improvement were recommended in compliance with current regulations, standards and best practice guidelines. • Immediate improvement plan initiated re		• Immediate improvement action taken and practice confirmed. • DPA summary	• HIW satisfied with immediate improvement plan. • DPA's in correspondence with provider

		website)	emergency drugs and resuscitation equipment • The practice must provide evidence to HIW that the dental nurse has undertaken the required number of hours (five) of verifiable training in disinfection and decontamination. • Feminine hygiene bins must be made available within the appropriate toilets and feminine hygiene waste must be disposed of appropriately. • Patient records must be fully maintained in keeping with current guidance and professional standards for record keeping (including those recommended within this report).		report Complete • DPA letter	
60	N Dental (Grangetown)	24/10/18 Report published 25/01/19 UHB and practice did not receive report. RH requested final report.	Overall a good report confirming safe and effective care. We hope the report highlights areas to further improve the service. • Welsh and English language information to be made available • The practice must ensure that the clinical waste storage remains locked at all times. • The practice must ensure it completes its COSHH protocol and mercury handling policy to be included in its policy file. • The practice must ensure that Infection Control audits comply with WHTM 01-05 • The practice must ensure that the wear and tear of both treatment chairs is repaired or replaced on moving premises. • The practice must ensure that the floors in both surgeries are properly repaired to an acceptable standard whilst waiting for a move to alternative premises. • The practice must ensure there is a specific policy in place covering medical emergencies		• DPA summary report completed. • DPA letter	Waiting for further correspondence from practice.

			and cardiopulmonary resuscitation. • The practice must ensure that all items within the first aid kit are up to date. • Local radiography rules displayed • The practice should undertake a broad range of Audits and MMD to ensure they are meeting with best practice • A secure system for holding records outside of archive • The practice must ensure that when updating the practice policies and procedures they signpost which area of the regulations they are covering			
55	Cathays Dental Practice (Gracias, Kevin)	06/08/19 Improvement letter 08/08/19	• The service must ensure healthcare waste is being stored appropriately and securely within the dental practice premises in line with best practice guidelines.		• Practice emailed 09/08/19 for confirmation of action. • Response received 09/08/19 • DPA's satisfied	• Email response received 09/08/19 • HIW email response 12/08/19 • Ongoing support being provided to practice
52	Cathedral Dental Clinic	26/03/2019 Improvement Plan issued from HIW	Overall, Cathedral Dental Clinic was working hard to provide a high quality experience for their patient population. • Update practice leaflet with current staff and Violent and abusive behaviour policy • Statement of purpose on website and available on request • Clear and prominent signage stating CCTV in operation • Update CCTV policy and guidance including storage, retention and disclosure • Fire safety training, exit signage throughout practice and risk assessment submitted to HIW		• Letter sent to practice 28/6/2019 requesting confirmation / evidence of completed improvement plan • DPA letter resent 10/10/19 requesting evidence.	• HIW satisfied with improvement plan submitted 29th April 2019 • Ongoing corespondance

			• HTM01-05 guidance to be followed including dirty to clean workflow and clearly marked transport boxes • System to check use by dates for emergency drugs and equipment • Review adequacy of private consent forms • Performers require annual documented appraisal • Emergency drugs and emergency flow charts kept in clear folders		• Response received 21/10/19 unsatisfactory, more evidence requested 25/10/19 • Full response with evidence received 12/11/19	

HIW Immediate Assurance Letters (received since last update)

Members should note that Immediate Assurance letters for Primary Care are *issued* to the Practice for response and *copied* to the UHB for Information and to feed into the broad Performance Management of the practice.

	Practice Name	*Inspection Date*	*IA Letter Date*	*Summary*	*UHB Actions*
	N/A				

HIW Concerns Raised (received since last update)

	Practice Name	*Contact from HIW*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*
	N/A				

KEY

Issues		Status
Minor issue e .g :	Price list not displayed Translation services not present Patient Feedback	GREEN

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2020) - TABLE OF INSPECTIONS

Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	**YELLOW**
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	**AMBER**
Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment - HTM 01-05 : Major	**RED**

Report Title:	**Themes and Trends in Never Events**						
Meeting:	**Quality, Safety and Experience Committee**				**Meeting Date:**	**13.04.2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Assistant Director, Patient Safety and Quality** **Patient Safety Facilitators**						

Background and current situation:

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. Learning from what goes wrong in healthcare is crucial to preventing future harm.

The purpose of this paper is to provide an overview of the Never Events reported by Cardiff and Vale UHB to the Quality and Safety Executive Committee. Themes and trends and actions taken to reduce recurrence are discussed.

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

Since 1st April 2015 34 Never Events have been reported by the Health Board. The highest number per year is 7 and the lowest 3. There has not been an increase in the number reported in the last financial year when compared to previous years.

Since 1st April 2018, the most common type of Never Event reported has been wrong site surgery with 8 incidents being reported (this includes wrong site anesthetic blocks and dental extractions). . The second most common is retained object post-surgery with 4 incidents occurring.

Half of the Never Events have occurred in University Hospital of Wales. All of the 8 wrong site surgery Never Events were reported by Surgery Clinical Board and half of them occurred in the Dental Hospital.

A number of themes have been identified and these include staff factors (particularly supervision of trainees), patient factors (clinical condition, anxiety and distress), distractions and non-adherence with established policies and processes.

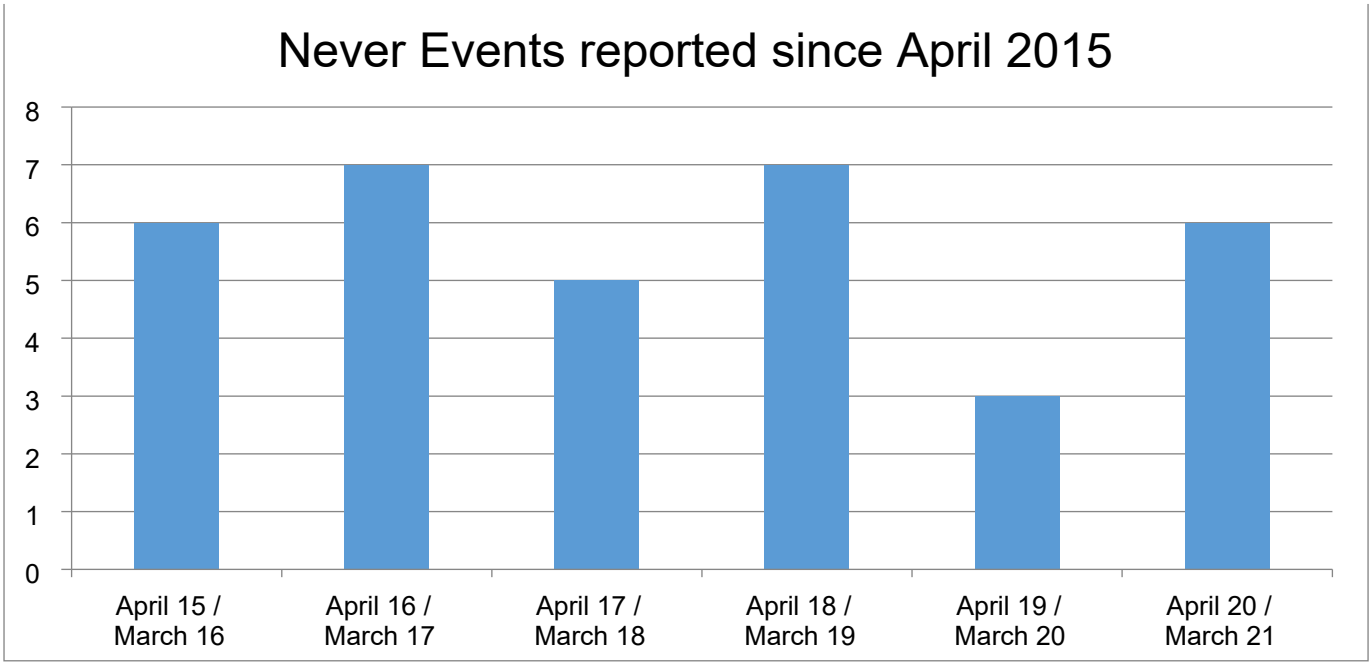
A Medical lead for the UHB NatSSIPs Group has been identified and a number of initiatives to reduce Never Events are being planned for the next 12 months.

The Committee should be advised that wrong site tooth extraction has been removed from NHS England's list of Never Events. Welsh Government has not as yet confirmed it's position in

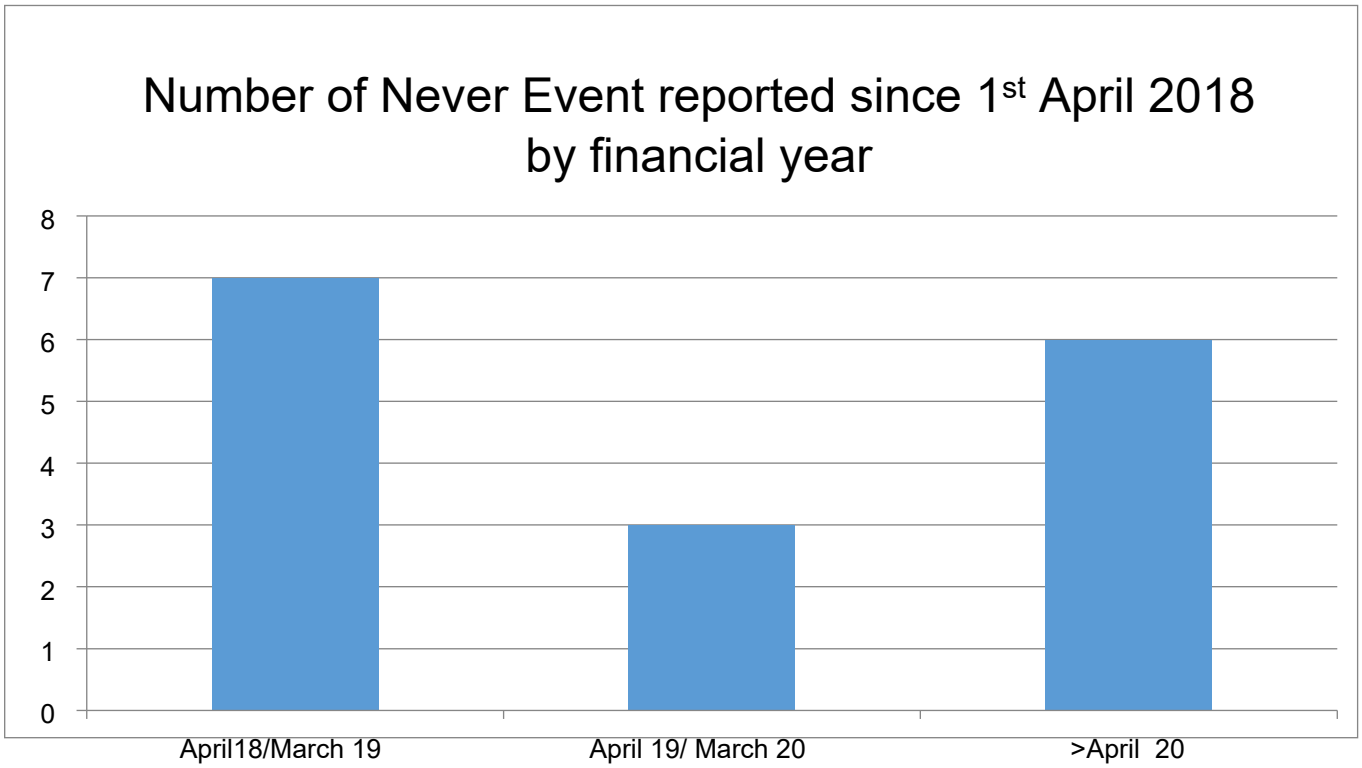
relation to this matter.

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

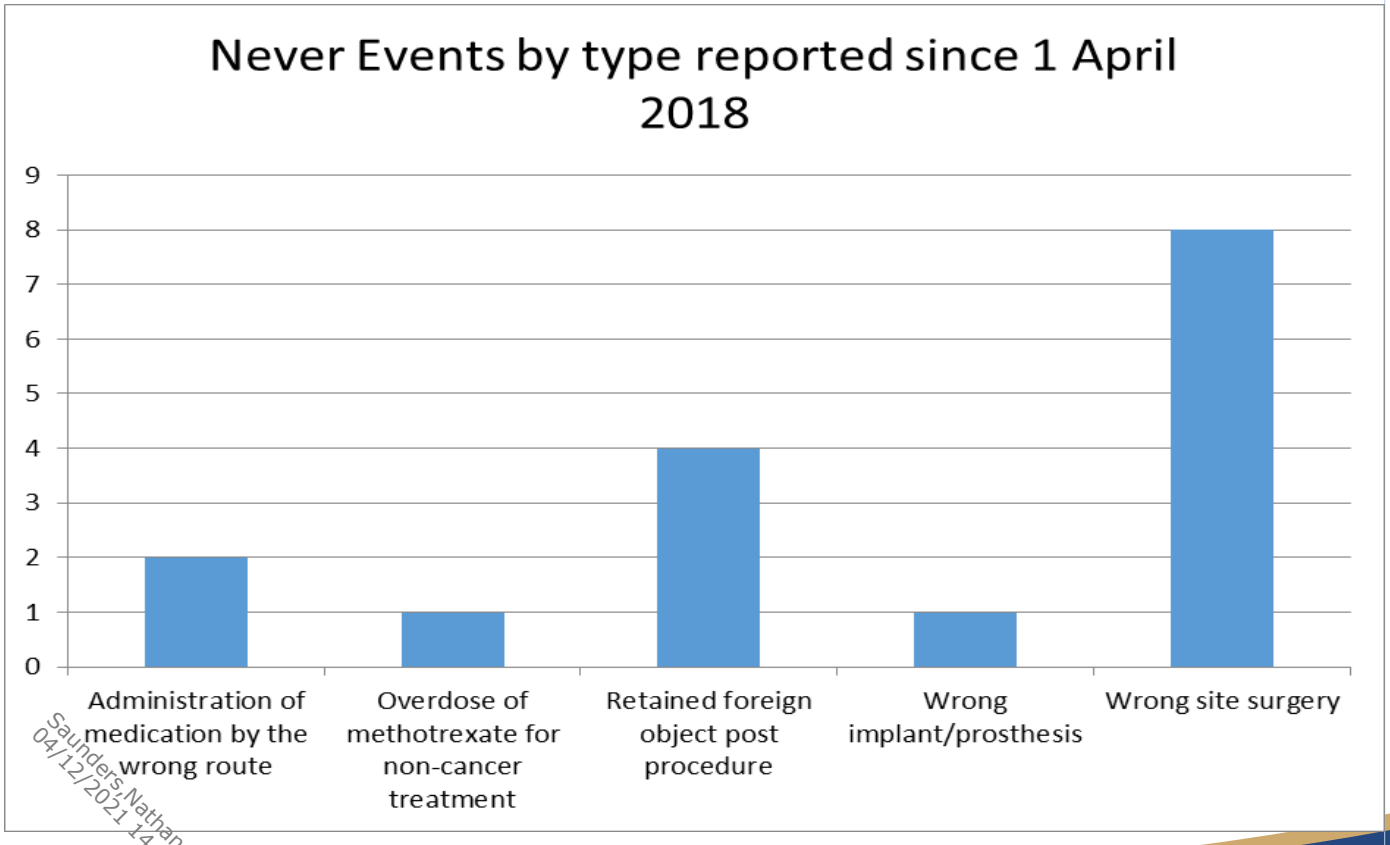
Since 1st April 2015 34 Never Events have been reported by the Health Board. The highest number per year is 7 and the lowest 3. There has not been an increase in the number reported in the last financial year when compared to previous years.



More detailed analysis will be presented of the Never Event data since 1st April 2018. Sixteen Never Events have been reported since 1st April 2018. It should be noted that following initial review of one of the Dental Never Event's (In115743), it was concluded that the correct tooth was in fact extracted. Another incident (In94465) concluded that the surgeon had operated on the correct side (and the patient had consented to this) however, the documentation explaining the rationale for changing the operating side was limited.



Types of Never Events reported since 1st April 2018:



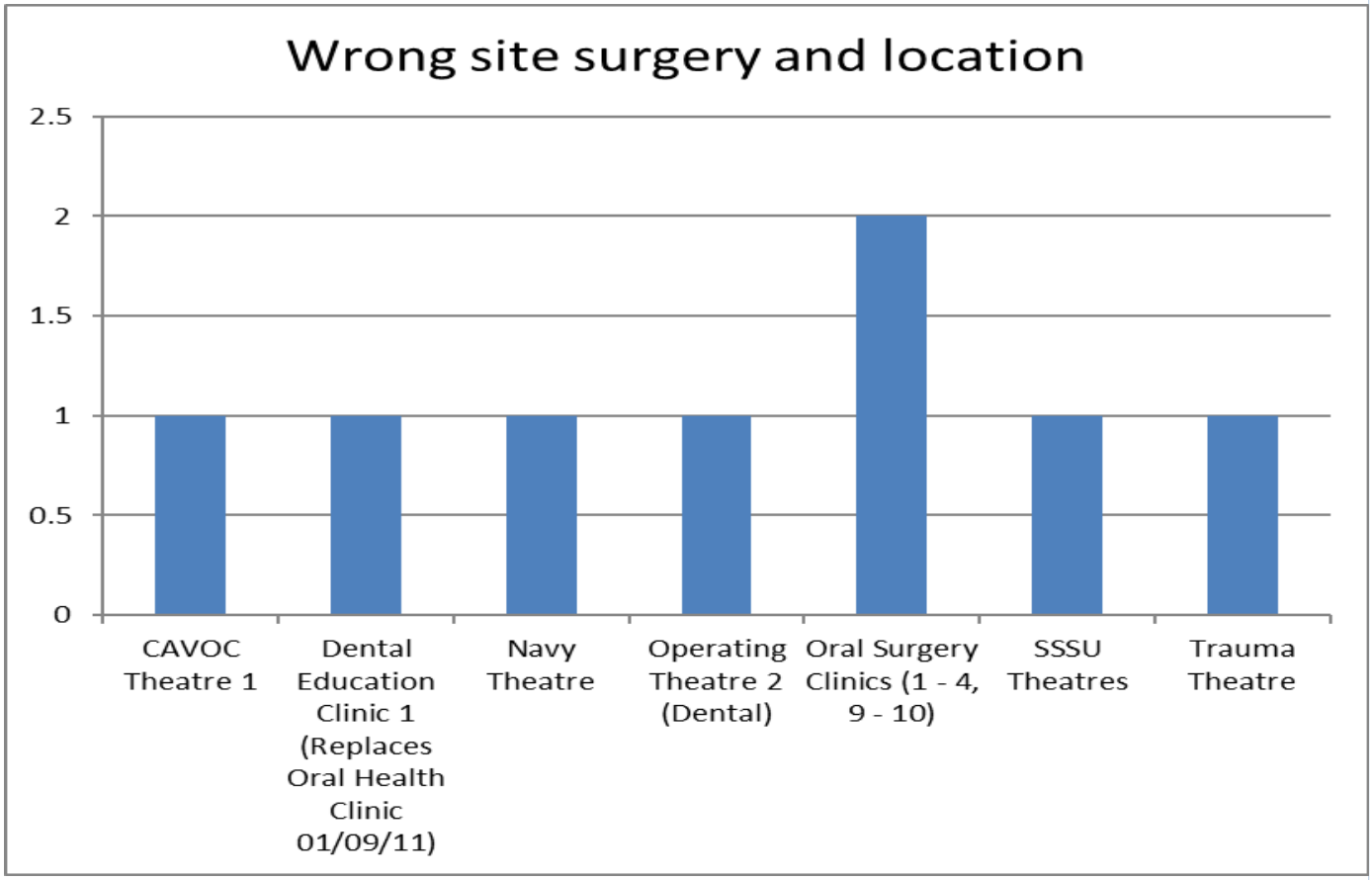
The most common type of Never Event reported is wrong site surgery with 8 incidents being

reported. The second most common is retained object post-surgery with 4 incidents occurring.

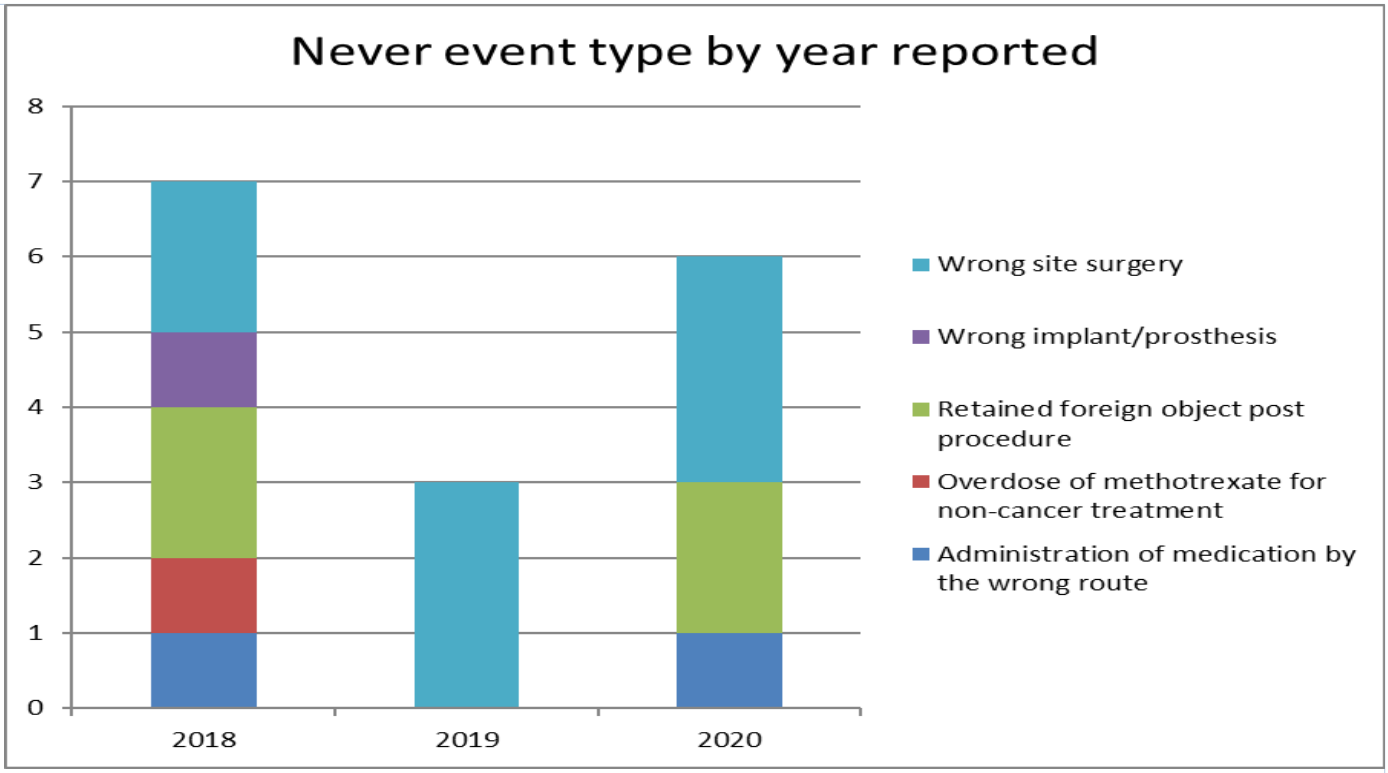
Location of Never Event

	Wrong route medication	Overdose of methotrexate	Retained foreign object	Wrong implant/ prosthesis	Wrong site surgery	Total
Dental Hospital	0	0	0	0	4	4
UHW	0	1	4	1	2	8
UHL	2	0	0	0	2	4
Total	**2**	**1**	**4**	**1**	**8**	**16**

Half of the Never Events have occurred in UHW. All of the 8 wrong site surgery Never Events were reported by Surgery Clinical Board and half of them occurred in the Dental Hospital.



Never Event type and year reported



During 2019 only three wrong site Never Events were reported during 2019/2020. No other types of Never Events were reported during this time frame.

Themes Identified

Staff factors

Five of the incidents involved staff being in training or new in post. In one wrong site surgery Never Event (In128110), a trainee Registrar was undertaking the operation and the Scrub Nurse was new in post and being supervised. The Consultant was supervising and marked the operating site for the trainee. As the Consultant was sitting on the opposite side than he would normally have been sitting he accidentally marked the incorrect site. The incident where a guide wire was retained (In77207), was performed by a junior Clinical Fellow. It was late in the evening and the supervising doctor had to leave causing the junior Clinical Fellow to look up from the procedure and be distracted. Dental Never Events (In66721 and In125764), involved dental students, another (In66169), involved an agency nurse who had not worked on the ward before and another (In110925), the ODP was newly qualified and was working her first weekend shift in Trauma Theatre.

Workload was identified as a contributory factor (In110925, In66169, In125764), with the anaesthetist being extremely busy with a complex caseload. House Officer reporting a very busy shift with competing priorities and staff shortages due to sick leave, maternity leave and annual leave. In another incident (In128573), several theatre staff went for lunch during the procedure and in the same incident no designated circulator was identified. In one of the dental Never Events (In66721), the student felt rushed.

The usual theatre staff were not working together so staff were unfamiliar with each other (In128110), staff not present for start of procedure (In87825, In125764) or team brief

(In110925).

Patient factors

Patients were noted to be nervous (In98676), distressed and restless (In110925, In77340), one patient had learning difficulties (In87825) and another was confused (In66169). In one incident (In125764) the patient was noted to be overweight so arrangements had to be made to treat the patient in the Blue room which is adapted with a special dental chair to accommodate larger patients.

Distractions

In one incident (In87825), the Theatre Assistant had to leave theatre as she wasn't feeling well and the ODP returned to the anaesthetic room to set up for the next case. In another case (In88119), a swab was found on the floor. In128573 several staff went to lunch throughout the procedure. Noise is mentioned as a distraction (In98676). In one incident (In110925), the patient, who was a child, was sent for without the anaesthetist's knowledge, the child was distressed as he had been waiting for a short period of time; this caused the anaesthetist to be distracted with trying to calm the child down.

Policies and Procedures

A common theme was non-adherence to policy. All sections of the WHO safety checklist were not completed and/or a lack of clarity on who was leading on completing the checklist (In128110, In88119, In119212, In128573, In110925 and In125764). In two of the Dental Never Events the SOP for dental extraction and minor oral surgery was not followed. Stop before you Block was not followed in In110925. The Swab, Instruments and Sharps Count Policy was not followed for two cases (In88119, In128573). The Administration of Controlled Drugs Procedure was not adhered to in the Never Event involving the wrong route administration of a medication (In83527).

Clinical findings

A common theme identified was when the clinical picture of the patient caused the surgeon to be distracted. In one case (In87825), where botox was injected into the incorrect leg, both of the patient's legs were spastic and based on examination the left leg felt worse than the right leg and the surgeon administered the injection accordingly (despite the patient being consented for the right leg). In another incident (In88119), the operating surgeon was concerned about the patient so called another surgeon for a second opinion. In one incident where an anaesthetic block was given (In110925), the anaesthetist had recently inserted two right-sided blocks the days prior so possibly his mind was focussed on the right side. In one of the Dental Never Events (In125764), the patient had multiple missing teeth with widespread periodontal disease.

Good practice

It was evident from reviewing the RCA investigations that patients were informed of the error as soon as appropriate and an apology given. The incidents were mostly reported on the electronic incident reporting system (Datix) in a timely manner and escalated to senior staff.

Recommendation:

Actions already taken

A meeting has taken place between the Clinical Lead at the Dental Hospital and Cardiff University to discuss how the supervision of trainee Dentists can be improved.

An external peer review of processes in the Dental Hospital is being planned for Q2 2021, when it is anticipated it will be safe to do so.

Critical Care have developed a LocSSIP invasive procedure safety checklist for the CVC insertion which mandates a two-person checking process and to minimise distractions within the environment.

Throat pack removal has been added to the WHO checklist sign out section.

The Swab and Instrument and Sharps Count policy has been updated and will be presented in the Perioperative Directorate Policy Group on 24th March 2021 and it is anticipated that it will be approved there. It will then go on to Perioperative Directorate Quality and Safety meeting in April 2021 and then to Surgery Clinical Board Quality and Safety meeting. Unfortunately the progress has been delayed due to the pandemic.

An Internal Safety Notice was distributed across the UHB highlighting to Medical and Registered Nursing staff the importance of following the procedures in the Medicines Code for the Safe Administration of Medicines.

Medication Management training has been provided to staff in MHSOP Directorate. At the moment, because of COVID, there will be some gaps in the training cover but this will be rectified as training schedules come back online.

The UHB launched the "Hospital by Day" module on clinical workstation in August 2018 which is used to log all job requests for junior doctors.

A UHB Medical lead (a colo-rectal Surgeon) has been identified to Chair the National Safety Standards for Invasive procedures (NatSSIPS) group. Trends in Never Events were discussed at the March 26th NaTSSIPs meeting – the group is putting in place a number of initiatives (including an awareness campaign, staff survey and observational audits of WHO Checklist compliance) to support staff in reducing the number of never events.

Development of a Human Factors Framework and Training Strategy will be an important element of our revised QSE Framework for the next 5 years. Embedding a Human Factors and Systems based approach to safety will support the reduction of Serious incidents and Never Events.

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.*

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Independent assessment of the Health Foundation funded project: *Harnessing data analysis to maximise NHS learning from patient safety incident reports*

My role

I was not directly involved in the planning and management of the project. I carried out an assessment from a position of relative independence. I brought contextual knowledge from: my NHS experience of managing and evaluating services; major reviews of quality, safety and clinical governance in Queensland, Australia and Northern Ireland; my 12-year period as Chief Medical Officer for England when I initiated the world's first national patient safety programme (set out in my report An Organisation with a Memory); and nearly 15 years as the World Health Organisation's Envoy for Patient Safety.

I interviewed the key staff involved in the project.

Background

Within the NHS, and indeed in health organisations and health systems in other high-income countries, large amounts of data are collected through patient safety incident reporting systems. In England and Wales, around a million such reports are sent each year from hospitals, primary care services and other

facilities to a central reporting centre in NHS England headquarters. This volume of data means that only a small proportion is investigated further or analysed in depth at local or national level. Policy is usually to concentrate on cases of severe harm and death resulting from unsafe care.

The purpose of requiring frontline clinical staff to notify incidents of actual or potential avoidable harm is to identify and mitigate sources of risk and unsafe practices, procedures and care environments. The very limited use of their reports is a highly unsatisfactory situation. Outside the research context, there are few examples of successful learning flowing from the analysis of patient safety incident reporting data. Thus, incidents such as wrong site surgery, medication-related harm, and diagnostic error continue to be reported, sometimes within the same health organisation.

Pre-project

Informal discussions with clinicians (junior doctors, consultants, nurses, and other health professionals) in the Children's Hospital for Wales, prior to the start of the study, emphasised how far detached they were from engaging with patient safety data. They recognised the importance of such data but firmly pointed out that they could not access it and had no expertise in how to analyse it. Thus, a group of highly capable, well-trained clinicians in a tertiary service did not feel confident, or confident enough, to conduct basic analyses of patient safety data. Nor did they feel encouraged to even look at such data in a critical and structured way to identify learning

for improving the care of children. Few staff were familiar with the concept a contributory factor and why that might be important in the causation of avoidable harm. This then impairs the quality of the report and the narrative that clinicians will write when reporting a patient safety incident. In addition, many staff did not believe that there is any point in reporting safety incidents, because they saw little evidence of anything being done with the information.

I have seen these attitudes and perceptions amongst clinical staff widely in the NHS and in other parts of the world. It is difficult to see how patient safety can be improved unless clinicians are actively engaged in accessing data, conducting analyses and further investigating the initial incidents.

Project findings and insights

The project sought to establish how the role of an analyst in a healthcare organisation can be optimised to enable frontline staff, management and their leaders to genuinely engage with routinely collected patient safety data in such a way that it leads to improvement.

The project team made some key initial “diagnoses” of problems in the relationship between clinical staff and patient safety data.

First, many clinicians struggle to get access to data. One member of the project team drew an analogy with an imaginary car driver and their dashboard. It is as if the clinician is driving a car with a dashboard containing no information. He or she has to send an email to a control centre to find out how much petrol is in the fuel tank and wait for a reply. Quite literally prior to the implementation of changes during the project, clinicians were having to make email requests for data. Sometimes they received a quick reply, sometimes not. Many gave up pursuing an avenue of investigation that could have led to benefits for patients and the organisation. It is cumbersome and daunting for busy clinical staff to request and receive patient safety data. This is a serious weakness because it will reduce interest and motivation amongst doctors and nurses to engage directly in the process of understanding the underlying causes of avoidable harm in their area of care and to work to find solutions.

Second, the project strongly confirmed the widespread experience of health organisations, particularly hospitals, that they are drowning in data. They have the capacity to look at a small proportion of all the incident data collected. They may choose to look at severe harm and death reports or use other criteria but, in either case, the majority of data still does not get looked at. Also, data are highly variable in quality. Hence, many opportunities to learn from patient safety incidents are not taken. In the Cardiff and Vale University Health Board, 20,000 patient safety incident reports are made each year and 250 "serious incidents" are investigated in-depth and reported to the Welsh Government.

Third is an overall lack of appreciation by NHS managers and clinical staff that there are different sources of data relevant to patient safety. This is not just patient safety incident reports, nor indeed any single kind of data. It includes other sources of data that contain information on patient safety events or occurrences of avoidable harm (e.g. coroners' reports, national clinical audits, complaints). If accessed, analysed and interpreted properly, they can help to understand the phenomenon of patient safety, much better than with incident data alone. This proved to be a major revelation for the clinical staff. One commented: "Even in my own area of service, I didn't know all this was being collected." Another said: "We are sitting on a goldmine." And further comments emphasised the wasted opportunity: "It goes into a black hole."

Fourth, there was little regular dialogue between the clinical staff and those in the information management and technology team. The latter are technically excellent but had no real understanding of clinical concepts and the kinds of questions that the clinicians might have about the safety or quality of their services.

Fifth, some information governance concerns came to light. Doctors in training were downloading data onto their personal computers and devices to be able to work on it when off-duty. To an extent, this is understandable. They were enthusiastic. Completing and writing up interesting projects was important to their career advancement. They did not have the time whilst at work. However, this practice infringes information

governance rules and standards. Use of data was not being properly regulated and needed to be put right.

Changes brought about by the project

A key aim of the project was to build the capacity and capability of the administrative and informatic teams to enable clinicians and managers in the organisation to generate learning from patient safety event data. The project sought to develop standardised operating procedures for data requests and analyses.

Much of the work of the project team through a standardised approach to enabling access to data and analysis involved automating as much as possible. Up until the start of the project, if a clinician wanted data he or she would have to telephone or email the patient safety team. Some clinical staff would not even have known how to contact them in the first place. The eventual receipt of data might have involved multiple contacts, extended delays, and numerous misunderstandings about what was required.

The project team identified a wide range of data sources that could be used to explore, more extensively, patient safety concerns identified by incident reports or that had arisen in other ways. This was facilitated by the creation of a dashboard. The combined effect of making available a richer set of data to enhance the core patient safety incident reports coupled with ease of access to such data was transformational for clinical staff. Interest in the safety performance of their services and

curiosity about sources of risk and causes of harm were galvanised.

The project team also carried out development work with junior medical staff. There was a willing group of specialist paediatric trainees. As part of the project, they were trained in patient safety concepts and given patient safety incident reports from the child health directorate. For the first time, they were helped to explore those data, identify priorities and then discuss their findings with the patient safety team as well as with people, from across children's services, interested in quality and safety.

They were then given access to all the other data sources that the project team had collated, for example previous specialty audits, national audits, complaints. This showed how readily clinicians understood what the different data sources could and could not tell them; it also confirmed that use of different sorts of data enable a deeper exploration of a patient safety problem. Last came their response and solution: the design of the quality improvement project. They have been supported and facilitated to do this.

There were some immediate gains for the service and the safety of its patients. For example, incident reports were consistently showing a very specific medication error. Acutely ill children admitted to hospital were being given paracetamol at 10 times the dose that they should have received and were at risk of serious harm as a consequence. It was happening every few weeks with no resolution of the problem.

The new relationship between clinicians and data that the project created helped to solve the problem. The teams analysed and discussed the data and found that the key factor that generated the harm was as children were being transferred between different clinical areas. Different documentation was in use. So, children coming into the accident and emergency department, had emergency unit documentation. There is a space on the notes to show where drugs were prescribed, but that is separate to the main drug chart if a child is admitted to a ward. Similarly, if the child goes for surgery, the prescriptions of drugs on the anaesthetic chart were not transcribed back onto the main drug chart. This enabled a rationalisation of charts in a way that was less prone to error.

More generally, the project work served to strengthen the role of patient safety risk managers. They were given greater support in order to regularly learn from patient safety incident reports and other data. From this work, a quality improvement agenda was established with clinical staff and the senior management of the organisation.

A further benefit was the way in which the quality improvement work of the organisation became more focussed on major patient safety priorities. A clear link was forged between patient safety data and analysis and improvement project planning. This is a model that is uncommon within the NHS and hardly features in international discussions on how to make health care safer.

A great deal of attention is given globally to the role of patient and family involvement in patient safety improvement. The project team noted that this had been discussed locally during preparations for World Patient Safety Day in the last couple of years. They saw it as their opportunity to think boldly and creatively about how better to engage with patients and the public. However, there was an acknowledgement that much greater emphasis needed to be given to this aspect of the local patient safety programme. The Welsh government's initiative on the duty of quality opens a door to do just this.

Key generalisable lessons

The experience of conducting this project has highlighted a number of important factors that are likely to enhance the effectiveness of patient safety programmes in any health organisation:

1. **Leadership from the top.** The importance of visible and demonstrable board level commitment to improving the safety of care is vital. This should come mainly from a trinity of chief executive officer, medical director and nurse director. It should be cascaded through other clinical and managerial leadership posts. Without the passion of leaders for patient safety, the risks of care will remain higher than they should.

2. **Coordination of multiple data sources.** Patient safety incident reports are the core information required to assess the risks and potential for harm in particular areas of

service. Many other sources of data can enhance the insights gained from incident reports about the causation of harm and the opportunities to reduce its occurrence. Every effort should be made to map these alternative data sources and make them available for in-depth exploration of patient safety concerns. More data of different kinds increases the power of analysis of "Why?"

3. **Easy access for clinicians to data.** If the scale of avoidable harm in routine health care and the concepts underpinning a patient safety perspective are explained to clinical staff, they will become interested. Converting that interest into a curiosity-driven engagement with local patient safety programmes depends upon them having relevant data at their fingertips. This "clickability" factor is vital. Otherwise frustration sets in and clinicians lose interest and disengage.

4. **Supporting infrastructure is mission critical.** No health organisation can mount an effective programme to keep patients safe without a core patient safety team to lead, facilitate and educate staff. It is also essential to have a dedicated group of analysts to source data and produce analyses on request, for monitoring purposes and to check that agreed improvements are being sustained. The core team and analysts need to be close to service level and cannot be provided from a central information management and technology department. However, close working with those providing business intelligence for the whole organisation is very important.

5. **Formal quality improvements methods are essential.** The project was innovative in harnessing the skills and methods of quality improvement to design and implement patient safety solutions. Whilst most of this work was undertaken with paediatric trainee doctors, it is clearly something that could be used more widely with senior doctors, nurses and other health professionals. The methods are particularly suited to safety improvement work within multi-professional service teams.

6. **Much greater engagement and involvement of patients and families is needed.** In the strongest patient safety programmes around the world, the experience of patients and families is a core component of their work. In fact, there is often direct participation of victims of harm through discussions on the redesign of services and in telling their stories at clinical meetings and in health professional education and training programmes. This would be an excellent area to develop further in the next phase of this project. An immediate initiative to establish and encourage incident reporting by patients and family members would be ground breaking and add a rich new dimension to the available data.

Project continuity

The Cardiff and Vale University Health Board has committed to continue funding the Patient Safety Manager two days a week for the next two years with a view of sustaining this work,

converted from a project to a programme, in the Children and Women Clinical Health Board. It will also be scaled-up to two additional areas in the next two years: the Mental Health Clinical Board and the Directorate of Clinical Gerontology (within the Medicine Clinical Board).

Sir Liam Donaldson 25th February 2021

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Honorary Distinguished Professor
Cardiff University

Report Title:	**Board Assurance Framework – Patient Safety**							
Meeting:	Quality, Safety & Experience Committee					**Meeting Date:**	13th April2021	
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 March 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. It has remained at 20 since.

There are also a number of risks on the Corporate Risk Register 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 March 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:

- 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 further COVID surge Or because the demand on elective services as the Health Board moves to a recovery position after cessation of planned care for the second time 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 and deployed to optimise internal acute and critical care capacity with external options having been utilised and the building of the lakeside wing. • Internal estates and facilities team deployed to provide infrastructure enhancements to enable internal capacity plan • surge capacity available in Lakeside facility • 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 January 21**
1. Reconfiguration of COVID/Non-COVID capacity– ongoing process.		Steve Curry	31.03.21	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 continue and staff mix being reviewed in line with action 1 above.
3. 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– complete and ongoing
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

Report Title:	**Approval of 'Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients'**						
Meeting:	QSE Committee				**Meeting Date:**	13th April 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
Lead Executive:	Stuart Walker						
Report Author (Title):	**Marilyn Rees Lead VTE and Thromboprophylaxis CNS**						

Background

An estimated 25,000 people in the UK die from preventable hospital acquired VTE every year. There is a considerable cost to the Health Service associated with treatment of non-fatal symptomatic VTE and related long term morbidities

Virtually all patients admitted to hospital have one or more risk factors for VTE with around 40% having three or more risk factors. These include but are not limited to:

- Age over 60 years
- Obesity (BMI greater than 30kg/m²)
- Acute medical/Critical care admission
- Dehydration
- Pregnancy or < 12 weeks post-partum
- Varicose veins or active phlebitis
- Active cancer or cancer treatment
- Use of oestrogen containing contraceptive therapy
- Personal or first degree relative with history of VTE
- Known thrombophilia

Without VTE prophylaxis the incidence of hospital associated DVT has been calculated to fall between 70 and 80% in medical patients and about a third of those patients undergoing general surgery were found to have developed a DVT. Approximately 50% of patients undergoing major orthopaedic surgery developed a DVT with the majority being asymptomatic. A third of these patients will develop symptomatic proximal vein thrombosis that are likely to result in a PE.

Up to 10% of deaths in hospital are linked to PE with PE being the second most common cause of maternal (pregnancy associated) death in the UK (House of Commons Health Committee, 2005).

There is significant cost to hospitals associated with diagnosing and treating VTE as well as possibly prolonging the patient's length of stay. There is the introduction of unnecessary risk to patients having to take anticoagulant therapy as well as the risk of recurrence of VTE and the longer term debilitating conditions of chronic post thrombotic syndrome and pulmonary hypertension.

VTE prophylaxis is cost-effective in preventing symptomatic VTE and fatal PE. Methods include pharmacological treatments (such as heparin and other anticoagulant drugs) with little to no increased risk if clinically relevant bleeding and where appropriate mechanical methods (AES & IPC).

Current Situation

The current thromboprophylaxis policy requires updating to ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The updated policy must reflect the guidance as set out in the NICE NG89 and those measures required by the Welsh Assembly Government (WAG):

- All adult and teenage patients admitted to hospital are assessed, using an appropriate UHB Risk Assessment tool within 14 hours of admission, and appropriate preventative measures are instituted as a result.
- All episodes of hospital associated VTE will be reviewed to establish if potentially preventable
- RCA of potentially preventable cases will be undertaken by each clinical board and actions and learning outcomes reported to WAG on a quarterly basis

Scope

This document sets out the processes to follow for assessing the risk of VTE in patients who require hospital admission or attending the hospital for a day case surgical procedure and the prescribing of standard thromboprophylaxis measures.

This document does not include guidelines for bridging between pharmacological thromboprophylaxis agents or treatment guidelines for VTE. The advice in this guideline covers the care and treatment that should be offered to all patients. This includes those admitted to a hospital bed for day-case medical or surgical procedures.

Each clinical board are responsible for ensuring a thromboprophylaxis risk assessment is undertaken for patients admitted under their care using a specialty specific tool to support their decision process. The VTE prophylaxis section in the All Wales In-Patient Medication Administration Chart must be completed for each patient within 14hrs of decision to admit. Regular re-assessment should be performed as clinical picture changes. Clinical Board nominated individuals are responsible for auditing practice to ensure appropriate risk assessment is performed.

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

- Individual Clinical Boards are responsible for ensuring thromboprophylaxis risk assessment is embedded into each patients care from point of admission to discharge and where appropriate for up to an extended 6 weeks
- Regular audit of risk assessment and prescribing practices are key
- Review of recurring themes highlighted in RCAs of HAT cases to improve practice and reduce harm.

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

Consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholders and the UHB. The consultation undertaken specific to this document was as follows:

- The document was added to the Policy Consultation pages on the intranet between February 16th 2021 and March 16th 2021;
- The document was shared with the Surgical Thrombosis and anticoagulation group (Taag) and Clinical Board Leads for Thromboprophylaxis
- Comments were invited via individual e-mails from the named individuals of the above group and named leads for the UHB.

Where appropriate comments were taken on board and incorporated within the draft document

The document will require monitoring as NICE guidance and international guidelines are updated and every 3 years

Compliance to be monitored by Surgical Taag (for Surgical Clinical Board) and Individual Thromboprophylaxis Leads for each remaining clinical board.

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

Recommendation:

The Board (or name of Committee) is asked to:

- **APPROVE** the Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients **and**
- **APPROVE** the full publication of the venous thromboembolism (VTE) in adult and teenage inpatients in accordance with the UHB Publication Scheme.

Shaping our Future Wellbeing Strategic Objectives

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

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time						10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives			
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	✓	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Yes *If "yes" please provide copy of the assessment. This will be linked to the report when published.* *Please note that an EHIA will have been completed for the policy (and where appropriate procedure) so the answer will nearly always be "Yes" and the completed EHIA will form part of the document to be approved.*								

Reference Number: UHB 106 **Version Number:** 3	**Date of Next Review:** To be included when document approved **Previous Trust/LHB Reference Number:** UHB 362

Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it is the policy of Cardiff and Vale University Health Board (UHB) to follow the guidance as set out in the NICE NG89 and those measures required by the Welsh Assembly Government (WAG):

- All adult and teenage patients admitted to hospital are assessed, using an appropriate UHB Risk Assessment tool within 14 hours of admission, and appropriate preventative measures are instituted as a result.
- All episodes of hospital associated VTE will be reviewed to establish if potentially preventable
- RCA of potentially preventable cases will be undertaken by each clinical board and actions and learning outcomes reported to WAG on a quarterly basis
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Policy Commitment

- To maintain adequate processes in all clinical boards for the assessment of the VTE risk for adults and teenage children during an admission to hospital;
- To ensure that all staff and patients receive adequate information and education regarding the development of VTE whilst in hospital and the processes required to reduce its risk, and:
- To ensure that each Clinical Board has a designated medical and nursing lead for thrombosis and anticoagulation that develop and review processes within that board for minimising the risk of VTE whilst in hospital

Supporting Procedures and Written Control Documents

This Policy is to be used in conjunction with the supporting documents listed below:
Patient Identification Policy
Anticoagulation Policy
Medicines Management Policy
Making Decisions on Individual Requests for Treatment Policy
Patient Handover Policy
Single Nurse Administration of Drugs in Hospital Policy
Writing Prescriptions Policy

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact.
Health Impact Assessment	A Health Impact Assessment is not required for this policy.
Policy Approved by	Quality, Safety and Environment Committee
Group with authority to approve procedures written to explain how this policy will be implemented	C & V UHB Clinical Medical and Nursing Lead for Thromboprophylaxis, Clinical Board Quality, Safety and Environment sub-Committees.
Accountable Executive or Clinical Board Director	Executive Medical Director

Disclaimer

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

Coronavirus Disease 2019 (COVID-19) Statement

Any patient admitted with confirmed or suspected infection with SARS-CoV-2 should receive pharmacological thromboprophylaxis if there is no contraindication. These patients are at high risk of developing hospital acquired thrombosis, particularly if immobilised and admitted to critical care. Please follow the CAV UHB COVID 19 Thromboprophylaxis pathway 'Reducing the Risk of Venous Thromboembolism in Patients Admitted with Suspected or Confirmed COVID-19'

Thromboprophylaxis should be reviewed regularly and adjusted according to the clinical situation, risk of bleeding vs risk of thrombosis.

Scope

1.1 Groups that will be covered:

a) Adults (16 years and older) who are admitted to hospital for 24 hours or more (including through surgical day units).

b) Pregnant women admitted to hospital - they have been identified as a group requiring special consideration.

c) Children aged 13 or over or who are post-pubertal, who require an inpatient admission for a surgical procedure

d) Any additional groups identified who are at risk of thrombosis due to their personal or family history, or the indication for attending hospital e.g. adult patients requiring immobilisation in a lower limb cast.

1.2 Groups that will not be covered:

a) People younger than 16 (except as 1.1 c)

b) Elderly or immobile people cared for at home, or in external residential accommodation, unless admitted to hospital

c) Patients admitted to hospital with a diagnosis of, or suspected diagnosis of, deep vein thrombosis or pulmonary embolus that will require specific assessment and treatment.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	21 February 2012	19 March 2012	Policy supersedes policy of former Trust. • Updated Risk Assessment tools under Clinical Policies and Procedures. • Update to Audit Proforma • Update since NICE initial publication
2	23 February 2016	26 Apr 2016	• Update on current Welsh Government stance on thromboprophylaxis • Updated risk assessment tools • Use of direct oral anti-coagulants (DOACS)
3	20 October 2020		• Update on NICE NG89 • Updated risk assessment tools

1. INTRODUCTION AND BACKGROUND:

Venous thromboembolism (VTE) accounts for approximately 10% of all hospital deaths. Approximately one third of episodes of VTE occur in association with a hospital admission and thus hospital acquired thrombosis contributes significantly to the total cost of managing VTE in the UK, which is estimated to be around £640 million per year. Around 10% of patients treated for deep vein thrombosis (DVT) subsequently develop debilitating venous leg ulceration, treatment of which is estimated to cost £400 million in the UK.

The aetiology of VTE is multifactorial and risk factors associated with its development are clearly identified. Hospitalised patients with stroke, myocardial infarction, severe heart failure, chronic respiratory disease, active cancer or those receiving cancer therapy are at greater risk of developing VTE which, for example; may occur in up to 50% of patients with stroke/MI. Patients with a personal or family history of venous thrombosis are also at risk of developing VTE whilst in hospital.

The risk of VTE increases with age, particularly in patients over 50 years. Other ''acquired'' risk factors include:

- Surgery, especially orthopaedic, neurosurgery or pelvic surgery for cancer
- Pregnancy
- Obesity, BMI >30kg /m^2
- Oestrogen-containing drugs, such as the combined oral contraceptive pill and hormone replacement therapy
- Kidney disease, such as nephrotic syndrome and myeloproliferative disorders.

The most serious complication of VTE is pulmonary embolism (PE) which, untreated has a mortality rate of 30%. However, with appropriate treatment this figure is reduced to 2% (House of Commons Committee, 2005). Unfortunately, the diagnosis of VTE is often delayed until the development of a sometimes fatal PE.

Without prophylaxis, 45-51% of orthopaedic patients develop DVT (of which 50% may be symptomatic) and it is estimated that in Europe around 5,000 patients are likely to die per year of VTE following hip or knee replacement when prophylactic treatments are not prescribed.

About a third of all surgical patients developed VTE (diagnosed venographically) before the introduction of prophylactic treatments. The routine implementation of venous thromboprophylaxis guidelines (issued by the Royal College of Obstetricians and Gynaecologists) for women undergoing caesarean section has seen a substantial fall in morbidly and mortality from VTE (House of Commons Health Committee, 2005). However, VTE is still a leading cause of maternal morbidity and mortality and ongoing assessment of a woman's risk of VTE throughout pregnancy remains essential.

It is clearly established that hospitalisation is associated with an increased risk of VTE, with an incidence 135 times greater in hospitalised patients than in the community. It is estimated that 70-80% of hospital-acquired VTEs occur in 'medical' patients (House of Commons Health Committee, 2005).

National Clinical Guidance

Clinical guidelines for thromboprophylaxis have been published by some specialties in the UK and also in other countries. These include the guidelines published by the Royal College of Obstetricians and Gynaecology 2015 (CG37a), the 9th American College of Chest Physicians (ACCP) and the Scottish Intercollegiate Network (SIGN) as well as NICE Guidelines CG92. NICE Guideline (NG) 89 replaced NICE Clinical Guideline 92 in August 2019.
This guideline mandates that ALL patients admitted into hospital must be fully assessed for their risk of venous thromboembolism within 14 hours of admission. The guidance also recommends that patients are re-assessed for their risk of VTE at the point of consultant review and if their clinical condition changes.

Welsh Government Stance

In Wales in May 2012, the Welsh Assembly Government Health and Social Care committee held a one-day enquiry into in to Venous Thrombo-embolism Prevention in Welsh hospitals. The All Wales Thrombosis Group manages the implementation of the NICE NG89 clinical guidance, the Welsh Assembly Government (WAG) recommendations and audit of Hospital Acquired Thrombosis (HAT) through a means of continuous Root Cause Analysis (RCA). The group reports directly to WAG.
Five recommendations were made following the one-day enquiry in May 2012:

Recommendation 1: Compliance with relevant NICE guidance.

Recommendation 2: Clinicians are mandated to carry out VTE risk assessment for all hospitalised patients and prescribe thromboprophylaxis as appropriate.

Recommendation 3: Health boards will develop a standardised method of demonstrating their HAT rate.

Recommendation 4: An RCA will be undertaken for all patients who develop a VTE during their hospital stay or within 90 days following discharge to establish if the event is hospital acquired.

Recommendation 5: Welsh Government and health boards work together to raise awareness amongst patients and clinicians of the risks of developing HAT.

Cardiff and Vale University Health Board is committed to thrombosis prevention and has promoted the use of specialty-specific risk assessment, so that clinicians are best able to balance the risks and benefits of thromboprophylaxis. Both clinicians and the general public require ongoing education to increase awareness of the problem and each Clinical Board has nominated thrombosis and anticoagulation leads to review the safety and compliance with relevant protocols. They are supported in these roles by the Lead Clinical Medical and Nursing Lead for Thromboprophylaxis.

2. CLINICAL PROCEDURES AND METHODS OF PROPHYLAXIS AGAINST VENOUS THROMBOEMBOLISM

Each patient admitted to the hospital should have a risk assessment completed and appropriate measures prescribed and documented in their notes.
(Some specialities utilise a risk assessment tool adopted for their area – please review with individual clinical board).

Low Molecular Weight Heparins (LMWH) has been shown to be effective in many clinical settings e.g. general surgery, obstetrics, orthopaedic surgery and general medicine in reducing the incidence of VTE. For example, the use of thromboprophylaxis in hip replacement surgery can reduce venographically confirmed DVT from approximately 50% to 10-15% (House of Commons Health Committee, 2005).
The introduction of direct oral anti-coagulant (DOACs) has also been found to reduce the risk of VTE in Hip/Knee replacement surgery (NICE TA 245).These are examples of preferred interventions at Cardiff and Vale University Health Board

2.1 PHARMACOLOGICAL PROPHYLAXIS

a. Heparins

Lower Molecular Weight Heparin: Enoxaparin: is the preferred low molecular weight heparin (LMWH) for indications for which it is licensed.

Contradictions for use of prophylactic heparins
Active bleeding, hypersensitivity to heparin, coagulopathy, acute renal failure, chronic renal disease (eGFR <30ml/min), endocarditis, history of heparin induced thrombocytopenia (HIT), lumbar puncture or neuroaxial anaesthesia within 12hrs, recent intraocular or intracranial surgery. Use with caution in uncontrolled hypertension.
The use of LMWH should be re-assessed where there is chronic renal disease (eGfr <30ml/min) or evidence of acute renal failure. In these circumstances consider the use of subcutaneous unfractionated heparin 5000u bd.
This list is not exhaustive and a speciality specific risk assessment should take place for **each** patient.

b. DOACs (Direct Oral Anti-Coagulants)

Apixaban is a recommended option for the prevention of VTE in adults after elective hip or knee replacement surgery (NICE TA 245)

- The recommended dosage of apixaban is 2.5mg orally twice daily.

The initial dose should be taken 12-24 hrs after surgery. The duration of treatment depends on the individual risk of the patient for VTE which is determined by the type of orthopaedic surgery.

- Recommended treatment durations are 32–38 days for patients having hip replacement surgery and 10–14 days for patient having knee replacement surgery

Rivaroxaban is also recommended as an option for the prevention of VTE in adults after elective hip or knee replacement surgery (NICE TA 170) as is **Dabigatran (**NICE TA 157**)**

(N.B – Apixaban is the current DOAC of choice used within the Orthopaedic Directorate at Cardiff and Vale UHB)

Aspirin is NICE NG89 approved for use as thromboprophylaxis in patients who have had a total hip replacement or total knee replacement. However it does not have a UK marketing authorisation for use as thromboprophylaxis medication and is not currently ratified for use in Cardiff & Vale UHB

2.2. MECHANICAL METHODS OF PROPHYLAXIS

These are examples of preferred interventions within the UHB.

2.2.1 Anti-embolism Stockings (AES)

Anti-Embolism Stockings (AES) are an adjunct or alternative to pharmacological prophylaxis where there is an increased risk from heparin use due to patient or procedure related factors. AES's may be used with pharmacological prophylaxis when risk of VTE is high. There is an All-Wales guideline and local UHB guidance for the use of AES's.

N.B.

- **Unless contra-indicated surgical patients should receive pharmacological *and* mechanical thromboprophylaxis**
- **In medical patients mechanical methods should *only be considered* if pharmacological thromboprophylaxis is contraindicated.**
- **Cautions as described below should be considered with *all* patients before prescribing AES.**

Cautions for use of AES

Peripheral vascular disease, longstanding diabetes, ulcers, trauma, infection, recent skin grafts, massive oedema, pulmonary oedema, present or previous pressure damage to heels, severe leg deformities. Pulse palpation and arterial Doppler assessment are not reliable assessments of skin perfusion and regular inspection if there is suspicion or risk of vascular compromise.

1. **Nurses** need to be aware that in patients with skin, neurological or peripheral vascular diseases, AES may be contraindicated and that the incorrect fitting of AES can be detrimental to the patient. Therefore observation and continual re-assessment are required.
2. It is crucial that the prescriber and practitioner responsible for measuring and applying stockings are sure that the arterial, skin and neurological status of the patient is sufficient to allow safe compression.
3. **Nurses** should complete the AES sheet on all patients prescribed AES, (see appendix for example of sheet)

2. 2. 2 Other mechanical devices

Intermittent Pneumatic Compression (IPC) Devices/ Mechanical Foot Pumps
These are suitable alternatives to AES. **However,** they are not widely available in the UHB and should be used as part of a local specialty specific thromboprophylaxis protocol and ratified at the speciality Q & S Committee. The contraindications to their use are as for AES.
When prescribing mechanical thromboprophylaxis only one device is to be prescribed and fitted at a time- there is no evidence to support the use of more than one mechanical at the same time

3. PATIENT EDUCATION

Patients should be made aware of the increased risk of VTE associated with hospital admission. In specialties where extended thromboprophylaxis is required, involving the administration of subcutaneous low molecular weight heparin, the patient should be advised, in advance of the procedure that they will be trained to self-administer the medication at home.
The UHB has designed "in-house" patient information leaflets. These should be given to patients in the pre-operative assessment area and on admission to all adult wards. (See appendix for copy of Reducing the Risk Patient Leaflet) Plasma screens are used to increase patient awareness; thrombosis prevention campaign material is regularly updated and displayed.

4. PROCESS

a. On admission **all** adults over 16yrs and children >13yrs old /post puberty who are admitted to hospital will be assessed for their risk of VTE. The outcome of this assessment should be documented as appropriate for the particular clinical board.

b. Completion of the Venous Thromboembolism Risk Assessment Section on page 5 of the All Wales In-patient Medication Administration Chart is advised as a minimum standard. Each speciality will incorporate a risk assessment tool as appropriate to that area.

Risk Assessment Tools for the clinical boards are included in the appendices. Any modification by individual directorates should be approved at Clinical Board Level, with oversight by the Leads for Thromboprophylaxis and ratified by the Clinical Board Quality and Safety Committee

5. ROLES AND RESPONSIBILITIES

5.1 Executive …….. …

It is the responsibility of the Executive ……to guide the UHB on the content of this Policy and monitor compliance. It will receive reports regarding the development of hospital acquired thrombosis from all the clinical board leads to establish any UHB-wide trends that need addressing.

5.2 Clinical Board Directors

It is the responsibility of the Clinical Board Directors (or their equivalent) to ensure, where appropriate, that the Policy is implemented within clinical areas for which they hold responsibility.

5.3 Medical Staff

Ensuring quality and safety standards which are defined by the UHB are the responsibility of all medical staff. It is their responsibility to ensure that they are conversant with this policy and their role in minimising the risk of HAT.

5.4 Admitting Clinician

It is the responsibility of the admitting clinician to assess each patient using the risk assessment appropriate to the speciality and to document the outcome of that assessment in the medical notes. Adherence to the speciality-specific guidelines will enable the clinician to prescribe the correct thromboprophylaxis.

An explanation for any deviation from the recommendations should be documented in the notes.

5.5 Registered Nurses and Midwives

Registered nurses and midwives should ensure that patients in their care have been assessed for their risk of thrombosis within 24 hours of admission. Where thromboprophylaxis is prescribed (in the form of AES or LMWH) then, prior to administration, the nurse or midwife should check whether a risk assessment has been documented, and if not, bring this to the attention of a member of the medical team.

The prescriber and the registered nurse or midwife are responsible for the accurate administration of prescribed thromboprophylaxis

5.6 Pharmacists

Pharmacists for each speciality have a responsibility for ensuring that prescribing of pharmacological thromboprophylaxis is appropriate. Pharmacists are responsible for monitoring the documentation of administration of the prescribed thromboprophylaxis and should highlight the need for review / reassessment as the patient's clinical condition alters.

The pharmacist is responsible for liaising with the medical and nursing team to ensure appropriate, accurate and timely thromboprophylaxis is prescribed.

6. RESOURCES AND TRAINING

6.1 Printed risk assessment tools and patient information leaflets are available for each specialty. The cost for printing will be carried by individual Clinical Board.

6.2. Ongoing training of all Doctors and Nursing staff is essential to ensure success and to ensure evidence based practice. This incorporated into the Clinical Board Quality, Safety and Experience Meetings, Grand Rounds and Registered Nurses Educational Programmes and Induction Programmes.

6.3 This policy will be published on the Intranet, Clinical Portal and Internet

6.4 It is the responsibility of the Clinical Board Directors to ensure that members of the Clinical Boards and Directorates are conversant with the policy and implement the relevant risk assessments.

7. HOSPITAL ACQUIRED THROMBOSIS (HAT) REVIEW PROCESSES

The clinical notes of all patients who develop a VTE during their current inpatient admission (length of stay to be greater than 24 hours of being admitted) or having had a hospital inpatient admission (length of stay to be greater than 24 hours) in the health board within the previous 90 days following discharge will be reviewed to establish whether:

- A thromboprophylaxis risk assessment has been completed on admission as per health board policy
- Appropriate treatment has been offered.

Where the answer to either of these questions is 'No' a RCA will be undertaken to establish if the HAT was potentially preventable. The result of the RCA will be discussed at the clinical board Q & S meeting to improve processes and ensure learning from adverse events takes place.
The number of suspected HAT cases related to a hospital stay are collated by the Health Board monthly and RCA's and associated actions are reported to WAG on a quarterly basis

8. FURTHER INFORMATION AND REFERENCES

Dentali F, Douketis J D, Gianni M et al *Meta-analysis: anticoagulant prophylaxis to prevent symptomatic venous thromboembolism in hospitalised medical patients.* Ann Intern Med 2007; 146:278-288

Department of Health (2007). *Report of the Independent Expert Working Group on the Prevention of Venous Thromboembolism in Hospitalised Patients.* HMSO.London

Geerts, W.H. Bergqvist D, Pineo, G.F, J.A, et al *Prevention of venous thromboembolism: the Eighth ACCP Conference on Antithrombotic and Thrombolytic Therapy,* Chest 2008; 133:381S-453S

House of Commons Health Committee 2nd report of session 2004-2005 (2005) *The Prevention of venous thromboembolism in hospitalised patients.* London: HMSO

National Institute for Health and Clinical Excellence (NICE) (2007). *Venous Thromboembolism – Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients undergoing surgery,* April 2007

National Institute for Health and Clinical Excellence (NICE) (2010) *Venous thromboembolism: reducing the risk. Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital. NICE clinical guideline 92*
http://www.nice.org.uk/nicemedia/live/12695/47195/47195.pdf

National Institute for Health and Clinical Excellence (NICE) (2018) *Venous thromboembolism in over 16s: Reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism. NICE national guideline 89*
http://www.nice.org.uk/guidance/ng89/full-guideline-volume-1-pdf-4787002769

Royal College of Obstetricians and Gynaecologists (2015) *Thrombosis and Embolism during Pregnancy and the Puerperium, Reducing the Risk (Green-topGuidelineNo37a)*
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-37a.pdf

Scottish Intercollegiate Guidelines Network (2010) SIGN Publication No122:*Prevention and management of Venous Thromboembolism http://www.sign.ac.uk/pdf/sign122.pdf*

Speciality Specific Guidelines

Acute spinal injury (T&O): Patients should receive mechanical prophylaxis in the form of AES. Please discuss with the consultant spinal surgeon if enoxaparin should be prescribed as they may require surgical intervention.

Elective spinal surgery (T&O): Prescribe foot impulse device to be applied in theatre. Do not prescribe LMWH (enoxaparin) or AES pre-operatively. Discuss with consultant spinal surgeon before starting enoxaparin post-operatively. Patients with ruptured cranial/spinal vascular malformations or acute traumatic/non traumatic haemorrhage must not be offered enoxaparin prophylaxis until the lesion is secured or the patient's condition stabilised.

Trauma: There is an increased **initial** risk of haemorrhage in patients following poly- trauma, multi part or unstable pelvic fractures and potentially unstable spinal pathology pending MRI scan. Discuss with consultant

Suspected fracture of hip/femur:
All admissions with hip or femoral fracture should receive enoxaparin – unless specifically contraindicated
Mechanical thromboprophylaxis need only be considered in the rare cases where it is not possible to use any form of anticoagulant

Cardiac surgery: 'Patients should be prescribed enoxaparin pre-operatively *unless contraindicated*, but enoxaparin should be omitted for at least 24 hours prior to surgery. Patients should be prescribed mechanical prophylaxis. Prescribe prophylactic enoxaparin post-operatively until discharge, unless patient is receiving therapeutic anticoagulation (either IV heparin or therapeutic enoxaparin) or acquires a contraindication.

Head and Neck surgery: Thromboprophylaxis is determined according to patient risk and surgery planned – please see local directorate guidance

Haematology: For patients with significant thrombocytopenia or bleeding disorders, discuss with Haematology

Ophthalmology: Day case / SSSU patients do not require VTE prophylaxis if (1) LA (2) GA less than 90mins. Patients with GA > 90mins should receive AES prophylaxis. This does not apply to paediatric cases.

Nephrology and transplant: For this patient group refer to **appropriate** risk assessment form

Urology specific guidelines:

Ambulatory care surgery (e.g circumcision, hydrocoelectomy, vasectomy):
No pharmacological or mechanical prophylaxis necessary.

Inpatient urological procedures including Robotic procedures (whether day case or inpatient):
Pharmacological prophylaxis with Enoxaparin 40 mg od (40 mg bd for patients >100Kg and 20 mg od for patients <50kg)

Mechanical prophylaxis with AES alone.

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

Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it is the policy of Cardiff and Vale University Health Board (UHB) to follow the guidance as set out in the NICE NG89 and those measures required by the Welsh Assembly Government (WAG):

- All adult and teenage patients admitted to hospital are assessed, using an appropriate UHB Risk Assessment tool within 14 hours of admission, and appropriate preventative measures are instituted as a result.
- All episodes of hospital associated VTE will be reviewed to establish if potentially preventable
- RCA of potentially preventable cases will be undertaken by each clinical board and actions and learning outcomes reported to WAG on a quarterly basis

Policy Commitment

- To maintain adequate processes in all clinical boards for the assessment of the VTE risk for adults and teenage children during an admission to hospital;
- To ensure that all staff and patients receive adequate information and education regarding the development of VTE whilst in hospital and the processes required to reduce its risk, and:
- To ensure that each Clinical Board has a designated medical and nursing lead for thrombosis and anticoagulation that develop and review processes within that board for minimising the risk of VTE whilst in hospital

Supporting Procedures and Written Control Documents

This Policy is to be used in conjunction with the supporting documents listed below:
Patient Identification Policy
Anticoagulation Policy
Medicines Management Policy
Making Decisions on Individual Requests for Treatment Policy
Patient Handover Policy
Single Nurse Administration of Drugs in Hospital Policy
Writing Prescriptions Policy

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact Key actions have been identified and these can be found incorporated within this policy/supporting procedure. ***Note: Policies will not be considered for approval without an EHIA***

Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	……. Director [insert title of post holder]

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	21 Feb 2012	19 March 2012	Policy supersedes policy of former Trust. • Updated Risk Assessment tools under Clinical Policies and Procedures. • Update to Audit Proforma Update since NICE initial publication
2	23 February 2016	26 Apr 2016	• Update on current Welsh Government stance on thromboprophylaxis • Updated risk assessment tools Use of direct oral anti-coagulants (DOACS)
3	20 October 2020		• Update on NICE NG89 Updated risk assessment tools

Equality & Health Impact Assessment for

Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients
Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

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

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients Reference Number – UHB 106 Version 3 (previous reference number 362)
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Haematology Directorate/Specialist Services Marilyn Rees Lead VTE CNS Marilyn.Rees2@wales.nhs.uk

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

3.	Objectives of strategy/ policy/ plan/ procedure/ service	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it is the policy of Cardiff and Vale University Health Board (UHB) to follow the guidance as set out in the NICE NG89 and those measures required by the Welsh Assembly Government (WAG): • All adult and teenage patients admitted to hospital are assessed, using an appropriate UHB Risk Assessment tool within 14 hours of admission, and appropriate preventative measures are instituted as a result. • All episodes of hospital associated VTE will be reviewed to establish if potentially preventable • RCA of potentially preventable cases will be undertaken by each clinical board and actions and learning outcomes reported to WAG on a quarterly basis The objectives of this policy and associated procedure are to provide a rational and practical framework on which to maximise patient safety during and following their hospital stay minimising their risk of developing hospital associated thrombosis
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively The policy details the assessment and management of VTE in the adult patient. The assessment ensures that all patients are individually assessed for their risk of VTE, risk of bleeding and appropriate clinical intervention/management is delivered.

	• list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	Each year, one in every 1,000 people in the UK is affected by DVT. Anyone can develop it but it becomes more common with age. As well as age, risk factors include: • previous venous thromboembolism • a family history of thrombosis • medical conditions such as cancer and heart failure • inactivity (for example, after an operation) • being overweight or obese VTE assessment provides a standardised approach that will help identify those with differential health outcomes and lead to positive action where required. There may potentially be an impact on patients understanding of information and use of a clear concise risk assessment utilising an appropriate educational approach for the patient or carers requirements should be utilised. Google search for Thromboprophylaxis Policy /Thromboprophylaxis Policy Equality / In-patient thromboprophylaxis equality impact assessment accessed 24th October 2020 1. Thromboprophylaxis Policy and Guidelines – Sherwood Forest Hospitals 2016 2. Policy for Reducing the Risk of VTE in Adult Patients Admitted to Hospital Portsmouth Hospitals NHS Trust 2019 3. Prevention of Venous Thromboembolism Policy Lincolnshire Community Health Service NHS Trust June 2020

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

		4. VTE Risk assessment Policy Mersey Care NHS Foundation June 2019 5. Thrombosis Prevention and Anticoagulation Policy – Royal Cornwall NHS Trust 2016 Comparison made with these policies of equality impact taking into account age, race, disability, gender, sexual orientation, religion or cultural beliefs. All policies accessed support the content of this policy and the approach recommended to patient groups and risk assessment for venous thromboembolism. Welsh Government supports and is committed to reducing the incidence of hospital acquired thrombosis and this is described in the Quality Delivery Plan (QDP) for the NHS: Achieving Excellence generating a tier 1 approach and focus. 2012.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Population Group – All adult patients and teenagers from 13yrs and over admitted to Cardiff and Vale UHB. There are no foreseen specific language/religious /cultural issues.

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	This policy applies to all adults over the age of 16. Regardless of their age, uniform assessment will be undertaken, which is free from bias or discrimination according to protected characteristics. Where an age is considered to be an individual risk factor, this is considered within the context of the whole risk assessment process, which is based on national guidance	Not applicable	Not applicable

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all adults over the age of 16. Regardless of whether they have cancer or any other disability, uniform assessment will be undertaken, which is free from bias or discrimination according to protected characteristics. Where cancer, or any other disability eg long term condition is considered to be an individual risk factor, this is considered within the context of the whole risk assessment process, which is based on national guidance		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all adults over the age of 16. Regardless of their gender, uniform assessment will be undertaken, which is free from bias or discrimination according to protected characteristics. Where the use of hormonal therapy for gender reassignment is considered to be an individual risk factor, this is considered within the context of the whole risk assessment process, which is based on national guidance		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available	Not applicable	Not applicable
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There is specific guidance within the Obstetric Directorate for assessment and management of risk in patients during pregnancy and following birth for those patients found to require thromboprophylaxis	Not applicable	Not applicable
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found	Would need to ensure patient information leaflets were accessible to patients requiring them.	This would be provided by the relevant clinical teams

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers	from the assessment review of the information. Patients whose first language is not English may require written information in the language of their choice to enable understanding of the need for thromboprophylaxis	These can be accessed from thrombosis.org	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is a need to be aware that heparins are of animal origin and this may be of concern to some patients. Discuss the alternatives with patients who have concerns about using animal products, after discussing their suitability, advantages and disadvantages with the person.	Not applicable	This would be done by the relevant clinical teams

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact on staff or patients	Not applicable	Not applicable
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Bilingually patient information leaflets will be available for patients. This is in line with our current Welsh Language Standards. The aim of the 'active offer' is that staff should ask for the language choice (of either Welsh or English) of the patient. The language choice should then be	The policy will prompt staff to ask patients which language the patient/service users would like to communicate	This will need to be done by the relevant clinical teams

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	integrated into the patients' treatment. In other words the patient could request their treatment be in Welsh. If we are unable to provide a fluent Welsh speaker to consult with the person then an interpreter would be provided through video consulting services.	in, either English or Welsh, in line with the 'Active Offer' requirements of the Welsh Governments' More than Just Words Strategy.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact	Not applicable	Not applicable

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff, and this policy has a positive impact on people on low income as the policy is applicable to all people. All patients admitted to hospital risk of thrombosis according to clinical presentation and following risk assessment tools for their particular speciality		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Other groups to be considered would include carers/family members who may need education with regards administering thromboprophylaxis for those requiring extended thromboprophylaxis. It would	Patient/family member/carer education prior to discharge as well as patient information leaflets to support understanding following discharge into the community	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	also be important for those family members/carers as well the patient to understand symptoms suggestive of development of thrombosis following discharge from hospital as the risk remains in place for up to 90 days.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Access to risk assessment for thromboprophylaxis is not affected by living conditions. On discharge these patients may require additional support to ensure the extended thromboprophylaxis treatment plan is enabled		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and	As a policy, there will be no impact. As thrombosis risk increases in patients with higher BMI it is imperative to encourage and support patients in healthy living/eating strategies and make services known to them as per the 'healthier Wales' goal by sign posting to available services. General advice would also include reducing alcohol		This will need to be actioned by each clinical board

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	intake to within national guidelines and reduce or stop smoking utilising smoking cessation services for example		
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	As a policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	As a policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	As a policy, there will be no impact.		
7.6 People in terms of macro-economic, environmental and	As a policy, there will be no impact.		

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	On reviewing the previous policy and writing the latest version, overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	On reviewing the previous policy and writing the latest version, overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy. There is a need to ensure risk assessments are available for each clinical board to ensure appropriate risk is assessed and treatment prescribed as required There is a need to ensure patient information leaflets are available during their hospital stay and following discharge to risk of reduce hospital acquired thrombosis	M Rees		

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited negative impact identified, it is unnecessary t undertake a more detailed assessment	M Rees		

	Action	Lead	Timescale		Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	On reviewing this policy minor positive changes will need to been made. The EHIA has been consulted. It has been approved by…….. The EHIA will be placed on intranet once approved Adherence to the policy will be monitored through …….. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).				

Appendix 2 – The Human Rights Act 1998[4]

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

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

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

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

Appendix 3

Tips

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

Report Title:	**Swab, Instrument and Sharps Count Policy and Procedure**							
Meeting:	Quality, Safety and Experience Committee					**Meeting Date:**	13/04/2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	
Lead Executive:	**Executive Medical Director**							
Report Author (Title):	**Barbara Jones, Perioperative Care Directorate Education Lead**							

Background and current situation:

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The overriding principle for the count is that all swabs, instruments and sharps must be accounted for at all times during an invasive surgical procedure in any setting, to prevent foreign body retention and subsequent injury to the patient.

The overall aim of this policy is to ensure that all swabs, needles and instruments are accounted for at all times to prevent foreign body retention and subsequent injury/harm to the patient.

The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the “WHO” checklist process.

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The Perioperative Care Directorate Policy & Procedure group identified the need for the Swab Instrument and Sharps Count procedure to be considered for ratification as a UHB policy so that clear guidance can be accessible for all those affected and accountable.

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

This is an existing policy and procedure that required a review and update of content.

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

Wide consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was shared with the Perioperative Care Directorate Quality & Safety Group and Surgery Clinical Board Quality and Safety Group and following discussions both groups approved the content of the document
- Comments were invited via individual e-mails from the Perioperative Care Directorate Policy and Procedure Group. Comments received gave approval of the document.

The primary source for dissemination of the Swab, Instrument and Sharps Count Policy and Procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Committee is asked to:

- **APPROVE** the Swab, Instrument and Sharps Count Policy and Procedure; and
- **APPROVE** the full publication of the Swab, Instrument and Sharps Count Policy and Procedure in accordance with the UHB Publication Scheme

Shaping our Future Wellbeing Strategic Objectives

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

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click here for more information

Prevention	√	Long term		Integration		Collaboration	√	Involvement	√
Equality and Health Impact Assessment Completed:	**Yes** *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

Reference Number: UHB 191 **Version Number:** 3	**Date of Next Review:** **Previous Trust/LHB Reference Number:** Trust Ref No 70

SWAB INSTRUMENT AND SHARPS COUNT – POLICY AND PROCEDURE

Introduction and Aim

Ensuring the correct count of swabs, instruments and sharps is crucial to ensuring the safety of patients during the peri-operative period.

The overriding principle for the count is that all swabs, instruments and sharps must be accounted for at all times during an invasive surgical procedure in any setting, to prevent foreign body retention and subsequent injury to the patient.

A count must be undertaken for all procedures in which the likelihood exists that swabs, instruments and/or sharps could be retained.

Although UK statute law does not dictate what system or method of swab, instrument and needle counts should be performed within a peri-operative environment, as a healthcare provider, the law is quite clear in that the UHB and its staff have a 'duty of care' to all its patients. Therefore the UHB and its peri-operative staff are accountable to patients for the care delivered and, as such, must ensure that the patient is not harmed by negligently leaving foreign objects within body cavities during clinically invasive procedures.

Retained objects are considered a preventable occurrence, Never Events List England (2015). Careful counting and documentation can significantly reduce, if not eliminate these incidents (AORN, 2006). A count must be undertaken for all procedures for which swabs, instruments and sharps could be retained.

Although it is the responsibility of the user to return all items, it is recognised as ‘custom and practice’ that the scrub practitioner implements the checking procedure in order to be able to state categorically that all items have been returned.

Team work, good communication and accountability are all crucial to safe practice within the peri-operative environment. This is recognised by the various professional bodies.

The overall aim of this policy is to ensure that all swabs, needles and instruments are accounted for at all times

The UHB is committed to ensuring patient safety and recognises that the peri- operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the World Health Organisation (WHO) checklist process.

Objectives

- To prevent foreign body retention and subsequent injury/harm to the patient.

Scope

The Royal College of Surgeons in their Good Surgical Practice (2008) state that "Surgeons work in partnership with others in the health care team – which includes other professionals, technicians, support staff and management – in order to offer safe and effective care to patients. They must work to develop effective relationships, respecting the professionalism of all colleagues. Knowledge and understanding of, and respect for, the roles and views of others are essential to achieving good patient outcomes."

The Health Professions Council (2014) states that as a professional "You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner and that you must communicate properly and effectively with service users and other practitioners."

The Health Care Support Worker Code of Conduct (2011) states that "You must be accountable by making sure you can always answer for your acts or omissions".

The NMC Code of Conduct (2015) states that "you must maintain you knowledge and skill for safe and effective practice" and "be aware at all times of how your behaviour can affect and influence the behaviour of other people".

Equality Impact Assessment	An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found here to be no impact.
Documents to read alongside this Procedure	Waste Management Policy Risk Management Policy Equality and Human Rights Policy Policy for the management of a throat pack
Approved by	Quality Safety and Experience Committee

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Peri-Operative Care Directorate Education Lead

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
UHB 1	14/06/2013	05/07/2013	Document revised and updated. Replaces previous Trust version reference no 70
UHB 1.1	30/12/2014	31/12/2014	Section 4.8 updated Section 8 – numbering corrected. Procedure for Ensuring Correct Swab, Instrument & Sharps Count updated to include new Section 6 - The Procedure for the Insertion of Throat Packs. All subsequent sections moved to next number.
UHB 2	15/12/2015	15/12/2015	Scope updated to reflect new references. The following aspects of section 14: 2.2, 4.1, 4.3, 4.11, 5.3, 5.9, 5.14, 5.17 6 - Throat pack removed as specific policy developed and subsequent sections numbered accordingly. 6.1 and 6.12 were all updated.
UHB 3			Section 4.3 updated to reflect checking procedure should designated runner change

CONTENTS

1. METHOD

All staff are responsible for ensuring that:

- Their practice is in line with this policy and any additional local guidelines
- Staff must comply with the provision of this policy and where requested demonstrate compliance
- Information regarding failure to comply with the policy is reported to their line manager and where appropriate the incident reporting system is used
- Information regarding any changes in practice or legislation that would require a review of this policy is immediately responded to.

Countable items may include, but are not limited to:

• X-ray detectable gauze swabs	• Blades
• packs	• local infiltration needles
• lahey swabs (peanuts, pledgets)	• tapes
• gauze strips	• liga-reels
• neuro patties	• slings/sloops
• needles	• shods
• instruments, including screws or detachable parts	• ophthalmic micro sponges
• sponges	• bulldogs
• red swab/pack ties	• cotton wool ball (including dental) and dental rolls
• diathermy tips and cleaners	• throat packs

A full swab, instrument and sharp count should be performed prior to;

- The commencement of surgery
- The commencement of the closure of any cavity
- Where there is a changeover of scrub practitioner
- At the commencement of skin closure

When checking swabs the scrub practitioner should ensure the integrity of the swab.

Instruments and items with detachable parts should also be included in the count at the commencement and end of the procedure. The surgical team must allow time for these counts to be undertaken without pressure.

The count must be audible to those counting and be conducted by two members of staff, one of whom MUST be a registered member of the Perioperative team (i.e. a registered nurse, operating department practitioner (ODP), registered midwife or dental nurse).

On completion of any count, a verbal statement must be made by the scrub practitioner to the effect that all swabs, instruments and sharps are accounted for, and verbal acknowledgement should be received from the operating surgeon in order to avoid any misunderstanding

2. RESOURCES

No additional resources were identified as a result of approval of this policy and procedure.

3. TRAINING

Cardiff and Vale UHB is a teaching hospital and therefore supports the placement of students in the peri-operative environment. During their placement in the department they will have supernumerary status and will not be asked to participate in the count.

During the orientation/induction programme for all new peri-operative staff, an introduction and a copy of the UHB Policy and Procedure for Swabs, Instruments and Sharps Count will be given to individuals by a member of the peri-operative education team. All new peri-operative staff, including healthcare assistants/support workers, will undertake the 'in-house' training programme, which leads to the competence required in the induction booklet.

Additional training and department meetings will be used to update peri-operative staff with regards to the any changes in practice and the principles of best-practice in swab, instrument and needle checking, during quality and safety sessions.

4. AUDIT

Compliance with this Policy and Procedure will be internally audited on an annual basis. Compliance will also be monitored through the external QUAD annual process.

5. DISTRIBUTION

This Policy and procedure will be shared at Clinical Board and Directorate Quality and Safety meetings, will be displayed on departmental notice boards and will be available for viewing via the Cardiff and Vale UHB Intranet. A copy will also be provided to all Clinical Directors, Clinical Board Nurses, Lead Nurses for onward distribution and circulation to staff as necessary

6. REVIEW

This policy and procedure will be reviewed every 3 years or as often as is necessary to ensure continued compliance.

7. FURTHER INFORMATION

AORN 2006 Recommended Practices for Sponge, Sharp and Instrument Counts. In: Standards, Recommended Practices and Guidelines Denver AORN Inc

Association for Perioperative Practice 2007 Standards and Recommendations for Safe Perioperative Practice Harrogate, AfPP

Australian College of Operating Room Nurses 2006 Counting of Accountable Items Used During Surgery, Standard S3. In ACORN Standards for Perioperative Nursing ACORN, Australia www.acorn.org.au

Brigden, R. (1998) Brigdens Operating Department Practice London Churchill Livingstone

Bynom (1998) Reflection – a lost swab *British Journal of Theatre Nursing 8 (5) 15-18*

Fulbrook S (1995) Duty of Care. *British Journal of Theatre Nursing 5 (5) 18-19*

Grandusky & Phippen (2000) *Patient Care During Operative and Invasive Procedures 94-96* London Harcourt Brace

Haken A (2003) Poor Swab Management *The Clinical Services Journal*. February 50-51

Health and Care Professions Council (2014) Standards of Conduct, Performance and Ethics, London, HPC. Available from: http://www.hcpc-uk.org/registrants/standards/download/index.asp?id=46

Lamont S (2005) A swab story. *British Journal of Perioperative Nursing* 15 (11)
495-499

Medical Devices Agency 2007 Reporting medical device adverse incidents and disseminating medical device alerts Ref: MDA/2007/001 London, MDA Available from: www.medical-devices.gov.uk (Type the reference number into the 'search' window and click 'go'. NB This is updated and reissued as the first safety notice of each calendar year.)

Medicines and Healthcare products Regulatory Agency (MHRA) 2005b One Liners Issue 35 (July) London, MHRA Available from: www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary = true&ssDocName=CON1004209&ssTargetNodeId=574 [Accessed 5 April
2007]

NATN (1997) Universal *Precautions and Infection Control in the Perioperative
Setting*. Harrogate, NATN

NATN (1998a) *Infection Control. Principles of Safe Practice In the Perioperative Environment* Harrogate NATN

NATN (1998b) Safeguards for Invasive Procedures: *The Management of
Risks* Harrogate NATN

NATN (1998c) .The *Count Principles of Safe Practice in the Operating Theatre* 79- 82 Harrogate NATN

NATN (1998d). *Universal Precautions Principles of Safe Practice in the perioperative Environment* 92-95 Harrogate NATN

NATN (1998e) Use *and handling of Instruments Principles of Safe Practice in the Perioperative Environment* 88-90 Harrogate, NATN

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2004 The NCEPOD Classification of Interventions (p5) London, NCEPOD Available from: www.ncepod.org.uk/pdf/NCEPODClassification.pdf [Accessed 5 April 2007]

Never Events List (2015) NHS England. Available at: http://www.england.nhs.uk/ourwork/patientsafety/never-events/

Nursing Midwifery Council (NMC) (2015) Code of Professional Conduct London NMC

Olsen C (1995) Sutures, Needles, and Instruments in Meeker M H (1995)
Alexander's Care of the Patient in Surgery 10th Edition St Louis Mosby

Operating Room Nurses Association of Canada (ORNAC) 2005b Module 3
Safety/Risk Prevention and Management 5 Surgical Counts, in Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice Available from: www.ornac.ca

Royal College of Surgeons (2008) Good Surgical Practice, London, RCSEng

Rothrock J (Ed) (2002) Alexander's Care of the Patient in Surgery 12th Edn p36-37 London, Mosby

Tingle J (1997) Legal problems in the operating theatre: learning from mistakes *British Journal of Nursing* 6 (15) 889-891

WEDS (2011) Health Care Support Worker Code of Conduct and Code of Practice. Available from www.weds.wales.nhs.uk/codehcsw-code-of-conduct-code-of-practice [Accessed 7July 2015]

Woodhead K, Wicker P (2005) A Textbook of Perioperative Care Oxford, Churchill Livingstone

8. PROCEDURE FOR ENSURING THE CORRECT SWAB, INSTRUMENT AND SHARPS COUNT

1. INTRODUCTION

The overriding principle for the count is that all swabs, instruments and sharps (this will include surgical blades, suture and injection needles and all other disposable items) must be accounted for at all times during an invasive surgical procedure in any clinical setting, to prevent foreign body retention and subsequent injury to the patient. For guidance in relation to management of Throat Packs please see separate UHB Policy.

The main areas for consideration are:

- Education/Training
- Packaging
- Responsibility for counts
- Checking procedure
- Counting Techniques
- Count Discrepancy
- Documentation

2. EDUCATION AND TRAINING

	ACTION	RATIONALE
2.1	On induction all staff (nurses, operating department practitioners (ODP) and unregistered staff) must have a supernumerary status whilst training.	So that they are supervised prior to working independently. All staff know how to access the policy and its importance in safe peri-operative practice.
2.2	All staff will have their own copy of the Swab, Instrument and Sharps Count policy and have read and understood it before participating in swab, needle and instrument counts. Staff will be expected to sign a signatory sheet when issued with the policy which will then be placed in their training file.	New staff are aware of the location of the policies and procedures To provide an audit trail

2.3	All newly appointed staff will be trained and assessed against the standards in the induction booklet before participating in swab, needle and instrument counts. This booklet will be retained in the staff member's training/personal file on completion of their induction which is kept with the practice education team.	All staff are to be aware of their responsibilities regarding the adherence to departmental policies. To maintain records and ensure evidence of training.

3. PRINCIPLES OF PRACTICE

	ACTION	RATIONALE
3.1	A swab, instrument and sharps count must be performed for all clinically invasive procedures and recorded immediately on the swab board using one pen colour only	In the event of an incident the procedure was followed and the checking procedure was complete.
3.2	All swabs, including lahey swabs, patties and packs that are used during invasive procedures must have an x-ray detectable marker fixed securely within the swab or pattie. This excludes cotton wool balls used in ENT	The swab will be visible on an X- ray and the swab marker will not become detached.
3.3	All swabs must be in bundles of five (5) and of a uniform size and weight and counted in fives (5) and recorded on the swab board as such.	There is a standardised procedure for counts and to reduce the risk of errors occurring and to provide an accurate baseline for all subsequent counts.
3.4	All items used as swabs must be counted in fives and documented on the swab board. This includes patties, lintenes and cotton wool balls.	To provide an accurate baseline for all subsequent counts

3.5	At all times during the procedure the scrub practitioner must be aware of the location of all swabs, instruments, sharps and medical devices used in the procedure.	The scrub practitioner is aware of the location and use of all the swabs, sharps and instruments.
3.6	The surgeon must not remove any item from the scrub practitioner's trolley without permission.	The scrub practitioner is aware of the location and use of all the swabs, sharps and instruments.
3.7	The surgeon will inform the scrub practitioner of the placement of any swab inside the patient and this will be recorded on the swab board.	The scrub practitioner is aware of the location of all swabs.
3.8	All scrub staff must maintain a neat and organised approach to their work.	If there is a change of scrub practitioner that the working area is easy to take over and check.
3.9	In the event of a NCEPOD (National Confidential Enquiry On Patient Outcome and Death) 1 emergency, it is recognised that a count may not be performed until the patient's condition has stabilised. Packaging of all recordable items must be retained as a cross check.	The packaging can be used to facilitate a count at the earliest appropriate opportunity, and this must be documented in the patient's notes and patient's theatre care plan.
3.10	If any interruption occurs during the counting procedure, the count should be started again from the beginning	To allow a complete and accurate count.
3.11	If a counted item is inadvertently dropped off the sterile field, the circulating staff member should retrieve it, show it to the scrub practitioner and segregate it from the sterile field but remain visible to be included in the count.	To maintain the integrity of the count.

4. RESPONSIBILITY FOR COUNT

	ACTION	RATIONALE
4.1	Each count must be performed by the scrub practitioner and another member of staff, one of whom must be a registered theatre practitioner who will be able to count the swabs, sharps, instruments and other items. If the scrub practitioner is of a supernumerary status the responsibility of the count will remain with the supervising registered practitioner.	So that the correct swabs, sharps, instruments and other items are accounted for.
4.2	The same two members of staff (registered practitioner and designated circulator) must perform all the counts during the procedure whenever possible.	Continuity of the count and checking procedure will be maintained reducing the risk of errors occurring.
4.3	Should the scrub practitioner change for any reason during the procedure, a complete count must be performed together by the incoming and outgoing practitioner where possible, recorded in the patient's care plan and signed by both practitioners. If it is not possible to do the check together then the incoming practitioner and outgoing practitioner will carry out their own checks with the designated runner. Should the designated runner change for any reason during the procedure a complete count must be performed together with both the incoming and outgoing runner and the scrub practitioner where possible, recorded in the patients care plan and signed by all involved with the check. If it is not possible to do the check together then the incoming designated runner will carry out the checks with scrub practitioner.	To check that the count is correct at handover or change of team members and that all items are accounted for.

4.4	Where there is a changeover of staff and a check is not possible, the reason must be recorded in the care plan	To provide best practice and safety for the patient.
4.5	When there is more than one scrub practitioner, a decision must be taken prior to the commencement of the case to establish who will be the lead scrub practitioner for the duration of the procedure (see multi-site procedure).	To provide continuity of care and safe practice throughout the procedure for patients and staff
4.6	All items that remain in the patient intentionally such as packs must have a radio opaque marker and the number and type recorded in the patient's notes and care plan.	To inform the ward staff that the patient has an insitu pack and to prevent inadvertent retention.
4.7	Swabs, sharps, instruments and other accountable items must remain in the theatre until permission for removal has been given by the lead scrub practitioner.	To provide best practice and safety for the patient, to ensure integrity of count.
4.8	Dressings must not be opened before the final count. Should the dressings be included in the procedure pack, they should be isolated on the sterile tray until the final count is complete.	These items are not X-ray detectable.
4.9	All staff present in the operating theatre must assist in the count by allowing the scrub practitioner to complete the count without interruptions.	To allow a full and accurate count.
4.10	On completion of the final count the scrub practitioner will inform the surgeon that the swabs, instruments, sharps and all other accountable items are correct and the surgeon must audibly acknowledge the results. If the count is incorrect then follow the procedure in section 8.	The theatre team are all aware of the correct count to minimise Misunderstandings.

4.11	Immediately prior to the patient leaving the theatre the theatre team must complete the World Health Organisation (WHO) sign out checklist and the designated circulator and lead scrub practitioner must record on the WHO checklist form and in the patient's care plan that all checks were undertaken and were correct.	A permanent record is maintained and care is documented.

5. CHECKING PROCEDURE FOR SWABS

SWABS INCLUDE ALL ITEMS USED AS A SWAB E.G. PATTIES, LINTENES AND COTTON WOOL BALLS.

	ACTION	RATIONALE
5.1	A full swab count must be performed prior to the commencement of surgery.	To provide a baseline for further checks.
5.2	The swabs will be recorded on the swab board in the theatre immediately after completion of the count and prior to the commencement of surgery.	To provide a visible record of swabs in use.
5.3	At the initial count, and when added during the procedure, swabs must be counted into separate bundles of five. All swabs should be separated so that the radio-opaque line is visible throughout the check.	To maintain the integrity of the count.

5.4	In the event of an incorrect number of swabs (i.e. not five) the entire bundle; red tie and outer packet must be removed from the sterile field, sealed in bag, removed from theatre and the duty manager informed. The batch/lot number and packaging must be retained so as to ensure other items in the batch are removed from stock and that appropriate bodies/agencies are notified. An incident form via e-datix must be completed.	To ensure that the count is accurate and to follow reporting procedures.
5.5	When checking each bundle of swabs the red tie must be accounted for and stored securely in a designated place and be accounted for at the end of the procedure	The scrub practitioner is aware of the location and use of all the swabs
5.6	A full swab count will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (final count) this must be documented in the patient's care plan.	To assist the practitioner in maintaining control of the swabs
5.7	Swabs should be counted out of the sterile field. The technique used should be safe and incorporate infection control measures in conjunction with standard precautions. All swabs should be completely separated and counted in multiples of five before they are placed into an appropriate disposal system.	To maintain the sterile field and to reduce to a minimum any risk of cross-infection.
5.8	When abdominal mops are used they may be handed out individually to be weighed. They must be kept in full view of the scrub practitioner at all times. They must only be discarded when in multiples of 5.	All swabs are counted and discarded in multiples of 5 to prevent any errors.

5.9	Swabs must be recorded on the swab board; the circulating staff member must finish this procedure without interruption. The information on the swab board must not be wiped clean until the patient has left the operating theatre.	To prevent any errors.
5.10	The surgeon will inform the scrub practitioner of the placement of any swab inside the patient and this will be recorded on the swab board by the designated circulator. When the swab is removed the indicator on the swab board is to be crossed out but not erased from the board.	To reduce the risk of leaving a foreign body in the wound.
5.11	Swabs must not be cut or altered unless specifically intended for this purpose.	To reduce the risk of leaving a foreign body in the wound.
5.12	It is acknowledged that for specific cardiac operations it is necessary to cut swabs to remove them from the operating site. These must be tied together immediately and counted as one swab within a bundle of 5.	To reduce the risk of leaving part of the cut swab in the wound.
5.13	The integrity of the swabs must be checked during the count including any attached tapes.	To prevent tapes or markers being lost or left in the patient.
5.14	All abdominal mops must be used with a clip attached to its tape and all small swabs must be mounted on sponge holders/relevant device once a deep cavity is open. Any deviation from the above must be on the consultant's instruction.	To maintain safe use of the swabs.
5.15	In surgery where the cavity is too small to take mounted swabs (e.g. paediatrics and cardiac) loose swabs may be used. Where these are used entirely within the cavity, they must be documented on the swab board.	To assist the practitioner in maintaining control of the swabs.

5.16	Any additional items added to the sterile field must be counted and recorded on the swab board by the designated circulator.	To maintain the accuracy of the count.
5.17	In ophthalmology where the operation site is on the lids or the globe, swabs are not counted. These swabs are not x-ray detectable. Best practice would indicate however that a count be undertaken.	Swabs are too large to be lost in this type of surgery.
5.18	All used swabs should remain in theatre and be available for inspection throughout a clinically invasive procedure.	To allow checks to be made in the event of a discrepancy.
5.19	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed	To allow a systematic approach to the search for the lost item.

6. CHECKING PROCEDURE FOR INSTRUMENTS

	ACTION	RATIONALE
6.1	Before starting any case trays and supplementary instruments must be checked that; • They are correct for the surgery planned and are in good working order • Are in date • That packaging is intact, dry and without holes • Sterility indicator strips If any tray or supplementary instrument does not comply then it should be rejected and another item used.	To ensure that the tray/instruments are fit for purpose.

6.2	The tracker label must be removed and put on the correct form. This form must be completed with the patient's hospital number, date and scrub practitioner's name and taken with the used trays/instruments to HSDU or SSU.	To provide an audit trail.
6.3	A full instrument count must be performed prior to the commencement of surgery by the lead scrub practitioner and designated circulator.	To provide an accurate baseline for all subsequent counts.
6.4	All tray instruments including loan trays are to be checked against a pre- printed tray list. Any discrepancy is to be noted on the tray list and reported to the decontamination unit using the appropriate non conformity form. This form must be returned with the instrument or tray at the end of the procedure.	To provide an accurate baseline for all subsequent counts.
6.5	The designated circulator must call aloud from the tray list. The lead scrub practitioner must acknowledge verbally that each item is present. Items should be completely separated during the checking procedure. At the initial and final count each item must be ticked on the tray list.	To provide an accurate count and to record that these items are present. Separation of items allows items to be easily seen and counted.
6.6	The designated circulator must record on the tray list; • The name of the lead scrub practitioner and designated circulator in full • The theatre • Patients hospital number • Patient (e.g. 1st, 2nd) • date	To maintain a record of the staff involved in the counts in the event of a discrepancy.

6.7	All instruments and items with removable parts must be checked for integrity and included in the counts at the commencement and end of the procedure.	To prevent any loss and discrepancies.
6.8	Supplementary instruments must be counted at each instrument count. They can be checked against their packaging, their barcode or the tracking list.	To prevent any loss and discrepancies.
6.9	A full instrument count will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (final count). This must be documented in the patient's care plan.	To prevent any loss and discrepancies.
6.10	All instruments must be returned to the HSDU/SSU on the correct tray according to that tray list accompanied by the completed tracking form. The tray list must be Completed and all instruments secured on pins as appropriate.	To prevent any errors.
6.11	All supplementary instruments must be returned to HSDU/SSU either in an appropriate container e.g. inside a plastic bag and then placed on the instrument tray and accompanied by the completed tracking form.	To maintain an audit trail.

6.12	In the event of an instrument breaking during the procedure the scrub practitioner must ensure that all pieces have been returned to them. The instrument must be returned with either the appropriate tag attached or in a bag clearly labelled, to the HSDU / SSU. An electronic incident form is to be completed via e-datix.	To prevent injury to staff or the patient and to allow decontamination before being sent for repair or investigation.
6.13	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed.	To allow a systematic approach to the search.

7. CHECKING PROCEDURE FOR SHARPS AND OTHER ITEMS

	ACTION	RATIONALE
7.1	Sharps should be recorded at the commencement of the procedure and recorded individually on the dry wipe (swab) board according to the number marked on the outer package. Sterile suture packs must be retained and used for a check back procedure.	All sharps are to be recorded accurately. Saving the suture packet will aid the scrub practitioner in maintaining an accurate count.

7.2	Opening all packages during the initial sharps count is not recommended. Used sharps on the sterile field should be retained in a disposable, puncture resistant sharps container.	To reduce the chance of needle stick injury and to aid with the ongoing count.
7.3	A full count including sharps will be performed at the commencement of the closure of any cavity and at the commencement of the skin closure (Final count). This must be documented in the patient's care plan.	To prevent any loss and discrepancies.
7.4	A correct sharps count must be performed before the closure of sharps containers/pads.	They should not be opened once closed.
7.5	Snuggers are to be counted and recorded on the swab board.	To prevent loss of the item inside the patient.
7.6	Any additional sharps and recordable items as listed on page 4 must be included in the count and added to the swab board.	To ensure an accurate count.
7.7	In the event of a sharp breaking during the procedure the scrub practitioner must ensure that all pieces have been accounted for and returned to them. It may be necessary to inform the manufacturer and the Medical and Health Care Products Regulatory Agency if a manufacturing fault is suspected. An incident form is to be completed via E-Datix.	To prevent harm to the patient and staff and to record the incident.
7.8	If there is a discrepancy in the closure counts, the procedure described in section 8 Count Discrepancy must be followed.	To allow a systematic approach to the search.

8. PROCEDURE TO BE FOLLOWED FOR COUNT DISCREPANCY

	ACTION	RATIONALE
8.1	If any discrepancy in the count is identified by the scrub practitioner, the operating surgeon must be informed immediately and a search implemented at once. Closure should cease unless it is a life or limb situation.	The surgical team are made aware of the issues and they will assist in the checking for the missing items.
8.2	If a thorough search does not locate the item, an X-ray is to be taken before the reversal of anaesthesia and before the patient leaves the operating theatre if undergoing local / regional anaesthetic procedures.	To confirm that the patient is not at risk of a retained foreign body and to prevent further surgery to remove the item.
8.3	A plain X-ray is recommended (MHRA 2005b). Fluoroscopy/image intensifier should not be used in these circumstances.	Fluoroscopy/image intensifier may fail to locate radio opaque swabs.
8.4	Missing micro items (such as needles which cannot be detected on X-ray) are to be recorded on the patient care plan and the theatre register (e.g. Theatreman). An X-ray should be performed at the discretion of the surgeon.	All records are correct should the item be found at a later date.

8.5	If an instrument, swab, sharp or other item is missing the following action must be taken; • The surgeon will check the patient's surgical cavity and the area around the wound • The scrub practitioner will perform another count • Circulating staff will check the theatre and the area immediately around and under the operating table. • Circulating staff will check all bins in the theatre and will open all swab bags and recount their contents if still missing • Circulating staff will open all swab bags and recount their contents if still missing	To confirm that the item is not in the patient. Correct reporting of incidents will allow staff to be able to learn from the incident through investigation.
	If still missing: • Inform the patients consultant • Inform the duty manager / senior nurse • X-ray the patient in theatre • Document the incident in the patients care plan and notes • Complete an online e-datix incident form and refer to the Incident, Hazard and Near Miss Reporting Policy Complete a HSDU / SSU document for missing instruments	

10. DOCUMENTATION

	ACTION	RATIONALE
10.1	It is the responsibility of the scrub practitioner to ensure that department documentation and the patient's computerised record e.g. Theatreman is completed and record the outcome of the count	As per UHB and AfPP guidelines to maintain correct records.
10.2	A record of the count must be recorded in the patient's care plan indicating name of lead scrub practitioner and designated circulator responsible for the final count.	As per UHB and AfPP guidelines to maintain correct records.

Equality Impact Assessment

Section A: Assessment	
Name of Policy	**SWAB INSTRUMENT AND SHARPS COUNT POLICY AND PROCEDURE**
Person/persons conducting this assessment with Contact Details	Barbara Jones Perioperative Care Directorate Education Lead – 02920 745537
Date	8th April 2021

1. The Procedure
Is this a new or existing procedure? Existing – this is version 3 of the procedure. Version 2 was approved in July 2016.
What is the purpose of the procedure? The overriding principle for the count is that all swabs, instruments and sharps must be accounted for at all times during an invasive surgical procedure in any setting, to prevent foreign body retention and subsequent injury to the patient. The overall aim of this policy is to ensure that all swabs, needles and instruments are accounted for at all times
How do the aims of the procedure fit in with corporate priorities? i.e. Corporate Plan The UHB is committed to ensuring patient safety and recognises that the peri-operative period poses a high risk to the patient. It is the intention of this policy to identify good clinical practice within the peri-operative environment and to ensure the health and safety of patients throughout their journey within this environment. To reduce the incident of a “never event” and promote engagement in the World Health Organisation (WHO) checklist process. This Procedure is linked with the following documents: • Health and Safety Policy • Waste Management Policy • Risk Assessment and Risk Management Procedure • Risk Management Policy • Incident Reporting and Investigation Procedure • Management of a Throat Pack Policy and Procedure

Who will benefit from the procedure?

This policy and procedure will benefit all staff and patients in ensuring adequate arrangements are in place to manage the risks associated with management of swabs, instruments and sharps.

What outcomes are wanted from this procedure?

- To prevent foreign body retention and subsequent injury/harm to the patient.

Are there any factors that might prevent outcomes being achieved? (e.g. Training/practice/culture/human or financial resources)

Contributory factors may include

- Adequate training provision
- Safe Systems of working

To address these factors we have put in place the following:

- Cardiff and Vale UHB is a teaching hospital and therefore supports the placement of students in the peri-operative environment. During their placement in the department they will have supernumerary status and will not be asked to participate in the count.

- During the orientation/induction programme for all new peri-operative staff, an introduction and a copy of the UHB Policy and Procedure for Swabs, Instruments and Sharps Count will be given to individuals by a member of the peri-operative education team. All new peri-operative staff, including healthcare assistants/support workers, will undertake the 'in-house' training programme, which leads to the competence required in the induction booklet.

- Additional training and department meetings will be used to update peri-operative staff with regards to the any changes in practice and the principles of best-practice in swab, instrument and needle checking, during quality and safety sessions.

The outcome of the policy and procedure can be affected detrimentally by any of the above not being in place.

2. Data Collection

What qualitative data do you have about the policy relating to equalities groups (e.g. monitoring data on proportions of service users compared to proportions in the population)?

There was no specific equalities data available.

What quantitative data do you have on the different groups (e.g. findings from discussion groups, information from comparator authorities)?

Data was collected relating to the ethnicity of our staff.

Please indicate the source of the data gathered? (e.g. Concerns/Service/Department/Team/Other)

Reference was made to the Equality Impact Assessment undertaken for the Recruitment and Selection Policy, which had gathered data from the workforce profile of the Cardiff and Vale UHB and information was obtained from NHS Jobs.

What gaps in data have you identified? (Please put actions to address this in your action plan?)

Not applicable.

The following documents were referenced when undertaking this Equality Impact Assessment.

Cardiff and Vale University Health Board, November 2013, *Recruitment and Selection Policy Equality Impact Assessment*, http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/238805

3. Impact

Please answer the following

Consider the information gathered in section 2 above of this assessment form, comparing monitoring information with census data as appropriate (see www.ons.gov.uk Office National Statistics website) and considering any other earlier research or consultation. You should also look at the guidance in Appendix 1 with regard to the protected characteristics **stating the impact and giving the key reasons for your decision.**

Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people)

No

Do you think that the policy impacts on people because of their caring responsibilities?

No

Do you think that the policy impacts on people because of their disability? (This includes Visual impairment, hearing impairment, physically disabled, Learning disability, some mental health issues, HIV positive, multiple sclerosis, cancer, diabetes and epilepsy.)

No

Do you think that the policy impacts on people because of Gender reassignment? (This includes Trans transgender and transvestites)

No

Do you think that the policy impacts on people because of their being

married or in a civil partnership? No
Do you think that the policy impacts on people because of their being pregnant or just having had a baby? No
Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.) No
Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range of groupings the most of which are Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs. Consider these categories individually and collectively when considering impacts) No
Do you think that the policy impacts on men and woman in different ways? No
Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexuals, lesbians and bisexuals) No
Do you think that the policy impacts on people because of their Welsh language? No
4. Summary.
This policy and procedure aims to implement actions that will minimize the risk of foreign body retention and subsequent injury/harm to the patient.
Impact expected to be **neutral.** The supporting procedure seeks to address any issues regarding language and disability.

5. Report, publication and Review **Please record details of the report or file note which records the outcome of the EQIA together with any** **actions / recommendations being pursued (date, type of report etc)**

Please record details of where and when EQIA results will be published On UHB intranet and internet site			
Please record below when the EQIA will be subject to review. 3 years after approval of procedure, or earlier if required by changes to legislation or best practice			
Name of person completing	Barbara Jones		
Signed	Barbara Jones		
Date	08/04/2021		
Name of Responsible Executive/Clinical Board Director Authorising Assessment and Action Plan for publication	Medical Director Quality Safety and Experience Committee		
Signed		**Date**	

Saunders,Nathan
04/12/2021 14:33:00

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 26th January 2021, 8.30am via Microsoft Teams

PRELIMINARIES		
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Clare Rowntree, Clinical Board Director Nia John, Consultant, Children Young People & Family Health Services Directorate Mary Glover, Lead Nurse, Children's Hospital for Wales Services Directorate Sarah Spencer, Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Becci Ingram, General Manager, Children's Hospital for Wales Services Directorate Louise Young, Risk Manager, Children Young People & Family Health Services Directorate Martin Edwards, Assistant Clinical Director, Children's Hospital for Wales Services Directorate Sarah Davies, Risk Manager, Obstetrics & Gynaecology Directorate Rhodri John, Directorate Manager, Obstetrics & Gynaecology Directorate Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Directorate Anthony Lewis, Clinical Board Pharmacist Matthew McCarthy, Patient Safety Advisor Diana Wakefield Paula Davies, Lead Nurse, Children Young People & Family Health Services Directorate Karenza Moulton, Senior Nurse, Children's Hospital for Wales Services Directorate **In Attendance** Kirsty Hook, Board Secretary Judith Cutter, Consultant Midwife, Obstetrics & Gynaecology Directorate	
1.2	**Apologies for absence** Laura Owens, Linda Hughes-Jones, Angela Jones	
1.3	**To note the Minutes of the previous Q&S meeting held on 24th November 2020** The minutes of the meeting held on 24th November were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 24th November 2020** The action log was updated. **Matters Arising:** **RCA LC** A request has been made for this presentation to be shared at the Resus Committee. CH agreed to follow up if this has happened with. **PEWS Chart** Discussions have taken place and concern has been raised with regards to the effects on the PUMA trial. It was also noted that the chart needs to be redesigned as it is still not fit for purpose. Concerns were raised that there has been a significant delay in getting this implemented, and there is a need to implement the chart as soon as possible. Discussion ensued with regards to the recommendation from the coroner's case of the need to implement a paediatric observation chart and this is still outstanding. ME agreed that there is an	CH ME

	urgency and that a meeting is scheduled to take place imminently, to look at a unified observation chart for the Children's Hospital. Feedback on the outcomes will be provided at a future meeting. **Children's Rights Charter** Discussions have taken place and a plan has been agreed to take forward this work. When the plan has been finalised, this will be shared for noting at a future meeting. **Continence Service** Further discussions have taken place and options to support the service going forward are in progress. **Hep A Administration RCA** This RCA is finished, and it was agreed that this will be added to be agenda for next month **Fracture RCA** Almost complete and will be shared as soon as this is finalised. **HIW Recommendations** Work is progressing on the recommendations, not yet finalised this was agreed that this will be discussed and shared at the February meeting. **NICU Improvement plan – Newborn Screening** MG agreed to chase and share for information. **Electronic Prescribing** This is progressing well and communications will be circulated in due course.	PD PD SH MG
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – EPAU Experience** Anonymous concern received into the Chief Executive Office with regards to the experience of the patient who attended the EPAU during the COVID19 pandemic with a request to share this experience widely for sharing and lessons learnt. Some of the issues identified related to lack of communication, introductions and lack of reassurance and support. As part of the concern, the following recommendations were highlighted by the patient: • All staff should introduce themselves by name and role, and wear visible name badges • All procedures and options should be fully explained, and allow time to listen, to be listened to and to understand • Allow patients to have a partner to support when receiving bad news • Follow up to be offered to all women and their partners The concern has been shared with widely with staff, as a number of the recommendations highlighted should be offered routinely as part of the care provided. The importance of kindness and compassion has also been reiterated. A number of actions are already underway, including the introduction of name badges and lanyards to ensure that all staff have the appropriate identification and the importance of introducing themselves to patients. Attendance of partners is being revisited in order to ensure that this can be accommodated for consultations such as this. The concerns of the staff have been reviewed in relation to the environment and the setup of EPAU has been altered in order to ensure that is more self-contained. Emergency gynaecology has also been moved so that the same area is being used.	

2.2	Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues) CHFW Services Directorate • Importance of increased awareness of social distancing and TTP guidance has been reiterated. Small number of staff have been TTP due to an issue with a staff member's app not being disabled whilst in work. • Staff vaccinations are underway • X1 RCA is ongoing, further work is underway and will be shared once completed. • X1 extravasion injury on PCCU patient in Nov patient transferred back to Swansea and Plastic surgeon involved. This was also received as a concern, which has been completed. • Single Nurse Checking has been rolled out on the two pilot wards and feedback to date has been positive. • Medicines Management group has been reinvigorated, including medical representation. • Research department is now back open following COVID19, with a number of studies underway. • All newly qualified staff are in post. Some are helping to support adult wards. Qualified per shift going to support adult critical care, and also x1 qualified per shift to C1. • New consultant Ceri Jones commenced in post last week. • The therapies vacancies are currently being progressed for recruitment. • There are a number of vacancies within the admin team specifically within outpatients due to shielding, COVID sickness etc. To support, consultants are being requested to complete the clinic without the notes where possible due to the challenges within the team. Options are being explored in order to address and relieve the pressures going forward. Obstetrics & Gynaecology Directorate • Started training for POCT for COVID this week • Staff vaccinations • 9 ongoing Obstetric RCAs, 3 Gynae RCA's and x4 timeline reviews. X3 of the Obstetric RCA's have also been reported as Serious Incidents • HIW National report was published in November 2020. Learning event was held in December 2020. HIW community review has been delayed until the Spring 2021. • Ockenden report was published in December 2020, which has been shared for information with the papers. A draft response is being produced for submission at the end of January 2021. • X4 Pressure damage reported, x3 of which were present on admission. All were managed well on Gynae before the patients went home. • X1 fall in Gynaecology, no harm caused to the patient. There was x1 dropped baby in December. In response, an audit has been completed on the Babies Don't Bounce. Since the audit, work is being undertaken to address the lack of compliance highlighted within the audit. • A SOPS has been completed to address the issues of Covid 19 safety in the community, this will be presented at next MPF Jan 2021 • Community midwives expressed concerns regarding car sharing with students in the context of Covid 19. RCM are working with the Health Board to develop guidance on this. However agreed standard is that students continue to attend community placements. • Ongoing issues with regards to fluid balance, C and V HB to consider development of adjunct to NLP to include fluid intake monitoring in response to themes identified in risk: Hyponatremia and acute kidney injury • Medication errors reported. No adverse outcomes however X2 fact finding exercises are ongoing for learning. • Safeguarding – 100% compliant with regards to patients receiving a social birth plan, which includes clear instructions for the staff following the birth of an unborn who is open to social services. • Continued awareness of zero tolerance of blood samples.	

	• Lockers and tables for C1 surgical beds acquired and new mood light has been installed on delivery suite • C1 have implemented a revised MEWS chart and work is underway to look at options for adapting and implementing within Maternity also. • Trialling clear face masks on delivery suite, however it was noted that these are not fit for purpose. • X8 formal concerns, themes and learning points relate to "hello my name is", delayed treatment etc. • Recruitment is progressing across a number of areas within the Directorate. Children Young People and Family Health Services Directorate • Deployed Band 5 School Nursing workforce to support the mass immunisation programme for COVID. • Staff vaccinations are ongoing. • Community HPV sessions are being reviewed if schools continue to remain closed in order to help with the catch up programme that has been delayed as a result of COVID19. Fluenz mop up programme is also being offered. • IT issues continue and is creating Datix incidents due to pressures experience for staff. Equipment issues have been escalated. • CAMHS & ND pressures continue, agency staff have been booked in order to help support. There is a need to help staff within these services to manage expectations of families, local authorities etc. This is impacting the staff significantly due to the expectations. This is also having a significant impact within Community Paediatrics for children with mental health problems. It was agreed that there would be more detailed discussions outside of the meeting with regards to how this can be managed, the approach required going forward and escalated where appropriate, as well as ensuring that staff are supported. PD noted that on review of a number of cases where concerns have been received, there has been significant input from CAMHS, however families are at crisis point (which is exacerbated due to the current position) and as a result, continue to raise concerns. • OCP commencing on 28th January 2021 for additional funding for x3 crisis staff within CAMHS which will extend the hours of the crisis team later into the evening to reduce the demand for on call, which will require a change in working hours. This is being taken forward with staff side colleagues. • Plan progressing for the replacement to the Directorate Community Pharmacist role. • Growth in CCNS service and the impact on the establishment is being reviewed to look at appropriate way forward to support the CCNS growth. • RCA – fracture is being finalised. A pathway is being developed for children with osteopenia and manual handling needs and it was agreed that this would be shared at a future meeting. • SL – Inquest case for Looked After Child. This case is subject to Child Practice review and work is being taken forward in partnership with Hywel Dda Health Board. • Pressure ulcer task and finish group to develop a community pathway is progressing. • Woodland and Riverbank Special Schools healthcare plans issues have been raised. A review is underway in order to better understand the issues and the required health responsibilities. • CAMHS Delivery Unit report – agreed that this would be shared at a future meeting, once it has been discussed at Directorate Q&S Meeting. • Redaction of records – advice has been sought from information governance to agree a formal procedure for release of records going forward without redaction. Further meetings are being arranged. • Deployment of staff to support adult services continues. Some issues with regards to request for staff secondment, however due to pressures across the services this is unable to be supported at present.	CH/CR/PD PD

	• 16-18yr old pathway is being progressed with Adult Mental Health to review appropriate staffing model for patients within Hafan y Coed. Task and finish group has been arranged to look at the required staffing model to support this. PD also agreed to link with Karenza Moulton to include the inpatient pathway to the CHFW.	PD
2.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** There were no specific exceptions to note for this meeting.	
2.4	**Long Waiting Patients Update** **CHFW Services** Directorate continue to review all patients over 52 weeks through clinical priority. Level 2 and Level 3 remain problematic, however additional elective capacity has been implemented. There is currently x1 patient waiting 96weeks for surgery, a plan is in place to resolve as soon as possible. Reports continue to be sent to the surgeons for review, and patients re-categorised were necessary. Options are being explored to look at bringing all children waiting over 52weeks back to clinic for review also. Outpatient waits for all specialties continue to grow with the longest waits at 65 weeks. Funding has been received in order to look to support additional outpatient's clinics. Cleft Lip and Palate children who are usually undertaken in Swansea, are being reviewed in order to ascertain if these patients can be treated in the CHFW. Work is taking place in partnership with Surgery Clinical Board and MG agreed to update as this work progresses. **Obstetrics & Gynaecology** Dependent on pressures across the organisation, 11.5 sessions should be returned by mid-February which it is hoped will improve the position overall. Cancer: Pre-covid: 0 – 1 breaches per month Current: still 0 – 1 breaches per month Outpatient waiting list: Pre-covid, this time last year, circa 1900 Current position reported at: 1851 Inpatient waiting list: Pre-covid: 786 on waiting list Current position reported at: 1022 **CYPFHS Services** Significant waiting time in Neurodevelopment and an action plan is in place to address this. Continence service issues continue with current waiting time being reported of 103 weeks. Continual reviews are taking place for all cases and work continues to reduce the waiting times. CAMHS have a WLI in place at present in order to help support the pressures within the service.	
2.5	**Business Continuity Update** There were no items to note for this meeting.	
SAFE CARE		
3.1	**Update on Serious Incidents** The SI report was noted for information. There were no exceptions to note for this meeting.	
3.2	**SI's/RCA's/Closure Forms for noting** **Closure Form (In100656)**	

	Deferred to the next meeting. **RCA & Action Plan AS (In309003)** The background to the case was shared for information. The case related to patient AS which was reported as a maternal death. Some initial issues around WAST response with regards to the delay in getting the patient to hospital. An investigation has been undertaken by WAST and some practices changed following the findings of this case and improvement plans are in place. Root causes were identified: • Delay in ambulance transfer by WAST to hospital, due to wrong prioritisation of call and staff unaware of process to escalate in the event of a clinical concern • Inappropriate management of secondary PPH in an anticoagulated patient • Delay in performing the laparotomy and commencement of the anticoagulation The lessons learnt related to: • WAST delay has been managed and awareness has also been raised with regards to the process to escalate. • Explicit guidelines for the management of secondary PPH have been completed and reflection from the staff involved has been undertaken. • Electronic discharge summary and process for notes of complex cases has been tightened to ensure that information is readily available where required. It was agreed that this could be progressed to closure and assurance requested that the recommendations and lessons learnt are ongoing. **RCA, Action Plan & Timeline NJ (In305448)** Detail of the case was discussed. This case involved a lady who had a complete symphysis pubis diastasis and anterior vaginal wall tear. It was acknowledged that this is a very rare complication and was completely unexpected. The root cause noted that whilst this is a very rare complication, which can occur with both a spontaneous or forceps delivery, it was identified that there was a failure to recognise progress of labour was slow and to recommend a caesarean section. If a caesarean section was performed earlier, this would have prevented the rare and unpredictable complication of pubic symphysis diastasis. Lessons learnt have been shared with regards to documentation and is also being included as part of clinical supervision. **RCA & Action Plan CBVA (In316793)** Detail of the case was discussed. This involved a retained instrument in theatre. Root causes identified; • A stitch at the right uterine angle was not cut off as is routine practice. The instrument went back into abdomen due to exteriorisation and replacement of uterus into abdomen • An instrument, sharps and swab count was conducted "too early" immediately following the closure of the uterus. This is not in line with the Health Board (2018) "Swab Instruments and Sharps Count - Policy and Procedure". • The skin layer was closed despite the instrument count being incorrect. SIM training is being progressed in order to share lessons learnt and look at addressing the culture and processes within theatre. Reflection has been undertaken by both junior and senior clinicians. The report is also being shared via the Maternity Network.	MM/KH
3.3	**To note the minutes of the Extra Ordinary Q&S Meeting – 15th January 2021** The minutes were noted for information.	

3.3	**Infection Prevention Control Update** There was no update to note. CH agreed to follow up outside of this meeting.	CH
3.4	**Safeguarding** • 7 Minute Briefing - Professional curiosity • Child Practice Review (dental decay and neglect) The documents were noted for information and sharing as appropriate.	ALL
3.5	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN 2020 012A - Risk of incorrect results when using SST (gold top) sample tubes for patients on treatment-dose anticoagulants IN SECONDARY CARE ONLY • ISN 2020 011 - T34 syringe driver - battery update • Urgent Field Safety Notice - Tracheostomy Tubes – Kapitex • Recall Notice - CIRRUS2 Nebuliser • CMO Alert - UPDATED GUIDANCE FOR WALES - INVESTIGATION AND MANAGEMENT OF SARS-COV-2 VIRUS NEW VARIANTS OF CONCERN All alerts have been shared widely across all areas within the Clinical Board and it was noted that there were no exceptions to note for this meeting.	
3.6	**NCA Assurance Report – Perinatal Mortality Review** The clinical report audit was shared for information. As part of the audit the following were identified against National guidance: • Reduced fetal monitoring guideline needed to be updated and it was noted that this has been completed. • Aspirin dosage to be increased in line with RCOG (GTG37a) and NICE (CG 107) guidance has been completed. • Screening for gestational diabetes for women with BMI of 30 and over to follow NICE (NG3) guidance. This is currently being completed for BMI of 35 and over at present, and this has been included on our risk register. • Bereavement pathway needs to be updated and work is underway to address this. As part of the audit the following were identified against Local guidance: • Inconsistent routine enquiry screening from booking – work is underway to look to address this. • CO monitoring discontinued due to COVID restrictions – this will be brought back as soon as possible. • No external reviewer present for perinatal mortality review forums – this is being taken to the Neonatal/Maternity Network • Inconsistent Risk and governance and neonatal nursing presence at perinatal mortality review forum. • Staff to be updated regarding criteria for Symphysis fundal measurements in line with perinatal institute guidance. The infographic was shared and has been produced as a summary of Perinatal Mortality Review Forum 2020 and the position against the national average. The current position for C&V is just below the national average. The infographic details the themes highlighted and the actions that have been received. Future work has been identified with regards to: • Fetal surveillance midwife & smoking cessation HCSW recruitment in 2021 • Early Neonatal Deaths, low PAPP-A and SGA babies to be reviewed • External reviewer to be present at every review meeting	

	• Recommendation of compassionate care from Ockenden (2020) to be reviewed and implemented	
INDIVIDUAL CARE		
4.1	**Update on latest 2 minutes of your Time feedback** No exceptions to note for this meeting.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**To note the Medicines Safety Briefing – December 2020** Noted for information and sharing.	
5.2	**To note the Paediatric Medicine Safety Update – December 2020** Noted for information and sharing.	
5.3	**To note the Child Health Safe Medications Practice Group Minutes January 2021** Shared for information and to share good practice that is taking place. This group will be accountable to the CHFW Directorate Quality & Safety governance structure.	
5.4	**To note the PMRT Report** Noted for information.	
5.5	**To note the C & V MBRRACE report 2018** Noted for information	
5.6	**To note the HIW National Feedback Report** The feedback report was shared for information. It was agreed the presentation of the recommendations would be shared at the February Q&S Meeting.	SH
5.7	**To note the Ockenden Review** Noted for information and sharing of recommendations. It was agreed that the action plan will be presented at a future Q&S.	SH/SS
ANY OTHER BUSINESS		
6.1	**Mary Glover Retirement** Congratulations to Mary Glover on her impending retirement. Thanks were expressed to Mary for her significant contribution to the Clinical Board and Directorate quality & safety agenda for children in our care. Karenza Moulton has been appointed to the role of Lead Nurse and will commence in post in February 2021.	
6.2	**Research Project in Health Visiting and impact of COVID on Families** It was noted that this is progressing well through UHB Research & Development department and likely to become an All Wales initiative. Further updates will be provided as this progresses.	
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 23rd February, 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.

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 (H&S Focus)

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 23rd February 2021, 8.30am via Microsoft Teams

PRELIMINARIES		Lead
1.1	**Welcome & Introductions** Cath Heath, Director of Nursing (Chair) Clare Rowntree, Clinical Board Director Suzanne Hardacre, Head of Midwifery, Obstetrics & Gynaecology Directorate Louise Young, Risk Manager, Children Young People & Family Health Services Directorate Matt McCarthy, Patient Safety Advisor Martin Edwards, ACD Quality & Safety Lead, Children's Hospital for Wales Services Directorate Rhodri John, Directorate Manager, Obstetrics & Gynaecology Directorate Becci Ingram, General Manager, Children's Hospital for Wales Services Directorate Karenza Moulton, Lead Nurse, Children's Hospital for Wales Services Directorate Anthony Lewis, Clinical Board Pharmacist Sarah Davies, Risk & Governance Midwife, Obstetrics & Gynaecology Directorate Rose Whittle, General Manager, Children Young People & Family Health Services Directorate **In Attendance** Kirsty Hook, Board Secretary	
1.2	**Apologies for absence** Jane Jones, Angela Jones, Paula Davies, Alison Davies	
1.3	**To note the Minutes of the previous Q&S meeting held on 26th January 2021** The minutes of the meeting held on 26th January 2021 were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 26th January 2021** **RCA LC** Awaiting update from Angela Jones to confirm this is now closed and has been presented at the resuscitation meeting. **PEWS Chart** Working group being set up in conjunction with EU staff. The EU chart is not fit for purpose within the CHFW and work is ongoing to look at a uniformed chart in the longer term that can be implemented across all paediatric areas, however EU have confirmed that they wish to pilot the current chart and further update is awaited on the outcome from EU. Agreed that this will be a rolling agenda item for updates whilst the work continues. Agreed that the PUMA chart is utilised at present within the CHFW to ensure that there is just one single chart until a final one is agreed. **NICU Improvement Plan Newborn Screening** Report is awaited and an action plan is being produced and will be shared at the next meeting. **CAMHS Delivery Unit Report** Feedback has been received from the Delivery Unit, reflections on the changes required are taking place and once the formal report is finalised this will be shared for information.	KM KM PD/RW

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – Talking Heads** Presentation in conjunction with the MSLC to gain women's experiences with Maternity in order to help capture the good practice, and also experiences that could be used to help adapt and changes services, specifically through the COVID19 Pandemic. Partners attendance was the biggest concern that was raised, however there was acknowledgment and understanding as to why this could not happen during the Pandemic. There was a positive impact with regards to the socialisation of the women which was very palpable to experience during this difficult time. Communication was shared through the Maternity Services Facebook page which provided some information videos for women to access. Continuity of carer was highlighted and whilst some benefits were identified, there were a number of lessons that could be learnt from this which is being taken forward. It was acknowledged however that services continued to be provided for all women. Breastfeeding rates increased and further videos have been developed to help support further. Perinatal Mental Health referrals have increased during this time and work is underway to look at how these patients can be further supported going forward. The YouTube link is included below for information and onward sharing. https://youtu.be/uufQrjCfqmY	
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **CHFW Services Directorate** • Staff vaccinations are going well • X1 RCA ongoing RJ, meeting has been arranged to review the report and will be brought back to Q&S next month • Request has been received by patient safety in relation to a previous complaint regarding an extravasation injury on PCCU which has been referred to the Ombudsman. • Request for review of process for patient transfer has been received following an incident in May 2020. This is progressing and is being lead by ME. Work taking place to look at an agreed e referral process through Welsh Clinical Portal. • Risk Register has been updated and top 5 risks have been identified including Neurology Service, Diabetic Pump service, Endoscopy and sleep studies. • 18 medication errors incidents have been identified and the themes identified – work is being taken forward to look at how this can be addressed going forward. TTH and discharge specifically is being reviewed in order to ensure that there is a robust and uniformed approach across the CHFW • Nurse staffing triangulation process has commenced and significant work is being taken forward to ensure that the workforce is robust. This will be presented to the Board when complete. • Continence service across tertiary and secondary care work is being taken forward • Cleft palate surgery is being implemented from 5th March 2021 on a Saturday and Sunday. This will be regularly monitored. • Noah's Ark post on Facebook – this has been reviewed and an SOP is being developed to ensure that the correct processes are followed prior to information being uploaded to social media sites in the future. • Access to PARIS is being increased across the CHFW • 6 formal complaints, patient waiting times and follow up is the main theme. • Phenobarbital RCA is being taken forward by PCIC and an action plan is being developed within Paediatrics with regards to standard strength for this medicine. **O&G Directorate**	

- Staff vaccinations are going well
- Secured funding from Public Health Wales for midwives to commence the tongue tied course which is hoped will help aid the continuation of breast feeding.
- 10 ongoing RCAs and x3 timelines which are progressing.
- Top 5 risks have been identified within the Directorate, there is a significant ongoing risk with regards to the lifts within Maternity Services and this has been further escalated with the Estates Department.
- X2 reported pressure damage within Gynaecology
- Babies don't Bounce audit has been completed and further audit will take place in March 2021. Reiteration to all staff has been shared as part of the safety briefing with regards to the importance of completing the tool.
- SOP completed to address issues within the community of Covid19 safety. This will be shared at the next MPF for ratification.
- T2 to be reverted back to a non covid area elective area and work is ongoing with IPC in order to manage this appropriately.
- POCT Covid training is under review at present due to erroneous conflicting results with swabs. Further updated is awaited.
- Increase in patients birthing outside of guidance is being seen across the service. A monitoring system is in place to discuss each case and those requesting home birth will be seen in a new clinic.
- X10 additional PANDA resuscitaires purchased in order to standardise resuscitation equipment.
- Guidelines have been reviewed and are all now accessible on the Clinical Portal
- Think Tank exploring instrumental deliveries is being arranged
- Induction of Labour working group has been set up. Some provisional discussions looking at how we can open up the criteria for the out-patient induction service which is evaluating extremely well from the women
- Two new research midwives have now started working with the team
- The Core Research Team were featured in the Clinical Audit Heroes Clinical Audit Awareness Week newsletter.
- Hello my name is badges have been implemented across Gynaecology.
- RCA process patient information leaflet being developed for women and their families to explain process and timeframe
- Number of compliments received in month.
- Concerns themes identified with regards to attitude of staff and behaviour within clinical areas. This is being reviewed. Appointment/surgery dates continues to be an ongoing theme.

CYPFHS Directorate

- Staff from CYPFHS are supporting the mass vaccination programme which is ongoing. Relevant CYPFHS staff are accessing their vaccinations via the UHB system as appropriate.
- CYPFHS continues to be at risk in regard to PCIC immunisation posts and HV's /SHN's being attracted, now advertising Band 6 substantive posts.
- HV and other service IT Issues continue. Work is being taken forward with regards to the roll out of agile working within community nursing. Additional capital funding received to purchase kit for the community nurses to enable the mobile working.
- CAMHS Concerns Clinics are being developed in order to help address some of the concerns being raised across the service.
- New medicine guideline being developed for nurse transcribing in special schools.
- Succession planning for Directorate Pharmacist is ongoing
- CYP on wards at Hafan y Coed due to lack of suitable beds for 16 - 18 requiring admission, continue to be an issue. Regularly discussed at CB and Executive level and at the relevant MDT meetings.
- Changes to CAMHS OOH services is progressing.
- Palliative Care capacity – lack of resourced integrated pathway for CYP, resultant difficulty in delivering safe care where choice is to be cared for and die at home

	• CCNS capacity continues to be an issue to meet statutory requirements to deliver care packages. • Hep A RCA – once RCA is complete this will be shared at a future Q&S Meeting • Fracture RCA – discussed as part of extra ordinary meeting held on 19th February and has been closed. • Medicines management meetings are in place and new medication guidance has been produced for Special Schools. Once finalised the guidance will be shared for information. • LAC notification process has been reviewed and staffing within the team is being changed to better support. • Safeguarding supervision for the CCNS Team is being reviewed. • Record keeping in CAMHS, highlighted as part of the Delivery Unit report is being addressed and training has been provided in order to ensure that a robust process is in place and the service has also transitioned to the PARIS system. • SL Case – pre-inquest review due to be held this month. On-going CPR in conjunction with neighbouring Health Board. Staff being supported by Legal Team via Patient Safety.	
2.3	Exception Reporting / New Risks to be considered for the Clinical Board Risk Register Discussed as part of item 2.2. Work is continuing with regards to the Directorates and Clinical Board risk register and once finalised the Clinical Board register will be shared at a future meeting for noting.	
2.4	Long Waiting Patients Update CHFW Paeds Surgery – additional lists have been increased to 10.5 sessions per week (pre covid was 24) which is a significant increase compared to the beginning of the year. Over 52-week waits are continually reviewed by the Paediatric Surgeons and clinical priority amended where necessary. Additional outpatient echo scanning clinics are being implemented in order to help manage the backlog of patients, commissioned by WHSSC. Endoscopy is a significant issue within Paediatrics due to current capacity levels. This is jointly managed across Paediatrics and Surgery and further meetings are taking place to discuss the best way forward. Paediatric MRI – work is being taken forward with Radiology in order to look at the potential of increasing the MRI capacity where possible. O&G Directorate USC Cancer – 0-5breaches being reported per month with no increase from Pre Covid rate Theatres update UHL week 1 & 3 all day theatre recommencing from 18th March – 2 sessions UHW SSSU every week all day theatre recommencing from 19th March – 2 sessions Once the sessions above are in place - Gynae onc – 6.5 sessions per week Benign Gynae – 6 sessions per week Total: 12.5 (gap: 7.5, compared with 20 sessions pre-covid) • Spire contract is ending at the end of March – Kate is in contact with Surgery CB exploring utilising St Jo's one day per week from April – awaiting a reply from Karen, Simon or Denis regarding this.	

	• Directorate have enquired with finance as to whether outsourcing STOP procedures can continue beyond the end of March – If this is not approved Benign Gynae capacity will be reduced due to Gynae Onc utilising a session of UHL Thursday for Colposcopy work. CYPFHS Directorate • ND waiting times continue to be an issue both in eDatix reporting and Concerns, plan in place to address wait list. • Continence service waiting times remain an issue. Work continues to monitor and work towards a more robust resolution. • Difficulties in accessing a Tier 4 bed. WHSSC and inpatient team gatekeeping referrals and monitoring. • CAMHS waiting lists for both assessment and intervention are high – plans for support with early intervention models from this month to help. High numbers of Concerns. It was noted that a more comprehensive report will be provided going forward.	
2.5	Business Continuity Update No issues to note.	
SAFE CARE		
3.1	Update on Serious Incidents The report was shared for information. X1 new SI reported since the last meeting and is under investigation. Reporting has recovered as activity has increased and a gradual increase is now being seen. It was acknowledged that there is a good reporting culture across all Directorates. The eDatix system is being replaced on an All Wales basis. The incident module will be replaced and this will take place sometime in the Spring 2021, date to be confirmed and this will be circulated for information. Where possible, any incidents on the current system should be reviewed to see what can be completed and closed in order to help transition to the new system.	ALL
3.2	SI's/RCA's/Closure Forms for noting Closure Form (In100656) Noted for information and sharing of lessons learnt. There were no exceptions to note. RCA Report – AT (Datix Ref 299506) Noted for information. The detail was discussed as part of the extra ordinary held on 19th February 2021. It was agreed that the minutes, once finalised will be shared for information. There were no specific exceptions to note for this meeting and it was agreed that the RCA could be closed as all necessary actions are being taken forward/completed. RCA Report – LC (Datix Ref 314998) Noted for information. The detail was discussed as part of the extra ordinary held on 19th February 2021 as noted above. There were no specific exceptions to note for this meeting and it was agreed that the RCA could be closed as all necessary actions are being taken forward/completed. SBAR - SM (Datix Ref 303468) Noted for information. This case was related to an unexpected neonatal admission, it was identified at clinical risk that the woman was not booked for induction at term for maternal age. Booked for MLC care for labour. The case was considered a near miss in view of the increased risk of still birth with advanced age in pregnancy. A detailed timeline was therefore recommended to better understand how. The recommendations were noted and it was acknowledged that there was no recurring theme and that all necessary actions had been completed.	KH

	Fetal Medicine Management Report – KR Out of area patient and was referred for fetal medicine support. This was discussed and reviewed as part of the perinatal mortality review process. There were no care issues identified as part of the labour, and on further review the complexities could not have been identified antenatally. The report has been shared with the family and a further meeting is being arranged to address the further concerns raised.	
3.3	**Learning from Events – CN/UHW/3598 Patient PD** The learning from events was shared for information and sharing of learning. The case relates to the events leading unfortunately to a neonatal death in 2014. It was alleged that the treatment of the claimant was negligent and that there was a failure to expedite the delivery of the baby after CTG monitoring. A thorough investigation was undertaken and the expert findings were reported as a failure to interpret and act upon CTG reading in a timely manner (Montgomery findings were applied). Evidence of learning has been provided and assurance has been provided that the training is still on track. A comprehensive plan was developed with regards to CTG monitoring and escalation of process. More work is required with regards to antenatal learning and this is currently being reviewed to address.	
3.4	**Infection Prevention Control Update** Discussions are taking place with regards to representation at meetings going forward. There have been a number of MRSA and MSSA cases reported and work will be taken forward in relation to this. **HCAI Performance Report – January 2021** The report was noted for information.	
3.5	**Safeguarding** **Safety Planning – Patient HS** Incident where a mum was prevented from taking baby home – SPR for phototherapy. Mum has a complex history and unfortunately the situation escalated through a safeguarding process, however on reflection all cases should be individually reviewed. A working group is being developed to implement some safeguarding plans in order to ensure that the best approach is taken. **Child Practice Review Report – C&VRSB 2/2018** The report was shared for information. As part of the report it highlights missed appointments for a child that was not known to the system early on and concerns were raised that read only access is available within hospital, which would not capture the missed hospital appointments. It was noted that community staff can access Welsh Clinical Portal so this should cover any inpatient cover. The following reports were shared for information and onward dissemination as appropriate. There were no specific exceptions to note for the Clinical Board. • Protocol for the Resolution of Professional Differences • Wales Safeguarding Procedures Newsletter – Autumn 2020 • SBAR re: Modern Slavery • Emergency and Acute Medicine Adolescent Safeguarding Update	
3.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • 2021 Feb 004 Community Blood Sampling • ISN 2021 Feb 002 PPE Changes • ISN 2021 001 – Copan Swabs Contamination Risk	

	• Message from Welsh Government - INVESTIGATION AND MANAGEMENT OF SARS-COV-2 VIRUS NEW VARIANTS OF CONCERN • ISN 2021 Feb 006 – Nasogastric Tubes All alerts have been shared and all appropriate actions undertaken. There were no specific exceptions to note.	
3.7	HIW Report & Response to Recommendations Include detail from the presentation. Following the national review, a report was provided and a series of recommendations were received. An action plan has been developed to provide the current position against the recommendations. The formal response will be provided to HIW, and all were asked to review and provide any further comments.	
3.8	SaTH (Ockenden) Report & Response to recommendations The recommendations to the SaTH report have been completed and all were asked to review and provide any comments prior to the response being submitted.	ALL
3.9	PROMPT Assurance The report was shared for information. Assurance has been provided to the report. Attendance at training was highlighted as part of the recommendations, some of which was as a result of required changes through the COVID 19 Pandemic.	
INDIVIDUAL CARE		
4.1	Update on latest 2 minutes of your Time feedback SH agreed to follow up with Angela Hughes with regards to availability of updates.	SH
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	To note the Medicines Safety Briefing – February 2021 Noted for information. All were asked to provide any feedback	ALL
5.2	To note the Paediatric Medicine Safety Update – January 2021 Noted for information.	
5.3	Management of Incident Queues ahead of implementation of RLDatix Discussed as part of item 3.1	
5.4	To note The Welsh Gender Service Presentation Noted for information.	
ANY OTHER BUSINESS		
6.1	Routine COVID Swabbing Maternity have been included as part of this process, however it was noted that at present Paediatrics are not included. Guidance has been received on the staff and priority areas that are being tested and further roll out will take place at a later date.	
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for Tuesday 23rd March (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.

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

Minutes
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 20th November 2020
Skype Meeting

Attendees:

Claire Main (CM), Interim Director of Nursing (Chair)
Hywel Roberts (HR), Critical Care Consultant and Medical QSE lead
Colin Gibson (CG), REU/ALAS
Suzie Chessman (SC), Patient Safety Facilitator
Tessa Northmore (TN), Senior Nurse, Neurosciences
Sian Williams (SW), Interim Lead Nurse, Cardiothoracics
Richard Parry (RP), QSE Facilitator
Khalid Hamandi (KH), Consultant Neurologist
Lisa Higginson (LH), Lead Nurse, N&T
Hywel Pullen (HP), Head of Finance and Assistant Director of Finance
Ceri Phillips (CP), Lead Nurse, Cardiothoracics
Carol Evans (CE), Assistant Director Patient Safety and Quality
Kevin Nicholls (KN), Service Manager, Cardiothoracics
Nick Gidman (NG), Directorate Manager, Cardiothoracics
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology and Metabolic Medicine
Matt Wise (MW), Clinical Director, Critical Care
Anne Marie Morgan (AMM), Directorate Manager, Haematology, Immunology and Metabolic Medicine
Tom Hughes (TH), Clinical Director, Neurology
Vinod Ravindran (VR), Consultant Nephrologist

Present:

Gemma Williams (GW), PA for the Specialist Clinical Board (Note taker)
Nia Williams (NW), Critical Care
Caroline Burford (CBur), Consultant, Critical Care
Sarah Doherty (SD), Clinical Nurse Specialist, Bone Marrow Transplant Unit

PART 1: PRELIMINARIES		**ACTION**
1.1	Welcome & Introductions	
1.2	Apologies for absence Gareth Jenkins, Clare Mahoney, Steve Gage, Chris Williams, Guy Blackshaw, Cath Wood and Keith Wilson.	
1.3	To review the Minutes of the previous meeting 30th October 2020 The minutes were agreed as an accurate record, subject to Suzie Cheesman and Keith Wilson to be added to the apologies list. HR requested that it was noted in the minutes that there were IT issues so some people struggled to log on and dipped in and out of the meeting. Matters Arising	**GW** **GW**

	Item 1.3 • GW has amended the previous minutes (page 2) to note a backlog of "IP&C" RCAs and not RCAs in general. • CM to circulate the Clinical Board HCAI action plan. Richard Parry is on leave so will aim to meet up next week with him and Clare Mahoney. CM will then hand over to Mary Harness who has agreed to take the Clinical Board HCAI meetings forward. • GW circulated the UHB QSE Minutes from Suzie Chessman for April, September and the Annual October minutes. • Change to routine screening in renal – on the agenda to be discussed. • Critical Care MSSA – increased bacteraemia infections. Work sat with estates. CM will pick this up outside of the meeting. • Documentation audit – GW has received some of the summaries of findings and will follow up on the outstanding areas. • As above – GW has circulated the UHB QSE minutes from April, September and October Annual Minutes. Item 1.4 • Attend Anywhere presentation – GW circulated the information on the evaluation lead to the group. Item 2.1 • In101282 MB – Cardiac waiting list death. Due to the significance of the case the closure form required further review after the last meeting. CM met with CE to discuss the wider implications. CE made some amendments to the form and SC has sent it to everyone. KN will catch up with CP to discuss and finalise it today. Item 2.3 • In122276 Closure Form – cardiology fall. Re-iterated that Directorates needed to take this message back to their areas re the need to take standing and sitting observations. • CM noted that there was a Closure Form relating to Neuro that wasn't discussed but has been closed – on the agenda to be discussed.	**CM** **GW** **KN**
PART 2: SAFE CARE		
2.1	<u>Open Serious Incidents</u> SC updated the group. 8 open SIs at the moment. 5 overdue, 3 due in December, 1 in January and 1 in February. 2 new SIs reported this month – both relate to outbreaks on B1 and B5.	
2.2	<u>Alerts/Patient Safety Notices</u> <u>ISN: 2019/003</u> This safety notice relates to Resuscitation Trolleys – it has become apparent during formal inspections of clinical areas that the formal checking of the contents and operational functionality of Resuscitation Trolleys is not being undertaken within the correct timescales as specified. CM requested that the alert is circulated widely if not already and that appropriate measures are in place. HR noted that there is a group in Critical Care working on this (as well as working on stocking which came from another email). HR noted that defib checking is very robust and that they need to ensure that the checking of the equipment is as robust. All in hand for Critical Care. All the other Directorates confirmed that it had been circulated and appropriate action has been taken. <u>PSN 055 Oct 2020</u> This safety notice relates to the Safe Storage of Medicines: Cupboards. Medicines	

	need to be located appropriately and bed side lockers must be secure. No issues raised so assumed all in place. PSN 056 Oct 2020 Foreign body aspiration during intubation, advanced airway management or ventilation. CM noted that this particularly relates to Critical Care and that it has been circulated within the Directorate. HR has spoken to Ian Sidney, Stock Controller who thinks that the caps are too large to be a concern – the issue highlighted on the notice relates to a small cap which may find its way into the breathing circuit. The other concern is around ECG stickers which again are too large to be a concern. This notice will be taken to the Critical Care QSE meeting to be discussed further – are there any amendments needed in relation to customs/behaviours. Another one of the required actions is not an issue as all the airway equipment is already wrapped in plastic. CM requested an update on actions at the next meeting. BO informed the group that she had shared the notice within Cardiac ITU and that John Hall the Clinical Lead was aware and looking into it - similar to Critical Care. ISN 2020 / Nov / 010 Wrong route administration of a controlled drug. There have been a couple of incidents where drugs have been administered through the wrong route. Everyone needs to be up to date on what is required. The notice has been disseminated to DMTs to share previously.	**HR/BO** **Dirs**
2.3	Closure Forms IN103031 – relates to a patient in Critical Care and issues with the haemofilter functioning. The patient sadly passed away. The action at the last meeting was to review the form and make some small changes. The action plan needed to be timely given the length of time between the event and improvement plan. SC sent the form to BO and Judith Burnett in order for them to add some actions. CE noted that she has looked at the improvement plan but was slightly anxious to send it to WG – it may get challenged as to why it has taken so long to take some of the actions. There may be some actions that were taken at the time that can be added into the form. Judith Burnett noted that she hasn't as yet had chance to look at it but will update it as soon as possible. Need to change it to an updated action plan. In106895 (sent out just ahead of the meeting and not embedded in agenda) - TN fed back re this neuro closure form. The incident relates to a man who was admitted to hospital for a spinal cord stimulator and it was not identified that he had raised blood sugars whilst in hospital and it was another 18 months/2 years before the GP identified that the patient was diabetic under routine testing. The patient feels that things may have been different if he had known about it earlier. SC noted that the improvement plan notes a number of actions taken which were discussed with the group. The case has also been discussed at the Neuro Directorate QSE meeting with all of the junior doctors. Outstanding blood results must be handed over. There is also now a regular audit programme and the issue will form part of the junior doctors induction programme. A system change to the clinical IT system has also provided an alert to test requester which wasn't in place at the time. Clinical teams to engage with lab colleagues to ensure investigation request reviewed in timely fashion. Part of the new process in neuro is that the Nurse Practitioner is now in place to check all blood results. The Concerns team have shared the report with the patient – no feedback as yet. CM asked that the group is updated as and when. Quite a few learnings for all.	**JB** **TN/SC**
2.4	Outcome of QPIDS inspection JP fed back. Haematology were inspected back in October and were denied their accreditation at the time due to improvements needed. Two of the main requirements were that Haematology needed to find an estate to deliver infusions	

	and staffing levels below what they should be. In July they were given their accreditation as they are now satisfied that the appropriate work has taken place. Able to get facilities to delivery our infusions safely and also had an uplift with staffing on the back of the WHSSC business case. CM congratulated the team and acknowledged their significant hard work.	
2.5	<u>Covid Risk Assessment for Inpatient Admission</u> MH presented to the group. In a recent Haematology HCAI meeting, infection control noted that they should be isolating all unplanned admission patients. JP noted that if they were to isolate every patient they wouldn't be able to have any activity at all as they only have 2 isolation cubicles. In order to mitigate this, every patient will be risk assessed. This won't be 100% accurate every time but if they have made a decision it can used to provide justification for the decision made. The document has been brought to this meeting to hopefully have it signed off for use. The document will mean they can continue business as usual. CM noted that it looks very comprehensive. The document was created with infection control and microbiology. If agreed will start a training programme and implement it. No issues raised therefore the document was signed off. HR asked what the hospital position was with regards to screening. It was noted that A&E have tried to screen everyone coming in but that there are purple areas while they have to wait for swabs to come back. HR noted that his personal view is that every admission to hospital should be screened for covid and have a swab at the front door. SW confirmed that all patients are swabbed as they come in but the problem is they don't wait for swab to come back before the patient is moved around. CG raised concern with regards to the use of forehead thermometry as it is not reliable if used in a particular way and this could cause a false assurance issue. MH noted that Haematology were using the forehead thermometry. It was agreed that a swab test was best. CM noted that there were a number of processes in place to protect staff and patients as much as possible. HR asked if the rapid results tests would be available to use that some other Health Boards have been using. CM noted that there are a limited number because of the platform used to process them. It was agreed that the rapid tests would be beneficial - would need around 1,000 a day. CM informed the group that discussions had been taking place at exec level. CM will escalate the request next week. CP agreed that their use would be really beneficial – need to get patients appropriately in the right place and there has been massive impacts from closed beds. Specking up the labs is an issue but CM will get an update and feedback.	**CM**
2.6	Healthcare Associated Infections • Specialist HCAI report • HCAI review to end of October • Change to routine screening in renal – meeting with microbiology – update (as per 30th Oct minutes) • Flu update CM updated the group (CMah not available). There have been a number of outbreaks within the hospital. CP provided an update on the covid outbreak on B1. 3 positive patients, 2 sad deaths and 14 positive staff so really challenging over the last 3 weeks. B1 has been closed and they had to open additional capacity elsewhere. Everyone has worked really hard. Things have progressed well in the last week so more positive. All of the north side is now open. Review on Monday re the south side. There is a clear escalation plan if they need to open some beds on the north side. Hoping early next week that B1 will be back open.	

	LH provided an update on the B5 outbreak in renal. There has been 3 deaths which has affected staff. Working with employee wellbeing. Opening up for emergency dialysis for specific cases to make renal services still run. On the A4 Polytrauma unit there are 2 positive patients and 5 staff members as well. A full screening programme has taken place. As it is a multi-professional ward that has daily MDTs it is a high traffic area and there have been difficulties with regards to tracking and therefore A4 remains closed. Waiting for results but working though as quickly as possible. MT service still running – currently going back to their specialty area as PT unit closed. Outreach practitioners have been supporting closely. There has also been outbreaks in the Helen Durham unit on T4 and ward 7 in Rookwood. TN updated the group. In the MS unit there has been 8 staff positive. 15 were in isolation due to a regional meeting that they weren't aware of. In Rookwood 1 patient is a low positive. No further outbreaks since. No cases in Rookwood. T4 has 1 patient outlier. CM noted that there were a number of issues to manage. Directorates to reinforce appropriate hand washing and PPE etc. Also issues with klebsiella patients in Rookwood and there is a meeting later to discuss. Increased pseudomonas in Haematology – this will be observed as no further cases. TN to invite SC to the Klebsiella meeting and send her the link. Number of cases of ecoli which seems to be an ongoing pattern. <u>Change to routine screening in renal</u> VR provided an update on progress. Matt Davies has circulated an email to all dialysis leads in the unit in relation to 5 day eradication therapy. Instead of swabbing patients with Button holing techniques they are advising 5 days of this therapy and skin wash. The rationale for this is for the patient's safety - better to give washes and eradication. Every dialysis unit is doing something different so this change means one process. Trying to co-ordinate with renal pharmacists that would be eligible and patient issues appropriate DW10s for therapy. CM felt that this was a positive change in standardising practice and reducing infections. The new practice has come into place and the dialysis leads need to submit the list of patients. CM requested that this is brought back in 2 months to the meeting to see how the roll out is going. <u>Flu update</u> MH updated the group. Specialist is currently the top Clinical Board in the UHB with 72.6% of staff vaccinated. Only need another 38 staff to hit the 75% target. As an organisation we are at 58.6% of staff vaccinated. The Welsh Assembly target is 75%. The Specialist Clinical Board is helping other Clinical Boards out with vaccinating staff.	**Dirs** **TN** **GW**
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	<u>Feedback from UHB QSE Committee</u> SC noted that the April, September and Annual October UHB QSE Committee minutes had been circulated. The minutes are now available on the internet instead of the intranet. Corporate Governance is in a transition period. SC advised the group to read the minutes – if anything needs to be highlighted in our Specialist meeting let her know.	**Dirs**

3.2	<u>Update from the CAVUHB Mortality Review Group</u> HR introduced Dr Caroline Burford (CBur) as our Specialist rep on this group. CBur updated the group. As of April next year all deaths will be reviewed by medical examiners. One big focus of this Mortality Review Group is how this will work logistically. CBur wanted to warn everyone early as to the associated impacts of this on death certification being released to the families. The Medical examiners will not be on site, but located in a warehouse outside of Newport so all patient notes need to be sent to the examiners to be reviewed. There are a number of them working on the reviews. The process of copying the notes will take time. The turnaround time is 24-48 hrs to getting the final decision out. If the death is on a Friday and no one is in the bereavement office to copy the notes then there will be a delay until the Monday. From a family perspective having to register the death in 5 days will be tricky. The second impact will be on cultural deaths and prompt burials. Need to start setting expectations for families. There is no way of getting the patients paperwork over the weekends. Jason Shannon has said that cultural deaths can be highlighted to the bereavement office so that they will be at the top of the pile. In relation to the stage 1 mortality reviews, JW there will still be an obligation to complete these even after the ME process begins. No legal enforcement to do stage 2 review but that the ME may recommend this as an outcome of their case review. Each department to think about the process they will have to review these deaths. It was agreed that poor electronic note access has made it harder for us. Directorates to let CBur know what processes Directorates have in place. Keen to get more senior trainees involved and to see if these roles may be something they are able to take on. Understanding the governance processes is really useful and the timeliness of review processes. In relation to the Stage 2 reviews themselves it was noted that Raj Krishnan, Corporate Government Officer, has a few things to still address. No timescale set for stage 2 reviews but the feeling is that we will be looking at a standard of 30 working days. Looking at processes internally to improve compliance. VR noted that some direction was needed. CBur noted that in Critical Care they feed stage 2 learning back to their Q&S meeting each month. It's a regular agenda item for those meetings. However it is something that the board has recognised that there is so much disparity across the departments. Any reviews get uploaded on the Critical Care folder on the S drive. Directorate actions are to understand the processes and provide updates as things progress.	**Dirs** **Dirs**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Capacity Issues in Critical Care</u> HR raised concern re capacity issues in Critical Care. Not able to maintain 1-1 working or level 3 patients. CM noted that this was discussed in the Critical Care Performance review yesterday. Craig Spencer is working on an escalation policy which will highlight these issues every day and the risks associated with it. JB noted that it has been escalated at the daily Critical Care Network meetings. Critical Care are not able to staff the unit within current guidelines. <u>Covid Risks</u> CG asked if there was a separate risk register for covid risks. The only ones escalated formally are 20 and above. CM noted that if specific covid issues need to be raised then to do so. RP will pick this up next week and make sure that the risks keep coming through along with any covid specific issues. CM important to share the learning as well. Pick up as an action to take forward. <u>QSE Terms of Reference (TOR)</u> CG requested a copy of the TOR for this group. CM will look into this for CG and sent to him.	**RP** **Dirs** **CM**

	Epilepsy Surgery and EEG Monitoring TH raised an issue with regards to epilepsy surgery and EEG monitoring of patients for diagnostic purposes or in preparation for surgery. This potentially part of the issues with access to C4 where the service would have sat. AMM noted that there was a Clinical Board meeting regarding the use of C4 coming up so will feed back after that meeting Cardiac Services NG raised concern that cardiac has lost the pacing theatre which is a significant risk to specific patients. They are also a high risk group of patients. Need to find a way of getting that back or somewhere else. CM will pick this up in the Cardiac Directorate Performance Review later on today and the directorate will then feedback to this meeting.	**AMM** **NG**
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Medicines Safety Briefing – Nov 2020 (previously circulated 13/11/20) SC highlighted to the group that there is information about discharge advice letters on the newsletter to ensure that they are completed correctly. There has been some issues with a change in medication and people not ticking the change on the discharge advice letter. One patient had the wrong GP listed on their letter for 18 months. Need to make sure that the correct GP is on the admission information – Directorates to pick this up in their areas. CB noted a big issue whereby when patients leave Critical Care their responsible consultant is not being changed. The patient is often discharged under the intensivist which causes significant issues. This needs to be picked up with Medicine and Haematology. CM will follow this up.	**Dirs** **CM**
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business	
PART 6: DATE OF NEXT MEETING		
6.1	Fri 11th December 2020, 8-9am, Venue to be confirmed.	

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

MINUTES OF THE MEETING HELD ON 9TH DECEMBER 2020

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Meriel Jenney	Clinical Board Director
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
Emma Cooke	Head of Physiotherapy
Bolette Jones	Head of Media Resources
Lesley Harris	Professional Head of Radiography UHL
Rhiannon Williams	Dietetics (for Judyth Jenkins)
Edward Chapman	Clinical Engineering
Mathew King	Head of Service, Podiatry
Robert Bracchi	Medical Advisor to AWTTC
Nigel Roberts	Laboratory Service Manager, Biochemistry
Suzie Cheesman	Patient Safety Facilitator
Saul Harris	Clinical Engineering
Paul Williams	Clinical Scientist, Medical Physics
Timothy Banner	Head of Patient Services, Pharmacy

Apologies:

Matthew Temby	Clinical Board Director of Operations
Jo Fleming	Quality and Safety Lead, Radiology
Scott Gable	Laboratory Service Manager, Cellular Pathology
Maria Jones	Sister, Outpatients
Nia Came	Head of Adult Speech and Language Therapy
Anthony Powell	Medical Devices Safety Officer, Clinical Engineering
Judyth Jenkins	Head of Dietetics
Seetal Sall	Point of Care Testing Manager
Louise Long	Public Health Wales Microbiology
Jamie Williams	Radiology

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 20/415 Welcome and Introductions

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

CDTQSE 20/416 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 20/417 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 11th November 2020 were **APPROVED.**

CDTQSE 20/418 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

As the Clinical Board Health and Safety Adviser is still on secondment, Sue Bailey will consider how to escalate the issues that have been raised relating to the Contractors Policy.

Action: Sue Bailey

CDTQSE 20/137 Risk Registers

Risk register returns are outstanding from Pharmacy, Haematology and Speech and Language Therapy.

Action: Alun Roderick/Tim Banner/Nia Came

CDTQSE 20/335 Diagnostic Images

Matt Temby and Sue Bailey will discuss with Meriel Jenney how to review consent issues and review of diagnostic images outside of Radiology.

Action: Sue Bailey/Meriel Jenney/Matt Temby

CDTQSE 20/339 Podiatry Accommodation

Mathew King and Matt Temby to discuss requests from the CHC relating to when Podiatry rooms in the Vale will reopen.

Action: Matt Temby/Mathew King

CDTQSE 20/377 Rolling Programme for Patient Stories

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

Action: Sue Bailey

CDTQSE 20/382 Mental Health First Aid training

The Clinical Board is awaiting for an appropriate time for when staff can be released staff to undertake the training.

CDTQSE 20/393 Capital Bids/ T34 Syringe Drivers

End of year capital funding is available for items for medical equipment over £5k. Clive Morgan is requesting that Clinical Boards create a top 3 priority list for medical equipment bids and submit to him by Monday. Directorates to send bids to Sue Bailey and the Clinical Board will then review and submit a priority list to Clive Morgan. A smaller amount of funding is also available for medical equipment items costing under £5k.

Action: Directorates

It was noted that a replacement bid for T34 syringe drivers is being submitted as part of the capital equipment bidding process.

CDTQSE 20/400 Estates Environmental Audits

Speech and Language Therapy has volunteered to participate. Any other volunteers to contact Sue Bailey.

CDTQSE 20/401 Job Description for R&D Lead

The job description is being finalised.

Action: Meriel Jenney/Matt Temby

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 20/419 Patient Story

No story was presented at today's meeting.

CDTQSE 20/420 Feedback from UHB QSE Committee

The minutes of the meeting held on 13th October 2020 are not yet available.

CDTQSE 20/421 Health and Care Standards

The self-assessment process is currently stood down.

CDTQSE 20/422 Risk Register

AWTTC Spira System

Robert Bracchi presented a paper. WAPSU uses Tableau, a visual dashboard system for reporting purposes, which is hosted on Public Health Wales' Enterprise

Tableau Server. Separate datasets held locally at Cardiff and Vale and Betsi Cadwaladr Health Boards are fed into a series of dashboards, which are collectively called SPIRA.

Due to the absence of a shared data repository, it's not possible to share/ collaborate on data processing duties between Cardiff & Vale and Betsi Cadwaladr Health Boards, which is major risk, particularly when one of the two data analysts are on annual leave or sick.

WAPSU has a long standing SLA with Public Health Wales for provision of access to and publishing of data via Public Health Wales' Enterprise Tableau Server. The SLA is in place until March 2022. Public Health Wales has been asked by Tableau to review its licencing model, as the current model does not allow separate entities to publish data on the same server and therefore they may move to another provider. This would result in AWTTC having to identify another package which will be costly.

The best possible solution for the data architectural needs of WAPSU is a single hosted SQL database within a managed data centre, which can be accessed by analytical staff from different locations in Wales. Ideally the data centre would sit within the NHS Wales network and be managed in a way that acknowledges the national remit of AWTTC. Assurance of the longevity of the PHW Enterprise Tableau Server and its associated licence agreement for AWTTC is needed.

AWTTC Review of IT Services

The All Wales Therapeutics and Toxicology Centre (AWTTC) is also seeking advice and guidance in relation to IT services, in particular those not currently supported by Cardiff and Vale UHB. It is seeking clarification on the current and planned IT support offered by Cardiff and Vale UHB to enable the delivery and potential expansion of the AWTTC work programme. Sue Bailey will submit the paper to the Clinical Board Formal Board Meeting for discussion.

Action: Sue Bailey

CDTQSE 20/423 Exception Report

Emma Cooke reported that the Physiotherapy department at UHW is still being held as a potential ward area however it is not in the UHB plans for opening. The Physiotherapy service has a need for the space to be operational again for patient care. She is also concerned that other services are looking to utilise the department as office space. Sue Bailey will ask the Local Coordination Centre for an update and request to reclaim the space. It was acknowledged that there is potential in an extreme position that this space may be need to be utilised as a ward area.

Action: Sue Bailey

Mathew King advised that the service Partnership between Podiatry and Cardiff Met has been temporarily withdrawn due to capacity issues in Podiatry.

It was noted that professional groups within this Clinical Board are disappointed with the lack of communication from the Health Board relating to the appointments process for the Covid vaccine and there are concerns that staff at the highest risk level are not being prioritised to receive the vaccine. Communication is being issued today that all staff working in priority areas will get vaccinated over the next few weeks. Each department to send Sue Bailey the names of their priority staff.

Action: Directorates

Staff within the Emergency Unit and Covid wards as their main area of work are deemed the priority for the first round. It was noted that some staff who are not a priority have received the number of the appointment line and have booked appointments. These appointments are not being cancelled. It was noted that further communication will be circulated asking those staff to reflect on whether it is appropriate for them to receive the vaccine and consider giving up their appointment slot. Individuals who have received a positive test result should still receive the vaccination but must leave a 28 day gap. Staff need to be informed that the booking lines are very busy and there may be a wait before getting through.

Sion O'Keefe reported that the Health Records department has been affected by Covid in the last 2 weeks. An IPC plan was put in place and the situation is being monitored. One section has been wholly affected and will impact on subject access requests.

There has also been two confirmed cases in Radiology UHW which has impacted on staffing as a consequence with a number of staff awaiting testing or self-isolating. The department is taking the learning from the Health Records department to develop an action plan.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 20/424 Initiatives to Promote Health and Wellbeing of Patients and Staff

Sue Bailey was pleased to report that the Clinical Board has exceeded the 75% target of uptake of the flu vaccination by frontline staff.

SAFE CARE

CDT QSE 20/425 Concerns and Compliments Report

In November 2020 the Clinical Board reported an Amber/Green status. It received 13 concerns and 5 compliments. 31% of the concerns were resolved within early resolution timeframes and there were 0 breaches in response times.

Overall departments reported good performance with responses to concerns. Areas to highlight in terms of good concerns management are Physiotherapy which

received 1 concern which it resolved informally and the department also received 2 compliments. Dietetics received 0 concerns and received 1 compliment.

CDTQSE 20/426 Ombudsman Reports

Nothing to report.

CDTQSE 20/427 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 20/428 Patient Safety Incidents

SI Report

The Clinical Board currently has 2 open SIs:

In122136 - case in cardiac theatre. Lesley Harris has undertaken the RCA which is being finalised.

In82274 - incident involving a choking episode. The RCA is complete and will be shared with clinical areas involved to request their support for the improvement plan.

CDTQSE 20/429 New SI's

There were no new incidents to report.

CDTQSE 20/430 RCA/Improvement Plans

Nothing to report.

CDTQSE 20/431 WG Closure Forms – Sign Off

There were no closure forms requiring sign off.

CDTQSE 20/432 Regulation 28 Reports

Nothing to report.

CDTQSE 20/433 Patient Safety Alerts

ISN 20202 011 T34 Battery Update

The alert has been circulated across the Clinical Board for information.

ISN 2020 012 Risk of Incorrect Results when using SSST Gold Top Blood Sample Tubes for Patients on Treatment Dose Anticoagulants

The alert was reissued to advise that it was not applicable to the Primary Care setting. It is mainly applicable to Haematology wards.

CDTQSE 20/434 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 20/435 Medical Device Risks/Equipment and Diagnostic Systems

Nothing to report.

CDTQSE 20/436 IP&C/Decontamination Issues

Decontamination concerns relating to medical equipment and wheelchairs coming in to the Clinical Engineering department for repair have been escalated to the UHB Decontamination Group. A meeting is being set up to try to address the issues.

CDTQSE 20/437 Point of Care Testing

The highest scoring risks in the Point of Care Testing department have been submitted for inclusion on the Clinical Board risk register.

CDTQSE 20/438 Key Patient Safety Risks

Safeguarding

Maria Jones was not present to provide an update from the UHB Safeguarding Group.

Mental Capacity Act

Nothing to report.

CDTQSE 20/439 Health and Safety Issues

It has been reported that a chemical odour is being emitted from the drains in the mortuary. This is being investigated.

Lesley Harris reported that patients attending Radiology are choosing not to wear masks or face coverings despite having no medical exemption. They are being challenged in terms of courtesy to staff but are refusing to wear them. The question was raised whether they can be asked to leave the department. Sue Bailey perceives that they should be imaged as they have a medical need. Alicia Christopher offered to seek clarification on this with the IPC team.

Action: Alicia Christopher

It was noted that the problems with pigeons at the CRI have not been resolved. There is also a major leak in the communal area within the podiatry department when it rains.

CDTQSE 20/440 Regulatory Compliance and Accreditation

The Regulatory Compliance Group did not meet in December. Sue Bailey has received the metrics and will review them.

A virtual UKAS inspection is being held in Biochemistry this week. Nigel Roberts explained the difficulties this presents to the department in terms of providing information.

The ONR inspection in Radiopharmacy was very positive. The Inspector was informative, helpful and gave good direction on the improvements to be made.

CDTQSE 20/441 Policies, Procedures and Guidance

Radiology ID Policy

During an investigation of an incident that occurred in another Clinical Board where an incorrect patient received imaging, Radiology was criticised for having a different ID process to the UHB policy. Lesley Harris advised that the Radiology ID process is different to the UHB ID Policy in order to align itself to IR(ME)R legislation. This does not require the patient hospital number and NHS number to form part of the 3 points of identification checks, as a high percentage of patients seen in Radiology are Outpatients and a large number of patients are not wearing wrist bands with their hospital number on them. From an IR(ME)R perspective, Radiology ID checks with the patient include name, address, date of birth and also include the patient's medical condition against the request form and expected examination.

Radiology is seeking approval to continue to work to their own policy. The College and Society of Radiographers endorse this process. The UHB Policy does state that deviation is allowed from the UHB Policy, providing there is ratification at QSE.

Sue Bailey will discuss further with Lesley Harris outside of the meeting and the issue will be brought back to the next meeting.

Action: Sue Bailey/Lesley Harris

Ultrasound Policy

The policy has been out to consultation following approval at the Ultrasound Governance Group and needs to be submitted to the UHB QSE Committee for final ratification. Paul Williams to complete the necessary form and submit.

Action: Paul Williams

Medical Equipment Management Policy

It was noted that due to Brexit EU Medical Device Regulations will not come into force as anticipated and the Medical Equipment Group will consider best practice going forward as there will need to be a quality management system in place for organisations that manufacture devices.

EFFECTIVE CARE

CDTQSE 20/442 Clinical Audit

Directorates are encouraged to send any clinical audit information they are involved in to Sue Bailey.

CDTQSE 20/443 Research and Development

Expressions of interest for the Clinical Board R&D Lead post will be sent out in January.

The current focus for the Clinical Board R&D Group is working to ensure the funding streams are robust for directorates supporting research. The strategy is to encourage directorates to undertaken their own research and the Group is identifying the barriers that are making this a challenge.

CDTQSE 20/444 Service Improvement Initiatives

Sion O'Keefe reported that a new project management system, Verto, is available in the Health Board with 100 licences for 2 years. The system has the option to capture general service improvements and the Clinical Board will look to utilise this functionality to manage the ETR programme. Any departments that would like further information on Verto to contact Sion O'Keefe. It was noted that Microsoft Teams has some project management functionality and Verto will eventually interface with Teams.

Meriel Jenney advised that significant resource allocation has been made available to support the infrastructure for ETR.

CDTQSE 20/445 NICE Guidance

Nothing to report.

CDTQSE 20/446 Information Governance/Data Quality

Due to staffing issues, there is currently a delay with Subject Access Requests. The issue has been escalated to the Executives.

Information Governance Asset owners have been requested to identify all data processing activities between the UK and EU and forward to the Information Governance Department. Sion O'Keefe has request further information on this and an approach.

DIGNIFIED CARE

CDTQSE 20/447 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 20/448 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 20/449 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 20/450 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 20/451 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 20/452 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

It was noted that at the end of October there are 5677 patients waiting over 8 weeks in Radiology and Medical Physics. This number is reducing.

There are 72 waiters at 14 weeks and over in Therapies.

CDTQSE 20/453 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 20/454 National User Experience Framework

Currently no national user experience questionnaires are being collated.

STAFF AND RESOURCES

CDTQSE 20/455 Staff Awards and Recognition

The UHB Staff Recognition Awards are being streamed on-line tonight.

The Clinical Board Staff Recognition Scheme is seeking nominations this month in the category of Quality, Safety and Patient Experience.

CDTQSE 20/456 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting a compliance rate for statutory mandatory training of 81.75% against a target of 85%.

Fire training compliance is 68.63%. This has deteriorated from last month.

Job planning – 21.31%. A plan is in place increase compliance.

Values Based Appraisals compliance rate is 42.6%. Directorates have been challenged by the Clinical Board to produce plans to bring their compliance on track.

Sickness is 3.9% against a target 3.57%. 34 staff are absent with Covid-19, 5 staff are shielding and 10 are self-isolating and able to work from home. 15 are self-isolating and unable to work from home.

Government rules for d self-isolation have changed. From today the period for self-isolation has reduced to 10 days from 14 days. It is not clear whether this relates to patients who are awaiting a procedure.

It is likely to be announced that there will be early school closures for the Christmas period. Guidance from HR is requested.

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

The following minutes were received:

Biochemistry Quality Group Minutes November 20
Outpatients/Patient Administration and Medical Illustration QSE Group Minutes November 20
Clinical Board R&D Group Minutes November 20

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 6th January 2020 at 2pm via Microsoft Teams.

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 3RD FEBRUARY 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Jo Fleming	Quality and Safety Lead, Radiology
Scott Gable	Laboratory Service Manager, Cellular Pathology
Maria Jones	Sister, Outpatients
Judyth Jenkins	Head of Dietetics
Seetal Sall	Point of Care Testing Manager
Louise Long	Public Health Wales Microbiology
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
Emma Cooke	Head of Physiotherapy
Bolette Jones	Head of Media Resources
Lesley Harris	Professional Head of Radiography UHL
Mathew King	Head of Service, Podiatry
Robert Bracchi	Medical Advisor to AWTTC
Nigel Roberts	Laboratory Service Manager, Biochemistry
Timothy Banner	Head of Patient Services, Pharmacy
Sian Jones	Assistant Head of Workforce and OD

Apologies:

Meriel Jenney	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Suzie Cheesman	Patient Safety Facilitator
Paul Williams	Clinical Scientist, Medical Physics
Nia Came	Head of Adult Speech and Language Therapy

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/001 Welcome and Introductions

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

CDTQSE 21/002 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/003 Approval of the Minutes of the Last Meeting

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

CDTQSE 21/004 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 20/122 Contractors Policy

Sue Bailey will escalate the concerns that have been raised with the policy with the Clinical Board Health and Safety Adviser when he returns from secondment.

Action: Sue Bailey

CDTQSE 20/335 Diagnostic Images

Matt Temby, Sue Bailey and Meriel Jenney will discuss how to review consent issues and review of diagnostic images outside of Radiology.

Action: Matt Temby/Sue Bailey/Meriel Jenney

CDTQSE 20/377 Patient Stories

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

Action: Sue Bailey

CDTQSE 20/422 AWTTC IT Paper

Sue Bailey has escalated the paper to the Clinical Board Formal Board Meeting. She will ask for an update on any progress.

Action: Sue Bailey

CDTQSE 20/439 Patients Refusing to Wear Masks

Alicia Christopher received clarification that departments cannot refuse admission to patients who are refusing to wear face masks and have no medical exemption, however departments need to document in the patient's case note that they refused to wear a mask.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/005 Presentation from the Safeguarding Violence Prevention Unit

Vicky Lee provided an overview of the service based in A&E. This is a nurse led initiative funded by South Wales Police with the aim of providing help and advice to patients attending A&E with violence injuries. The team also collates and reports statistics on knife injuries to the police. The long term goal is to lower re-admission rates.

Since lockdown and the resulting changes that have been implemented where patients now present alone, a new pilot has commenced 'Ask and Act' for domestic abuse. This pilot has resulted in significant engagement and increase in disclosures. The Ask and Act form is available on the UHB intranet for departments outside of A&E to use for patients that disclose in other services.

Whilst the team are primarily based in A&E, there are plans to expand to a Health Board wide service.

Aimee Cox joined the meeting and provided an update on safeguarding cases and training.

She noted that Covid is having an impact on families with a lot of cases being reported relating to criminal exploitation.

Conferences and strategy meetings are being held via Teams. Adult safeguarding cases and professional concerns are being supported. If staff are contacted by the police for statements they should contact the Safeguarding team, who coordinate statements for the Health Board.

A safeguarding audit for children and young people has been completed.

A new drop in Mental Health service has commenced for staff to discuss concerns.

In terms of training, the focus for the team at present is establishing what training can now be taken forward.

Pressure damage concerns are being supported via vulnerable adult referrals. The All Wales review tool for pressure areas need to be completed within 5 days of identification. Mathew King reported that Podiatry have raised ongoing issues relating to the implementation of a foot assessment tool where there is evidence that this reduces pressure damage risks. However there is an issue that additional documentation would be a burden upon nursing teams. It was noted that the Safeguarding Team only have involvement when pressure damage is established however Aimee Cox would welcome a discussion on the issues with Mathew King outside of the meeting.

Action: Aimee Cox/Mathew King

CDTQSE 21/006 Feedback from UHB QSE Committee

The minutes of the meeting held in December 2020 are not yet available.

CDTQSE 21/007 Health and Care Standards

The self-assessment process is currently stood down.

CDTQSE 21/008 Risk Register

Directorates to continue submit any updated directorate risk registers to Helen Jenkins.

CDTQSE 21/009 Exception Report

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/010 Initiatives to Promote Health and Wellbeing of Patients and Staff

Flu Vaccinations

Flu vaccinations are still available via Occupational Health and Outpatients at UHW and UHL.

Mental Health and Wellbeing Training

Sian Jones has been in contact with Afta Thought, the provider of mental health and wellbeing training, whose sessions to the Clinical Board were postponed due to Covid. A meeting is being held tomorrow to discuss alternative approaches to delivering the sessions.

An online version of Mental Health First Aid Training provided by MIND Cymru is also being explored.

It was noted that a Staff Haven has opened in Lakeside Wing. It is planned for a similar facility to be opened across other sites. Mathew King asked if the CRI site is included in this. Sue Bailey will make enquiries.

Action: Sue Bailey

SAFE CARE

CDT QSE 21/011 Concerns and Compliments Report

In January 2021, the Clinical Board is reporting an Amber/Green status. It received 9 concerns, there were no breaches in response times and 4 compliments were received.

Most departments are reporting a green status. No departments reported a red status. Areas reporting an amber status are:

Radiology which received 6 concerns but also received 1 compliment.

Laboratory Medicine which received 2 concerns but resolved 50% by early resolution.

Dietetics which received 1 concern.

In terms of themes, 4 concerns were raised against the Ultrasound department although different issues were raised.

It was reported that Podiatry staff who are deployed to wards are receiving compliments from other Clinical Boards. It was noted that these should be forwarded to the Clinical Board for logging.

CDTQSE 21/012 Ombudsman Reports

Nothing to report.

CDTQSE 21/013 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 21/014 Patient Safety Incidents

SI Report

The Clinical Board is reporting 3 open SIs:

In122136 – an incident involving the removal of a pace wire. The RCA has been completed.

In82274 – an incident involving a choking episode of a patient. The RCA has been completed. The case is with the Coroner.

In92837 – an incident involving a delay in treatment for a neuro patient. The action plan is to be completed.

CDTQSE 21/015 New SI's

Nothing to report.

CDTQSE 21/016 RCA/Improvement Plans

Nothing to report.

CDTQSE 21/017 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 21/018 Regulation 28 Reports

Nothing to report.

CDTQSE 21/019 Patient Safety Alerts

MHRA: All brands and models of gastric bands

The alert has been circulated across the Clinical Board. It was noted that this is relevant to the MRI team and has been brought to their attention for awareness.

Public Health England - Outbreak of Burkholderia aenigmatica, UK (Update) – Ultrasound gel recommendations

The alert has been circulated across the Clinical Board. It was noted that it is relevant to Ultrasound Services and has been brought to the department's attention for awareness.

ISN 001 – Copan Throat Swab

This alert has been circulated across the Clinical Board. It was noted that throat swabs are used in the Point of Care Testing Service, however it does not use this particular swab**.**

ISN 002 – Valved FFP3 Masks Changes

The updated guidance has been circulated across the Clinical Board. It was noted that powered hoods were required in Radiology.

CDTQSE 21/020 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 21/021 Medical Device Risks/Equipment and Diagnostic Systems

It was noted that Tony Powell has left the UHB. Sue Bailey to contact Edward Chapman to request a replacement Medical Device Officer for the Clinical Board.

Action: Sue Bailey

Seetal Sal reported that the Point of Care Testing Service recently had to submit yellow card alert due to strips reporting a batch of false positives.

CDTQSE 21/022 IP&C/Decontamination Issues

Nothing to report.

CDTQSE 21/023 Point of Care Testing

Connectivity audits have been undertaken and it was identified that there has been a vast removal of key network ports required for POCT devices. A report was

produced for each Clinical Board. A re-audit was undertaken and the results had worsened with a reported loss of even further connectivity.

The service has been approached by the Maternity department to roll out POCT devices purchased by Welsh Government however the service is reluctant to commence rollout until the connectivity issues have been resolved.

CDTQSE 21/024 Key Patient Safety Risks

Safeguarding

Maria Jones reminded the Group that documents pertaining to Safeguarding are stored on Teams.

Clinical Boards have been asked to provide assurance that staff are aware of safeguarding procedures and that safeguarding is a standing agenda item on QSE meetings.

Safeguarding Training compliance has been poor over the last few months and it is requested that new starters are prioritised to receive the training.

Level 2 violence and domestic abuse training compliance needs to be improved across the Health Board.

It has been reported that more children are attending the Emergency Unit with injuries due to being at home**.**

FGM clinics are continuing to run at CRI on a weekly basis**.**

Mental Capacity Act

Nothing to report.

CDTQSE 21/025 Health and Safety Issues

The Medical Physics department is dealing with a major leakage and has relocated from its current offices.

It was noted that a quote is being obtained for door holders for the fire doors in Toxicology.

CDTQSE 21/026 Regulatory Compliance and Accreditation

The Clinical Board Regulatory Compliance Group was held last week. Good assurance was provided against metrics. The challenges with releasing staff to undertake quality tasks has been acknowledged.

CDTQSE 21/027 Policies, Procedures and Guidance

Nothing to report.

EFFECTIVE CARE

CDTQSE 21/028 Clinical Audit

There are no clinical audits to report.

An environmental impact audit has been undertaken within the Speech and Language Therapy department. The audit inspected the fabric of the building, heating, waste control etc. The findings noted:

- The heating in the department is insufficient.
- Concerns were raised relating to pigeon excrement.
- The department is using water bottles as opposed to plumbed water coolers
- Waste is not being segregated appropriately.

If any other departments wish to participate in an environmental audit, to contact Sue Bailey.

CDTQSE 21/029 Research and Development

An opportunity within this Clinical Board has been circulated to departments to bid for research funding.

The Clinical Board R&D Lead role vacancy has been circulated for expressions of interest.

CDTQSE 21/030 Service Improvement Initiatives

Sion O'Keefe is actively involved in the Outpatients Transformation programme which is currently focusing on the allocation of outpatient rooms and planning around their usage. A virtual village is being trialled.

Opportunities are being explored with the IM&T team around the use of Power Apps in Office 365 to provide a Choose and Book service functionality for patients. If there are any individuals in departments interested in joining a working group to contact Sion O'Keefe.

The ETR Programme plan is progressing with good engagement.

Sion O'Keefe has also been tasked to consider transportation within the UHB in the event of snow as there are limited number of vehicles available.

CDTQSE 21/031 NICE Guidance

Nothing to report.

CDTQSE 21/032 Information Governance/Data Quality

It was noted that the UHB is exploring the possibility of patients opting out of text reminders.

It was also reported that robust mechanisms need to be put in place for staff who are homeworking and handling case notes.

DIGNIFIED CARE

CDTQSE 21/033 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 21/034 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 21/035 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 21/036 Equality and Diversity

Nothing to report.

TIMELY CARE

CDTQSE 21/037 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 21/038 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

It was noted that there are currently 5292 patients waiting over 8 weeks in Radiology and Medical Physics.

There are 44 patients waiting 14 weeks and over in Therapies.

CDTQSE 21/039 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 21/040 National User Experience Framework

There are currently no national user experience questionnaires being collated. Gaining feedback on the patient experience post Covid and identifying if patients expectations are being met will be important.

STAFF AND RESOURCES

CDTQSE 21/045 Staff Awards and Recognition

Nothing to report.

CDTQSE 21/046 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting good compliance overall against mandatory training.

PADR compliance needs to be improved however directorates have reported that plans are in place to improve their compliance rates.

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

The following minutes were received:

CD&T Clinical Board R&D Minutes February 2020

ANY OTHER BUSINESS

Alicia Christopher is due to commence on maternity leave. Sian Jones has been appointed in the secondment to the Operations Manager role.

Emma Cooke and Mathew King have been appointed as Assistant Director of Therapies and Health Sciences alongside Paul Rogers in ALAS and Kim Atkinson in Occupational Therapy.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 10th March 2021 at 2pm via Microsoft Teams.

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 19th January 2021, 08:00-10:00 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Adrian Turk	Pharmacist
Barbara Jones	Educational Lead, Perioperative Care Directorate
Catherine Evans	Patient Safety Facilitator
Hayley Dixon	General Manager ENT, Ophthamology & Dental
Helen Luton	Lead Nurse T&O
Mark Bennion	Quality & Safety Lead, Perioperative Care
Rowena Griffiths	Governance & Quality Lead Manager
Richard Coulthard	Consultant Urologist, Ward A5
Terry Stephens	Procurement Nurse, Procurement

In attendance:

Zoe Brooks	Surgery Clinical Board Secretary

PRELIMINARIES *(Chair)*		
SCB/QS: 21/01	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS: 21/02	**Apologies for Absence**	
SCB/QS: 21/03	**Minutes of meeting held 17th November 2020** The Group approved the minutes of the previous meeting.	
SCB/QS: 21/04	**Action Log** Please see Action Log for update	
SCB/QS: 21/05	**Presentation Mandatory safeguarding compliance** Deferred to the next meeting in March 2021	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS: 21/06	**Patient Story –** Peri-Operative Care Directorate Chest swab found following surgery Report and Action Plan received by the Group Quality & Safety Lead, Perioperative Care- MB gave an overview of the incident reporting that On 13th November 2020, a patient was admitted to ward A5S,	

	University Hospital of Wales following a fall at home, which resulted in him sustaining a fractured right neck of femur. It was noted that the Patient attended theatre 11 in UHW later that day for surgery where the surgery was uneventful and following a successful recovery patient was transferred back to ward A5S for rehabilitation. MB reported that on the 16th November, a Consultant Orthopaedic Surgeon reviewed the routine post-op x-rays where a foreign body in the surgical wound site was evident; which resembled the appearance of a swab. It was noted that the patient was scheduled for exploratory surgery that took place on the 17th November where exploratory surgery revealed that a chest swab had been left in the surgical site following surgery. It was highlighted that following this incident a full investigation was conducted, where recommendations were established and an action plan generated. Full details of these can be found within the Action Plan. The Chair thanked MB for presenting this to the Group. The Chair highlighted that previous incidents had suggested unity of the swab boards as a recommendation. MB confirmed that a design and costing had been agreed and purchase was in process. Consultant Urologist – RC suggested that technological solutions were available and informed the Group of a wand type instrument that scanned the body for swabs following surgery. RC was not aware of costing however MB reported that he would look into this. Director of Nursing – CW queried whether there was a delay getting boards up and if this would have made a difference. MB confirmed that boards were available, however were not filled out. It was agreed that this would be put onto the Action log to review progress and also taken to the Never Events meeting. **Action MB**	
SCB/QS: 21/07	**Matters Arising** **Field Safety Notice (FSN) - TRACOE twist plus Tracheostomy Tubes** Director of Nursing - CW highlighted that the Field Safety Notice (FSN) was received prior to this meeting and was brought to this meeting for noting. Concerns were raised in relation to the date on the FSN was the 3rd November 2020, however was only recently received. Procurement Nurse- TS confirmed that this FSN was received in November 2020 and was sent to all areas that had purchased the tubes. It was noted that there was no process to ensure that areas had received and actioned.	

	CW informed the Group that all FSN are taken to local Q&S Groups for discussion and action. CW asked for the information of where the tubes were in the Health Board. TS agreed to send this information on this; information was sent to CW and the Chair during the meeting. CW asked that this is put onto the Action Log for assurance to be given at the next meeting that this had been actioned. Action: Lead Nurses	
SCB/QS: 21/08	**Feedback from UHB QSE Committee:** Director of Nursing - CW reported that Surgery Clinical Board was asked to present at the last UHB Q&S meeting on achievements over the previous year. It was noted that a report was submitted and accepted by the UHW Q&S Committee. This report was circulated to the Group for information.	
SCB/QS: 21/09	**Health and Care Standards – sign of self-assessment/ ongoing review of implementation/ improvement plan:** Director of Nursing - CW reported that this had been stood down due to Covid and no further update to report.	
SCB/QS: 21/10	**Regulatory compliance and external accreditation (where relevant):** Educational Lead, Perioperative Care Directorate – BJ reported that a number of audits had taken place during the period and gave an overview of the findings:- • Peri-Operative Care Directorate consent and laterality audit –it was noted that there were report of non-compliance at Llandough from issues such as missing dates and abbreviations being used. It was highlighted that following these findings a comprehensive action plan had been established. • WHO Checklist Dec 2020 – Action plan developed to implement recommendations. • Internal Quad Audit Results December 2020- It was noted that a 100% compliance was achieved across all areas. • VTE Audit – A few issues was identified at Llandough, where the Pri-op check lists were not completed as well as issue with other documentation. It was noted that this had been shared with Senior Management and continued to be monitored.	
SCB/QS: 21/11	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities:** • Directorates	

	Quality & Safety Lead, Perioperative Care - MB gave feedback on Peri-op activities and position during the period. It was noted that:- • staff across the directorate continued to support Critical care, which has affected the number of lists that can be delivered. • A divided wall had been erected within Main Theatre, to ensure Green Zone is fully locked down. • Two power losses in Main Theatres and Childrens Hospital on 6th and 10th of January, which affected the ventilation systems and heating. This was actioned efficiently and surgery continued. • Ongoing issue with provision of surgical scrubs within Llandough. Negotiations had taken place with linin room to prioritise delivery and TDSI access had been reviewed. • Cardiac On-call services experiencing difficulties due to a number of scrub nurses absent. This is resulting in other nurses covering a number of on calls each week. It was noted if sickness continued, this could cause issues with this service. • Porters out of hours provision is a concern at Llandough, high level of sickness amongst the blood porters; discussions had taken place to ensure appropriate service as usual and in a timely manner. General Manager Dental/ENT and Ophthamology - HD reported on Dental's position:- • Air purifying systems had been rolled out and would support Theatres, which was due to re-start early February. • Clinics are running as usual, however reduced to release staff to support Critical care. • No Q&S issues Pharmacist- AT gave an overview of the Corporate Med's management Group, highlighting that:- • E-learning for management of insulin was available. • Approval of implementation of erectile dysfunction medication. • A review of the over active bladder pathway had occurred and amendments approved. • Opthamology – It was reported that a meeting took place last week where the Medical Director queried the position on MAD's. HD agreed to pick this up.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 21/12	**Initiatives to promote health and wellbeing of Patients and Staff:** **Meeting Update** • SCB H&S/IPC meeting update Director of Nursing- CW reported that this meeting had been stood down in December, due to operational pressures. It was noted that there were a number of outbreaks across the Health Board and especially within Surgery. It was reported that this had an effect on amber capacity in particular at Llandough, where a significant number of ward outbreaks had been reported.	

	Patient Safety Facilitator – CE queried whether all front line staff had received their Covid vaccination. CW reported that all staff had been asked to book. It was noted that there was issues with the booking phone lines, however an electronic form had been established and it was reported that this system had been working well. • Decontamination Group update Meeting had not taken place during the period. • Water Safety Group Update No meeting had taken place during the period. Educational Lead, Perioperative Care Directorate-BJ informed the Group that at the last meeting it was agreed that the piped water fountain in Main Theatres would be repaired as a matter of urgency. It was noted that this was still outstanding and had been raised with the Director of Capital Estates and facilities.	
SCB/QS: 21/13	**Bring forward –progress on relevant improvement plans (previously approved/discussed):** No Updates	
PART 3: SAFE CARE		
SCB/QS: 21/14	**Implementation of relevant care bundles and changes to patient pathways** **NATSSIP** Educational Lead, Perioperative Care Directorate – BJ reported that there had been no update during the period; awaiting new dates for 2021 meetings.	
SCB/QS: 21/15	**Patient Safety Incidents** The Group received the Closure form report, the Open inquest report and the Open Serious incident report for information and noting. Patient Safety Facilitator- CE highlighted that no closure forms were submitted last month, however efforts are being made to close these out. Director of Nursing – CW thanked CE for all her support and help with these. It was noted that a new member of staff would be joining the Patient Safety Team on a six month secondment and would be covering Surgery to help with closing items out. CE reported that the Inquest of patient (BH) involved in a Never Event was still ongoing and further statements had been requested from the coroner's office.	
SCB/QS: 21/16	**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 during the period, the being:- Recall Notice - CIRRUS2 Nebuliser, Adult, Intersurgical Ecolite Mask Kit Procurement Nurse-TS confirmed that these are used within the Health Board. Concerns were raised around the product change process, TS highlighted that there are no product detail or code changes, therefore can be very difficult in tracing the items. It was noted that this had been communicated throughout the Health Board. ISN 2020 010 Wrong Route Administration of a Controlled Drug – The Chair highlighted that this was for information. ISN 2020 011 T34 battery update The Chair reported that the notice highlighted that Duracell batteries are the only batteries to be used with the T34 Syringe drivers. ISN 012 SST Gold Top Tubes v8 It was noted that this notice was for information and to be circulated to ward areas.	MB
SCB/QS: 21/17	**Health Care Associated Infections** HCAI rate – December data The Director of Nursing - CW gave an overview of the data report, highlighting that Surgery Clinical Board was doing very well. It was noted that during the period there was one new case of C.difficile**,** this resulted to only four cases reported over the year, a significant reduction on the previous year. Equally, the Group were informed that MRSA continues to be zero and MSSA was showing a reduction against the previous year, however two cases were reported in December 2020. The Director of Nursing – CW highlighted that there had been a vast reduction in all health care associated infections, in particular within the green zones. Full details can be found within the report. HCA Covid -19 The Group received and noted the Rapid Assessment of Exposure Tool for Probable or Confirmed Hospital Acquired Covid-19 Infection (NOT deaths) Patient. It was reported that the tool was to be complete for each Patient who has acquired a Covid-19 Infection whilst an inpatient >8days.	

	The chair queried whether this could be shared with Velindre. Patient Safety Facilitator- CE believed this was an All Wales form, however would look into this. **Action CE**	
SCB/QS: 21/18	**Any key patient safety risks:** The Group received the flowing reports for information:- **Q&S performance data** Director of Nursing gave an overview of the report. Full details can be found within the report. **Falls reduction and Pressure and tissue damage reduction and prevention reports** Report's received and noted by the Group Lead Nurse T&O- HL reported an increase in grade 2 pressure damage on ward West 5. It was noted that Medstrom have been contacted to obtain a Duo2 for pri-op neck of femur patient. HL also reported that there had been one injurious fall on West 1. It was noted that an investigation was underway; details on findings would be brought to the next meeting. **Medicines management issues/incidents/audit findings** No issues or update reported. **Corporate Meds management minutes** No Update **Safeguarding – any key issues; action being taken** No Update **Medical devices/equipment issues** The Chair reported that there had not been a meeting during the period. **Blood management** Director of Nursing – CW informed the Group that a Blood transfusion meeting took place on Friday 15th January 2021. It was agreed that Minutes would be circulated to the Group.	

	Q&S Workplan 2021 -2022 Director of Nursing – CW reported that the Q&S Workplan had been updated for 2021. The Group were asked to review and provide any comments to the Clinical Board Secretary – ZB by the end of January.	
SCB/QS: 21/19	**Mortality data analysis** The Chair reported that there had not been a meeting during the period. No update	
PART 4: EFFECTIVE CARE		
SCB/QS: 21/20	**Monitoring of CB Clinical Audit plan** The Director of Nursing – CW informed the Group that following feedback from the audit leads the audit plans had been resubmitted in November/December 2020.	
SCB/QS: 21/21	**Implementation of key NICE Guidance** No Update	
SCB/QS: 21/22	**Research and development update** No Update	
PART 5: DIGNIFIED CARE		
SCB/QS: 21/23	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** No update.	
SCB/QS: 21/24	**Initiatives to improve services for people with:** **Dementia** **Sensory loss** **Learning Disabilities** No Update	
SCB/QS: 21/25	**Any initiatives specifically related to the promotion of dignity** No Update	
PART 6: TIMELY CARE		
SCB/QS: 21/26	**Initiatives to improve access to services/ management of risk** Director of Nursing CW – Reported that due to Covid, it is difficult to discuss at present and highlighted that this will be picked up in the March/ May meeting to look at performance. Lead Nurse – HL informed the Group that the Annual Report from the NAFD had been published and asked whether this should be brought to the next meeting. It was highlighted that the report demonstrated an improvement for T&O and HL suggested that Dr Johansson could come to the next meeting to give an overview on this. The Chair agreed that this would be beneficial.	

PART 7: INDIVIDUAL CARE		
SCB/QS: 21/27	**Feedback from surveys – relevant improvement plans** Director of Nursing – CW reported that a number of compliments are received and shared with the Concerns Team. CW highlighted that there were a number of areas that she would like to carry out patient surveys on; in particular Green Zones to look at patient pathways. It was noted that this will be carried out over the next few months. .	
PART 8: Staff and Resources		
SCB/QS: 21/28	**Staff awards and recognition** Director of Nursing – CW informed the Group that the Clinical Board was now in the position to start handing out awards to the winners and this would be carried out over the next coming weeks. The Chair Highlighted that the Anaesthetics Team from Cardiff and Vale had recently won a poster award at the recent National Anaesthetic Meeting.	
SCB/QS: 21/29	**Staffing levels** Director of Nursing – CW reported that meetings are taking place to discuss the ability to release more staff to help ward areas. It was noted that around 130 staff had been released to date.	
SCB/QS: 21/30	**Monitoring of attendance at relevant training e.g IP+C, Safeguarding, MCA, DoLs pressure damage, falls prevention.** It was noted that staff were still completing Mandatory training throughout these current times.	
DATES OF NEXT MEETING 16th March 2021 – 8-10PM – Ms Teams		
ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
22 October 2020 14:30 – 16:00
Venue: Teams Meeting

Attendees:
Rebecca Aylward, MCB Director of Nursing (Chair)
Geraldine Johnston, Director of Operations
Jane Murphy, Deputy Director of Nursing
Kath Prosser, Quality & Governance Lead, Medicine
Diane Walker, Lead Nurse, Integrated Medicine
Sarah Capstick, Health and Social Care Facilitator (SCa)
Matt Cornish, General Manager, Specialised Medicine
Iain Hardcastle, General Manager, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Jacqui Westmoreland, Senior Nurse, Acute/Emergency Medicine
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team (SC)
Rob Foley, Service Manager, Integrated Medicine
Ruth Cann, Senior Nurse Integrated Medicine
Elaine Williams, Service Manager, Specialised Medicine
Gill Spinola, Senior Nurse, Specialised Medicine
Gemma Murray, Professional Practice Development Nurse
Sam Baker, Professional Practice Development Nurse
Carla English, Patient Safety Facilitator
Vince Saunders, Infection Prevention and Control Nurse
Anthony Jones, Charge Nurse, Acute Stroke Unit
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Aled Roberts, MCB Clinical Board Director Carol Evans, Assistant Director, Patient Safety & Quality Jeff Turner, Consultant Gastroenterologist, Specialised Medicine Clare Tibbatts, Clinical Director, Specialised Medicine Sarah Follows General Manager Acute and Emergency Medicine Barbara Davies, Lead Nurse Specialised Medicine Derek King, Clinical Nurse Specialist, Infection Prevention & Control David Pitchforth, Senior Nurse, Integrated Medicine Sarah Cornes-Payne, Senior Nurse, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted.	
1.2	**Maters arising**	

1.3	**Good News Story, presented by Ward Manager A Jones Acute Stroke Unit** Anthony shared information in relation to a service improvement project for improving the Stroke pathway for patients which was published in a national journal. The project, led by Nikki Turner, looked at: - In and out of hours performance regarding stroke performance. - How to support CNS's out of hours. - If there was a specialised workforce assessing patients and meeting targets to enable improvement. - After a specialist training programme, 3 candidates were trained to enable 7 nights of the week being covered by the Stroke/ Thrombolysis Nurse role. Results/Feedback - Good results. One nurse dropped out, so the project was extended. - Results showed reduced door to needle time, swallow screening time improved, and transferring patients to wards out of hours improved. - Project provided a better experience for patients. - Good feedback from staff, including A&E staff. There are now more skilled staff working on the ward. - Would like to reintroduce this role now the project has finished. - Excellent to have an article published in a national journal.	
1.4	**Feedback from UHB QSE Committee –** The minutes will be circulated when approved.	
1.5	**Directorate QSE minutes – exception reporting** Minutes noted.	
1.6	**Papers for noting/feedback/sharing with wards** - LED Newsletter - National Inpatient Diabetes Covid 19; Front Door Guidance	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Flu update** – **Stock control** – there has been a huge demand leading to the 10,000 stock for the whole of the season being released and now going into contingency stock. **Covid** – vaccination availability date to be confirmed. It is anticipated that Flu Champions will administer the Covid vaccines.	
2.2	**Covid:** **Risk Register update** Risk Registered should be reviewed at individual directorate QSE meetings. DW and GS will add this to their directorate QSE agenda's. **Covid outbreak update** **East 6** closed on 1/10/20 after 3 patients screened for discharge purposes tested positive, two of which were healthcare acquired. A decision was made by the outbreak team to screen all staff and patients, which highlighted a medical member of staff testing positive, no other staff tested positive. A risk assessment was carried out, with the identified risks mitigated and the ward re-opened after 14 days with WG's backing on 19/10/20. **SRC** – 2 staff members (1 admin assistant and 1 OT) tested positive, followed by one nursing staff receiving a positive test. A total of 16 staff were swabbed. The decision was made to close the ward over the weekend, and remained closed in line with IP&C guidance. 32 patients	DW/ GS

	were swabbed in total with all results reported as negative. On 16/10/20 a further staff nurse tested positive. All outbreaks are subject to 'live action plans' with Directorate, IP&C and Clinical Board oversight. The Clinical Board is working with the Patient Safety Team for all healthcare acquired Covid outbreaks.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**Serious Incidents Update/ Serious Incidents for closure:** Noted that there are 7 open Serious Incidents across the Clinical Board. 3 Integrated Medicine; 1 Specialised Medicine; 3 Acute & Emergency Medicine. Serious Incidents presented for closure: **Integrated Medicine: In124519** – Injurious Injury Elizabeth ward resulting in a fractured neck of femur which required surgical intervention. The investigation highlighted that this was an unwitnessed mechanical fall for a patient who was able to mobilize independently. Evidence that all risk assessments and fall prevention measures completed and updated in line with best practice. Post falls procedures undertaken in line with UHB and NICE 2015 post falls guidance. . **Integrated Medicine: In123379** – Injurious Injury Elizabeth ward resulting in a fractured neck of femur which required surgical intervention. The investigation highlighted that this was an unwitnessed fall for a patient with cognitive impairment and a significant falls history. Risk assessments and care plans noted the patient to be a falls risk with evidence of falls prevention and mitigation in place. Post falls procedures undertaken in line with UHB and NICE 2015 post falls guidance. It was recognised that Elizabeth ward had two injurious falls close together. The ward has a positive culture of falls prevention and education for staff and patients. Practice Development Nurse GM to liaise with the Ward Sister to provide support as needed. **Datix Queues** KP advised that there were 300 Datix submitted awaiting review and stressed the importance of timely review and actions taken to ensure patient safety and governance is maintained. All staff have a responsibility to ensure that this is undertaken.	GM All
3.2	**Infection Prevention and Control update** **Overview of the Clinical Boards IP&C information for August 2020**: 8 days since last MRSA bacteraemia (UHW C6) 38 days since last MSSA bacteraemia (UHL E6) 15 days since last *C difficile (UHW E2)* 4 days since last E. *Coli* bacteraemia ((UHL E7) 44 days since last Pseudomonas bacteraemia (UHW C6) 78 days since last Klebsiella bacteraemia (UHW B6) **Outbreaks for September**	

Date	Ward	Cause	No. Patients Affected	No. Staff Affected	Bed days Lost

	No outbreaks					

Reduction goals set by WG have not been set at yet.
Concern – regarding Staph.
MSSA remains a concern across the Clinical Board. VS/DK to provide an update at the next meeting regarding the reporting of MSSA of wards that are not managed by the Clinical Board from a governance and performance perspective. — VS/DK
Glan Ely Ward referenced in the report – this is not open yet.
.
Outstanding RCA's must be completed – action for improvement. — ALL

VIP scores – Yvonne Hyde is in discussion regarding having the VIP score added back into the Integrated Assessment booklet. Areas of improvement noted include documenting the dates cannula's are inserted – it has been noted that medical staff do not always complete paperwork and add to the patient file.

News / Issues / Concerns
There is an ongoing outbreak on E6 in UHL.

1. No outbreaks in September.
2. 10 outstanding RCA's.
3. C4C scores – Excellent C4C scores across medicine in UHW (99.03 on B7). EU general areas need improvement (95.58%). UHL also has excellent scores with E4 at 99.37% and outlying hospitals excellent. Much improvement was seen on a recent audit of EU (report to follow)
   HCAI reduction goals: There were not cases of MSSA and Klebsiella reported in September. The Clinical Board remains on target to achieve the expected HCAI reduction goals for C difficile.
4. Overall there has been a reduction in C.*difficile* (9%) and E. *coli* (50%) when compared to September results last year. Pseudomonas reduction goals are static and an increase in SAUR (66%) and Pseudomonas (50%) is noted.
5. Note an 88% reduction with MSSA HCAI's was achieved last year.
6. Influenza Vaccination: vaccines currently available in the community (phased introduction) and for UHB staff. Consider vaccination programmes for in-patients. Influenza remains below baseline activity in the community. Currently no cases within medicine.
7. Please ensure that the correct PPE according to the latest guidance is being adhered to.
8. PHW is currently reviewing guidance.

3.3	**Point of Care Testing** - any actions required following circulation of information from POCT team.	
3.4	**Medical devices/equipment issues** – no issues.	
3.5	**Patient Safety** – shared for information and cascading as required Notices/MDA's/ISN's ISN 2020 009 Expired blood tubes	
DIGNIFIED CARE		
4.1	**HIW action plan AU UHW (March follow up visit)** **Actions and recommendations** – visit went well, all improvements made were recognised.	

	Virtual HIW Inspections – carried out for Sam Davies Ward Barry Hospital and East 4 UHL. Minor recommendations were noted for East 4, and no recommendations for Sam Davies Ward Barry.	
TIMELY CARE		
5.1	**Procedure for the appropriate transfer of patients off ASU and SRC for ratification** DW will take this back to the Stroke Team to fit in with current process (with SRC currently closed), make amendments and send to RA.	DW
5.2	**Update on 52 week breach position** **Gastroenterology** - 5 patients waiting over 52 weeks, all complex patients and have been validated. Putting in place a monthly list at UHW to get the patients through. 36 week position and 26 week position – zero for both. Surveillance increases monthly, and there is an acknowledgement of risk to patients. Looking to increase capacity, fit testing, use of Spire and insourcing. The surveillance list is being managed by Endoscopy nurses, previous CD and current CD. EW will enquire if any assistance is required. KP to arrange a meeting with EW/RA to discuss governance. **Dermatology** – 52 week breaches = 1198. 20 of which are urgent patients and have been appointed. Longest wait 68 weeks. All in process of being validated. Reporting on weekly basis at RTT weekly meetings. **Rheumatology** - 154 waiting over 52 weeks. All validated. **Integrated Medicine** - no 52 week breaches. Clinical Pharmacology is coming close.	EW KP
5.3	**Update on 4 and 12 hour performance Emergency Medicine** No update	
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans	
6.2	**DTOCs** – no update.	
6.3	**Compliments** **Integrated Medicine, East 6** 'Ward staff and the hospital were praised following a patient's brain surgery in June and ensuring blood pressure issues since. The Doctors who performed a lumbar puncture were absolutely amazing and the patient did not feel a thing, previously had found this agonising. The nursing staff were very helpful and the patient wanted them to receive this positive recognition'. B7 – card sent thanking all staff on B7 for the care given. Sam Baker, new Practice Development Nurse was welcomed to the meeting.	
6.4	**Safeguarding** JM meeting with Linda next week and will provide KP with an update.	JM
6.5	**Concerns update**	

	Some concerns have been received regarding communication during Covid period and visiting. A couple of concerns received regarding the management of learning disability patients coming through the EU footprint. It would be useful to feedback some of the learning from this. Staff are trying hard to identify patients who need extra support when entering the unit and to allow a relative/ carer to enter with them as required. There is guidance at the front door on who to allow. KP/ CM/JW to meet to discuss the concerns and any potential learning. 84% in 30 days – improvement over last few months. Thanks to all for their hard work. SC updated on a matter discussed at a meeting she attended recently, regarding a different Health Board. A child was brought into EU, the patient's mother advised it was a major trauma call, only one person introduced themselves out of all staff involved. They could not see name badges due to PPE. The child was transferred to Bristol, there they could see who the staff were and job title. In C&V ED, everyone has a name badge to be worn outside the PPE.	KP/CM/JW
Staff and Resources		
7.1	**Staff well-being Covid work**	
7.2	**Congratulations to Paula Gallent** – services to the NHS during Covid 19 Medalist of the Order of the British Empire.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Clinical Audit Hero's** - RA would like all to give some thought to this. **Patient Safety Team** – have asked for the clinical audit plan to be reviewed. All to email RA with the name of the audit and the audit lead. **Agenda items for next meeting** - central monitoring for A7, B7, Heulwen. **Congratulations** were extended to JM on her secondment role as Director of Nursing, UHL, starting on 16/11/20. **Visors** – the use of these was reinforced in Amber and Red area and risk assess in green area. **Date and time of next meeting** – TBC	ALL ALL KP

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
25 February 2021 14:30 – 16:00
Venue: Teams Meeting

Attendees:
Rebecca Aylward, Director of Nursing, MCB (Chair)
Aled Roberts, Clinical Board Director, MCB
Jane Murphy, Director of Nursing, UHL & Community Hospitals
Matt Cornish, General Manager, Specialised Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team (SC)
Sarah Follows, General Manager, Acute and Emergency Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
David Pitchforth, Senior Nurse, Integrated Medicine
Vicci Page, Service Manager, Specialised Medicine
Tracy Johnson, Practice Development Nurse
Annie Burrin, Patient Safety and Quality
Hannah Mastafa, General Manager, Specialised Medicine
Shannon Bakan, Service Manager, Specialised Medicine
Craig Davies, Interim Assistant Directorate Manager
Sally Gronow, Deputy General Manager, Integrated Medicine
Lisa Waters, Senior Nurse, Acute & Emergency Medicine
Wayne Parsons, Lead Nurse, Acute & Emergency Medicine
Sian Brookes, Senior Nurse, Integrated Medicine
Angela Jones, Senior Nurse
Elinor Gerrard, Senior Nurse, Integrated Medicine
Natasha Whysall, Senior Nurse, Integrated Medicine
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Kath Prosser, Quality & Governance Lead, Medicine Jeff Turner, Consultant Gastroenterologist, Specialised Medicine Carol Evans, Assistant Director, Patient Safety & Quality Geraldine Johnston, Director of Operations Keithley Wilkinson, Equality Manager Diane Walker, Lead Nurse, Integrated Medicine Iain Hardcastle, General Manager, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted.	
1.2	**Maters arising**	

	Clinical Audit Hero's Confirm if Simon Barry received a Clinical Audit Hero award.	
1.3	**Patient Story** – Acute and Emergency Medicine A 21 year old female was seriously injured in an RTA. Lifesaving intervention was given at the scene and the patient was taken by helicopter to the Emergency Department at UHW and further resuscitated. The patient was later transferred to ITU for on-going treatment. The patient had 4 surgical procedures, physiotherapy, dietary intervention and steadily improved. The patient was discharged home with continuing care. Prior to the Major Trauma Centre launching, modelling data year 1 showed 298 patients in year 1 with an incremental increase in subsequent years. Since the launch, the Major Trauma Centre has had 24 patients. The Major Trauma Centre network is working well.	
1.4	**Feedback from UHB QSE Committee** The minutes will be circulated when approved.	
1.5	**Directorate QSE minutes – exception reporting** Minutes noted and accepted.	
1.6	**Papers for noting/feedback/sharing with wards** **HIW Annual Report 2019-2020** **Action:** All to read the report and note the sections about C&V which shows recognition of excellent work that the Emergency and Assessment team at Cardiff and Vale have done. **Action:** SG to arrange for the report to be emailed to the group as it cannot be opened from the agenda.	ALL SG
1.7	**Joint working with WAST and Serious Incident Reporting**	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Covid:** **Risk Register update/review any amendments required** It had previously been agreed to combine Covid and Directorate risk registers. Top 3 risks have been discussed. Corporate are currently reviewing the risk registers. **Action**: Discuss further at the next meeting. **Update on Clinical Board Covid Outbreak position** **Healthcare acquired Covid investigations – HCAI Covid reviews and IP&C outbreaks** Today's Covid meeting outlined numbers of staff and patients affected by out-breaks. A risk assessment is to be carried out for each patient who had hospital acquired Covid. RA is sourcing additional resource to assist with this work. The Patient Safety Team are looking at all Covid related deaths. **Action**: RA will circulate the report. **Action**: TC to provide the name of a nurse in her area who could assist. **Action**: this should be discussed at Directorate QSE meetings. **Action**: RA will update RC if RCA's for Sam Davies ward need to be done.	ALL RA TC ALL RA
2.2	**Central monitoring for A7, B7, Heulwen** Agreed with end of year funding. Awaiting installation programme.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**Serious Incidents Update:**	

	Delivery Unit and reporting of Serious Incidents during the ongoing Covid Pandemic There are currently 4 open SI's. 1. SS – ongoing. 2. DC – awaiting the Coroner to confirm if an inquest will be held. 3. TP – RCA with RA for sign off. 4. WAST incident relating to a gentleman who had a delay in WAST getting to him. The patient was then taken to the Emergency Unit. **Action**: SC and RA to discuss this further outside the meeting. All agreed this should be a Corporate SI (not Medicine). RCA's have been completed for all of the above.	SC / RA
3.2	**Infection Prevention and Control update** **Overview of the Clinical Boards IP&C information for August 2020**: 18 *C difficile* infections from April to March (4 new cases today) 4 cases of MRSA this year so far (2 last year) goal is 0 14 cases of MSSA this year (11 last year) 28 cases of E. *Coli* bacteraemia far (26 last year) goal is 24 4 cases of Pseudomonas bacteraemia this year (10 last year) goal is 0 4 cases of Klebsiella bacteraemia this year (19 last year) goal is 12 **Outbreaks for September** There have been significant outbreaks in MCB since Oct 2021. Current outbreak areas are being managed by Deputy Executive Nurse Director, and the Multi-factoral Team. Some staff have generally stopped wearing visors, which is causing concern. It is still in the guidance that visors/ goggles should be worn in amber and red areas. Lead nurses challenge when they see staff not wearing them when in close patient contact. Staff at LSW B side are reminded constantly to wear goggles/visors. This is to protect staff from Covid. Even when vaccinated, this is only 95% effective. If staff refuse to wear visors/goggles this is a health and safety breach which could be resolved through disciplinary channels. If staff are not wearing visors/ goggles, speak to the individual, follow up with a letter, then if they are still non-compliant, follow the disciplinary route. Corporate should be requested to send further messages about visor/goggles use and displaying posters would be useful. Covid transmission is higher in hospital, than in community. **Action**: All to reinforce the use of good IP&C practice in all clinical areas and remind staff to change PPE between patients to avoid transmission. **Outstanding RCA's must be completed** – action for improvement.	ALL
3.3	**Point of Care Testing** - any actions required following circulation of information from POCT team. No issues raised.	
3.4	**Medical devices/equipment issues** – no issues. **Action**: All to be mindful of sharing equipment and taking equipment to different areas/wards.	ALL
3.5	**Lumira Standard Operating Procedure for ratification** Discussion took place regarding using this point of care testing for asymptomatic patients, to enable bed space to be sought swiftly. The SOP	

	which still has comments on it. The SOP should stay live as staff learn. Lumira test accuracy will change over time. **Action**: Nick Manville to send the updated version to RA who will circulate it. **Action**: Discuss and update in directorate QSE and then report by exception at the MCB QSE.	NM/ RA A&E
3.6	**Patient Safety** – shared for information and cascading as required Notices/MDA's/ISN's ISN Ref 2021/Jan/001 Copan Throat Swabs ISN Ref 2021/Feb/002 Valved FFP3 masks	
3.7	**Clinical Audit Plan 2021** Request that all audits should feature on clinical audit plan. A1 link is carrying out a falls audit. **Action**: to be discussed at Directorate QSE's.	ALL
DIGNIFIED CARE		
4.1	**HIW Report MEAU** Deferred to next meeting.	
4.2	**Lakeside Wing – Quality and Safety Inspection. Staff feedback and Datix reporting** Main themes: team work and organisation on the wards. Sustaining a 77 patient capacity area. **Action**: RA will follow up with the Assistant Director of Patient Safety and Quality on when the report will be received. RA will ensure the report and patient feedback is on the next meeting agenda.	RA
TIMELY CARE		
5.1	**Standard Operating Procedure Immediate Release** New version of the document presented for ratification. All agreed it was an unrealistic timeframe having to respond and confirm a safe space within 2 minutes, or this is classed as a decline to immediate release. This is a standard ask per Health Board. This has been escalated to be looked into. This procedure is instigated by WAST. **Action**: SC will email her comments to RA when she has read the document. Await SC's comments, then agree the procedure.	SC/ RA
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans.	
6.2	**DTOCs** – no update.	
6.3	**Compliments** On 6/11/20 the patient was an emergency admission by ambulance to UHW after becoming unwell with a high temperature and flu like symptoms. He was rapidly taken to the assessment area for tests which confirmed he was Covid+ and very unwell. He was transferred to Heulwen and put on CPAP and said a nurse called Angela and a duty doctor were especially kind to him. He was overwhelmed by their professionalism, compassion and empathy. His condition rapidly deteriorated, he was prepped for transfer to ITU, but eventually stayed on CPAP and improved. The patient's wife was informed of how ill he was. The patient thoroughly trusted all the staff involved in his care and said they were amazing. He was transferred to A7 South by very caring Porters. After a few days he was moved to A7N and continued to improve. Amazing Physiotherapists called Owain and Connell,	

	were so inspiring and motivated him to get stronger. Nurse Vicky Batten played a large part in the patient's physical and mental recovery. The patient wanted to express his sincere thanks to all staff who attended him. The only staff name he could remember was Kissinger. Prior to this, the patient had been recovering from Stage 4 Non-Hodgkins Lymphoma and again during that time all the doctors and nurses were amazing and he is forever in the NHS's debt.	
6.4	**Safeguarding** A significant number of cases have been closed, with the overall position being good.	
6.5	**Concerns update** Managing concerns during the Covid period has gone well, response rate continues to be well maintained. Need to close down longstanding open concerns.	
Staff and Resources		
7.1	**Staff well-being** It is important over the next few months to look after self and others to ensure all OK and reflect. B7 feedback is that is has been useful to have Nikki's visits over the last few weeks. Chaplaincy team have been useful as well. Staff are tired, however, they remain upbeat and positive. **Action**: AR will contact the wellbeing team to continue the visits.	AR
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	• SC's husband fell in Cardiff recently and rang CAV 247 which was a very positive experience and swiftly carried out. • Tracey Johnson has joined the Patient Safety Team for 6 months and will be covering MCB along with SC. AB is working in the Patient Safety Team and has responsibility for falls. Looking at inpatient prevention and management and will be contacting staff shortly. • Farewell to TC who will be joining the Patient Safety Team, and thanks for all TC has done over time in Medicine. • Farewell to WP and thanks for amazing contribution and patient care and wished him well in new role in March. • **Action**: BD will send communication regarding Montreal Cognitive Assessment (MoCA) to SG to send to the meeting group. **Date and time of next meeting** – TBC	BD

MINUTES
PCIC Clinical Board
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Date and time: Wednesday, 10th March, 2021 at 10.30 am
Location: Nant Fawr 1, 2 and 3, Woodland House, Maes-y-Coed Road, CF14 4TT

Richard Desir (RD) (Chair)	Director of Nursing
Rachel Armitage (RA)	Quality and Safety Manager
Judy Brown (JB) (Agenda Item 18 only)	Safeguarding Nurse Advisor
Rhys Davies (RDA)	Locality Manager, N&W Locality
Louise Driscoll (LD)	GP Contract and Development Manager
Helen Donovan (HD)	Senior Nurse, Vale Locality
Helen Earland (HE)	Clinical Operational Lead
Judith Harrhy (JD)	Assistant Head of Workforce
Gareth Hayes (GH)	Clinical Director, Clinical Governance
Angela Jones (AJ)	Senior Nurse, Resuscitation Service
Karen May (KM)	Head of Medicines Management
Laura O'Connor (LO)	Quality and Safety Officer (minutes)
Carol Preece (CP)	Lead Nurse, S&E Locality
Denise Shanahan (DS)	Consultant Nurse
Vince Saunders (VS)	Infection Prevention and Control Nurse
Diane Walker (DW)	Deputy Director of Nursing

Apologises:

Suzie Cheeseman	Patient Safety Facilitator
Tara Cardew	Lead Nurse
Sarah Griffiths	Head of Primary Care
Anna Kuczynska	Community Director
Anna Mogie	Lead Nurse, N&W Locality
Andrea Rich	Lead Nurse, Palliative Care

Part 1: Items for Action

ITEM NO.	TITLE	ACTION
1	**WELCOME AND INTRODUCTIONS** All present introduced themselves and were welcomed by the Chair. RD welcomed and introduced DW, the new Deputy Director of Nursing to the Group. RD advised the group that the agenda has been tailored slightly to focus on the Risk Register and Business Reports.	
2	**APOLOGIES FOR ABSENCE** Apologies noted.	
3	**DECLARATIONS OF INTEREST**	

	No declarations of interest were raised.	
4	**MINUTES OF THE LAST MEETING AND MATTERS ARISING** The minutes of the meeting on 6th November 2020 were accepted as an accurate record, save for the following amendments. Minute 112018: Terms of Reference Review was deferred until January 2021 to allow the Clinical Board Director and Director of Operations to be part of the discussion, both January and February meetings were cancelled, and those people did not attend today's meeting (10th March 2021) The Group agreed to defer this minute to the next meeting in May. Minute 112022 – The Group agreed to amend the last sentence to 'may have' as it remains unclear if this will have an impact or not. There were no other matters arising.	
5	PCIC CB Quality & Safety Committee Action Log: The Clinical Board Quality, Safety and Experience (QSE) Group action log was reviewed. Members noted the content. The following points were discussed in more detail: **01/19/021 Research and Development – Glucometer Audit Results by Locality:** The Group agreed that a new narrative to be written by RD to include the Broader Audit Schedule. Action transferred to LO. **01/20/035 Dignified Care:** Action plan for carer engagement – to be submitted to QSE in January 2021**Action Closed**, due to re-open with new narrative 1**1/20/012 Business Unit reports:** Ongoing discussions regarding reset of services which links to the deployment of staff back to localities. RD advised the Group that talks were ongoing and a Transformation Steering Group has been set up. RD will update the Group with further developments. **00/20/041 AOB:** Staff flu vaccination update to be given at January QSE meeting. It was agreed that this action would be deferred to May as no update was presented to the Group. **00/20/041 AOB:** Lone working compliance reports to be provided at January QSE meeting: Action transferred to Diane Walker as part of Audit Schedule Work The QSE Group noted the above.	RD/LO RD DW
6	**High Level Risks** The PCIC Risk Register was reviewed, and RD noted the following items for discussion. The Group ONLY discussed the 10 risks that currently have a rating of 16 or higher. The full Risk Register was not reviewed.	

Risk 1: Workforce:

JH highlighted the following to the Group:

- Training on the Disciplinary Process and Clarity on roles is being organised.
- JH asked that grievances are acknowledged and actioned quickly, to prevent delays.
- PADR rate has decreased. Target is 85%. This will continue to be monitored.
- Sickness rate has increased and staff off work due to stress and anxiety is high across the Health Board. The team are looking at hotspots but some issues are because of processes.
- Staff are being reminded to use Workforce Surgeries and Action Point for queries.
- A newsletter will be released shortly reminding people that COVID19 rules still apply even if vaccinated.
- EU Settlement Scheme application deadline is June. After that, Staff will be working illegal unless they have a visa. A further report is to follow to identify those who will be affected by this.
- The Trade Union is leading on the NHS pay deal.
- Mediation Services are beginning again. Staff are being encouraged to use this service.

GH reminded the group that special emphasis is needed on Long COVID-19 and its impact. JH confirmed that talks are in place to class Long COVID-19 as an occupational disease and an extension of sick pay for those affected has been granted.

It was agreed that the Workforce risk should remain at a risk score of 20 and is subject to ongoing monitoring.

Risk 2: COVID-19

It was agreed that the COVID-19 risk should remain at a risk score of 20 and is subject to ongoing monitoring.

RA suggested separating the risk into the 3 separate categories, as they currently grouped together, under one universal risk:

1. Epidemic impacting on business as usual on service delivery for NHS provided and contracted services.
2. Sickness and workload pressures.
3. Impact on independent contractors – Nursing Homes /Residential homes/Hospice and Hospice at Home services in continuing business as usual.

RA to review this.

Risk 3: GMS Services/Primary Care Capacity and Sustainability

It was agreed that the risk should remain at a risk score of 16 and is subject to ongoing monitoring.

Risk 4: Community and Primary Care Estates Developments:

It was agreed that the risk should remain at a risk score of 20 however Lisa Dunsford and RD to meet to discuss this further.

Risk 5: Complex Packages of Care

It was agreed that the risk should remain at a risk score of 16 and is subject to ongoing monitoring

	Risk 6: Local Development Plan It was agreed that the risk should remain at a risk score of 20 and is subject to ongoing monitoring **Risk 7: Patient Flow** It was agreed that the risk should remain at a risk score of 16 and is subject to ongoing monitoring **Risk 7: HMP Cardiff Healthcare –16** CP updated the group highlighting the following: • All vacancies have been recruited for, save for one Band 4 vacancy. Band 5 recruitment has also been completed. • All actions resulting from the Serious Incidents have been implemented. • Medicines: CP advised that due to COVID-19, the prison has staggered/implemented a rolling unlock and inmates are in their cells more so less able to share medication. Therefore this risk can be lowered. CP and RA to discuss the HMP Cardiff risk, as multiple risks are grouped together, and these could be separated. The QSE Group agreed the risk could be lowered following these discussions. **Risk 8: Service Change Capacity** The QSE Group agreed the risk should remain at 16. This was also supported by DW who will incorporate this risk into her work with the Transformation Agenda. The QSE Group **noted** the above Risks.	
7	PPE Posters	For Noting Only
8	Delivery Unit launch of a pilot system for Covid-19 rapid sharing of early learning: CoRSEL.	For Noting Only
9	CMO Alert - Updated Guidance for Wales - Investigation and Management of Possible Mink Variant SARS CoV2	For Noting Only
10	Cardiff Care Home Survey	For Noting Only
11	Guidance for CVUHB Clinical Boards, Local Authorities and Regional partners in establishing and operating Coronavirus Antigen Testing in our Community and hospital sites to support Validation of Point of Care Test (POCT).	For Noting Only
12	Primary, Community & Intermediate Care Clinical Board (PCIC) Assurance Report	For Noting Only
13	**PCIC Quality Dashboard** RD noted the number of open SI's (12). No new ones since November.	

	RD praised the Business Units on their compliance with responding to concerns within the 30 day target. December 2020 was 97%, January was 100% and February was 98%. February also had the highest ever amount of concerns (31) in one month, LO provided a brief overview of the common trends seen within Concerns such as: • The difficulties accessing NHS Dentists and wait times for Orthodontists. • Patients accessing the booking systems and not being able to get through to on the phone to GP's or Mass Vaccination Centres. • Patients, particularly those from overseas, not being able register with GP Practices without an NHS Number. Practices have been reminded that NHS number is not needed when registering new patients. • Covid-19 Vaccination Eligibility. The general public are still concerned that GP Practices are going at different paces and there seems to be lack of understanding regarding invitations to Mass Vaccination Centres instead of GP Practices (and vice versa) • Two concerns where family members felt they were not notified when a loved one had been vaccinated by the mobile vaccination team, causing distress to the patient and family member. These cases are being investigated further. The group agreed most of the issues are process issues and those will not be investigated further. VC provided a verbal update regarding Infection Prevention Control Compliance. The latest results were as follows: • Fluid Intake – 64% - this is below the target (75%) Healthcare targets – • C. diff . +3 so won't hit target (22 last year, 25 this year) • MRSA – 5 Cases last year. 3 this year. • MSSA – +12 cases 35 cases last year, 47 cases this year • E.coli - significant reductions down from 208 last year, to 144. • Pseudomonas – Down to 6 cases from 14 last year. • Klebsiella – 32 Cases Achieved on MRSA, MSSA and Pseudomonas. The group discussed the significant reduction in E. coli. Although there has been a significant reduction in E. coli numbers GH raised a note of caution as the numbers of urine samples has reduced. DW also stated that it is not known how many catheters are in the community and a reduction of catheters could also have an impact on E. coli data. DW also raised a concern that we may see C. diff numbers increase. The QSE Group **noted** the above.	
14	**<u>SI Action plans</u>** • Action Plan AB • Action Plan RP The group noted that all Actions resulting from the above SI's have beeimplemented.	

15	**Compliment from SEWROC** The group **noted** the compliment received for Optometry.	
16.	**St Judes Care Home Update** DW gave a verbal update regarding the closure of St Jude's Care Home. A quick snapshot audit had taken place to identify any missed opportunities, It was concluded that initial investigations showed there were not any missed opportunities to raise a safeguarding alert. The welfare checks were implemented once the alert had been raised. DW raised the question whether continuity, or lack of, with Community Nurses had had an impact but discussions are ongoing in this regard. DW also stated that a PARIS and a documentation audit is needed by locality lead nurses as initial findings show that a more robust system is needed. RD congratulated CP on her exceptional leadership during the St Jude's closure and the work of the Community Nursing Teams during that period. The QSE Group **noted** the verbal updates.	
17	• Splott Mass Vaccination Centre Review • MVC Testing Update No update was presented – deferred to the next meeting.	
18	**Safeguarding** JD provided a verbal update for the group. The QSE group were encouraged to read the latest guidance regarding Safeguarding Adults and Children which has just been released. JD advised Aimee Cox is the new Senior Nurse, so recruiting has begun for a Band 7 to replace her. JD also advised the QSE Group that she is retiring end of April so recruitment will be needed for a Band 7 post to replace her. Safeguarding have committed 1 member of staff a week to the vaccination programme. JD raised concerns over the difficulties they have found in training staff. A two-day course for District Nurses in Level 2 Children and Adults was arranged but only 8 people applied, which was too low for the course to run so it was cancelled. Another session is planned for June. It was highlighted that mandatory training compliance is low and needs to be prioritised. RD highlighted that components of the Level 2 Training were raised due the St Jude's Care Home investigation and agreed that compliance in the mandatory training was low. Level 3 Adults will be available online in the summer to help increase participation. It was agreed that there was no need to place the above training difficulties on the risk register as training is planned for June,	

	JD stated that during Practice Reviews the same themes were coming up and the importance of naming associated people on the PARIS record was raised. It was agreed and supported by RD that DW that a wider review was needed thereof. The QSE Group noted that all Practice Reviews involving an adult, child and a domestic homicide will be reviewed as whole, compared with previously when they were review separately. This will be known as a Comprehensive review. Safeguarding currently have 7 domestic homicide cases. JD encouraged the group to have a look at the 7-minute briefings released by PHW for training and guidance purposes. LD gave a quick overview of the IRIS Scheme noting that all GP practices are IRIS trained and refresher training has been offered to the practices for the 23rd March 2021 and 14th April 2021. This will be rolled out to all Primary Care, including District Nurse Teams, Physio, Health visitors, Midwives who are employed by the Practice over the coming months. GP Trainee training is also commencing from 17th March 2021. The QSE Group **noted** the guidance.	
19	**Primary Care Business Unit Reports** **19.1 GP OOH Business Unit** HE verbally updated the group, focusing from the report on the following: • Telephony system: awaiting further news as the Net installation remains ongoing – once completed the staff in the Communication Hub (Barry) will move to CRI. • Call recording within the triage suite CRI – the system has not been working for over a month. The issue has been escalated with work ongoing to resolve it. A temporary backup system is being used. However, this is now having a financial implication. • Discussions are still ongoing with 8 GPs whose 3-month fixed term contract was extended for a further two months, ending 28th April 2021. RD highlighted a compliment received about a call handler. **19.2 Vale Locality Business Unit** HD advised the biggest issues are: • Workforce and capacity especially in the District Nursing teams. Currently Operating on Level 3, almost level 4. • Vale Community Resource Service (VCRS) has constrained capacity due to staff shortages • Space constraints in all bases in the Vale locality. No clinic space available for wound and continence and reduced clinic space for Acute Response Team (ART).	

- ART – Vacancies and redeployments to CTU adding significant pressure on team. Hours will remain reduced until new staff join the team over the coming months.

19.3 S&E & HMP Cardiff Business Unit

CP explained that the overall picture is improving.

- There are several fact finding and initial assessments ongoing, including a new one since the last meeting within the Rumney Team
- Audits have taken place at HMP Cardiff to look at the content of nursing records and medical records.
- All actions from the action plan have been implemented from the historic SIs
- Two RCAs on the latest two SIs have now been completed, action plans are being drafted.
- Recruited for HMP Cardiff as improved
- HMP Usk Pharmacy Technician Model is being reviewed to see if it can be implemented in HMP Cardiff.

19.4 N&W Business Unit

RD advised the group that the impact of COVID-19 sickness or self-isolation on District Nurse services has decreased with general sickness levels improving. However, the OOH DN service remains particularly affected. All vacancies have now been recruited except for one in the District Nurse Team. .

RD also updated the team with the following:

- A Cluster outbreak of COVID-19 was noted in N&W CRT at the beginning of the year.
- The UHB wide migration to Microsoft 365 and upgrade to Windows 10/netbooks is impacting on staff access to e-mails etc. which has been identified as a risk on the Locality Risk register
- Mobile phones with data now being rolled out to all DN and CRT staff to support more agile working.
- iPADS are now available to gather Patient Experience feedback.
- Lateral Flow devices have been implemented in the Nurse Assessor teams and is being rolled out to CRT.
- Weekly monitoring is still taking place at Pen-y-lan Care Home

DW raised the question of whether iPADS to gather patient experience feedback was being used in any other locality or just N&W.
RD advised it was just currently in N&W, although OOH have just received them but they are not yet in use. The group agreed that this should be rolled out to other localities.

19.5 Pharmacy & Medicines Management

KM highlighted the following from the report.

- Requirement for Pharmaceutical Needs Assessment: health boards must prepare their first PNA and publish by the 1st October 2021. Steering Group met in January 2021 and February to lead on this.

	• 300 people responded when asked to provide feedback on their experience using community pharmacies in C&VUHB. Report to follow • The Phenobarbital SI Action Plan has been implemented and is the point of being signed off. • Workforce skill mix recruitment still ongoing. RD asked for an update on the National Prescribing indicators KM advised we are still best or second best on all of the indicators despite an increase in antibiotic prescribing. A decrease in Tramadol prescribing was also noted. KM advised this is due to E-learning and concentrated incentives on Pain management. **19.6 Palliative Care** Andrea Rich – sent apologies, report noted. No comments **19.7 Primary Care** LD advised the Group that a meeting between Welsh government and GP Practices had been arranged to look at GMS recovery. There are currently 30 practices operating at level 2, 30 Practices at level 1. Oxford AstraZeneca Vaccination Programme – GPs are due to complete 65–69-year-old cohort on 22nd March. Then Second doses will commence for 80+ and 75–79-year-olds. The QSE group noted the above updates. No further comments made.	
20	Terms of Reference Review - **DEFERRED TO MAY MEETING**.	
21	DATIX queue management review DW asked the group to be vigilant and timely as all DATIX incident need to be reviewed within 7 days, as the current number is too high and there is a risk that harm will be missed if DATIX are not reviewed within 7 days The QSE Group noted the above.	
ESCALATIONS TO BE SHARED WITH PCIC CLINICAL BOARD		
	RD summarized the points to be escalated to the PCIC Clinical Board, In particular Good Practice- • IPC position for E. coli • Compliance and concerns responses • Support given by the Community Nursing team, in particular to Care Homes across Cardiff and the Vale. • The overall Safeguarding picture • The IRIS roll out It was noted that areas to be Focused on were • Schedule of Audits	

	• Programme of work for Patient Experience and Staff Experience The QSE noted the above. No further comments made.	
	NO AOB was raised. **DATE AND TIME OF NEXT MEETING:** **Wednesday, 12TH May, 2021 10.30 am – 12.30 pm** ***Room To be notified, Woodland House and via Microsoft Teams***	

Report Title:	**Corporate Risk Register**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	13th April 2021	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information**	✓	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates and has, since November 2019. The Register includes those risks which are rated 15 and above and provides the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Each risk within the Register is linked to a Committee of the Board and the Board Assurance Framework. These risks were, for the first time, shared in public at the January 2021 Board meeting. Those operational risks, which are linked to the Quality, Safety and Experience Committee have previously been shared at private QSE meetings as the register and it's contents developed but will be shared in public moving forward.

The entries within the Corporate Risk Register which are linked to the Quality, Safety and Experience Committee for assurance are attached at Appendix A.

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

The Head of Risk and Regulation and his team continue to work with clinical colleagues to refine risk descriptors, controls and actions within Risk Registers and over the following months the quality and consistency of risk scoring should noticeably improve.

Alongside this process the Risk and Regulation Team have introduced a Risk Management Training programme that is being delivered to risk leads across the Health Board. The initial round of training was well received and since the January 2021 additional requests for training from clinical colleagues have increased significantly. In April 2021 a risk management refresher and Q&A session will be undertaken with senior nursing and management teams from the Medicine Clinical Board with plans to roll out similar sessions within other Clinical Board's over the course of the year.

Alongside this process the Risk and Regulation Team host weekly Health Board wide Risk Management training session via teams which all staff members are able to attend.

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

At the Health Board's March Board meeting a total of 14 (from a total of 25 live) Extreme Risks reported to the Board related to patient safety and are linked to the Quality, Safety and

Experience Committee for assurance purposes. Details of those risks are attached at Appendix 1 but can be summarized as follows:

Risk Score (1 to 25) - Clinical Board	15/25	16/25	20/25	25/25
CD&T		1		
Medicine		1	3	
PCIC	1	1	1	
Specialist Services	3		2	
Surgery		1		
Total: 15	**4**	**4**	**6**	

Although there are a high number of risks rated 20 and above, over the course of time, as the impact of Covid-19 reduces and with appropriate scoring these risks should reduce. It should also be noted that the register, despite being over scored in some areas, does provide an indication of the patient safety risks the organisation is dealing with operationally.

It should be noted that Command Centre risk registers for UHW and UHL were not shared with the Board in March. It was therefore assumed that the entries had remained stagnant and that no extreme risks were reportable.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that will be rolled out by the Head of Risk and Regulation to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Committee is asked to:

NOTE the Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the work which is now progressing.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	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	x	9. Reduce harm, waste and variation sustainably making best use of the	x

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

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

CORPORATE RISK REGISTER MARCH 2021

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
CD&T	1	14/07/2020	**Backlog of diagnostics and services.** **Context**: COVID 19 security, resilience and response **Risk:** Increased morbidity and mortality to patients due to delayed pathways. Missed and/or delayed cancer or critical illness diagnosis due to incorrect prioritisation. **Cause:** Reduction in capacity of the service (as a consequence of COVID 19) as follows: - A reprioritisation of activity - The imposition of social distancing on staff working in diagnostic and therapeutic areas - A need for additional decontamination with a commensurate demand on staff time - Additional constraints on staff availability (due to shielding, sickness absence) - A reduced number of patients attending hospital **Impact:** Resulting in adverse impact on patient safety and service quality, with an increase in concerns/complaints and an adverse impact on reputation.	4	5	20	Priority matrices Scheduling based on priority rather than time waited Virtual consultation Communication with service users Health Pathways redesign (e.g. foot pain, DXA)	4	4	16	Explore opportunities across professions Fully embed clinical prioritisation model of performance	4	3	12	Mar-21	Quality, Safety and Experience Committee	Patient Safety
Medicine	2	M5/11	As a result of difficulties recruiting appropriate numbers of nursing staff the Health Board may not comply with the Nurse Staffing Levels (Wales) Act 2016 leading to a risk of patient or staff harm.	4	5	20	Posts advertised in a timely manner. Authorisation of vacancies reviewed efficiently. Maximisation of medical ward float staff. Dedicated recruitment officer in post. Bimonthy recruitment events held. Engagement with Project 95. Overseas recruitment. Adaptation programmes,student streamling and staff return to practice	4	4	16	Clinical Board and UHB staffing Huddles. Acuity audits twice a year and All Wales Staffing Levels reviewed against this.	4	3	12	Mar-21	Quality, Safety & Experience Committee	Workforce
	3	12/06/2020	Due to failures to maintain aqequate social distancing in ward and emergency unit areas there is an increased risk of transmitting Covid-19 and the consequential risk of patient and/or staff harm.	5	5	25	Purple areas making attempts to adhere to social distancing in ward and emergency unit areas. It is recognised that social distancing is not always maintained on nightingale wards. Beds are blocked to create the correct social distancing space when capacity allows. UHB guidance is that capacity is not lost except in exceptional circumstances which are supported by the Clinical Board and IP&C and Executive team.	5	4	20	Review of all wards and Emergency Unit areas to ensure that bed/trolley spaces and patient areas adhere to the social distancing principles, as is reasonably possible, whilst not blocking physical spaces. Ensure that patients have received appropriate education in social distancing and maintaining their safety in hospital. Any areas that have been assessed by the Senior/Lead Nurse and IP&C that do not adhere to social distancing principles and still pose an increased risk to patients secondary to unchangeable environment and ergonomics should be escalated to the Clinical Board.	5	2	10	Mar-21	Quality, Safety and Experience Committee	Patient Safety
	4	01/12/2021	There is a risk of patient harm due to patients remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB.	5	5	25	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patient's condition, the WAST crew will immediately inform the MAN. Concern by either party about the length of any delay or the volume of crews being held will be escalated by the Senior Controller/EU NIC to the Patient Access for usual UHB escalation procedures, or by WAST to their Silver Command. WAST have introduced a number of hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer. For patients arriving in UHW and UHL assessments units, the NIC will assess these patients and escalate in line with policy. Standard Operating Procedure in place within the Emergency Department to support any 'Immediate Releases' requested by WAST.	5	4	20	Review of all wards and Emergency Unit areas to ensure that bed/trolley spaces and patient areas adhere to the social distancing principles, as is reasonably possible, whilst not blocking physical spaces. Ensure that patients have received appropriate education in social distancing and maintaining their safety in hospital. Any areas that have been assessed by the Senior/Lead Nurse and IP&C that do not adhere to social distancing principles and still pose an increased risk to patients secondary to unchangeable environment and ergonomics should be escalated to the Clinical Board.	5	2	10	Mar-21	Quality, Safety and Experience Committee	Patient Safety
	5		There is a risk of delays in patient care and serious incidents for delayed cancer diagnosis due to an accumulation of therapeutic and sureveillance backlog for Endoscopy secondary to COVID restrictions.	4	5	20	Temporary additional capacity as Spire. Regular review of endoscopy template throughput in line with IP&C regulations. Change in pathway for some patients using alternative yet suboptimal alternative investigation eg, minimal prep CT	4	5	20	Endoscopy unit expansion (as per IMTP). Introduce 6 day working. Establish appropriate endoscopy workforce levels. SBAR completed highlighting plans and risks going forward to be discussed with Clinical Board. August 20 Endoscopy recovery plan commenced with further benefits of FIT testing being discussed with the Clinical Board.	4	3	12	Mar-21	Quality, Safety and Experience Committee	Patient Safety

PCIC	6	01/10/2019 (ongoing since September 2014)	**Community: Complex Care Packages** **Risk:** A risk of breakdown of community complex care packages leading to hospital admission, disrupted patient flow, and adverse impact on the afected patients/family. **Cause:** Due to there being a number of complex care packages, including ventilated patients, being delivered by independent nursing care agencies in the community, but a lack of capacity in the market, meaning that several complex care patients are delayed in placements and in hospital. There is an issue with the appropriate skills within the two main care agencies, such that there are increasing gaps in cover within the packages. Off Contract Nursing Agency switch off is adversely affecting 2 complex care packages. **Impact:** Adverse impact on service delivery due to additional demands for inpatient beds and services. Adverse impact on UHB reputation and potential financial loss. risk for the UHB. Increasing time demands on nurse assessor and senior nurse conducting case management and co-ordinating cover for the packages.	4	5	20	• Nurse Assessor and Senior Nurse conductng case management and co-ordinating cover for the packages. Work with Procurement towards developing and implementing a framework contract/SLA arrangement which would put in place more sustainable and robust contracting arrangements for complex packages of care and ensure that robust quality, safety and experience criteria are included • Testing out new agencies which have come onto the market, prioritising framework contract with Procurement • Risk updated and shared with clinical boards affected	4	5	20	Planned Review by 2021	4	3	12	Mar-21	Quality, Safety and Patient Experience	Sustainable Primary and Community Care
	7	12/03/2020	**Risk:** Significant negative impacts of COVID on the health of the resident population, allied to significant negative impacts of COVID on service delivery. Leading to an inability to guarantee safe, accessible and quality care. **Causes:** COVID is a global epidemic affecting 80% of the population with mild symptoms, 20% of individuals with serious illness with 4% requiring hospitalisation. Epidemic impacting on business as usual service delivery for NHS provided and contracted services (GMS/GDC/Optometry/Community Pharmacy); existing pressures on these services (sustainability issues, staffing vacancies, sickness and workload pressures) likely to be exacerbated by the effects of COVID and COVID public health restrictions. There will also be an impact on Independent contractors (Nursing Homes /Residential homes/Hospice and Hospice at Home services) who are likely to be unable to continue business as usual. **Consequence/Impact:** -NHS Staff not being available for work due to needing to self-isolate or because they are unwell or have carer responsibilities (up to 20%). -Unsustainable services across the Third sector /Independent sector due to impacts on staffing, IP&C, financial viability etc. -Impact on Nursing homes and residential homes service delivery; staffing availability, potentially older frail patients are COVID +ve, access to PPE and appropriate training. -Will impact on NHS services trying to support patients and manage illness and EOL care. -Staff may need to undertake clinical and non clinical activities that they have not been trained to undertake - requiring corporate and professional indemnity. - Polentially increased mortality/morbidity rate in the most vulnerable population cohorts. **19/3/2020: UPDATE** - changes made to risk assessment form to reflect patients with complex care packages and information governance. Score unchanged. **25/03/2020: UPDATE -** • Staff testing service may be unable to sustain current levels of testing due to the fragility of the model including laboratory testing services. Testing capacity is also a concern as there may be an increase in requests coupled with lack of available staff. • GP services are converting from a GP model to a Cluster model to deliver GP 24/7 services. If this is not sustainable GP OOH services will need to be used. Score unchanged.	4	5	20	1. Business continuity plans being worked through and assciated actions 2. PHW and PHE guidance provided to all staff and appropriate stakeholders 3. Executive Strategic Group set up to escalate immediate issues for esolution from PHW 4. Regular Senior Management team meetings increased to oversee Business Continuity Planning service delivery and operations. 5. Business Continuity Action Log established to monitor actions taken	4	4	16	Workforce priortisation exercises are to be undertaken.	4	3	12	Mar-21	Quality, Safety and Experience Committee & Strategy and Delivery Committee	Test Trace & Protect
	8	01/05/2020	**Risk:** That GP practices become unsustainable and unable to maintain their contract. **Causes:** -Difficulty in recruiting and retaining GPs in practice. - Increasing amount and complexity of general practice workload as population numbers and patient demand increase -Condition and size of GP premises, and security of ownership or tenure of GP premises **Impact:** -Reduced general practice capacity impacting the UHBs ability to ensure access of C&V UHB population to general practice services and other essential healthcare. - The increased demand on remaining contractors will also adversely impact on patient access resulting in longer waiting times, increased telephone call waiting times etc. - May lead to list closures, further limiting patient access to GP services. - Subsequent risk of increased demand on unscheduled services e.g. A&E and OOH services if people can't register with or access GMS services. This results in a suboptimalservice that is non-compliant with national standards.	5	4	20	1. Contract assurance process, including annual returns, provides an opportunity to identify and engage with practices potentially at risk of closure. 2. Supporting Primary Care Development with a view to improving sustainability of services. 3. Peer support opportunities for practices to discuss potential issues or concerns with CDs for Primary Care Contract and Development. 4. Discretionary funding streams available to incentivise practice mergers. 5. Developing funding streams for practices taking on significant patient growth, as a result of a practice closure. 6. Contract variations which impact on sustainability - boundary changes to help manage patient demand, temporary list closures to enable practices to "stabilise", branch surgery closures which enable practices to improve sustainability and resilience by focusing resources on a single site. 7. Practice Nurse Trainee Scheme being rolled out to practices offering support to nurses moving from secondary to primary care nursing and developing a future nurse workforce. 8. Improved links between primary care team, clusters and planning officers regarding planned population growth and local capacity to absorb, or developments required. 9. Development of CAVGP – website supporting GP recruitment. 10. Investment in IM&T support to practices, covering improved clinical coding, searches to support effective and efficient patient care. 11. Workforce data established to provide a baseline and ability to track changes moving forward.	5	3	15	Review of "covid expereicne" to consider improvements to business continuety and longer term sustainability	5	2	10	Mar-21	Quality Safety and Experience Committee	Sustainable Primary and Community Care

Specialist Services Clinical Board	9	26/09/2011	**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 Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	20	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.	5	20	20	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	10	Mar-21	Quality, Safety and Experience Committee	Patient Safety/Planned Care Capacity
	10	60/01/2016	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	5	25	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently.	5	3	15	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	10	Mar-21	Quality, Safety and Experience Committee	Capital Assets
	11	17/02/2020	**Haematology, Immunology & Metabolic Medicine - TYA Oncology Services** TYA cancer patients may elect to have their treatment on the designated TYA cancer unit hosted in University Hospital of Wales. 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 care delivery work, including patients and families to provide history.	5	4	20	Email correspondence from VCC Clinician confirming treatment plans. Expertise in pharmacy and nursing teams involved in TYA cancer care delivery.	5	3	15	Access to VCC chemocare on TCTU. Treatment plan proforma to be usitlsed by all TYA cancer patients. TYA team to access and use Canisc.	5	1	5	Mar-21	Quality Safety and Experience Committee	Patient Safety
	12		**Cardiothoracic - Clinical Area Relocations and Reduced Footprints** Following multiple relocations of the level 2 CCU Unit, Pacing theatre, PCI Service and acute cardiology beds there is a risk of sub-optimal patient experience and/or patient harm. Causes: 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 reduced 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 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.	5	5	25	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. •Reallocation of services	5	4	20	Continuous monitoring of covid 19 prevalence and impact and return to original service footprint as soon as is possible	5	2	10	Ongoing	Quality Safety and Experience Committee	Patient Safety

	13	28/10/2019	**Cardiac - Access to Cardiac Surgery** COVID 19 impacts have significantly reduced cardiac surgery provision. This results in the inability to meet 36 week RTT, and an inability to treat urgent patients. This may lead to increased mortality and morbidity of patients on the waiting list or those who freshly present to the service in an emergency. This will have a major impact on patient safety and quality of service and may result in adverse publicity and reputational harm.	5	4	20	Daily validation of cardiac surgery waiting lists by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly cardiac surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Standardised communication processes for patients on the waiting list for cardiac surgery. The transfer of Cardiothoracic surgical services to a Green Zone in have enable cardiothoracic surgery to resume within a safe environment and led to a material reduction in waiting times.	5	3	15	Due to the reallocation of cardiac services to UHL in response COVID 19 access to cardiac surgery has significantly improved. It is imperative that when the service returns to UHW from UHL that this level of performance and activity is maintained.	5	2	10	Mar-21	Quality, Safety and Experience Committee	Patient Safety/Planned Care Capacity
Surgery Clinical Board	14	SSDiv/01/2013	Failure to provide timely access to surgery which significantly affects the patients quality of life and can in some cases exacerbate their condition. Increased risk to patients who's condition may deteriorate whilst waiting for surgery due to Covid	4	5	20	Development of Green Zones in both UHW and UHL to protect cancer and urgent patients who require surgery. Proactive Discharge Planning required to ensure bed availability in a timely manner and ensure. Quality assurance of patients waiting on list is undertaken and treatment expedited if GP requests urgent referral or if information received indicated urgent need of referral - this is overseen by a consultant. Weekly discussions to review longest waiters and the appropriate booking of them. Audit data on surgical patients has been collected since March 2020	4	4	16	Due to changes in requirements in theatre due to Covid pandemic our ability to provide theatre and PACU slots is greatly reduced. CB still supporting the T&T and MERIT teams. Delays in opening Green Zone for Orthopaedics and breast in UHL due to estate delays - now due to open 9th Nov	4	2	8	Mar-21	Quality, Safety and Patient Experience	Patient Safety/Planned Care Capacity