Quality, Safety & Experience Committee

Wed 15 September 2021, 13:30 - 15:30

MS Teams

Agenda

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the Committee Meeting held on 15 June 2021

Ceri Phillips

1.4 PUBLIC QSE MINS 15.06.21 - AF.NF.pdf (13 pages)

1.5. Action Log – Following the meeting held on 15 June 2021

Ceri Phillips

1.5 Action Log QSE for Sept 2021 meeting.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

2. Items for Review & Assurance

2.1. Medicine Clinical Board Assurance Report

Aled Roberts / Geraldine Johnston / Rebecca Aylward

2.1 QSE Clinical Board assurance report - July 2021 (Final).pdf (27 pages)

2.2. Perfect Ward Report

Ruth Walker

2.3. Quality, Safety and Experience Framework Update

Carol Evans

Including Quality Governance Structure

2.3 QSE Framework- QSE - September 2021.pdf (4 pages)
2.3a Appendix 1 -QSE Framework 2021-2026 v6 26-08-2021.pdf (21 pages)
2.3b Appendix 2 - Clinical Safety Group - Terms of Reference - v2.pdf (6 pages)

2.3c Appendix 3 - Organisational Learning Committee,RW v3.pdf (4 pages)

2.4. Quality Indicators Report

Ruth Walker

2.4 Quality Indicators - Sept QSE 2021 v1.pdf (15 pages)

2.5. Exception Reports – Verbal

Ruth Walker / Stuart Walker

2.6. HIW Activity Overview & Primary Care Update

Carol Evans

2.6 HIW update on activity_QSE September 2021 V1.pdf (4 pages)
2.6a Appendix 1 - NHS SoC Engagement Proposal -2021-01-11.pdf (11 pages)
2.6b HIW Primary care overview - SBAR August 2021.pdf (4 pages)
2.6c HIW Primary Care SBAR August 2021 Appendix 1 GDS.pdf (5 pages)
2.6d HIW Primary Care SBAR August 2021 Appendix 2 GMS.pdf (2 pages)

2.7. Board Assurance Framework – Patient Safety

Nicola Foreman

2.7 BAF Covering Report.pdf (2 pages)
2.7a Patient Safet1.pdf (3 pages)

3. Items for Approval / Ratification

3.1. Incident, Near miss and Hazard reporting Policy

Carol Evans

3.1 Incident, hazard and near miss reporting procedure QSE Committee - Sept 2021.pdf (2 pages)
3.1a Incident reporting Procedure Sept 2021 v2.pdf (16 pages)
3.1b EHIA Incident, Hazard and Near Miss Incident reporting Procedure.pdf (18 pages)

3.2. Patient Identification Policy

Carol Evans

3.2 Review of pt ID policy - QSE Committee - 2021 -.pdf (2 pages)
3.2a Appendix 1 - Patient identification procedure v3 2021.pdf (10 pages)
3.2b Appendix 2 - EQI Assessment Form- Patient ID - OCT 2020.pdf (25 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 & Womans Clinical Board Minutes - 25.05.21 & 22.06.21
b) Specialist Clinical Board MInutes - 04.06.21 & 25.06.21
c) CD&T Clinical Board Minutes - 09.06.21
d) Mental Health Clinical Board Minutes -
e) Medicine Clnical Board Minutes - 20.05.21 & 17.06.21
f) PCIC Clinical Board Minutes - 12.05.21 & 14.07.21

4.1a C&W 25.05.21.pdf (8 pages)
4.1a C&W QSPE Minutes 22.06.21.pdf (8 pages)

- 4.1b Specilaist 04.06.21.pdf (6 pages)
- 4.1b Specialist 25.06.21.pdf (5 pages)
- 4.1c CD&T 09.06.21.pdf (12 pages)
- 4.1f Medicine 20.05.21.pdf (6 pages)
- 4.1f Medicine 17.06.21.pdf (7 pages)
- 4.1g PCIC Minutes 12.05.21.pdf (7 pages)
- 4.1g PCIC Minutes 14.07.21.pdf (9 pages)

4.2. Corporate Risk Register

Nicola Foreman

- 4.2 QSE - Corporate Risk Register Covering Report - September 2021.pdf (3 pages)
- 4.2a QSE - Detailed Corporate Risk Register.pdf (3 pages)

4.3. National Patient Safety Incident reporting policy

Carol Evans

- 4.3 New NIR process v2 - QSE Committee - 2021 -.pdf (3 pages)
- 4.3a Appendix 1 - Phase 1 Policy Guidance Document v1.0.pdf (15 pages)
- 4.3b Appendix 2 - National Incident Reporting Flow Chart - Final.pdf (1 pages)

4.4. Update From Clinical Effectiveness Committee

Stuart Walker

- 4.4 CEC QSE SEPT 2021 V2.pdf (14 pages)

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

Ceri Phillips

6. Any Other Business

Ceri Phillips

7. Review of the Meeting

Ceri Phillips

8. Date & Time of Next Meeting:

Tuesday, 26 October 2021 (Special)

Time - 9am
Via MS Teams

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 15th June 2021 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authority
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Michael Imperato	MI	Independent Member – Legal
In Attendance		
Sue Bailey	SB	Director for Quality, Safety and Patient Experience – CD&T
Siobhan Bird	SB	Student Nurse
Annie Burrin	AB	Patient Safety Team
Tara Cardew	TC	Lead Nurse
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Aaron Fowler	AF	Head of Risk and Regulation
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Christopher Lewis	CL	Deputy Director Finance
David Poland	DP	Audit Wales
Jason Roberts	JR	Deputy Executive Nurse Director
Paul Rogers	PR	Assistant Director in therapies and Healthcare Science
Matthew Temby	MT	Director of Operations (CD&T)
Stuart Walker	SW	Executive Medical Director
Joy Whitlock	JW	Head of Quality & Safety
Wendy Wright	WR	Deputy Head of Internal Audit
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Fiona Kinghorn	FK	Executive Director of Public Health
Catherine Phillips	CP	Executive Director of Finance

QSE 21/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting. It was noted that Paul Rogers - the Assistant Director in therapies and Healthcare Science (ADTHS), Tara Cardew – Head of Patient Safety and Siobhan Bird – Student Nurse would be in attendance at the meeting.	**Action**
QSE 21/06/002	**Apologies for Absence** Apologies for absence were noted.	

QSE 21/06/003	**Declarations of Interest** The Executive Director of Therapies & Health Science (EDTHS) advised the Committee that her role in Cwm Taf Morgannwg University Health Board (CTMUHB) be identified as a declaration of interest. The Independent Member – Legal advised the Committee that he had a declaration of interest in agenda item 4.4 – Blood Inquiry Update.	
QSE 21/06/004	**Minutes of the Committee Meeting held on 13 April 2021** The minutes of the meeting held on 13 April 2021 were received and confirmed as a true and accurate record of the meeting **The Committee resolved that:** a) The minutes of the meeting held on 13 April 2021 were approved as a true and accurate record of the meeting.	
QSE 21/06/005	**Action Log following the Meeting held on 16 February 2021** The action log was received and the Committee noted that the majority of the actions had been completed or were on the agenda for discussion during the meeting, or were due for discussion at a future meeting.	
QSE 21/06/006	**Chair's Action taken since last meeting** No Chairs Actions were noted.	
QSE 21/06/007	**CD&T Clinical Board Assurance Report** The CD&T Clinical Board Assurance Report was received. The Director for Quality, Safety and Patient Experience – CD&T (DQSECDT) presented a staff story to the Committee. The story highlighted a member of staff who had been redeployed to a Covid-19 area during the pandemic and their feelings and experiences towards that. It was noted that the staff member had both negative and positive experiences and the DQSECDT advised the committee that the staff member had received relevant support from the clinical board and staff well-being service. The DQSECDT presented the key learnings from the staff story and advised the committee that although deployed staff had faced challenges, the feedback received from the wards had been positive and it was noted that staff provided by CD&T had been a credit to the clinical board. The CC asked the DQSECDT to pass on the QSE Committee's thanks to the member of staff who had provided the story and thanked the CD&T	

	clinical board for providing members of staff who had been redeployed to various areas during the pandemic. It was noted that commendation and thanks from the committee should be shared with all clinical boards for their efforts during Covid-19. The DQSECDT presented the CD&T Clinical Board Assurance Report and noted that the first section provided an insight as to what had happened during the pandemic and some of the things that the CD&T Clinical board had changed and reflected upon. The Director of Operations (CD&T) (DOCDT) highlighted a number of changes within CD&T teams during the pandemic and the impact they had on patient experience. The DOCDT provided an example of the Physiotherapy department which during the first wave had circa. 2000 patients waiting which had been reduced to zero. It was noted that this was due to a combination of efforts including virtual working and management of face to face appointments. The Executive Medical Directed (EMD) advised the committee that CD&T were subject to more regulatory compliance than other areas and noted that the data shown in the report in this regard was a positive outcome. He added that there was information in the report around Electronic Test Requesting (ETR) and asked if more information could be provided. The DOCDT advised the committee that the previous year, the Clinical Board recognised the need to progress ETR for Laboratory Medicine and noted that good progress had been made especially within the laboratories. It was noted that the Clinical Board would provide further updates on ETR work in future assurance reports. The EMD advised the committee that there was nothing around NICE guidance in the report and asked if the DQSECDT could provide more information on this area. The DQSECDT responded that NICE guidance was something that would be worked on now that a new member of staff had been appointed who could support that stream of work. The Independent Member – University (IMU) asked if preparation had been given to electronic prescribing and medicine management (EPMA). The EMD responded that good progress was being made and that it was something that had been needed since 2007. It was noted that a decision was made at Board level to take a leadership role in Wales in delivering EPMA. The IMU noted that in relation to reporting incidents, two thirds of incidents had come from laboratory medicine and asked for clarity on that number.	**NS**

	The DQSECDT responded that the numbers were collected from the number of laboratory incidents around poorly labelled specimens and noted that this was why the ETR process would be crucial in rectifying those issue. The Independent Member – Legal (IML) noted that the report mentioned innovative approaches to delivery and asked for clarity on what work had been undertaken. The DOCDT responded that virtual working had been very innovative for CD&T and the strategy for services to be more community based. He noted that there was a real drive in those areas and one of the Clinical Board's recovery strategies would look to pull people from core waiting lists to provide them with wellbeing support in the community. **The QSE committee resolved that:** a) The progress made by the Clinical Board to date and its planned actions were noted. b) The approach taken by the Clinical Board was approved.	
QSE 21/06/008	**Quality, Safety and Experience Framework Update** The Quality, Safety and Experience Framework Update was received. The Assistant Director of Patient Safety and Quality (ADPSQ) advised the committee that it had previously been agreed that an update would be provided to the committee with a view to bringing the final Quality, Safety and Experience Framework (QSE Framework) to the September committee meeting. The ADPSQ presented to the Committee the Quality, Safety and Patient Experience Framework 2021 – 2026. It was noted that a workshop had taken place in 2020 and had provided discussion around QSE priorities for the next 5 years. This included: • A Healthier Wales 2018 • National Clinical Framework: a Learning Health and Care System 2021 • NHS Patient Safety Strategy 2019 (2021) • WHO Global Patient Safety Action Plan 2021-2030 • The Patient Safe Future: A Blueprint for action 2019 • Patient Experience Improvement Framework 2018 It was noted that since September 2020 there had been wide engagement within the organisation and with external stakeholders. It was noted that a Safety Culture Survey had been sent out to staff and that 988 members of staff had started the questionnaire but, due to the length of the questionnaire, a number had not completed it upon starting.	

	Themes identified from the survey included: • The need to improve feedback following incidents, more work would be needed on 'Just culture', workload, time for training, near-miss reporting and information exchange between departments. It was noted that 50% of staff felt that the organisation were promoting a climate that promoted patient safety and 50% of staff felt that there were good systems and processes in place for preventing harm. The ADPSQ advised the committee of the 8 areas within the framework: • Safety Culture, • Leadership and Prioritisation, • Patient experience and involvement, • Patient safety learning and communication , • Staff engagement and involvement, • Data and Insight, • Professionalism, • Quality Governance It was noted that the eighth area, Quality Governance, would have a final structure brought to the September Committee meeting. The IMU advised the Committee that he had read the Gosport Report and it had struck him how it could relate to the QSE Framework and noted that the safety culture would need to be embedded across CVUHB so that the whole system could be immersed with this approach to quality and safety and he asked how primary care practitioners were being engaged on the issue. The ADPSQ responded that health care was risky and that even when aiming for zero avoidable harm, things could go wrong. She added that what needed to be avoided were systemic issues that CVUHB were not aware of. It was also noted that conversations had started with Primary care and it was recognised that the QSE framework felt more secondary or tertiary focused which needed to be addressed. **The QSE committee resolved that:** a) The Quality, Safety and Experience Framework Update was noted.	
QSE 21/06/009 Saunders,Nathan 09/09/2021 09:43:30	**Quality Indicators Report** The Quality Indicators Report was received. The DEND highlighted some areas to note: • In May 2021, Welsh Government (WG) in partnership with the Delivery Unit have issued a new All Wales Patient Safety Incident Reporting Policy. • Phase 2 would commence in July 2021 and would focus on developing new thematic ways of reporting certain incident types	

	across a number of specialities, including commonly reported incidents such as pressure damage, falls, and hospital acquired infections (including nosocomial Covid-19). • The number of reported pressure ulcers continued to increase and it was noted that the trend would be kept under review by the UHB Pressure Ulcer Collaborative. It was noted that considerable work had been undertaken in the organisation to improve the rate and quality of reported pressure damage; nevertheless this was a trend which would require continued monitoring. • The stroke position. There were a number of indicators in the report which show how challenging performance had been. • The IP&C Team were working with relevant Clinical Boards to identify possible areas for improvement. • Nutritional assessments had increased since the last committee meeting. The IMU noted that the number of significant pressure damage incidents had dropped and asked if that was due to the way in which pressure damage was recorded. The ADPSQ responded that although the reporting mechanism had changed, a local report was still kept for all incidents. **The QSE committee resolved that:** a) The contents of the Quality Indicators Report and the actions being taken forward to address areas for improvement was noted.	
QSE 21/06/010	**Exception Reports – Verbal** The DEND advised the Committee that there was no specific items to bring to the attention of the Committee and gave a brief Covid-19 update. It was noted that transmission had been building over the previous weeks and was being closely monitored as at the time of the meeting there were 3 patients with Covid-19 in a hospital setting. It was noted that there were 61 cases in Cardiff and the Vale and that all 61 cases were being treated as a variant of concern despite further clarity being needed. **The QSE committee resolved that:** a) The Exception Report was received.	
QSE 21/06/011	**Waiting Lists and Cancer Services update** The COO presented to the Committee.	

	It was noted that there were 4 harms in the Welsh Government annual framework: • Harm from COVID • Harm from an overwhelmed NHS and social care system • Harm from wider societal actions/lockdown • Harm from reduction in non-covid activity. The COO advised the Committee that focus of his presentation would be on the "Harm from reduction in non-covid activity" element of the framework. The amount of activity lost over the pandemic between March 2020 and February 2021 was noted. The Coo shared that over 22K inpatient day case surgeries were not undertaken during that period. In the Health Board's plans being submitted to WG, some assumptions had been made and Health Board Level Scenario Modelling had been undertaken which identified the following: • Substantial uncertainty in forward projections due to lack of predictability of; - Further wave(s) - The point at which additional IP&C measures could be removed - The proportion of lost activity that would need to be re-provided • Three case scenarios had been developed to better understand the range of possible scenarios; - Best-case - Central-case - Worst-case. It was noted that when the scenarios were applied to the modelling, it showed that in the best case scenario, waiting lists would go back to pre-Covid levels by 2024. In the central-case scenario the average timescale was December 2028 and in the worst-case scenario the timescale was brought out at "never" which was not an option to consider. The COO advised the Committee that a full recovery from the pandemic would likely take at least 5 years and would require sustained and significant additional capacity. It was noted that additional capacity alone would not be enough and the NHS would need to fundamentally review the services it provided and the way in which they were being provided. Both additional capacity and pathway redesign would take time and therefore there would be a need to support patients, manage expectations and enhance the services which were alternatives to treatment. The COO advised the Committee that all patients on the inpatient waiting list who were on the Patient Management System (PMS) had been categorised against the Royal College of Surgeons categories.	

	It was noted that the ambition was to return to elective activity of 70% pre-Covid levels in Q1 of 2021 which had been achieved and for that to be increased to 80% in Q2. The CC asked the COO if learning could be taken from anywhere else in the UK around the approach to waiting list management. The COO responded that there was and learning that had been adopted in Wales around ophthalmology could possibly be applied to the Cancer services. The IML asked the COO how staff and patients would receive the relevant information about the approach that CVUHB would be taking. The COO responded that it would be crucial to have communication with staff and patients and that openness would be required. The COO advised the committee that the presentation would be shared via email post meeting. **The QSE committee resolved that:** a) The Waiting Lists and Cancer Services update was noted.	SC/NS
QSE 21/06/012 Saunders,Nathan 09/09/2021 09:43:30	**Pressure Damage Report** The pressure Damage Report was received. The ADPSQ presented to the Committee on behalf of the Director of Nursing for Surgery who was also the professional lead for pressure damage prevention and management within CVUHB. It was noted that the activity of the pressure group had decreased during the Covid-19 pandemic but was increasing again and a collaborative had been formed that encompassed both Primary and Secondary Care. It was noted that the aim of the Collaborative was: • To reduce the incidence of healthcare acquired pressure damage within the Health Board. • To speed up adoption of innovation into practice to improve clinical outcomes and patient experience. It was noted that a project plan had been put together for some of the key themes of work that needed to be taken forward to tackle pressure damage within CVUHB. It was noted that the focus moving forward would be on information and data around the damage and that work was ongoing to build a specific dashboard.	

	The EMD advised the committee that due to the END sending apologies for the meeting he would recommend that a further update be provided at the next QSE committee meeting. He added that a decision about what was appropriate for escalation and assurance would be needed and what the right amount of oversight and escalation would be for the QSE committee. It was noted that thought would also be required as to how the QSE committee would escalate information it received to the Board. **The QSE committee resolved that:** a) The contents of the report and the actions being taken forward to address areas for improvement were noted.	NS
QSE 21/06/013	**Falls Group Update** The Falls Group Update was received. The EDTHS advised the committee that falls had been a big issue for CVUHB and assurance was needed about where the organisation was in relation to falls. It was noted that a dashboard had been created to provide further information to members of the committee. It was noted that CVUHB could not stop people falling but could try to deliver a patient centered service that looked at multi-factorial risk assessment and intervention around falls patients. The EDTHS advised the committee that mandatory training should be provided for staff around falls as recommended by the Royal College of Physicians. It was noted that the head injury figures were not huge but assurance could be given that the organisation had looked at each of the cases in detail and WG were also looking at how to develop further supporting guidance. **The QSE committee resolved that:** a) The Falls Group Update was noted. b) Training in falls assessment, prevention and management should be mandatory and monitored on ESR.	

QSE 21/06/014	**Gosport Review Update** The ADPSQ advised the Committee that the update provided information on outstanding issues from previous meetings. It was noted that the ADPSQ had met with relevant key stakeholders and had provided a high level of assurance that there were processes and systems in place to monitor prescribing habits across CVUHB. The IMU noted that a section would be added to the medicines code and asked what that would be. The ADPSQ responded that the medicines management group had agreed a standard operating procedure (SOP) and that the medicines code was widely accessible to staff and it was agreed that she would find out what the relevant section would be and feedback to the IMU offline. **The QSE committee resolved that:** a) The Gosport Review Update was noted.	
QSE 21/06/015	**HIW Activity Update** The HIW Activity Update was received. It was noted that HIW activity had reduced over the pandemic but that it was evident that activity had begun to increase. Since the last HIW activity report in April 2021, there had been checks on Owl Ward on 12th May 2021 and a positive check to the teenage cancer trust and Hazel Ward. It was noted that as part of the HIW annual review programme for 2020-21, a local review of the Welsh Ambulance Service Trust (WAST) was being undertaken and that the focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and overall patient experience. It was advised that HIW had announced their intention to carry out a National Review Of Mental Health Crisis Prevention in the Community and it was anticipated that the review would be completed and published by Autumn 2021. It was noted that a review of diagnostic imaging would be carried out in August 2021. **The QSE committee resolved that:** a) The level of HIW activity across a broad range of services was noted.	
QSE 21/06/016	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received.	

	The Head of Risk and Regulation (HRR) advised the committee that the BAF recorded the Strategic Risks faced by the Health Board and the paper presented highlighted the patient safety risks within the BAF that were reviewed and approved by the Board in May 2021. The ADPSQ advised the Committee that it was worth mentioning Covid-19 recovery and the risk in terms of that to patient safety. She added that WG had commented that CVUHB had not been explicit enough in the current Quality framework on the work being undertaken on Covid-19 recovery. **The QSE committee resolved that:** a) The Board Assurance Framework risk in relation to Patient Safety was noted and reviewed.	
QSE 21/06/017	**Health Care Standards Strategy and Action Plan** The Health Care Standards Strategy and Action Plan was received. The DEND advised the committee that there had been an internal decision to review the 16 standards internally and that they had been taken to Board and Independent members. **The QSE committee resolved that:** a) The progress made against each of the Health and Care Standards was noted. b) The Corporate Priorities for 2021/22 were approved.	
QSE 21/06/018	**Prevention and Management of In-Patient Falls Policy** The Prevention and Management of In-Patient Falls Policy was received. It was noted that the policy had been quality impact assessed. **The QSE committee resolved that:** a) The Policy and Procedure for the Prevention and Management of Adult In-patient Falls, subject to any changes required following consultation, was approved. b) Subject to appropriate approval of any changes that may be required following consultation, the full publication of the Policy and Procedure for the Prevention and Management of Adult In-patient Falls in accordance with the UHB Publication Scheme was approved.	

QSE 21/06/019	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from the Clinical Board QSE Sub-Committees were received: 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 **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees be noted.	
QSE 21/06/020	**Committee Effectiveness Survey results 2020-2021** The HRR advised that CVUHB had undertaken a review of the Board and its Committees, using survey questions derived from best practice guidance, including the NHS Audit Handbook, and using the following principles: • the need for Committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives, • the requirement for a Committee structure that strengthens the role of the Board in strategic decision making and supports the role of Independent Members in challenging executive management actions, • maximising the value of the input from Independent Members , given their limited time commitment, • Supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2020-2021, relating to the Quality Safety & Experience Committee were noted. b) The action plan developed for 2020-2021, which will be progressed via Board Development sessions was noted.	
QSE 21/06/021	**Corporate Risk Register** The HRR advised the Committee that there was nothing further to add and that the report be taken as read.	

	The Committee resolved that: a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the work which is now progressing was noted.	
QSE 21/06/022	**Blood Inquiry – Update** The Blood Inquiry Update was received. **The Committee resolved that:** a) The contents of the report and links to inquiry resources were noted.	
QSE 21/06/023	**Items to bring to the attention of the Board / Committee** The EMD suggested to the Committee that stroke performance measures and pressure ulcer updates be taken to the Board.	**NS**
QSE 21/06/024	**Any Other Business** No other business was noted	
QSE 21/06/025	**Review of the Meeting** No further comments were made.	
QSE 21/06/026	**Date & Time of Next Meeting:** **Thursday 16 September 2021 at 9am** Via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 16 September 2021
(Following the meeting held on 15 June 2021)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 21/04/014	Quality, Safety and Experience Framework update	An update on Quality, Safety and Experience Framework	15.06.21	Carol Evans	**COMPLETE** On **June** Agenda
QSE 21/04/013	Gosport Review	Provide an update on all outstanding issues	15.06.21	Carol Evans	**COMPLETE** On **June** Agenda
QSE 21/04/008	Falls group update	The falls group to provide an update and give assurance around the work being done.	15.06.21	Fiona Jenkins	**COMPLETE** On **June** Agenda
Actions In Progress					
QSE 21/06/012 **QSE 21/04/008**	Pressure Damage Report	A pressure damage update would be brought to the September 2021 meeting	28.09.21	Carol Evans	On **September** Agenda. Stuart Walker asked for it to be brought back for further discussion
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					
QSE 21/06/023	Items to bring to the attention of the Board	Stroke Performance and Pressure Ulcer updates to be shared with the Board		Stuart Walker	Date to be confirmed.

Report Title:	**QSE Medicine Clinical Board Assurance Report**	**Agenda Item no.**	**2.1**
Meeting:	**QSE Committee Meeting**	**Meeting Date:**	**16th Septemer 2021**
Status:	**For Discussion**	**For Assurance**	**For Approval** **X** **For Information**
Lead Executive:	**Executive Nurse Director Ruth Walker**		
Report Author (Title):	**Quality and Governance Lead Katherine Prosser**		

Background and current situation:

This report provides detail of the clinical governance arrangements within Medicine Clinical Board in relation to Quality, Safety and Patient Experience (QSPE). It identifies the achievements, progress and planned actions to maintain the priority of QSPE. This is aligned to the UHB's Shaping Our Future Well Being Strategy 2015 – 2025, underpinning the development of our service, and going forward the Quality, Safety and Patient Experience Framework 2021-2026.

The Medicine Clinical Board offers high quality clinical care for people with multiple, complex health needs, minor injuries and serious disease. The services provide for the wider regional and Welsh population eg, Infectious Diseases, Welsh Gender, Stroke, Diabetes, Dermatology and Gastroenterology. The Clinical Board also provides secondary care services to the local Cardiff and Vale population

The Clinical Board for 2021/22 has an annual budget of £116.5m, and a current workforce establishment of 1642.69 WTE staff in post which includes 717.70 Registered Nurses, 454.37 Health Care Support Workers, 199.55 Admin and Clerical, 221.03 Medical and Dental staff, 5.85 Additional Prof Scientific and Technic, 30.12 Additional Clinical Services, 8.0 Allied Health Professionals, 1.0 Student and 5.07 Health Care Scientists. It has an inpatient bed base of 607, three Day Units and several outpatient suites. In addition, there are currently 115 additional un-commissioned inpatient beds open which includes, C7, Lakeside Wing and Heulwen.

Secondary to the diversity and high activity provided across the Clinical Board, it is essential that robust risk management arrangements are in place to reduce the risk to our staff and service users.

The aims of the Medicine Clinical Board in summary are:

- Ensuring that there is a process in place to continually monitor and review the quality and safety risk register, acting to mitigate risks on an ongoing basis;

- Maintaining an open culture of improving quality, safety and patient experience across all teams and all staff; and

- Promoting a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care.

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

The Current Registered Nurse vacancy position is 10%, an improved position to previous years when the Clinical Board reported a vacancy position of 25%. However, the additional capacity of 115 beds requires 85 WTE Registered nurses. This Registered nurse gap is having a significant impact on the ability to provide a consistently good standard of care, which is also having a negative impact on staff health and well-being.

As a recovery project following the first wave of Covid-19 Cardiff & Vale delivered CAV 24/7 – which has been successful in scheduling unplanned care in the Emergency Department. Following on from this MCB has embarked upon "Right Bed First Time" (RBFT) aiming to achieve efficiencies in patient bed days by placement of the right patients in the correct inpatient beds with the most appropriate Specialist team, and minimising inpatient moves. This project is being supported with recovery unscheduled care funds. Without CAV 24/7 and RBFT efforts the UHB would likely be feeling much more keenly the effects of the increasing difficulty in transferring care of complex patients following their acute inpatient admissions.

Other projects that MCB are undertaking utilising unscheduled care recovery funds are enhanced triage by senior decision maker ("RATZ" – rapid assessment and triage zone) in ED and augmented ambulatory care in the Medical Ambulatory Emergency Care Unit (MAECU) to bring a 7-day ambulatory Acute Medicine, same day emergency care (SDEC) service, supported by Specialist Acute Physicians, for the first time to C&V.

All these initiatives transform the way in which we provide acute services, delivering senior decision makers with the support of the wider MDT, early in the pathways of the acute care of unscheduled Medical admissions.

The challenges of the review and provision of social care in the community, and the staffing issues within care agencies as well as a crisis in the availability of Nursing and Residential home beds, has resulted in a significant increase in the number of medically fit patients residing in acute hospital beds. This has resulted in the requirement to maintain large numbers of inpatient hospital beds throughout the summer to accommodate the medically fit population. The resultant pressure in the system has impaired flow of medical patients, increased outliers, led to the need for extra inpatient capacity, and caused accumulation of patients with a decision to admit (DTA) in our Emergency Department.

This risk will significantly increase given the pressure's winter, facing into a potentially significant flu season, ongoing Pandemic pressures, RSV and a workforce that is fatigued.

Our medical admissions are slightly below pre Covid-19 levels, and our ambulatory, frailty and acute streams are working well in terms of early discharge and admission avoidance which is currently mitigating this risk somewhat. The unscheduled care initiatives described above (RATZ, MAECU 7 days, RBFT) will further support minimising patient time in our inpatient setting.

ASSESSMENT

1 GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

1a Clincial Board QSE arrangements

Quality, Safety and Patient Experience (QSPE) is the highest priority for the Clinical Board and has developed significantly. Both the Clinical Board Director and Director of Nursing lead the agenda.

QSPE group meetings are planned for every month and are well represented by medical, nursing and managerial staff for all Directorates as well as other multi-disciplinary colleagues from corporate areas who all take an active part in the meetings and shape the overall agenda. During the ongoing Covid-19 pandemic some of the QSPE meetings were cancelled secondary to overall UHB operational pressures, but any QSPE concerns identified were actioned and shared accordingly across all Directorates. The Terms of Reference and Work Plan are reviewed annually.

Date	Numbers who attended	Date reported to QSE
19/08/2021	27	(next meeting October 2021)
17/06/2021	25	20/08/2021
20/05/2021	25	01/07/2021
15/04/2021	24	26/05/2021
25/03/2021	25	26/05/2021
25/02/2021	24	26/03/2021
22/10/2020	21	15/03/2021
24/09/2020	16	09/11/2020
20/08/2020	27	01/10/2020
16/07/2020	23	01/10/2020
18/06/2020	16	20/07/2020

1b Current top 5 Clinical Risks:

Description of risk and date added to RR	Consequence (1-5)	Likelihood (1-5)	Risk rating (1-25)	Controls in place
20/01/2021: The Clinical Board has experienced a significant number of healthcare acquired Covid-19 outbreaks during the ongoing pandemic. It is currently unknown to what extent the level of harm that has been sustained for both patients and staff. The Clinical Board currently do not have an accurate oversight for the total number of patients who have acquired Covid-19, and those patients that have died. The Clinical Board are therefore unable to provide meaningful evidence that would support the UHB in the investigations required, and to understand any learning or themes.	5	5	25	A Senior Nurse has been appointed for Covid-19 for a six-month secondment to lead on the investigations for healthcare acquired Covid-19. To implement COVID 19 HCAI Governance framework to identify learning and themes. To review IP&C processes within clinical areas. To support the UHB in completing the required level of investigations to establish level of harm for both patients and staff
01/03/2019: Patients are remaining on WAST ambulances for above the agreed 15-minute Welsh Government turnaround time secondary to lack of capacity across the UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	4	20	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
2017: Patients with suspected BCC are added to a routine waiting list. There is a risk that these may actually be unusual presentation of a higher risk SCC. Secondary to existing RTT waiting times for routine referrals (target 36 weeks) there is a risk that increased waits could impact on a patient's prognosis.	5	4	20	Ongoing work within the Directorate with Clinical Board oversight to reduce waiting lists. Live action plan in place with expected trajectory for improvement. Clerical and clinical validation of historic waiting lists are undertaken to ensure patients with abnormal presentation and histopathology results are pulled through the system.
01/01/2017: As a result of difficulties recruiting appropriate numbers of nursing staff and additional bed capacity being opened, the Clinical Board may not comply with the Nurse Staffing Levels (Wales) Act 2016 leading to a risk of patient or staff harm.	5	4	20	Posts advertised in a timely manner. Authorization of vacancies reviewed efficiently. Maximization of medical ward float staff. Regular recruitment events held. Engagement with Project 95. International Nurse recruitment. Adaptation programmes, student streamling and staff return to practice. Jan 2021: Risk staff framework completed daily by the Clinical Board and shared at daily LCC (Local Command Centre) UHB meetings which are held 4 times a day. May 2021: Daily UHB staff escalation meeting chaired by DoN to share Registered Nurse shortage across site.
01/01/2021: The ability to safely provide medical cover across all Specialties and disciplines across the Clinical Board secondary to ongoing Covid-19 pressures and overall recruitment is resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience. Increased current pressures due to additional bed Capacity Saunders,Nathan 09/09/2021 09:43:30	5	4	20	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.

07/06/2020: There is a risk of delays in patient care and serious incidents for delayed cancer diagnosis due to an accumulation of therapeutic and surveillance backlog for Endoscopy secondary to COVID restrictions. Update 23.8.21 - change in the local lower GI pathway has shifted all USC priority CT pneumocolon requests into secondary care. Implementation of FIT stool testing into pathway now requires result for some patient groups delaying decision making and waiting times for USC referrals	4	5	20	Waiting list initiatives in place. 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 Update 23.8.21 - triage is now undertaken in line with an updated local lower GI pathway. 6 rooms of insourcing activity (UHL & UHW sites) currently being undertaken every weekend.

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

2 SAFE CARE

Patient Safety Alerts/Internal Safety Notices

The Clinical Board has a robust management system in place for Patient Safety Alerts working in conjunction with the Patient Safety Team. An identified member of staff within the Clinical Board is responsible for all alerts received, and is responsible for the dissemination and actions where applicable. These are shared at Directorate and Clinical Board QSPE meetings. Patient Safety Alert PSA 13/June 21 Ligature and Ligature point risk assessment tools and policies has identified that further estates work is required by Capital and Estates to ensure that both the Emergency and Acute departments comply with this alert. A local risk assessment has been undertaken with internal measures in place to minimize any potential risk for patients. The Clinical Board is compliant with 96% of all Patient Safety Notices issued over the last year.

Mortality reviews

Mortality reviews are routinely undertaken as part of all Directorates QSPE meetings in line with the All Wales Checklist. Mortality Level 2 reviews are undertaken and a proportion of them shared at Directorate QSPE meetings as a means of discussion and shared learning. The Clinical Board is fully engaged and supportive of the Independent Medical Examiner at UHL and

in UHW when in post. The Clinical Board is currently identifying a process that will support embedding Mortality reviews in normal practice.

Health and Safety

In the period 01.08.2020 to 31.07.2021 9 incidents were reported to the Health and Safety Executive as RIDDOR events:
3 staff assault incidents, one of which resulted in a fracture to the arm
3 manual handling incidents
3 trip and fall incidents resulting in soft tissue injuries

All incidents were investigated in line with Health and Safety guidance, with the required support given to individual staff members. No common themes or areas of concern were noted. The Clinical Board had a well embedded Health & Safety meeting which formed part of the Clinical Boards's QSPE meetings every third month. Unfortunately, this was stood down over the two Covid-19 pandemics, but will be re-established over the next two months.

Falls

Falls remain the most reported incident within the Clinical Board via E - Datix, and these are shared at Clinical Board QSPE to identify any common themes or trends. The Clinical Board reports an average of 150 – 180 falls per month. However, for the months of December 2020 and January 2021 215 and 234 falls were reported. This can be attributed to the acuity of patients during the second Covid-19 pandemic and the deconditioning of patients whilst in the community and acute settings. Reassuringly, no patients were reported as 'major' harm for this period. In addition, for March 2021 203 falls were reported, which can be attributed to the opening of additional capacity in Lakeside Wing.

The Clinical Board remains fully engaged with the UHB's Fall's Delivery Group working in partnership with Primary Care colleagues and third sector agencies, and is supportive of the UHB falls review panel. The Clinical Board continues to undertake an Injurious Assessment for all falls, with a progression to a full Root Cause Analysis if required. All death related falls are referred to Her Majesties Coroner. These reports are shared across other Clinical Boards as appropriate to share wider learning, and also with families and carers to ensure transparency and rigor in the investigation process and learning outcomes.

In March 2021 Ward A1L (OPSU) commenced the Royal College of Physicians Gaining Insight from Inpatient Falls; Hot Debrief Pilot. Its aim was to draw out learning which could be shared immediately following a fall with a two-part approach including a hot debrief (as soon as possible after the fall; on the same shift and an after-action review), involving both patient and carers. This pilot can be completed electronically or manually, and some area's have requested the additional use of 'Measles Maps'. The debrief consists of capturing what the patient said happened, what staff said happened, measurables; where, when and how, performance against multifactorial risk assessments (MFRA) and what was learnt from the fall. The pilot identified there was a drop in the number of falls reported, learning identified to support NICE 2015 falls guidance for the completion of lying and standing blood pressure, and the lack of formal delirium assessments. The pilot identified there were no falls from over bedrails, and Measles Maps

identifying common areas for patient falls. This pilot is being widened to other inpatient areas, eg Sam Davies Ward Barry Hospital.

Pressure and tissue damage reduction and prevention

The Clinical Board continues to learn from all avoidable and unavoidable healthcare acquired pressure damage. Key areas for continued improvement include the use of appropriate heel offloading, and the use of repose cushions whilst sat in the chair, and the correct categorisation of pressure areas. There is a well embedded governance process that supports clinical areas to ensure the appropriate Welsh Government Pressure Damage tools are completed, and comply with the expectations of the Safeguarding Team, to ensure referrals are submitted in a timely manner for all avoidable healthcare acquired pressure damage.

From 01st August 2020 to date the Clinical Board reported 38 Category 3 and 16 Unstageable unavoidable pressure damage, 5 of which were device related. The investigations highlighted the majority of the patients were admitted with pre-existing pressure damage which evolved as part of their co-morbidities and acute illness. The Clinical Board would have retrospectively reported 9 avoidable healthcare acquired pressure damage to the Delivery Unit, if reporting had not been relaxed secondary to the ongoing Covid-19 pandemic. The investigations highlighted learning in terms of the correct categorisation and reporting of pressure damage, particularly around the identification of Fibrin compared to 'Slough', and confusion over what is Unstageable or Suspected Deep Tissue Injury (SDTI) pressure damage. The importance of accurate and timely documentation and update of multifactorial risk assessments to inform a patients plan of care.

In order to support these areas to improve practice, educational workbooks were completed, and support provided from Practice Development Nurses and Tissue Viability in providing education, and the completion of documentation audits to ensure that standards are maintained in line with best practice. Whilst the Clinical Board has seen an increase in the number of healthcare acquired pressure damage over the last year within E-Datix, this can be attributed to the additional inpatient bed capacity, and the co-morbidity of patients admitted with pre-existing pressure damage with acute illness and deconditioning. The Clinical Board is well represented within the Pressure Damage QSI project.

National Reportable Incidents

The Clinical Board are currently investigating the following National Reportable Incidents:

- Delay in Radio Frequency Ablation (RFA) Endoscopy
- Delay in surveillance Endoscopy
- 3 catastrophic head injuries
- 1 Injurious injury

In line with new guidance from the Delivery Unit and Patient Safety Team, fact finding tools and closure forms where ever possible are submitted within the expected timeframe.

The Clinical Board has recognized the risk that the ongoing Covid-19 pandemic has had on the ability to undertake Endoscopy and Colonoscopy procedures in line with recommendations for 'urgent suspected cancer', surveillance and RFA specialist referrals. Specialised Medicine have

developed a 'live action plan' with Clinical Board oversight and discussed at both Directorate Performance Reviews and QSPE forums to ensure that actions are being taken forward. This includes detail of the ongoing recovery plans, such as waiting list initiatives, provision of a mobile endoscopy unit and a Transnasal Endoscopy Pilot funded by Moondance and Olympus for a period of 3 months, which will increase capacity within Endoscopy. The clinical validation of GA/Propofol waiting lists to prioritise urgent patients.

The overall RTT position for Gastroenterology in July 2020 reported a 0 projected month end for 26, 36 and 52-week targets. For July 2021 8 patients were breaching Urgent Suspected Cancer (USC), 1834 patients who are overdue 8-week diagnostics, and 1467 patients overdue surveillance procedures. There are 484 patients breaching the 36-week target, of these 38 patients are breaching the 52-week target.

Likewise, Dermatology have seen significant challenges secondary to the ongoing Covid-19 pandemic and the number of patients breaching both 36 and 52-week targets. There is a 'live action' plan in place with Clinical Board oversight and discussed at both Directorate Performance Reviews and QSPE forums. Health Board validation of long waiters is being undertaken and reports are sent to Service Managers for review. Recovery funding has been agreed for waiting list initiatives and recorded on a position tracker to ensure that all information is captured from a governance perspective, with trajectory forecasting undertaken weekly to ensure corrective actions are taken. Dermatology have also been piloting Teledermoscopy with a view to continuing this once the resource requirements are determined.

Dermatology reported a 0 RTT 36 week position for February 2020 and for MOH's procedures. For July 2021 there are a total of 1863 patients breaching at month end, of these 1417 are breaching the 52-week target. For USC there is one projected breach for July.

The Clinical Board were jointly involved in a Regulation 28 from her Majesties Coroner with Children and Women's Clinical Board. This related to the recognition of Sepsis in young children and babies. As a result, a Paediatric Sepsis Screening Tool has been implemented which is undertaken on triage, which triggers the Sepsis Pathway and follows the patient through the UHB.

Safeguarding

All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals, with the appropriate actions taken and shared more widely if required. The Clinical Board are currently investigating 24 safeguarding referrals, 7 of these relate to healthcare acquired pressure damage. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency. From April 2020 to March 2021 55 safeguarding referrals were received for Adults, compared to 60 for the same period the previous year. For safeguarding children from April 2020 to March 2021 1,527 safeguarding referrals were received, compared to 1,459 referrals for the same period the previous year. Child referrals are high as these are submitted via the Paediatric Emergency Unit.

Concerns

Concerns between 01st August 2020 – 31st July 2021

The management of concerns is a key priority for the Clinical Board. The implementation of tracker meetings across all Directorates aligned to the Clinical Board tracker database is well embedded and allows an overview prompting timeliness of responses and actions undertaken where delays are identified.

The Clinical Board aims to resolve all concerns by early resolution with contact from the relevant Ward Sister/Manager, Senior/Lead Nurse or clinician. From August 2020 to July 2021 the Clinical Board responded to 806 concerns.

Compliance with the timescale for formal concerns has improved significantly. The current 30 day position for the Clinical Board 81%. This is discussed at all Directorate Performance Reviews and Clinical Board QSPE to help drive the continued improvement that is required.

Reasons of concerns are noted below:

Subject	Number
Clinical Treatment/Assessment	349
Appointments	66
Communication	197
Attitude/Behaviour	48
Discharge Issues	35
Other	28
Patient Care	10
Referral	8
Medication	10
Personal property/finance	18

Case reviews are undertaken as part of the Directorates QSPE to share any potential learning and themes. 'Learning From Events' and feedback from Welsh Risk Pool are shared at Clinical Board QSPE to inform shared learning and outcomes.

Infection, Prevention and Control

The Clinical Board is fully engaged with the expected reduction figures for all healthcare acquired infections and the challenge that this brings to promote safe and clinically effective care. Shared learning forms part of the QSPE and Clinical Board Infection, Prevention and Control agendas for all healthcare acquired infections and RCA's.

Clostridium Difficile

30 incidents of C. *Difficile* were reported for the Clinical Board from August 2020 – July 2021, this is a significant deterioration for the same time period the previous year where 19 incidents were reported. The investigations and discussion with Infection, Prevention and Control have identified the increased use of antibiotics for Covid-19 patients, has been a significant contributary factor

for the increase of cases. Environmental audits continue with evidence of compliance in most areas for Hand Hygiene, Bare Below the Elbow and Equipment. Where areas of improvement are identified actions are addressed with Clinical Board oversight.

MSSA

17 incidents of MSSA Bacteremia were reported for the Clinical Board from August 2020 – July 2021, this is a slight deterioration from the previous year where 13 incidents were reported. The investigations highlighted these were skin or line associated. With the support of Infection,

Prevention and Control colleagues focused work has been undertaken around PVC compliance and VIP scoring.

MRSA

The Clinical Board reported 4 incidents of MRSA Bacteremia from August 2020 – July 2021, this is a slight deterioration from the previous year where 2 incidents were reported. The investigations identified these were attributed to 3 skin contaminates and 1 urine source secondary to frequent catheterization for retention of urine.

E Coli

32 incidents of E Coli were reported for the Clinical Board from August 2020 – July 2021, which is a significant improvement from the previous year where 47 incidents were reported. These were mainly attributed to Urinary and Biliary sources. CAUTI audits are well embedded across the Clinical Board with actions undertaken within areas where improvement is required. Case note reviews with the support of Infection Prevention and Control colleagues note that the urinary sources predominately relate to patients presenting with long term catheters that require replacement.

A working group has been established to review how the risk of hospital associated bacteraemias associated with catheters can be reduced. These bacteraemias can increase a patient falls and delirium risk, impair recovery and mobilization, can cause recurrent urinary tract infections, with increased cost and length of stay. The aim is to embed a system for the daily review of catheters and removal of a catheter within 48 hours if possible.

Klebseilla

12 incidents of Klebseilla were reported for the Clinical Board from August 2020 – July 2021, this is a deterioration from the previous year where 6 incidents were reported. The investigations identified these were predominately urinary and biliary sources.

Psuedomonas

4 incidents of Pseudomonas were reported for the Clinical Board from August 2020 – July 2021 which is an improvement from the previous year where 5 incidents were reported. The investigations identified 3 were urine and 1 chest source.

The Clinical Board are participating in a PRONTO (Procalcitoinin and NEWS2 for Timely identification of sepsis and Optimal use of antibiotics) trial that could cut down the use of unnecessary antibiotics in suspected sepsis patients, save lives and minimize the risk of antimicrobial resistance. A randomised controlled trial is taking place in the Emergency Unit at UHW in partnership with the Centre for Trials Research at Cardiff University. The aim is to optimise the use of antibiotics in patients with suspected sepsis with point of care testing at triage. It is hoped that this will lead to an improvement in sepsis care at the 'front door' generally, and improve outcomes for everyone by improving the awareness and management of patients with suspected sepsis.

2a. Quality Metrics – Generic

No.	Rating	Rating last period	Quality metric	Period	Threshold source	Red	Amber
HB01			Percentage of patients receiving VTE risk assessments		National	≤95%	N/A
HB02	0		Number of Hospital acquired thrombosis (judged avoidable)	Last quarter 01st April 2021 – 30th June 2021	Internal		
HB03	30	19	Number of cases of Clostridium Difficile after >72 hours of in patient stay (cumulative year to date)	01st August 2020 – 31st July 2021	National		
HB04	4	2	Number of cases of MRSA bacteraemia after >48 hours of in patient stay (cumulative year to date)	01st August 2020 – 31st July 2021	Internal		
HB05	193		Number of Hospital acquired COVID 19 cases between 8-14 days on in patient stay	01st August 2020 – 31st July 2021	Internal		
HB06	253		Number of Hospital acquired COVID 19 cases after 15 days of in patient stay	01st August 2020 – 31st July 2021	National		
HB07			Percentage of patients who had Sepsis Six bundle completed in 60 minutes		National		
HB08	830	565	Number of newly acquired pressure damage (stage 2-4 or unstageable)	01st August 2020 – 31st July 2021	Internal		
HB09			Percentage of NEWS score >5 escalated		Internal		
HB10			Percentage of deaths requiring Stage 2 mortality review		Internal		

HB11			Percentage of death Stage 2 mortality review completed within 30 days of notification		Internal		
HB12	26		Number of cases awaiting a Coroner's inquest	To date	Internal		
HB13	6		Number of open Nationally Reportable Incidents currently under investigation	01st August 2020 – 31st July 2021	Internal	N/A	N/A

HB14	2		Number of open Nationally Reportable Incidents currently breaching agreed timescales for investigation	01st August 2020 – 31st July 2021	Internal		
HB15	23		Numbers of Nationally Reportable Incidents closed with the Delivery Unit (in last 12 months)	01st August 2020 – 31st July 2021	Internal		
HB16	0		Number of open Never Events	01st August 2020 – 31st July 2021	Internal	N/A	N/A
HB17	105		Number of open concerns	01st August 2020 – 31st July 2021	Internal		
HB18	81%		Current response time to concerns	01st August 2020 – 31st July 2021	Internal		
HB19	25% (within 2 working days)		% concerns managed under early resolution	01st August 2020 – 31st July 2021			
HB20	38		Number of open claims	01st August 2020 – 31st July 2021			
HB21	10		Number of referrals to Public Service Ombudsman	01st August 2020 – 31st July 2021	Internal		
HB22	0		Number of Regulation 28 reports	01st August 2020 – 31st July 2021	Internal		
HB23	5		Number of incidents where Nurse Staffing Levels was a contributory factor to either healthcare acquired pressure damage or an injurious injury	01st August 2020 – 31st July 2021	Internal		
HB24	97%		Compliance with Patient Safety Solutions	01st August 2020 – 31st July 2021	Internal	100%	

2b. Quality metrics – Medicine specific

Medicine Clinical Board							
No.	Current rating	Rating last period	Quality metric	Period	Threshold source	Red	Amber
MCB01	July 72%	June 72%	Percentage of EU patients seen, assessed and discharged within 4 hours of arrival		National	≤85%	≤95%
MCB02	36.4%		Percentage of Stroke patients receiving thrombolysis within 60 minutes of arrival	Jan – March 2021	National		
MCB03	53%	May 45%	Percentage of Stroke patients admitted to Stroke Ward within 4 hours	June 2021 - MTD	National	≤75%	≤85%
MCB04			Condition specific mortality rate – Stroke (numbers)		Internal	N/A	N/A
MCB05			Percentage of Dementia patients aged >75 admitted as emergency who are screened		National	≤80%	≤90%
MCB06			Percentage of patients under Diabetic Team who have minor or major lower limb amputation		Internal		
MCB07			Percentage of patients with known inflammatory bowel disease (IBD) admitted for >72 hours who received low molecular weight (LMW) heparin during their admission				

3 EFFECTIVE CARE

Each Directorate has a Clinical Audit Lead and forms part of the Clinical Board Director's responsibilities. The Clinical Board has an audit/research plan for 2020/2021. The Clinical Board would welcome the introduction of AMaT to support accurate and timely audit programmes and compliance. Examples of some of the clinical research/audits are noted as:

3a NICE Guidance (issued over last 12 months)

NICE Ref.	Title	Date issued	Compliance status Yes/No/Partial	Comment
DG40	High Sensitivity troponin tests for the early rule out of NSTEMI	01/08/2020	Yes	
TA655	Nivolumab for advanced squamous cell lung cancer after chemotherapy	01/10/2020	Outstanding	
TA653	Osimertinib for treating EGFR T790M mutation-positive advanced non-small cell lung cancer	01/10/2020	Outstanding	
TA654	Osimertinib for untreated EGFR nutation-positive non-small cell lung cancer	01/10/2020	Outstanding	
TA652	Alpelsib with fulvestrant for treating hormone-receptor positive, HERS2-ngeative, PIK3CA-positive advanced breast cancer (terminated appraisal)	01/10/2020	Outstanding	
TA662	Durvalumab in combination for untreated extensive stage small cell lung cancer (terminated appraisal)	01/11/2020	Outstanding	
TA665	Upadacitinib for treating severe rheumatoid arthritis	01/12/2020	Outstanding	
HST14	Metreleptin for treating lipodystrophy	01/02/2021	Outstanding	
NG190	Secondary bacterial infection of eczema and other common skin conditions; antimicrobial prescribing	01/03/2021	Outstanding	
NG167 (U)	Covid-19 rapid guideline; rheumatological autoimmune, inflammatory and metabolic bone disorders	01/03/2021	Yes	
NG191	Covid-19 rapid guideline: managing Covid-19	01/03/2021	Outstanding	
NG196	Atrial fibrillation: Diagnosis and management	01/04/2021	Outstanding	
NG172(UU)	Covid-19 rapid guideline: Gastrointestinal and liver conditions treated with drugs affecting the immune response	01/04/2020	Yes	
NG169 (U)	Covid-19 rapid guideline: dermatological conditions treated with drugs affecting the immune response	01/04/2021	Outstanding	
CG57	Atopic eczema in under 12's: diagnosis and management	01/03/2021	Outstanding	
NG144 (U)	Cannabis-based medicinal products	01/03/2021	Yes	
CG137 (UUU)	Epilepsies: diagnosis and management	01/05/2021	Outstanding	

3b National Audits

Name	Overall RAG rating	Highlights (areas of high compliance/areas for improvement)
European NET Society Centre of Excellence accreditation		
TARN		Ability to submit data within expected timeframe
Sentinal Stroke National Audit		
National Diabetes Audit		
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme		Undertaken in Primary Care
Royal College of Emergency Medicine Fractured Neck of Femur		
Royal College of Emergency Medicine Pain in Children		
Royal College of Emergency Medicine Infection Control		
Venous Thromboembolism Risk in Lower Limb immobilisation		

3c Local Clinical Audit (progress in line with local clinical audit plan)

Name	Overall RAG rating	Highlights (areas of high compliance/areas for improvement)
Management of infliximab patients during COVID pandemic		
Capsule endoscopy KPI audit		
Audit of appropriateness of faecal calprotectin and POCT in tertiary care		
TIA assessment and referral		
Paediatric Emergency Department Radiology Report Sign off		
Penicillin Delabelling		

Gastroenterology as part of their Covid-19 recovery plan are due to commence a Transnasal Endoscopy pilot which is tolerated much easier by patients, and does not require any recovery time. It is also safer for patients who have significant comorbidities. This will also act as another option for patients who are on the Propofol endoscopy waiting list secondary to poorly tolerated procedures.

Diabetes have set up a drive through HbA1C clinic, and provided virtual education for patients during the ongoing Covid-19 pandemic. An e-referral system has been implemented for inpatients to support effective patient care. Insulin safety training has been made mandatory for all new starters across the UHB, and provided Diabetes safety weeks for the UHB. The Community Diabetes Nursing Team have implemented a new referral process, and developed nursing home educational packs that are being adapted across Wales.

In April 2021 across Acute and Emergency Medicine domestic abuse work commenced with the routine enquiry of 'ask and act'. A total of 802 referrals were submitted for May 2021 with follow up provided from the Emergency Units Domestic Abuse Team with support and sign posting.

The Welsh Gender Service continues to provide a service for adults across Wales in spite of the coronavirus pandemic. The coronavirus pandemic enabled the service to deliver activity in the form of gender assessment and psychological therapies virtually and accommodate the needs of our vulnerable patient cohort increasing the equity of service provision and patient experience. As a result, patients have reported that they are happier with the service as it has become more accessible for many. In the same way, this has also enhanced the clinical expertise available within the service by way of clinicians working virtually from across the country in a specialism that is competing with other specialist services across the United Kingdom. The service is well under way in consolidating future growth plans by way of a new research group including collaboration with the Centre for Trials Research in Cardiff University; conversations with the sexual health team at CRI and Fast Track Cities Cardiff about increasing awareness and update of sexual health and HIV services for trans people; Cardiff and Swansea University students have undertaken elective placements with the Welsh Gender Service and new health education films in collaboration with the trans community, as well as networking with North Wales to begin planning for Welsh Gender satellite clinics to form part of an All Wales pioneering service over the next two years.

Stroke performance for the following indicators saw a significant decrease in Q4 2020/2021:

- Percentage of patients scanned within 1 hour of arrival
- Percentage of patients swallow screened within 4 hours of arrival
- Percentage of patients admitted to Stroke Unit within 4 hours of arrival

These indicators have a significant impact on the UHB's Sentinel Stroke National Audit Programme (SSNAP) score. SNAPP indicators continue to perform well for the following reported for June MTD:

- Assessed by Stroke Consultant in 24 hours 93%
- Assessed by a Stroke Nurse in 24 hours 93%
- Assessed by Multidisciplinary team in 24 hours 89.7%

Some of the disruption as a result of the Covid-19 pandemic have included the streaming of potential or positive Covid-19 Stroke patients streamed to non-stroke beds. These patients have to be recorded as a SSNAP breach. Those patients who were admitted to the Acute Stroke Unit were required to have a rapid Covid-19 swab which resulted in Stroke patients not always being transferred within 4 hours. There are increased cleaning procedures in place for the CT scanner to ensure good infection, prevention and control and to keep patients safe. This resulted in some delays for patients being scanned. Patients on an MTC pathway would take priority for scans, this impacted on 15% of Stroke patients. Capacity on both the Acute Stroke Unit, and Stroke Rehabilitation Centre from December 2020 to February 2021 secondary to Covid-19 outbreaks and bed closures impacted on patient flow.

From May 2021 a number of initiatives have taken place to improve Stroke performance and early indications suggest that performance continues to improve.

4 DIGNIFIED CARE

The UHB is introducing a Ward Accreditation & Improvement (WAI) Programme. All inpatient areas will work to attain a bronze, silver or gold accreditation rating. The ratings will reflect the quality of care, patient experience, staff experience, leadership and efficiency on each ward. Development of a WAI framework will be informed by the views of the MDT and progression to 'Gold' will require collaboration across professional groups. Medicine Clinical Board are leading on this work and plan to have several Bronze accredited wards by Feb 2022.

One of the metrics used to inform ward accreditation ratings will be audit scores, Perfect Ward is the digital app and current audits include; Key Harms, IPC and Environment, Medication Management and Documentation.

Health Inspectorate Wales undertook a virtual Quality Check of Morgannwg Ward, Barry Community Hospital as part of its programme of assurance work. Morgannwg Ward was opened as part of the Covid-19 pandemic with 11 beds adjoining Sam Davies Ward. Both wards were run as one unit with one Ward Sister and a Deputy Sister in charge. As part of the review Covid-19 arrangements, the environment, Infection Prevention and Control and Governance arrangements were discussed. The report was extremely complimentary of the care provided to patients, and staff well-being. No improvements were identified.

Likewise, in October 2020 HIW undertook a virtual Quality Check for Wards East 3 and 4 UHL. The only area of improvement noted was that environmental risk assessments were not supplied as part of the evidence to support the quality check as part of Managing Risk and Promoting Health and Safety. This was undertaken immediately following receipt of HIW's report and improvement plan.

HIW visited MEAU in December 2020. Whilst positive feedback was provided, there were some areas of improvement noted. These included:

- The UHB to put in place a mechanism of sharing HIW reports with all staff as a means of shared learning
- No evidence of an environmental risk assessment was available
- Infection Prevention and Control policies that were available were overdue an update
- The UHB should consider introducing targets and measures that would capture a patients length of stay in the department, including trolleys and ambulatory care to support patient care

Feedback from HIW reports are now detailed within the Patient Safety Team newsletters which are shared widely across the Clinical Board. To ensure that staff received updates and service reminders staff are expected to sign a register confirming completion, and reviewed every two weeks. During the Covid-19 pandemic environmental checks were undertaken by the Unit Managers. The Infection Prevention and Control Policy for hospital outbreaks secondary to the second Covid-19 pandemic is yet to be uploaded into the UHB Intranet, however national guidance remained unchanged. The Acute and Emergency Medicine Directorate is actively working with the UHB IT development department to progress electronically reporting a patients length of stay in the Unit. Work is ongoing around the criteria of patients that can be seen in MEAU.

In February 2021 the Clinical Board requested an Internal Quality Check in Healthcare for Lakeside Wing. It identified that patients were clean and appeared comfortable and were very complimentary of staff. Opportunities for improvement were noted around aspects of documentation, environmental/estates concerns, not being fully compliant with IP&C PPE guidance and the lack of a cohesive nursing workforce. In order to provide the required level of nurse staffing for LSW the Clinical Board has required the support of other Clinical Boards, including staff that were redeployed, and temporary staffing bank/agency staff. Following this inspection specific actions were taken to promote a cohesive workforce with positive results supporting staff wellbeing. The area is visited daily by a Senior Nurse with IP&C to ensure that all staff comply with PPE guidelines. Since this inspection the wards have moved to another area which has improved the environmental and estates concerns.

The new Cystic Fibrosis Unit was handed over in April 2021 and completes the full transition of the CF service to the CF Centre. The ward provides all en-suite facilities, which meets Standards of Care for CF patients Guidelines in terms of infection control in this extremely vulnerable patient cohort. The investment from Welsh Government also made the financial provision for 4 outlying en-suite bedrooms for special infection patients. Unfortunately, this work is delayed secondary to Covid-19 and the high demand on bed occupancy at UHL. It is hoped that work will begin at the earliest opportunity for equity of care for all CF patients. Patient experience is vastly improved as patients no longer share facilities and the bedrooms are equipped with bespoke furniture and appliances to ensure minimal potential for cross infection at all times. The additional space on the new ward has enable closer working within the ward MDT, which not only improves efficiency, but also enhances patient experience. Since the introduction of CFTR modulator therapies and triple therapy a vast reduction in inpatient activity

has been seen. Some of this could be attributed to the effect of shielding for such a long period resulting in non-exposure to airbourne pathogens, causative of infective exacerbations. However, benchmarking has shown that all CF Centre's across the UK have reported a significant down trend of inpatient activity, with the general consensus attributed to the CFTR modular therapies. It is hoped that work will commence soon on the two side gardens, which will further enhance the patient experience by providing private sitting areas for patients to 'escape from the ward' for quiet time. It is also planned that this area is used for some psycho-social appointments when the weather is permitting.

5 TIMELY CARE/ ACCESS TO SERVICES

CAV 24/7 has just celebrated its first birthday. This is the first of its kind in Wales, the most pioneering out of any of the call first models across the United Kingdom. A phone first triage system was introduced to allow patients to be seen at the right place, first time (not always an Emergency Department) and keeps the staff and patients safe, allowing patients to wait in the comfort of their own home before their allocated time slot to arrive. This has also supported patients and staff to socially distance by avoiding overcrowded waiting areas. The aim of CAV 24/7 is the ability to control the flow of patients into the department, but not attempting to reduce patient numbers into the department. It has provided the opportunity to make a huge change to patient experience and staff satisfaction. Future developments include the expansion of CAV 24/7 with more direct access to outpatients and hot clinics and increased direct referrals to specialties.

Underpinned by the Respiratory Health Delivery Plan the development of outpatient services for admission avoidance and rapid interventions has been implemented and the exploration to enhance both preventative care services such as CRRU, HVT and Bronchiectasis.

Right Bed First Time (RBFT) project commenced in March 2021. RBFT's is a workstream that is focused on putting patients in the right bed when they are admitted to hospital. It is widely recognised that patients spend too long waiting for a bed in an inappropriate environment, or admitted to an area that does not meet their clinical or nursing needs, leading to an increased length of stay and potentially causing harm and poor patient experience. It is recognised that RBFT requires fundamental changes to how patients flow through the hospital; the transformation required to implement these changes in a sustainable way will be widespread and include many aspects of patient care, decision making around admission and discharge and access to beds. It should be recognised that current practices are firmly embedded and changing the culture of how things are done will require significant engagement to win hearts and minds in addition to the necessary changes to operational activity. RBFT aims for patients to have the best experience when in our care, that they are in the right bed the first time when admitted to hospital, and discharged to the most appropriate setting as soon as possible. A patients journey through the hospital is guided by their clinical pathway, and that these pathways operate 24/7. To deliver an evidenced based bed capacity model, with appropriately resourced and skilled workforce.

Working with the National Collaboration Commissioning Unit the Emergency Department has adopted the ED Rule of Six approach and has worked tirelessly to collect and catalogue the initial three of the six key indicators for the department using the Business Intelligence System. These improvements have had a significant impact on triage times, bringing the departments

average inside the 15 minute national target for the first time. The provision of the data set provides the department with the key for further improvement in the future.

The Older Persons' Short Stay Unit (OPSSU), on A1Link provides comprehensive geriatric assessment for frail older people who present to urgent care and require a brief, focused inpatient stay to support them through a mild illness, acute injury or exacerbation of their underlying frailty conditions. The unit operates in tandem with the Frailty Intervention Team (FIT), who are based in the Emergency and Acute Units, who actively seek and find older patients with frailty and act early to address any issues that could lead to a prolonged hospital admission. In particular there is a focus on planning discharge at the first point of contact and the teams are active in involving carers from day one to identify both the potential barriers to discharge and any unmet health and well being concerns. The OPSSU and FIT models allow us to bring highly specialist frailty expertise right to the beginning of the patient stay. This collaborative approach means improved communication and less duplication across teams. A focus on early mobilization and discharge allows older people to remain active and independent and avoids many of the pitfalls of longer hospital stays such as delirium, falls and hospital associated infections. Through collaboration with the Right Bed First Time work there have been improvements in the proportion of patients who are admitted to OPSSU that meet our admission criteria, with 75% of patients in whom an OPSSU bed was requested and transferred appropriately in July 2021. Thanks to these improvements the number of patients who are

discharged within 5 days has increased from 33% in Autumn 2020 to 61% in Spring 2021, with a median length of stay of 4 days during this period.

6 INDIVIDUAL CARE

All areas of the Clinical Board are engaged with the Patient Experience Framework. Gastroenterology have recently added a QR code onto the patient information leaflet following their procedure to allow patients to provide feedback. This has allowed the Endoscopy Units to make their practice look and feel engaging for patients in their care and improved communication with easy access.

The Clinical Board share a patient story and compliments at Clinical Board QSPE each month to share good practice, areas for improvement and learning outcomes for patients in our care. An example of this is noted below from Ward B7:

> ' *Jade, I wanted to reach out to you on behalf of my family to express our heartfelt gratitude to you for being with my Grandfather in his final hours. I understand you dedicated your time to sit by his side, hold his hand and pass on messages into his ear in his final moments. I cannot express the heartfelt appreciation we all have towards you and your team for making him so comfortable when we couldn't be there for him. It has been truly heartbreaking thinking of him all alone in a Covid ward in his final moments, but to hear of the time and care you showed him is such a comfort to the family and I. We will never forget it.*
> *Hugh was an astounding Father, Grandfather and gentleman. I'm not sure if you're aware but he was going to turn 90 on 25th May and was still a practicing accountant who completed his clients' accounts by hand or on his typewriter. He was extremely independent, still living his life to the fullest, driving every couple of months up to London to spend time with us, going to Waitrose every morning for his 07:30am coffee without fail. If you found yourself on Who Wants To Be A Millionaire' and you had any historical question, he'd be the first person you'd call as he was a walking encyclopedia. He was such a traditional gentleman and wore a suit and tie every day,*

even when he was in Spain. Everyone used to look at him because he looked like some sort of Spanish mafia boss. He was loved and respected by so many people and still had so much to live for.
Finally, thank you all so much for the sacrifice you are making and for putting your own safety at risk to help others. You have such an impact on patients and their families and we are so appreciative of the time, respect and care you showed my Grandfather'.

7 STAFF AND RESOURCES

Medicine Clinical Board consists of 1642.69 WTE staff; as of July 2021, the professional break down as follows:

Staff Group	**Establishment WTE**
Additional Professional & Technical	5.85
Additional Clinical Services	30.12
Administrative and Clerical	199.55
Allied Health Professions	8.0
Healthcare Scientists	5.07
Medical and Dental	221.03
Nursing and Midwifery Registered	717.70
Students	1.0
Unqualified Nursing	454.37

The Clinical Board currently has an 8.34% turnover rate. Cumulative sickness reported for July was 8.3% which is above the cumulative target of 6.45%. The Current Registered Nurse (RN) vacancy position is 70 WTE 10%. This is an improved RN vacancy to previous years when the Clinical Board reported a vacancy position of 25%. However, the additional capacity of 115 beds

requires an additional 85 WTE Registered nurses. Consequently, a RN gap of vacancies and additional capacity equates to 155 RN, this is having a significant impact on the ability to provide consistently good standard of care and there has been an increase in the number of E- Datix reports which reference to low RN staffing levels. This RN position is also having a negative impact on staff health and well-being. The Clinical Board are committed to ensuring staff feel supported

and have the required resources to enable them to deliver the care required by our patients. There is a significant focus on staff well being and the Health Intervention team and Occupational Health are engaged in providing a service to our staff, which includes visiting wards and focused support for individuals and groups.

As expected the biggest part of the workforce is Registered Nurses, and as such requires ongoing recruitment, training and retention to ensure there is a workforce that is fit for purpose to deliver the fundamental and specialist care that people require. This is noted within the relevant Directorate's and Clinical Boards Risk Registers. A robust recruitment plan is in place and the Clinical Board is proactively recruiting staff both within the UK and overseas to provide safe staffing levels. The Clinical Board is pleased to note 30 international nurses are currently working across clinical areas with a further 5 waiting for their PIN registrations. These international nurses have been recruited within the last 12 months and are extremely valued. The clinical Board are recruiting high numbers of students via student streamlining and are committed to their continuing learning and professional development.

The Clinical Board in patient wards are reviewed against the All Wales Nurse Staffing acuity data, and triangulated with quality indicators and professional judgement; to ensure the Clinical Board in patient wards have the right number of registered nurses and the right skill mix to ensure the delivery of a high quality and standard of care for our patients.

The Medical Workforce Hub hosted in the Directorate of Internal Medicine co-ordinates the incredibly complex work of multiple trainee and consultant Physician rotas for in and out of hours patient care. The Hub also manages gaps within the Medical Workforce. The Hub co-ordinates filling gaps in out of hours rotas but is increasingly participating in the substantive recruitment of training grade Doctors into rota gaps in order to mitigate the risk of employing expensive locum cover at the last moment to ensure rota safety. The Workforce Hub is temporarily supported by Dr Siobhan Lewis who co-ordinates the trainee rotas and liaises with trainee Doctors to co-design rotas and ensure the wellbeing of trainees within their rotas.

Senior Medical staffing within MCB benefits from the attraction of Cardiff as a capital city and the excellent reputation of C&V now as a progressive provider of secondary and tertiary care, together with a team of dynamic and open-minded Clinical Directors intent upon growing and evolving services with likeminded colleagues.

Trainee grade staffing provides challenges year to year, but the risks resulting from trainee gaps are mitigated as far is possible by the Workforce Hub. These risks are significantly more challenging this year given the un-commissioned bed base now open in UHW and the need to appropriately staff these areas, as well as the requirement to staff Covid-19 wards (Heulwen – un-commissioned capacity in normal summers), and to be Covid-19ready.

The importance of staff appraisal cannot be underestimated. The Clinical Board and Directorates are working hard to improve compliance with PADR and pay progression. The current compliance is as follows:

Emergency and Acute Medicine	51.35%
Integrated Medicine	50.0%
Specialised Medicine	73.9 %
MCB Non Medical	25.85%
Clinical Board Total	**50.28%**

Staff engagement

The Clinical Board has long recognised the importance of listening and engaging wih staff. The engagement of staff in the development of the Clinical Board is inherit to its values. Issues in relation to staff concerns have to be addressed robustly and sustainably and the Clinical Board is committed to that. During the last 18 months in order to support staff across the Clinical Board '**CAV A Catch Up'** has allowed staff across all disciplines and sites to discuss and listen to any concerns with senior members of the Clinical Board. Information to keep staff appraised of the Clinical Boards plans/vision are widely shared within MCB Community Staff Connect App which all staff in MCB can access. The Clinical Board hold montly/bimontly '**Town Hall' meetings virtually** where all staff can attend. These meetings aim to share updates on workstreams within the Clinical Board, and provide supportive information and guidance for staff. The focus of July's meeting was around staff wellbeing. Medicine Clinical Board provided all staff with Team Medicine Lanyards and mugs as a small gesture to thank staff for their dedication and support over the last 12months.

The Clinical Board is fully supportive and engaged with the UHB's values and behavours and has strategies in place to manage staff who fail to meet the expected standard. The Clinical Board supports the UHB's commitment for talent management and leadership and the importance of creating the right vision and enviroment for change, to enable teams to drive the change forward to improve the experience of our patients and staff.

The Clinical Board strives to recognise and celebrate success in the form of Celebration Events. There are many excellent examples of innovative practice making real improvements in the quality and safety of the care we provide. In this years Staff Recognition Awards, we were honoured to have the support of Max Boyce MBE, who presented awards and read his poem "When just the tide went out", which he has dedicated to the NHS. Our award winners, Elizabeth Davies a Medical Secretary for Hepatology/Gastroenterology was the winner of Living Our Values. Elizabeth showed compassion, care and reasoning with an inner calm and confidence which helped so many staff over the last 18 months. Elizabeth was a point of contact for many, offering reassurance and advice in a respectful manner, and started a prayer request 'board' for staff which encouraged and deeply touched them.

Dr Zoe Roberts Consultant for Paediatric Emergency Medicine was the winner for Partnership Working. Zoe led a multi-disciplinary team to deliver a huge piece of work producing a fit for purpose safe sepsis screening tool inorder to ensure consistency and safety for patients across the whole patient journey. Zoe has worked closly with nursing and medical colleagues in Child Health to produce a single observation chart which highlights abnormal observations. By keeping the patient at the centre of everything, this has resulted in significant improvements in patient safety and quality care.

Dr James Dunn Consultant Emergency Medicine was the winner for outstanding contribution Medical Workforce. James has displayed an exceptional level of commitment to working in partnership with colleagues across the hosptial to deliver improved healthcare outcomes in the most extreme of conditions in their role as Covid Lead for the Emergency Department. James developed the multi-disciplinary policies and standard operating procedures in response to Covid in collaberation with colleagues from Microbiologiy, Respiratory, Critical Care and IP&C.

James established and run weekly updates, both virtual and in person, for the whole Emergency Medicine clinical and nursing teams. James has been instrumental in ensuring staff safety, focusing not only on the safety of staff within the emergency department, but in all departments with whom they interact.

The Senior Nursing Team were the winners for Inspiritional Leadership demonstrating professional inspirational leadership with an energy and can-do attitude. They demonstrate compassion and dedication to each other and their teams. Even when the pressure was on, they pull together, lead and motivate their teams to achieve the impossible.

Staff Nurse Emma Simpkins was the winner for the outstanding contribution to Nursing Workforce. Emma developed a morale booster for the teams whereby each month they organised a raffle for staff with prizes they collect from donations. Emma ensures each special day such as Easter, Mothers Day, Fathers Day is marked with gifts that they deliver to staff, bringing a smile to everyone's faces.

Words cannot describe how thankful the Clinical Board are for the sheer determination, enthusiasm, commitment and above all courage that all of our staff have demonstrated over the last 18 months. The Covid-19 pandemic has united teams, sharing both good and bad times, learning to work in different ways inorder to ensure that patient safety, quality and experience is maintained.

MCB COVID 19 reflections #NHS@72

Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the contents of the Medicine Clinical Board QSE assurance report and **AGREE** the mitigation being taken to improve quality, safety and experience and reduce harm.

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

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

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

Report Title:	Quality, Safety and Experience Framework 2021-2026 Clinical Safety Group – TOR Organisational Learning Committee - TOR					Agenda Item no.	2.3	
Meeting:	Quality, Safety and Experience Committee					Meeting Date:	15th September 2021	
Status:	For Discussion		For Assurance		For Approval	x	For Information	
Lead Executive:	Executive Nurse Director Executive Medical Director							
Report Author (Title):	Assistant Director Patient Safety and Quality Assistant Director Patient Experience Assistant Medical Director, Clinical Governance and Patient Safety							

Background and current situation:

The purpose of this paper is to present our Quality, Safety and Experience (QSE) Framework 2021-2026 (Appendix 1) This has been developed through extensive engagement with thousands of stakeholders throughout the Health Board, community and with many external partners, over the last 12 months. This has helped define our priorities for the next 5 years.

We believe that by focusing on 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience equal to the best healthcare organisations in the world. These eight key areas are:

- Safety culture
- Leadership and the prioritisation of QSE
- Patient Experience and Involvement
- Patient Safety Learning and Communication
- Staff Engagement and Involvement
- Data and insight
- Professionalism of QSE
- Quality Governance arrangements

To further strengthen our Quality Governance arrangement we will be establishing two additional Committees –the Clinical Safety Group –Chaired by the Executive Medical Director and the Organisational Learning Committee – Chaired by the Executive Nurse Director. The Terms of Reference are attached at **Appendix 2** and **3.**

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

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

STRATEGIC CONTEXT

A Healthier Wales (AHW)[1] sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social

[1] A Healthier Wales: Our plan for Health and Social Care. Welsh Government 2019.

care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is “Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times.”

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. Our philosophy of value-based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent **Health and Social Care (Quality and Engagement) (Wales) Act** which places both an enhanced duty of quality and an Organisational Duty of Candour will strengthen the approach to high quality, safe care. The UHB will be required to set out how it is meeting its statutory duties in annual reports to Welsh Government.

The recently-published National Clinical Framework[2] provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centered on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care.

To achieve the aspiration of having a quality-led health service, all organisations need to operate within an effective quality management system. This **Quality and Safety Framework**[3], which will be published in September 2021, will describe the interlinked key elements that must always be working together to ensure continuous improvement in quality: planning; improvement; and control; and to provide overall assurance that the system is working effectively to deliver the outcomes that we need for the people of Wales.

In 2019, the NHS Patient Safety Strategy[4] was published in England. It set out three strategic aims to build a stronger patient safety culture and safety systems. These three aims are:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

The NHS Patient Safety Strategy was updated in 2021[5], to set out how the Strategy will effectively contribute to the reduction in health inequalities.

The World Health Organisation has recently published its Global Patient Safety Action Plan**[6]** **.** The ultimate goal is to achieve the maximum possible reduction in unavoidable harm due to unsafe health care globally.

Seven guiding principles establish underpinning values to shape the development and implementation of the action plan:

- engage patients and families as partners in safe care
- achieve results through collaborative working
- analyse and share data to generate learning
- translate evidence into actionable and measurable improvement

[2] National Clinical Framework: A Learning Health and Care System. Welsh Government 2021.
[3] All Wales Quality and Safety framework. Learning and Improving. 2021.
[4] NHS Patient safety Strategy. Safer culture, safer systems, safer patients. NHS England and NHS Improvement. 2019.
[5] NHS Patient Safety Strategy. NHS England and NHS Improvement. 2021 update.
[6] Global Patient Safety Action plan. Towards eliminating avoidable harm in healthcare. World Health Organisation. 2021.

- base policies and action on the nature of the care setting
- use both scientific expertise and patient experience to improve safety
- Instil a safety culture in the design and delivery of health care.

The Patient Safe Future: A blueprint for action[7], sets out six evidence based foundations for action to address the causes of unsafe care. This particular publication has been influential in shaping our priorities for the next 5 years.

Local context

As an integrated healthcare provider, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided. We understand that this cannot be a Framework that focuses on secondary care, but one that recognises that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patients pathway, is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings. What really matters for our patie carers and people in our communities must be central to our decision making, so that we can use time, skills and other resources more wisely. There is no simple solution to improve safety and nc single intervention, implemented in isolation that can fully address the issue (Patient Safety 2030) The challenge to commission services that improve the health of our residents in Cardiff & Vale ar provide prudent, integrated health and social care for a growing local population whist providing increasingly complex emergency, elective and tertiary care to meet local and regional demand wit the resources available, has never been greater.

We are always mindful that we are a Statutory organisation and are also bound by primary legislation, statutory instruments and standing orders which are the rules by which the 'organisati works and makes decisions'.

Our public, communities, staff and partners are at the centre of everything we do. There is no better and more important way of developing or improving services than by listening to what individuals think, feel and experience throughout their journey of using any of the NHS Wales services, programmes, functions and beyond. Whether this is in a hospital ward, outpatient appointment, any of the national Screening programme, GP practice (primary care), engaging with health promotion practitioners or at any event delivered by an NHS Wales organisation. It is a key element of quality, alongside providing governance assurance and safer services. The way that the wider health and prevention/promotion system delivers its service and supports the wider systems – from the way the phone is answered, to the way cleaning staff speak with you all the way to mangers engage with the public and staff– has an impact on the experience and should be used for quality improvement and governance assurance. If clinical and general excellence is the 'what' of healthcare and health prevention, then experience is the 'how'. Starting with and listening to the needs, and designing the experience to meet these needs is achievable and results in an environment where individual feel valued and supported.

One of the most important lessons learnt in the last few years is that organisations need to be ambitious. The experience we deliver for our service users will only ever improve when an entire organisation examines and re-creates its culture which is more than just words, leadership, public and community engagement, staff engagement and cross-organisational measurement systems in order to improve quality and strive for excellence.

[7] The Patient Safe Future: A blueprint for action" Patient Safety learning. 2019

Recommendation:

The QSE Committee is asked to **APPROVE** the:

- Quality, Safety and Experience Framework 2021-2026, and the
- TOR for the Clinical Safety Group and the Organisational Learning Committee.

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.*

Cardiff and Vale UHB

Quality, Safety and Experience Framework 2021 -2026

Safety Culture

Leadership and prioritisation

Patient experience and involvement

Staff engagement and involvement

Patient safety learning and communication

Professionalism

Data and insight

Quality governance

Foreword – Ruth Walker, Executive Nurse Director, Stuart Walker, Executive Medical Director, Charles Janczewski, Chair.

We are very proud to present our Quality, Safety and Experience (QSE) Framework 2021-2026 which has been developed through extensive engagement with thousands of stakeholders throughout the Health Board, community and with many external partners. This has helped define our priorities for the next 5 years. We have been inspired and enthused by the level of engagement, discussion and the overwhelming enthusiasm and support for what we are proposing.

Our journey began on World Patient Safety Day, September 17th 2020, when we held a virtual workshop with staff, to begin to identify important issues that needed to be considered to make things better for citizens and staff alike. We realised that we needed a shift in our approach.

Traditionally we have focused on things that go wrong, and of course this is important and something we will always be committed to. However, to really become one of the safest, high quality organisations in the UK where people and patients experience great care, we recognise that there are a number of key enablers that we have to address.

We are now ready to move away from current approaches which focus on harm (Safety 1) to more contemporary methods which align with other safety critical industries (Safety 11). Our approach to safety needs to move from ensuring that 'as few things as possible go wrong to ensuring that as many things as possible go right'**[1]. We need to achieve a whole system shift in which our QSE priorities in Community and Primary care carry equal attention to that in our secondary and tertiary care services.

We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience equal to the best healthcare organisations in the world.

These eight key areas are:

- Safety culture
- Leadership and the prioritisation of QSE
- Patient Experience and Involvement
- Patient Safety Learning and Communication
- Staff Engagement and Involvement
- Data and insight
- Professionalism of QSE
- Quality Governance arrangements

[1] From Safety 1-Safety 11 –A White paper. Erik Hollnagel et al. 2015

The Health and Social Care (Quality and Engagement) (Wales) Act 2020, introduces a statutory duty of Quality and a Duty of Candour and we look forward to working with colleagues across Wales to implement the Quality and Safety Framework: Learning and Improving.

Our vision is ambitious and needs to be achieved while recognising the work that is required to deliver the 'four harms approach' to our Covid-19 recovery plans. It has been an extraordinary 18 months for the NHS and for our population and partner organisations. Many people have died or have long terms effects as a direct result of Covid-19; our healthcare system has been overwhelmed and this has impacted on our ability to deliver non-Covid-19 services. We cannot underestimate the wider harm that our population and our staff have experienced as a direct result of lockdown and protracted restrictions to our normal way of life. The challenges of meeting the current and future healthcare requirements of our communities in a timely way, cannot be underestimated.

We also need to focus on how we most effectively contribute to the reduction of health inequalities. There is increasing evidence of the differences in healthcare outcomes and access to services experienced by different ethnic and cultural groups within our communities. We know that socioeconomic status and where someone lives also impact on mortality and morbidity. The pandemic has magnified these inequalities. In line with our strategic vision we want to involve all of our communities in shaping the delivery and evaluation of their experience of healthcare in our communities and hospital settings.

We cannot deliver this Framework in isolation of other important work that is already being undertaken across the organisation. We will work closely with colleagues in Workforce and Organisational Development to support work on our culture, values and behaviours and Leadership programmes. We will also align with colleagues in the Improvement and Innovation Team particularly in developing effective sustainable solutions to our QSE trends and themes.

We would like to thank you for the engagement and enthusiasm that you have demonstrated in helping us to identify our QSE priorities for the next 5 years and look forward to working with our staff, people in our communities and with our partner organisations to make this ambitious plan a reality.

Ruth Walker	Professor Stuart Walker	Charles Janczewski
Executive Nurse Director	Executive Medical Director	Chair

STRATEGIC CONTEXT

A Healthier Wales (AHW)[2] sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is "Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times."

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. Our philosophy of value-based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent **Health and Social Care (Quality and Engagement) (Wales) Act** which places both an enhanced duty of quality and an Organisational Duty of Candour will strengthen the approach to high quality, safe care. The UHB will be required to set out how it is meeting its statutory duties in annual reports to Welsh Government.

The recently-published National Clinical Framework[3] provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care.

To achieve the aspiration of having a quality-led health service, all organisations need to operate within an effective quality management system. This **Quality and Safety Framework**[4], which will be published in September 2021, will describe the interlinked key elements that must always be working together to ensure continuous improvement in quality: planning; improvement; and control; and to provide overall assurance that the system is working effectively to deliver the outcomes that we need for the people of Wales.

[2] A Healthier Wales: Our plan for Health and Social Care. Welsh Government 2019.
[3] National Clinical Framework. A Learning Health and Care System. Welsh Government 2021.
[4] All Wales Quality and Safety framework. Learning and Improving. 2021.

In 2019, the NHS Patient Safety Strategy[5] was published in England. It set out three strategic aims to build a stronger patient safety culture and safety systems. These three aims are:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

The NHS Patient Safety Strategy was updated in 2021[6], to set out how the Strategy will effectively contribute to the reduction in health inequalities.

The World Health Organisation has recently published its Global Patient Safety Action Plan[7] **.** The ultimate goal is to achieve the maximum possible reduction in unavoidable harm due to unsafe health care globally.

Seven guiding principles establish underpinning values to shape the development and implementation of the action plan:

- engage patients and families as partners in safe care
- achieve results through collaborative working
- analyse and share data to generate learning □
- translate evidence into actionable and measurable improvement
- base policies and action on the nature of the care setting
- use both scientific expertise and patient experience to improve safety
- instil a safety culture in the design and delivery of health care.

The Patient Safe Future: A blueprint for action[8], sets out six evidence based foundations for action to address the causes of unsafe care. This particular publication has been influential in shaping our priorities for the next 5 years.

[5] NHS Patient safety Strategy. Safer culture, safer systems, safer patients. NHS England and NHS Improvement. 2019.

[6] NHS Patient Safety Strategy. NHS England and NHS Improvement. 2021 update.

[7] Global Patient Safety Action plan. Towards eliminating avoidable harm in healthcare. World Health Organisation. 2021.

[8] The Patient Safe Future: A blueprint for action[8] Patient Safety learning. 2019

Local context

As an integrated healthcare provider, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided. We understand that this cannot be a Framework that focuses on secondary care, but one that recognises that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patients pathway, is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings. What really matters for our patients carers and people in our communities must be central to our decision making, so that we can use our time, skills and other resources more wisely. There is no simple solution to improve safety and no single intervention, implemented in isolation that can fully address the issue (Patient Safety 2030). The challenge to commission services that improve the health of our residents in Cardiff & Vale and provide prudent, integrated health and social care for a growing local population whist providing increasingly complex emergency, elective and tertiary care to meet local and regional demand within the resources available, has never been greater.

We are always mindful that we are a Statutory organisation and are also bound by primary legislation, statutory instruments and standing orders which are the rules by which the 'organisation works and makes decisions'.

Our public, communities, staff and partners are at the centre of everything we do. There is no better and more important way of developing or improving services than by listening to what individuals think, feel and experience throughout their journey of using any of the NHS Wales services, programmes, functions and beyond. Whether this is in a hospital ward, outpatient appointment, any of the national Screening programme, GP practice (primary care), engaging with health promotion practitioners or at any event delivered by an NHS Wales organisation. It is a key element of quality, alongside providing governance assurance and safer services. The way that the wider health and prevention/promotion system delivers its service and supports the wider systems – from the way the phone is answered, to the way cleaning staff speak with you all the way to mangers engage with the public and staff– has an impact on the experience and should be used for quality improvement and governance assurance. If clinical and general excellence is the 'what' of healthcare and health prevention, then experience is the 'how'. Starting with and listening to the needs, and designing the experience to meet these needs is achievable and results in an environment where individual feel valued and supported.

One of the most important lessons learnt in the last few years is that organisations need to be ambitious. The experience we deliver for our service users will only ever improve when an entire organisation examines and re-creates its culture which is more than just words, leadership, public and community engagement, staff engagement and cross-organisational measurement systems in order to improve quality and strive for excellence.

Safety Culture

'Quality, Safety and Experience is everybody's business'

Building a strong patient safety culture where staff are supported to raise concerns, families and clinicians are treated fairly and incidents of unsafe care are investigated consistently, with a focus on systems rather than individuals[9] is the cornerstone of our vision for the next 5 years. Establishment of a Just Culture is critical to improve patient safety.

More than 20 years of research demonstrates that organisations with higher levels of psychological safety perform better on almost any metric or key performance indicator (KPI) in comparison to organisations that have low psychological safety[10]

OUR PRIORITIES for 2021 -2026

- Achieve the maximum possible reduction in avoidable harm
- Introduce Safety Culture work programme
- Agree a common language for quality, safety and experience
- Increase knowledge and awareness of Safety 1 – Safety 11
- Promote a culture of openness and transparent
- Develop a Psychological Safety Framework
- Develop and implement a Framework to support staff involved in incidents, complaints, claims and inquests
- Support the implementation of Shwartz rounds
-

[9] The Patient safe Future - Blueprint for action. Patient Safety Learning. 2019.
[10] A practical guide to the art Psychological safety in the real world of health and care. NHS Horizons, Novartis. June 2021.

Leadership and Prioritisation

Management is doing things right; leadership is doing the right things".

Good leadership is one of the most positive influential factors in shaping our organisational culture[11]; poor leadership can have the opposite effect[12]'. We need

OUR PRIORITIES for 2021 -2026

- Provide board and leader education in safety, quality, and improvement concepts.
- Expand the number of specialist patient safety, simulation and human factors experts throughout the organisation
- Support the Compassionate Leadership programme
- Align with current in-house leadership programmes
- Align with and support implementation of the Health Board People and Culture Plan

leaders who are comfortable to challenge a blame culture and champion a Just Culture. The World Health Organisation[13] recognises that 'Developing and sustaining a strong patient safety oriented culture requires strong leadership at all levels ……….. There is a need for a new generation of patient safety leaders who are skilled and passionate to create the conditions and organizational and team cultures r safer care, to ensure that all systems and procedures comply with the highest standards and to guide and motivate staff'

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[11] West M, Armit K, Loewenthal L, Eckert R, West T. *Leadership and Leadership Development in Health Care: The Evidence Base*. Faculty of Medical Leadership and Management; 2015.

[12] The Joint Commission. *The Essential Role of Leadership in Developing a Safety Culture*. The Joint Commission. ttps://www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf.

[13] Global Patient Safety Action Plan 2021-2030. Towards eliminating avoidable harm in Healthcare. World Health Organisation 2021.

Patient experience and involvement

'No decision about me, without me'[14]

Many patients would like more control of, or say in, the decision-making process, so their views and preferences are taken into account. It can sometimes be hard to judge where an individual patient lies on this spectrum. The best solution is to ask the patient and this can start with the question - What matters to you[15]?

[14] No decision about me, without me. Department of Health 2012.
[15] What matters to you? Healthcare Improvement Scotland.

OUR PRIORITIES for 2021 -2026

- Establish a Patient Experience Reference Group
- Establish competencies for all health care professionals for the engagement of patients, families, and care partners.
- Ensure that health care professionals and staff are trained to recognize and prevent unconscious bias and are competent in equitable, effective communication strategies.
- Implement a 'What matters to you' campaign
- Develop and implement a Patient Safety Partner (PSP) Framework
- Implement the Once for Wales service user experience system in line with National Programme Board requirements
- Develop a library of patient/ staff/ carers stories to inform learning and to listen to experiences
- effectively contribute to reducing health inequalities and developing a greater understanding of diversity in the safety of healthcare
- Develop 'Patient Safety, Quality and Experience' cards to actively involve patients
- Develop a digital story training module online to support staff and volunteers
- Develop a toolkit that supports staff understand mechanisms for

Staff engagement and involvement

'Inspire, educate, skill and protect health workers to contribute to the design and delivery of healthcare systems'[16]

[16] WHO Global Patient Safety Action Plan. 2021.

It is vital that all people working in healthcare understand QSE. They must be clear about the nature and importance of risk and how harm occurs, the concepts of patient safety science, the ways in which we review and investigate unsafe care and concerns and the actions necessary to ensure that care is high quality and as safe as possible.[17]

OUR PRIORITIES for 2021 -2026

- Embed a systems based and human factors approach to safety investigations and solutions
- Establish a Patient Safety Specialist Network and a Safety Champion Role
- Establish a revised Patient Safety Incident Investigation Training programme in line with contemporary methods and approaches
- Establish a Quality, Safety and Experience Communication and engagement strategy
- Establish a regular schedule of MDT Patient Safety and Quality Clinics
- Fully implement TALK de-briefing approach
- Support the 14,000 voices campaign

Patient Safety learning and communication

'let's focus on systems and human factors; not on individuals'

[17] As above

We want to embed learning through creativity and innovation across the Health Board focussing upon identified themes from a range of different QSE sources.

OUR PRIORITIES for 2021 -2026

- Establish a QSE Organisational Learning Committee to implement reliable learning systems
- To become a High Reliability Organisations
- Development the best possible safety learning networks across the organisation and Wales
- Strengthen input in to undergraduate and postgraduate educational programmes
- Establish Simulation based learning from thematic analysis
- Implement Greatix/Learning from Excellence and compliments
- Strengthen staff feedback mechanisms

'If you don't measure, you don't know'

Our current methods of analysing data from QSE activities focus on counting things that go wrong. This is a measure of how unsafe we are –rather than how safe we

are. We will capture and analyse different data sources to identify themes and trends of patient safety incidents to impart learning and undertake improvement activities.

OUR PRIORITIES for 2021 -2026

- Become a data driven healthcare organisation
- Implement the **Once for Wales Concerns Management System** to maximise opportunities for learning and benhcmarking
- Implement **AMAT** to strengthen governance in relation to National and Local audits, NICE Guidance and Patient Safety Solutions

‘ if we always do what we’ve always done, we’ll always get what we’ve always gotten’

It is essential that all health workers, managers and leaders understand patient safety. In particular, they must be clear about the nature and importance of risk and how harm is generated, the core concepts of patient safety science, the ways in

which the causes of unsafe care are investigated and understood, and the actions necessary to ensure that care, and its constituent individual processes, is as safe as is possible.'[18]

OUR PRIORITIES for 2021 -2026

- Implement the National Patient Safety Syllabus and competency framework
- Ensure that accreditation processes for safe care are incorporated as part of the Ward Accreditation process

'The Standard you walk past is the standard you accept'[19]

We have to have processes in place to answer three simple questions:

- 'Are we safe?
- Are we delivering high quality care and excellent outcomes?

[18] Global Patient Safety Action Plan 2021-2030. Towards eliminating avoidable harm in Healthcare. World Health Organisation 2021.

[19]

- Are the people who use our services getting a great experience?'

OUR PRIORITIES for 2021 -2026

- Embed the Health and Social Care (Quality and Engagement) Act (Wales) 2020 and establish robust Annual Quality Reporting requirements
- Enact the All Wales Quality and Safety Framework and establish robust Quality Management Systems
- Establish a revised committee and QSE group structures
- Implement a revised Clinical Board QSE assurance reporting template and set of QSE indicators
- Ensure that quality, safety and experience of services remains a central element to the Covid -19 recovery plan

MONITORING ARRANGEMENTS

Implementation and monitoring of this Framework will be overseen by the Health Board Quality, Safety and Experience Committee.

ACKNOWLEDGEMENTS

Thank you to everybody who engaged in the discussion to agree our QSE priorities for 2021- 2026:

Internal Stakeholders

Sept 17th 2021 QSE Workshop

November 2021 QSE Follow up workshop

December 2020 - Board Development session

April 2021 - Quality Safety Experience Committee

March 24th 2021 – Health Board Volunteers Forum

March – May 2021 - Clinical Board Quality Safety Experience Groups (7)

May 2021 - Nursing and Midwifery Board

May 2021 – Presentation at Patient Safety Clinic

June 2021 – open QSE sessions x 3 across the Health Board

June 2nd 2021 – Strategy Development and Delivery Group

June 9th 2021 - Clinical Psychologist Forum – QSE Group

June 9th 2021 - Director of Therapies Group

July 22nd 2021 - Stakeholder Reference Group

July 2021 - Medical Leadership Group

August 4th 2021 - Strategic Commissioning Group

August 5th 2021 - Health Systems Management Board –

August 6th 2021 - Medical Advisory Group –

August 2021 - open QSE sessions x 3 across the Health Board

September 1st 2021 – Youth Board

ACKNOWLEDGEMENTS continued ……..

Surveys

Organisation wide Patient Safety Culture Survey

Community wide Patient Experience Survey

External Stakeholders

Improvement Cymru – 13th April 2021

Welsh Health Specialised Services Committee – 19th May 2021

The Delivery Unit – 3rd June 2021

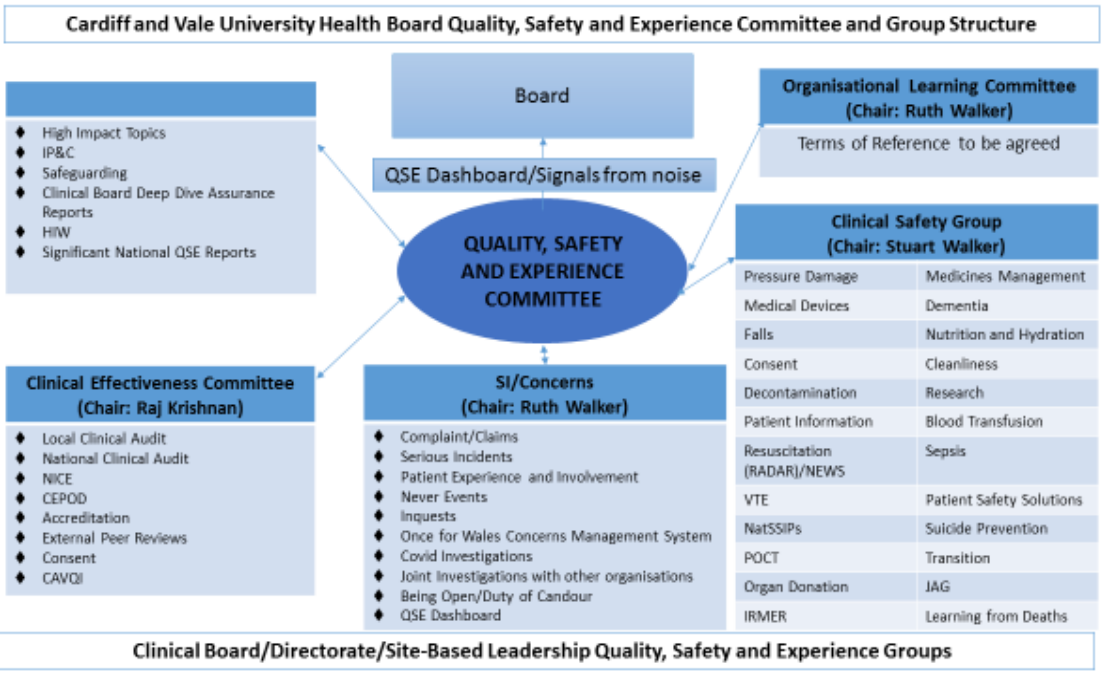
Welsh Government – 14th June 2021

Healthcare Inspectorate Wales - 9th July 2021

Community Health Council – 5th August 2021

Much appreciated engagement with all of our Twitter followers on CV_UHBSafety; @CAV_PETeam

Appendix 1



Clinical Safety Group

Terms of Reference

Approved by the Quality, Safety and Experience Committee;
xxx 2021.

CLINICAL SAFETY GROUP

TERMS OF REFERENCE

1 CARDIFF AND VALE UHB VALUES AND BEHAVIOURS

- We are kind and caring
- We are respectful
- We show trust and act with integrity
- We take personal responsibility

The Clinical Safety Group meetings and associated work will embed the UHB values through the behaviour and actions of the members.

2 PURPOSE AND OBJECTIVES

The purpose of the Clinical Safety Group is to:

- Evidence based and timely advice to the QSE Committee to assist it in discharging it's function and meetings its responsibilities with regards to patient safety, quality and experience
- Assurance to the QSE Committee that governance arrangements are appropriately designed and operating effectively to ensure the provision of high, quality, safe health care and improvement across the whole of the UHB QSE related activities and responsibilities.

3 DELEGATED POWERS AND AUTHORITY

3.1 The Clinical Safety Group will, in respect of its **provision of advice** to the QSE Committee:

- Oversee the initial development of UHB plans for the development and delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;

- Consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;

- Consider the outcomes for patient feedback methodologies in line with the National Service User Framework

• Review achievement against the Health and Care Standards to inform the Annual Duty of Quality Report

• Consider and approve policies/procedures as determined by the QSE Committee.

• Approve and monitor implementation of the Quality, Safety and Experience (QSE) Framework and oversee the necessary developments to deliver the eight identified workstreams:

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

3.2 The Committee will, in respect of its **assurance role** to the QSE Committee, ensure that:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability across all established QSE related groups and functions
- the organization, at all levels has a person centred approach, putting people, patients and carers, patient safety and safeguarding above all other considerations;
- the care planned or provided across the breadth of the organization's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the organization, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient,effective, equitable, timely and safe services;
- the organization has effective systems and processes to meet the Health and Care Standards;
- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory arrangements, professional standards and registration/revalidation requirements are maintained;
- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organization
- there is good team working, collaboration and partnership working to provide the best possible outcomes for users of its services;
- risks are actively identified and robustly managed at all levels of the organization;
- decisions are based upon valid, accurate, complete and timely data and information;
- there is continuous improvement in the standard of quality and safety across

the whole organization – continuously monitored through the Health and Care Standards in Wales;

- all reasonable steps are being taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that: - sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;
- recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as 'concerns', (noting that concerns information is routinely included in the standing item on the Board agenda (Patient Safety Quality and Experience Report) and will not be duplicated in Committee)

3.3 Authority

The QSE Committee has approved the following established QSE Groups shall report in to the Clinical Safety Group:

- Blood Transfusion
- Cleanliness
- Consent
- Decontamination
- Dementia
- End of Life Care
- Falls Delivery Group
- IRMER
- JAG
- Medicines Management Group
- Medical Devices Group
- Mortality/ Learning from Deaths
- NatSSIPS/Venous Access T&F Group
- Nutrition and Hydration Group
- Organ Donation Group
- Pressure Damage Group
- Patient Information
- Patient Safety Solutions
- Research Governance
- Resuscitation (RADAR)/NEWS/PART
- Sepsis
- Suicide Prevention
- Transition (Paediatric to Adult Services)
- Venous Thromboembolism (VTE) Group

4 MEMBERSHIP

A minimum of 3 members, comprising

Chair: Executive Medical Director

Vic Chair: Executive Nurse Director

Members: Assistant Director Patient Safety and Quality

Assistant Medical Director Patient Safety and Quality

Assistant Director Patient Experience

Assistant Director Therapies and Health Sciences

Head of Patient Safety and Quality

Head of Concerns and Claims

Head of Quality Assurance and Clinical Effectiveness

Chairs of relevant UHB QSE Groups (as relevant and required)

Deputy Director of Operations

Head of Corporate Governance

And others as appropriate

5 COMMITTEE MEETINGS

5.1 Quorum

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

5.2 The agenda will be drawn up by the core committee.

5.3 Administrative and secretarial support to the Clinical Safety Group will be provided.

5.4 Minutes of the meeting will be distributed to members within 10 working days of the meeting date.

6 REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Chair of the Clinical Safety Group will:

- Report formally, regularly and on a timely basis to the QSE Committee on its activities. This includes verbal updates, the submission of Clinical Safety Group minutes and written reports.
- Bring to the attention of the QSE Committee and significant matters under consideration

- Ensure appropriate escalation arrangements are in place to alert the QSE Committee of any urgent, critical matters that may compromise patient care and affect the operation and reputation of the UHB.

7 REVIEW

7.1 These Terms of Reference and operating arrangements will be reviewed on an annual basis.

Organisational Learning Committee

Terms of Reference

Approved by Quality, Safety and Experience Committee: xxxx 2021

VERSION 1 DRAFT

ORGANISATIONAL LEARNING COMMITTEE

TERMS OF REFERENCE

1. CARDIFF AND VALE UHB VALUES AND BEHAVIOURS

- We are kind and caring
- We are respectful
- We show trust and act with integrity
- We take personal responsibility

The Organisational Learning Committee meetings and associated work will embed the UHB values through the behaviour and actions of the members.

Role and Purpose

The purpose of the Organisational Learning Committee is to share themes across the Health Board that will enable members to:-

- provide strategic direction and leadership to ensure cross organisational learning in relation to key themes from internal and external reviews/ reports.
- Tackle complex problems identified learning received through other groups
- Triangulate learning and evidence based themes and trends emerging from other groups and Committees;
- agree action for improvement and monitor progress that address the adverse themes and trends as part of the UHB Quality Management System;
- agree action and monitor the spread of good practice identified from themes and trends;
- provide assurance to the QSE Committee that governance arrangements are appropriately designed and operating effectively to ensure the identification, action and sharing of learning in a culture of improvement across the whole of the UHB QSE related activities and responsibilities.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Organisational Learning Committee will address major learning themes and trends currently faced by the UHB. This will be done by:

- receiving the learning themes and trends
- identifying and discussing cross learning opportunities for the UHB
- reviewing available evidence;

- overseeing the initial development of UHB plans that enable the delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any

requirements and standards set for NHS bodies in Wales;
- Ensuring consideration of the implications for patient and citizen experience regarding themes

3.2 The Group will ensure that:

- decisions are based upon valid, accurate, complete and timely data and information;
- all participants have an equitable opportunity to present their opinions and that these are respected;
- learning is appropriately shared and embedded;
- the care planned or provided across the breadth of the organisation's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the right systems and processes are in place to deliver safe, efficient, effective, timely, equitable and patient/citizen centred services;
- there is an ethos of continual improvement and regular methods of updating the workforce in the skills needed to demonstrate improvement throughout the organisation;
- Assurance to the QSE Committee that governance arrangements are appropriately designed and operating effectively to ensure the identification., action and sharing of learning in a culture of improvement across the whole of the UHB QSE related activities and responsibilities.
- Mandatory training requirements are identified and implemented as appropriate
- Ensure that any learning in relation to Covidd-19 recovery is identified and fed back in to quality/service improvement initiatives.

3.3 Authority

The Organisational Learning Committee has authority to:

- to make recommendations following a consensus opinion;
- hold to account and monitor agreed actions/improvements.

4. MEMBERSHIP

Chair: Executive Nurse Director
Vice Chair: Executive Medical Director

Members: Assistant Director Patient Safety and Quality
Assistant Medical Director Patient Safety and Quality
Assistant Director of Patient Experience
Assistant Director of Organisational Development
Director /Assistant Director Innovation and Improvement
Clinical Board representative
Representative from the Health Schools within the University
Senior Member from Learning Education and Development
Post graduate medical education
Undergraduate medical education

Allied Healthcare Professionals Forum representative.
Individuals with expertise/ interest in an agenda topic
interested parties with diverse perspectives

5. COMMITTEE MEETINGS

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

5.2 The agenda will be drawn up by the emerging themes and trends identified and the work programme within the UHB Committee.

5.3 Administrative and secretarial support to the group will be provided.

5.4 Minutes of the meeting will be distributed to members within ten working days of the meeting date.

5.5 The Committee will meet quarterly (TBC)

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Chair of the Organisational Learning Committee will:

- Report formally, regularly and on a timely basis to the QSE Committee on its activities. This includes the submission of Organisational Learning Committee minutes and written reports.

- Bring to the attention of the QSE Committee and significant matters under consideration.

- Ensure appropriate escalation arrangements are in place to alert the QSE Committee of any urgent, critical matters that may compromise patient care and affect the operation and reputation of the UHB.

7. REVIEW

7.1 These Terms of Reference and operating arrangements will be reviewed in six months to start with until the group is properly established, then on an annual basis.

Report Title:	**Quality Indicators – Progress Report – Item 2.4**						
Meeting:	Quality, Safety and Experience (QSE)				**Meeting Date:**	15/09/2021	
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:

At the time of writing however, the UHB has 47 open SIs compared to 67 reported to the Committee in June 2021

There have been no further Never Events since the last report to the Committee in June 2021.

More recently there had been a marked increase in patient's raising concerns relating to delays in follow-up appointments and planned procedures within the Surgical Clinical Board, therefore, following discussions with the Clinical Board to address these issues, the Directorates are in the process of contacting patients on their waiting lists to provide an update on the current position.

It is pleasing to note that the Health Boards 30 day performance in responding to concerns has remained consistent despite the continuing demand on the Health Board, we are still exceeding the Welsh Government target of 75%.

The SSNAP data has consistently showed Cardiff and Vale UHB to be performing poorly in relation to:

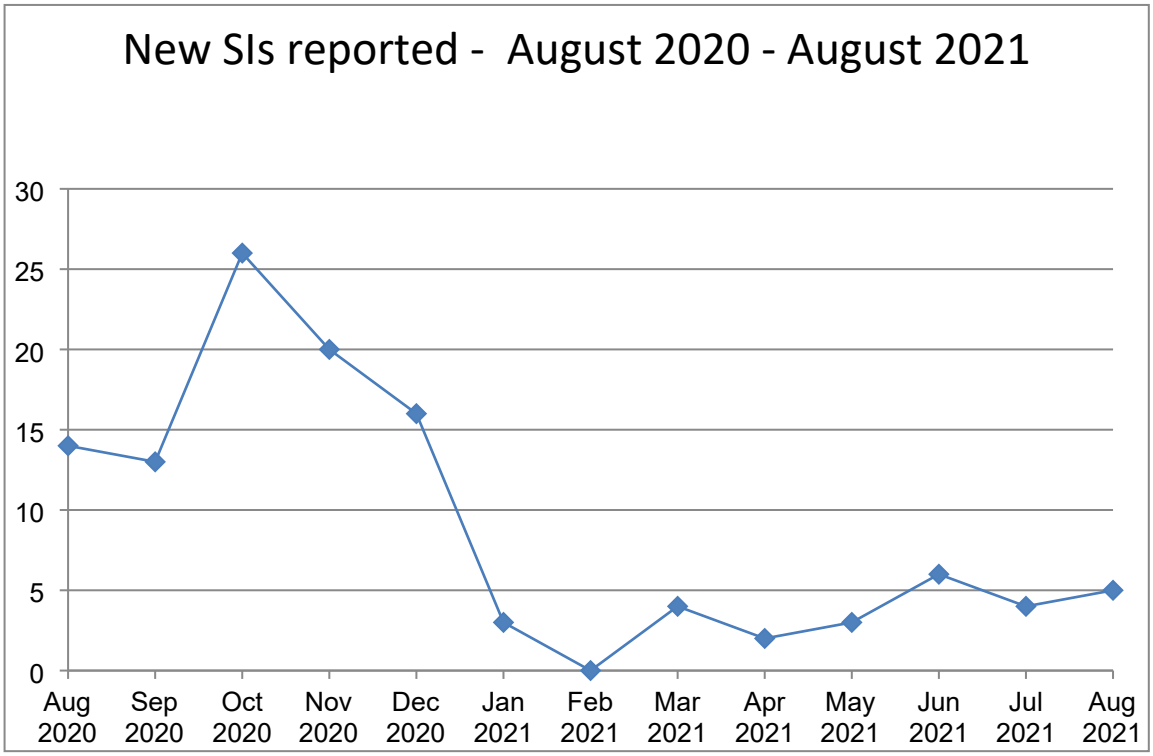
- Admission to Stroke unit
- Time interval to thrombolysis
- Specialist assessments

An Introduction of a HASU Unit consistent with the rest of the UK would significantly improve outcomes for patient admitted with stroke.

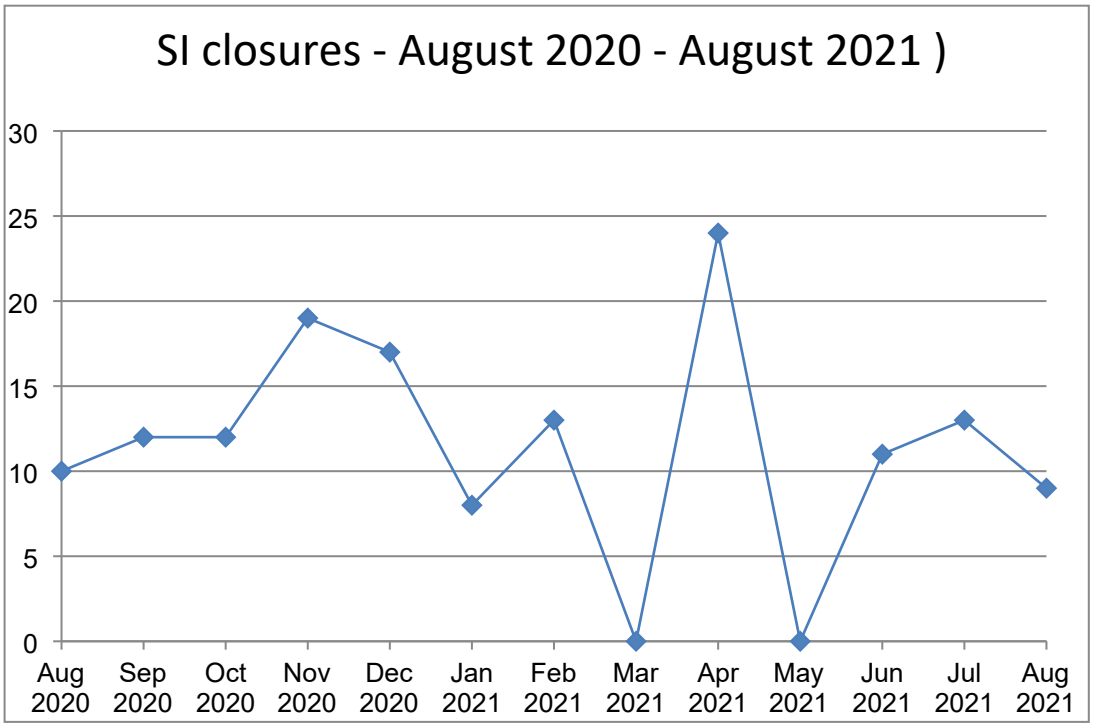
The data for sepsis compliance is currently disappointing in terms of the Sepsis Six compliance

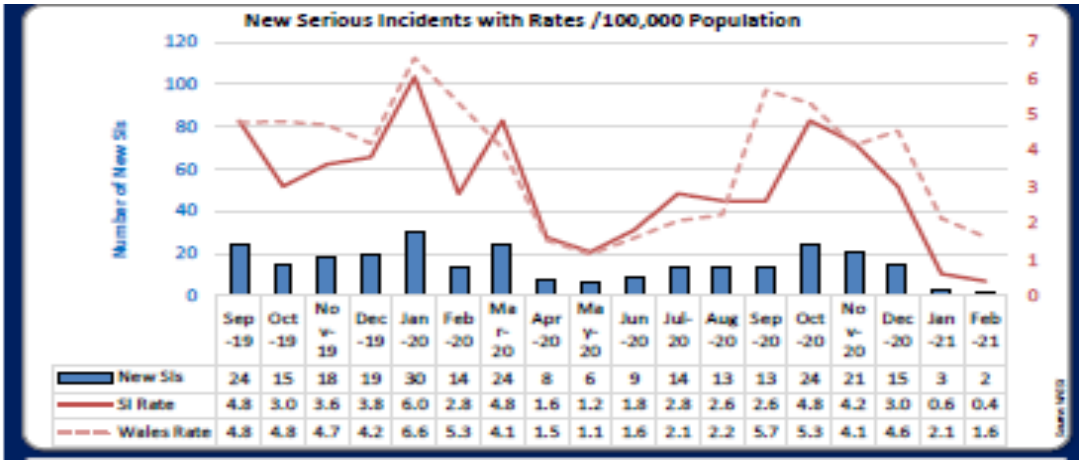
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Serious Incidents reported



Serious incidents closed/numbers breaching





Performance on SI closures submitted to WG/DU is variable from month to month and largely relates to capacity within the Health Board to draft closure forms and to approve them. The Patient Safety Team continue to 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 however, the UHB has 47 open SIs compared to 67 reported to the Committee in June 2021.

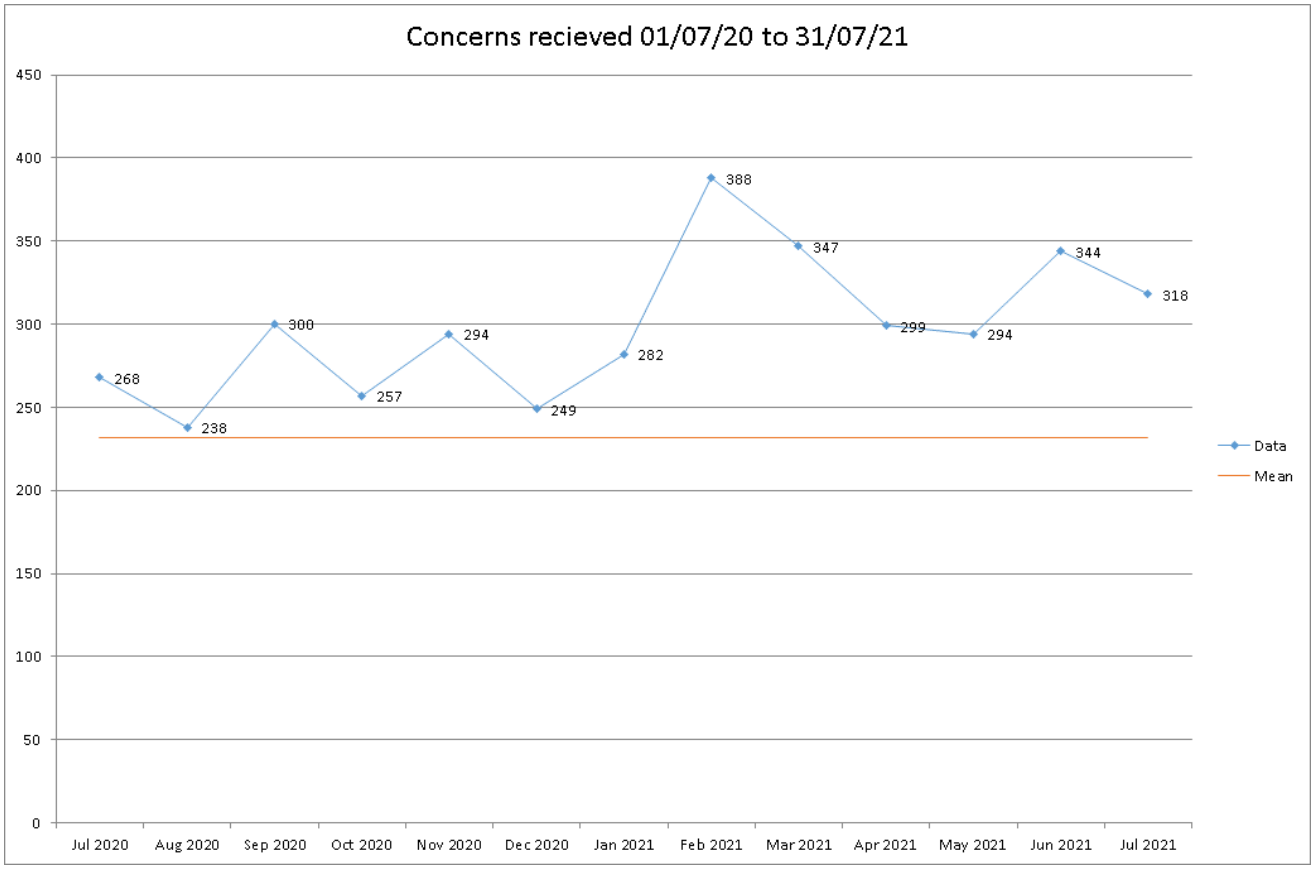
Never Events

There have been no further Never Events since the last report to the Committee in June 2021.

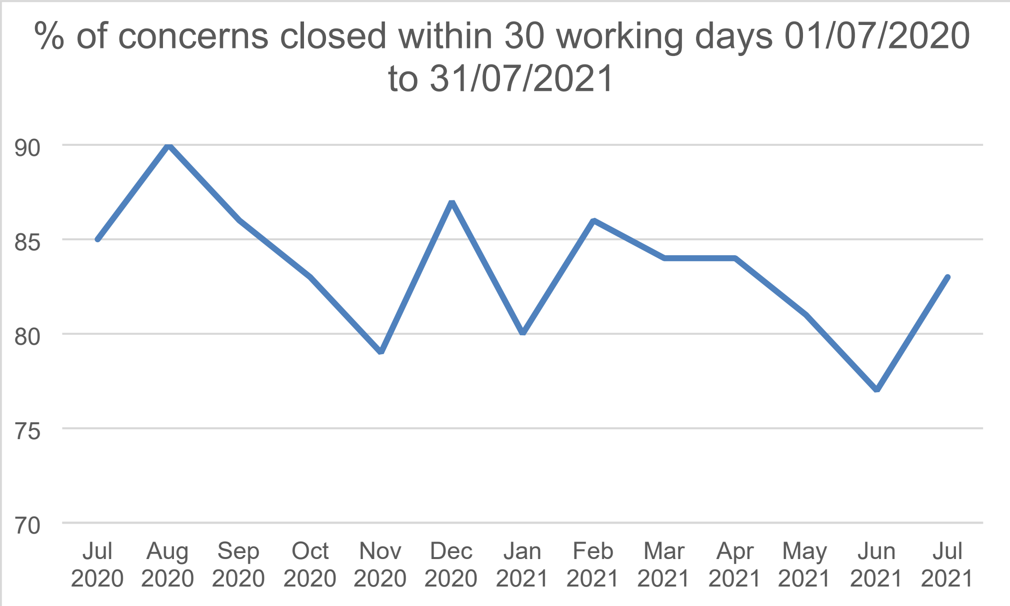
There are curently two Never Events under investigation. The results from a recent Staff Survey in relation to WHO Checklist compliance is due to be discussed at the next NaTSSIPS meeting on 24th September 2021. WHO checklist complaince is also currently being reviewed as part of the Internal Audit programme. As stated in the previous report to the Committee, development of a Human Factors Framework and Training Strategy will be an important element of our revised QSE Framework for the next five years.

A campaign on Safety Culture is being planned and embedding a Human Factors and Systems based approach to safety will support the reduction of Serious incidents and Never Events.

Complaints



30 day performance



We have continued to see a consistently high number of concerns both formal and early resolution enquiries over the past year.

More recently there had been a marked increase in patient's raising concerns relating to delays in follow-up appointments and planned procedures within the Surgical Clinical Board, therefore, following discussions with the Clinical Board to address these issues, the Directorates are in the process of contacting patients on their waiting lists to provide an update on the current position.

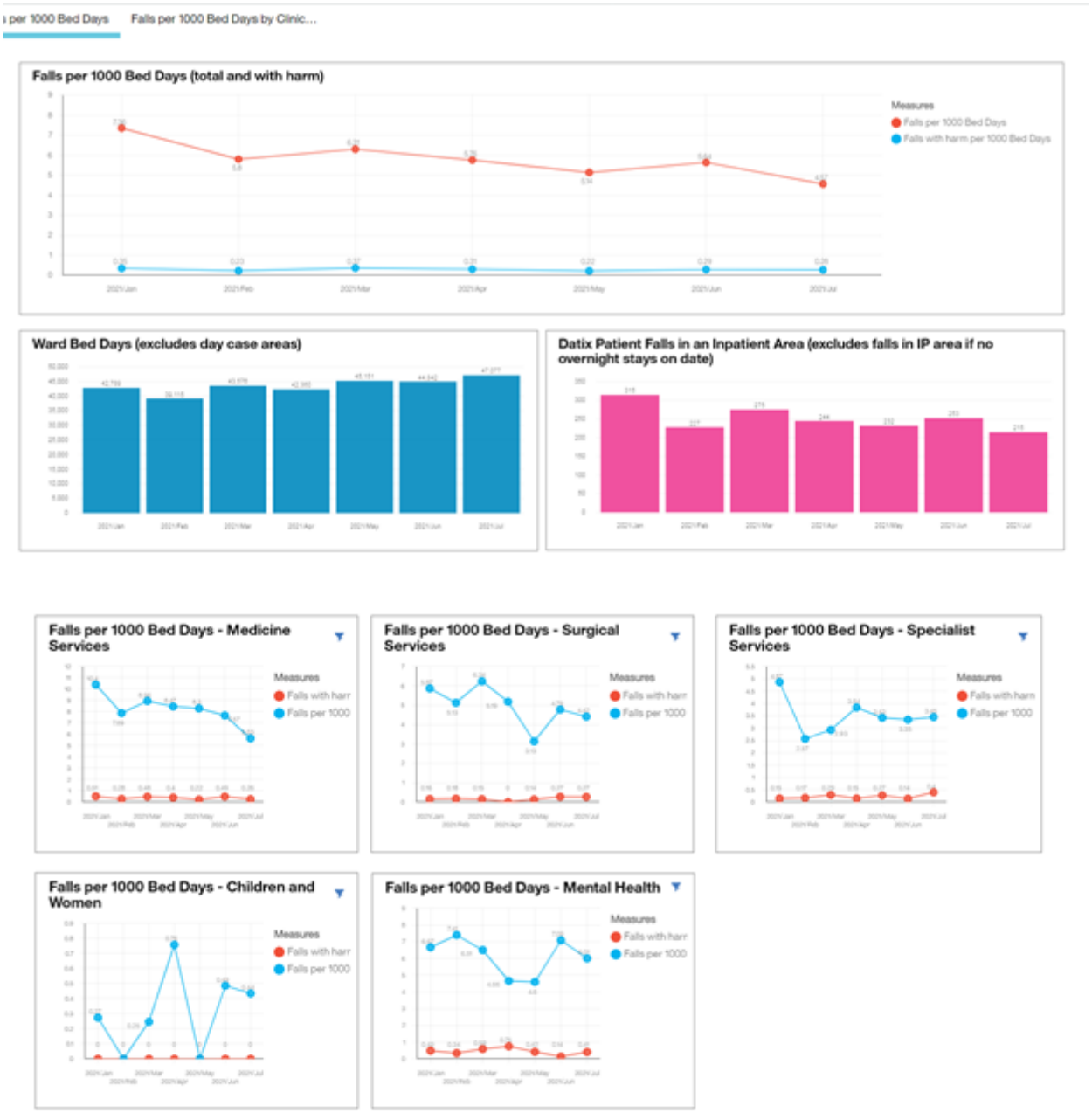
It is pleasing to note that the Health Boards 30 day performance in responding to concerns has remained consistent despite the continuing demand on the Health Board, we are still exceeding the Welsh Government target of 75%.

Pressure damage

	Incident Date								
Pressure Damage Classification	2018		2019		2020		2021		Grand Total
Grade 1: Non-Blanchable redness of intact skin	234	11.08%	246	10.17%	231	9.46%	132	9.72%	843
Grade 2: Partial thickness skin loss or blister	1262	59.75%	1459	60.31%	1396	57.17%	724	53.31%	4841
Grade 3: Full thickness skin loss (fat visible)	277	13.12%	267	11.04%	239	9.79%	127	9.35%	910
Grade 4: Full thickness skin loss (muscle/bone visible)	26	1.23%	26	1.07%	20	0.82%	18	1.33%	90
Suspected Deep Tissue Injury (SDTI)-depth unknown	143	6.77%	255	10.54%	350	14.33%	232	17.08%	980
Unstageable/Unclassified	170	8.05%	166	6.86%	206	8.44%	125	9.20%	667
Grand Total	**2112**		**2419**		**2442**		**1358**		**8331**

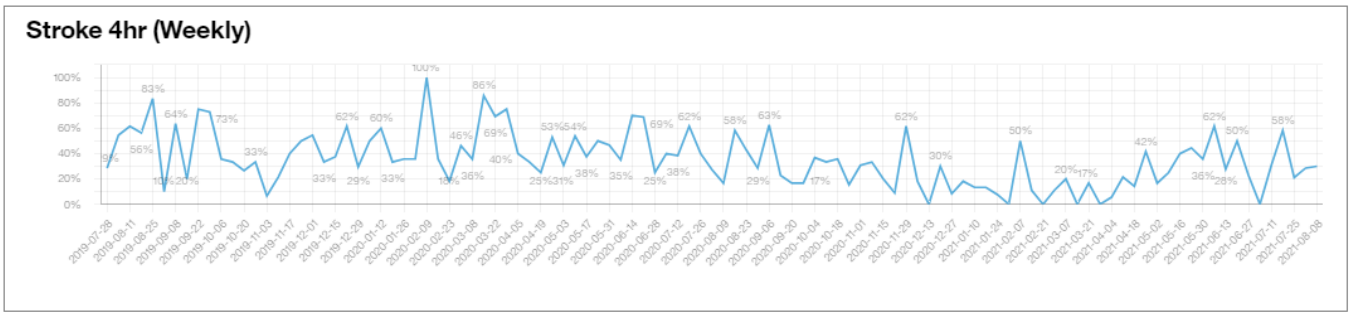
A Pressure damage collaborative has been established with support from the Patient Safety and Quality Improvement and Organisational learning team. A number of excellent initiatives are underway and areas for improvement for 2021/2022 were described in a report to the June 2021 QSE Committee.

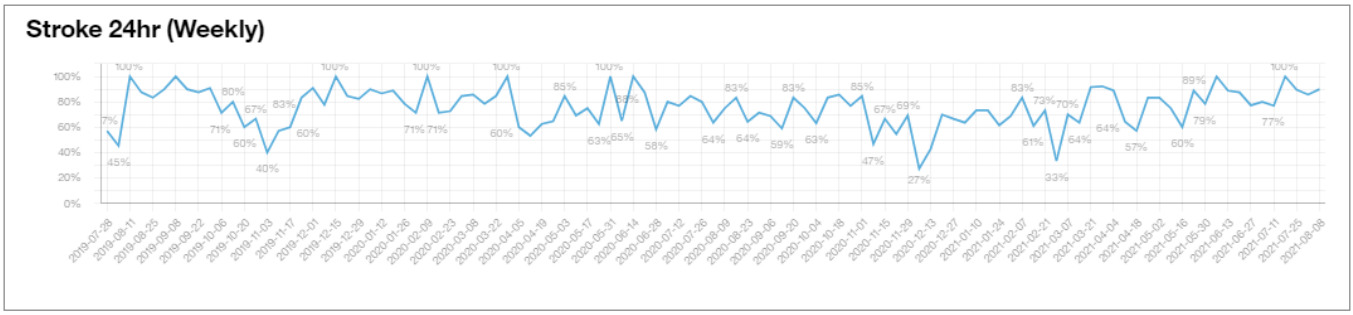
In-patient falls



The Falls Delivery Group reviews the detailed Falls Dashboard at every meeting. This is supplemeented by learning from the Falls Review panel.

Stroke indicators





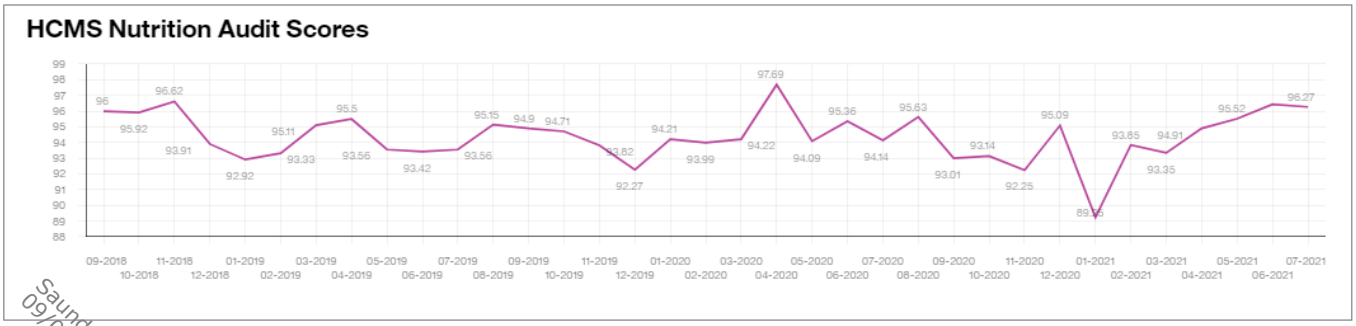
Further detail in relation to Stroke Performance is included in the Clinical Effectiveness report to the September QSE committee.

The SSNAP data has consistently showed Cardiff and Vale UHB to be performing poorly in relation to:

- Admission to Stroke unit
- Time interval to thrombolysis
- Specialist assessments

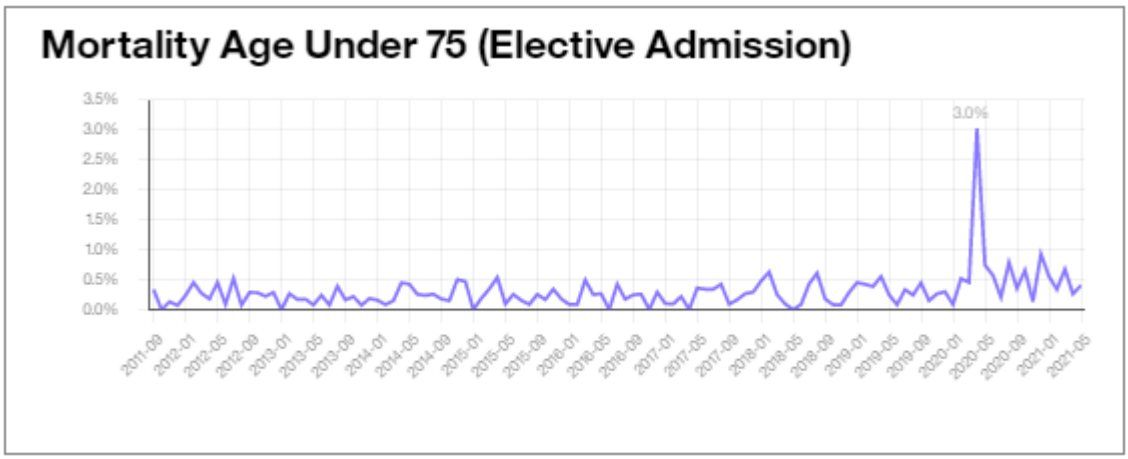
An Introduction of a HASU Unit consistent with the rest of the UK would significantly improve outcomes for patient admitted with stroke.

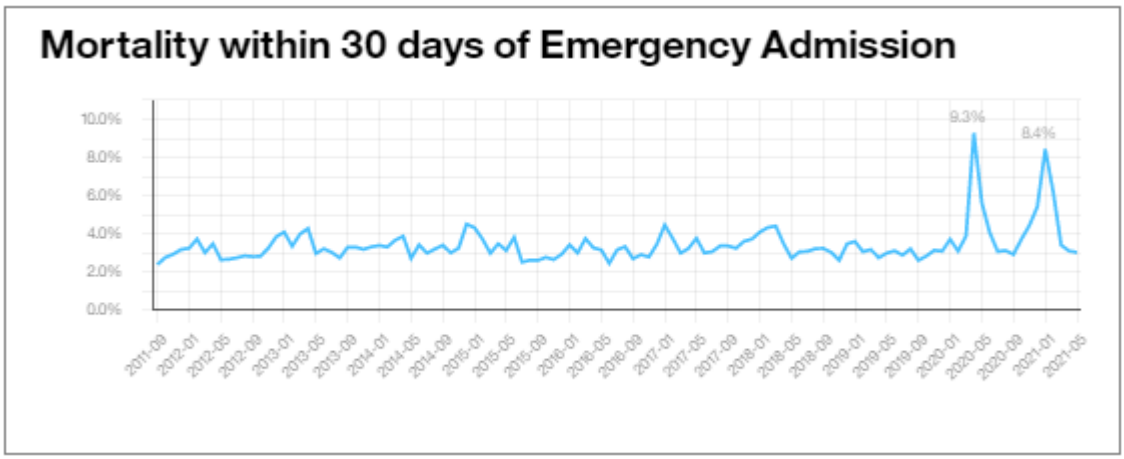
Nutritional assessment scores

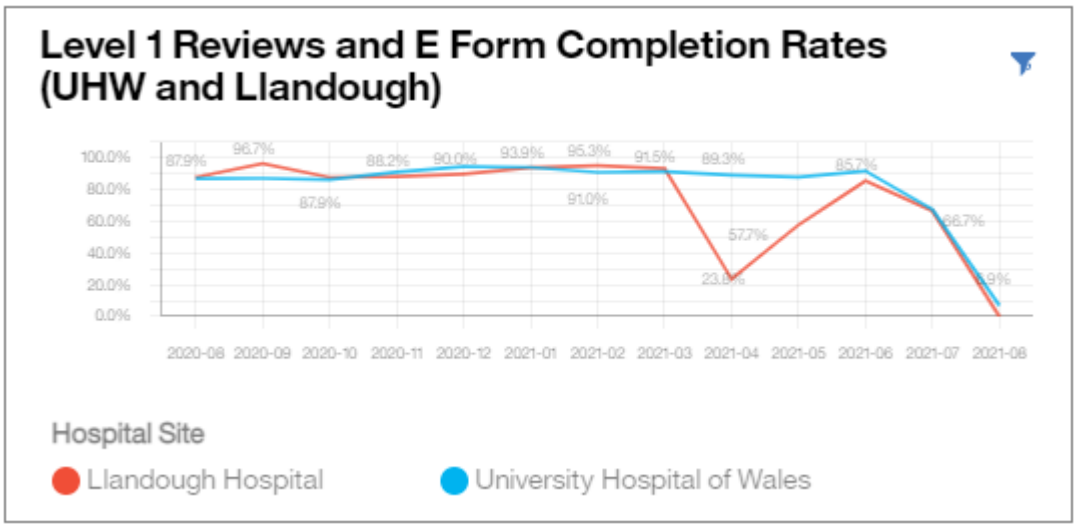


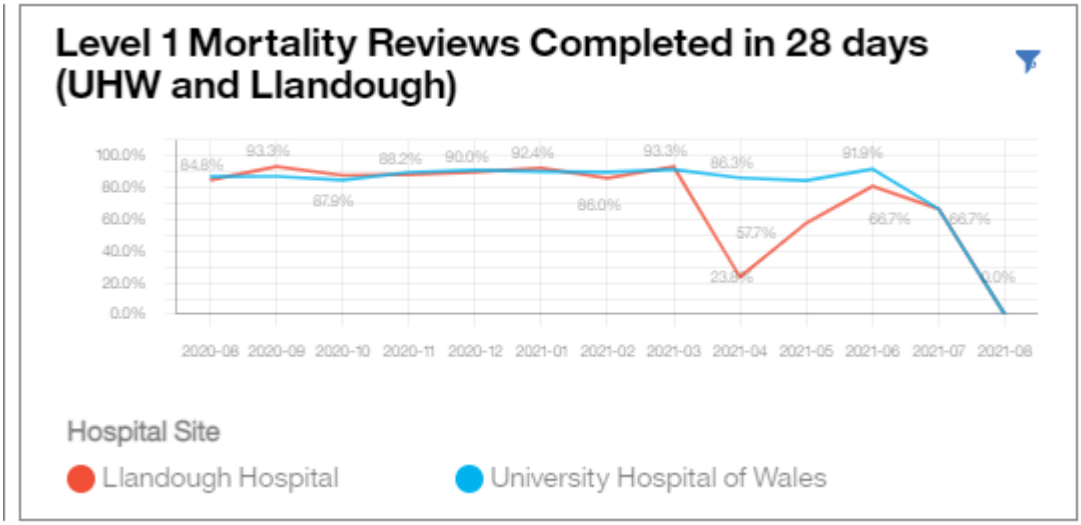
Compliance with nutritional assessment scores continues to improve. Performance with the standard is monitored by the Nutrition and catering Steering Group.

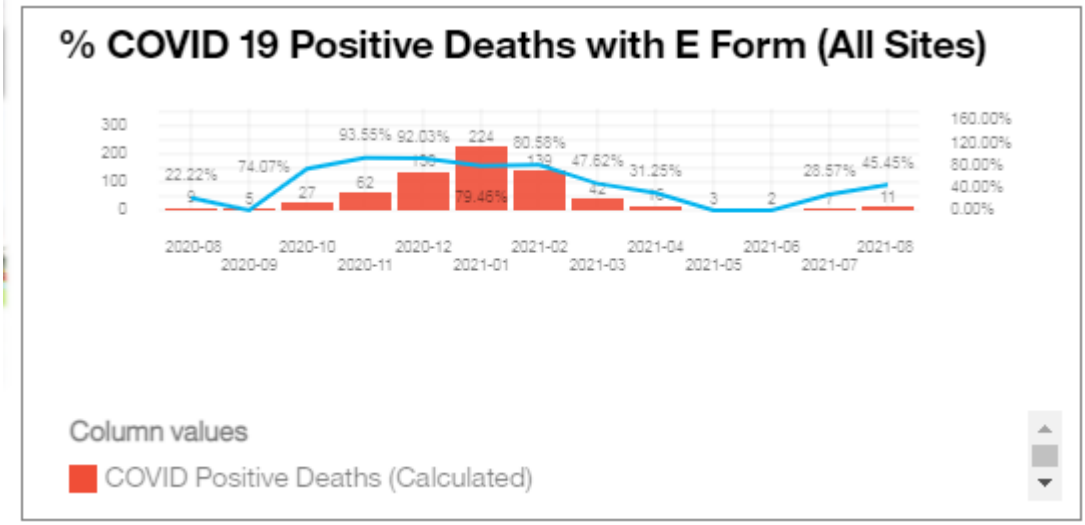
Mortality Indicators





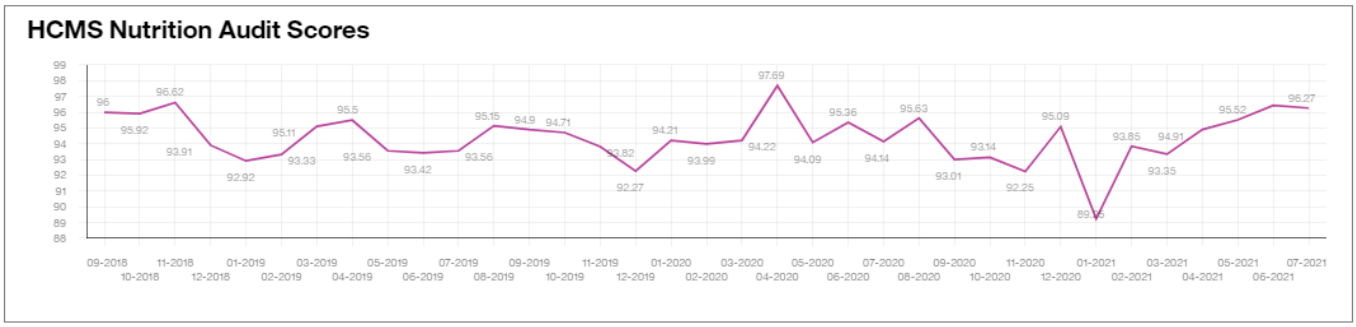




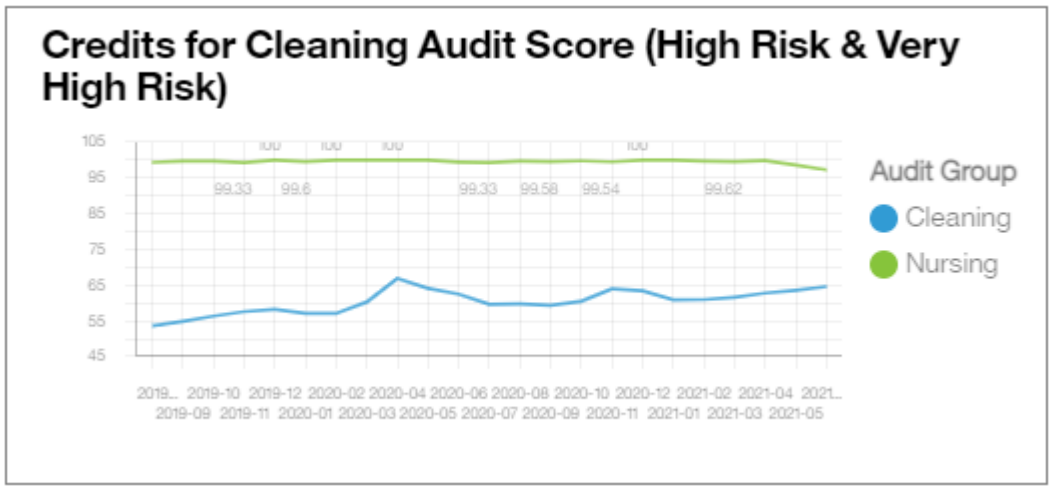


A detailed review of Mortality data is undertaken by the well - established Mortality Group.

Hand Hygiene



Cleaning scores



Infection Prevention and Control

Wales 2020/21 HCAI mandatory surveillance summary, Apr - Jul 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	77	38.51	0	0.00	40	20.01	40	20.01	122	61.02	40	20.01	11	5.50	173	86.52
Betsi Cadwaladr UHB	70	29.78	3	1.28	53	22.54	56	23.82	153	65.08	45	19.14	16	6.81	214	91.03
Cardiff and Vale UHB	48	28.47	3	1.78	39	23.13	42	24.91	107	63.45	43	25.50	7	4.15	157	93.11
Cwm Taf Morgannwg UHB	49	32.59	1	0.67	47	31.26	48	31.92	144	95.77	27	17.96	10	6.65	181	120.38
Hywel Dda UHB	50	38.38	4	3.07	39	29.94	43	33.01	133	102.10	21	16.12	9	6.91	163	125.13
Powys THB	4	9.00	0	0.00	0	0.00	0	0.00	1	2.25	0	0.00	0	0.00	1	2.25
Swansea Bay UHB	68	52.04	3	2.30	44	33.67	47	35.97	114	87.24	29	22.19	7	5.36	150	114.79
Velindre NHST	1		0	0.00	0	0.00	0	0.00	3		1		1		5	
Wales	367	34.83	14	1.33	262	24.86	276	26.19	777	73.73	206	19.55	61	5.79	1,044	99.07

C.Diificile

Chart 2. Cardiff and Vale UHB monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Jul 21

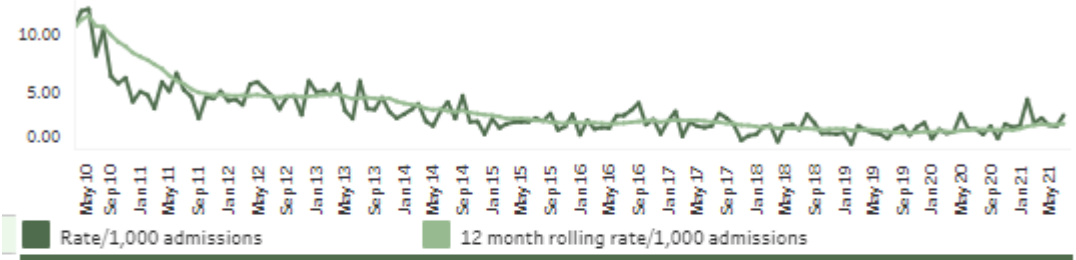


Chart 3. Cardiff and Vale UHB cumulative monthly numbers of C. difficile for Apr to Jul 21 compared to the equivalent period in 2020/21

MRSA

Chart 2. Cardiff and Vale UHB monthly rates of MRSA bacteraemia per 1,000 hospital admissions, Apr 10 to Jul 21

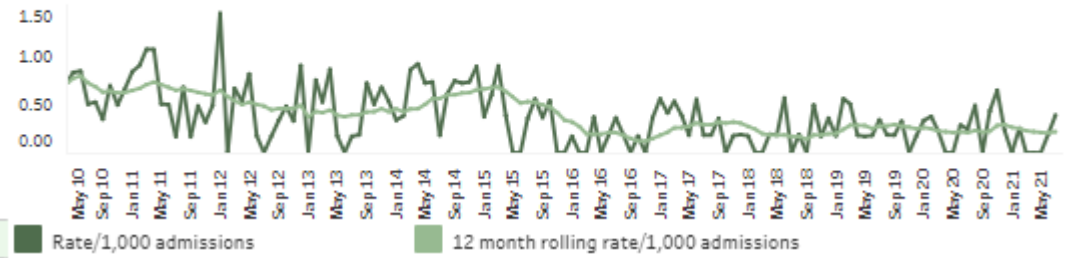
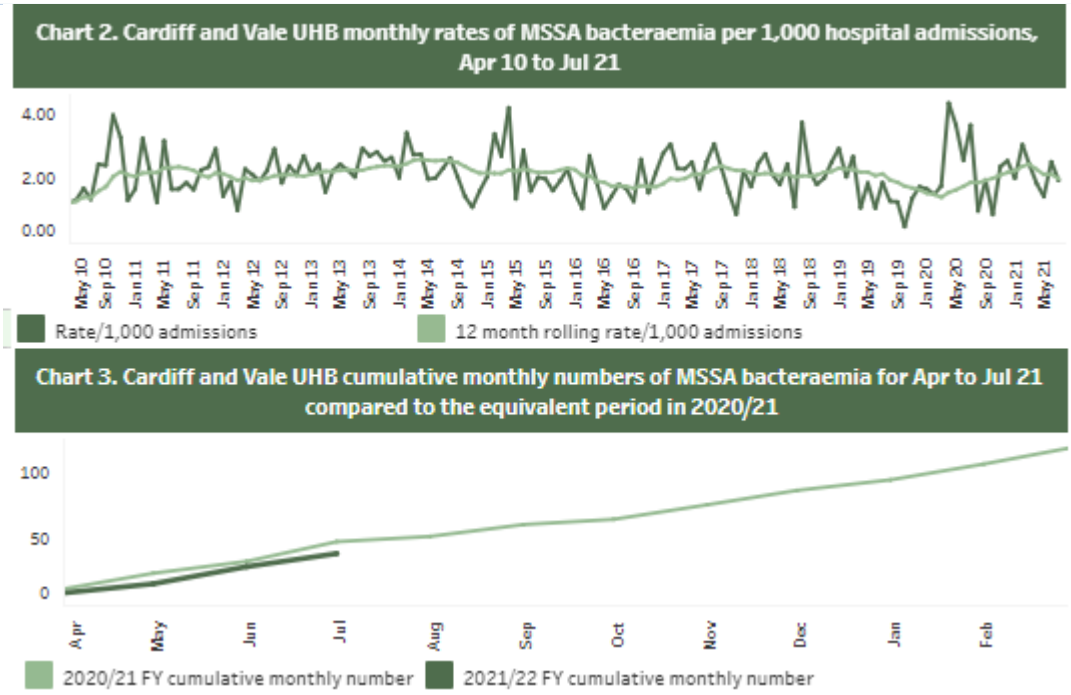
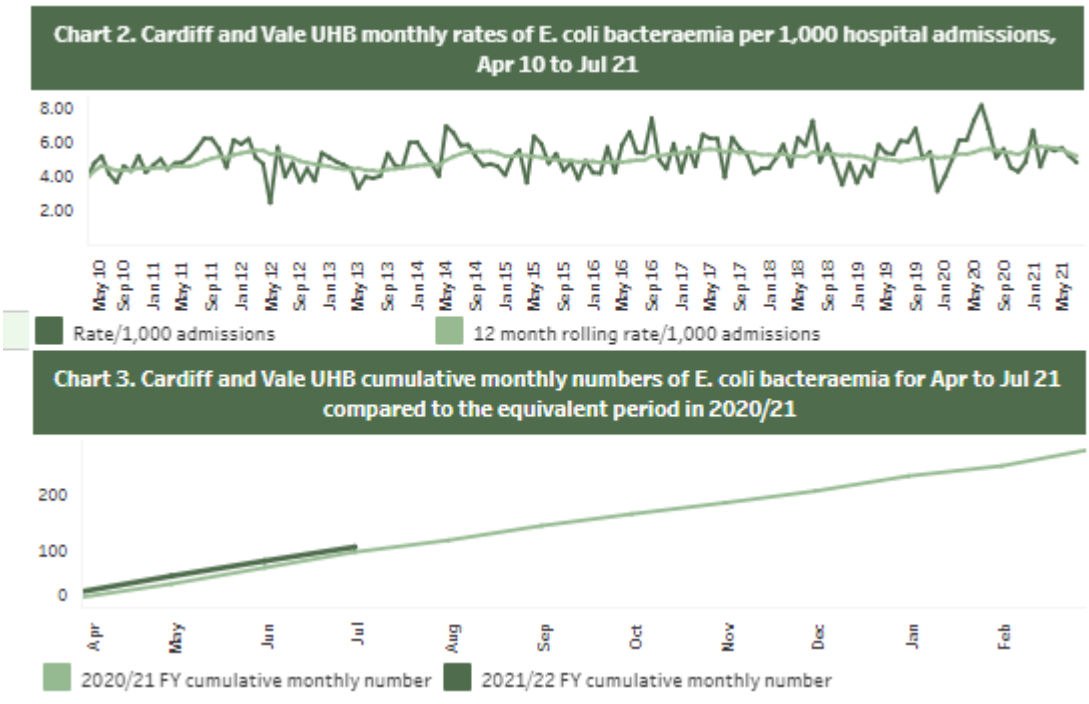


Chart 3. Cardiff and Vale UHB cumulative monthly numbers of MRSA bacteraemia for Apr to Jul 21 compared to the equivalent period in 2020/21

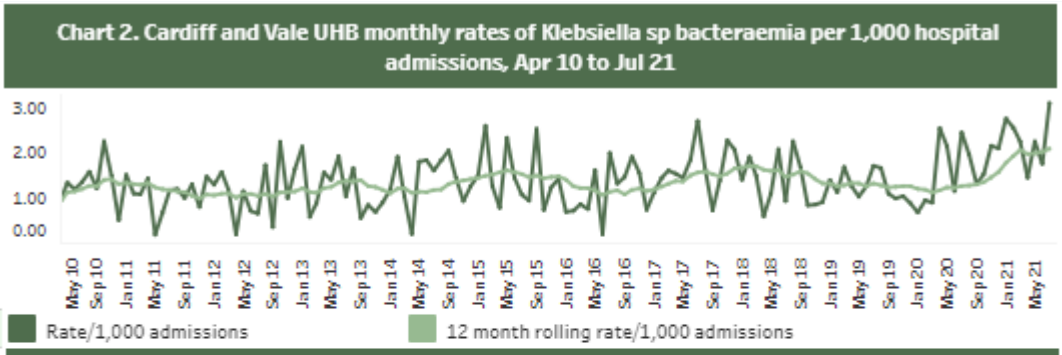
MSSA

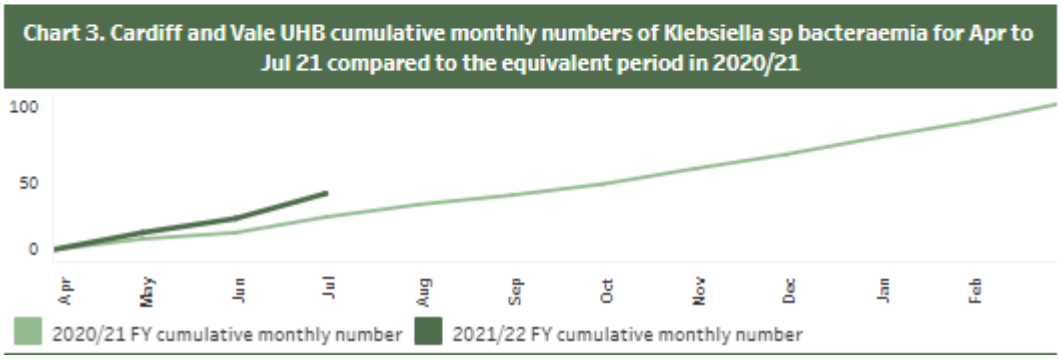


E-Coli

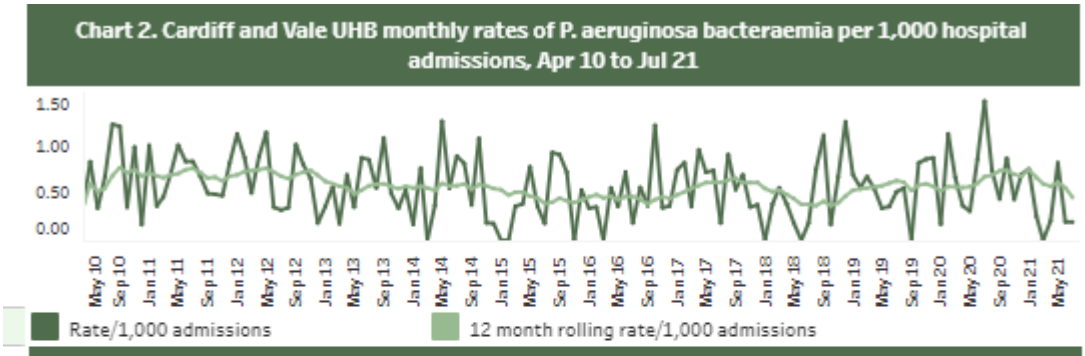


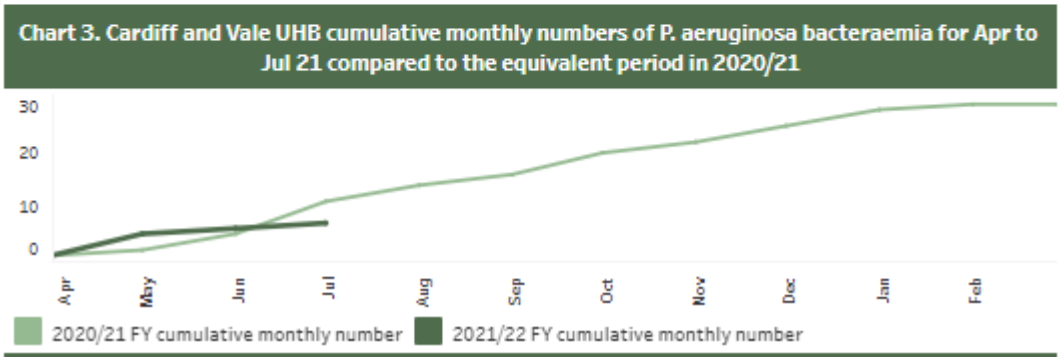
Klebsiella



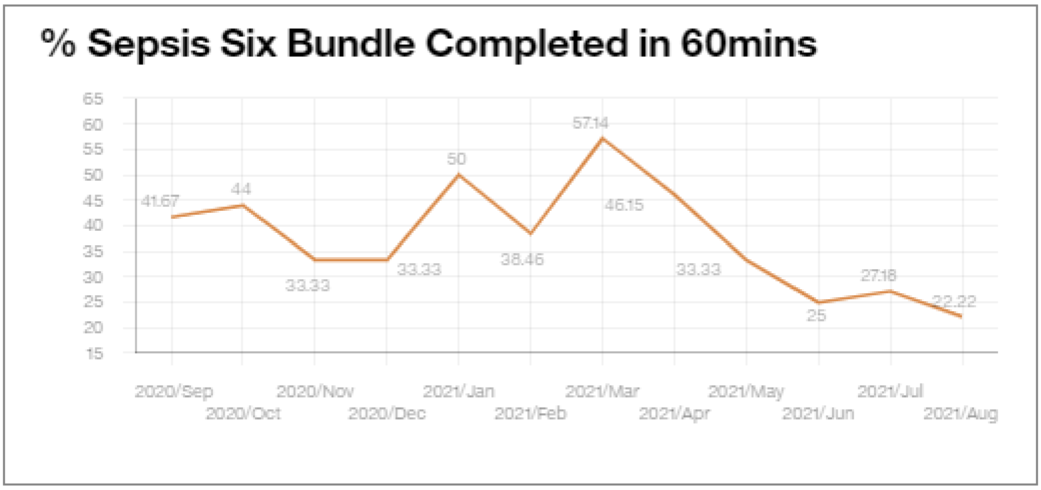


P. aeruginosa





Sepsis



The data for sepsis compliance is currently disappointing in terms of the Sepsis Six compliance. Unsurprisingly, the quality and quantity of sepsis data has taken a substantial hit as a consequence of the focus on managing the CoVID-19 pandemic. The uptake of the Star flag system on the EU/Ward Clinical Workstation, feeding in to the Sepsis Dashboard on the Cognos Analytics system, remains patchy as it adds to staff workload rather than replacing it, as was envisioned. The lack of electronic patient records and an electronic patient observations system has undoubtedly hindered progress on this.

However, the opportunity afforded by the establishment of the PART (P Acute Response Team), together with the implementation of NEWS version 2, should enable the UHB to gather more, better quality information across both UHW and UHL sites.

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 - ITEM 2.6**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**15.9.21**	
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:

The UHB continues to work with HIW and respond to the findings of Quality Checks and Inspections.

HIW are currently consulting on a ‘Service of Concern’ process. It is anticipated that the introduction of a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. It is anticipated that the process will be introduced in Autumn 2021.

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

Quality Checks

Owl (surgical ward) Noah's Arc 12th May 2021

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Owl Ward at Noah's Ark Children's Hospital for Wales as part of its programme of assurance work.

During the quality check, HIW considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. The HIW report reflected positively on how the challenges during COVID-19 had been overcome to safety provide care for children, which included providing separate areas for children requiring elective and emergency care. The large ward area ensured that social distancing rules could be adhered to, meeting rooms were turned into additional staff rooms to ensure staff had adequate room to take breaks safety, and children were provided with toys to play with at the bedside to reduce the risk of transmission and ensure that children continued to have stimulation and play.

Welsh Government guidelines were adhered in terms of visiting during the pandemic and measures were in place to preserve children's' dignity including the a recent initiative where pyjama sets and velcro suits were purchased by the Noah's Ark Children's Hospital charity for children on the ward. The suits ensure that only the area of the body that the surgeon requires access to is exposed.

HIW were assured with the IP&C arrangements to reduce transmission of COVID -19, which includes daily staff briefings, availability and appropriate use of PPE, training and access to up to date guidance. Fortnightly IPC audits had recently been implemented on the ward. HIW welcomed this as a positive initiative to help monitor compliance and identify improvements.

The monthly hand hygiene audits demonstrated that over the last 12 months the ward mostly achieved 100 per cent compliance. However, it was noted that in all cases where issues were identified, it was due to doctors wearing watches in the clinical areas. An action featured in the Improvement plan to address this which was addressed immediately and further audits have reported an improvement in bare below the elbow compliance.

Arrangements are in place to ensure sufficient staff skill mix and staff numbers are on duty each shift, preparations were being undertaken by senior staff to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016 , which will apply to the ward from October 2021 onwards .A review of staffing levels using the Nurse Staffing levels (Wales) Act 2016, triangulation process was undertaken which did not identify any potential issues, and that the ward was currently fully staffed.

Staff mandatory training attendance was 86 %. However, compliance with PADR;s was 66% an action was included in the improvement plan to address this, measures are now in place to ensure that all staff will have received a PADR by the end of September 2021.
The full report is available here

Update on thematic reviews:

WAST
As part of Healthcare Inspectorate Wales' (HIW) annual reviews programme for 2020-21, a local review of the Welsh Ambulance Service Trust (WAST) is being undertaken. The focus of the review is to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience. A copy of the Terms of Reference will be available here

The UHB has working with HIW to encourage relevant staff to participate in a survey in relation to ambulance handovers. This has been promoted though all available UHB communication channels which has now closed.

The draft report has been received and the UHB will now work with WAST and WG to submit a joint action plan to address the findings by the deadline of September 24th.

Mental Health Crisis Prevention in the Community

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

Review of Maternity Services in Wales – remains on hold.

IRMER

HIW undertook an on-Site inspection of the Diagnostic Radiology and Interventional Imaging Department in the 17th and 19th of August. We are awaiting the final report and the findings will be presented in the next HIW activity report.

Service of Concern process for NHS – out for consultation

The HIW Strategy and Operational Plan for 2021-22 highlights their intention to implement a Service of Concern process relating to our NHS assurance activities, aligned with their approach in the independent healthcare sector.(see Appendix 1) It is anticipated that the introduction of a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided.

HIW currently follows an internal escalation process when an issue of significant concern comes to their attention. The Service of Concern designation will be distinct and separate from the NHS Wales Escalation and Intervention arrangements. However, this process will inform HIW's view and contribution to the discussions on overall status of NHS bodies. HIW have offered the opportunity for Health Boards to review and raise any comments or concerns by the 30th of September.

The HIW Strategy and Operational Plan 2021-2022 is available 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.*

Healthcare Inspectorate Wales

Service of Concern process for NHS Bodies in Wales

July 2021

Engagement Proposal

Background

It is our continued commitment and goal at Healthcare Inspectorate Wales (HIW) to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards. Our goal is to encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

One of the key priorities set out within Healthcare Inspectorate Wales' (HIW) strategic plan is to take action when standards are not met. In line with this priority, and wishing increase transparency about how it discharges its role in in providing assurance to the public regarding the quality and safety of healthcare services, HIW is proposing to introduce a Service of Concern process and designation for the NHS.

Currently, HIW follows an internal escalation process when an issue of concern comes to our attention. Our new proposal is to formally use a Service of Concern designation when HIW identifies significant singular service failures, or cumulative or systemic concerns regarding a service or setting. HIW's escalation and enforcement process for independent healthcare currently utilises such a process.

We believe that using a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided.

The Service of Concern designation will be distinct and separate to the NHS Escalation and Intervention arrangements. However, this process will inform HIW's view and contribution to the discussions on overall status of NHS bodies.

What does HIW want to achieve from this engagement?

- To communicate our intentions around the NHS Service of Concern designation to stakeholders, and build a greater understanding of HIW's extant escalation process. We also wish to alert health board or trust representatives to the implications of this process, and highlight that they are likely to be called upon to attend formal meetings and account for matters arising in settings or services

- To raise awareness of HIW's intention to actively call upon NHS services to account for improvements that are required within services, and raise awareness that identification as a Service of Concern will be a key step in our escalation process

- To respond to queries from stakeholders who may wish to offer feedback about this process.

What will happen?

Annex A, *Service of Concern process for NHS Bodies* outlines HIW's extant escalation process, and details how a potential Service of Concern may be identified by HIW, and how this is managed, and de-escalated.

If a Service of Concern is identified, HIW will communicate this fact publicly, most likely within a report that relates to an inspection or review of a health board/trust. HIW may also, depending on the nature of the concerns, reserve the right to produce a separate communication around a Service of Concern on our website.

When will it happen?

If you wish to comment about this approach, then please send your contributions to Scott Howe, Senior Escalation and Enforcement Manager (Scott.Howe003@gov.wales) or Rhys Jones, Head of Escalation and Enforcement (rhys.jones2@gov.wales) by **30th September 2021**. We will consider any responses we receive, in order to inform the implementation of this process.

We are aiming to implement the Service of Concern approach for NHS services from autumn 2021.

Annex A

Healthcare Inspectorate Wales

Service of Concern process for NHS Bodies in Wales

Draft 5.0

Background
Healthcare Inspectorate Wales (HIW) inspects NHS Services under its powers set out within the Health and Social Care (Community Health & Standards) Act 2003 and its associated regulations and standards.

The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. HIW's inspections are based around these standards.

What are HIW's powers in relation to the NHS?
Under sections 72, 73, 74 and 75 of the Health and Social Care (Community Health and Standards) Act 2003, HIW has the following powers in relation to the provision of health care by and for Welsh NHS bodies:

- To inspect, take copies of and remove from the premises any documents or records (including personal records);
- Inspect any other item and remove it from the premises;
- To interview in private any person working at the premises or any person receiving health care there who consents to be interviewed;
- To make any other examination into the state and management of the premises and treatment of persons receiving health care there;
- To be able to require any person holding or accountable for documents or records kept on the premises to produce them;
- In relation to records kept on computer, the power to require the records to be produced in a form in which they are legible and can be taken away;
- To check the operation of any computer and any associated apparatus or material which is or has been in use in connection with the records in question.

HIW also has the power to require any person to provide it with any information, documents, records (including personal records), or other items which relate to the provision of healthcare by or for a Welsh NHS body. This would only be relating to the discharge of any of the functions of a Welsh NHS body and which it considers necessary or expedient to have for the purposes of sections 72, 73, 74 and 75.

Within the Health and Social Care (Community Health and Standards) Act 2003 (Healthcare Inspections) (Wales) Regulations 2005, HIW:

- Can require the persons named below to provide an explanation, in person or in writing, of any documents, records or items inspected, copied or provided under the Act:

  - A Welsh NHS Body;
  - A Chairman, member, director, employee, member of a committee or sub-committee of a Welsh NHS Body;
  - A service provider;

- A Chairman, Director or employee of a service provider;
- A person, other than the ones named above, who is assisting a service provider in the provision of health care for a Welsh NHS Body;
- A person, other than the ones named above, who is assisting, has assisted or is to assist a Welsh NHS Body in the exercise of its functions.

HIW is unable to take enforcement action against NHS services. The NHS Wales Escalation and Intervention Arrangements process sets out how broader concerns regarding NHS services are dealt with.

HIW focuses its inspections and reviews on the quality and safety of service provision, and the experience and outcomes for people using healthcare services. When the service provision or outcomes for people are poor, HIW will take action. This may include issuing improvement notices, escalating concerns to the executive team and board members within a health board/trust, or to the Welsh Government. HIW will also escalate significant concerns about NHS services into the NHS Wales Escalation and Intervention Arrangements, which may impact the overall escalation status of a Welsh NHS Body, or on an individual service provided by a Welsh NHS Body.

How is a Service of Concern identified?

The *NHS Service of Concern pathway* (appendix 1) illustrates HIW's escalation process in relation to NHS services, and how a Service of Concern may be identified, managed and de-escalated. Each step of the process is detailed below.

Intelligence gathered through HIW inspections, reviews, concerns and notifications, and/or other bodies. HIW may seek to verify any external intelligence.

All information that is collated by HIW will be considered at this initial stage. Information that has not been verified internally by HIW will be corroborated if possible, either through communication or on site work.

Stage 1 - Conduct an Escalation Triage discussion to determine whether further action is required and the level of escalation.

HIW will consider this information and convene an *escalation triage* meeting to determine next steps, and whether further escalation is required. This internal discussion can take numerous forms and can involve different HIW representatives. The aim is to ascertain whether escalation is the most appropriate pathway. This discussion along with any decisions and rational will be recorded. This may include a discussion with the relevant Relationship Manager around further assurance activity (follow up) being undertaken and escalation to Stage 2. However, if HIW believes the

risks to patient safety are significant enough, the issue may be escalated to a Service of Concern meeting at Stage 3.

Stage 2 - Follow up / post follow up activity discussion to determine whether further escalation is required or de escalation

Following the decision from stage 1, HIW may conduct a follow up inspection. This could be in the form of a quality check to gain further information that can be obtained off site. A further onsite focussed or full inspection. This would not necessarily be limited to one piece of work, however, a stage 1 discussion will take place after each piece to determine the most appropriate next step.

How is a Service of Concern designated?

Stage 3 – Conduct a Service of Concern meeting to determine whether a service meets the threshold of Service of Concern

The key element that will determine designation a Service of Concern is whether HIW believes there to be a clear and significant risk to patient safety. In determining this, at least one of the threshold questions may be met for a service to be designated as a Service of Concern. The three threshold questions are detailed below;

a) Have Immediate Assurance (IA) and/or Improvement plan recommendations been actioned to an acceptable standard and agreed timescales?

If an IA or improvement plan is issued following an inspection, it indicates that there are serious patient safety concerns about a service. The decision to issue an immediate assurance notice is made in consultation with the inspection manager, the Head of NHS Inspection and a clinical advisor. In addition to evidence gathered, previous judgements about quality and safety of a setting will also be considered.

Following receipt of an IA, a health board/trust is required to submit an immediate improvement plan to demonstrate how they will achieve the improvement. Failure to comply with this process will result in escalation to the Service of Concern pathway.

Following an assurance activity, a health board/trust will be provided with a full improvement plan. This sets out improvements required to meet standards set out in the Health and Social Care (Community Health & Standards) Act 2003. Failure to complete all improvements to an acceptable standard or within the agreed timescale, in particular for matters directly relating to patient safety, may result in escalation to the Service of Concern pathway.

b) Have the same issues been raised during previous inspection/review activity and insufficient improvements been made?

If HIW continues to find the same or similar issues, either following successive inspections or reviews of a service, or across similar services within a health board/trust, the service may be escalated to the Service of Concern pathway.

If actions taken by the health board/trust have resulted in insufficient improvements, or actions are not having the desired impact, or HIW is not satisfied that there is sufficient learning being demonstrated by a health board/trust following an assurance activity, the service may be escalated to the Service of Concern pathway.

c) Have we received reliable information or gathered evidence to identify a matter requiring urgent action?

If HIW identifies immediate significant risk(s) to patient safety, this may result in immediate escalation to the Service of Concern pathway, in addition to an IA being issued following the conclusion of the assurance activity.

If any of the threshold questions are answered 'yes' and/or there is a risk to patient safety, then the threshold is met for identification as a 'Service of Concern'.
This meeting along with any decisions and rational will be recorded.

How is a Service of Concern managed?

Once identified, a Service of Concern will be subject to a higher level of monitoring by HIW. Each service of concern will be under review by the Escalation and Enforcement team.
HIW will communicate in writing that this determination has been made and will include a summary of our concerns and, if deemed relevant, a copy of any immediate improvement plan or other information. The communication will also include an invite with a date and time to a service meeting. A copy will be sent to the health board/trust, Welsh Government, and any other relevant stakeholders.

Service meetings

Service meetings are an essential step in the Service of Concern pathway. Once a service is designated as a Service of Concern, a service meeting will be convened. The following parties may be invited to attend:

- HIW representative
- Health board/trust representative
- Welsh Government representative
- Other relevant stakeholder representatives

This meeting is an opportunity for the health board/trust to discuss the concerns raised directly with HIW and other parties at the meeting. It is an opportunity to

provide any mitigation and assurance along with details of how the service intends to deal with the improvements and issues identified. Potential outcomes from the meeting are listed below:

- Resolution of the outstanding improvements / agreement that sufficient improvement has been made or is taking place
- Agreement of further actions and timeframes to provide assurance to HIW
- Schedule further assurance activity (announced/unannounced)

A summary of this meeting will be captured in writing and a letter issued to each attending party outlining what was discussed and the resulting actions. The health board/trust will have the opportunity to advise HIW of any factual inaccuracies or corrections they wish to be considered. These should be received within 10 working days. It is the health board/trust's responsibility to ensure that action is taken and that required improvements are achieved. There may also be further assurance activity carried out by HIW, the outcome of which will be communicated to the interested parties through the same process.

Further service meetings will be convened, as appropriate, until HIW is satisfied that improvements have been made and the risk to patient safety is reduced. Continuous failure to provide assurance, or engage with the Service of Concern process may result in further escalation through the NHS Wales Escalation and Intervention Arrangements.

How is a Service of Concern de-escalated?

A Service of Concern will be de-escalated once HIW is satisfied with the actions taken by the health board/trust to address required improvements. It may be necessary to convene further service meetings and conduct further assurance activity before HIW is satisfied that improvements have been made and the risk to patient safety is reduced.

Following any assurance activity, a service of concern meeting will be convened to discuss outcomes and determine whether HIW's position on the service has altered.

When HIW is satisfied with the actions of a service and decides to de-escalate the service, this will be communicated in writing to the relevant health board/trust, to Welsh Government, and any other relevant stakeholder(s).

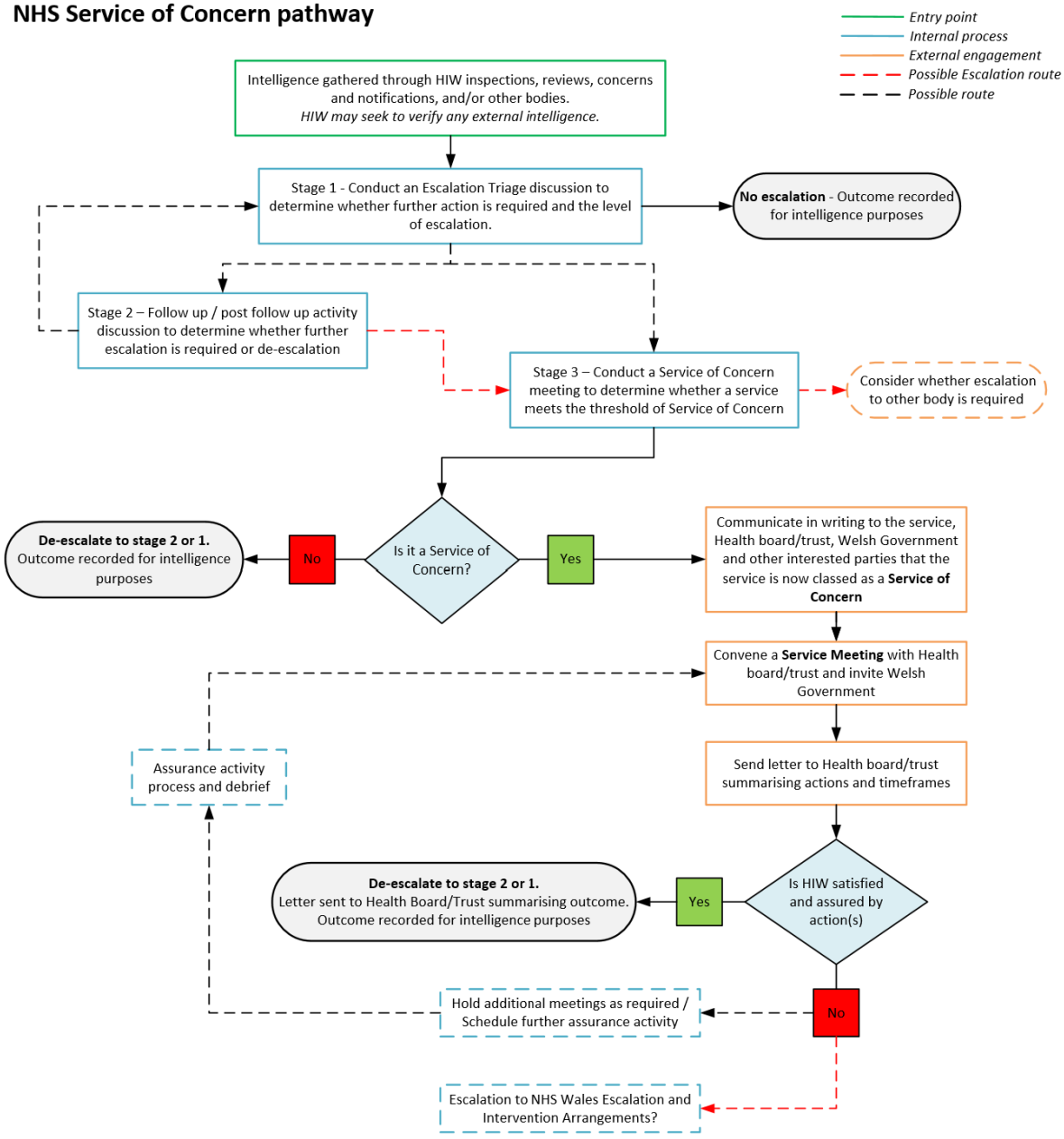
Monitoring and Governance

HIW's Escalation and Enforcement team are responsible for monitoring services of concern. Each Service of Concern will be reviewed on a regular basis.

Service of Concern status will form part of HIW's evidence to the NHS Escalation and Intervention Agreement process, and may therefore influence the outcome of that process.

Appendix 1

NHS Service of Concern pathway



REPORT TITLE:	**HIW Primary Care Contractor Report**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**15th September 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:

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

REPORT:

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

HIW visits were suspended at the start of the Covid-19 pandemic. The Primary Care Team received notification that HIW visits would now take place remotely in the form of a Covid-19 "Quality Check" report for both GMS and GDS. 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"

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 Dental Team have been informed that they will no longer receive notifications of planned inspections.

The review and summary of reports are attached **(GDS Appendix 1 & GMS Appendix 2).**

General Medical Services:

Since the last SBAR report to the committee March 2021 there have been two GMS HIW reports received by the Primary Care Team, with another report rending publication.

The following reports were received:

- Ravenscourt Surgery (Vale Group Practice)
- Radyr Medical Centre

The following practice has received a Quality Check, but the report has not yet been published:

- Western Vale Family Practice

Both reports are positive and describe the processes that have been put in place during the Covid-19 pandemic and make reference to the challenges that have been overcome.

The Quality Check report from Ravenscourt Surgery found that there was no formal risk assessment process in place for home visits and care home visits during Covid-19. This issue was rectified by the practice before the publication of the report and the practice now have a formal risk assessment process in place, with risk assessments taking place before each home visit and care home visit.

The Quality Check report at Radyr Medical Centre lists no areas for improvements.

The Primary Care Team have received no Concerns Raised, or Immediate Assurance letters in relation to GMS practices since the last report to the committee.

General Dental Services:

Since the last SBAR report to the committee March 2021 there has been one HIW report received by the Primary Care Team.

The following report was received:

- Six Gables Dental Practice Ltd

This HIW report is the first dental "Quality Check" that has been received by the dental team and lists a number of positive actions from the practice. The report makes no recommendations for areas for improvement. The report is due to be reviewed by a Dental Practice Adviser (DPA), who will advise if there are any follow up actions for the practice or the Primary Care Team.

Outstanding actions from HIW visits highlighted in previous reports have been updated and included in Appendix 1.

The Primary Care Team have received no Concerns Raised, or Immediate Assurance letters in relation to GDS practices since the last report to the committee.

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
09/09/2021 09:43:30

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

Total 7	*Practice Name*	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
65	Six Gables Dental Practice Ltd	Quality Check Summary Activity date: 26 May 2021 Publication date: 01 July 2021	The report makes reference to a number of positive findings, including: • provided with various documents for the prevention and control of infection, which included Protocols and Risk Assessments for working during the Coronavirus Pandemic. • evidence of training records, which showed compliance with mandatory training. • process of checking emergency equipment and medicines was provided. There we no suggestions for improvements. Pending review from DPA to look for any follow-up Health Board Actions.		• DPA to review Quality Check summary document • Awaiting improvement plan agreement to be published on HIW website	
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 practice 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		• DPA summary report complete. • DPA letter • Ongoing investigations into provider	Response from practice, ongoing correspondence.

			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			
61	Newport Dental Practice (321 Newport Road S Yeganeh)	02/10/19 Report published 03/01/2020 (Full report found on website)	The practice was found to be committed to a positive patient experience and rated excellent by patients. Areas of improvement were recommended in compliance with current regulations, standards and best practice guidelines. • Immediate improvement plan initiated re emergency drugs and resuscitation equipment • The practice must provide evidence to HIW that the dental nurse has undertaken the required number of hours (five) of verifiable training in disinfection and decontamination. • Feminine hygiene bins must be made available within the appropriate toilets and feminine hygiene waste must be disposed of appropriately. • Patient records must be fully maintained in keeping with current guidance and professional standards for record keeping (including those recommended within this report).		• Immediate improvement action taken and practice confirmed. • DPA summary report Complete • DPA letter	• HIW satisfied with immediate improvement plan. • DPA's in correspondence with provider
60	N Dental (Grangetown)	24/10/18 Report published 25/01/19	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		• DPA summary report completed. • DPA letter	Waiting for further correspondence from practice.

		UHB and practice did not receive report. RH requested final report.	• 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 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.	• Email response received 09/08/19 • HIW email response 12/08/19 • Ongoing support being provided to practice

					• Response received 09/08/19 • DPA's satisfied	
52	Cathedral Dental Clinic	26/03/2019 Improvement Plan issued from HIW	Overall, Cathedral Dental Clinic was working hard to provide a high quality experience for their patient population. • Update practice leaflet with current staff and Violent and abusive behaviour policy • Statement of purpose on website and available on request • Clear and prominent signage stating CCTV in operation • Update CCTV policy and guidance including storage, retention and disclosure • Fire safety training, exit signage throughout practice and risk assessment submitted to HIW • HTM01-05 guidance to be followed including dirty to clean workflow and clearly marked transport boxes • 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		• Letter sent to practice 28/6/2019 requesting confirmation / evidence of completed improvement plan • DPA letter resent 10/10/19 requesting evidence. • Response received 21/10/19 unsatisfactory, more evidence requested 25/10/19 • Full response with evidence received 12/11/19	• HIW satisfied with improvement plan submitted 29th April 2019 • Ongoing correspondence

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	*Inspectio*	*IA Letter Date*	*Summary*	*UHB Actions*

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

		n Date			
	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**
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**

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
Western Vale Family Practice	15/07/2021	*This report has not yet been published.*		

Radyr Medical Centre	20/04/2021	The report makes reference to a number of positive findings. The Practice has:
		• developed robust safety measures to reduce the risk of Covid-19
		  ○ Covid-19 risk assessments
		  ○ Updated IPC policy
		  ○ One way systems
		  ○ Separate rooms for patients with Covid-19 symptoms
		• increased access via remote consultation methods (telephone, video, electronic)
		• ensured all staff are up to date with IPC training
			G	There were no improvements suggested by HIW.

Ravenscourt Surgery (Vale Group Practice)	01/12/2020	The report makes reference to a number of positive findings. The Practice has: • developed Covid-19 safety measures including a risk safety checklist • replaced carpeted floors to improve IPC • switched to a telephone first model • used a “hot hub” for suspected Covid-19 patients	G	HIW found that there was no formal risk assessment process in place for home visits and care home visits. The practice is required to complete a document risk assessment for home visits and visits to care homes with specific procedures identified for COVID-19.

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

		• ensured all staff are up to date with IPC training		Action Complete
HIW Immediate Assurance Letters (received since last SBAR update)				
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*	
N/A	N/A	N/A	N/A	
HIW Immediate Concerns raised (received since last SBAR update)				
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*	
N/A	N/A	N/A	N/A	

Report Title:	**Board Assurance Framework – Patient Safety**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	xx Sept 2021	
Status:	**For Discussion**		**For Assurance**		**X**	**For Approval**		**For Information**	
Lead Executive:	**Director of Corporate Goverance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

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

The Board Assurance Framework 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 July 2021) is considered to be a key risk to the achievement of the organisation's Strategic Objectives. This risk has been adjusted to take into account recovery and the impact on patient safety this will bring.

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 May 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:

'There is a risk to patient safety due to COVID 19 Recovery and this has resulted in a backlog of planned care and an aging and growing waiting list'.

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

1. **Patient Safety - Lead Executives Stuart Walker, Ruth Walker and Fiona Jenkins**

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity. Due to a 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 post Covid 19 recovery.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care during COVID 19 creating both longer and ageing waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Spire Hospital • In-house and insources activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN to manage the risk • Hire of additional mobile theatres		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board. • CAHMS position reviewed at Strategy and Delivery Committee • Mental Health Committee aware of more people requiring support. • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
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 March 21
1. Recovery plan in place and constantly being reviewed	Steve Curry	31.03.22	Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: the risk of inadequate planned care capacity
2. Waiting list position plan to be presented to Quality, Safety and Experience Committee to see if harm has occurred to those on the waiting list and what we are doing to prevent it going forward.	Steve Curry	30.06.21	Complete presented to QSE 15.06.21 To be presented to QSE Committee
3. CAHMS impact to be presented to Board Development in June due to demand and support for children increasing	Steve Curry	30.06.21	Complete presented to Board Development 24.06.21 To be presented to June Board Development session
4. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Ruth Walker	30.09.21	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

Report Title:	**Revised Incident, Hazard and Near Miss Reporting Procedure**	**Agenda Item no.**	**3.1**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	15th September 2021
Status:	**For Discussion**	**For Assurance**	**For Approval** **Y** **For Information**
Lead Executive:	**Executie Nurse Director**		
Report Author (Title):	**Tara Cardew (Head of Patient Safety)**		

Background and current situation:

Following the changes made by NHS Wales Delivery Unit to the way Organisations report their more serious patient safety incidents, the Cardiff and Vale Incident, Hazard and Near Miss Reporting procedure has been updated to reflect these changes.

The Health and Safety element has also been updated to reflect the fact that the Executive Lead is now the Executive Director for People and Culture. Additional information on evidence gathering has also been included in section 4.

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

The updated procedure supports the changes made to national incident reporting by NHS Wales Delivery Unit and outlines the key requirements of members of the UHB in meeting these changes.

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

This updated procedure has been shared for consultation with key stakeholders. The new National Incident Reporting process has been shared with Clinical Board colleagues for dissemination and a separate paper highlighting these changes has also been presented at this September 2021 meeting

The revised **Incident, Hazard and Near Miss Reporting Procedure** can be viewed in Appendix 1.

Recommendation:

The QSE Committee is asked to **APPROVE** the revised policy.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	Y	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	Y	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	Y	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes – included in appendix …… *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Reference Number: *UHB 433* **Version Number:** 2	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** **N/A**

INCIDENT, HAZARD AND NEAR MISS REPORTING PROCEDURE

Introduction and Aim

Cardiff and Vale University Health Board (UHB) is committed to the health, safety and welfare of its staff, patients, visitors, all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.

It considers that it is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken with the aim of preventing their reoccurrence, improving staff and patient safety and experience and improving services and the environment where appropriate.

It is the policy of the UHB to ensure that staff feel comfortable to report incidents, hazards and near misses. Therefore, the UHB encourages an open and just culture. The aim of reporting and investigating incidents, near misses and hazards is not to blame but rather to learn from the event and to minimise risk of reoccurrence.

A key aim is to encourage staff to report incidents and for managers to treat staff involved in incidents in a consistent, constructive and fair way. The emphasis is on the "how" and “why” rather than the "who".

However, the UHB will act on information to protect the safety of other staff, patients and visitors where appropriate. Disciplinary action may result from incidents such as those relating to criminal activity, malicious activity and patient care or treatment contrary to the relevant professional code of conduct.

Objectives

- To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.
- To promote a culture in which incidents are reported and investigated appropriately and proportionately to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff and patient safety and well-being.

- To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting.

Scope

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

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed. The assessment found that there was no adverse impact to the equality groups mentioned.
Documents to read alongside this Procedure	• Incident, Hazard and Near Miss Reporting Policy • Health and Safety Policy • Policy for Reporting Research Related Adverse Events • Being Open Policy • Records Management Policy • Risk Management Policy • Welsh Government Putting Things Right Guidance November 2013 • NHS Wales National Incident Reporting Policy June 2021 • Never Events April 2018 • UHB National Patient Safety Incident process which includes Never Event processes • Just Culture guide from NHS Improvement • All Wales Root Cause Analysis (RCA) toolkit • Statement Writing guidance • UHB Coroner's Inquests – A guide for NHS staff RIDDOR Guidance September 2016 • Risk Assessment and Risk Register Procedure • Process for Undertaking an RCA
Approved by	*Health and Safety Committee* *Quality, Safety and Experience Committee*
Accountable Executive or Clinical Board Director	*Director of Corporate Governance* *Executive Nurse Director*
Author(s)	*Head of Health and Safety* *Assistant Director of Patient Safety and Quality* *Head of Patient Safety and Quality*

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*18.09.18*	*20.09.18*	A new document was created to separate the policy and procedures into two different components.
2	16-09-2021		The document was updated to reflect changes in NHS Wales National Incident Reporting policy.

1. DEFINITIONS

1.1 An *Adverse Incident* is defined as “any unplanned event that resulted in, or had the potential to result in, an injury or the ill health of any person, or the loss of, or damage to, property”.

1.2 A patient safety incident is defined as “any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care”. (National Patient Safety Agency, 2011).

1.3 A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

1.4 A near miss is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

1.5 A National Patient Safety Incident is defined as: ‘A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare”.’

The above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community based services

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1.6 When considering whether to report a National Patient Safety Incident the following should be applied:

- a patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm.

- as it will not always be possible to determine the extent to which a patient safety incident caused or contributed to the harm or death of a patient within seven working days, responsible bodies should report in line with the criteria where it is known, and/or suspected, that a patient safety incident has caused or contributed to harm or death. In this scenario, for clarity, the responsible body should specify on the form that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date as set out later in this guidance.

- all such incidents must be reported to the Delivery Unit within seven working days from the occurrence, or point of knowledge.

1.7 Specific National Incidents

- In-patient suicides
- Maternal deaths
- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months.
- Never Event – all Never Events are defined as National Patient Safety Incidents although not all Never Events necessarily result in severe harm or death;
- Incidents where the number of patients affected is significant such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure. The key wording in this reporting requirement is "the number of patients affected is significant".
- Unusual, unexpected or surprising incidents where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

For more information relating to NHS Wales National Incident Reporting Policy click here.

1.6 *RIDDOR* is the recognised abbreviation for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

These Regulations specify the accidents, ill health and dangerous occurrences that must be reported to the Health and Safety Executive by the Health and Safety Department. This includes:

- An *over 7-day injury* – an accident that results in an employee being away from work or unable to perform their normal duties for more than seven consecutive days as the result of their injury, not including the day of the incident.
- A *Specified Injury arising out of or in connection with work,* generally more serious injuries for example a fracture or serious burns.
- A *Dangerous Occurrence* is a certain specified near miss event, which may not result in a reportable injury, but have the potential to cause significant harm. A needlestick injury from a known high risk source is reportable as a Dangerous Occurrence.
- A *Reportable Disease* – a disease that may arise from an individual's occupation. They are specified in Schedule 3 of RIDDOR. Such diseases have to be diagnosed by a doctor and the person's job has to involve a specified work activity.
- Should a member of staff advise that they are absent from work, for over 7 days, due to an injury sustained at work, the Manager must ensure that the relevant Health and Safety Advisor is advised of this at the earliest opportunity. This action should be taken even if it is some time after the incident and the information comes to light as part of the sickness review process.

  Further information can be found can be found on the Health, Safety and Environment Unit RIDDOR intranet page here:

2. ROLES AND RESPONSIBILITIES

2.1 The **Chief Executive** is ultimately responsible for ensuring compliance with the Health and Safety at Work etc Act 1974 and associated legislation including NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, and that the Incident, Hazard and Near Miss Reporting Policy and these associated procedures are implemented effectively within Cardiff and Vale University Health Board.

2.2 The **Executive Nurse Director** is the lead Executive with responsibility for clinical governance/patient safety and quality.

The Executive Medical Director and Executive Director of Therapies and Health Sciences also have responsibilities in relation to these matters within their professional groups.

2.3 The **Executive Director of People and Culture** has Board level responsibility for health and safety which includes Health and Safety risks and incident management.

2.4 The **Assistant Director of Patient Safety and Quality** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical/Service Boards to enable timely reporting and investigation of incidents.

2.5 The **Head of Health and Safety** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for health and safety related incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical/Service Boards to enable timely reporting and investigation of health and safety incidents.

2.6 The **Patient Safety Team** and **Health, Safety and Environment Unit** are responsible for supporting the implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigation.

2.7 The **Clinical/Service Board Management teams** are responsible for ensuring that staff within their Board are briefed on their individual and collective responsibilities within the incident reporting process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice.

2.8 **Department/Line Managers** are responsible for cascading the procedure to staff ensuring that they are fully conversant with the process to be followed for all incidents.

Department/Line Managers are responsible for reviewing, escalating, taking appropriate action and feeding back to incident reporters in a timely manner in line with UHB procedures.

Significant incidents, for example, those that may require onward reporting to an external agency must be escalated promptly with actions recorded on the electronic incident reporting system. Delivery Unit expects National Patient Safety Incidents to be reported to them via the Patient Safety Team within 7 days of the incident occurring where possible.

There is an expectation that incidents reported on the electronic reporting tool will be reviewed by the relevant manager within 7 days. Where possible, incidents should be concluded within 30 days. More complex incidents, for example National Patient Safety Incidents reported to the Delivery Unit should be concluded within the agreed timeframe (30, 60, 90 or 120 days) in order to comply with the Delivery Unit closure process.

It is imperative that managers review and conclude incidents in a timely manner in order that the UHB fulfils its quality, safety and governance responsibilities, which also includes uploading incident information to the National Reporting and Learning System (NRLS) within prescribed timescales.

Department/Line Managers are responsible for ensuring that an appropriate investigation is undertaken for all incidents that have occurred in their area of responsibility and ensuring that measures to prevent recurrence are implemented within the shortest appropriate timescale. Timeframes regarding general incidents and National Patient Safety Incidents have been outlined in Section 2.8. RIDDOR incidents are to be investigated within 21 days although there will be exceptions for more serious incidents. Incidents which are also investigated by the Health and Safety Executive may result in an extended investigation period.

It is the responsibility of Department/Line Managers to ensure that appropriate disclosure of incidents is made to patients and their families in line with the UHB's Being Open Policy.

It is also important that Department/Line Managers are conversant with the Just Culture Guidance from NHS Improvement in order that the appropriate support can be provided to staff. The guidance can be accessed here

2.9 **All employees** are responsible for ensuring that the immediate area and staff and patient safety is secured following an adverse incident. The incident must be promptly reported to an

appropriate senior member of staff if significant harm or injury has occurred. Employees must ensure the incident is reported on the electronic incident reporting tool provided by the UHB, available via the intranet, as soon as it is safe and practical to do so. The incident form can be accessed here.

Employees may be required to provide additional information on incidents during investigations; this may include provision of statements or attendance at interviews.

Under the Safety Representatives & Safety Committees Regulations 1977, **Safety Representatives** are also allowed to investigate: potential hazards, dangerous occurrences, and causes of accidents and occupational ill-health within the area of their responsibility.

2.10 **Contractors** such as estates and equipment maintenance contractors and building contractors have a statutory responsibility to report adverse incidents, hazards and near misses that have occurred on UHB sites to the UHB in line with their contract arrangements.

3. TRAINING

3.1 Information on incident reporting is provided to all staff on induction and supporting materials are available on the intranet on the incident reporting pages.

3.2 Incident reporting is included in Health and Safety mandatory training through an e-learning module or via face to face presentation.

3.3 Incident reporting procedures must be included in local departmental induction.

3.4 Support for staff is available via a Datix Help Desk, intranet page and Datix Superuser Group.

3.5 Training for line managers who require log-in to the electronic incident reporting system will be provided by the Patient Safety Team and Health, Safety and Environment Unit.

3.6 Incident investigation (RCA) training is provided by the Patient Safety Team.

4. ADVERSE INCIDENT, HAZARD AND NEAR MISS REPORTING AND MANAGEMENT

4.1 When an incident occurs staff must first ensure the people or area concerned are made safe. The incident must be reported through the recognised UHB incident reporting mechanisms, this being the Datix system available on the intranet; a link is provided in Section 2.9.

All incidents will be graded according to the actual impact on the individual(s) involved using the Grading Framework for Dealing with All Concerns in the Putting Things Right guidance (November 2013) which can be accessed here.

Grade	Harm
1	None
2	Low
3	Moderate
4	Severe
5	Death

Staff are also able to reflect the potential future risk to individuals and to the organisation on the incident reporting system.

4.2 **A duty of candour to tell a patient** / Being Open

If adverse events have occurred to patients, the incident should be communicated to the patient or their representative as soon as is practical. There is an expectation that incidents of moderate, severe and catastrophic harm will be disclosed. In exceptional circumstances, if it is deemed that the impact of disclosure will adversely affect the patient's psychological wellbeing, a decision may be taken not to inform the patient. Reasons for this decision must be clearly documented in the patient's health records. Advice can be sought from the Patient Safety Team.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020, introduces a new Statutory Duty of Candour**.**

Further guidance on Being Open can be found in the Being Open policy and procedure and it is anticipated that over the next 12 months guidance in relation to e statutory duty of candour will be published by Welsh Government.

4.3 National Patient Safety Incidents

If a National Patient Safety Incident occurs, supporting information to guide staff can be located within the National

Patient Safety Incident flowcharts on the intranet which can be accessed here.

The organisation recognises that National Patient Safety Incidents or incidents requiring investigation may be potentially stressful and difficult for staff, patients and their families. It is essential that appropriate and timely support is offered and made available to everyone involved.

4.4 Never Events

Never Events are defined as National Patient Safety Incidents that are wholly preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Never Events require full investigation under the National Patient Safety Incident framework. This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

Further information on the management of Never Events is provided in the National Patient Safety Incident Flowcharts which can be accessed on the intranet, here.

Further information from Welsh Government on Never Events can be found on the Patient Safety Wales website.

4.5 Supporting staff to report incidents and following an incident occurring

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about their concerns allows valuable lessons to be learnt so issues can be dealt with and prevented from being repeated.

The UHB actively encourages staff to raise concerns about safety. If for any reason they feel unable to report an incident in line with this procedure, there are other routes for them to raise

their concerns. These would include Freedom to Speak Up, Safety Valve and Whistleblowing Policy. Click here for more information about raising a concern.

The UHB recognises that being involved in an adverse incident can have devastating effects on staff. It is vital that the appropriate supporting mechanisms are put in place.

The Just Culture Guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Further information can be found here.

4.6 Legal Status and Retention of Incident Reports

It is a requirement of WHC 2000(71) that Incident Reports relating to adults will be retained for ten years after the date of the incident, and Incident Reports relating to incidents involving children will be retained until the child is 25 years of age or for eight years after the death of the child (whichever is the sooner).

The electronic incident reporting system fulfils the requirement of the UHB to maintain accident book(s) at strategic locations in accordance with the Social Security (Claims and Payments) Regulations 1979.

4.5 Reporting Information Governance breaches

Events of failure to comply with information governance requirements are considered to be an incident and should be promptly reported using the electronic incident reporting system. These events can be viewed by the Information Governance Department for appropriate further action, monitoring of investigation and remedial actions.

On occasion, onward reporting to the Information Commissioner may be required. Appropriate incidents must be reported to the Information Commissioner within 72 hours of the incident occurring and so prompt incident reporting and review by line managers is of critical importance. Further guidance can be sought from the Information Governance Department.

5. INVESTIGATION

All incidents will be investigated appropriately. Investigations will be proportionate to the incident that has occurred. Investigations may

also be undertaken if there is repetition of similar incidents or clusters of incidents.

Due consideration must be given to the independence of the investigating officer in order that the UHB and its staff, patients and their families can have confidence in the transparency of the investigation process.

Investigation of patient safety incidents will be carried out in line with the All Wales How to Learn Lessons from Concerns Toolkit which can be accessed here.

Information is available on the intranet to support staff who are required to write a statement following an adverse incident by clicking here.

The Patient Safety Team will provide regular Incident investigation/Root Cause Analysis training opportunities and maintain a record of staff who have attended the training.

There is an expectation that staff who attend Incident Investigation/ Root Cause Analysis training will support the investigation of patient safety incidents across the UHB.

Timeframes for investigation of incidents are outlined in Section 2.8.

6. REPORTING TO EXTERNAL AGENCIES

Some specified incidents are required to be reported to external agencies. The National Patient Safety Incident Flowchart and standard agenda template prompt attendees at the National Patient Safety Incident meeting to consider whether communication with external agencies is required.

Communication with external agencies will be undertaken through the agreed UHB incident reporting mechanisms by the appointed persons as outlined below. It should be noted that this list is not exhaustive.

External Agency	Requirement	Appointed Department
National Reporting Learning System (NRLS)	All patient safety incidents (irrespective of seriousness and degree of harm) to the National Patient Safety Agency (NPSA) Reporting and Learning System.	Patient Safety Team
Health and Safety Executive - RIDDOR The Reporting	Work related deaths, specified injuries, dangerous occurrences and accidents resulting in over 7 day injury which results in incapacity to undertake normal work duties. Also specified diseases.	The Health and Safety Department Occupational

of Injuries, Diseases and Dangerous Occurrences Regulations 1995		Health Department
NHS Wales National Incident Reporting Policy June 2021	Reporting of National Patient Safety Incidents to the Delivery Unit should be undertaken within 7 working days and Early Warning Notification (replaces No Surprise/Sensitive Issues) to Welsh Government should be undertaken as soon as is practicable.	Patient Safety Team
Medicines and Healthcare Products Regulatory Agency (MHRA)	Incidents involving a medicine or medical device may be reportable to the MHRA. Breaches to the Blood Safety and Quality Regulations may be reportable to the MHRA as Serious Adverse Blood Reactions or Events.	UHB nominated liaison officer in Pharmacy or Clinical Engineering respectively Blood Transfusion Team
Communicable Diseases	In the event of an infectious disease outbreak and any serious single infection with public health implications.	The Consultant in Communicable Disease Control, Health Protection Agency (HPA) should be contacted
Healthcare Inspectorate Wales – Ionising Radiation Medical Exposure Regulations (IRMER)	Breaches in IRMER to Healthcare Inspectorate Wales. Such incidents will also be reported to the Delivery Unit in line with National Incident reporting if the incident is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to severe harm or death	Patient Safety Team
Information Commissioner (ICO)	Breaches of the Data Protection Act may require reporting to the Information Commissioner.	Information Governance Department
Welsh Health Specialised Services Committee (WHSSC)	WHSSC would expect to be informed of any incidents of a catastrophic nature to an individual; any incidents which raise concerns in relation to delivery of a particular commissioned service or emerging themes/trends. The Assistant Director of Patient Safety and Quality and Patient Safety Team representative meet with WHSSC on a regular basis where appropriate concerns are raised for discussion.	Assistant Director of Patient Safety and Quality
Human Tissue Authority (HTA)	Breaches of the Human Tissue Act require reporting to the Human Tissue Authority under the Human Tissue Authority Reportable Incident (HTARI) process	Designated Individual or Deputy.

	https://www.hta.gov.uk/sites/default/files/Guidance_for_reporting_HTARIs.pdf	

7. IMPLEMENTATION

This procedure reflects existing practice across the UHB and will therefore be implemented with immediate effect. The requirements of this procedure will be re-enforced within Clinical/Service Boards and Directorates/Departments by local risk management, health and safety and quality and safety arrangements.

8. EQUALITY

We have undertaken an Equality Impact Assessment and received feedback on this policy and procedure and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no adverse impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

9. MONITORING

It will be necessary to ensure that Clinical/Service Boards are adhering to the requirements of this procedure. This will be monitored via a number of agreed performance indicators.

The Quality, Safety and Experience Committee and Health and Safety Committee will monitor implementation of this policy.

10. DISTRIBUTION

10.1 This procedure will be available on the UHB Clinical Portal, Intranet and Internet Site.

10.2 Line Managers/Departmental Managers/Lead Nurses/Directorate Managers/Clinical Directors are responsible for ensuring that all staff have access to this document.

11. REVIEW

This procedure will be reviewed every three years or sooner if required.

12. FURTHER INFORMATION/REFERENCES

HSE (1994), *Management of Health and Safety in the Health Service*, Health Service Advisory Committee, Health and Safety Executive.

HSE (1995) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.*

HSE Reporting injuries, diseases and dangerous occurrences in health and social care – Guidance for employer. HSE Health Services Information Sheet No 1 (Revision 2)

Ionising Radiation (Medical Exposure) Regulations 2017

NPSA (2006), *Being open: Communicating patient safety incidents with patients, their families and carers* (Re-launched 2009)

NPSA (2004), *Seven Steps to Patient Safety*

Social Security (1987), Claims and Payments Regulations No 1968
Welsh Government *Putting Things Right/NHS Redress (Guidance November 2013)*

Welsh Government (2015) Health and Care Standards

Welsh Government (2004) *Medical Device Alert 054: Reporting Adverse Incidents – Guidance on New Arrangements for NHS Wales Organisations*

Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Equality & Health Impact Assessment for

INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Incident, Hazard and Near Miss Reporting Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Services – Director of Corporate Governance Author- Head of Health and Safety – 43751
3.	Objectives of strategy/ policy/ plan/ procedure/ service	• To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework. • To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being. • To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting
4.	Evidence and background information	

	considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All Staff and Patients

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** 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	The incident reporting database details age of victim, which allows for subsequent analysis.		
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	No Impact		

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	The incident reporting database details gender of victims, which allows for subsequent analysis.		
6.4 People who are married or who have a civil partner.	No Impact		

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
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No Impact		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The incident reporting database records incidents which are related to racial aspects.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a	As above		

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
religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The incident reporting database covers homophobic and sexual related incidents.		
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	The database includes a racial aspect, which has included Welsh.		

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
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No Impact		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No Impact		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Incident reporting is available to all staff, through all UHB electronic outlets i.e. computers.		

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

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			

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal - A more equal Wales			
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc	The incident reporting database allows for analysis of events with a clear aim to improve patient care and staff working conditions.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No Impact		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the	The incident reporting database collects data in relation to environmental events, which allows for analysis and appropriate resolution.		

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
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			
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;	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
cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No Impact		

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Positively supports equality issues, through facilitating reporting of related events and requires managers to progress actions, towards resolution.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents.			

	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?	N/A			

	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
	N/A			

Report Title:	**Updated Patient Identification Policy**	**Agenda Item no.**	**3.2**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	15th September 2021
Status:	**For Discussion**	**For Assurance**	**For Approval** Y **For Information**
Lead Executive:	**Executive Nurse Director**		
Report Author (Title):	**Tara Cardew (Head of Patient Safety)**		

Background and current situation:

The purpose of this paper is to present the revised Patient Identification Policy. This sets out the procedures which must be followed to ensure that patients are correctly identified at all stages of their interaction with the Health Board. This updated policy applies to all of our staff in all locations including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.

This policy has been reviewed and updated in line with UHB governance arrangements.

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

Cardiff and Vale University Health Board (UHB) are committed to ensuring that all patients are correctly identified using standardised personal information and will achieve this through the implementation of this policy.

This policy will provide a framework to enhance Patient Safety across the UHB, the policy aims to reduce incidents of misidentification that may cause harm to a patient.

The policy will:

- Provide instruction on the process of checking patient identity and when this should occur.
- Describe how to standardise wristbands
- Explain the responsibilities of staff when checking patient identification.

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

Patient misidentification has been recognised as a widespread problem within healthcare organisations and has been recognised by the former National Patient Safety Agency (NPSA) as a significant risk within the National Health Service (NHS).

The extent to which patient misidentification happens is thought to be widely underestimated by clinical staff, as very often they are unaware that a misidentification has occurred.

In July 2007 a “Safer Practice Notice” was issued by the former NPSA 1 that highlighted the risks of incorrect patient identification and required all NHS organisations in England and Wales to standardise the design of patient wristbands (ID bands), the information on them and the processes used to produce and check them in order to improve patient safety. The UHB is now compliant with this notice and has introduced electronic printing of identity bands across the UHB.

Recommendation:

The QSE Committee is asked to **APPROVE** the updated version of this policy which has been shared for consultation and is included in Appendix 1. The EqIA is included in appendix 2.

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	Y
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	Y
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Y	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	Y	Long term		Integration		Collaboration	Y	Involvement	

Equality and Health Impact Assessment Completed:	Yes (attached) *If “yes” please provide copy of the assessment. This will be linked to the report when published.*

Reference Number: *TBA unless document for review* **Version Number:** 3	**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*

Patient Identification Procedure

Introduction and Aim

This document supports the Health Board's Patient Identification Policy and sets out the procedures which must be followed to ensure that patients are correctly identified at all stages of their interaction with the Health Board.

Objectives

- Provide instruction on the process of checking patient identification and when this should occur.
- Describe the systems used to identify patients, including wristbands.
- Explain the responsibilities of staff to confirm correct patient identification.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.
Documents to read alongside this Procedure	• Blood Transfusion Policy • Drug administration policy Procedure for the Safe Administration of medicines • Equality and Human Rights Policy • Labelling of Specimens submitted to Medical Laboratories Policy • Latex Policy • Major Incident Policy • Massive Transfusion Policy • Maternity Services Guidelines • Medicines Management Policy • Mental Health Service Guidelines • Neonatal Services Guidelines • Procedures for the Identification of Deceased Patients • Safe Use of Ionising Radiation Policy • Theatre Service Guidelines
Approved by	*Committee/ Group*
Accountable Executive or Clinical Board Director	Executive Medical Director Executive Nurse Director

	Executive Director Therapies and Health Sciences
Author(s)	Patient Safety Team
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments).* *List title and reference number of any documents that may be superseded*

1. INTRODUCTION

Patient misidentification has been recognised as a widespread problem within healthcare organisations and has been recognised by the former National Patient Safety Agency (NPSA) as a significant risk within the National Health Service (NHS).

The extent to which patient misidentification happens is thought to be widely underestimated by clinical staff, as very often they are unaware that a misidentification has occurred.

Patient misidentification can lead to a range of detrimental outcomes for patients, such as:

- Administration of the wrong drug to the wrong patient.
- Performance of the wrong procedure on a patient.
- Patient is given the wrong diagnosis.

- Patient receives inappropriate treatment.
- Wrong patient is taken to theatre.
- Serious delays in commencing treatment on the correct patient e.g. mislabelling of an abnormal blood sample or tissue sample. (An abnormal histology specimen, which has been wrongly labelled can lead to a delay in diagnosis of the correct patient, and potential misdiagnosis of another patient).
- Unnecessary exposure to radiation - IRMER reportable events. (IRMER is the Ionising Radiation (Medical Exposure) Regulations).
- Cancellation of operations due to the misfiling of results, GP letters and correspondence.
- Patient identity related blood transfusion incidents.

In July 2007 a “Safer Practice Notice” was issued by the former NPSA 1 that highlighted the risks of incorrect patient identification and required all NHS organisations in England and Wales to standardise the design of patient wristbands (ID bands), the information on them and the processes used to produce and check them in order to improve patient safety. The UHB is now compliant with this notice and has introduced electronic printing of identity bands across the UHB.

2. POLICY STATEMENT:

Cardiff and Vale University Health Board (UHB) are committed to ensuring that all patients are correctly identified using standardised personal information and will achieve this through the implementation of this policy.

3. AIMS AND OBJECTIVES:

This policy will provide a framework to enhance Patient Safety across the UHB, the policy aims to reduce incidents of misidentification that may cause harm to a patient.

The policy will:

- Provide instruction on the process of checking patient identity and when this should occur.
- Describe how to standardise wristbands
- Explain the responsibilities of staff when checking patient identification.

4. SCOPE:

This policy applies to all UHB staff in all locations and sets out the processes to be followed to ensure correct identification for all UHB patients.

5. ROLES AND RESPONSILITIES:

The Medical Director, Executive Nurse Director and Executive Director of Therapies and Health Sciences hold ultimate responsibility for ensuring effective clinical governance arrangements and the quality of patient care. This

responsibility is discharged within the Clinical Boards and Directorates via the Clinical Board Directors and appropriate Senior Managers.

It is the responsibility of Clinical Boards to implement this policy, ensuring that appropriate up to date guidance is available and implemented at Directorate level and that compliance is audited.

All staff are responsible for ensuring that:

- Their practice is in line with this policy and any additional local and national 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 that the incident reporting system is used when appropriate.

- Incidents of failure to ensure positive patient identification will be reported and investigated as appropriate. Investigations may be concise or comprehensive investigations dependant on the incident and Patient outcome. Advice on investigations can be sought from the Patient Safety Team.

- Evidence of continued failure to comply with the provision of this policy may be dealt with via UHB Disciplinary Procedures.

- Information regarding any changes in practice, organisational structure or legislation that would require a review of this policy is immediately reported to their line manager.

6. GENERAL PRINCIPLES OF PATIENT IDENTIFIACTION:

When identifying a patient (known as a 'patient ID check') the following three pieces of information must be confirmed:

- Full name (first name and surname)
- Address
- Date of birth

The preferred method of confirming this information is by asking the patient themselves. The patient must be asked to confirm their details in a non-leading way, for example:

✓ "Please could you confirm your full name for me?"
× "Are you Mr Jones?"

✓ "Please could you tell me your address?"
× "Do you live at 1 North Street?"

✓ "What is your date of birth please?"

- ✗ “Is your date of birth 01/05/1950?”

The patient details must be checked against any documentation related to the task or treatment to be completed, such as test request forms, medical records or medication charts.

An interpreter or sign language interpreter should be used to assist with the patient identification check if necessary.

If a patient is unable to identify themselves due to their condition or other impairment and a relative or carer is not present, the patient’s identification wristband should be checked.

In the following limited areas, patient ID wristbands are not used:

- Mental Health Clinical Board
- Day Hospital
- Outpatients
- Primary Community and Intermediate Care areas

Areas that do not use ID bands must locally define how they will comply with this policy. The local policy must be agreed at the Clinical Board Quality & Safety Meeting.

A patient ID check is mandatory before any of the following:

- All investigations, including radiology, ECG, blood sampling and point of care tests.
- All interventions, treatments and surgical procedures.
- The administration of medicines or blood products.
- Transport of a patient to another ward, department or area.
- Receiving a patient from another ward, department or area.

Ensure that each patient’s full birth-registered or married/legally changed name is captured on admission. Many patients are known by other names, for example Mary Jones may be known to friends and family as Molly Jones. It is also common for patients to choose to be referred to by a middle name. The full legal name must be used for all identification purposes. If patient’s have an alternative preferred name, this should be clearly recorded in their notes.

7. SAMPLE AND DOCUMENT LABELLING:

Always check that any forms or documentation have the correct patient ID and wherever possible complete them while you are with the patient.

Label any samples taken from a patient straight away. The safest way is to label any bottles or sample pots after the sample has been taken and before leaving the patient’s bedside.

Pre-labelling sample tubes is not recommended practice.

National guidance advises against the use of addressograph labels on cross match blood samples; and promotes handwriting on the sample. This should be done at the patient's bedside (see transfusion policy).

Other specimens and/or samples can be labelled with an addressograph (see labelling of specimens policy).

Always check the details on any addressograph before use. You must not assume that addressographs stored within a patient's notes are correct.

8. PATIENTS WITH THE SAME OR SIMILAR NAMES:

If there are patients with the same or very similar names in a clinical area, all staff within the area must be alerted. This must also be passed over to any incoming staff at each shift handover.

Evidence suggests that putting patients with the same name next to each other in clinical areas reduces the risk of misidentification and is safer than locating them on separate parts of the clinical area.

The risk of misidentification of patients with the same or similar names can also be reduced by:

- Reminding staff during safety briefings.
- Applying alert stickers (available from medical records) to patient notes and other documentation such as drug or observation charts.
- Marking it on the patient name boards at the nurse's station and above the relevant beds.
- Informing the patients and their relatives/carers that there is someone else with a similar name in the clinical area. This encourages patients to challenge any treatments or investigations that they are not expecting and may be intended for another patient.
- Ensuring full ID checks are carried out at all times (see section 6).

9. PATIENT IDENTITY WRISTBANDS:

Other than in the exception areas listed in **section 9.8**, printed patient ID wristbands are the primary method of identifying patients who are, or become unable to confirm their own details.

9.1 When to apply an Identity band:

ID wristbands must be applied to all patients on admission to hospital. Wristbands must also be applied to any non-admitted patients who are receiving interventions that require positive patient identification such as:

- Blood transfusion
- Medications
- Invasive treatments or procedures

If patients do not fall into any of the categories above, but there is concern about their safety or the risk of misidentification, an ID wristband must be applied while they are in the department and removed when the patient leaves.
If patients do not fall into this category, for example attendees of outpatient clinics, and there is concern about the safety of the patient, an identity band must be applied while they are in the department and removed when the patient is leaving.

On transfer of a patient to a new location, the identity band must be checked by the person taking over responsibility of the patient. This includes porters/staff who transport patients to other departments, who must check the identity band before transporting the patient and on arrival in the department.

9.2 Unknown Patients:

Where the patient's details are not known on admission (e.g. if they arrive at the Emergency Unit without ID or are unable to verify their ID) a temporary emergency hospital number will be issued and an identity band with this number will be applied to the patient until their identity is known. As soon as the patient's identity is known a new identity band containing all the required fields must be applied.

For unknown patients attending theatre, local Theatre Service Guidelines must be adhered to.

For unknown patients who require a blood transfusion the UHB Transfusion Policy must be followed.

9.3 Printing of the identity band:

The UHB has rolled out a system which prints patient ID wristbands that are compliant with former National Patient Safety Agency (NPSA) Safer Practice Notice 24.

Patient identity bands must be electronically printed using the printers situated in clinical areas.

The identity ID band should be generated as close to the patient as possible. There must be no delay between printing and applying the ID band which should be applied immediately.

If electronic generation is not available (e.g. during a power cut) an addressograph can be applied to an identity band as an interim measure however an identity band should be printed as soon as possible. If an addressograph is not available, a blank addressograph should be placed on the Identity bands and must be hand written. Full guidance and troubleshooting guide can be found on the Intranet Wristband page.

9.4 Application of the identity band:

Wherever possible the identity band must be applied to the patient's wrist. Where this is not possible the band must be applied to the patient's ankle. Ensure when applying the band that the band can freely move and does not constrict the patient's limb. For patients attending theatre two identity bands should be applied in accordance with the "The procedure for patient identification in theatres".

If a limb is not available, the band must be firmly attached to the patient's clothing in an area of the body which is clearly visible, using a suitable adhesive tape. The band must be reattached as clothing is changed and must accompany the patient at all times. In emergency or operative situations where the clothing has to be removed, the identification part of the band must be applied to the skin using see-through adhesive film.

Before an identity band is finally applied, the patient / relative or carer must confirm the patients' details again and you must check that these correspond to the details on the identity band.

9.5 Replacement of Wristband:

If the identity band is removed it is the responsibility of the person who removed it to replace it promptly. Any staff member who notices that a band is missing must take prompt action to either replace it or inform the nurse looking after the patient. If an identity band becomes illegible, damaged or contaminated it must be replaced at the earliest opportunity.

9.6 Babies born in the UHB:

9.6.1 For babies in the Maternity Departments the "Guideline for the Identification of Babies in the Consultant Led Unit and Midwifery Led Unit (2020) should be followed.

The mother must have a standard information ID band applied as soon as she is admitted (as above).

As soon as possible after the birth two bands should be attached to the baby 1 around wrist and 1 around ankle, giving the following information:-

- Mother's surname and forenames.
- Mother's Unit Number, if allocated.
- Date and time of birth of baby
- Sex of the baby, recorded as boy or girl (not male or female since these terms are more likely to be misread).

The band placed on the mother's wrist only has the band number on it. The information on the three bands must be checked by:-

- the midwife and another responsible person who is usually one of the parents verifying the details or

- the delivering midwife and another member of staff in the presence of the mother

One band to also be applied to the mother's wrist with the same identifying number as the baby's bands.

A baby's wristband must be renewed when:

1. Baby is allocated a name
2. NHS number is allocated
3. Baby's name is changed

9.6.2 For babies in the neonatal unit

- If mother is still an inpatient on maternity, baby has 2 name bands with mother's details as per 9.6.1 **plus** 1 ID band with patient details as section 6
- If mother is discharged, the baby has 2 of its own ID bands only.

This changes if baby goes to theatre:

- The baby is required to have 2 of their own ID bands
- Local guidelines must be adhered to when a baby is attending theatre.

For incidents when a baby requires / is going to receive a blood transfusion please see transfusion policy re: identity requirements.

This also changes if the baby dies:

- For the mortuary the baby has to have a set (x2) of name bands with mother's surname and father's surname (if they are different)

9.7 Deceased Patients:

All deceased patients must be clearly identified before leaving the clinical area where they died. Identification will consist of 2 identity bands (preferably one on the wrist and one on the ankle). Always cross check the patient details on the identity band with the mortuary form.

9.8 Patients who do not wear identity bands:

There may be some situations where a patient may not wear an identity band but the general principles of identification still apply before any procedure or interventions can take place.

9.8.1 If the patient refuses to wear it – the patient must be informed of the potential risks of not wearing an identity band and if the patient does not have the capacity to understand the risks, application to other limbs or to clothes must be considered.

9.8.2 Prior to any intervention the patient's ID must be checked against the Drug Chart, Notes and verbal checks be performed to ensure a positive identification.

The reason and any explanations given to the patient must be documented in the patients' notes in either of the situations above.

9.8.3 The majority of patients within Mental Health Settings and in some Primary Community and Intermediate Care areas do not wear identity bands as they may be perceived as being at odds with the principles of normalisation, promotion of independence and reduction of stigma that are fundamental to their treatment / recovery. However, identity bands must be worn when attending specific treatments such as Electro Convulsive Therapy. If patients from these areas are admitted to other secondary care areas then a wristband must be applied.

10. TRAINING:

It is the responsibility of Directorate Teams to identify any training needs and action appropriately.
Training and information on the use of the printed wristband system can be found on the UHB intranet. Select 'Wristbands' from the A-Z index. Patient identification during drug administration is covered during Medicines Management Study Day.

11. IMPLEMENTATION:

It will be the responsibility of the Directorates and Clinical Boards to ensure the implementation of this policy in their clinical areas

Part A: Preparation and Assessment of Relevance and Priority

Part A is a three step process which will help you to prioritise work and prepare for EqIA.

Step 1 - Preparation:
identify the title of the Policy/function/strategy, the main aims and the key contributors
(see **Form 1**)

Step 2 - Gather Evidence:
collect, but do not analyse information at this stage - just see what evidence is available
(see **Form 2**)

Step 3 - Assessment of Relevance and Priority:
determine whether or not the evidence demonstrates high, medium, low, or no relevance and priority across the core dimensions of the equality duties, by each of the equality strands
(see **Form 3**)

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence. (Refer to the Step-by-Step Guide for additional information).

Step 1 - Preparation		
1.	**Title of Policy**	Patient Identification Policy (UHB V3)
2.	**Policy Aims and Brief Description**	Misidentification is recognised as a wide spread problem across NHS organisation in both England and Wales. The consequences of misidentification are often underestimated by clinical staff. The aim of this policy is to ensure that health care providers have an understanding of their role when examining, prescribing or giving an intervention to a patient. The objectives are: ▪ To ensure a process of checking patient's ID is undertaken
3.	**Who Owns/Defines the Policy?**	Chief Executive Executive Nurse Director Medical Director Medical and non-medical Staff across the UHB
4.	**Who is Involved in undertaking this EqIA?**	Carla English, Patient Safety Team has led the EQiA and shared the response with the wider Patient Safety Team.
5.	**Other Policies**	This policy should be used in conjunction with several policies within the UHB including: • Latex Policy • Blood Transfusion Policy • Major Incident Policy • Procedures for the Identification of Deceased Patients

Step 1 - Preparation		
		• Drug administration policy Procedure for the Safe Administration of medicines • Medicines Management Policy • Maternity Services Guidelines • Neonatal Services Guidelines • Mental Health Service Guidelines • Equality and Human Rights Policy • Safe Use of Ionising Radiation Policy • Labelling of Specimens submitted to Medical Laboratories Policy
6.	**Stakeholders**	The Strategy and Framework potentially affects a wide range of Departments and services working with volunteers within the Cardiff and Vale UHB. This policy applies to all health care providers, including those on honorary contracts, working at all locations in Cardiff & Vale UHB. The principles of this policy apply to patients, carers and health care providers.
7.	**What factors may contribute to the outcomes of the Policy? What factors may detract from the outcomes?**	The UHB is committed to ensuring a safe and consistent method of positively identifying patients is integrated within the UHB, this includes the use of electronically generated wristbands for patients. The UHB is committed to ensuring that appropriate roles for staff are developed to ensure positive patient identification. The UHB is committed to ensuring that the procedures stated in the policy are put into action. The UHB takes account of the training needs that may be required for members of staff.

Form 2: Evidence Gathering

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this Policy/work? Tick as appropriate.							
		Eliminating Discrimination and Eliminating Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging participation in Public Life		Take account of difference even if it involves treating some individuals more favourably*	
Race	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.		√		√		√				

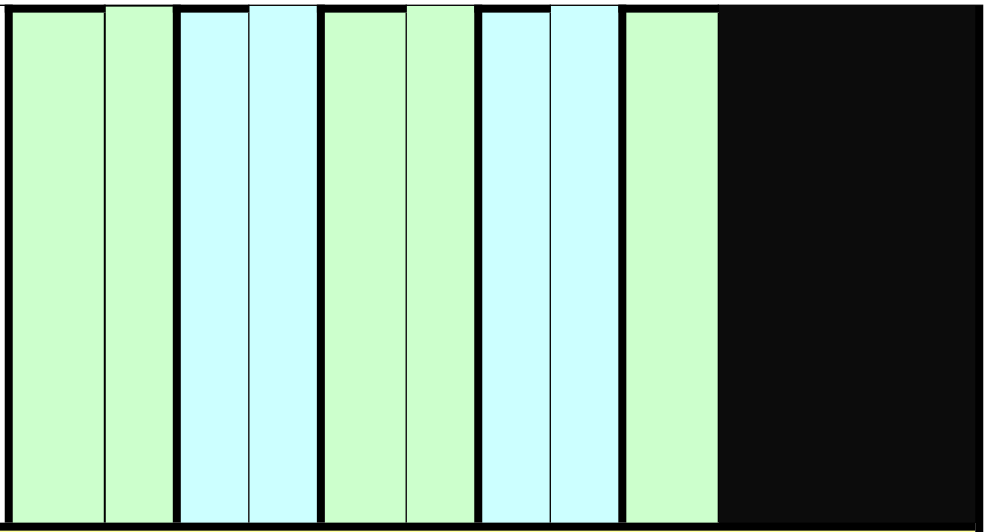
Disability	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.		√		√		√				√								
Gender	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived		√		√		√												

	NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.									
Sexual Orientation	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018)		√		√		√			

	Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.									
Age Saunders,Nathan 09/09/2021 09:43:30	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS		√				√			

	Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.										
Religion or Belief	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019)		√		√		√				

	Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019) The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.										
Welsh Language	National Patient Safety Agency (NPSA): Report Guidelines on standardising Patient Wristbands (2009) - Archived NHS Improvement – Recommendations from National Patient Safety Agency alert that remain relevant to the Never Events list (2018) Cardiff and Vale NHS Health Board 'Patient Identification Policy' (2012) Rotherham Doncaster and South Humber NHS Foundation Trust – Patient Identification Policy (2019) University Hospitals Birmingham NHS Foundation Trust – Policy for Identification of Patients (2019) Rotherham Doncaster and South Humber NHS Foundation Trust - Patient Identification Equality Impact Assessment (2019)		√		√		√				

	The Society & College of Radiographers – Patient Identification guidance and advice (2019) University Hospitals Plymouth NHS Trust – Identification of Patients Policy with Equality Impact Assessment (2020) Lincolnshire Community Health Service NHS Trust – Patient Identification Policy with Equality Impact Assessment (2020) Google searches 20 October 2020 on Equality Impact Assessment Patient Identification Policy and Patient Identification Policy Virtual copies of this Google search will be kept as evidence.	
People have a human right to: life; not to be tortured or treated in a degrading way; to be free from slavery or forced labour; to liberty; to a fair trial; not to be punished without legal authority; to respect for private and family life, home and correspondence; to freedom of thought, conscience and religion; to freedom of expression and of assembly; to marry and found a family and to not be discriminated against in relation to any of the rights contained in the European Convention.		
Human Rights	**It is the right of EVERY patient to receive the correct treatment, therefore ALL patients must be correctly identified prior to any medical intervention being undertaken The policy was developed in response to NPSA guidance (NPSA, Nov 07 and July 07)**	

*** This column relates only to Disability due to the specific requirement in the DDA 2005 to treat disabled people more favourably to achieve equal outcomes. This is not applicable to the other equality strands.**

Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing evidence to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race	**1**	**0**	**(N)**
Disability	**1**	**0**	**(N)**
Gender	**1**	**0**	**(N)**
Sexual Orientation	**1**	**0**	**(N)**
Age	**2**	**0**	**(P)**
Religion or Belief	**2**	**+1**	**(P)**
Welsh Language	**2**	**+1**	**(P)**
Human Rights	**1**	**0**	**(P)**

Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

FORM 4: (Part A) Outcome Report

Policy Title:	Patient Identification (ID) Policy
Organisation:	Cardiff and Vale University Health Board (UHB)
Name: **Title:** **Department:**	Carla English Patient Safety Patient Quality and Safety Team
Summary of Assessment:	**This policy applies to ALL clinical staff across the UHB and carries with it little or no impact on any equality standard.**
Decision to Proceed to Part B Equality Impact Assessment:	**No** **Due to the evidence suggesting a neutral or positive impact it is not necessary to proceed to Part B at this point. Any impact raised in the consultation would be dealt with within the action plan.**

Action Plan

You are advised to use the template below to detail any actions that are planned following the completion of Part A or Part B of the EqIA Toolkit. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual adverse impact, as well as any arrangements to collect data or undertake further research.

	Action(s) proposed or taken	Reasons for action(s)	Who will benefit?	Who is responsible for this action(s)?	Timescale
1. What **changes** have been made as a result of the EqIA?	n/a	n/a	n/a	n/a	n/a
2. Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to **mitigate** these impacts?	This is a revised version of an existing Policy. A Consultation period for all staff in the UHB to comment on the proposed document	To ensure staff are aware of the revised policy and have the opportunity to make suggestions / comments	Staff Patients UHB	Professional Development Nurses, Senior Nurse for standards and professional regulations.	There is no timescale as this will be responsive to individual need.

3. **Justification**: For when a policy may have adverse impact on certain groups, but there is good reason not to mitigate.	The policy guidelines are slightly different for patients who lack the capacity to correctly identify themselves	To ensure health and safety of all patients is protected	Staff Vulnerable patients	Inclusion in the Patient Identification Policy	There is no timescale as this will be responsive to individual need

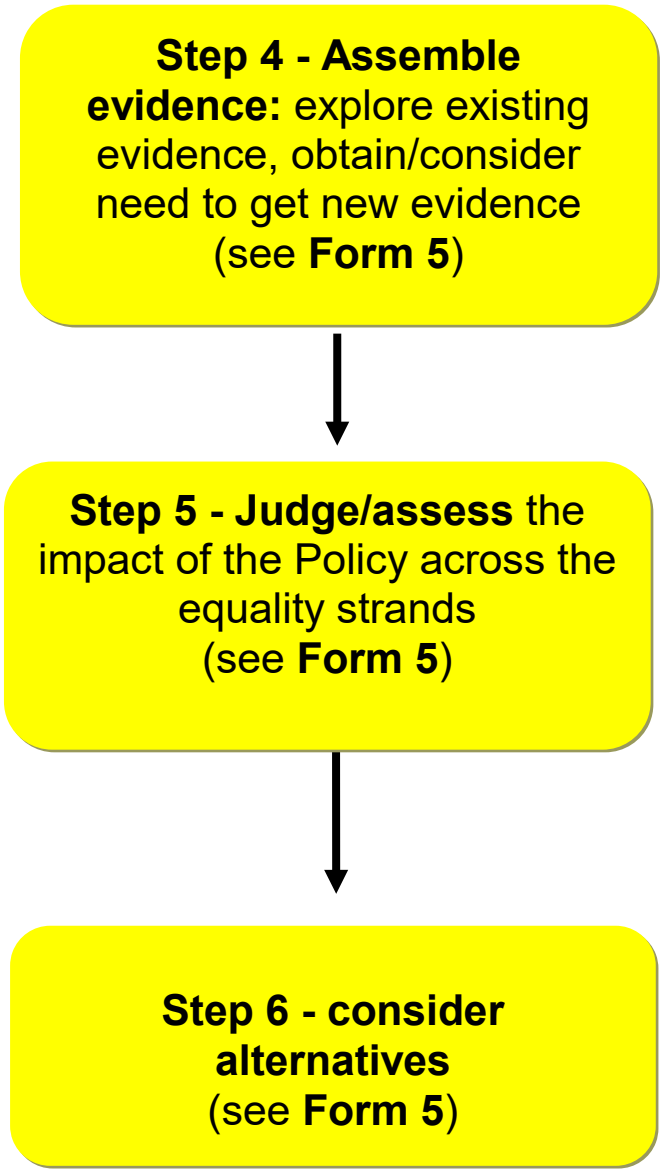
4. Describe any **mitigating actions** taken?	The policy has had an equality impact assessment undertaken to ensure fairness and consistency to all patients within the UHB.	n/a	n/a	n/a	There is no timescale as this will be responsive to individual need
5. Provide details of any actions planned or taken to **promote equality**.	We would provide copies of the document in alternative formats, including Welsh if required as via appropriate	The UHB want to be explicit about its commitment to the equality agenda/legislation. To ensure that are	Patients will be primary benefit which will impact positively on their families and/or patients as applicable	Appropriate staff and Managers	Already completed within the document There is no timescale as this will be responsive

	Single Equality and Welsh Language Schemes.	policies are accessible to all	Any individual making the request as well as the organisations reputation.		to individual need.

Date:	20.10.2020 (reviewed 31.08.21)
Monitoring Arrangements:	The Patient Identification Policy will be reviewed every 3 years or when new information / guidelines are introduced to the National Health Service.
Review Date:	20.10.2023
Signature of all Parties:	Carla English 20.10.2020 Tara Cardew 31.08.2021

Part B: Equality Impact Assessment

Part B has three steps:



Form 5: Equality Impact Assessment

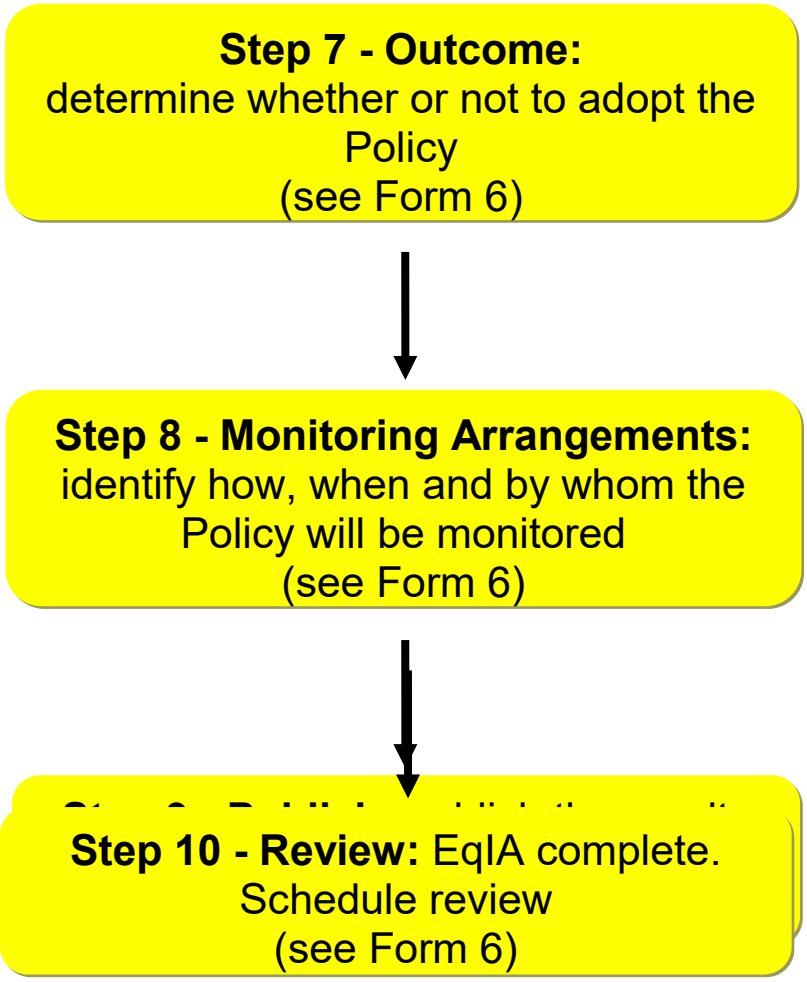
Step 4 - Assemble evidence		
1.	Do you have adequate information? Refer to **Form 2** (Part A, Step 2: *Evidence Gathering*) If not, can the Policy go ahead during this process?	
2.	Does the evidence relate to all strands? (please explain)	
3.	What additional information is required?	
4.	State which representative bodies of relevant groups you will liaise with for support. Is the information representative?	

Step 5 - Judge/assess the impact of the policy across the equality strands					
Detail below whether you have identified any positive, adverse or differential effect for any of the following strands:					
EQUALITY STRAND/GROUP					
		Adverse	**Differential**	**Positive**	**Comments**
Age					
Disability					
Gender					
Race					
Religion or Belief					
Sexual Orientation					
Welsh Language					
Human Rights					

Step 6 - Consider Alternatives					
6.	Describe any mitigating actions taken to reduce adverse impact.				
7.	Is there a handling strategy for any unavoidable but not unlawful negative impacts that cannot be mitigated?				
8.	Describe actions taken to maximise the opportunity to promote equality i.e. changes to the Policy, regulation, guidance, communication, monitoring or review				
9.	What changes have been made as a result of the equality impact assessment?				

Part C: Outcome, Monitoring, Publication and Review

Part C is a four step process as follows:



Form 6: Outcome, Monitoring, Publication and Review

Step 7 - Outcome: determine whether to adopt the policy or not		
1.	Will the policy be adopted?	
2.	If **No** please give reasons and any alternative action(s) agreed: (If the policy is **not** to be adopted please proceed to step 9).	
Step 8 - Monitoring arrangements: identify how, when and by whom the policy will be monitored.		
3.	How will the policy be monitored?	
4.	What monitoring data will be collected?	

5.	How will this data be collected?	
6.	When will the monitoring data be analysed?	
7.	Who will analyse the data?	
Step 9 - Publish the results of the assessment		
8.	What changes have been made?	
9.	Describe any mitigating actions taken Provide details of any actions taken to promote equality	

10.	Describe the arrangements for publishing the EQIA Outcome Report	
Step 10 - Schedule review		
11.	When will the policy be subject to a further review?	

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 25th May 2021, 8.30am via Microsoft Teams

PRELIMINARIES		**Action**
1.1	**Welcome & Introductions** Cath Heath (Chair), Director of Nursing Louise Young, Quality & Safety Manager, Children Young People & Family Health Services Directorate Angela Jones, Senior Nurse, Resuscitation Service Rhodri John, Directorate Manager, Obstetrics & Gynaecology Directorate Sarah Spencer, Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Ashleigh Trowill, Assistant Service Manager, Children Young People & Family Health Services Directorate Laura McLaughlin, Risk Manager, Obstetrics & Gynaecology Directorate Paula Davies, Lead Nurse, Children Young People & Family Health Services Directorate Martin Edwards, Asst Clinical Director, Children's Hospital for Wales Services Directorate Matt McCarthy, Patient Safety Facilitator Anthony Lewis, Clinical Board Pharmacist Becci Ingram, General Manager, Children's Hospital for Wales Services Directorate Natalie Vanderlinden, Designated Education Clinical Lead Officer (DECLO) Karenza Moulton, Lead Nurse, Children's Hospital for Wales Services Directorate Suzanne Hardacre, Head of Midwifery/Directorate Lead Nurse, Obstetrics & Gynaecology Directorate Diana Wakefield, Safeguarding Nurse Advisor Faye Mortlock, Clinical Nurse Specialist, Infection Prevention & Control **In Attendance** Kirsty Hook, Risk Governance & Patient Experience Facilitator (Interim) Ceri Lovell, Senior Nurse CAMHS, Children Young People & Family Health Services Andy Jones, Lead Nurse Surgery Services Clinical Board (shadowing Cath Heath) Carol Evans, Assistant Director Patient Safety & Quality	
1.2	**Apologies for absence** Clare Rowntree,	
1.3	**To note the Minutes of the previous Q&S meeting held on 27th April 2021/Matters Arising** The minutes of the meeting held on 27th April 2021 were agreed to be an accurate record. **NBS Performance Report** Assurance required that the avoidable repeats in NICU are being actioned. KM agreed to follow up outside of the meeting and update at the next meeting.	**KM**
1.4	**To note and update the action log of the meeting of 27th April 2021** Update was provided on the actions from the last meeting. A number of actions were closed, and an update was provided on the actions that remain in progress; **PEWS Chart** Chart has been developed and is currently with Media Resources prior to dissemination. KM agreed to share at the next meeting prior to undertaking the PDSA cycle on the wards.	**KM**

	eDatix MM agreed to change ACH to CHFW on the new system. **RCA BM** Surgery Services Action Plan shared. Closed. **DECLO Presentation** It was agreed that an update would be shared at the next meeting.	**MM** **KH**
1.5	**Presentation of Draft QSE Framework** Carol Evans was welcomed to the meeting to provide an update on the Draft QSE Framework for the UHB. It was agreed that the presentation would be shared for information outside of the meeting. Key themes were identified which included: • Safety Culture • Leadership & Prioritisation • Patient Experience & Involvement • Patient Safety, Learning and Communication • Staff Engagement and Involvement • Data and Insight • Professionalism • Quality Governance Work has commenced across the themes and an update was provided on the position to date. Organisational Learning committee is being established to oversee the implementation of learning systems. CAVQI Workstream is being progressed which will allow data to be more readily available to all. Discussion ensued with regards to the digital solutions and the work that is being undertaken across the UHB. It was agreed that this would be added as a priority as part of the framework. Sharing of information request has been made from Aneurin Bevan in relation to investigations and ombudsman reports etc. It was noted that this is a positive approach, subject to appropriateness and anonymisation.	**CE/KH**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Update on Delivery Unit Report – Crisis & Liaison Psychiatry Services (CAMHS)** The DU Report & Action Plan was shared for information. An overview was provided by Ceri Lovell. A review of the CAMHS Crisis Service was undertaken in August and September last year. Meetings were undertaken with representatives and partner agencies of the service. Referrals to the service are received from Acute Hospital, A&E, Adult Mental Health and GP's. Verbal feedback was received, overall the feedback was positive and acknowledging that some work had already commenced/practices needing to be changed due to the COVID 19 Pandemic and work was already in place for a number of areas, it was noted that the following required immediate action/serious risks; • Lack of whole cohesive CAMHS Service • Lack of dedicated Medic for Crisis • Client Records Since receiving the report, there was a significant amount of work that has been undertaken and the action plan was produced, acknowledging that this has been a very difficult year for the service. It was noted that a number of actions have now been completed and work continues on the remaining actions.	

	With regards to the liaison service within EU, there is no capacity within the team for a designated liaison for EU, however prioritisation and risk assessments are undertaken regularly. Work continues in order to increase the team in order to look to further improve the service going forwards. Information is now available on PARIS which has significantly improved communication. Work is progressing with regards to Care Groups which will significantly improve the services, and work is also developing towards a single point of entry. Access for 16-17yr olds pathway is being developed in conjunction with Adult Mental Health and Local Authority however this is a significant challenge. The service is nurse led, and it was acknowledged that there does need to be a designated medic, however this has been difficult to recruit, and options are being explored as to the best potential options to take this forward. Thanks, were expressed to the senior team for the significant work that has been undertaken. It was noted that there is great partnership working between the service and acute services. Also, to note, a recent peer review of the service has been undertaken and the feedback received was very positive and staff were commended on the service. Queries were raised with regards to the option of uploading key documents to Welsh Clinical Portal as the acute services and GP's don't have access to PARIS, which this would significantly improve communication between services. It was suggested that the service links in with the primary interface which is led by Karen Pardy and Siske Struik in order to connect directly with the GP service. CL agreed to take this forward.	**CL**
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues, Long Waiting Patients & Business Continuity Update)** **Children's Hospital for Wales (CHFW) Services Directorate** • Greatest risk at present is children in Mental Health Crisis and is causing significant impact on the medical flow. Increase in sectioned patients, which is increasing the need for RMN input. Concerns are being reported from staff and a number of actions are being implemented, including psychology input for staff, which will be funded by Noah's Ark Charity. • Lower GI patient concerns have been reported. A meeting has been undertaken and all patients are being reviewed and to identify if any further actions are required. Patient Safety are engaged with the process. • Predicted increase anticipated for RSV patients and data has been requested on surge planning for the winter period. 50% increase is being planned for. Jungle will not be ready until September, therefore this could impact flow significantly. This will continue to be monitored and feedback provided as necessary. • HIW inspection undertaken on Owl Ward, and the outcome is awaited. Initial verbal feedback was positive. • MRSA Outbreak on NICU is progressing well. X-ray and ECG staff are currently being swabbed. X1 positive case has been reported and the type is awaited. Once received, it is anticipated that this may close the outbreak if nothing further is found. • Number of medication errors reported in month, specifically in relation to IV paracetamol and work is being undertaken to review this. SNAP protocol is being progressed. • Paediatric Surgery waiting times currently at 471, 209 waiting over 36 weeks and 140 waiting over 52 weeks. Some improvement from last month but remains a challenge. Outpatient position is improving. For General Paeds 108 patients waiting over 36 weeks but only 12 are awaiting a TCI. Risks continue in gastro (over 40 children awaiting endoscopy) and over 55	

	patients awaiting an MRI. Ongoing discussions are taking place with Surgery and Radiology for MRI in order to review options to increase the MRI capacity as soon as possible. • Neurology service risk – advert has been placed for x3 Neurology Consultant posts and it is hoped that this will improve the position going forwards. **Children, Young People & Family Health Services (CYPFHS) Directorate** • ND Waiting times continue to rise with the longest wait is currently at 109 weeks with 832 patients on the waiting list. Capacity planning is being progressed. 42% compliance for Community Paediatrics, with the longest wait at 65weeks 249 patients. CAMHS has increased to 144 patients which is impacting referral to assessment times, PMH waiting list with compliance at 35%. Waiting List Initiatives have been implemented in order to mitigate these issues and this is regularly being monitored. There are significant pressures within the Crisis Team, however 85% of referrals were assessed within 48hrs. Within the continence service, the waiting list is currently at 718 patients with the longest wait being 108 weeks. It was noted that there is a risk that some patients will be over 16 before they are seen. This is regularly being reviewed. • School immunisation is of significant concern. Staff due to be back from 7th June 2021. The programme will be increased from June, however will run into September. It was noted however that the service is compliant with guidance. • Work continues on the risk register and work will be devolved to the Care Groups. Training sessions continuing to be accessed via Tim Davies. • Issues arising in relation to staffing within LAC Services, a risk assessment has been completed and has been added to the risk register in relation to timely assessment. • Information governance with regards to records storage which is being progressed. Digitalisation of records is being reviewed as an option. Cost based analysis being completed. • Psychology service risks associated with LD, which is being monitored and is linked to vacancies. PMH services and agency staff are being utilised to support. • SBAR for Health Visiting and School Health Nursing regarding attendance at Safeguarding Review case conferences. Benchmarking is being undertaken and meetings arranged to discuss the risks, associated with staff workload capacity. • HEP A vaccination incident will be confirmed at the next Directorate Q&S Meeting for final closure. This will be reviewed in 12months to monitor actions in place. • X1 pressure sore reported. This will be presented at the next Directorate Q&S Meeting. • Patient AB case was presented at the last directorate meeting and is part of a child practice review. It was agreed that this would be presented at a future Extra Ordinary Clinical Board Meeting. • Bag and Mask for resus will be issued routinely to CCNS and will only be provided to other areas via an individual risk assessment process. • Shire Newton Traveller Site visiting has been stopped, however controls are in place for anyone requiring visiting. • New Directorate Pharmacist has commenced in post and work progressing on the Melatonin Switch Over. • Safeguarding issues raised in relation to Ty Coryton service provider Orbis. Anonymised concern has been raised. Further meetings are being undertaken with legal services and information is awaited. There may be the potential delay of a court process for package of care for a patient. Further update will be provided outside of meeting. • CAMHS services risks have been highlighted with regards to a number of DTOC. Escalation pathway is being developed in order to support the CAMHS Team going forward. CH/PD to discuss urgently outside of the meeting. **Obstetrics & Gynaecology Directorate** • Relaunch of SAFER Pregnancy campaign messages shared via Comms Team • 10 Obstetrics and 2 Gynae RCA's ongoing of which x2 are SI investigations.	**PD** **CH/PD**

	• X2 falls reported. No injuries and concerns in care to note. • Babies don't bounce audit due to be undertaken in June 2021 • T2 to be revert back to elective sections/induction suite. Meeting planned with estates to discuss concerns with ventilation not meeting existing IP& C requirements within obstetric theatres. • Discussions continue with regards to fluid balance being updated on MLU and local guidance is due to be ratified in line with the NICE guidance. • X1 medicines management incident reported, medication left on the bus. Further patient review was undertaken and medication required/provided. • Multidisciplinary pathway being developed to support clinicians in the event that a mother wishes to take her baby home from hospital against medical advice following a formal concern. • Scanning capacity has increased. • Peer review of Clinical Supervision is scheduled in July with a self-assessment being undertaken in June • SARC Guidelines are being reviewed and further work is being undertaken on the ratification process. • Service Evaluation tool developed in EPAU regarding Dignified Care • Update for 2 minutes of your time received for March and outcome were positive. • Maternity Performance Indicators Report along with an overview presentation will be brought to the next meeting to share for information • Improvements are being seen in Cancer Breaches, with June anticipated to be more positive. 940 patients on the inpatients waiting list, with the average wait being 10 weeks. 1100 patients on the waiting list, with the average wait being 100 weeks. Work is being taken forward with Lightfoot to implement a plan to improve this position. RJ agreed to provide a further update at the next meeting.	
2.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **Clinical Board Risk Register Assurance** Noted for information. Thanks were expressed to all for the significant work that has been undertaken in ensuring that all risk registers are robust. **Risk Assessment – Bed Pressures CAMHS CHFW** Noted for information. Discussed as part of item 2.2	
SAFE CARE		
3.1	**Update on Serious Incidents** The report was shared for information. 6 open incidents with x1 closure form due to be submitted. It was noted that there has been an increase in the number incidents reported. All were asked to review and ensure that actions are being taken forward accordingly. A guide for closure of incidents is being developed and it was agreed that this would be disseminated for information. It was noted that with regards to the number of open incidents within the CHFW a number of have now been reviewed and the position has improved. A process has been implemented with regards to the current incidents which are being reported daily. In relation to the increase in incidents, this specifically relates to x2 individual patients and it was agreed that this would be shared for information at the last meeting. MM agreed to check that the incidents have been linked. SI Reporting Framework from Welsh Government is changing and it was noted that this will be moved to more thematic reporting. Once the details are received, this will be shared for information on the new process.	**ALL** **MM** **MM**
3.2	**SI's/RCA's/Closure Forms for noting** **RCA EC – 329281**	

	The action plan has been drafted and completed and will be shared for noting at the next Extra Ordinary Q&S for ratification and completion. • RCA RY – 307036 • RCA CLA – 325236 • RCA HS – 332425 • Birth Injury Tool – PW – 327369 • Birth Injury Tool – KE – 314400 • Birth Injury Tool – HA – 314603 All of the above RCA's/Birth Injury Tools were discussed and ratified at the Extra Ordinary Meeting on 15th May. There were no specific exceptions to note for this meeting. The draft minutes of the meeting were noted to be included as part of the papers for information and noting/sharing of lessons learnt.	**LM**
3.3	**Update on Regulation 28 – Patient LC** Meeting was undertaken and it was noted that C&W Clinical Board will lead on updating the action plan from the regulation 28 meeting. There will be a joint audit undertaken against the Royal College of Paediatrics. It was noted that a lot of this is already undertaken and further meeting will be undertaken to agree how this will be completed. The action plan will be updated and it was agreed that this will be shared for noting at a future Q&S Meeting prior to submission.	**KM/ME**
3.4	**Infection Prevention Control Update Report** The report was noted for information. There were no specific exceptions to note. **HCAI Reduction Goals for 2021/22** The HCAI Reduction proposed goals for 2021/22 were shared for information. Official goals are awaited from Welsh Government. The proposed reduction goals include: • C Diff from 7 – 6 – to date there have been zero cases reported • MRSA from 2 - 0 • MSSA from 5 -4 – one MSSA Bacteraemia case reported in May 2021 • E Coli no change • KLEB – from 8 - 4 • PAER (Pseudomonas) from 4 - 0 Comparison of the data from 2019/20 - 2020/21 shows a reduction across the Clinical Board. Against the data from last year, the proposed goals were noted. RCA's are completed for C Diff, MRSA, MSSA, KLEB and Pseudomonas and these will be reviewed in order to review any lessons learnt and understand the areas that require further support and training. **MRSA – NICU Update** Update provided as part of item 2.2. Staff were commended for the work undertaken throughout the outbreak and it was noted that BBE has been 100% compliant throughout the whole process.	
3.5	**Safeguarding** Request was made for encouragement for the completion of safeguarding training as the numbers are low at the moment- including mandatory safeguarding training. There has been a large increase in domestic violence, violent incidents and mental health concerns and therefore for the safety of staff and patients it is important to keep updated.	
3.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • **ISN 2021/05/010 POCT Pregnancy Testing**	

	It was agreed that an update would be provided outside of the meeting and would be fedback to patient safety. CH agreed to discuss with SS. • **Safety Alert – Boron & Chloramphenicol** Guidance and practice remains the same and are safe to use, use should be considered on a case by case basis. • ISN 2021 May 007 Ported Cannula Recall • ISN 2021 April 005 Cytotoxic Leaks • Field Safety Notice Update – Blood Syringes & Cannulas – relating to Recall notice of PICO70 Arterial Blood Sampler All the alerts have been circulated widely for information and there were no other exceptions to note.	**CH/SS**
3.7	**Paediatric Ketamine Protocol** Shared for information. It was highlighted that esketamine is no longer available and a switch over to ketamine is being progressed.	
3.8	**To note the Welsh Risk Pool Learning Advisory Panel Newsletter** Noted for information.	
3.9	**To note the Use of Rapid Tranquilisation Guidelines for Young People & Adolescents** The guidelines were noted for information. This process has been implemented within the CHFW and has been developed collaboratively with EU.	
INDIVIDUAL CARE		
4.1	**Update on latest 2 minutes of your Time feedback** No further update to note. Discussed as part of item 2.2	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**Qualitative Face Fit Testing Training Sessions** Noted for information.	
5.2	**Mortality Review Group Minutes 04.05.21** Noted for information.	
5.3	**Coroners Inquest Guide** Noted for information.	
5.4	**To note the Paediatric Medicine Safety Update April 2021** Noted for information.	
5.5	**Draft Minutes from Extra Ordinary Q&S Meeting – Friday 15th May 2021** The minutes were noted for information and to note and sharing the lessons learnt from the RCA's noted as part of item 3.2. It was acknowledged that there were no specific exceptions to note for this meeting that had not been included as part of the minutes and all cases were ratified for sharing with families and staff for lessons learnt.	
5.6	**Medicines Safety Briefing – May 2021** Noted for information.	

ANY OTHER BUSINESS		
6.1	**NICE Guidance – New Clinical Board Process** A new process has been implemented within the Clinical Board in order for a robust record of compliance to be available. A flowchart is currently being developed outlining the required actions and it was agreed that once finalised, this will be shared for discussion/agreement. **Resuscitation Guidelines** Guidelines are changing. It was agreed that a further update will be shared when available. **Cath Heath – Retirement** Thanks, were expressed to Cath Heath for her hard work, commitment and dedication to the Quality & Safety agenda and to the Clinical Board during her time as Director of Nursing. Andy Jones, has been appointed as the interim Director of Nursing for Children & Women's Clinical Board and will commence in post in June 2021.	**KH** **AJ**
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for **Tuesday 22nd June 2021 (H&S Focus), 8.30am, Via Microsoft Teams**		

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 22nd June 2021, 8am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJ), Director of Nursing (Chair) Angela Jones (AJones), Senior Nurse Resuscitation Service Janice Aspinall (JA), Health & Safety Representative, Royal College of Nursing Mal Perratt (MP), Fire Safety Advisor Louise Young (LY), Quality & Safety Manager, Children Young People & Family Health Services Directorate Becci Ingram (BI), General Manager, Children's Hospital for Wales Services Directorate Anthony Lewis (AL), Clinical Board Pharmacist Karenza Moulton (KM), Lead Nurse Children's Hospital for Wales Services Directorate Martin Edwards (ME), Assistant Clinical Director, Children's Hospital for Wales Services Directorate Sarah Spencer (SS), Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Matthew McCarthy (MM), Patient Safety Facilitator Ashleigh Trowill (AT), Assistant Service Manager, Children Young People & Family Health Services Directorate Laura McLaughlin (LM), Risk Manager, Obstetrics & Gynaecology Rachael Sykes (RS), Health & Safety Advisor Faye Mortlock (FM), Suzanne Hardacre **In Attendance** Kirsty Hook, Risk Governance and Patient Experience Facilitator	
1.2	**Apologies for absence** Clare Rowntree,	
1.4	**To note the Minutes of the previous Q&S meeting held on 25th May 2021** The minutes of the meeting were agreed to be an accurate record.	
1.5	**To note and update the action log of the meeting of 25th May 2021** **Newborn Screening (NBS) Performance Report** KM agreed to follow up on actions and update. *Postscript – confirmed that the action plan has been fully implemented and the action is now closed.* **PEWS Chart** Chart finalised. It was agreed that this would be circulated outside of the meeting. The PDSA Cycle pilot will commence in the next few weeks before full roll out. **RCA Investigation Case Patient AB** It was agreed that this would be scheduled for discussion at the next Extra Ordinary Q&S Meeting. **RCA EC – 329281**	

	The action plan has been drafted and completed and will be shared for noting at the next Extra Ordinary Q&S for ratification and completion. **Update on Regulation 28 – Patient LC** Meetings have taken place and updates are being provided against the action plan. Updated action plan will be circulated in advance of the next meeting with the Executive Nurse Director. **NICE Guidance – New Clinical Board Process** A flowchart is currently being developed outlining the required actions and it was agreed that once finalised, this will be shared for discussion/agreement.	
PRESENTATIONS		
	Digital Programme Update David Thomas and Angela Parratt were welcomed to the meeting and provided an update on the digital programme being taken forward across the UHB. Digital infrastructure is being addressed/progressed across the UHB. X4 programme boards have been developed; • Patient Channel • Clinician Channel • Analyst & Platform • Capabilities Programme Programme of work has been developed which will be progressed over the next 5 years and robust governance structures are in place. Co-production is key and it was requested that Clinical Information Officers and change co-ordinators are identified across the Clinical Board. Discussion ensued and it was noted that a Digital change lead has been appointed within the CYPFHS Directorate and has been taking forward some of the IT issues within the community services. The Directorates were asked to consider representation to link with the Digital programme team. It was agreed that consideration be given to having a digital team presence at Clinical Board meetings going forward to continue the open channel of communication. The presentation will also be shared for information.	**ALL** **AJ** **KH**
HEALTH & SAFETY		
2.1	**To note the latest Health & Safety Report** The report was shared for information. X1 incident report to HSE in 1st Floor Maternity where an Anaesthetist sustained dirty needlestick, BBV+. This was reported as a dangerous occurrence. Learning has been shared with the department. **H&S Dashboard – May 2021** Shared for information and onward sharing as appropriate. **PPE Lessons Learnt** Shared for information and onward sharing as appropriate.	
2.2	**Feedback from UHB Operational H&S Meeting** • Feedback was provided on the H&S Review that was undertaken recently. A working group is being arranged to take forward the recommendations from the findings • H&S Training for V&A and Manual Handling is booked through self-serve and liaison with managers will need to be undertaken • Reintroduction of DNA fees are being reinstated • Classroom based training for manual handling is poor, and it was noted that changes have been made to the modules and training. • Care and control training for V&A is being reviewed to ensure that this is suitable for the Clinical Board	

2.3	**To note the latest COSSH Report** Noted for information. Directorates were asked to review and request the COSSH assessments for those areas that require updates.	**ALL**
2.4	**Fire Safety Update** Change in fire safety team personnel. Fire safety training drive is being taken forward and COVID safe training is being carried out face to face. Any training requirements to be sent through, and Fire Safety Team will provide the training. All clinical staff should have face to face training on an annual basis. 50 Drop in sessions will be arranged over a week in September 2021, and it is hoped that this will increase compliance significantly and may be a possibility for this to be taken forward on an annual basis. MP agreed to forward the contact details outside of the meeting in order that this can be shared across the Clinical Board. Enforcement notices received as an estate, and it was noted that the focus on the recommendation of the Chief Fire Officer for the UHB's across Wales relates to control of ignition sources, fire assessments in date and training.	**MP/KH**
2.5	**Feedback from H&S Staff Side** Workplace inspections have been reinstated following the suspension due to COVID-19. It was acknowledged that there are some issues within maternity at present, and would benefit from early inspections. JA agreed that these areas will be prioritised. A programme will be developed. Monthly meetings are taking place with Robert Warren and further update will be provided at the next meeting. Staff side H&S meetings are also being reinstated. Executive walkabouts have been planned and will be taking place in due course.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues, Long waiting patients update)** **O&G Directorate** • Mortality data was shared for information • 8 ongoing RCA's, x1 Gynae SI, x8 timelines ongoing and x6 birth injury tools • X2 pressure damage reported. Grade 1 pressure area within Obstetrics and all measures were implemented. The other was a moisture lesion within Gynaecology, but patient was declining to reposition. • No falls reported in May and the Babies Don't Bounce audit is being undertaken this month and feedback provided at the next meeting. • T2 to be revert back to elective sections/induction suite. Meeting with estates to discuss concerns with ventilation not meeting existing IP& C requirements within obstetric theatres. Risk assessment being developed with H&S input to re-open T2. • Funding for dietician BMI >40 for healthy pregnancy clinic- Dietician 0.6 WTE time. • X5 medication errors reported in month. X3 of the errors were in relation to patient factors however no harm was noted for all patients. AL agreed to follow up with the Directorate Pharmacist to review. Datix incidents completed and the medication error pathway to be completed for all. It was agreed that the investigation tool would be shared for information following the meeting. • Peer Review of Clinical Supervision of Midwives will be undertaken in July 2021. The self-assessment has been shared as part of the papers for this meeting for information. • Streamlining was completed yesterday and 24 students have been allocated. • RTT update was not available within the report. It was agreed that this would be followed up outside of the meeting and information shared as appropriate.	

CYPFHS Directorate

- Immunisation programme modelling is being undertaken. Delivery of extended Fluenz programme being taken forward however staffing is challenging at present and there is no additional funding available at present. Working with PCIC and Public Health on the model. Ongoing discussions are taking place with regards to delivery of the vaccine to 16-17yr olds in schools through summer and a provisional plan will be submitted to Welsh Government.
- Planning for staff flu campaign for Winter will commence shortly, it was noted that a Clinical Board lead will need to be identified for this year and further discussion is required.
- Several multi-disciplinary workstreams progressing for emotional mental health pathways for C&YP and it was agreed that streamlining is required going forward to manage the workplan robustly. It was noted that concerns processes will be implemented for children in crisis in order to notify patients and their families with regards to waiting times, and outlining actions that have been implemented, in order to help manage expectation.
- Pressures within LAC services at present. Caseloads are growing significantly and sickness which is creating further pressures in the service, which will continue to be monitored.
- Two risks on RR for Psychology service – tier 2 service limited capacity, tier 3 service unable to take new referrals. Impact on high risk LD CYP with challenging behaviour.
- Reviews being undertaken on risks being raised in relation school nurses not meeting safeguarding requirements. It was agreed that the risk assessment and action plan will be shared at the next meeting.
- MJ SI closure form has been completed. WHSSC processes continue.
- AB case was shared as part of the meeting – timeline produced and Child Practice Review being undertaken.
- RCA for DC is progressing and will be presented at a future Q&S
- Risk Assessments are being undertaken with regards to the Bag Valve Masks for services.
- Neurodevelopment Waiting List – 864 patients with longest wait at 114weeks, CAMHS longest wait is currently at 35 weeks, PMH service 168 patients – 29% compliance for Part 1 and this figure is being reviewed to ensure that this is correct due to issues within PARIS. Additional agency staff have been appointed which is hoped will help to achieve the 80% target. Crisis team – 94 referrals received in May, 80% of patients seen within 48hrs. Community Paeds longest wait 68 weeks. Continence service – 689patients and longest wait is currently at 108weeks. Due to staffing pressures the service has suspended new patients on the waiting list and it is anticipated that this is likely to increase the waiting lists further. Regular reviews are undertaken across all waiting lists to ensure that all patient waits are monitored/validated and expedited where necessary.

CHFW Directorate

- Visiting to change within NICU and CHFW following Welsh Government update from July 2021 which will be a positive change.
- X5 patients (Children in Mental Health Crisis) which is a reduction to previous weeks.
- Lower GI Patients – investigations are being undertaken and regular meetings to review actions.
- MRSA Outbreak in NICU, hoping to close the outbreak as all actions have been undertaken and no significant concerns raised.
- RSV surge plan is being developed, anticipated increase from August 2021 and will be shared when finalised.
- Nurse staffing act triangulation is ongoing in preparation for presentation in August.
- HIW inspection on Owl Ward. Positive feedback has been received. PADR rates and BBE were highlighted. Action plan has been completed to address these issues.
- 40 streamlining students have been appointed.
- Pressures continue within Paeds Surgery. IP waiting list is currently at 464patients, 238waiting over 36 weeks, 171 waiting over 52 weeks, with the longest wait being 106weeks with no TCI. All over 52 weeks are reviewed by surgeons and a number have been expedited as appropriate. A number of lists have been cancelled and meetings are being undertaken to understand the CAT prioritisation. For outpatients, there has been a slight improvement and list is currently at 600 wait, small number over 36 weeks but all of which have a TCI.

	Gastro continue to see over 40 children waiting over 8weeks for diagnostic endoscopy. Sleep service 72weeks for sleep study – a number of workstreams have been included as part of the COVID recovery plans and feedback is awaited on the outcome.	
3.2	**C&W Clinical Board Risk Register** The latest Clinical Board Risk Register was shared for information. It was agreed that any updates would be provided following the meeting in order to ensure that the document remains live and up to date.	**ALL**
3.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **Maternity Lifts** One of the control measures has been reviewed and Induction of Labour is being reviewed to move from first floor to second floor. SS agreed to follow up with IP&C in order to progress this move which will help mitigate some of the risks. **Ventilation in Maternity Theatres** Work is being undertaken with the clinical leads on the SOP and the pathway to ensure all risks are mitigated. FM agreed to review the SOP and provide feedback asap. **Imms Delivery** New risk assessment to be undertaken to consider the risks associated with the delivery of this programme. PD agreed to share at a future meeting as soon as this is completed.	**SS** **FM** **PD**
3.4	**Business Continuity Update** Discussed as part of item 3.1 with regards to the RSV surge plan.	
SAFE CARE		
4.1	**Update on Serious Incidents** The report was noted for information. X6 open SI's for the Clinical Board. Incident management has improved and it was noted that there has been a significant improvement specifically across CHFW Services. Thanks were expressed to all for the continued hard work undertaken. Information relating to changes to SI reporting has been circulated and a guide is currently being developed by the Patient Safety Team to understand and outline the changes in practice. Reporting of SI's and definitions are changing and there will be 7 days to consider and decide if this should be reported. Consideration is also being given to implementing a rapid review tool and once finalised this will be shared at a future meeting.	**MM**
4.2	**SI's/RCA's for discussion** **SI MH – In126242** The RCA was shared for information. The case involved UHB Safeguarding being notified of the tragic death of a teenage girl found deceased on a railway track in Cardiff. A full investigation has been undertaken. Discussion ensued and it was noted that the main theme issue related to borders, as some of the services were being split between Aneurin Bevan and Cardiff & Vale UHB. Whilst it should be acknowledged the borders issue did not appear to impact on the provision of services in this case, it is apparent that clarity is required for CAMHS around what the boundaries with neighbouring Health Boards are set upon. There was also variable engagement and missed appointments by with PMH Services and CAMHS Crisis Since this case was reported, the appointment of x2 Band 7 practitioners has been progressed, and they will work with PMH workers within the school in order to improve partnerships. Discussion ensued in relation to the concerns that had been disclosed by the boyfriend of the young person and it was agreed that consideration should be given to how we interact with	

	young people going forwards and whether this could be through a more digital approach, which could improve the engagement of young people. It was agreed that the SI could be submitted for closure and the closure form progressed for Welsh Government.	**PD/MM**
4.3	**SI's/RCA's/Closure Forms for noting** **RCA JC – 314858** The SBAR was noted for information and outlined the background and all recommendations and actions taken. Action plan completed and the closure form is being progressed. It was noted that this is also a potential claim, and work is progressing to ensure that all actions are completed and evidenced. There were no exceptions to note and it was agreed that report could be signed off. **RCA RR – 297581** The SBAR was noted for information and outlined the background and all recommendations and actions taken. Recommendation for consultant review has been changed to obstetric review. There were no exceptions to note and it was agreed that report could be signed off. **RCA CL – 317765** The SBAR was noted for information and outlined the background and all recommendations and actions taken. A concern has also been received for this, the investigation has been undertaken and a response is being progressed, along with any actions identified. There were no exceptions to note and it was agreed that report could be signed off. **Birth Injury Tool – MS – 324327** The SBAR was noted for information and outlined the background and all recommendations and actions taken Desperate Debra model is being considered and a business case is being developed to take forward for some additional training. It was agreed that this was approved by the clinical Board and **Birth Injury Tool – EE – 321117** The SBAR was noted for information and outlined the background and all recommendations and actions taken. This was a temporary injury that was sustained and it was noted that the injury is now resolved**.** No concerns in care were noted, and the recommendation was to continue with PROMPT training which is continuing. **Birth Injury Tool – MM – 315294** The SBAR was noted for information and outlined the background and all recommendations and actions taken. Incidental finding of a fractured clavicle. Prompt training to continue was a recommendation, there were no concerns with care provided. The recommendation was to continue with PROMPT training which is continuing.	
4.4	**Infection Prevention Control Update** **MRSA Outbreak** No positive cases since February and audits have been continuing. It is anticipated that the outbreak will be closed this week. Awareness was raised for staff capitus in Neonatal Units. X3 cases sent for typing and results are awaited. No specific issues to note for the Clinical Board at present and FM agreed to confirm if any further work is required. Room identified for HPV cleaning in NICU and FM agreed to follow up with Estates in relation to the ventilation prior to use.	**FM** **FM**

4.5	**Safeguarding** • All Wales Safeguarding procedures - https://safeguarding.wales/ • SOP Parental Consent – Paediatric Radiology • UHB Safeguarding Allegation/ Concern Procedure (2021) • Safeguarding Training Compliance The safeguarding documents were noted for information and onward sharing. There were no specific exceptions to note from the meeting.	
4.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Message from Welsh Government - CPhO/MedsLet/2021/16 - Disruption to the supply of Verteporfin (Visudyne®) 15mg powder for solution for infusion – Update • Internal Safety Notice 2021 Jun 012 Blood Transfusion Special Requirements • Patient Safety Notice PSN057 Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children • Message from Welsh Government - CEM//CPhA/2021/16 Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd All alerts have been shared widely across the Clinical Board, there were no exceptions to note for the Clinical Board.	
4.7	**NICE Guidance** • HST14 – Use of Metreleptin in the treatment of lipodystrophy in children • IPG686 – Minimally invasive radical hysterectomy for early stage cervical cancer • NG191 – COVID-19 Rapid Guideline: Managing COVID-19 • IPG689 – Transcervical ultrasound-guided radiofrequency ablation for symptomatic uterine fibroids • NG192 – Caesarean Birth • NG195 – Neonatal Infection:antibiotics for prevention and treatment • NG193 – Chronic pain (primary & secondary) in over 16's • NG194 – Postnatal Care • CG57 – Atopic eczema in under 12's: diagnosis and management All NICE Guidance has been shared with the relevant Directorates and requests were made for the compliance forms to be completed outlining compliance and any necessary actions undertaken. A Clinical Board pathway is being developed outlining the required process and the actions that need to be undertaken to ensure compliance. This will be shared when completed.	
4.8	**CAMHS Admissions Pathway T&F Group** Deferred to next meeting.	
4.9	**Stage 2 Mortality Review Tool** Deferred to next meeting.	
TIMELY CARE		
5.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** No items to note.	
INDIVIDUAL CARE		
6.1	**Employee Health & Wellbeing Pulse Survey** Noted and shared for information.	
6.2	**Employee Wellbeing Workshops** Noted and shared for information.	

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
7.1	**Medicines Safety Briefing – May 2021** Noted for information.	
7.2	**Paediatric Medicine Safety Update – May 2021** Noted for information.	
7.3	**Resuscitation Guidelines - https://www.resus.org.uk/library/2021-resuscitation-guidelines** Noted for information.	
7.4	**ARK-Antibiotic Review kit initiative** Noted for information.	
7.5	**Final CCNS Rostering Audit Report** Noted for information. Report noted that the audit received substantial assurance and work is continuing on the action plan to ensure all actions identified are complete.	
ANY OTHER BUSINESS		
8.1	No items to note.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 27th July 2021, 8.30am, 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 – 10.30am**. All meetings will be held via Microsoft Teams – links will be circulated.

24th August
28th September (H&S Focus)
26th October
23rd November
21st December

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 4 June 2021
Teams Meeting
MINUTES

In Attendance:

Claire Main (CMain)
Hywel Roberts (HR), Consultant, Critical Care and QSE Medical Lead
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Lisa Higginson (LH), (Interim) Lead Nurse, N&T
Tracy Johnson (TJ), Patient Safety
Maurice Wentworth (MW), ALAS
Keith Wilson (KW), Consultant, Haematology
Fiona Kear (FK), Assistant Service Manager, Haematology
Sharon Daniels (SD), Directorate Support Manager Nephrology & Transplant
Alannah Foote (AF), Directorate Support Manager Nephrology & Transplant
Claire Mahoney (CM), CNS Infection Prevention & Control
Tom Hughes (TH), Consultant Neurologist
Dan Jones (DJ), Deputy General Manager, Critical Care & MTC
Judith Burnett (JB), Senior Nurse, Critical Care
Tessa Northmore (TN), Senior Nurse, Neurosciences
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Ravindra Nannapaneni (RN), Consultant Neurosurgeon
Paul Rogers (PR), Directorate Manager, ALAS
Beverley Oughton (BO), Senior Nurse, Cardiothoracic
Jonathan Elias (JE), Senior Nurse, Critical Care
Joanne Bagshawe (JB), Senior Nurse, Haematology
Jenny Labaton (JL), Interim Senior Nurse, Haematology
Lisa Simm (LS), Interim Directorate Manager, Neurosciences
Caroline Burford (CB), Consultant in Critical Care

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain thanked HR for chairing the last meeting.	
1.2	Apologies for absence Received from Cath Wood, Guy Blackshaw, Khalid Hamandi, Colin Gibson, Suzie Cheesman, Jennifer Procter, Aled Lewis, Abbas Zaidi, Gareth Jenkins, Emma Swales, Rachel Barry, Tom Holmes, Mathew Price, Angela Jones.	
1.3	To review the Minutes of the previous meeting 14 May 2021 The minutes were agreed as an accurate record, subject to the following amendments • amending the title of CM to CNS IP&C. • Item 1.3 paragraph 3 ”JC accreditation” should read “JACIE accreditation” • Item 3.3 Haematology Update “department QSTE should read “Directorate QSPE” Matters Arising	

	• Item 1.3 Issue with opening embedded papers when using office 365 web version. Some members are still experiencing problems in accessing the embedded papers, CMain suggested that a short-term solution will be to send all papers separately via email and continue to work on resolving this issue. Todays' papers will be sent out after this meeting. • Item 2.2 ISN Ref 2021 May 007 BD Venflon Pro Safety (VPS) Needle Protected IV Cannula – URGENT PRODUCT RECALL CMain asked if there was any update on this situation. HR reported that he has not been contacted by the Radiology Team investigating the issue of leaking ports, he thought that the two issues maybe linked and wanted to explore this possibility by looking at the investigations carried out by Radiology, CMain said that she would find details of contacts from Patient Safety and would take this forward with HR outside of this meeting. • Item 3.3 Closure of the Transplant Unit, CMain asked if the summary regarding this situation had been sent to her, KW said that he has not sent this through yet as the date for closure has yet to be finalised, KW will update CMain in due course.	**CMain** **KW**
1.4	<u>Patient Story</u> CMain informed that she would like to restart formally discussing patient stories from each Directorate on a meeting by meeting basis, a rolling rota will be issued to identify who will present when. Claire added that this is a very good opportunity to showcase what we are doing well and will be useful to pick up on any issues we need to highlight and potentially discuss some of the options and what may be needed from the Clinical Board or other Directorates in terms of expertise or different ways of looking at things. Rota to be circulated.	
2.1	<u>Open Serious Incidents</u> TJ updated the group. There are currently 5 open SI's it is hoped that 3 of these will be closed this month. There are 2 potential SI's which have been around for some time. One case may possibly not need to be reported on, the second case is that of a lady in Intensive Care with an Enoximone under-dose, TJ asked if someone could let her know if the under-dose caused the lady any harm, once this information has been received it is possible that this case could also be resolved. <u>Open Inquests</u> Nothing to report, document is for information.	
2.2	<u>Alerts/Patient Safety Notices</u> CMain informed the group of the recent change to how these are reported on with a specific call to action on each safety notice in respect of responding by a certain date, to ensure that the information has been disseminated to the Directorates and that each Directorate has read them and actioned accordingly. Richard is maintaining a database, Clare asked that each Directorate acknowledge receipt. Currently looking at how best to streamline the process. • Welsh Resuscitation Forum – Update on PPE and Resuscitation	

	Guidelines to be implemented from 1 July 2021. HR reported that Critical Care have adopted this process all through the pandemic, all trainees go to all cardiac arrests fully equipped and Critical Care continue working to these guidelines. • Field Safety Notice PICO70 Arterial Blood Sampler, products to be recalled, CMain asked if the areas using these have complied with the notice, HR reported that Critical Care have returned the small amount of stock they held. • PSN057/June 2021 Emergency Steroid Therapy Cards: Supporting Early Recognition and Management of Adrenal Crisis in Adults and Children, CMain asked that everyone please ensure this is disseminated widely and actioned where appropriate. • ISN Ref 2021 / May/ 011 High Risk of Accident in MRI Suite, CMain asked that everyone is made aware of the processes in place and transfer of patients and completing the safety questionnaires within the MRI suite with the Radiology staff. • MHRA Field Safety Notice Ref 2021/005/005/601/530 - Clinell Universal Wipes (CW200). This was not included on agenda, CMain said that due to the volume of these wipes used it is anticipated that all stock will have already been used up. HR confirmed that Critical Care estimated that their stock of this batch had been used in September 2020.	
2.3	<u>Closure Forms</u> There were no closure forms to report on this meeting	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report May 21 CM updated the group on the MDRO outbreak in Rookwood, currently the situation seems to be under control on Wards 4 and 5, from the last round of screening there were no further patients identified. However, in March there was one patient on Ward 7 who, from clinical sample, matched the outbreak strain in Wards 4 and 5 unfortunately, it seems that a further patient on Ward 7 has potentially acquired the outbreak strain, currently awaiting confirmation from the Reference Laboratory. The plan is that following the move to UHL all patients will be screened, both from Wards 4 & 5 and Ward 7 on a monthly basis for a 12month period. All patients currently on Ward 7 will be screened this week. B4 Neuro have had an outbreak of C.Difficile, there has been a new positive since the last Q&S meeting, CM reported that the ward staff have been working very hard to address the issues encountered as a result of the 2 wards merging into 1 and the increase storage of equipment, however there are still problems. The staff are unable to access the hand hygiene sink in the area where the positive patient is, there are potential patient safety issues which are out of the ward staff hands, they need some assistance in relocating all the equipment which is preventing them from undertaking their clinical duties appropriately. CMain replied that work is underway to gain space on C4 to allow Neurosurgery/ Neurosciences to be in the appropriate area, however, we need to look at anything that could be done in the short term to help alleviate the problems. TN confirmed that there is no space at all and added that the Physio's are also still using the ward to store equipment and that only space available was the counselling room which is currently being used for all meetings, handovers, Physios, OT's as well as using this to store equipment. CMain will raise this issue today at LCC there are plans afoot to gain C4 back Haematology are working to release part of C4 but the big win would be to regain C4 South which is currently the Stroke Unit but with the site on the current level 3 / 4 situation	

	this has proved to be difficult, Claire will highlight the infection risk and the general implications to the ward. CMain informed the group that Jen Proctor has kindly agreed to be the IP&C lead for the Clinical Board, Jen is currently on leave, on her return it is planned for her to meet with CM, RP and CMain and then to formally reinstate the IP&C meetings with the Directorates.	
3.1	<u>Feedback from UHB QSE Committee</u> TJ reported that there was nothing to feedback	
3.2	<u>Mortality Review</u> CB reported that there had not been a mortality review meeting to report back on. CB said that she had asked that a request made by Jason Shannon, regarding the Coroner referral requirements, be disseminated as there have been some compliance issues in reporting deaths to the coroner. CB wanted to highlight the legality of the process as there are significant implications for clinicians who do not choose to refer their patients to the coroner, CB said that this issue is being noted at a higher level and there have been discussions about referral to the GMC for those medics who do not comply. CB asked about the Enoximone case as neither she nor HR knew about this case, HR asked that TJ email both HR and CB with the details and they would look into the case as soon as possible.	**TJ/HR/CB**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> KW informed the group of a "Good News Story" that has been published on the UHB website, details will be sent after this meeting. KW asked that the minutes of this meeting recognise the fact that Orla Morgan made a significant contribution to this Group and that she was a tremendous influence in both Critical Care and the wider Quality and Safety Clinical Board committees. JB added that with regard to C4 issue both she and Gareth Jenkins are keeping in regular contact for those works on A4 North and will be meeting with Karen Doyle today. <u>Critical Care</u> HR said that there were no issues to report <u>ALAS</u> MW said that there were some concerns regarding the impact the closure of Rookwood Hospital will have on the buildings that will remain occupied as a lot of the services for IT and Telecoms run through the main hospital and are distributed from there. PR replied that he will be meeting with Capital and Estates fairly soon and will gain a wider view on their plans and operational changes moving forward. They have identified Telecoms as an action and there is a plan to resolve this issue.	

	Neurosciences LD informed the group that after 100 years as from Tuesday 8 June there will no longer be in-patients at Rookwood Hospital. CMain agreed that this is a significant change and wished all well for the move on Tuesday. Claire gave thanks to all for working tirelessly to achieve this relocation. TH added that Lorraine had undertaken a superb job and overseen a smooth transition. PR said that Rookwood isn't closing but that Neurosciences are relocating, Rookwood is very much still open for business. Nephrology and Transplant Nothing to report Cardiac Nothing to report Pharmacy SG has devised a checklist which is intended to be an aide memoire when transferring medicines between locations, he asked that any necessary amendments identified be fed back to him to action. Major Trauma Nothing to report	
4.1	Manual Handling Workplace Competency For information only.	
5.1	Any Urgent Business Plasma Exchange HR gave an overview of the discussions held at the last QS&E meeting and explained that the drive for this particular issue at the moment is the anticipated upsurge in demand for plasma exchange. CMain informed the group that the aim of the rota which has been put in place is to provide cover 7 days a week, daytime only, however it is not a stand-alone rota but it is incorporated into where people are and where they can be released from at that time. HR gave details of a case transferred from the Grange on Bank Holiday Monday when because of the logistics of having everything in place to start the plasma exchange, the person identified as the plasma exchange person to undertake this was unable to stay on to complete the plasma exchange. HR said that historically this is usually the case, in that the first plasma exchange always runs into the early evening therefore a service that cannot run into the evening is always going to struggle. CB had provided details of all patients for plasma exchange in Critical Care since 2016 and HR looked at those which were time sensitive. He explained that due to the length of time taken to diagnose TTP the plasma exchange usually needs to be started in the evening. KW said that there maybe a little more leeway with VITT patients. HR said that approximately ¾ of the plasma exchanges undertaken since 2016 are time sensitive. KW reported that across Renal, ITU and Haematology there are various forms of apheresis expertise available and without injecting more bodies into the	

	system it might mean that we need to look at what we have with the existing expertise and could we draw up something that is safe and doesn't overburden one service over another. With goodwill it means that routine commissioned service suffers the following day when people are brought in out of hours to provide this service with a result that they are unable to carry out their planned duties the following day. KW offered to provide data on activity in Haematology to give a feel for the current demand. There is significant emotional burden when staff are asked to exchange so we need to have a service that ensures that no one feels responsible for. CMain summarized the current situation, there are a number of different apheresis techniques delivered across the services for very specific patient groups and there is not a universal apheresis service for these emergency patients. Claire met with Peter Collins, Stuart Walker and Welsh Government to discuss particular issues associated with the VITT patients. They have drawn up a clear pathway in terms of identifying these patients and initial treatments which will be circulated widely and the next step for those patients who do not respond to the initial treatment regimes is plasma exchange. Due to the fact that this is a second line treatment this allows a little more time to plan. The Haematology team are putting together the additional appendix outlining the roles and responsibilities which will be circulated as quickly as possible. We are pulling together a day rota for 7 days a week. Anything required out of hours would need to be decided on an individual patient basis. As this is an issue which has evolved over a short period of time we are unsure of what the timeframes are so we are looking to a short-term solution and then move forward to develop a wider service. A decision is needed as to whether this should be a South Wales or an All Wales Service. There have been some similar initiatives in England recently looking at centralising services, Claire is speaking to someone next week who has been involved in this and after this conversation, the intention is to scope out exactly what we have, what is needed and what the demands are, at present we fit the service to what we can supply at the time as opposed to identifying what best practice is, what the evidence tells us and what we need to deliver. We then need to meet with all stakeholders to decide what it needed to provide a robust service which supports all areas. After the initial discussions Claire will put together a series of meetings with the various stakeholders and look at how the service can be mapped out, but in the short-term we are going to have to monitor the VITT process. KW reported that Ed Massey, Deputy Medical Director of the Blood Service has contacted him to explore whether the Blood Service could be part of the solution to this problem. CMain added that she too had spoken to Ed who had provided her with the details of useful contacts who Claire would be contacting in due course.	
6.1	<u>Next Meeting</u> Friday 25 June 2021 8am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 25 June 2021
Teams Meeting
MINUTES

In Attendance:

Claire Main (CMain), Interim Director of Nursing, Specialist Services Board
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Tracy Johnson (TJ), Patient Safety
Keith Wilson (KW), Consultant, Haematology
Sharon Daniels (SD), Directorate Support Manager Nephrology & Transplant
Alannah Foote (AF), Directorate Support Manager Nephrology & Transplant
Claire Mahoney (CM), CNS Infection Prevention & Control
Dan Jones (DJ), Deputy General Manager, Critical Care & MTC
Judith Burnett (JB), Senior Nurse, Critical Care
Beverley Oughton (BO), Senior Nurse, Cardiac Services
Jonathan Elias (JE), Senior Nurse, Critical Care
Joanne Bagshawe (JB), Senior Nurse, Haematology
Jenny Labaton (JL), Interim Senior Nurse, Haematology
Caroline Burford (CB), Consultant in Critical Care
Sian Williams (SW), Senior Nurse, Cardiac Services
Angela Jones (AJ), Senior Nurse, Resuscitation
Aled Lewis (AL), Consultant Nephrologist
Kevin Nicholls (KN), Service Manager Cardiac Services
Suzie Cheesman (SC), QSE Facilitator
Emma Swales (ES), Senior Nurse, Nephrology and Transplant
Gareth Jenkins (GJ), Service Manager, Haematology
Bryony Roberts (BR), Lead Nurse, MTC
Tom Holmes (TH), Clinical Director, Critical Care

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting.	
1.2	Apologies for absence Received from Ceri Phillips, Rachel Barry, Ravi Nannapaneni, Colin Gibson, Hywel Roberts, Sarah Lloyd	
1.3	To review the Minutes of the previous meeting 4 June 2021 The minutes were agreed as an accurate record. Matters Arising • Plasma Exchange Rota, CMain will update later in the meeting	
1.4	Patient Story CMain introduced Holly Jenkins, Clinical Scientist, EAT Service. Holly gave a presentation introducing the work undertaken by the EAT Service. CMain thanked Holly for her presentation.	

2.1	Open Serious Incidents TJ updated the group. There are currently 5 open SI's all well-advanced with no issues to report, it is anticipated that 2 of these will be closed this month. There are no potential SI's. CMain thanked all in the team for timely actions with these cases. Open Inquests SC updated the group that the date for the inquest on LP, Inquest ID 3754 will be held on 3 August 2021 and there have been 3 witnesses called. CB asked if TJ was aware of the outcome of the Stage 2 review of the case mentioned in the last meeting of the Enoximone under-dose. TJ confirmed that she had received all the feedback on this.	
2.2	Alerts/Patient Safety Notices The following notices have been disseminated to the Group, nothing further to discuss. • Internal Safety Notice Ref 2021/Jun/012 Communication of Clinical details for the BT Laboratory • CEM//CPhA/2021/16 Recall of Co-codamol 30/500 Effervescent Tablets • Internal Safety Notice Ref 2021/ Jun/015 VRIII Fluids UPDATED • Internal Safety Notice Ref 2021/Jun/016 Unsecured Medical Gas Cylinders • CPhO/MedsLet/2021/16 Disruption to the supply of Verteporfin (Visudyne) 15mg powder for solution for infusion – Update • CPhO/MedsLet/2021/17 Disruption to the supply of Dalacin (clindamycin) 2% vaginal cream • Internal Safety Notice Ref 2021/Jun/014 Esketamine withdrawal from C&V UHB	
2.3	Closure Forms There were no closure forms to report on this meeting	
2.4	Healthcare Associated Infections • Specialist IP&C Report June 21 CM informed the Group of the improved position with the Healthcare Associated Infections compared to last year.	

ACTION	CM reported that there have been no further MDRO positive results on West 8 since March 2021, but unfortunately since screening began on West 10 there have been 2 further positive results, screening will continue for the next 4 weeks and regular meetings held. CMain informed the Group that Jen Proctor as IP&C lead for the Clinical Board, is currently in the process of setting up IP&C meetings with the Directorates. CMain asked that each Directorate confirm their IP&C leads in order to ensure that the correct people are involved from the outset. BO reported that a member of staff who is a Covid positive contact had been informed by RCT if the infection was the new variant then contacts must isolate for 14 days. BO had tried unsuccessfully to confirm this information with C&V Occupational Health Department, the member of staff is also waiting for T&T to confirm the strain of Covid. BO asked if others had any information regarding this new isolation guidance. CMain said that she had also heard similar from Cwm Taf but nothing official. BO will try to contact Occupational Health today and update CMain on their advice. CB asked whether CM had any feedback regarding Covid related deaths which have been escalated to Carla, CM replied that she had not received any feedback to date. CMain said that Carla is leading on the work associated with Covid related deaths and that with the volume of work going through it's likely to take some time to work through all the information. A team is being put together to undertake this work and it would be good to invite Carla to a future QS&E meeting to provide an update. SC added that there are 50 full reviews being undertaken and 400 rapid reviews and they are still in the process of recruiting additional staff to help deal with the volume of work.	**All** **BO/CMain**
3.1	<u>Feedback from UHB QSE Committee</u> SC reported that the QSE Committee met this month but there are no papers issued to date.	
3.2	<u>Mortality Review</u> CB said that given the changes made recently this would be a good opportunity to give an overview of the process. Stage 1 Mortality Reviews, also known as Universal Mortality Forms, (recently circulated) are completed, at the same time as the rest of the bereavement paperwork, by one of the Juniors on the Team looking after the patient, questions on the back of the form trigger a potential Stage 2. These forms are logged by the Audit Department who have an electronic audit tool (EMAT) which allows data gathering, through EMAT a Stage 2 request is sent to the departmental dedicated Clinician, usually the Q&S lead. The usual conversion rate of Stage 1 to Stage 2 is around 10%, the data obtained from EMAT this week suggests that there are a couple of departments within Specialist Services that haven't triggered any Stage 2 reviews at all, Haematology and Nephrology & Transplant, so it may be worth looking at what's happening within those departments. Previous conversations with KW regarding Haematology is that a lot of their cases are reviewed by their own system, however we need to ensure that, whatever system each department has, it reflects what the HB is trying to achieve with regards to Mortality Governance. CB reported that within Cardio-thoracic the conversion rate is less than 5% so there maybe a little work required in that area too.	

ACTION	The completed forms should be returned to Joy Whitlock and Ann Jones, the contact details for both are held within the form, they will be monitoring the forms at a HB level. The HB expectation is that the outcomes of Stage 2 will sit within the CB's. CB suggested that a copy of the Stage 2 forms is sent to Richard Parry in order for Richard to keep track of everything that needs to take place and that this point is kept as a standing agenda item. Stage 2 reviews are part of the PTR process and the Gold Standard from the HB requires that these are completed within 30 working days from request. CMain suggested that she, CB, SC, TJ and RP remain on the call after the meeting to discuss processes going forward. KW outlined the current process within Haematology and asked that a copy of the forms be resent. KW suggested that he and CB meet outside this meeting to discuss the way forward. CMain replied that she and CB would discuss the best way forward and disseminate this information in due course.	**CMain/ CB**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> KW reported on the intended closure of the Transplant Unit in order to clean the air controls ducting, he has been informed that the process will require 21 non over-lapping days to carry out the work, and if extra time is built in to allow for any problems and to take into account the time needed to discharge of patients the length of closure would be approximately 6 to 8 weeks which we cannot afford to do from a risk point of view. His intention is to prepare an SBAR to enquire on the possibility of using the 10 cubicle HCID unit as a decant for the closure of the Haematology Transplant Unit. News of a potential 3rd Wave has thrown some uncertainty on the timing of these plans and there is a possibility that plans will need to be deferred until after the winter closure, however he will proceed with the SBAR. <u>Critical Care</u> No issues to report. <u>ALAS</u> No issues to report. <u>Neurosciences</u> No issues to report. <u>Nephrology and Transplant</u> AL will meet outside of this meeting to discuss Mortality Reviews with CMain and CB. Nothing else to report. <u>Cardiac</u> Nothing to report	

ACTION	Pharmacy SG reported on the difficulties of providing medicines to patients at Rookwood now that Security and Portering have been stepped down at the site. CMain will catch up with the Team to look at resolving this problem Major Trauma Nothing to report Plasma Exchange CMain advised that there is still an ad-hoc provision of the Plasma Exchange service particularly focussing on ViTT patients and TP patients. Claire is meeting with some of the teams next week to look at funding of the interim period providing an emergency rota with a view to meeting each of the directorates involved to pulling a wider stakeholder meeting to put together a case to WHSCC in terms of supporting a service formally and having a plasma exchange service that's robust and deliverable.	**CMain** **CMain**
4.1	ARK-Antibiotic Review kit initiative For information only.	
4.2	WHSCC Publications For information only.	
4.3	Dressings Ordering Update – Oracle Training For information only.	
5.1	Any Urgent Business SC asked if Patient Safety could be invited to any future meetings regarding the MDRO on West 8 and West 10as WHSCC also ask them for information	
6.1	Next Meeting Friday 16 July 2021 8am via 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 9TH JUNE 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Alun Roderick	Laboratory Service Manager, Haematology
Kim Atkinson	Acting Head of OT
Suzie Cheesman	Patient Safety Facilitator
Jonathan Davies	Health and Safety Adviser
Maria Jones	Sister, Outpatients
Nia Came	Head of Adult Speech and Language Therapy
Robert Bracchi	Medical Advisor to AWTTC
Jo Fleming	Quality and Safety Lead, Radiology
Bolette Jones	Head of Media Resources
Judyth Jenkins	Head of Dietetics
Jacqueline Sharp	Acting Head of Physiotherapy (for Emma Cooke)
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Paul Williams	Clinical Scientist, Medical Physics
Mathew King	ADOTH/Head of Podiatry
Sian Jones	Operational Service Manager
Seetal Sall	Point of Care Testing Manager
Nigel Roberts	Laboratory Service Manager, Biochemistry
Scott Gable	Laboratory Service Manage, Cellular Pathology
Tim Banner	Outpatients Manager, Pharmacy

Apologies:

Sandeep Hemmadi	Clinical Board Director
Lesley Harris	Professional Head of Radiography UHL
Louise Long	Public Health Wales Microbiology

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/178 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 21/179 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/180 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 12th May 2021 were **APPROVED.**

CDTQSE 21/181 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 21/116 Data Quality Meeting

It was noted that the first meeting of the UHB Data Quality Group has not yet been held. A new UHB Data Quality Policy is being developed. When this has been drafted a meeting will be arranged.

CDTQSE 21/134 Paediatric Metabolic Risk Assessment

Judyth Jenkins to review the risk assessment and revise the score.

Action: Judyth Jenkins

CDTQSE 21/155 Opportunities for R&D

Seetal Sall to meet with Rhys Morris to discuss opportunities around R&D in Point of Care Testing.

Action: Seetal Sal

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/182 Patient Story – Pharmacy

Alana Adams presented a patient's experience relating to the Covid Vaccination Programme at the early stages of the pandemic and the lessons that have been learned following this experience.

Pfizer was the vaccine of choice at that time. A citizen arrived at a vaccination centre but was turned away as they had a complicated allergy history. They were informed that they would be issued an appointment at UHL in a special supervised clinic.

A week later they telephoned as they had been to their GP not having been notified of an appointment data and their GP had refused to undertake the vaccination and advised that they call the designated number. At this early stage of the pandemic there were a number of routes to call and the individual returned to their GP dissatisfied that they had still been unable to progress in making an appointment.

A further week later they received notification of an appointment at UHL. However they had no transport available to them and was not willing to use public transport as they were shielding. They asked if the UHB could organise transport form them but this could not be organised. The individual became very frustrated to the point where she was ready to give up trying to arrange a vaccination and submitted a concern to the Concerns Team. A time period lapsed as nothing could be done from the Health Board's perspective to arrange transport however they eventually received their vaccination at UHL. This was a similar situation for a number of citizens.

There is now much better engagement and communication with vaccination centres and these issues can now be resolved more easily. Also home visits can now be organised for housebound citizens although those with allergies need to receive their vaccinations in an appropriate setting.

CDTQSE 21/183 Feedback from UHB QSE Committee

The minute from the previous meeting in April are not yet available.

CDTQSE 21/184 Health and Care Standards

No update to report.

CDTQSE 21/185 Risk Register

The Clinical Board risk register is due for submission to the corporate team.

CDTQSE 21/186 Exception Reports

Nigel Roberts reported that a fire inspection was held in Biochemistry UHL. Recommendations were issued relating to waste that needs to be cleared.

There was an issue this week with the LIMS system where results from 13th April did not get transferred to the Welsh Clinical Portal (WCP). They were transferred on 24th and 27th May therefore Cardiff and Vale had to review over 300 results to identify if there were any risks. Results to CAV portal and Primary Care were unaffected. There was one result which was of concern which is being looked into. There are no issues of concern from Haematology currently identified.

Matt Temby asked if further safety nets can be put in place by Digital Health and Care Wales (DHCW formerly NWIS). Sue Bailey discussed the issue with the Patient Safety Team earlier today. The results were resent to WCP but there is no process for checking by DHCW. Sue Bailey is also concerned at the mechanisms in place for alerting Health Boards of the issue and assurance is needed that a process can be put in place to identify issues earlier. Suzie Cheesman suggested emails and alerts from DHCW are sent to the Patient Safety inbox which is regularly accessed rather than to named individuals in the Patient Safety Team.

Jo Fleming advised that the risk assessment is being updated relating to the issue of damaged radiology records in storage.

She also raised a potential issue with funding for 6th year of Interventional radiologist training. The department is seeking clarity from the Academy as there are 4 registrars that are specialising in Interventional Radiology. The issue has been risk assessed.

It was noted that the fridge and air conditioning breakdown in Pharmacy is not yet resolved. Matt Temby will ask Estates to contact him urgently.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/187 Initiatives to Promote Health and Wellbeing of Patients and Staff

Sue Bailey noted that Maria Jones will be retiring in July and the Clinical Board will need to identify a new Flu Champion. Sue Bailey thanked Maria Jones for all her hard work and efforts over the past few years in taking forward successful flu campaigns.

Sian Jones provided an update on the Afta Thought video. The video is currently being edited by Cardiff Council to include Welsh subtitles.

SAFE CARE

CDT QSE 21/188 Concerns and Compliments Report

In May 2021, the Clinical Board is reporting a Red status. The Clinical Board received 18 concerns and it reported 1 breach in response times. 17% of concerns were resolved within early resolution timeframes and 5 compliments were received.

Speech and Language Therapy reported a Green status. It received 0 concerns and 1 compliment.

Physiotherapy received 4 concerns however 25% were managed through early informal resolution.

Outpatients and Patient Administration received 3 concerns and managed 33% within early resolution timeframes.

Radiology is reporting a Red status. The department received 6 concerns and there was 1 breach in response times. However, 17% of the concerns were resolved informally and it also received 1 compliment.

There was no particular theme identified for the formal concerns this month.

CDTQSE 21/189 Ombudsman Reports

Nothing to report.

CDTQSE 21/190 RCA/Improvement Plans for Serious Complaints

Ref CN/LLAN/3612 – Learning from Event

This event relates to learning from a clinical negligence claim involving a patient with a long history of ankle pain and trauma. In April 2015 the patient's ankle worsened and he was referred to Orthopaedics where it was decided he should have a distal tibial osteotomy and lateral ligament reconstruction to his ankle. This was very much prophylactic surgery to prevent future ankle anthrodesis (fusion).

On 7th December 2015 a left ankle osteotomy was performed. He was reviewed in clinic on 15th January 2016. On 27th January 2016 the patient attended A&E with a swollen leg where he received a diagnosis of cellulitis of the left lower leg. He received a course of antibiotics and was discharged. The patient attended an Orthopaedic Review clinic on 26th February and it was discovered that the plate fixation and the screws in the ankle had failed. An x-ray performed on 4th March 2016 identified that both plate screws had also broken.

On 12th August 2016 the patient was reviewed again in the Orthopaedic foot and ankle clinic and he was referred for an urgent CT scan and referral to physiotherapy. A referral was also made to the smoking cessation service.

A letter dated 23rd February 2017 to the patient's GP advised that the patient has not attended clinic and a further letter dated 10th March 2017 was sent to the GP advising that the patient did not attend clinic.

The patient was seen on 3rd August 2017 and it was noted that his ankle was unlikely to heal at this stage. He was placed on a waiting list for further surgery and advised to stop smoking to give surgery its best possible chance of success. The patient continued to experience pain and discomfort and on 15th November 2017 he underwent a left ankle osteotomy. He was reviewed on 29th December 2017 with a plan to review him again in 4 weeks' time.

The patient was reviewed on 26th January 2018 and there was no evidence of bone union. The patient was reviewed again 3rd August 2018 and 26th October 2018 where it was noted that he may benefit from an ankle infusion. On 15th February 2019, the patient was reviewed by a Podiatrist and offered the patient and arthrodesis.

The negligence claim alleged that there was a failure to arrange follow up after the appointment on 4th March 2016 after it was observed that the fixation plate screws had broken.

A review was undertaken of the patient's appointments and it was noted that

On 20th January 2017, the patient's appointment was cancelled 30 minutes prior to the appointment with no further appointment made.

7th February 2017, the patient went to see his GP who referred him back.

23rd February 2017, the patient DNA'd, and arrangement was to be made for an urgent outpatient appointment.

7th July 2017, the clinic appointment was cancelled.

The Trauma and Orthopaedics department were unable to establish why the appointments were cancelled.

It was reported that over the last five years, work and improvements have been undertaken which will help prevent further similar events from reoccurring:

The UHB Follow up Group was established to manage patients in the follow up appointment system for acute patients.

Significant work has been undertaken on the PMS system for follow up patients.

Outcomes are recorded electronically to ensure that clinical decisions are better captured and support appointments being made.

More recently there has been the establishment of the Outpatients Transformation Board and the delivery of a patient facing communications programme to ensure there is active engagement with patients.

A choose and book option has been implemented.

A validation exercise is being undertaken linked to new Outpatient acute appointments to ensure that patients are continually engaged with to check they still require an appointment.

The Health Board is also looking at introducing an electronic patient record that will allow patients to see their appointments.

The Health Records department is embarking on an additional appointment query form which will particularly benefit patients with sensory loss and hearing difficulties as they will be enabled to engage through a survey. This will be trialled internally before being piloted in Orthopaedics.

CDTQSE 21/191 Patient Safety Incidents

SI Report

There are 2 Open SIs:

In122136 relates to a case in pacing theatre. The RCA is complete and has been circulated for any final comments.

In92837 relates to a neuroradiology patient and delays to treatment. This incident involves a number of services across Clinical Boards. The action plan has been finalised and progressing to the point of closure.

CDTQSE 21/192 New SI's

There are no new SIs to report.

It was noted that during the pandemic Welsh Government only required the reporting of specific incidents. From next Monday any issues relating to severe harm will need to be reported including avoidable pressure damage and any incidents of high impact that affect a large group of people. Welsh Government is implementing an updated policy for incidents, moving away from the terminology of SI and incidents will now be classed as national reportable patient safety incidents.

Previously any serious incidents needed to be reported within 24 hours. The reporting timeframe is now 7 days. Closure forms will no longer be submitted. A number of forms will now need to be submitted i.e. learning from events form, outcomes form and if an incident need not be reported there is the option to complete an incident stood down form.

A 60 day working day timeframe was previously in place to close an incident. The form now asks if Health Boards if they require a 30, 60, 90 or 120 days' timeframe. The Patient Safety Team will put processes in place relating to the new policy and communicate this to teams.

Suzie Cheesman will share a link to the policy.

Action: Suzie Cheesman

CDTQSE 21/193 RCA/Improvement Plans

Nothing to report.

CDTQSE 21/194 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 21/195 Regulation 28 Reports

Nothing to report.

CDTQSE 21/196 Patient Safety Alerts

ISN 2021 011 High Risk of Accident in MRI Suite

The alert was raised following an incident where an ODP attempted to take an oxygen cylinder into the MRI scanner room. Due to the strength of the magnetic field in the room this could have been catastrophic. There are a lot of risk assessments and checking procedures already in place and staff should be trained before they have access to the suite however the alert was raised for awareness. The key to addressing this risk is through awareness, education and training. Radiographers have also been reminded to monitor every individual entering the area.

PSN 057 Adrenal Crisis

This notice was shared for information.

CDTQSE 21/197 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 21/198 Medical Device Risks/Equipment and Diagnostic Systems

Edward Chapman referred to a safety alert which has been circulated on damage to medical device regulators. Integrated cylinders are the preferred option as they are not vulnerable to the type of damage described.

Nigel Roberts reported that communication is being prepared on changes to the urine collection system. Clear instructions will be provided for patients and Primary Care will have the information available in surgeries. Junior doctors will be trained on the new system when they commence in August. Maria Jones commented that patients in Outpatients will need assistance. There may also be cost implications for the department. Nigel Roberts will send Maria Jones the pack for her to look at.

Action: Nigel Roberts

CDTQSE 21/199 IP&C/Decontamination Issues

The UHB Decontamination Group was held last Friday and the issue was raised that equipment coming into Clinical Engineering for repair is not always cleaned. Clive Morgan is escalating the issue to the Office of Professional Leadership Meeting. ATP testing has been undertaken on equipment arriving in the department which proved that even a basic wipe down with a Clinell wipe demonstrated a significant difference.

The decision has been taken that Clinical Engineering will not accept equipment without a decontamination certificate and Datix reports will be submitted against any departments sending items to Clinical Engineering that are not cleaned. Items also coming to the department for disposal also need to be cleaned. Sue Bailey suggested the department produce an internal safety notice to circulate across services.

Action: Edward Chapman

CDTQSE 21/200 Point of Care Testing

Seetal Sall reported that the Point of Care Testing Team alongside Clinical Leads and Public Health will review devices used for Covid testing to put in place a strategy for the winter season.

CDTQSE 21/201 Key Patient Safety Risks

Safeguarding Update

Maria Jones noted that the focus of the Safeguarding Group is on a drive to improve training compliance as training had been suspended during the pandemic. Directorates were asked to review the compliance in their areas.

Action: Directorates

CDTQSE 21/202 Health and Safety Issues

Estates have addressed the concrete falling off the building onto the road outside Medical Physics and have made the building safe. An independent inspection is being taken forward to provide additional assurance that the building is safe.

Mathew King advised that there have been numerous leaks at the CRI affecting a number of services.

Work has not yet been undertaken to put in place the equipment procured to deal with the pigeons. Sue Bailey and Matt Temby will discuss outside of the meeting.

Action: Sue Bailey/Matt Temby

It has emerged that refurbished rooms in Podiatry had not been linked to the fire safety system despite sign off by the fire safety team. Nigel Roberts reported that a similar issue occurred in Biochemistry where their rooms were not linked to the fire system.

CDTQSE 21/203 Regulatory Compliance and Accreditation

Sue Bailey noted that there are no regulatory compliance issue to report and no regulation or accreditation visits are due.

CDTQSE 21/204 Policies, Procedures and Guidance

The following UHB Policies are out to consultation:

Falls Policy
Risk Management and Board Assurance Policy

EFFECTIVE CARE

CDTQSE 21/205 Clinical Audit

Nothing to report.

CDTQSE 21/206 Research and Development

Rhys Morris chaired his first meeting of the R&D Group. There is a drive for the Clinical Board to produce its own research and Rhys Morris is keen to identify the barriers preventing directorates from taking forward their own research.

CDTQSE 21/207 Service Improvement Initiatives

The Digital Department is focussed on the implementation of electronic test requesting (ETR) in the Emergency Unit.

There is 55% uptake with ETR across the Health Board. There is a plan that by 1st August for the majority of the Health Board to be paperless.

The GPETR programme is progressing. 31GP practices have received their pre-checks and training. Outstanding practices will be addressed over the coming months.

Sue Bailey asked will the benefits of ETR within this Clinical Board be demonstrable. Nigel Roberts stated the main difference is improvement in turnaround times and speed that clinicians receive their results back. Patient Safety will also be improved.

It was noted that in terms of the Laboratory Information System that is due to be implemented, a pre-requirement is ETR needs to be at 90%.

CDTQSE 21/208 NICE Guidance

Nothing to report.

CDTQSE 21/209 Information Governance/Data Quality

Most services transferred from Rookwood yesterday. All services need to ensure they do not leave any medical records on the decommissioned site. The Information Governance Team will be visiting the site to undertake checks.

DIGNIFIED CARE

CDTQSE 21/210 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans
Nothing to report.

CDTQSE 21/211 Initiatives to Improve Services for People with:

Dementia

No update to report.

Sensory Loss

Nothing to report.

CDTQSE 21/212 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 21/213 Equality and Diversity

Keithley Wilkinson and Alun Williams will be invited to attend the next meeting.

Action: Helen Jenkins

TIMELY CARE

CDTQSE 21/214 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 21/215 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Sion O'Keefe provided an update on waiting times. At the end of April 2021, the number of patients waiting 8 weeks or more for diagnostics and Radiology was 1730.

The May position is likely to remain static.

The number of patients waiting 14 weeks or more for Therapies was 229. Anticipating a slight deterioration in May.

CDTQSE 21/216 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 21/217 National User Experience Framework

National User Experience feedback is not currently being collated.

STAFF AND RESOURCES

CDTQSE 21/218 Staff Awards and Recognition

A large number of nominations have been submitted for the Clinical Board Staff Recognition Awards in July.

Dietetics has won an award for an article relating to critical care work.

CDTQSE 21/219 Monitoring of Mandatory Training and PADRs

Compliance against mandatory training and PADRs is being discussed at directorate performance reviews.

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

The following minutes were received:

Outpatients/Patient Administration and Medical Illustration QSE Minutes May 2021
Biochemistry Quality Minutes May 2021
Clinical Board R&D Group Minutes May 2021

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 23rd July 2021 at 1.30pm via Teams.

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
20 May 2021 14:30 – 16:00, via MS Teams

Attendees:
Aled Roberts, Clinical Board Director, MCB (Chair)
Geraldine Johnston, Director of Operations
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Angela Jones, Senior Nurse
Barbara Davies, Lead Nurse, Specialised Medicine
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Sally Gronow, Deputy General Manager, Integrated Medicine
Ceri Richards-Taylor, Lead Nurse, Integrated Medicine
Annie Burrin, Patient Safety and Quality
Gemma Taylor, Practice Development Nurse, Integrated Medicine
Sam Baker, Practice Development Nurse, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Frances Wilcox, Senior Nurse, Integrated Medicine
Natasha Whysall, Senior Nurse, Integrated Medicine
Elinor Gerrard, Senior Nurse, Integrated Medicine
Jane Murphy, Director of Nursing, UHL & Community Hospitals
Sarah Follows, General Manager, Acute & Emergency Medicine
Gill Spinola, Senior Nurse, Specialised Medicine
Maitrayee Choudhury, ST7
Craig Davies, Deputy Service Manager, Acute & Emergency Medicine
Lisa Waters, Senior Nurse, Acute & Emergency Medicine
Emma Keen, Service Manager, Integrated Medicine
Tracy Johnson, Patient Safety Facilitator
Nikola Creasey, Paediatric Consultant
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Rebecca Aylward, Director of Nursing, MCB Kath Prosser, Quality & Governance Lead, Medicine Jeff Turner, Consultant Gastroenterology, Specialised Medicine Lyndsey MacDonald, Consultant, Acute & Emergency Medicine Cath Morris, Senior Nurse, Acute & Emergency Medicine Sarah Cornes-Payne, Senior Nurse, Diabetes, Integrated Medicine Ceri Martin, Lead Nurse, Acute & Emergency Medicine Vicci Page, Deputy General Manager, Specialised Medicine Sam Barratt, Deputy General Manager, Integrated Medicine Ruth Cann, Senior Nurse, Integrated Medicine Manju Kalavala, Consultant, Dermatology, Specialised Medicine Iain Hardcastle, General Manager, Integrated Medicine Carol Evans Deputy Assistant Director Patient Safety and Quality.	

Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.0	**Minutes of the previous meeting** – received and accepted.	
1.1	**Maters arising** – none raised.	
1.2	**Patient Story** – Acute & Emergency Medicine A 2 year old girl, was brought to the Emergency Department (ED) front door by her parents who advised her head had been run over by a tractor. The child looked very unwell, was taken to resus and later taken to intensive care. She had significant face and scalp wounds, multiple rib fractures, liver lacerations, multi-trauma. The Trauma team was managed very quickly. During this trauma call, staff were alerted to another trauma coming in. There was discrepancy in opinion with imaging for the child (ED and Radiology had differing views), multi-disciplinary meeting hastily arranged with an agreed approach established. ED staff now have monthly meetings with Radiology. Some issues with timing of CT reports noted. Now working with theatres and surgical leads for children going direct to theatre from the ED. Summary: it was traumatic for front door staff and a de-briefing was arranged for staff to ensure they were OK following this major trauma call. Action points have been picked up and acted upon to support staff as required. The family sent a thank you to staff for the help they gave to their daughter, who made a good recovery. ED very aware of de-briefing, so after very traumatic events, it was felt that they do not really have the resource to have a proper programme for de-briefing staff regarding their wellness. Some psychology support could also be useful for de-briefing staff going forward.	
1.3	**Feedback from UHB QSE Committee** February 2021 Full minutes available on UHW Intranet page. For noting reference was made to some concerning trends around Stroke data, mainly around patients getting to the Stroke Unit within 4 hours which had reduced to 17%. This was due to be discussed in detail at a future clinical effectiveness meeting. It was acknowledged that the UHB performed better than other Health Boards and that it needed to recognise the impact of Covid-19 dictating the data and that the Stroke Team had been outreaching to other wards.	
1.4	**Directorate QSE minutes – exception reporting** Minutes received from Acute and Emergency Medicine	
1.5	**Risk Management Overview** There is a presentation in the meeting papers to inform risk register reviews.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.0	**Doctrina meaning learning; The quarterly newsletter of the Welsh Risk Pool's learning Advisory Panel** - for information and further sharing. Contains a relevant update on Prophylaxis.	
2.1	**Healthcare acquired Covid investigations update** Pursuing learning from Covid investigations so far, there are themes emerging and AR will request information on these from Carla English and will update at the next meeting. Welsh Government (WG) direction on Health Care acquired Covid is expected. A senior nurse has been released to support these investigations.	

	Action: AR will contact Carla English to find out about emerging themes.	AR
SAFE & CLINICALLY EFFECTIVE CARE		
3.0	**Serious Incidents update:** There are currently no SIs for closure. 4 open SIs – 3 of which are inquests with Her Majesties Coroner. - 3 catastrophic injurious injuries. - 1 delay in treatment. There is one other SI which sits corporately involving WAST delays.	
3.1	**Infection Prevention and Control update** 190 days since last MRSA 30 days since last MSSA 14 days since last *C difficile* 7 days since last E. *Coli* bacteraemia 19 days since last Pseudomonas bacteraemia 23 days since last Klebsiella bacteraemia. **Outbreaks** – none in April. No current outbreaks/incidents. **C4C scores** – all wards in MCB are compliant for 4 week period ending 10/5/21. Excellence shown with A1, CFU and EU showing 100%. A lot of areas are over 97%. Pseudomonas bacteraemia – achieved April goal 5 more *C difficile* than last year 1 more Staph Aureus bacteraemia 4 more E. *Coli* bacteraemia 3 more Klebsiella bacteraemia Achieved Klebsiella bacteraemia goal Staph Aureus has increased on previous year E. *Coli* bacteraemia reduced on previous year. *C difficile* increased on previous year which is deemed mainly secondary to the acuity of patients, particularly Covid and the requirement for anti-biotic therapy. **Audits** – PVC audits carried out over last 2 months, these are not satisfactory with compliance and have implications for IP&C. PVCs are not being reviewed on a daily basis. Work is ongoing across sites to improve compliance. **Covid -19** – numbers continue to decrease and now stepping back in line with national guidance regarding PPE, staff can now risk assess PPE in relation to the task being performed. Corporate statement to follow. Covid in community is significantly reduced. Over 2 million people have been vaccinated in Wales. Cardiff reported 2 cases of Covid yesterday. Note: during AGP cardiac response – level 2 PPE is still required. **RCAs** – 11 outstanding. **Raise awareness from learning following MSSA bactereamia** – a canula had been in situ for 8 days in gastro. A focused piece of work has been carried out and compliance improved. Action: BD will share an update on this with this group.	BD

3.2	**Point of Care Testing** - any actions required following circulation of information from POCT team **Issue with front door pregnancy testing** – information shared yesterday and this should be shared widely within the directorates. Action: AB to re-send information to AR and this will be re-circulated. **LSW** – not using point of care testing glucose meters, therefore, there is no record or trail of who did the BM. LSW was classed as temporary initially, however, it is still open. Action: AR to follow up with Seetal Sall regarding the LSW POCT issue.	 AB/ AR AR
3.3	**Medical devices/equipment issues** – none discussed.	
3.4	**Field Safety Notice: Ref: P3/FSCA/009 Sapimed Rectoscopes, Procoscopes and related devices supplied by P3 Medical Ltd** MCB do not use these, so not an issue for MCB. **ISN 2021/Feb/005 Fresenius Ported Giving Sets: Leakage of Cytotoxic Fluids** – read and check as appropriate. **ISN 2021/Apr/008 Blood Gas Syringes** AR has circulated this to clinical leads for a medical perspective. These are used in MCB – all to note. **ISN 2021/May/007 Ported Cannula Product recall** - read and check as appropriate. Action: AR to request KP re-circulate this notice - completed	 AR
3.5	**Combined Insulin prescription chart and updated glucose monitoring chart -** useful document that adds to the current insulin chart. Action: AR will arrange for this chart to be circulated to the group for comment and asking for these to be taken to Directorate meetings for comments. Comments to be returned to AR. **Catheter insertions** – discussion ensued regarding using the catheter bundle, which includes a sticker and a space to put the reason required. Catheter passport should be updated on the ward. Action: MC will forward GT and LW the update from Laura Rozier and Rhian for further information. All happy to look at the information from MC and reinforce the importance of using the bundle and passport.	 AR MC ALL
3.6	**Patient Safety Spring Newsletter** – for information and sharing.	
DIGNIFIED CARE		
4.0	**Lakeside Wing – Quality and Safety Inspection/action plan** Neither SB nor DP were at the meeting, therefore, this agenda item is to be carried over to the next meeting. Action: AR to request KP add this to the next agenda.	 AR/ KP
TIMELY CARE		
5.0	**Update on Emergency Medicine 4 and 12 hour performance** Attendances – in April just short of 11,000. 4 hour performance – 84.08% in April 2021. 12 hour breaches – 79 in April 2021, 13 in April 2020, 51 in 2019.	

	Lost WAST hours 12 requests in April, all accepted. 4 hour performance per HB – currently highest performing HB in Wales. 12 hour breach – lowest number of lost hours across Wales. Lost ambulance hours – lowest number of lost hours across Wales. Numbers are back to pre-Covid numbers, however, now operating in a very different footprint.	
5.1	**Update on RTT position** WSG – shows great resilience over the last year. Important that operational managers provide assurance to this group that there is a recovery action plan in place to address the long waits and focus on the 52 week waits. Operational teams meet with GJ every month. **Future reporting** Action: rather than providing a monthly report with figures, a trajectory is required to show improvement month on month and to demonstrate there is an impact on waiting lists in line with the recovery plan. **<u>Mitigating Actions regarding SM RTT Performance</u>** • Rolling validation programme. • Prioritising patients over 52 weeks/Urgent/USC. • Approved WLI Funding – initiate WLI's focusing on patients waiting over 52 weeks. • Strict referral acceptance. **IM RTT position:** 52 week breaches: 1 (they have an appointment next week) 36 week breach = 23 26 week breach = 53 Returning to face-to-face and also virtual appointments. Most 36+ waits relate to Clinical Pharmacology and Syncope. Looking at options to transform and have blended outpatient clinics. **Peer review plans** Action: Lead Nurses to capture directorate Peer Review Reports and look at how this group can be sited on the reports and the action plans. Angharad Oyler or Raj oversee these reports. Action: to be a future agenda item.	Specialised Medicine / Integrated Medicine Lead Nurses KP
INDIVIDUAL CARE		
6.0	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans. Read and share. Action: AR to contact KP to ask how recent the information was and whether it will continue given the PROMS/PREMS work and a new piece of software in preparation for use from the patient safety team and to enquire if KP has any further information. Staff advised these have not been received recently. Pre-Covid, paper copies were being done, however, a patient experience package is in the process of being purchased so that an electronic system can be used. Action: LW will follow up on where this is at present with the electronic system.	AR LW

6.1	**DTOCs** - Judith meeting with Caroline Bird. Targeted work is progressing.	
6.2	**Compliments** **Endoscopy** A patient gave thanks for the level of care received, from being greeted at reception to leaving the unit they were made to feel totally welcome and relaxed. This person was an experienced colonoscopy patient due to their genetic condition and had plenty of experiences to compare and this time around really stood out. Names they particularly mentioned were: • Scott (nurse) - a very pleasant nature who really listened and empathised. He took time to ask how the patient was as they moved through the unit, which was very much appreciated. • Paul (the nurse that put my canula in -think name was Paul) - extremely pleasant and always smiling, which just helped to ease any nerves. • Natalie (nurse) - was in the procedure room and had a perfect level of caring, humour, professionalism that helped make the procedure easier. • Dr Ramaraj - totally professional also created a 'welcoming' atmosphere in the room through her relationship with both myself and the two nurses in attendance. This is a real skill as so many times the patient had experienced very clinical & regimented environments that do not help when it comes to being at ease, for what is not the most pleasant of experiences. It was the least uncomfortable colonoscopy ever had. • The other nurse in the procedure room, whose name was possibly Melanie, also helped contribute to the top level of care received. The patient wanted their thanks passed to all the staff, who are a credit to themselves, the Unit and the hospital. **Emergency & Acute Medicine** This person presented to the Emergency Department with chest pain, which turned out to be a PE. They were seen by a nurse practitioner who progressed tests, diagnosis and treatment professionally, very efficiently and she was lovely. Every contact in the unit was dealt with by professional people who cared. The patient gave thanks for looking after them so well.	
6.3	**Safeguarding** – Action: AR to advise KP that Jane Salisbury is to be invited to give a safeguarding update at the next meeting.	AR
6.4	**Concerns update** Last couple of meetings have not taken place due to various reasons. Action: JM will update at next meeting.	JM
Staff and Resources		
7.0	**Staff well-being** Tired workforce at present, thanks to all and teams for supporting work, coming up with recovery plans and hopefully replenish workforce and work on re-setting approach for the coming years.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Electronic test requesting in ED** – well done to EU department for a job well done and a very good initiative for patient safety and quality of care. **Date and time of next meeting** – 17 June 2021 14:30 via MS Teams.	

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
17 June 2021 14:30 – 16:00, via MS Teams

Attendees:
Rebecca Aylward, Director of Nursing, MCB (Chair)
Kath Prosser, Quality & Governance Lead, Medicine
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Annie Burrin, Patient Safety Org Learning, Patient Safety & Quality Team
Tracy Johnson, Patient Safety Facilitator
Angela Jones, Resuscitation Senior Nurse
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Gemma Taylor, Practice Development Nurse, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Ceri Richards-Taylor, Lead Nurse, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Ruth Cann, Senior Nurse, Integrated Medicine
Frances Wilcox, Senior Nurse, Integrated Medicine
Natasha Whysall, Senior Nurse, Integrated Medicine
Elinor Gerrard, Senior Nurse, Integrated Medicine
Emma Keen, Service Manager, Integrated Medicine
Jacqui Westmoreland, Senior Nurse, Covid Investigations
Rhian Morse, Consultant Physician
Laura Rozier, ST7
Maitrayee Choudhury Consultant Physician
Bethan Price, Ward Sister, LSW
Tom Pembroke, Consultant Hepatologist
Tara Rees, Specialist Nurse, Hepatology
Siobhan Bird, Student Nurse, Patient Safety Team (guest)
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Aled Roberts, Clinical Board Director, MCB Geraldine Johnston, Director of Operations Jane Murphy, Director of Nursing, UHL & Community Hospitals Sarah Follows, General Manager, Acute & Emergency Medicine Ceri Martin, Lead Nurse, Acute & Emergency Medicine David Pitchforth, Lead Nurse, Integrated Medicine Gill Spinola, Senior Nurse, Specialised Medicine Sarah Cornes-Payne, Senior Nurse, Diabetes, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.0	A&E staff were unable to attend, therefore, the meeting was not quorate. **Minutes of the previous meeting** – received and accepted.	
1.1	**Maters arising**	

	Insulin Chart – comments received have been shared with AR. **Peer Review Plans** – On the agenda.	
1.2	**Patient Story** – Hepatology, Specialised Medicine. Presented by Tom Pembroke (TP) and Tara Rees (TR) A 59yr old patient well known to the liver clinic on a background of previous drug and alcohol misuse. He had been abstinent for some years. There was a previous history of self harm, and was well known to the Emergency Unit. The patient was generally chaotic in nature, but responded well to Liver Clinic staff. Over a period of a few months the patient began to develop pain, and a CT scan diagnosed a cancerous lesion. The patient was advised of the diagnosis during a Friday afternoon clinic, and contact was made by TP with the GP. The HCC service is not funded by WHSSC and a cancer specialist nurse is not attached to the service which would have supported this patient following his clinic attendance. Sadly, a week after receiving his cancer diagnosis the gentleman was found dead at home. His death would have been referred to Her Majesties Coroner, awaiting further directions. This case highlights concerns that the patient received a cancer diagnosis on a Friday with no ability to follow up with a cancer specialist nurse. A business case is currently being prepared to submit to WHSSC applying for funding. RA offered support if/as required.	
1.3	**Feedback from UHB QSE Committee** - no minutes available at present.	
1.4	**Directorate QSE minutes – exception reporting** Minutes have been received from Gastroenterology; Emergency Medicine. Clinical Gerontology minutes received will be shared at the next meeting.	
1.5	**Peer Review Plans** **Dermatology Review 2019** BD shared a Peer Review that had been undertaken in Dermatology. Cardiff & Vale developed an action plan as an outcome of the report and will be reviewed again in October 21. This will assist enabling good practice within Dermatology and gives an opportunity to bench mark against other centres. These reports should be reported corporately and BD has forwarded the report to Angharad Oyler for corporate reporting.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.0	**Healthcare acquired Covid investigations update**, presented by JW Investigating information/data from the 2nd wave. **Investigations outstanding/completed:** UHW 110 outstanding, 16 completed UHL 44 outstanding, 111 completed JW is setting up meetings to see what can be implemented from the learning, then a taskforce will be set up initially looking at quick wins. **Full reviews into deaths** – awaiting review by nursing teams/ clinicians. Noted that there is some duplication of work being undertaken. **Common Themes** – to date the investigation have highlighted communication, swabbing, and patient movement as common themes. The movement of patients has been a significant theme. **Risk assessment form for wards for patients** – chronic conditions increase the risks for patients, there is a need to ensure that patients are safe to transfer to other clinical areas. IPC advice is to move a patient at	ALL

	risk, but stressed the importance of undertaking a risk assessment and to document the risk in the multidisciplinary notes. **Action: contact JW if you would like to be part of the learning implementation group.** **Action: KP to add this item to future agendas.**	KP
2.1	**Staff feedback** KP read an extremely emotive and resonating letter from a Podiatrist who had been redeployed to work as a HCSW on a Covid Red ward during the second pandemic. This has been widely acknowledged across the Clinical Board and has highlighted that deployed staff may not have cared for patients in the way they were expected to, and the emotional, physical and psychological stress that this can cause. Widely recognised that going forward it is important to ensure that staff are upskilled if required in the future.	
2.2	**Catheter Bundle Audit 10 – 14 Nov 2020 on medical wards** Presented by Rhian Morse and Laura Rozier A recent audit carried out at UHW looked at patients with indwelling urinary catheters. This data was compared with a similar audit conducted in 2015. Data was collected from 28 patients over a 5 week period. Of these 14% had no insertion date, 14% had no catheter type documented, 7% patients had no plan for review documented at the time of insertion, 32% had a plan for review documented at a later date and 79% had a catheter bundle in place; 68% of which were fully completed. Longitudinal data was collected for 12 patients noting a trial without catheter (TWOC) was only undertaken for 6 patients. Of the patients who hadn't had a TWOX 50% of the notes did not clearly document why the catheter remained, 2 still had clinical indications for a catheter, 1 required a long term catheter (LTC). A third of the patients had catheter associated complications. It was noted that the documentation of the date of insertion and catheter type was good. The majority of the patients had a catheter bundle. Many patients did not have a plan to review TWOC at the time of insertion. A 33% complication rate was found when a catheter was in for more than 28 days. Dr RM expressed that catheter care is important as 50% of all hospital UTI's are associated with catheters, catheter associated urinary tract infections (CAUTI) are the commonest hospital acquired infection noting a 20% hospital associated bacteraemias associated with catheters. Alongside this it is important to note that this increases a patients falls and delirium risk, impairs recovery and mobilisation, recurrent UTI's post removal, incontinence, increased length of stay and cost. Every day counts, after 4j8 hours bacteriuria increases by 5% per day. In order to reduce the risk there needs to be strict indicators for catheter insertion, a rapid removal of unnecessary catheters and proper insertion/catheter care. Aim towards embedding in the system daily reviews of catheters and removal within 48 hours if possible. Moving forward a small working group is being established with the following approaches being explored: A potential catheter prescription, a potential flag on clinical workstation and education. DK expressed an interest in engaging with this group. AB would be happy for someone from Patient Safety and Quality to be invited to assist with this going forward.	

	Action: if anyone would like to join the working group, please contact Rhian Morse/Laura Rozier	ALL
SAFE & CLINICALLY EFFECTIVE CARE		
3.0	**Serious Incidents update:** Current open SI's: 1 Acute and Emergency Medicine. Pre-inquest review 18th June. 3 Integrated Medicine, all catastrophic falls with investigations ongoing. Two are subject to Her Majesties Coroners inquest.	
3.1	**Infection Prevention and Control update** 219 days since last MRSA bacteraemia (UHW C5) 58 days since last MSSA bacteraemia (UHW C5) 4 days since last *C difficile (UHW B7)* 12 days since last E. *Coli* bacteraemia (UHL E7) 47 days since last Pseudomonas bacteraemia (UHW C7) 20 days since last Klebsiella bacteraemia (UHW LSW2) **Outbreaks/ Incidents** – there are no current outbreaks or incidents. **C4C scores** – all wards within MCB were compliant for the 4-week period 17/05/21-07/06/21. Excellence shown by UHW C6 98.98% and E2 unit UHL 98.31% with most audited areas showing compliance over 97%. Most areas in EU continue to achieve 100%. • Only HCAI reduction goal achieved is Pseudomonas. • MCB position: C.*difficile. goal is 20 for the year and already have 9* (+66%) Staph Aureus bacteraemia (SAUR) (33%) E.*coli +5* (63%) Klebsiella sp, already had 5 and goal is 6. (+80%) Psuedomonas (0%) • Continued Bare Below Elbow (BBE) non-compliance on the wards. • Ongoing audit plan developed, audits will be extended to include CRO screening. • Please be aware that fans are not permitted in clinical areas. • Influenza remains below the threshold for base line activity at 0.5 per 100,000. • Confirmed COVID cases 18.3 CAVHB per 100,000 over 7-day period (15.6 last month). This is below the national average 22.2 (9.6 last month). 2,222,281 people vaccinated in wales (1,432,201 both doses). Cardiff had 19 cases yesterday (141 in wales). 6 Covid admissions this week. **Outstanding RCA's** – 3	
3.2	**Point of Care Testing** - any actions required following circulation of information from POCT team - no issues raised.	
3.3	**Medical devices/equipment issues** – none discussed.	
3.4	**PSN/ISN/MDA's** • MHRA Field Safety Notice (FSN) Ref: 2021/005/005/601/530 – Clinell Universal Wipes • ISN 2021 Jun 012 Blood Transfusion Special Requirements • ISN 2021 May 010 POCT Pregnancy Testing • ISN 2021 May 011 MRI accidents	

	• PSN057 Adrenal Crisis	
3.5	**Welsh Resuscitation PPE Forum May 2021** - no issues raised.	
3.6	**Falls Review Panel Infographics -** no issues raised.	
DIGNIFIED CARE		
4.0	**Lakeside Wing – Quality and Safety Inspection/action plan** Bethan Price (BP) presented a brief overview of LSW. Following a request for an internal quality inspection feedback was provided with an action plan implemented. Patients were complimentary of staff, patients were clean, comfortable and assisted to eat. Areas of improvement were noted which were around the workforce which predominately consisted of redeployed staff including Clinical Nurse Specialists. The difficulty in accurately keeping track of what training staff had received, and overall morale and leadership. Mental Health Matters and the Staff Well Being Service were invited to support staff, with initiatives such as 'shout out boards' being implemented and the support for staff to make self referrals if needed. The environment and layout of the unit whilst on the North side of LSW was not conducive for patients and staff. This has significantly improved since moving to the South side. It was also noted that there was a lack of equipment/engagement for patients, and following this an activities day room is available with support from physiotherapy, televisions available for patients. It was recognised that LSW was originally set up as a field hospital and a lot of staff had been redeployed from their substantive post which was extremely difficult for everyone. The Dietetic Support Workers have been noted as being a great benefit. **Action: if anyone could spare activity items for LSW please contact BP**	ALL
TIMELY CARE		
5.0	**MEAU attendance Standard Operating Procedure** CM was not present at the meeting so this will be carried forward to next month.	
5.1	**Incident Closure Guide** Info shared from patient safety team – share with teams across all areas.	
INDIVIDUAL CARE		
6.0	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans This is not being received.	
6.1	**DTOCs** – nothing received this month.	
6.2	**Compliments** **Integrated Medicine Stroke** The Stroke Association sent a link of a very positive patient story regarding a patien treated here in October 2020 which has been published in the New Statesman. The patient was thrombolised within 30 mins and he was in the Angiogram Suite ready for the thrombectomy within 60 mins. The patient presented	

	with a large left MCA clot secondary to AF. The patients NIHSS score was 23 on arrival and dropped down to 0 after the procedure with full recovery. The procedure was undertaken with the interventional staff in radiology. The patient was recruited into the OPTIMAS trial and was anticoagulated with a NOAC and discharged home within 2 days of arrival. The patient was later seen in clinic and continues to play golf. This is a great example of when the whole system worked perfectly well with an excellent outcome. A link to the article is below, regarding how artificial intelligence speeds up stroke care. https://www.newstatesman.com/spotlight/healthcare/2021/05/it-should-be-available-everywhere-how-thrombectomy-saved-gerald **Endoscopy** A patient wrote to staff at the Endoscopy Unit at UHL to express his thanks. In May 21 the patient had an endoscopy. The Doctor explained everything, and Carol, the nurse, reassured him through the procedure. Staff were kind. Prior to the endoscopy the patient was concerned about her husband's welfare as she was his carer and was relieved that she could receive treatment and medication and that it was nothing 'nastier'. Grateful thanks were given to Dr Jabu, Carol and Dawn.	
6.3	**Safeguarding** – no update.	
6.4	**Concerns update** – no update.	
6.5	**Ombudsman Report 202001144/BN/DT shared learning** A patient complained about treatment received at the Emergency Unit (UHW) when clinicians misdiagnosed an injury sustained to the left ankle following a fall. The patient complained that after reviewing an x-ray, an Emergency Nurse Practitioner (ENP), diagnosed and treated the injury as a Grade 2 sprain. However, an x-ray report, which has not been seen by EU clinicians until several days later, confirmed an un-displaced fracture to the tip of the lateral malleolus. The patient complained that is was several weeks before being informed of this diagnosis, and that during this time the pain and swelling increased to the point where a GP referred for a further x-ray which confirmed the fracture. The patient complained that recovery was delayed. The Ombudsman concluded that the x-ray evidence of the fracture was subtle and that is was not unreasonable that it was missed by the ENP. The Ombudsman also concluded that the treatment, recovery time and prognosis for this type of fracture sustained and for a Grade 2 sprain are the same. As such, there was no evidence that a misdiagnosis led to any adverse clinical consequence and the Ombudsman did not uphold the complaint that it led to the patients recovery being delayed. The Ombudsman did however find that the Health Board was slow to identify that a misdiagnosis had occurred and failed to ensure that the patient was informed of it. Whilst it wrote to the patient recommending a physiotherapy follow up, it did not inform of the reason for this, nor did it ensure that the physiotherapist was made aware of the diagnosis. The Ombudsman considered this communication failing was an injustice to the patient and reflected a failure of clinicians to observe their duty of candour. The Ombudsman also recommended the Health Board share the report with the relevant EU clinicians and conducts a review of its x-ray recall system; in particular the standards for radiology report review within the EU, the information given to patients and the content of recall letters where a misdiagnosis has occurred. The Ombudsman recommended that the Health Board provides the patient with an apology for these failings and make a payment of £250.	

	Since this incident there are QI projects being undertaken with Emergency Medicine to improve the process for Radiology review and the recall system. The Emergency Unit have recently moved to using a virtual PRA system through SharePoint that enables consultants and secretaries to collaborate over outstanding tasks and Radiology recall is part of this work. In addition, Paediatric Emergency Unit are progressing really well with a quality improvement project which is looking at electronic radiology report sign-off by the EU team. The early results are promising and involves collaborating with Radiology, Radiologists and IT.	
6.6	**LFE CN/UHW/3606 shared learning** Following the completion of an investigation and review of the multidisciplinary notes the UHB failed to provide adequate clinical/nursing care for a patient despite knowledge of the patients co-morbidities and high Waterlow score on admission, placing them at very high risk of developing pressure ulcers. In particular, adequate pressure relieving measures were either not in place, or not put in place in a timely manner, resulting in unstageable pressure damage. In this case, there was a lack of documentary evidence within the nursing notes detailing the measures in place to prevent pressure damage or deterioration of any existing damage. The nursing staff were clearly aware of the condition of the patients skin and their existing co-morbidities having assessed these upon admission, and having taken steps to roll and reposition the patient. Given the difficulty in defending pressure sore claims NWSSP advised the UHB make limited admission and that the UHB serve alongside the letter of response a Part 36 offer, up to a headline figure of £15,000. KP re-iterated the importance of accurate and timely pressure damage prevention including documentation and pressure relieving equipment in line with a patients individual needs based on risk assessments completed. **Action: RA will arrange for this to be discussed further at Professional Nursing Board.**	RA
Staff and Resources		
7.0	**Staff well-being** – ongoing	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	Annie Burrin had been advised that not much sensor equipment had been ordered/purchased. **Action: RA advised that MCB ordered equipment earlier this year and will send AB the details.** Falls training will be mandatory for staff. New resuscitation guidelines come into place on 5 July 21 in the HB. **Date and time of next meeting** – 15 July 2021 14:30 via MS Teams.	RA

MINUTES

PCIC Clinical Board
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Date and time: Wednesday 12th May 10.30 pm –12.30 pm
Venue: MS TEAMS

Attendees:
Gareth Hayes (Chair) Clinical Director, Clinical Governance
Rachel Armitage (RA) Quality and Safety Officer
Emma Cain (EC) CHAPS Lead Nurse
Suzie Cheesman (SC) Patient Safety Facilitator, PCIC
Richard Desir (RDE) Director of Nursing, PCIC
Helen Donovan (HD) Vale Locality Lead Nurse
Lisa Dunsford (LD) Director of Operations, PCIC (left early),
Helen Earland (HE) Clinical Operational Lead GP OOH
Stuart Egan (SE) Lead Health and Safety Trade Union Representative
Carole Evans (CEv) (item 8 only) Assistant Director, Patient Safety and Quality Team
Clare Evans (CE) Head of Primary Care (left at 11am)
Sarah Griffiths (SG) Head of Primary Care, Contracts
Judith Harrhy (JH) Assistant Head of Workforce
Kelly John (KJ) Staff Nurse, Emergency Unit (item 9 only)
Anna Kuczynska (AK) Community Director (left at 11am)
Karen May (KM) Head of Medicines Management
Robert Parr (RP) Organisational Development Manager, PCIC
Laura O'Connor (LO) Quality and Safety Officer
Vince Saunders (VS) Infection, Prevention and Control Nurse
Denise Shanahan (DS) Consultant Nurse
Rachel Thomas (RT) Locality Manager, South and East Locality
Lynne Topham (LT) Locality Manager, HMP Cardiff
Matt Williams (MW) Deputy Clinical Shift Lead, CAV24/7

Apologies:
Anna Mogie (AM), Deputy Director of Nursing
Diane Walker (DW) Deputy Director of Nursing

TITLE	ACTION
GH welcomed everyone to the meeting. Apologies were noted as above No declarations of interest were expressed. RDE notified the Group that this was GH's last meeting as he is retiring end of June. The Group imparted their gratitude and good luck messages to GH.	
The minutes of the meeting held on 10th March 2021 were approved as a true accurate reflection of the meeting.	
PCIC Quality & Safety Action Log The action log was updated. One action was closed: Staff flu vaccination update to be given at January QSE meeting. RDEs to share latest figures/reports.	RDEs

Safeguarding Flow Chart Presentation: Kelly John presented to the Group safeguarding flow charts that have been designed in CHAP. The Group approved the immediate usage of the Flow Charts.	
5 Year QSE Plan presentation: CEv presented the Quality, Safety and Patient Experience Framework for the next 5 years emphasising the focus on Learning from Incidents. CEv briefly outlined the following 8 categories imbedded into the Framework: Safety Culture. Leadership, Patient Experience, Patient Safety, Staff engagement, Data and Insight, Professionalism and Quality Governance. Slides of the presentation to be circulated with the minutes of this meeting. GH complemented CEv on the presentation. He expressed his wish for people to pay more attention to near misses as they were a good opportunity for learning, CEv agreed that near misses enables the Health Board to respond strongly and quickly, to a weak trigger. RDE spoke about a 1 year QSE Plan which is in draft which mirrors the above categories. A gap in Data and Insight was identified which RDE will explore further. RDE and Matt McCarthy to meet and discuss CAVQI projects. It was also highlighted that a multi-disciplinary approach may be an option to best suit the complexities within Primary Care. LT also expressed the wish to use this Framework in HMP Cardiff. RDE also shared with the Group the success of learning events which have taken place following incidents, which haven't gone through the SI Process but key learning has been identified and subsequently actioned. The Group noted the above.	CE/LO RDE
1 year QSE Plan In addition, to the update provided by RDEs within the 5 year QSE discussion, RA confirmed that all the Q1 Targets are on schedule and set to be met.	
Terms of Reference Review RDEs asked that the new revised TOR be circulated and all comments to be collated by LO for next meeting.	LO
Review of Risk Register – CE updated the Group on the new risk for the Risk Register: Contractors Reset Assessment Form. There is an expectation that primary care contractor services reset and recover their services in line with contractual regulation and Welsh Government direction. However a backlog and increased workload has	

significantly impacted all contractor professions and pose a significant sustainability risk in maintaining primary care services, managing increased demand, complexity of patients, meeting contractual obligations as well as a financial and workforce. CE informed everyone that two Practices have asked to close their list and one Merger is ongoing. Furthermore, currently there is one practice at level 4 and 4 practices are at level 3: sighting patient demand for the reason for this. A number of Dental Services have returned however capacity has been reduced due to aerosol generating procedures. Emergency dental care demand is high. CE recommended the new risk be scored 20 but will be reviewed on a monthly basis. It was agreed that the risk also be brought to the Senior Management Team's attention and go on the corporate risk register. **The Group approved of the new risk to be added.** RDEs highlighted the current high risks which are rated above 15. • GMS Sustainability • Service change capacity • Workforce GH asked for an update on the GMS COVID-19 contract changes and enhanced services and whether services have returned to normal? CE answered that many elements of the contract have re-started as of 1st April 2021. All Enhanced services will be re-instated by Q3. However, this will impact on the Demand and financial risk as these services require face to face appointments. CE is working with the sustainability team and looking at what mitigating actions they can put into place. 1. KM updated the Group on a new risk for approval: Sodium Valproate. KM briefly explained that there is a risk that women of child bearing age, taking sodium valproate, may become pregnant resulting in significant risk of birth defects and persistent neurodevelopmental disorders in their offspring. KM warned that the Epilepsy Team do not have capacity to see these women on a yearly basis. Therefore, compliance is low for reviewing patients and yearly risk assessments are not being completed despite prescribing continuing. A Clinical Working Group has been assigned to this task, Also a Pregnancy Prevention Plan is now in place and the Medicines Management Group are reviewing the option of a Multi-Disciplinary Approach, including what resources are needed and routes available to women who become pregnant on the drug. KM advised there have been 6 pregnancies in the last 2 years, so Welsh Government are also investigating this issue, starting in June. RA requested that the risk also be shared with Mental Health Clinical Board and Medicines Clinical Board. KM advised it's also held within Special Services. SC advised there have been numerous Serious Incident in this regard within Special Services. RA and SC to review DATIX incidents thereof. **The Group agreed to add to the risk register** The Group noted the above.	RA/SC

HCAI review VS confirmed that the end of March figures compared to the previous year were as follows: • CDIFF 7+ cases • MSSA +18 cases (increase seen throughout Health Board) • MRSA 0 difference in cases • E-Coli -45 cases • Aeruginosa -8 cases • Klebsiella +3 cases VS confirmed that the new targets for this Year (1 April 2021 to 31st March 2022) have not yet been published. RDEs instructed that an E-Coli audit take place in June to understand the sudden increases in E-Coli cases in March, The Group noted the above.	
PCIC Quality Dashboard RDE draw attention to the following: • Work is planned for Q1 designed for CavQI - Data and Insight. • There are currently 12 SI's within the clinical board however, a number of those are due to close. • Responses to Concerns within 30 days in Q1 has been excellent. January was 100%, February was 98% (31 cases, highest ever rate) and March is 91% (29 cases) • Medication incidents are being logged for improvement work, especially with HMP Cardiff. The Group noted the above.	
QSE report and Audit Schedule Update RDE advised that the majority of the key performance indicators are green. A year ago PCIC had the highest amount of open incidents, as of today PCIC have the lowest. RDE congratulated the business units for this. It was also noted the pressure damage scrutiny panels has been re-instated and are meeting weekly. RA advised that the QSE report previously captured patient experience but this was stopped due to COVID-19. The North West Locality have set up a monthly Group to discuss how best capture this again. Additionally, Mass Vaccination Centre are also starting to do this. SC reminded the Group that DATIX incidents need to be reviewed and closed, where appropriate, before the new DATIX system is implemented in July. Lastly, RDE informed the Group that the Senior Leadership Rounds are starting again and visiting each of the business units, starting with CHAP on 20/05/2021. The Group noted the above.	

HIW for mass immunisations RDE advised that an inspection took place at the Mass Vaccination Centres. A Full report has been sent to HIW and immediate assurances given. No further comments made.	
SI Closure Forms: CP provided the following update: JJ – Action plan signed off, await closure form. TB Outbreak – action plan reflects precautions in place for COVID-19. Due to be signed off and closed by CEv RP – updated care plan sent, Closure form with CEv AB – has been sent to welsh government. KM – Action plan drafted. Only In house learning to be actioned. DM – Action plan set for next HMP QSE. No PPO report yet RA advised that in KM, PPO commended the prison and advised the patients received the same care as they would in the community, which is a key benchmark. No further comments made.	
Patient Story MW read aloud an extract from a reflection written by one of our GP's regarding the care of a palliative patients. The Group discussed the key learning points including the use of language by healthcare professionals and the importance of clear and consistent messages across teams where there are multiple teams involved in patient care. AR recommended that District Nurses (DN) and GP's should visit patients together to aid care and prevent miscommunication between all parties. **MW to share the details of the visit so AR can share the experience with the DN's also.**	MW/AR
Safeguarding Update RA informed the Group with that the Clinical Governance Team are aware of following 20 cases involving the following: • 6 Dentists • 13 GMS Cases (6 of which are safeguarding) • 1 Optometrist No further comments made. The Group noted the above.	
Compliments All compliments were noted by the Group.	

Reset Community Update RP highlighted the following: • Sickness target is 4.3%, As of March = 5.61% • Turnover Rate target is 7-9%. Currently = 9.19% - • Statutory Mandatory training is below 60% - target is 85% • Appraisal rates and PADR compliance is very low. Non-medical staff PADR is 28% • 37 Full time equivalents have been redeployed from PCIC to MVC • 8 staff redeployed to cover the vacancies due to the above vacancies. • Staff will start to be called back to original posts, causing issues for MVC. • There are currently 80 admin vacancies and MVC will need to replace staff when they go back to their original posts. RDE wanted to recognise that some of the key performance indicators will be difficult to achieve considering the past year and the impact of COVID-19. In particular, Statutory Mandatory training target (85%) RP stressed how important Statutory Mandatory training, Appraisals and PAR's are for the Health Board and Staff and asked that every effort is made to complete them. SE agreed with RDE and warned that Staff's workload is already very high and mandatory training will only increase the pressure on them. He advocated for more recruitment to allow staff to complete additional training. JH informed the group that there are 37.4 Band 5 full time posts vacant which is19.72%. For Band 6 posts there are 46.98 full time posts (25.63%. Together, totalling 84.38 full time posts (22.6%). It was noted that these figures include Mass Vaccination Centre vacancies. JH also raised that the Health Board are not capturing why people are leaving and asked that managers encourage staff to conduct leaving questionnaire with staff. GH advised that GP Appraisals were suspended for 18months due to COVID-19 but have been reintroduced in a new format, focusing on Wellbeing. GH recommended this is also the focus when conducting PADR. The Group noted the above.	
<u>Primary Care Business Unit Reports</u> GP OOH Business Unit ➢ HD drew attention to the Odessey, decision support templates which was upgraded in February but there are still ongoing issues, including prioritisation of urgent over non-urgent calls. N&W Locality Business Unit ➢ No further update as no N&W representative was in attendance. Vale Locality Business Unit ➢ No further update to the report submitted. S&E Cardiff Business Unit	

➢ No further update to the report submitted. HMP Cardiff Business Unit ➢ No further update to the report submitted. Pharmacy and Medicines Management ➢ KM informed the group that the Pharmaceutical Needs Assessment was well received at the Strategy and Delivery Committee. It will now be circulated for further consultation for the next 60 days. ➢ Band 6 Tech has been recruited for. Palliative Care. AR notified the Group that: ➢ An All Wales DNA CPR Policy has been updated. ➢ An All Wales Syringe Driver Chart is being rolled out. ➢ A checklist for discharging patients with NG Tubes for Gastric Drainage has been created. ➢ A review is taking place looking at Palliative Care across the Welsh and English Boarder. MVC Report ➢ No further update to the report submitted. Primary Care Report ➢ SG advised the Group that there are two GMS list closure applications going to Panel. No further comments made. The Group noted the above.	
AOB: Next Meeting Wednesday 14th July 2021.	

MINUTES

PCIC Clinical Board
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Date and time: Wednesday 14th July 2pm- 4pm

Attendees:
Richard Desir (RDe) Director of Nursing **(Chair)**
Rachel Armitage (RA) Quality and Safety Manager, PCIC
Suzie Cheeseman (SC) Patient Safety Facilitator
Lynn Cronin (LC) Senior Nurse
Helen Earland (HE) GP OOH Clinical Operating Lead, PCIC
Nicola Evans (NE) Head of Workforce
Louise Halliday-Jones (LHJ) Assistant Head of Workforce
Chris Kelly (CK) Senior Nurse, CRI
Helen Kemp (HK) Clinical Director, Clinical Governance, PCIC
Vince Saunders (VS) Infection, Prevention and Control Nurse
Natasha Street (NS) Senior Nurse, South East Locality
Laura O'Connor (LO) Quality and Safety Officer **(minutes)**
Diane Walker (DW) Deputy Director of Nursing
Lisa Waters (LW) Senior Nurse for Quality and Education
Tracey Valade (TV) Senior Nurse, North West Locality

Apologies
Tanya Balch (TB) Lead Nurse, North West Locality
Lisa Dunsford (LD) Director of Operations
Stuart Egan (SE) Lead Health and Safety Representative
Anna Kuczynksa, Community Director, PCIC
Karen May (KM) Head of Medicines Management
Anna Mogie (AM) Deputy Director of Nursing
Carol Preece (CM), Lead Nurse, South and East Locality

ITEM NO.	TITLE	ACTION
1.	Welcome & Introductions Richard Desir welcomed everyone to the meeting. LHJ introduced herself to the group as the new Assistant Head of Workforce and the Group also welcomed LW, the new Senior Nurse for Quality and Education.	
2.	Apologies were noted as above	
3.	No declarations of interest were raised	
4.	The Group agreed to approve the Minutes of the meeting held on 12th May 2021 subject to the following amendments: • 3rd page: 3rd paragraph. The word generating to be added to read 'A number of Dental Services have returned however capacity has been reduced due to aerosol **generating** procedures'	

	• Page 3: New Risk: Sodium Valproate. The word **not** is added to read 'KM warned that the Epilepsy Team do not have capacity to see these women on a yearly basis' • Reset Community Update. Amendment to wording made. Now reads 'key performance indicators will be **difficult to achieve** considering..' • Page numbers were also added to the document	
5.	PCIC Quality & Safety Action Log Action was updated separately.	
6.1	CAV24/7 & OOH Business Report HE highlighted the following further to the report submitted. Sickness levels are rising and this has been reported to Senior Management Team (SMT). Nursing levels are currently 10.1%. The number of patients needing the emergency dental service (EDS) have risen so high that the service will continue to sit alongside the nursing triage until the end of August. Work has commenced to transfer the day time dental services to CAV24/7 services by September 2021. CE advised that capacity within EDS is a significant problem, with a huge backlog, so work is ongoing and a will be raised with SMT at the next meeting. It was also noted that the emergency dental services manager vacancy within CAV24/7 & OOH is going out to advert this week. Discussions with NHS 111 Wales have re-started as the Health Minister noted that Cardiff and Vale UHB are the only ones in Wales not to have NHS 111 Wales fully implemented. RDe queried how CAV24/7 and Out Of Hours (OOH) are managing the increasing number of phones calls from patients. HE confirmed that management staff are working shifts or logging on to triage patients, alongside their day jobs, to help ease the pressure. NE reassured the Group that the staff are being supported however staff morale is low and turnover has increased. The results of the staff survey highlighted training needs for some staff members so training is. **HE, NE and RDe to meet to discuss this and recruitment following this meeting.** RA warned the group to ensure the governance of any recruitment, i.e. the use of cluster paramedics as mentioned in the report or other staff groups are robust, as incidents have occurred previously which lead to a significant event. LO confirmed OOH did have 7 concerns at the start of the month, however only 2 are outstanding a formal response. LO verbalised that concerns regarding dignified care have risen. However, the volume of people accessing the service has also increased expeditiously and patient expectations have also increased. Patient's	RDe

	requests often do not full within the service's remit, which patients may not understand. DW asked HE to ensure that they have capacity to respond to concerns in a timely manner and if managing them becomes more difficult to escalate the concern to DW. **The group noted the above.**	
6.2	N&W Locality Business Report TV highlighted from the report that general sickness levels has increased; due to short term sickness and self-isolation due to COVID-19. Recruitment has taken place to replace staff retirement and movement in the District Nurse (DN) teams. There is also a Night Visitor position still vacant. TV advised that staff who remain redeployed to support Covid-19 testing/immunisation continues to impact on MDT working and on therapies resources. Discussions have been scheduled to discuss remodelling the CRT to aid this. Furthermore, end of life care caseloads have increased due to the services being stepped down during COVID-19. Lastly, there is one safeguarding concern which Tanya Balch is currently investigating. The group **noted** the above.	
6.3	Vale Locality Business Report No representative from the Vale was present at the meeting. No further comments made to the report circulated.	
6.4	S&E Locality Business Report NS gave a brief overview on DN's, emphasising that DN teams are operating at Level 3 with a high potential of elevating to Level 4. The reasons cited are vacancies, sickness; including staff members who are pregnant unable to be patient facing due to COVID-19 restrictions and a fairly new and inexperienced team. It was stressed all Locality DN teams are providing support to each other to help provide the service. NS also raised that avoidable pressure damage incidents have been sighted in the Locality recently. An action plan has been produced and learning implemented to improve on this. CK highlighted that there is a backlog of work in CHC and FNC assessors due to the restricted access during pandemic. **CK to provide RDe the total numbers involved and the timescales to clear the backlog.** There are also a number of disciplinary issues ongoing and one member of staff is facing a disciplinary panel following being disqualified from driving.	CK

	Lastly, CK also stressed the risk in relation to the erectile dysfunction and psychosexual services. It has been escalated to SMT, as the waiting list is mounting but there is no service to address this. RDe agreed with this notion as it was affecting approximately 200 patients. RDe felt that this risk be a collaborative risk with other Clinical Boards and dialogues will commence with Urology. RDe also confirmed that the SBAR presented to SMT as been escalated to the Executive Team. **The group noted the above.**	
	HMP Cardiff Business Report HMP update was included in the South East Locality Report as above. No further comments made.	
	Pharmacy and Medicines Management No representative from Pharmacy was present at the meeting. No further comments made to the report circulated.	
6.5 **6.6** **6.7**	Palliative Care AR gave a verbal update. AR apologised for not submitting a formal report for this meeting. AR informed the group that there will be a change to the syringe drivers, across the Health Board, from the T34 to Bodyguard T. AR reassured the group that this change will not affect the administration of the drugs. DW asked for clarity about the documentation relating to the roll out of the Syringe Driver. AR explained that all the supporting documentation has been approved however the All Wales Pharmacy Group need to approve the Chart, to begin roll out in September 2021. RDe asked that an implementation plan be presented at the next Nursing and Midwifery Board meeting. There has been in increase in daily referrals and the hospital team are short staffed, One Clinical Nurse Specialist (CNS) is on secondment, There is one vacancy which has proven difficult to recruit for. One CNS on short term sick, one CNS working under reasonable adjustments (reduced workload) and one registrar who is pregnant, so will not be patient facing after 28 weeks. The new SLA contracts for the City Hospice and Marie Curie are still under development. Marie Curie currently have two members of staff not working due to COVID-19 so visiting has been temporarily stopped. Version 11 of the Care Decision Guide has been agreed. This will be rolled out across the Health Board over the next month. Palliative Care Education has also been planned across the Health Board for the coming months. The group **noted** the above.	

6.8	Primary Care and MVC Report CE notified the group that there are 9 out of 60 practices operating at Level 3 or above which equates to approximately 80,000 patients. The Primary Care team are liaising with practices who have applied to close or have formally closed their list, citing sustainability issues. The two main risks on the risk register are Recovery and Reset and the backlogs which have grown due to services not fully operating over COVID-19. Community Dental Services are working at 30% capacity due to staff redeployment but the demand for these services has increased. Additional funding has been made available to work on schemes to help reduce these backlogs but the waiting list is approximately 1500 patients. CE confirmed that the risks have been added to the Primary Care and Clinical Board Risk Register and discussed in the relevant forums. Furthermore, CE declared that a public meeting has taken place regarding a new premises for Pentyrch residents. 200 residents were in attendance and the final report is now awaited. Lastly, CE advised shortlisting has begun for 3 apprentices who will spilt their time in the Primary Care Team and supporting a GP surgery. As well as a Consultant Practice Manager position currently being advertised to support GMS sustainability. The group noted the above. The group **noted** that a MVC Report was submitted. No further comments raised.	
7.	Patient Story – South & East Locality - Grade 3 pressure ulcer incident NS spoke to the Group about an incident which occurred in the South East Locality and the learning that was identified as a result. NS explained the key areas for improvement and the recommendations suggested including the importance of communication: for example the use of safety notices & visual cues, leaflets and phone apps. LW raised awareness about a Pre Hospital Communication App developed by Welsh Ambulance Service Transport to help communicate with patients including those with sensory loss. RA applauded the notion of developing different types of communication and asked that they be logged on the Patient Experience Quadrant. SC championed the process and the engagement of the staff throughout. DW seconded this and thanked all the staff involved for their professionalism and advocated that learning events such as this be rolled out across all localities. NE expressed an interest in seeing if the new ways of working adopted and a more holistic approach will benefit staff, patients and lower the occurrence of incidents in the future. NS remarked that the team have had a similar case since and it was undisputedly unavoidable damage.	

	LO asked NS if the family are aware of the investigation and the actions that has been implemented subsequently. SC advocated for involving the patients and being open and transparent. **RDe to discuss this further with the Quality Team.**	RDe/HK
8	Terms of Reference Review LO advised the group that there has been one further amendment since the Terms of Reference (TOR) was circulated. In the Member's section a Locality manager and lead nurse for each locality has been added. **The group approved of the changes and final version of the TOR** **LO to circulate the TOR again after this meeting to all members.**	LO
9	Risk Register Update RDe voiced that the risk register does not reflect the business reports submitted in agenda item 6. RDe asked that the Locality leads review this. DW emphasised the Workforce Risk. RA and DW both expressed concerns that the narrative does not accurately reflect the risk. **RA, DW and NE to meet to discuss this further**. The group also **noted** the Primary Care: Reset and Recovery risk and the Emergency Dental Service risk. RDe stressed the importance that all narratives and risks be reviewed to reflect the conversations held in this meeting. The group noted the above.	DW
10	HCAI review VS verbally updated the group with the following June 2021 figures: • E-coli: 21 new cases. Total 53 Cases. Various Locations • cDIFF: 2 new cases Saltmead Medical Centre and Butetown Medical Practice. 6 cases in total since April 2021. • MRSA: no new cases • MSSA: 4 new cases in Cyncoed, North Cardiff, Ely Bridge and Caraeu Lane. Total 12 cases • Aeruginosa. 1 new case in Birchgrove surgery • Klebsiella – 3 new cases in Cloughmore Medical Centre, Sully Surgery, Albany Road. Total 9 cases. DW raised the question why we are collecting these figures, as no action is being taken as a consequence. Also, the above are community acquired and the Health Board has little influence of their transmission, VS informed the group that previously RCA's were completed but this is no longer happening. Additionally, figures were cross-referenced with antibiotic usage as part of the medicines management incentive scheme however this also stopped. HK agreed with DW that the data needs to be used more constructively aligning with closely with anti-biotic prescribing. RA advised that RCA's were completed in the community previously, however it was stopped by the Infection, Prevention and Control Team as they felt no learning was being collected.	

	VS recommended that patients presenting with E-Coli or those who contract Klebsiella and have catheters are worth investigating further, and cross referencing with DN caseloads, as learning could be obtained relating to the management of catheters. DW agreed with this. **The group agreed that further discussions were needed on who best analysis the data to make it beneficial for PCIC**. DW and RD to meet to discuss this Moreover, VS updated the group on the latest COVID-19 figures. • C&V 212 new cases. Positivity rate is 12.6% • In all of Wales 7.6% VS referenced that lockdown measures were enforced previously if percentage was over 5% however due to death rates and hospital admissions are lower than in the second waves. COVID-19 measures, unlike in England who has significantly reduced their restrictions, are likely to remain the same or vary slightly. VS also enlightened the Group following discussions and studies on PPE and the use of Face Coverings. VS concluded that IPC recommend that FFP3 face masks and eye protection continue to be worn with all patients. This is also championed by the LMC and the latest Welsh Government's guidance which states that face coverings should be worn in health care settings. The group **noted** the above.	DW/RDe
11	PCIC Quality Report and Audit Schedule Update DW briefly explained that this report now incorporates previous agenda items which have been removed for this meeting and incorporates the healthcare standards. DW gave a summary of the RAG ratings for the key performance indicators taken from the June. There are currently 10 National Reportable Incidents, however DW advised there are only 4 active cases, in which work is still ongoing. DW emphasised the need to continue to close DATIX reports to support the new management system due soon but congratulated those involved as improvements have been made DW presented new data gathered on avoidable pressure damage between January 2021 and June 2021. Scrutiny panels are now in place for each locality and the data presented has been used to look at the impact of these panels and whether they have had a positive impact and reduced incidents. DW declared that in October 2020 when the scrutiny panels were first implemented there was 22 cases. In June 2021, there has been a significant decrease and there are currently 7 Cases. The group agreed that the target is 0 cases but this was a huge improvement and positive for the future and the use of scrutiny panels. DW highlighted from the report that South and East Locality had the most medication errors in April and May, however 9 of the medication errors were from HMP. It was noted that these errors have caused only minor or no harm to patients, however work is ongoing in relation to this and internal investigations are being carried out on all incidents.	

	RDe asked for clarification, following an inquest for HMP, it was found that there was no policy or standard operating procedure in place for opiate detox prescribing. DW clarified that there is a policy but this was not picked up in the PPO or HIW inspection. CK publicised that he wrote the policy which was approved by medicines management group. DW announced that a quality audit will be completed by the professional development nurses and they will focus on 2 District Nurse teams per locality. The audit is schedule to be finished at the end of July and DW will report back to the group accordingly. DW voiced her gladness that performance to achieve complaint responses within 30 days is still above the 80% target. DW recommended that we start scrutinizing Interface Incidents, reported by GP's, to prevent the same themes being reported. HK asked if the number of concerns is stable or varies. DW advised they have not altered significantly in the last 6months. **DW to share the figures with HK. The group agreed to include more detailed figures in the next meeting.** DW emphasised that there are currently 18 open safeguarding cases, which is a huge improvement on May (37 open cases). Waiting Lists are now going to be included in the report to understand how we are responding to our patient's needs. RDe also requested that Nurse Assessors, Dental and Emergency Dental Services data are included in the next report also. The group **noted** the above.	DW/LO
11 12	HMP Closure Forms was included in the above agenda. The group noted the Crisis SBAR included in the papers.	
13	On Call Redeployment Piece NE has requested accurate figures as the latest shows there are still 38.27 whole time equivalent redeployed from PCIC. 3 whole time equivalents have returned to Design to Smile and a request has been made to SMT to release back more Community Dental Staff. SMT will need to consider MVC modules and the COVID vaccination booster modules. Furthermore, self-isolation and COVID sickness is still prevalent and impacting on workforce. RDe stressed the importance of having an accurate picture and all the figures in relation to redeployment of staff and asked this be reviewed as a matter of urgency. The health board are reviewing vacancies and how that aligns with recovery and reset plans. NW warned that the Health Board may all be trying to recruit the same staff, with limited availability of said staff and we need to manage and mitigate for that. A workforce profiling has been planned to assess the staff's levels of fatigue and morale. **NE and DW to meet to discuss the Workforce risk on the Risk Register, as it continues to be rated 20.**	NE/DW

	NE also informed the group of 2 employment tribunals, one in the South and East and one in the Vale. DW raised a concern over staff currently redeployed due to pregnancy and the impact of this. NE and DW to discuss this separately. The group noted the above.	
	AOB The Once for Wales Implementation Group which was paused as now re-started, the next meeting is 23rd July. The Serious Incident reporting procedure has changed. We now have 7 days (from the date of the incident/knowledge of incident) to determine if an incident is reportable. Whereas this is longer than we previously had, we very rarely met these timeframes. Therefore Patient Safety Fact Finding tool has been devised to help guide this decision and help us meet this new timeframe. RA also explained that once reported, cases can be withdrawn which allows more control over the incidents. **The group agreed that Negligence Claims will be added to the next agenda and a representative to be invited to the next meeting.** The group discussed the SBAR for sCAMHS Crisis Team circulated with the papers. The SBAR proposed a one week reduction in the service delivery hours for crisis, reducing to 9am - 5pm for a period of 1 week. HK shared her views and identified this service as a high priority for review. The group agreed that reducing the working hours could prove risky due to the increase in demand in the service and the team need to consider the wider implications on other primary care providers and EU. RA advised that the impact is already been unearthed, as 2 GP's have expressed difficulties in referring patients after 5pm. HK advocated the need to support patients before the Crisis is needed as EU is not the appropriate process for them. HK also updated the group that HIW are currently undertaking a national review of crisis in all age groups but the final report is awaited. LO also advised that the LMC are also reviewing the referral criteria on a national scale also. **RDe agreed to feed the above comments back to Anna Kuczynksa**. **Lastly, the learning from the SI in Bellavista Nursing Home was circulated and noted by the Group**. The group noted the above.	RDe DW
	Next Meeting is Wednesday 8th September 2021.	

Report Title:	**Corporate Risk Register**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	15th September 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. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Since July's Board meeting, where an updated version of the Policy was agreed, the Register has only recorded those risks scoring 20 and above.

Each of these risks is linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to the Quality, Safety and Experience Committee are attached at Appendix A for further scrutiny and to provide assurance to the committee that relevant risks are being appropriately recorded, managed and escalated.

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

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since July the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue deliver a weekly Risk Management Training session (each Friday) and provide ongoing support and training to risk leads across the Health Board.

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

At the Health Board's July Board meeting a total of 9 (from a total of 12 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	20/25	25/25
CD&T		
Medicine	2	
PCIC		
Specialist Services	3	
Surgery		
Digital Health		
Estates	2	
Children and Women	1	
Mental Health	1	
Total: 9	**9**	

An update Register will be shared with the Board at its September 30th 2021 meeting.

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 continues to be rolled out by the Risk and Regulation Team 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 entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and	

						provide an environment where innovation thrives			
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		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 JULY 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			
Estates & Facilities	1	Mar-21	Risk/Issue: UHW Cardiac Theatre GF AGSS Pump is faulty Impact: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Sep-20	Quality, Safety & Experience Committee	Patient Safety
Estates & Facilities	2	Mar-21	Risk/Issue: UHW Tunnels corroded Main O2 Pipeline due to building leakage Impact: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	20	Regular inspection and maintenance.	5	4	20	Repair building leak and renew section's of corroded pipework.	5	1	5	Sep-20	Quality, Safety & Experience Committee	Patient Safety
Estates & Facilities	3	Mar-21	Risk/Issue: UHL Main Boiler F&E TANKS are badly corroded and require renewing Impact: Corrosion causing tanks to leak and loss of Heating throughout Hospital	5	4	20	No controls in place as cleaning tanks may result in leakage	5	4	20	Renew or reline tanks to prevent leaks.	5	1	5	Sep-20	Quality, Safety & Experience Committee	Patient Safety
	4	Jan-21	The loss of Gastroenterology bed base (UHL) and staffed amber capacity secondary to Covid-19 has led to the inabilty to admit patients with suspected/confirmed cancer for treatment. This has included patients requiring oesophageal stents due to inablity to swallow and maintain nutrition/hydration. The cancellation of elective procedures and the inablility to access an inpatient bed post procedure is causing harm to a patients treatment/palliation control.	5	5	25	Each patient must be discussed at local LCC and MCB Hub to review patient priorty for admission and bed allocation. MCB currently reviewing Covid admission processes to support cancer patients (pre-existing process prior to Covid included ring fenced protected beds)	5	4	20	Ongoing MCB and LCC oversight and planning.	5	3	15	Jul-21	Quality, Safety & Experience Committee	Patient Safety

Medicine CB	5	Mar-21	The Clinical Board has experienced a significant number of healthcare acquired Covid-19 outbreaks during both pandemics. It is currently unknown to what extent the level of harm that has been sustained for both patients and staff. The Clinical Board currently do not have an accurate oversight for the total number of patients who have acquired Covid-19, and those patients that have died. The Clinical Board are therefore unable to provide meaningful evidence that would support the UHB in the investigations required, and to understand any learning or themes.	4	5	20	The Quality and Governance Lead is currrently supporting all areas with the completion of the required Covid-19 Rapid Assessments and the accurate completion of Datix. These have been commenced in some areas, but not all. The Clinical Board is working with the UHB Covid-19 Investigating Lead to support information required for those patients that have died as a result of healthcare acquired Covid-19. Support from IP&C and Covid-19 outbreak meetings to ensure that accurate and timely information is obtained.	4	5	20	Appointment of a Senior Nurse for Covid-19 for a six month secondment to lead on the investigations for healthcare acquired Covid-19. To identify learning and themes. To review IP&C processess within clinical areas. To support the UHB in completing the required level of investigations to establish level of harm for both patients and staff.	4	3	12	Jul-21	Quality, Safety & Experience Committee	Patient Safety
	6	Jan-21	The ability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment is resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience.	5	5	25	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.Options to expand highter training post with Deanery. Medical training initiatives to support Middle Grade Gaps. Support from other Clinical Boards	5	4	20	Medical staffing reviewed as part of the daily LCC meetings with ongoing planning to ensure safe staffing.	4	4	16	Jul-21	Quality, Safety & Experience Committee	Patient Safety
Children & Womens CB	7	Pre-2010	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	4	5	20	1 lift replaced in 2020 however continues to break down regularly. There are no plans in place to replace further two women's unit lifts. The escalation policy advices utilisation of T2 lift and in the event of this not working C block lifts. C block lift would come within an increased transfer time and as such would increase the risk. A tertiary tower lift is available for emergency transfers however this has been identified as COVID specific.	4	5	20	Continue to escalate with clinical board / health and safety team and executives. Request regular updates from capital estates. Datix to be submiited with ANC as the lead for submitting these..	1	1	2	Jul-21	Quality, Safety & Experience Committee	Patient Safety

Specialist Services CB	10	Jan- 10	**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	1. Risk specific policies, protocols, and guidelines. 2. Cleaning schedules. 3. Installation of air pressure gauges outside BMT cublicles to measure air pressures - monitored daily. 3. Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green).4. HCAI monitored monthly. 5. Air pressure system validated by Estates Dept. 6. High C4C scores consistently achieved.	5	4	**20**	Escalated to Clinical Board, estates and WHSSC. There is an urgent need for a capital investment program and business case developed to address this need.	5	1	**5**		Quality, Safety & Experience Committee	Patient Safety
	12	Jul-20	**Critical Care - Facility Issues** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit resulting in an inability to manage airborne infection risk or regulate ambient temperatures. This exacerbates IP&C risks and compromises the care of patients where temperature is a critical concern. The well being of staff working in the environment is also compromised. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, phamaceutical storage, device storage and management hubs areas.	5	5	**25**	The clinical area is divided into zones to where patients are grouped according to IP&C risk to reduce the risk of cross-infection. Staff entering the clinical area are required to wear full PPE to reduce the risk of cross-infection.	5	4	**20**	There is an urgent need for a capital investment programme and business case development to address this need.	5	2	**10**	Jun-21	Quality, Safety & Experience Committee	Patient Safety

Report Title:	**National Patient Safety Incident reporting policy**	**Agenda Item no.**	**4.3**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	15th Sept 2021
Status:	**For Discussion**	**For Assurance**	**For Approval** **Y** **For Information**
Lead Executive:	**Executive Nurse Director**		
Report Author (Title):	**Tara Cardew (Head of Patient Safety)**		

Background and current situation:

From 14 June 2021, the way Health Boards report incidents to NHS Wales Delivery Unit (Welsh Government) has changed following publication of the NHS Wales National Incident Reporting policy – See Appendix 1. Historically, the focus of incident reporting at a national level has been to examine in detail specific Serious Incidents as set out NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations), primarily through the use of Root Cause Analysis.

The new National Patient Safety Incident Reporting Policy (the Policy, May 2021) aims to bring about a number of key changes to national incident reporting. It is anticipated there will be approximately 12 months of work to allow for adaptation and continuous development. The Policy will be implemented in two phases:

 individual reporting of the most serious incidents occurring in healthcare (**Phase 1**),

and

 Thematic reporting of healthcare incidents based on common factors regardless of the harm outcome (**Phase 2**).

To manage the transition, new national guidance document has been developed to support the practical application of the Policy, and will be continually updated throughout the development phase. (See Appendix 1 and 2).

This is a 2 phase approach, phase 1 as described above replaces the previous Serious Incident (SI) reporting process and is already established within Cardiff and Vale UHB.

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

A revised approach to National Patient Safety Incident reporting has been introduced in Wales. This replaces the traditional approach which was set out in the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations). The UHB has worked with colleagues in Welsh Government and the Delivery Unit in the development and implementation of the revised approach.

The current arrangements for the reporting of No Surprises to Welsh Government, remains unchanged but I under review.

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

The current definition of a nationally reportable incident is;

*A patient safety incident which caused or contributed to the **unexpected** or **avoidable death**, or **severe harm**, of one or more patients, staff or members of the public, during NHS funded healthcare.*

Never Events, in-patient suicides, maternal deaths, and avoidable healthcare acquired pressure damage and incidents affecting a significant number of patients will continue to be reported to the Delivery Unit (DU) immediately.

Where there is uncertainty as to the level of harm caused and whether there are causative factors related to their healthcare provision, all NHS Organisations now have 7 days to fact find and report to the DU.

In addition, phase 2, which is yet to be implemented, involves the thematic reporting of healthcare incidents based on common factors regardless of the harm outcome. The finer details surrounding this are yet to be released by the DU, however we know this will look at themes and trends relating to incident categories such as falls, pressure damage and medication errors.

This process is not hugely dissimilar to the previously well-established SI investigation and reporting process. Following reporting to the DU, the Clinical Boards, supported by the Patient Safety Team, will undertake a proportionate investigation, as determined at the Fact Finding meeting held by the Clinical Board, to establish whether any action or inaction, unintended or otherwise, caused or contributed to the reportable incident. The Patient Safety Team has developed local guidance to support Clinical Boards in the initial fact finding exercise.

The process has been implemented since 14th June 2021 and has been well received by the Clinical Boards. Information and advice was circulated to the Clinical Boards to advise of these changes and the Patient Safety Facilitators have been highlighting this at Clinical Board QSE meetings.

By having more ownership around the decision making for reporting timeframes, we should be better able to meet the designated timeframes for closure which has in the past been challenging.

It is not yet known what changes will occur from phase 2 thematic reporting and whether this will require additional work from clinical staff. It is however expected that this will provide really helpful intelligence on themes and trends to help support quality improvement initiatives.

The processs is sumamrised in the flowchart in Appendix 2.

Recommendation:

The QSE Committee is asked to NOTE the contents of this paper.

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	Y	7. Be a great place to work and learn	Y
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	Y
4. Offer services that deliver the population health our citizens are entitled to expect	Y	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	Y
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Y	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	Y

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

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.*

NHS Wales National Incident Reporting Policy

Implementation Guidance Document (Phase 1)

This policy does not apply to incidents of nosocomial

transmission of Covid-19 until further notice

Date to be reviewed:	6 September 2021	**No of pages:**	15
Document author & owner:	NHS Wales Delivery Unit Quality & Safety Team		
Contact email:	NationalSIreports@wales.nhs.uk		
Approved by:	NHS Wales Delivery Unit		
Date approved:	7 June 2021		
Effective date (live):	14 June 2021		
Version:	V1.0		

Contents

Introduction

National incident reporting in NHS Wales is changing. Historically, the focus of incident reporting at a national level has been to examine in detail specific Serious Incidents as set out NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations), primarily through the use of Root Cause Analysis.

The new National Patient Safety Incident Reporting Policy (the Policy, May 2021) aims to bring about a number of key changes to national incident reporting. It is anticipated there will be approximately 12 months of work to allow for adaptation and continuous development. The Policy will be implemented in two phases:

- individual reporting of the most serious incidents occurring in healthcare (**Phase 1**), and
- thematic reporting of healthcare incidents based on common factors regardless of the harm outcome (**Phase 2**).

To manage the transition, this new national guidance document has been developed to support the practical application of the Policy, and will be continually updated throughout the development phase.

Context

In 2021, we find ourselves in a changed healthcare system. The Covid-19 pandemic has challenged traditional organisational and service delivery structures, and re-emphasised the need for ongoing compassionate leadership. The introduction of the Once for Wales Concerns Management System will also help drive a shift towards consistent national incident reporting and better, more intelligent use of incident data. New conceptual approaches to patient safety, in particular the Safety-II approach, require us to think differently, and ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities. To achieve this, processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The first obvious change in policy direction is a change in terminology with the removal of the term ‘serious incident’ from the Policy. This change is not intended to undermine or divert attention away from the fact that some patient safety incidents can have a catastrophic impact on patients, families and our staff, and should in that regard be managed as ‘serious’ incidents. Instead, the removal of the term ‘serious’ is to support a more just and learning culture where reporting incidents does not feel punitive to staff or organisations.

Historically, national serious incident reporting systems have focussed on reporting incidents with significant harm outcomes. However, in many cases, the same set of circumstances can lead to incidents with a range of harm outcomes, including no harm. For example, an avoidable patient fall can result in anything from tenderness to significant fracture or head injury leading to death. Historic systems could therefore be said to be affected by outcome bias by only focusing on the worst outcomes. Looking at a range of incidents with different outcomes gives us a much broader data set to learn from, and to understand not only what went wrong, but to also start to understand what might have gone right to prevent significant harm outcomes, and how we can replicate those practices to improve quality and reduce risk.

The Policy represents a first step in this new approach to incident reporting and management. It recognises a one-size fits all approach does not work, and allows us to think differently about what

should be reported, how it should be reported, and how the collected data is best used to support policy and practice development to help improve quality and reduce risk. The Policy will empower NHS Wales responsible bodies to take more ownership and accountability for incident reporting, changing the relationship and dynamic with Welsh Government.

The Policy has been produced by Welsh Government and sets out, at a strategic level, what needs to be reported. This guidance document sits alongside the Policy and provides the operational detail of how reporting will occur. To ensure this meets the needs of NHS Wales, the guidance document will be collaboratively produced in an ongoing manner with NHS Wales's partners. The Policy and guidance will evolve over time as we increasingly embrace alternative patient safety methodologies and sciences such as Safety-II, systems thinking, and human factors.

Whilst the coordination and production of the document will be overseen by the NHS Wales Delivery Unit, as the shadow form of the NHS Wales Executive, the document is owned by all NHS Wales organisations.

Notwithstanding the need to change traditional approaches to learning from incidents, there remains a requirement to ensure national oversight and focus where significant harm has occurred. The NHS Wales Delivery Unit will fulfil this function as part of its responsibility to manage the national reporting process.

Scope

This guidance document provides the practical detail to support how NHS Wales responsible bodies will implement the Welsh Government's National Incident Reporting Policy.

Together, this document and the Policy will supersede, **from the 14 June 2021**, the Serious Incident section (Section 9) of the Putting Things Right guidance.

Throughout 2021/22, this guidance document will evolve as Phase 1 and 2 are incrementally introduced.

This guidance, as does the Policy, applies to all NHS Wales responsible bodies. A responsible body is defined under the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) as:

(a) a Welsh NHS body

(b) a primary care provider, or

(c) an independent provider.

For the purposes of the Policy and this guidance document, a responsible body includes those who provide or support the provision of NHS healthcare funded through the Welsh NHS, including:

- NHS Wales Health Boards and Trusts
- Services commissioned by NHS Wales Health Boards and Trusts which are delivered in other organisations, including in private healthcare settings, other countries etc.
- Independent contractors who provide services including primary care practitioners (general practitioners, optometrists, dentists, pharmacists)
- Healthcare services provided in prison settings
- Independent healthcare (where care and treatment is commissioned by responsible bodies).

Local Reporting & Investigation Requirements

All incidents should continue to be reported and investigated locally in line with local policies and procedures. This may include escalation through other national frameworks (e.g. multiagency safeguarding processes) where appropriate.

All incidents should be subject to timely review to ensure immediate make safes are identified and actioned, to reduce future risk of patient harm where applicable, and to determine necessity for national reporting to the DU in keeping with policy timeframes.

Organisations should ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of the Policy.

National Reporting Requirements (Phase 1)

Overarching national reporting requirements

From 14 June 2021, the following definition of a nationally reportable patient safety incident applies:

> *A patient safety incident which caused or contributed to the **unexpected** or **avoidable death**, or **severe harm**, of one or more patients, staff or members of the public, during NHS funded healthcare**

The above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community based services (see also the “Scope” section).

When considering whether to report an incident, the following should be applied:

- a patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is **assessed or suspected** an **action or inaction** in the course of a service user’s treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to their **unexpected or avoidable death**, or **caused or contributed to severe harm**
- as it will not always be possible to determine the extent to which a patient safety incident caused or contributed to the harm or death of a patient within seven working days, responsible bodies should report in line with the criteria where it is known, and/or suspected, that a patient safety incident has caused or contributed to harm or death. In this scenario, for clarity, the responsible body should specify on the form that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date as set out later in this guidance.
- all such incidents must be reported to the Delivery Unit **within seven working days** from the occurrence, or point of knowledge.

*** This policy does not apply to nosocomial transmission of Covid-19 until further notice**

N.B. It is important to note that acts or inactions can also result from technical failure or delays in systems and processes, as well as human interactions.

To facilitate a consistent approach across Wales, the following definitions apply:

Policy Term	Applicable Definition
Unexpected and avoidable death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition
Severe Harm	An incident that appears to have resulted in **permanent harm** to one or more persons receiving NHS-funded care
Permanent Harm	Directly related to the incident and not to the natural course of the patient's illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual, including psychological harm
Action	Something done intentionally or unintentionally
Inaction	Indecision, unnecessary delay, failure to act
Service user	A person accessing NHS funded treatment or NHS funded care in any setting, including NHS staff accessing treatment and care through welfare/occupational health services

Specific National Incident Categories

The following incidents will also be nationally reportable from 14 June 2021. Whilst these fall under the broad definition of a nationally reportable incident as set out above, they have been drawn out in the policy to ensure clarity on expectations around national reporting.

1. Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months

2. In-patient Suicides

All completed in-patient suicides of any service user, in any clinical setting, will be reportable. The requirement extends to all service users, not just those being treated for mental health needs either within a Mental Health setting or otherwise.

Detained Mental Health patients on authorised/agreed leave away from the clinical setting who complete suicide, or are suspected to have completed suicide whilst away, regardless of the agreed leave timeframe, will be reportable as in-patient suicides.

3. Maternal Deaths

The national reporting requirement is confined to 'direct maternal deaths': the death of a woman while pregnant, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. These incidents will be nationally reportable from the 14 June 2021.

Other maternal deaths such as 'Indirect' and 'Late Maternal Deaths' will be considered as part of phase 2 reporting criteria – further guidance will be provided in due course.

4. Never Events

Reporting arrangements for Never Events will remain as outlined in the Welsh Health Circular (WHC) (2018) (12). Please refer to the below link for further details;

https://gov.wales/sites/default/files/publications/2019-07/never-events-list-2018-and-assurance-review-process.pdf

The Never Event list cannot be added to by responsible bodies in any way. Responsible bodies should ensure the term 'Never Event' is used only in reference to the current national list, or any revisions to the national list at later dates.

5. Incidents where the number of patients affected is significant

such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure

The key wording in this reporting requirement is "the number of patients affected **is** significant". The word 'is' has been purposely included to prevent unnecessary reporting where emerging issues, which could have resulted in harm, were avoided through corrective action or risk mitigation.

Where any incident has, or is likely to have caused an unexpected or avoidable death, and/or severe harm, this should reported as a national incident within seven days from the point of knowledge that harm has been caused (regardless of timeframe). It should be reported by the body responsible for coordinating the affected patient's/patients' care and treatment, regardless of whether the underlying incident was within that organisation's control. Reporting organisations can identify at the time of reporting who the appropriate investigating organisation should be where the incident is considered beyond their control. Organisations will remain responsible for coordinating and liaising with other organisations in relation to joint investigations. Also see 'Joint investigation' section.

All other incidents which do not meet national reporting thresholds should be reported and managed locally with consideration of submitting an 'early warning notification' at the appropriate time.

6. Unusual, unexpected or surprising incidents

where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

The nature of patient safety incidents makes it impossible to define a list to which all reportable incidents would comply – this is one of the problems observed with traditional 'category based' reporting methods. All organisations will have incidents occur that do not strictly meet the criteria set out in the policy or this guidance, but should still be reported. This may be because the incident was a significant near miss or because the circumstances of the incident make it impossible to determine a level of harm with any certainty.

The purpose of including this category within the policy was to enable organisations to report an incident they consider should be reported, even where the national reporting criteria cannot be met. This is in keeping with the spirit of the policy that a mature approach to assessing and reporting incidents should allow organisations to make decisions and, following assessment, report any such incidents they feel should be reported.

There is therefore an expectation that, as part of the systems and processes specified above, responsible bodies will consider all incidents, and where an incident of significant concern occurs, will report those incidents nationally even if they do not strictly meet the criteria set out in the Policy.

Whilst it is a decision for each organisation about serious patient safety incidents reported in this way, advice can be sought from the NHS Wales Delivery Unit to support decision making.

Special Reporting Arrangements

The following special reporting arrangements will be effective from the 14 June 2021 pending completion of the roll out of Phase 2. To provide clarity, this guidance document will be iteratively updated as these areas are resolved during Phase 2 work.

1. Pressure damage

Retrospective reporting arrangements for pressure damage will continue as outlined in the Welsh Health Circular (WHC) (2018) (051). Please refer to the below link for further details;

https://gov.wales/sites/default/files/publications/2019-07/welsh-health-circular-on-revised-pressure-ulcer-reporting-including-the-reporting-of-serious-incidents.pdf

N.B. An updated reporting and closure form is available (see "Revised forms" section below) and should be used from 14 June 2021.

2. Unexpected deaths in the community of patients known to MH&LD Services

All unexpected deaths of service users known to Mental Health & Learning Disabilities (MH&LD) services, including Drug and Alcohol Services, within 12 months immediately prior to their death, should be reported and proportionally investigated by responsible bodies.

As it is not possible to provide guidance for all eventualities of an unexpected death in this particular regard, the following is provided as broad guidance for responsible bodies to follow:

All deaths of MH&LD patients that are unexpected, i.e. not as a result of a diagnosed terminal illness, or end of life integrated pathway/care plan, should be reported locally in the first instance. An exception to this would be an unexpected death where there is clear indication at the point of knowledge that the death is related to a particular incident such as a road traffic collision, unless suicide is suspected.

All deaths of MH&LD patients will however always be locally reportable where the exact cause of death is not immediately known, or where an acute medical event such as a heart attack has occurred. This is to ensure firstly there is a broader data set for unexpected deaths for this category of service user, whether nationally reportable or not, and secondly to ensure responsible bodies then conduct a proportionate investigation to understand whether care and treatment over the service user's course has caused or contributed in any way to the death.

Local investigation methods should ensure that examination is given to factors in the service user's care which identifies things that could or should have been done differently, representing key opportunities for learning and improving service delivery. Local investigations must consider and review physical healthcare (where appropriate) in conjunction with MH&LD delivered services and therapies.

From 14 June 2021, where local investigations assess an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their death, responsible bodies must report as an individual national patient safety incident within 120 working days from knowledge of death.

Incidents of this nature should be reported using the general incident reporting and outcomes forms (i.e. there is no specific form for this category of incidents). It is acceptable for notifications and outcomes forms to be submitted together.

3. Safeguarding

Safeguarding incidents should be reported and managed in keeping with national safeguarding procedures and requirements. Safeguarding incidents should only be reported nationally to the DU, where it is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to their **unexpected or avoidable death**, or **caused or contributed to severe harm**. In all other instances, responsible bodies should consider submission of an 'early warning notification'.

4. Procedural Response to Unexpected Death in Childhood (PRUDiC)

PRUDiC incidents should be reported and managed locally in line with national PRUDiC requirements. PRUDiC incidents should only be reported nationally to the DU, where it is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to the **death**. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

5. Abuse / Suspected Abuse

Abuse incidents should be reported and managed locally. Abuse incidents should be reported nationally to the DU, where it is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to their **unexpected or avoidable death**, or **caused or contributed to severe harm**. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

6. Healthcare Acquired Infections (HCAIs)

HCAI incidents should be reported and managed locally. HCAI incidents should only be reported nationally where it is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to their **unexpected or avoidable death**, or **caused or contributed to severe harm**. HCAIs which appear on death certificates will by their nature be considered causative or contributory to the death, and will be classed as nationally reportable within seven days of point of knowledge. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

N.B. This requirement does not apply to nosocomial transmission of Covid-19 until further notice. Organisations should continue to maintain local records in this regard, and refer to separate requirements set out in the National Framework for the Management of Patient Safety Incidents from Nosocomial Transmission of Covid-19.

7. Commissioned Services

As set out in the policy, most NHS organisations will commission services from other organisations, including from WAST, neighbouring HBs/Trusts and outside of NHS Wales.

The policy sets out the general principles for consideration in relation to incidents occurring within commissioned services. A key fundamental principle is that responsible bodies are responsible for the health of their population, not just in relation to the care that they directly provide. Therefore NHS organisations have an explicit obligation to ensure appropriate mechanisms for following up incidents which affect members of their population even if they did not directly provide care themselves.

It is recognised that the commissioning organisation is unlikely to be able to directly investigate an incident occurring on the premises of another organisation and will usually rely on the provider organisation undertaking the investigation on their behalf. It is therefore expected that as part of the commissioning arrangements, consideration is given to how incidents which occur during commissioned services will be investigated by the provider organisation with the commissioner kept informed. The commissioning organisation must have systems and processes to assure themselves of the suitability of commissioned services.

Where an incident occurs during commissioned services and is nationally reportable to another authority (e.g. an incident which occurs in the English NHS will be reportable via STEIS), there is no requirement to duplicate report to the NHS Wales Delivery Unit. Responsible bodies should consider the submission of an 'early warning notification' where appropriate. An appropriate summary reporting mechanism for incidents of this nature will be developed during Phase 2.

From 14 June 2021, where an incident which occurs during commissioned services in Wales meets the national incident threshold, this should be reported in line with the Policy by the organisation responsible for the patient's care and treatment at the time the incident is identified.

8. Externally Reportable Incidents

There is no requirement within the Policy for responsible bodies to routinely generate a national incident report for matters which are already reportable to external organisations, regulators and national audits, such as the Human Tissue Authority (HTA), or Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE). These national reporting requirements, and any associated requirements relating to review and taking corrective or preventative actions, must still continue in line with the external organisation's requirements.

Responsible bodies should only report an incident of this nature as a national incident as well where the incident is **assessed or suspected** an **action or inaction** in the course of a service user's treatment or care, in any healthcare setting, **has**, or **is likely to have caused or contributed** to severe harm or death. In all other instances, responsible bodies should consider submission of an 'early warning notification' where appropriate.

Reporting Process

From the 14 June 2021, all nationally reportable incidents will be submitted to the NHS Wales Delivery Unit at the earliest opportunity, but no later than seven working days following occurrence or point of knowledge. All forms will continue to be submitted via email until such time that Once for Wales Concerns Management System processes allow for electronic submission. All forms will be sent to NationalSIreports@wales.nhs.uk.

1. Revised Forms

From 14 June 2021, a new suite of “Nationally Reported Incident” forms will be issued and should be used for all new incidents reported to the DU. These forms will be available on the DU’s website: https://du.nhs.wales/patient-safety-wales/patient-safety-incidents/

The forms include:

- Notification form
- Learning from Events form (in development)
- Outcomes form
- Combined pressure ulcer notification and outcomes form
- Downgrading form

In keeping with existing process, all forms must receive Executive sign-off prior to submission. Forms not reviewed and signed by a responsible Executive will be returned and not recorded.

2. New Additional Information Required

- **Investigation timeframes** - At the point of submitting a national incident notification to the Delivery Unit, responsible bodies will now be required to indicate the anticipated investigation timeframe of either 30, 60, 90 or 120 working days from the incident occurrence or the point of knowledge. Whilst responsible bodies will not be performance measured against the anticipated timeframes, quarterly reports, which will be individualised and private to each organisation, will be generated by the Delivery Unit listing how many open incidents the organisation has against the listed timeframes. The purpose of this reporting is to ensure good governance both on the part of the Delivery Unit, responsible for the national reporting process, and individual organisational governance responsibilities in keeping with NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

- **Level of Investigation** – At the point of submitting a national incident notification to the Delivery Unit, responsible bodies will now be required to indicate what level of proportionate investigation they intend to undertake. The plan in due course is to align the category of available investigation levels with the Once for Wales Concerns Management System implementation and roll out across Wales.

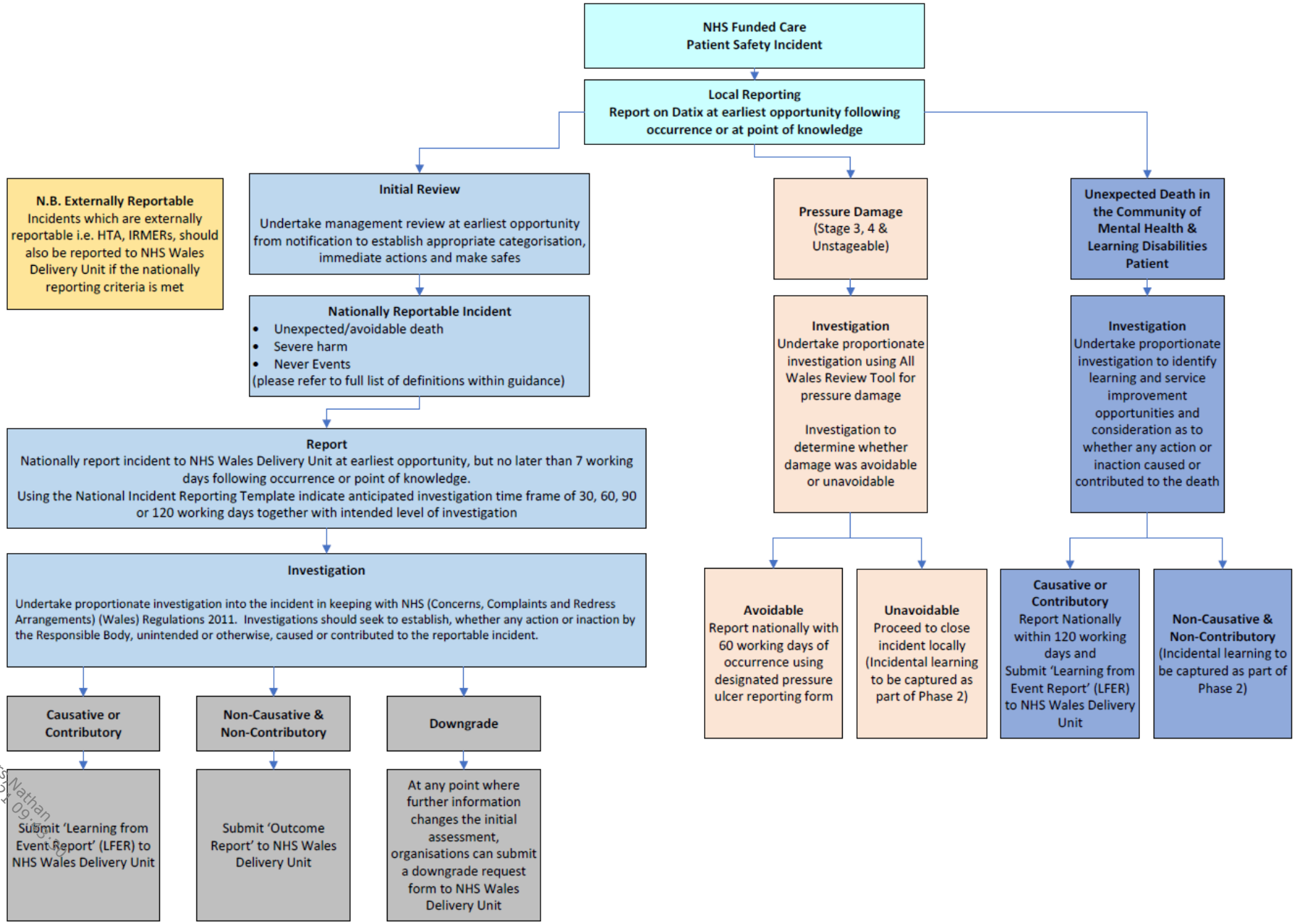
3. Notifications in relation to incidents involving Multiple Organisations

Where an incident is to be jointly investigated, only one notification in relation to the incident needs to be made. The organisations involved in the joint investigation should agree the lead organisation for reporting purposes.

4. Near-miss Incident Reporting

There is a strong desire to receive learning and information from significant near miss incidents, however it is recognised that it would not always be appropriate to require near misses to be reported as national incidents. The mechanism for near miss reporting will be nationally agreed as part of Phase 2. In the interim, responsible bodies can share learning from near miss incidents to the national reporting inbox clearly identifying the incident circumstances and learning identified.

National Incident Reporting Flow Chart (Phase 1)



Investigations

Following the notification of a nationally reportable incident, responsible bodies must undertake a proportionate investigation which is appropriate to the severity, and in keeping with NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Proportionality should consider the necessary scope required to undertake a robust investigation, in addition to the most appropriate investigation methodology.

All investigations should seek to establish whether any action or inaction by the responsible body, unintended or otherwise, caused or contributed to the reportable incident.

For pressure damage incidents, responsible bodies should complete the All Wales Pressure Damage Review Tool as set out in the relevant Welsh Health Circular, and complete more in depth investigations where required.

Joint Investigations

Joint investigations are essential when multiple organisations are involved in an incident. The Putting Things Right Guidance should be followed and responsible bodies should also be mindful of their obligations under General Data Protection Regulation in respect of the processing and sharing of data.

Organisations should continue to use existing joint investigation frameworks / arrangements where applicable. In keeping with single organisation reporting requirements, organisations must liaise and coordinate the investigative response when more than one organisation is involved, to decide who will assume responsibility and oversight.

Outcome Process

For incidents reported on or after 14 June 2021, the previous closure process will change. From the 14 June 2021, responsible bodies will have three options following the reporting and proportionate investigation of an incident, as set out below. The key overarching change is that full accountability and responsibility for closure of investigations will sit entirely with the responsible bodies. The information submitted to the Delivery Unit will not be used as a method of agreeing closure.

Organisations will still be expected to submit good quality information in a timely manner which evidences the suitability of investigation undertaken. This will be monitored though the NHS Wales Delivery Unit processes including Quality Assurance. Regular feedback will be provided directly to organisations including as part of regular interface Quality and Safety meetings.

Option 1 Causative or Contributory - will apply where investigations have determined an act or inaction, unintended or otherwise, has caused or contributed to the reportable incident.

In this instance, at the conclusion of the investigation, responsible bodies will be required to complete and submit a Learning from Events report to the Delivery Unit.

Option 2 Non-causative / Non-contributory - will apply where investigations have determined an act or inaction, unintended or otherwise, did not cause or contribute to the reportable incident.

In this instance, at the conclusion of the investigation, responsible bodies will be required to submit an Outcome Report to the Delivery Unit.

Option 3 Downgrade - At any point where further information changes the initial assessment, responsible bodies can submit a downgrade request form to the Delivery Unit.

Governance & Assurance Requirements

Responsible bodies should ensure they continue to have robust systems and processes that ensure the following requirements are met:

- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off of national incident notification and outcome forms (for all three options)
- Clear and demonstrable lines of reporting to relevant Committees and the Board
- Ensure processes which enact the policy in all areas of the organisation (including e.g. Primary and Community Services, Prison services etc.)
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate
- All incidents should be reviewed to determine those which should be nationally reported. These systems and processes should focus on a multi-disciplinary approach to decision making within an appropriate governance framework. Whilst advice and support can be sought from the NHS Wales Delivery Unit, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy
- Ensure robust mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes
- Ensure robust mechanism for demonstrating shared learning
- Ensure robust mechanisms for ensuring patient and family engagement where appropriate, in line with Being Open arrangements and in active preparation for the incoming Duty of Candour.

Transitional Arrangements

For all current open Serious Incidents, including incidents reported up to and including 13 June 2021, the previous 'Serious Incident' policy applies. Accordingly responsible bodies must continue to investigate and close such incidents using the existing closure or downgrading forms as follows:

- For incidents reported to Welsh Government (WG) on or before 30 March 2020, please submit a closure form directly to WG ImprovingPatientSafety@gov.wales
- For incidents reported to WG after 1 April 2020, or to the Delivery Unit thereafter, please submit a closure form directly to the DU NationalSIreports@wales.nhs.uk

All closure forms will be reviewed with confirmation of closure confirmed directly to organisations.

Early Warning Notifications

Early Warning notifications are independent of incident reports and will replace 'No Surprise' reports from the 14 June 2021.

Historically the No Surprise Reporting and Serious Incident reporting processes became interlinked, primarily because they were both communication channels into Welsh Government. With the NHS Wales Delivery Unit taking on responsibility for national incident reporting, as the shadow form of the NHS Executive, these communication channels are now much more clearly separated as they serve two distinct purposes.

As set out in the policy, Early Warning notifications are replacing No Surprise Reports and should only be used as a rapid communication channel to give an urgent notification to Welsh Government of a potential area of interest. Early Warning notifications should be sent as soon as practicable to ImprovingPatientSafety@gov.wales

In some cases, an incident may require both an Early Warning notification being sent to Welsh Government, and an incident report being sent to the NHS Wales Delivery Unit. Although these may contain elements of the same information, the detail of the report and the reporting timescales will often be different.

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National Incident reporting Flowchart (Phase 1)

NHS Funded Care
Patient Safety Incident

Local Reporting
Report on Datix at earliest opportunity following occurrence or at point of knowledge

N.B. Externally Reportable
Incidents which are externally reportable i.e. HTA, IRMERs, should also be reported to NHS Wales Delivery Unit if the nationally reporting criteria is met

Initial Review

Undertake management review at earliest opportunity from notification to establish appropriate categorisation, immediate actions and make safes

Nationally Reportable Incident

- Unexpected/avoidable death
- Severe harm
- Never Events

(please refer to full list of definitions within guidance)

Report

Nationally report incident to NHS Wales Delivery Unit at earliest opportunity, but no later than 7 working days following occurrence or point of knowledge.
Using the National Incident Reporting Template indicate anticipated investigation time frame of 30, 60, 90 or 120 working days together with intended level of investigation

Investigation

Undertake proportionate investigation into the incident in keeping with NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Investigations should seek to establish, whether any action or inaction by the Responsible Body, unintended or otherwise, caused or contributed to the reportable incident.

Causative or Contributory
Submit 'Learning from Event Report' (LFER) to NHS Wales Delivery Unit

Non-Causative & Non-Contributory
Submit 'Outcome Report' to NHS Wales Delivery Unit

Downgrade
At any point where further information changes the initial assessment, organisations can submit a downgrade request form to NHS Wales Delivery Unit

Pressure Damage

(Stage 3, 4 & Unstageable)

Investigation
Undertake proportionate investigation using All Wales Review Tool for pressure damage

Investigation to determine whether damage was avoidable or unavoidable

Avoidable
Report nationally with 60 working days of occurrence using designated pressure ulcer reporting form

Unavoidable
Proceed to close incident locally (Incidental learning to be captured as part of Phase 2)

Unexpected Death in the Community of Mental Health & Learning Disabilities Patient

Investigation
Undertake proportionate investigation to identify learning and service improvement opportunities and consideration as to whether any action or inaction caused or contributed to the death

Causative or Contributory
Report Nationally within 120 working days and Submit 'Learning from Event Report' (LFER) to NHS Wales Delivery Unit

Non-Causative & Non-Contributory
(Incidental learning to be captured as part of Phase 2)

Report Title:	CLINICAL EFFECTIVENESS COMMITTEE ACTIVITY – Item 4.4								
Meeting:	Quality, Safety and Experience Committee					**Meeting Date:**	**15.6.21**		
Status:	**For Discussion**		**For Assurance**	X	**For Approval**		**For Information**		
Lead Executive:	Executive Medical Director								
Report Author (Title):	Head Patient Safety and Quality Assurance								

Background and current situation:

There are 38 National clinical audits that Cardiff and Vale University Health Board are mandated by Welsh Government to participate in, as well as the National Clinical Outcome Review programmes and NCEPOD.

In December the Clinical Effectiveness Committee (CEC) was established, and is rapidly gathering momentum. To date the committee has met 6 times. In May 2021 for the first time, Clinical Boards and Directorate members were invited to attend to present their national audit findings.

The Clinical Effectiveness Committee has been established with the purpose of ensuring clinical effectiveness across the Health Board by:

1.1 Monitoring the implementation of NICE, national and local evidence, guidelines and standards to ensure best practice across the Health Board.

1.2 Providing strategic direction for the UHB's national and local clinical audit programme.

1.3 Providing assurance to the Quality and Safety Experience (QSE) committee on the above points through the production of reports.

1.4 Receiving reports from the sub groups and following analysis either escalate issues or provide assurance to the QSE committee and Board.

1.5 Contribute to the production of the Annual Quality statement to be presented to the Board of Directors

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the activity of the Clinical Effectiveness Committee since it was established in December 2021.

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

The CEC is now well established. However current resource to capture and monitor activity is limited. The UHB is proposing to invest in a governance system called AMAT once the appropriate investment and staff resource is secured. This would considerably improve the level of assurance that could be provided.

The Committee should be advised that the Internal Audit department are currently auditing Clinical Audit arrangements. There are early indications that this is likely to be rated with 'limited assurance'.

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

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards. NHS Wales needs to be a learning organisation which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World.

National Clinical Audit and Clinical Outcome Review Programme (NCACORP)

The UHB participates in the mandatory national clinical audits set out in the National Clinical Audit and Outcomes Review Plan, other national clinical audits of interest and local clinical audits that are designed and delivered, usually by medical students and junior doctors as part of their medical education. The table below sets out Clinical Effectiveness Committee activity/review since December 2020:

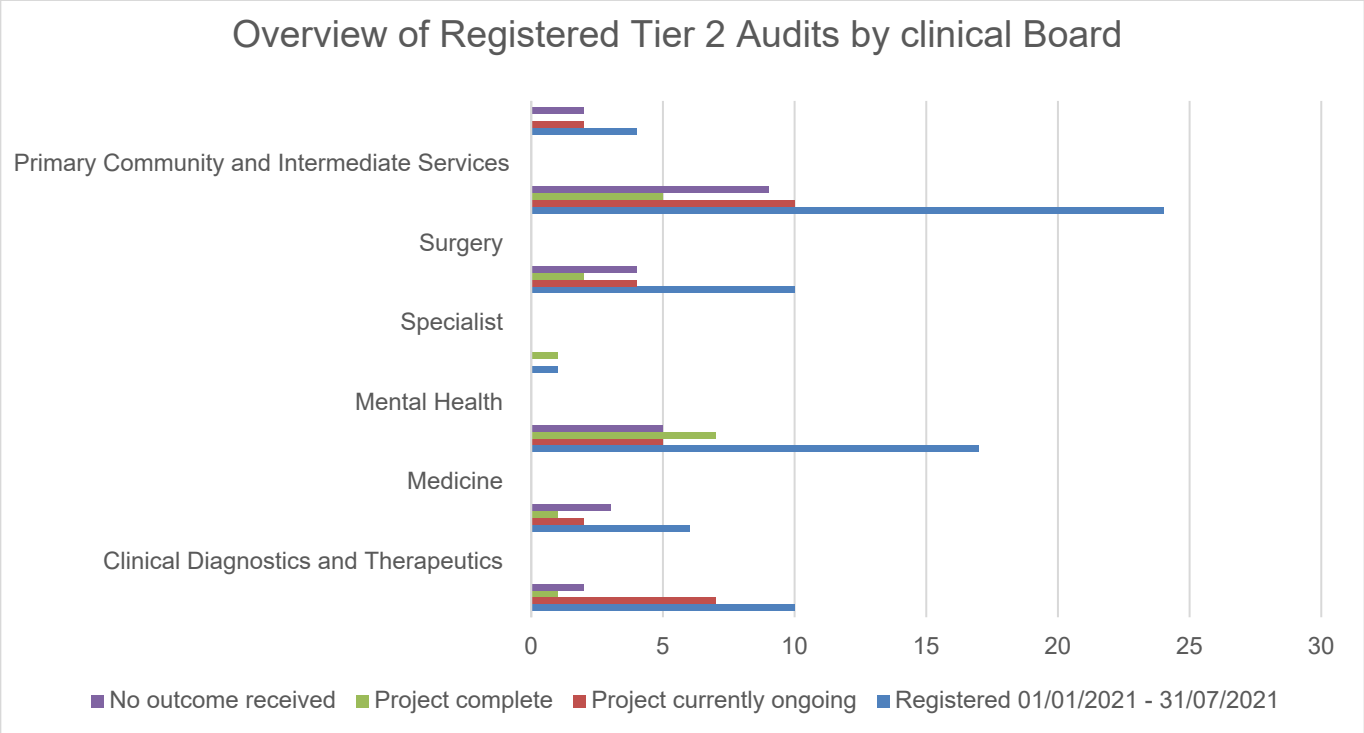
National clinical Audit	Report	Preliminary Overview	Further information required from clinical lead
National Asthma and Chronic Pulmonary Disease Audit Programme (NACAP)	Adult Asthma Audit 2019/20	√	Information Provided to CEC
National Hip Fracture Database (NHFD)	NHFS Annual Report 2019	√	Information Provided & Presented by Clinical Lead at CEC
National Prostrate Cancer Audit (NPCA)	Annual Report 2020	√	Information Provided to CEC
Sentinel Stroke National Audit Programme (SSNAP)		√	Presented by Clinical Lead at CEC
Perinatal Mortality Reporting Tool	Learning from Standardised Reviews When Babies Die – 2019 Annual Report	√	Information Provided to CEC
National Confidential Enquiry into Patient Outcome and death	Time Matters: A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out-of-hospital cardiac arrest	√	Presented by Clinical Lead at CEC
Paediatric Intensive Care audit Network	Annual report (2017/19)	√	Information Provided & Clinical lead invited to present at CEC
National Lung Cancer Audit	Annual Report 2018	√	Information Provided & Presented by Clinical Lead at CEC
TARN – The Trauma Audit & Research Network	Major Trauma Dashboard Measures 2020	√	Information Provided on Data Collection Issues
National Audit of Inpatient Falls (NAIF)	National Audit of Inpatient Falls Report	√	Presented by Fall's Lead at CEC

	2020 Inpatient falls in England and Wales 1st January – 31st December 2019		
Fracture Liaison Service Database (FLS-DB)	Annual report benchmarking FLS improvement and performance in 2019:Pre-COVID	√	Information Provided – Further MDT meeting to be arranged.
National Asthma and Chronic Pulmonary Disease Audit Programme (NACAP)	Children and young people asthma 2019/20 audit report	√	
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Annual Report (2008-2018)	√	
National Asthma and Chronic Pulmonary Disease Audit Programme (NACAP)	Wales Primary Care Clinical Audit 2020	√	Information Provided to CEC
National Asthma and Chronic Pulmonary Disease Audit Programme (NACAP)	COPD Audit 2019/20	√	Information Provided to CEC Re; data collection Meeting to be arranged with Clinical Lead
National Child Mortality Database	Second Annual Report 2019/20	√	
National Paediatric Diabetes Audit (NPDA)	Annual Report 2019/20 Care process and outcomes	√	
National Vascular Registry (NVR)		√	Information to be requested.
National Emergency Laparotomy audit (NELA)	7th Annual report	√	Presented by Clinical Lead at CEC
National Audit of Early Inflammatory Arthritis	Annual Report 2020	√	Information Provided to CEC

Overview of Tier 2 Registered Patient Safety Priority Audits Jan – July 2021

Children and Women		**Clinical Diagnostics and Therapeutics**		**Medicine**		**Mental Health**	
Registered 01/01/2021 - 31/07/2021	***10***	*Registered 01/01/2021 - 31/07/2021*	**6**	*Registered 01/01/2021 - 31/07/2021*	***17***	*Registered 01/01/2021 - 31/07/2021*	***1***
Project currently ongoing	7	Project currently ongoing	2	Project currently ongoing	5	Project currently ongoing	0
Project complete	1	Project complete	1	Project complete	7	Project complete	1
No outcome received	2	No outcome received	3	No outcome received	5	No outcome received	0

Specialist		Surgery		Primary Community and Intermediate Services	
Registered 01/01/2021 - 31/07/2021	***10***	*Registered 01/01/2021 - 31/07/2021*	***24***	*Registered 01/01/2021 - 31/07/2021*	***4***
Project currently ongoing	4	Project currently ongoing	10	Project currently ongoing	2
Project complete	2	Project complete	5	Project complete	0
No outcome received	4	No outcome received	9	No outcome received	2



Main issues discussed/escalated to the Committee are discussed below:

National Hip Fracture Database –

The National Hip Fracture Database Audit was presented by the Clinical Audit Lead, the Lead Nurse for Surgery was also in attendance. A demonstration was given on various aspects of the NHFD website, including an assessment benchmark summary that contains real time data. It was explained that using the website as a benchmarking tool with hospitals in England can be problematic due to the best practice tariff incentives in England. Below is the data and the expected standards developed by WG and presented to the Delivery Unit on a quarterly basis, however the thresholds for these standards are lower than the national standards.

Overview of Wales	AB		BCU			CTM			CV	HD			SB	Benchmarks				
	GWE	NEV	CLW	GWY	WRX	PCH	POW	RGH	UHW	BRG	WWG	WYB	MOR	NHFD	Wales	Eng	NI	Expectation
Prompt orthogeriatric review % (k1 annu	95%	93%	94%	39%	33%	0%	0%	8%	78%	95%	29%	64%	86%	87%	60%	89%	82%	75%
Prompt surgery % (k2 annual)	62%	79%	67%	81%	69%	65%	57%	75%	70%	44%	80%	74%	54%	69%	67%	69%	21%	75%
NICE compliant surgery % (k3 annual)	87%	79%	62%	64%	75%	46%	82%	83%	71%	95%	68%	76%	68%	71%	72%	71%	75%	75%
Prompt mobilisation % (k4 annual)	72%	71%	74%	85%	77%	76%	90%	61%	79%	78%	70%	61%	74%	80%	74%	81%	84%	75%
Not delirious post-op % (k5 annual)	58%	60%	78%	54%	18%	0%	73%	8%	51%	96%	63%	67%	74%	58%	54%	58%	36%	75%
Return to original residence % (k6 annual	75%	82%	77%	75%	67%	68%	64%	72%	77%	80%	76%	79%	76%	71%	75%	71%	79%	75%

*NEV data only up to April 2020

*NI data only up to Oct 2019. NHFD beyond Oct 2019 is only England and Wales.

For any questions regarding this spreadsheet, please contact James Davis, James.Davis2@wales.nhs.uk

Highlighted in red for CAV (KPI) , 'not- delirious post-operatively' is 51% and is an issue nationally, demonstrating the value of using real time data it was possible to see an improvement in this area, and audit data showing improvement on previous years. However, it was recognised that there is significant room for improvement. Current improvement plans are focused on the pre and perioperative period as well as the post-operative period. Inpatient falls as a result of post-operative delirium was also discussed and the need to develop a structured way of learning and sharing the learning across the Health Board. Learning from all inpatient falls is being picked up by the Falls Lead who was also present at the meeting.

Pressure area care was also identified as a concern, the Committee was informed of various work in process, including re-establishing the Pressure Damage Group, and working with bed suppliers to change Duo Two mattresses. Addressing post-delirium will also have an impact on safe post-operative mobilisation rates.

The National Early Laparotomy Audit (NELA)

The National Early Laparotomy Audit was presented by the Clinical Audit Lead.

Positives from the presentation were: Improvement seen in mortality rates year on year, Cat 1 decision to theatre time, lactate and Surgical Consultant presence.

Areas for improvement were: In relation to timely administration of antibiotics in suspected sepsis, documentation of risk, clinical fragility score, Anaesthetics Consultant presence and access to ITU.

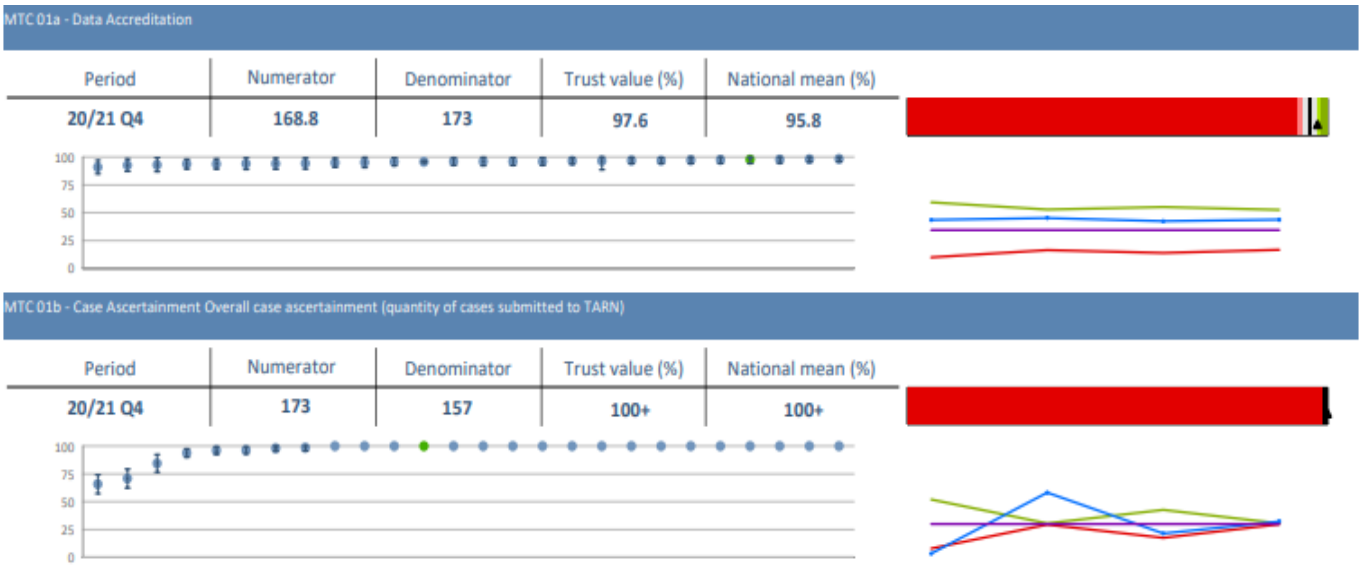
Work currently underway included a review of PTSD post emergency laparotomy, increase in frailty sessions, participation in UK-wide QI project, improving sepsis management and pathway documentation, working with Surgical Trainees and Nurse Practitioners.

NELA simulation is to commence when COVID-19 pressures ease. A national piece of work will be undertaken focusing on the patient's experience.

The Trauma Audit and Research Network (TARN) – May 2021 (Update)

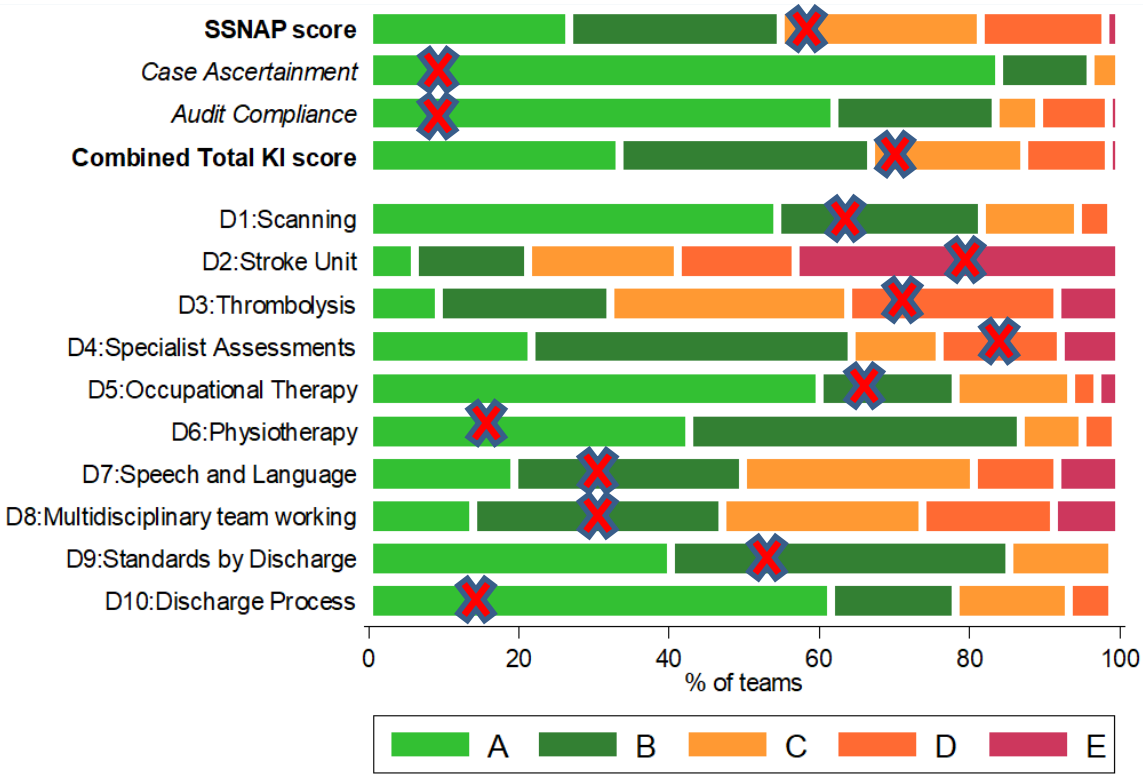
A reduction was seen in the case ascertainment figures for March – December 2020. Issues were as a result of a member of staff shielding during COVID-19, training needs and retention due to banding issues and funding which, whilst during the last three months no TARN coordinators have been in post. The shortfall has been absorbed by the Clinical Audit Team through working overtime and allocated time from other commitments, which has had an impact on other national clinical audits. Case ascertainment is 100% and data accreditation is 97.6% which has been consistently the best in Wales.

From 6th July 2021, two new TARN coordinators commenced their training. This has impact on case ascertainment during this period due to training requirements, and will be reflected in future reports. The complexity of the cases that are now seen in Cardiff and Vale UHB will also have an impact. Discussions have taken place with the MTC regarding the sustainability of the TARN audit and the need for additional funding to ensure future proofing from MTC as there is inadequate resource. The Clinical Audit Lead for TARN will be invited to the CEC meeting in November to present the data and the work that has taken place during the first year of the MTC.



Sentinel Stroke National Audit Programme (SSNAP) – June 2021

Currently there is no Clinical Audit Lead appointed for this audit and plans for recruitment are underway. The SSNAP audit was presented by other lead members of the Stroke Team.



Source: SSNAP Jan to Mar 2021
Patient-centred results at national level

A system is in place to monitor the SSNAP data and initiatives such as 'door to ward' where the Stroke Team work closely and meet with the Emergency Department, Radiology and Patient Access. Over recent years SSNAP data has been used in several service developments and improvements, including time interval from admission to thrombolysis, HASU workforce gap analysis undertaken, thrombectomy pathway and referral procedures, and Stroke Response Nurse project.

The SSNAP data has consistently showed Cardiff and Vale UHB to be performing poorly in relation to:

- Admission to Stroke unit
- Time interval to thrombolysis
- Specialist assessments

An Introduction of a HASU Unit consistent with the rest of the UK would significantly improve outcomes for patient admitted with stroke. The issues have previously been recognised as a priority, and will be escalated to the next QSE Committee meeting.

Time Matters – National Confidential Enquiry into Patient Outcomes (NCEPOD)

The TIME matters NCEPOD was discussed in the RADAR meeting and discussed at CEC by Aled Roberts, Clinical Board Director, Medicine and Angela Jones, Head of Resuscitation Services.

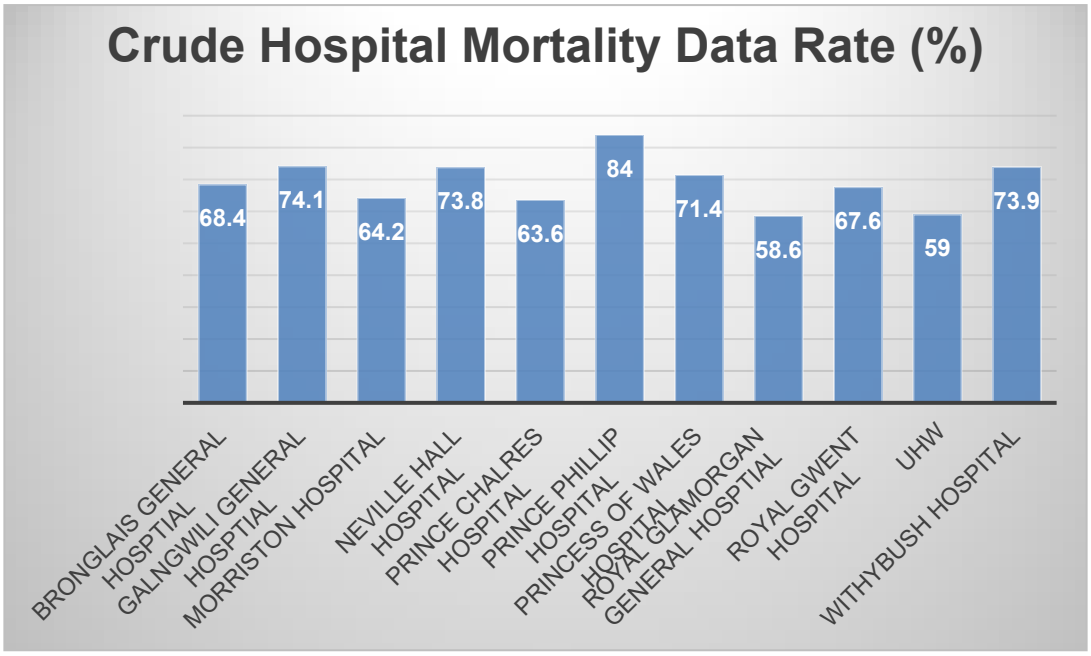
There were five key messages in the report:

1. Bystander cardiopulmonary resuscitation, including use of public access defibrillators improves outcomes.

2. Standardising advanced treatment plans helps patients receive realistic treatment based on their wishes, e.g. 'Do Not Attempt Cardiopulmonary Resuscitation'.
3. Delaying the assessment of neurological prognosis by at least 73 hours after the return of spontaneous circulation aids decision-making.
4. Ensure good temperature control is used following an OHCA as uncontrolled temperature is associated with a worse outcome.
5. Provide ongoing physical, neurological, cardiac and emotional support to ensure good quality of life for survivors on an OHCA.

From a resuscitation perspective, RADAR try to ensure that temperature control is discussed along with oxygen and DNR orders. However the RADAR Committee recognises that the process of sharing the learning from the meetings across the Health Board is difficult and needs to be strengthened.

The Resuscitation Service is currently under resourced. They currently have 2.8wte; the quality standard states it should be 14wte. The gap analysis will be presented at the QSE Committee.



Conclusions from report

- Mortality rates are higher in Wales than in other parts of the UK.
- Approximately one third of OOHCAs are cared for DGH's that have poor access to the neuro-prognostication tools required, with minimal local cardiology support 24/7 and struggle to engage tertiary services when they feel it is appropriate.
- There general trend is better survival rates in higher volume, well-resourced centres (although there is a selection bias with lower APACHE II scores).

National Clinical Audit of Asthma and COPD (NCAP) Adult asthma Clinical Audit 2019/2020

Issues with data collection are ongoing due to long term sickness within the Clinical Audit Team which has significantly affected case ascertainment. Meetings have been arranged with the Clinical Audit Leads to address the issues moving forward. Due to the current situation of staffing and capacity within the Clinical Audit Team, this will take some time to address, and is likely to impact on case ascertainment. This is a long standing issue with lack or resource and the fragility of the clinical audit team, investment in the clinical audit team features in the business case that is being submitted for patient Safety and Quality

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

The suicide rate for Cardiff and Vale UHB area was 11/100,000. The estimated number of patients who had been in contact with Mental Health Services across Wales in the twelve months before their death, in 2018, is estimated to be 73%. The number of patient suicides in Wales who died within three months of in-patient discharge was ten.

Rates of suicide per 100,000 population, by Health Board of residence (average rate 2016-2018)

Area	Rate
Aneurin Bevan	9.4
Cardiff and Vale University	11.0
Swansea Bay	12.4
Betsi Cadwaladr University	13.2
Powys Teaching	13.7
Hywel Dda	14.6
Cwm Taf Morgannwg	14.7

Service characteristics of patients who died by suicide in Wales (2008-2018)

National Audit of Inpatient Falls, (NAIF)

The NAIF data was presented by the Falls Lead. The audit report found the Health Board to be compliant in the majority of the standards. It had been identified that there had been data collection issues due to long term sickness and capacity within the Clinical Audit Team which resulted in some cases not being submitted by the deadline. This is being addressed through submission of a business case to supplement the resource within the Clinical Audit Team.

The reporting of hip fractures should be as 'severe harm' in national reporting and learning systems, it was agreed at the CEC meeting that this would be graded as 'severe harm' going forward.

The Falls Review Panel meets monthly to review falls tools completed to ensure robustness and that correct actions are being taken and learning can be shared. The Falls Delivery Group meets on a bi-monthly occurrence. Part A and B Welsh Government National Clinical Audit proformas have been submitted in advance of the deadlines.

Paediatric Intensive Care Audit Network for the UK (PICAnet)

The Paediatric Intensive Care Audit Network Annual Report for 2020 was discussed. It was noted that the refusal rate following referral for urgent paediatric intensive care transport for CAVUHB was 12.8% during 2017-2019 – this was high in relation to peers. The Clinical Audit lead was contacted to provide further information s to ensure the data was understood in context, it was advised that this data relating to refu7sal of referral refers to the refusal rates of WATCH retrieval service serving populations of both South West England and Wales which is located in Bristol serving both Bristol and Cardiff PICUs. CaV has an acceptance rate of around 95 % for referrals however can be challenging. Pre COVID, work was underway to increase PICU beds and staffing ratio implemented in Summer 2019 to meet national standards, COVID since delayed work in this area. Key work to address nurse staffing and skill mix is recognised as a priority in need revisiting particularly with recent resignations to ensure a focus on recruitment and retention.

National Lung Cancer Audit

Two areas of concern were identified for Cardiff and Vale in the recently published National Lung Cancer Audit annual report, The clinical audit lead attended the clinical effectiveness meeting to provide context to the data.

- **Reduction in the rate of surgical resections** – Data issues were identified and are ongoing issues, updated information is not reflected in the report resulting in inaccuracies, more complex patients with comorbidities are also seen in Cardiff which may influence the data for Cardiff. There has been a drive to improve the rates since this report (2017/18 data), however this is slow. Two key areas were identified as crucial to improve the number of surgical resections **a)** Prehabilitation of patients, and **b)** Lung cancer screening (already introduced in England, currently for which there is no funding in Wales)

- **Reduction in the number of pathological diagnosis** - Cardiff and Vale data showed 78.9%, which is lower than the welsh average of 85.5%. Significant issues were identified with data accreditation and the process in which the health board cannot validate the data prior to submission to the Royal College of Physicians. When local validation was undertaken the actual rates were 89% which is above the Welsh average. The cases that did not received a pathological diagnosis were also reviewed locally which identified several reasons for not undertaking further pathological testing including, patient choice and risks to patient due to comorbidities. Further issues with the data accreditation and submission are anticipated in the transition from CANSIG to the new system which will need to be taken into consideration for this and other national audits.

Fracture Liaison Service Database (FLS)

The FLSD report was discussed in CEC following a meeting with the FLS team and a GAP analysis undertaken in 2019. There are longstanding issues with data collection, resource and communication across clinical boards as well as internal data informatics systems that do not communicate with each other. The clinical leads for the audit and other areas that impact on the FLS-DB will be invited to CEC to progress with addressing the issues to ensure a more collaborative approach across clinical boards to improve compliance with the Key Performance Indicators.

National Audit of the Perinatal Mortality Review Tool (PMRT)

This is a national clinical outcomes review programme. The report reflected national themes and recommendations. Obstetric and Neonatal leads provided information on their position against the published report and demonstrated that the health board has made significant advances in recent years to establish a multidisciplinary approach to reviewing all perinatal morality cases. The collaborative monthly meetings includes a wide variety of health professionals, the electronic tool is completed during the multi-professional forum. An area identified for improvement is in relation to having an external member present for review of the cases, due to the nature of Maternity/Obstetric care being very specialized, obtaining an external view can be challenging. Work is being progressed through the perinatal mortality review forum and the Maternity and Neonatal Network, who will consider a reciprocal All Wales arrangement.

COPD clinical audit 2019/2020 (NACAP)

It was identified that there were data collection and quality issues with this report. The data is submitted by the clinical audit department, due to capacity within the clinical audit team the data accreditation and case ascertainment have been affected. Currently data is not been submitted for this audit due to capacity within the team. A business case is being submitted imminently requesting much needed investment in the clinical audit department to ensure that the department can function effectively.

National Vascular Registry : Developing and implementing implantable medical device capture for aortic aneurysm repair 2021

It was identified that there are significant data collection issues is this report, the clinical board has been contacted to discuss the audit and will be reported back to the next Clinical Effectiveness Committee meeting.

Tier 2 patient safety Priority Audits

Currently the clinical audit team are unable to support any local clinical audits due to capacity, the clinical audit team register the audits that are submitted by clinicians, the IT system is very old and is wholly dependent on clinicians notifying the clinical audit of continuation, completion or disbandment of the audits to update the database, audits are often left open with closure as the information cannot be captured, as there is no capacity to follow up with the audit leads. The limited information available suggests that the findings may not presented or the quality of the data reviewed, no assurance can be provided that improvement plans are developed from the audit recommendations and taken forward.

There is a significant risk that data protection polices and guidance are not adhered to as appropriate authorisation for the audits are often either not sought for or not evidenced when registering the audit. In addition, many of the clinical audits that are undertaken within directorates are not registered raising further, quantifying this is challenging as the unregistered audits are identified by chance. Additional investment for the AMaT audit management system and resource to administer this function will transform this process and help support the clinical board, this features in the Patient Safety and Quality business case.

NICE & Health Technology Wales

Nice and HTW guidance implementation information is shared on a quarterly basis. For the first 6 months of this year 108 Nice guidance have been shared with the clinical boards and directorates for

action or information. The level of responses remains poor but slightly improved now at 42%. Implementation across the Heath Board is 26% of those that had responded only. Where a response had been received, no evidence of implementation is provided which is a flaw in the current process. There are significant challenges associated with the current system and process in place for providing assurance against NICE and HTW implementation. It has been identified that investment in an audit management system such as AMaT software and the resource to manage and administer the system is required urgently. In the event of the required investment a more robust process can be implemented to ensure that evidence is provided of implementation of NICE and appropriate actions taken where NICE has not been implemented to mitigate against any potential risk.

The Wales NICE Health Network met in May 2021, compliance around four specific guidelines was discussed and the following as found (unable to capture information from current system):

- Chronic Heart Failure in Adults: Diagnosis and Management NG106 (2018) – *Not implemented – Business plan has been submitted and discussions are ongoing.*
- Cerebral Palsy in Adults NG119 (2019) – *Partially implemented - Response on position provided to WG.*
- TWIN Triplet Pregnancy (NG137) – *Implemented.*
- Asthma: Diagnosis, Monitoring and chronic Asthma Management NG80 2017 updated March 2021 – *Not complaint - following AWMSG which slightly differs from NICE, further discussions taking place.*
- Menopause: Diagnosis and Management NG23 – Compliant

The HTW Adoption Group has commenced and preliminary meetings have taken place with the Cardiff and Vale Associate Medical Director and Head of Patient Safety and Quality Assurance in attendance. Peter Groves has been invited to present implementation of NICE and HTW on the Grand Round to medical staff.

Peer Review and Accreditation

It has been agreed that all peer reviews will be reported through the CEC, the following peer reviews have been identified and noted at CEC

- CAHMS – *Review when report available.*
- Orthopaedic Joint replacement – *Invite to next CEC meeting with action plan.*
- Dermatology - *Action plan noted, discuss next CEC meeting and to review progress of Action plan in 6 months.*
- National Diabetes Quality Programme – Speciality leads and Directorate Clinical Board Directors have been invited to the September CEC to present the findings and Improvement plan.

Service Developments – Patient Safety Alerts.

New Neuraxial Connector Roll-Out across Wales – PSA003 and PSA007

There is a UK-wide plan to change the connector on lumbar puncture needles, so that they are incompatible with intravenous syringes (Luer).
This is expected to roll out in C&V at some point between April & November 2022.

The All Wales plan is being co-ordinated through the WNCRG to ensure adequate supply of the new connectors as changeover occurs.
There will be a lot of planning required prior to that date as it affects most departments, due to procedures including

- Anaesthetic procedures
- Intrathecal Chemotherapy
- Diagnostic lumbar punctures (Medicine, Neurology, Paediatrics, Neonates)
- Radiology procedures
- Pain procedures

Current practices relating to this topic have been identified as concerns due to non-compliance with two patient safety alerts and the supply and administration of medication in an unlicensed form. Further discussions are planned to support the roll out of this work which is anticipated will have significant impact across the health board and compliance with the Patient Safety Alerts. Patient Safety will support next steps, a Patient Safety Organisational Learning Manager sits on the local task and finish group and will attend the All Wales Meeting to support

Patient Safety Notices – Discussed in CEC

- Patient Safety Notice – MRI scan room oxygen cylinders, discussed further with CD&T Clinical Board E learning module in place.
- Patient Safety Solution PSA008 – NG tube training for medical staff. A letter has been sent to Welsh Government and HEIW – The Delivery Unit is now taking the lead on an All Wales approach.
- Patient Safety Solutions PSN040 – Compliance with adding flushing of lines following anaesthesia to the WHO checklist. Recent SI with investigation in progress, Investigating officer and clinical board to present findings at September CEC meeting.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of Clinical Effectiveness Committee 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.*