Quality, Safety & Experience Committee Meeting

Tue 22 February 2022, 09:00 - 12:00

Agenda

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the Committee Meeting held on 26.10.21 (Special Meeting) & 14.12.21

Susan Elsmore

1.4a Special October QSE Minutes MD.NF.pdf (7 pages)
1.4b QSE Public minutes14.12.21 MD.NF. SE.pdf (13 pages)

1.5. Action Log – Following the meeting held on 14 December 2021

Susan Elsmore

1.5 Action Log QSE for February 2022 meeting.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

- *Approval of Gene therapy Medicinal Products & Gene Therapy Investigational Medicines Products Policy, Procedure and EHIA*

1.6 GTMP_GTIMP policy final.pdf (2 pages)

2. Items for Review & Assurance

2.1. Surgical Clinical Board Assurance Report

Ruth Walker / Clare Wade

2.1 Surgical Clinical Board Report QSE.pdf (29 pages)

2.2. Presentation providing an update on:

Ruth Walker

- Healthcare Standards
- Duty of Candour
- National Quality Framework
- Annual Quality Statement

2.2 Update Reports QSE.pdf (19 pages)

2.3. Quality Indicators Report

Ruth Walker

2.3 Quality Indicators - February 2022 QSE.pdf (16 pages)

2.4. Exception Reports - verbal update

Ruth Walker / Meriel Jenney

2.5. HIW Activity Overview & Primary Care Update

Ruth Walker

2.5 HIW Overview and Primary Care Update QSE.pdf (4 pages)

2.6. Board Assurance Framework – Patient Safety

Nicola Foreman

2.6 BAF Covering Report.pdf (2 pages)
2.6a Patient Safety - BAF Risk.pdf (3 pages)

2.7. Patient Experience Overview

Angela Hughes

2.7 Patient Experience Overview QSE.pdf (10 pages)

3. Items for Approval / Ratification

3.1. QSE Committee Annual Work Plan

Nicola Foreman

3.1 Covering Report QSE Work Plan.pdf (2 pages)
3.1a QSE workplan 22.23.pdf (1 pages)

3.2. QSE Committee Terms of Reference

Nicola Foreman

3.2 Covering Report QSE Terms of Reference.pdf (2 pages)
3.2a QSE ToR.pdf (8 pages)

3.3. QSE Committee Annual Report

Nicola Foreman

3.3 Annual QSE Covering Report.pdf (2 pages)
3.3a draft Annual Report QSE 21-22 MDv2.NF.pdf (7 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:

4.1.1. CD&T Clinical Board Minutes –29.11.21 & 17.12.21

4.1.1a CD&T QSE Minutes 29.11.21.pdf (11 pages)

4.1.1b CD&T QSE MInutes 17.12.21.pdf (9 pages)

4.1.2. Children & Women's Clinical Board Minutes : 29.11.21 and 21.12.21

4.1.2a CW Minutes 23.11.2021.pdf (8 pages)
4.1.2b CW Minutes 21.12.2021.pdf (9 pages)

4.1.3. Specialist Clinical Board Minutes – 8 October 2021 and 19 November 2021

4.1.3a Specialist Clinical Board Minutes 08.10.21.pdf (7 pages)
4.1.3b Specialist Clinical Board Minutes 19.11.21.pdf (7 pages)

4.1.4. Mental Health Clinical Board Minutes - 21.10.21

4.1.4 Mental Health QSE Minutes - 21.10.21.pdf (8 pages)

4.1.5. Medicine Clinical Board Minutes – 21.10.21

4.1.5 Medcine QSE Minutes 21 October 2021.pdf (5 pages)

4.1.6. PCIC Minutes - 15.02.22

4.1.7. Clinical Effectiveness Committee Minutes

4.2. Corporate Risk Register

Nicola Foreman

4.2 QSE - Corporate Risk Register Covering Report - February 2022.pdf (3 pages)
4.2a Detailed Corporate Risk Register final.pdf (4 pages)

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

Susan Elsmore

6. Agenda for Private Board Meeting:

Ruth Walker / Meriel Jenney

i) Minutes of the Private Committee Meeting -14.12.21

ii) Pandemic Update & Any Urgent / Emerging Themes – Verbal

iii) Cardiac Surgery Report - Verbal

7. Any Other Business

Susan Elsmore

8. Review of the Meeting

9. Date & Time of Next Meeting:

Tuesday, 12 April 2022

Time 9am

10. Declaration

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Special QSE Committee
Held on 26th October 2021 at 9am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member - Council
Present:		
Gary Baxter	GB	Independent Member - University
Steve Curry	SC	Chief Operating Officer
Fiona Jenkins	FJ	Executive Director of Therapies & Healthcare Sciences
Meriel Jenney	MJ	Interim Executive Medical Director
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Ruth Walker	RW	Executive Nurse Director
Ceri Phillips	CP	Vice Chair
In Attendance:		
Annie Burin	AB	Patient Safety – Falls Lead
Tara Cardew	TC	Head of Patient Safety
Jayne Catherall	JC	People Experience Lead
Nicola Foreman	NF	Director of Corporate Governance
Judith Hernandez	JH	Operational Delivery Director
Angela Hughes	AH	Assistant Director of Patient Experience
Ann Jones	AJ	Patient Safety & Quality Assurance
Rajesh Krishnan	RK	Consultant Paediatric Nephrologist
Joy Whitlock	JW	Head of Quality & Safety
John Union	JU	Independent Member - Finance
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Akmal Hunak	AH	Independent Member

Item No	Agenda Item	Action
QSE 2021/10/001	**Welcome & Introductions** The Committee resolved that: a) The welcome & introductions were noted.	
QSE 2021/10/002	**Apologies for Absence** The Committee resolved that: a) The apologies were noted.	
QSE 2021/10/003	**Declarations of Interest** The Committee resolved that: a) No declarations of interest were noted.	
QSE 2021/10/004	**Chair's Action taken since the last meeting** The Committee resolved that:	

	a) There were no Chair's Actions noted from the last meeting.	
QSE 2021/10/005	**Hot Topics – Verbal** Tara Cardew (TC) delivered a presentation relating to patient safety & highlighted the following matters:– • NRI Process & Incidents and management reporting were undertaken. • Organisations had 120 days to review and report. • Mental Health were piloting suicide awareness and training to Mental Health staff. That would be evaluated by an independent review • The overall falls figure was starting to increase. • Cardiff & Vale University Health Board (the Health Board) had met the overall KPI. • A Falls Review Panel had been established. • There had been significant training and education with regards to patient falls • A Wound Healing team was launching a Pressure Ulcer Advisory Group. • There had been a number of staff challenges. It was likely that incidents had not been reported at the start of the pandemic. • The Swab and Sharp Instrument Policy had been updated. • At the start of the pandemic DATIX had an extra section added to it. • COVID incidents were not reducing in accordance with admissions • Safe 2 Move was delivered collaboratively – it's aim was to keep staff and patients safe. • DATIX had been developed as a concerns management system. • There were a significant number of open incidents. The Executive Nurse Director (END) thanked TC for the presentation. The aim was to highlight 3 areas – suicide, falls and pressure damage. The Independent Member for Trade Union (IMTU) acknowledged the breadth of services delivered by the Health Board and how the same were delivered in a professional way. He acknowledged that to do that correctly required resource together with the need to balance that resource. The Executive Director of Public Health (EDPH) queried whether the reason for the increase in falls was due to an increase in frailty. Annie Burin (AB) commented that she was considering a business plan to increase resources in the falls team. To date, there had been a focus on inpatient falls.	

	The Chair queried if the Health Board was in in constant dialogue with local authority partners? The Executive Director of Therapies & Healthcare Sciences (EDTHS) confirmed that was part of the Health Board's strategy. The central theme was rehabilitation, with the aim to keep people as independent as possible. The Independent Member for University (IMU) noted that the deep tissue damage figures had increased slightly. The END commented that whilst it was a challenge is to get the data correct, there was a growing number of patients with pressure damage. The Vice Chair noted that area of concern and recognised that some patients admitted to hospital may have a degree of damage from community settings. The END noted the comments made. She commented that the information did not suggest that acuity had increased during COVID. Frailty had increased. Staff may not have encouraged patients to move as much as they should be. There had been a huge improvement with regards to patients getting to theatre in a timely way. She acknowledged that suicide should be observed, although she noted that it was difficult to capture everything. A data analyst would be crucial to have as part of the team. Angela Hughes (AH) commented that that her team was looking at data definitions on the data quality at the all Wales meetings. The END noted there was a new framework and that a business case was being considered by the Executives to secure some additional resources.	
QSE 2021/10/007	**Quality, Safety and Experience Themes and Trends 2020-2021** Committee Members received a presentation from Vicky Stuart and the following matters were noted – • In March 2020 the Quality, Safety and Experience team introduced a seven day service. • A virtual visiting service was established. • Patients have been involved in their care and have used "what matters to you".. • A lack of communication with patients during COVID was recognised. • Staff were reminded of core values and reminders were sent out via "staff connects" to ensure all staff were aware of social distancing etc. • Currently there were 24 redress cases. • It had been recognised that some patients' personal items had been lost due to movements within the hospital • Feedback shared had shown how stressful staff had found inquests	

- It was important to highlight that the Patient, Quality and Experience team also received compliments.

The Interim Executive Medical Director (IEMD) noted that the loss of jewellery was concerning and queried if anything could be done to discourage patients bringing jewellery into hospital?

AH commented that there was a rise with regards to needles not being disposed properly. Regarding the property, a video was being developed for elective patients. There were currently 63 small claims, which was high and some work was being undertaken to address the issue, including the use of posters, cashiers and clear property bags. She acknowledged that money did not replace sentimental items.

The Independent Member for University (IMU) was pleased to hear that the team received compliments. He asked whether there had been any indications of poor staff attitude / behaviour and, if so, was that linked to stressful working?

The END recently undertook work in EU. She commented upon some staff / patients stories and staff stress in EU. The well-being services were discussed.

The Vice Chair noted there had been some complaints regarding the condition of some of the estate. He had been on a patients walk about and agreed with those complaints.

The END said that the patient & staff experience team had been fed in to the business case for UHW 2.

Bereavement Presentation

Faye Protheroe (Lead bereavement nurse) delivered a presentation and the following matters were noted–

- Links with a local counsellor service had been set up.
- Links were being set up with city hospice.
- Bank staff had been employed to take bereavement calls.
- Her team had to contact 2,500 next of kin during the pandemic.
- Over 120 of those bereaved were directed to a counsellor.
- People had thanked the team for caring, and feedback had been very positive

Joy Whitlock delivered an item regarding lessons learnt from deaths –

- Chief Medical Examiner had been complimentary in relation to the services the team had provided.
- Majority of families were complimentary about the care that had been provided
- The reports had been reviewed to determine what the next stage should be.

	• There had been some emerging themes, with communication being the biggest theme. Families were not able to speak to staff /patients. • Due to COVID restrictions, communication had been a big issue. IT have developed an IT tool to message relatives daily. • There was a need to be mindful of the impact upon the concerns team. A item regarding staff PPE was presented by Rajesh Krishnan- • Staff were wearing PPE for long period of time. • Issues had been raised on DATIX system. • Contacted dermatology colleagues who had opened a PPE clinic. A brief from the Clinical Effectiveness Committee was presented by Tara Cardew - • The committee would receive reports and assurance which would contribute to the Annual Quality Statement. • 22 national reports had been discussed and published. • All reviews undertaken would be discussed in the committee meetings. • A review of the committee's Terms of Reference would be undertaken. • A new Clinical Effectiveness Strategy would be reviewed. • The committee would work with clinical audit leads to identify any issues in a timely way. • The committee would work on the focus under the NICE guidance • The committee would continue to have membership on the Welsh network to ensure sharing across NHS Wales. • There was a plan to establish the process of tier 2 clinical audit. The IMU noted the dermatology issue which had arisen from staff wearing the PPE. He asked what the outcome was and had there been any recommendations to improve that issue. RK replied that there was a dedicated DATIX session regarding PPE and the main theme which had emerged was in relation to staff wearing PPE for a long time. Occupational Health was involved and had set up PPE clinics. The END commented that during the pandemic staff had seen a large number of patients pass away. She had recognised the work that had been carried out, in particular by the chaplaincy service and thanked all for their hard work. The Chair asked if all staff were supported by the bereavement service.	

	AH responded that all staff had been given support. They had provided support for staff during the pandemic along with the chaplaincy and well-being service. The EDPH queried whether the clinical effectiveness group, considered peer reviews? She noted that the paediatric diabetic review was due. The Committee were presented with two videos which related to patient surveys and the PENNA awards. AH thanked Jayne for the presentations. The IMTU thanked all for the presentations and the information shared. As an independent member of Health Board, he expressed his thanks to all volunteers. The IEMD agreed and noted that the key issue on a ward was how could volunteers give more support. The END thanked the team for the work that has been presented. The aim of the presentations was to illustrate the diversity and complexity of the team. She noted that patients continue to provide feedback and noted the need to have regard to that feedback in order to ensure no further harm. The Independent Member for Finance (IMF) asked if anything could be done to recognise the contribution made by the volunteers? AH commented that all volunteers were sent a “thank you” card and that, normally, there would be a “thank you” event. Due to COVID that could not take place. She also commented that some volunteers have been put forward for a volunteer award. The Executive Director for Therapies and Healthcare Sciences (EDTHS) thanked all for the hard work. The END wished to express her thanks to the volunteer who had sung at the last presentation and at the opening of the Dragon’s Heart Field Hospital. The Chair thanked all for their hard work. **The Committee resolved that:** a) The Quality, Safety and Experience Themes and Trends 2020-2021 were noted.	
QSE 2021/10/008	**Items to bring to the attention of the Board/Committee** The Chair noted a need to concentrate upon falls prevention, pressure damage and suicide. The END commented that staffing was noted on the risk register and that there was a need to be mindful that one of the risks for quality & safety of care was the staffing issue. **The Committee resolved that:**	

	a) The items to bring to the attention of the Committee were noted.	
QSE 2021/10/009	**Review of the Meeting** The Director of Corporate Governance (DCG) noted that the assurance provided by the session would be taken forward to the Board. **The Committee resolved that:** a) The review of the Committee was noted.	
QSE 2021/10/010	**Date and time of next Meeting: 15 December 2020 at 9.00am**	

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 14 December 2021 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Ceri Phillips	CP	Vice Chair of the Health Board
In Attendance		
Richard Desir	RD	Director of Nursing - PCIC
Amy English	AE	Deputy Chief Officer – Community Health Council
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Meriel Jenney	MJ	Interim Executive Medical Director
Helen Kemp	HK	GP / Deputy Clinical Board Director PCIC
Diane Walker	DW	Interim Deputy Director of Nursing PCIC
Ruth Walker	RW	Executive Nurse Director
Clare Wade	CW	Senior Nurse – Surgical Clinical Board
Observing		
Marcia Donovan	MD	Head of Corporate Governance
Meurig Francis	MF	Graduate Trainee Manager
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Fiona Kinghorn	FK	Executive Director of Public Health
Stuart Walker	SW	Interim Chief Executive Officer

QSE 21/12/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 21/12/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 21/12/003	**Declarations of Interest** No Declarations of Interest were noted.	
QSE 21/12/004	**Minutes of the Committee Meeting held on 15 September 2021** The minutes of the meeting held on 15 September 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 15 September 2021 were approved as a true and accurate record of the meeting.	
QSE 21/12/005	**Action Log following the Meeting held on 15 September 2021** The Action Log was received. **The Committee resolved that:** a) The Action Log from the meeting held on 15 September 2021 was noted.	
QSE 21/12/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
QSE 21/12/007	**PCIC Clinical Board Assurance Report** The Patient/Staff story was received. The Interim Deputy Director of Nursing PCIC (IDDN) advised the Committee that the story came from a District Nurse who had visited a patient. Upon performing baseline observations, she had noted that the patient's heart rate was 38 beats per minute and that the patient felt unwell. It was noted that the 999-emergency service was called and the patient was taken to hospital and was fitted with a pacemaker. The Executive Director of Therapies & Health Sciences (EDTHS) advised the Committee that the story showed that the Cardiff and Vale University Health Board's (the Health Board') Primary Care services were well used to holistic care rather than singular treatments. The END added that it was clear the pressures staff were under and noted that holistic thinking was good and helped patient outcomes. The PCIC Clinical Board Assurance Report was received. The Deputy Clinical Board Director PCIC (DCBD) advised the Committee that the PCIC Quality, Safety and Experience Committee Meetings had continued during the pandemic and that they were pivotal in ensuring that PCIC monitored and managed governance and/or performance issues with managed services and independent contractors. The Committee was advised of the progress that had been made during the past 18 months and how the same had supported the ongoing monitoring of the quality, safety and experience. As a result of Covid-19, a number of areas were developed, which had included: • A Covid- 19 safety risk register • The re-establishment of Quality and Safety meetings within all Business Units • Investment in the PCIC QSE team • Development of QSE Annual Plan	

The DCBD advised the Committee that assurance could be provided for all four independent contractors, and the governance relating to the same due to the regular monitoring meetings held with the both the GDS and GMS contractors.

It was noted that at the meetings, discussions took place with regards to incidents and/or concerns in relation to individual performers and/or individual practices.

It was noted that a further source of information in relation to GMS was the annual return which had just been sent out to all 59 GMS practices in the Health Board's area.

It was also noted that the Primary Care Team had been working on a quality dashboard which would detail matters such as complaints, concerns and access to services.

The DCBD advised the Committee that patient safety was paramount and that the welfare of practitioners was also important to the Health Board. She advised the Committee that the Clinical Board made proactive contact with practitioners.

The Independent Member – University (IMU) advised the Committee that Community Dental Services had received a mention in the report received by the Committee and he raised a concern following a Patient Safety Visit he had attended with the Executive Director of Public Health (EDPH). That was, there appeared to be an estates issue.

It was noted that the facilities were in much need of an update, especially considering that the service was trying to reach the "hard to reach" patients who were housebound, had severe learning difficulties or were from the refugee community.

The CC asked for clarity if the issues identified were safety based or environment based.

The IMU responded that it concerned the patient experience and that there was a possibility that patient safety could be at risk with crumbling ceilings and insufficient building structures.

It was also noted that a chair being used in the Community Dental Service was 40 years old and close to breaking at any given moment.

The DCBD thanked the IMU for raising his concerns and noted that the challenges raised within the Community Dental Service would be looked into.

The EDTHS advised the Committee that she was the lead for decontamination and that the Community Dental Service (CDS) had been reviewed 18 months ago where it was identified that it was one of the poorest estates within the Health Board and that it would need to be looked at again. The EDTHS also added that "old" did not necessarily equate to a requirement to no longer use that piece of equipment.

	The DCBD advised the Committee that the PCIC Clinical Board, in partnership with Ophthalmology colleagues, was about to open a retinal screening for hydroxychloroquine and chloroquine, and patients on hydroxychloroquine and chloroquine in January 2022. The END advised the Committee that mass vaccination also sat within the PCIC portfolio and noted that it was a changing picture hour by hour at the moment and asked if there was anything the DCBD wanted to share with the Committee in the context of mass vaccination. The DCBD responded that it she had wanted to ensure that all Clinical Boards were involved in the mass vaccination programme due to the impact it had from the workforce perspective. She queried whether some of the workforce required for the mass vaccination programme could come from other areas within the Health Board. The END noted that when the plan was put together initially for the booster vaccination, 89 pods were created rapidly to help deliver across the Health Board. She added that the Health Board had stepped down from the 89 pods because it was felt that there was a longer period of time but noted that from conversations had in the past 24 hours, that had changed and so the plan regarding 89 pods had been put back into action. It was noted that in relation to workforce, the request had already gone out to Clinical Boards whilst understanding the pressures being experienced across the Health Board. The EDTHS advised the Committee that a “Call to Arms” for staff had been issued and that a number of people had put forward their interest in helping with mass vaccination. The Interim Deputy Director of Nursing (IDDN) provided the Committee with assurance that the workforce process was working well and noted that emails from staff were being processed very quickly, as well as providing uniforms and other logistical areas of onboarding staff to the mass vaccination programme. The Deputy Chief Officer for the Community Health Council (DCOCHC) advised the Committee that there had been feedback from the public in the Penarth area that letters had been delayed due to postal issues. The CC responded that issue could be looked at offline. The END asked the DCOCHC to send an email and the relevant operational person would get in touch to discuss further. **The QSE committee resolved that:** a) The actions being taken by the PCIC Clinical Board were approved.	**RW**
QSE 21/12/008	**Pressure Damage Update**	

	The Pressure Damage Update was received. The END advised the Committee that the purpose of the report was to provide an updated assurance report to the Committee with regards to the goal to reduce health care acquired pressure damage within the Health Board. The Director of Nursing – Surgical Clinical Board (DNS) advised the Committee that she was the Chair of the Pressure Damage Collaborative Group which was set up earlier in 2021. It was noted that the group had taken over from the previous group that had been in place for a number of years. It was noted that there was a task and finish group across the Health Board, which had been stood down during the COVID pandemic. It was noted that the teams had come together and a refresh was implemented with a clear goal to reduce pressure damage. The DNS advised the Committee that the ambitious goal was to reduce health care acquired pressure damage across the Health Board by 25% by the summer of 2022. It was noted that the report gave an overview of (i) what the collaborative had achieved so far since it was set up earlier in 2021, and (ii) some of the data, that was available to the group, that had come out of E-datix reporting. The Assistant Director of Patient Experience (ADPE) advised the Committee a “Skin Safety Card” had been introduced and was an excellent way of empowering people. She thanked the DNS for the rebranding which was now working. The DNS responded that the Collaborative had been working with other Health Boards, mainly in England, and had implemented ideas that had worked. The Vice Chair of the Health Board asked to what extent were patients assessed in relation to the existence of pressure damage when admitted to hospital? The DNS responded that for many years the Health Board had used the “skin bundle” to monitor incontinence and nutrition and that it had been expanded recently, as part of the collaborative, to an assessment tool with multidisciplinary booklets and charts where pressure damage could be physically mapped. She added that a patient’s skin was always assessed within the first six hours of admissions to hospital. The Vice Chair of the Health Board noted that there was a need for (i) the Board to be alerted to the issue of pressure damage, as well as the	

	Committee being committed to look at pressure damage on a regular basis. The END responded that in six months' time a report should be brought back to the Committee with an update with regards to health care acquired pressure damage and whether the Health Board had seen a reduction in the same. **The QSE committee resolved that:** a) The contents of the report and the actions being taken forward to address areas for improvement were noted. b) An update report would be provided to the Committee in 6 months' time.	**RW** **NS**
QSE 21/12/009	**Quality Indicators Report** The Quality Indicators Report was received. The ADPE provided the Committee with a verbal update which included the following key areas: • Nationally reported incidents (NRI) It was noted that by using thematic analysis, areas were identified for learning and improvement and that improvements were now being put into practice. • Complaints The Committee was advised that there had been a significant rise in concerns being received by the Health Board. It was highlighted that it could be noted as a positive indication due to people being confident and comfortable to share their concerns. It was noted that the Patients Concerns team had moved to 7 day working week which had applied pressures over the weekends but that 30-day performance had been maintained. • Infection Control The Committee was advised that due to the acuity of patients and Covid-19 additional pressures had arisen with regards to infection control. • Pressure Damage The Committee was advised that the Serious Incident (SI) reporting process for Heath Acquired Pressure Damage had ceased during the height of the COVID pandemic. However, the Health Board had still captured the data and carried out appropriate investigations to ascertain learning and improvement during that period. • Mortality Reviews	

The Committee was advised that 7 reviews were being sent to the Medical Examiner service and that actions had been taken from the referrals received by the Medical Examiner for November which had included:

- 4 had been escalated to a full stage review (2 completed at present).
- 3 had been referred to the falls review panel
- 3 had been referred to the COVID investigation team
- 4 required no further action
- 6 others were escalated for a proportionate investigation (2 completed).

The Committee was advised that learning could be taken from the QSE information and data and a number of themes and actions were identified which included:

- Better communication with patients about their healthcare:
- Clinical Boards contacted patients to reassure them that they had not been forgotten.
- A corporate 7-day service for all enquires, visiting and mass vaccination queries.
- Pressure in Emergency Unit and across all “front doors” in the system:
- CAV 24/7 would be continuously promoted.
- The Majors Assessment Nurse (MAN) would be based at the front door of the Emergency Unit
- Concerns monitored on a weekly basis.

- In Patient Falls

The Committee was advised that there was a lot of ongoing work in relation to patient falls.

The ADPE advised the Committee of the key achievements seen within Patient Safety and Quality in 2021 which had included:

- Establishment of a Multidisciplinary Mortality Group
- A Medical Examiners Officer and system for level 2 reviews in all Covid cases was implemented.
- A Clinical Effectiveness Group with MDT engagement was established.
- Robust arrangements were put in place for the management of nosocomial Covid-19
- MDT Falls Review panel established.
- A 12-month Health Foundation Analytics project was completed.
- A virtual Patient Safety clinic was established to support staff with patient safety related issues/queries.

The END thanked the ADPE for the presentation and noted that she was looking at a way in which the data provided in the presentation could be brought back into quality and safety each time the Committee met.

The QSE committee resolved that:

a) The Quality Indicators Report was noted.

QSE 21/12/010	**Exception Reports** The IMD advised the Committee that it was very clear there were pressures at the "front door" which meant that patients were not getting to the front door with heart attacks, strokes and other conditions. It was noted that work was required at pace to help support staff and to alleviate pressures at the front door. The EDTHS noted that the Health Board had more patients in the system than ever before, they were staying longer than they perhaps should be and, that they were not always in the most appropriate place. As a result, the Health Board would see an increased incidence of falls. She noted that the learning being taken by the teams was a very positive outcome. The Vice Chair of the Health Board noted that the array of indicators presented should be contextualised, that performance had been generally maintained despite the difficult circumstances in which the Health Board had operated, and hence it was a significant credit to all concerned. He asked if more information could be provided on the increased prevalence of "C diff" in hospitals. The END responded that it was not being seen in hospitals but in Primary Care, and that it could be due to antibiotic prescribing. It was being looked at more closely. It was noted that very few of the patients related to inpatient stay and improvement of antibiotic prescribing would be required. The Independent Member University (IMU) noted that the data relating to stroke was not as comprehensive as he would have liked and noted that it had been a requirement for a detailed stroke report to be provided to the Committee. The END responded that it had originally been on the agenda for the meeting but noted a detailed report had been received twice by the Strategy and Delivery Committee, and hence it was not thought appropriate to bring the same report into different Committees. She added that the Interim Chief Operating Officer (ICOO) could meet the IMU outside of the meeting to discuss the report in detail. The Director of Corporate Governance (DCG) commented that a stroke report was planned to be received by the Board in January 2022 because it was deemed such a significant issue by the Committee. The END advised the Committee that in relation to pressures at the front door, she had, along with the IMD and the ICOO, met with clinical colleagues in the Emergency Unit (EU) to try and help them understand what action was being taken because they had not been sighted on that. It was noted that a further meeting had been scheduled that day with nurses, doctors, allied health professionals and managers across the	

	organisation to brief them on where the Health Board was, what was being done and how to take the actions forward. It was noted that the Health Board had over 400 patients who had been in hospital longer than 21 days. Of those 400 patients, 260 were medically fit for discharge and so it was very clear that the inability to be able to discharge patients in a timely way was putting pressure on the system and that, in turn, would cause harm to those that were waiting. The IMD added that the pressures were being addressed at pace and noted that it was a whole system issue. She added that there was a seven-point plan led by the Executives with senior responsible officers and wanted to provide that assurance to the Committee. **The QSE committee resolved that:** a) The verbal update regarding Exception Reports was noted.	
QSE 21/12/011	**HIW Activity Overview & Primary Care Update** The HIW Activity Overview & Primary Care Update was received. The END advised the Committee that the report was comprehensive and that the purpose of it was to provide the 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 sought to assure the Committee that action was already being implemented in response to the findings of those inspections and that appropriate monitoring of progress against the actions was being undertaken. The END advised the Committee that she was not concerned about any of the areas and that all areas identified were progressing well. It was noted that HIW were not identifying matters which the Health Board was not already aware of and noted that it was a very transparent report which aligned with the public reports. The END took the opportunity to say there was a lot of anxiety at the moment within the organisation that the HIW may come and visit and that the Health Board was not at the place it would like to be in with regards to the quality of care given in some areas and that was causing staff some considerable distress and worry. It was noted that everything was being done to support staff and discussions were taking place with regards to being open and transparent if and when HIW visit.	

	The Interim Medical Director (IMD) advised the Committee that she supported all of the END's comments. She added that she had met with all clinical leaders to discuss pressures across the board and the support that she could offer. The CC advised the Committee that discussions were also being had with Local Authority (LA) colleagues regarding the difficult circumstances and she wanted to alert Members that every part of the system needed to stand up and take responsibility for the pressures being seen across the Health Board. She added that there was one area of the report that had mentioned several incidents concerning staff feeling discriminated against in the work place and asked the END for a conversation offline to see what could be done. **The QSE committee resolved that:** a) The level of HIW activity across a broad range of services was noted. b) The appropriate processes are in place to address and monitor the recommendations were agreed.	**RW**
QSE 21/12/012	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The DCG advised the Committee that the full Board Assurance Framework (BAF) was presented to the full Board with ten risks identified. The Committee noted that patient safety was one of the top three risks alongside capital and workforce. It was noted that the difficulty with patients being unable to access the front door was now picked up in the BAF. **The QSE committee resolved that:** a) The risks in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 21/12/013	**Incident, Near miss and Hazard reporting Policy** The revised Incident, Hazard and Near Miss Reporting Procedure was received. The END advised the Committee that all polices noted had been through a robust process and was confident that it had been agreed at all levels. **The QSE committee resolved that:**	**NS**

	a) The revised Incident, Hazard and Near Miss Reporting Procedure was approved.	
QSE 21/12/014	**Patient Identification Policy** The Patient Identification Policy was received. **The QSE committee resolved that:** a) The updated version of the Patient Identification Policy which had been shared for consultation was approved.	**NS**
QSE 21/12/015	**Patient Falls Policy** The Patient Falls Policy was received. **The QSE committee resolved that:** a) The Patient Falls Policy was approved.	**NS**
QSE 21/12/016	**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) Mental Health Clinical Board Minutes e) Medicine Clinical Board Minutes f) PCIC Minutes g) Surgical Clinical Board Minutes The IMD advised the Committee that in the Children & Women's Clinical Board minutes an update on the maternity lift was asked for. The END responded that clarity would be sought and circulated to the Committee. The ADPE advised the Committee that it would be good to look at all of the minutes and for members of the Committee to provide any feedback/queries 48 hours before the Committee meeting. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees be noted.	**RW** **NS**
QSE 21/12/017	**Corporate Risk Register** The DCG advised the Committee that there was nothing further to add and that the report could 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 Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates was noted.	
QSE 21/12/018	**Patient Safety Solutions** The Patient Safety Solutions information was received. The END advised the Committee that the report would be taken as read and noted that the performance was being managed with Welsh Government. **The Committee resolved that:** a) The progress with compliance to implement of Patient Safety Solutions (PSS) was noted.	
QSE 21/12/019	**Section 23 – Ombudsman Report.** The Section 23 – Ombudsman Report was received. The END advised the Committee that on 7th December 2021 the Ombudsman had issued a section 23 Public report against the Health Board under the Public Services Ombudsman (Wales) Act 2019. It was noted that the Health Board had actioned all of the matters flagged within the report. The ADPE advised the Committee that the Health Board had offered to meet with the Patient involved. **The Committee resolved that:** a) The content of the report was considered and the agreed action was noted.	
QSE 21/12/020	**Update from Clinical Effectiveness Committee** The Update from Clinical Effectiveness Committee was received. The IMD advised the Committee that the Clinical Effectiveness Committee was constituted in December 2020 and that it had met ten times despite the pandemic and noted that it was part of the QSE framework. It was noted that there were over 30 national audits in the last year, and that the group reviewed patient safety solutions, compliance with safety alerts, peer reviews, complaints with NICE and other guidance. It was noted that action trackers were in place which were built around the peer reviews as part of the strengthened audit arrangements. **The Committee resolved that:**	

	a) The Update from Clinical Effectiveness Committee was noted.	
QSE 21/12/021	**Value of Volunteers** The Value of Volunteers information was received. The END advised the Committee that the role of hospital and community volunteers had adapted during the pandemic to support the changing agenda. It was noted that the paper celebrated some of the Volunteers' activity. The ADPE advised the Committee that the volunteers should be cherished because the Health Board could not run many of the services without volunteers. The CC asked the relevant members to relay the Committee's thanks and commendation to volunteers. **The Committee resolved that:** a) The work and support undertaken by volunteers in the Health Board was noted	
QSE 21/12/022	**Items to bring to the attention of the Board / Committee** The END advised the Committee that the risks being held within the organisation would need to be identified at Board level and that it would be raised during the Systems Resilience Report. The CC advised the Committee that she would publicly thank the Health Board staff and volunteers in the January 2022 Board meeting.	
QSE 21/12/023	**Any Other Business** No other business was received.	
QSE 21/12/024	**Review of the Meeting**	
QSE 21/12/025	**Date & Time of Next Meeting:** Tuesday 22 February 2022 at 9am	

Action Log

Quality, Safety & Experience Committee

Update for meeting 22 February 2022
(Following the meeting held on 14 December 2021)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 21/06/012 21/09/005	Pressure Damage Report	A pressure damage update would be brought to the December 2021 meeting following conversations with Independent Member - Legal	14.12.21	Ruth Walker	**COMPLETE** A pressure damage update report was presented to the QSE Committee in **December** (Agenda **item 2.2).** (Note Action number 21/12/008).
Actions in Progress					
QSE 21/12/016	Maternity Lifts	END would seek clarity around lifts being fixed.	22.02.22	Ruth Walker	Update to be provided in February
QSE 21/12/011	HIW Activity Overview & Primary Care report of discrimination	Concerns were highlighted in relation to several instances of staff feeling discriminated against in the workplace. An improvement plan has been submitted and accepted by HIW which includes actions to ensure measures are in place to eliminate potential areas of discrimination	22.02.22	Ruth Walker	Update to be provided in February
QSE 21/12/007	Mass Vaccination Letter issues - Penarth	The Deputy Chief Officer for the Community Health Council advised the Committee that there had been delayed letters due to postal service	22.02.22	Ruth Walker	Update to be provided in February

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		END requested an email to sort this out via operational means.			
QSE 21/12/008	Pressure Damage Update	A further updated pressure damage report to be brought back to the QSE Committee in 6 months' time.	14.06.22	Ruth Walker	To go to the June QSE Committee
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	27.01.22	Stuart Walker / Ruth Walker	**COMPLETED** Update reports were presented to January Board

Reference Number: *UHB 492* **Version:** 1	**Date of Next Review:** *27 December 2024* **Previous LHB Reference Number: N/A**

Approval of Gene Therapy Medicinal Products (GTMP) and Gene Therapy Investigational Medicinal Products (GTIMP) policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that GTMP use and trials using GTIMPs comply with regulations, and are conducted in a way that minimises risk of infectivity to patients, staff, other members of the public, and the environment.

Policy Commitment

The UHB are committing to use GTMP and GTIMPs safely and in accordance with relevant regulations.

Supporting Procedures and Written Control Documents

This Policy and supporting procedures describe the following with regard to GTMPs & GTIMPs

- Approval for use and safe management including compliance with relevant regulations
- Appropriate HSE notification
- Review of all licenced and unlicenced GTMPs as well as use of GTMPs in trials by the GMSC
- Clarification of roles and responsibilities of those involved in the delivery of GTMPs/GTIMPs
- Explain how advice on the risk of infection from genetically modified organisms (GMOs) is provided and any risks (to patients, staff, public and environment) are minimised

Other supporting documents are:

List all documents the reader needs to be aware of alongside / in support of this document

- Approval of GTMP & GTIMP procedure
- GTMP Handling SOP
- C&V UHB GMSC Risk assessment form,
- Pan UK PWG for ATMPs – Gene Therapy Governance and Preparation Requirements (available from www.sps.nhs.uk)

Scope

This policy applies to all of our staff in all locations including those with honorary contracts. This policy covers all clinical trial or other therapeutic use of GTMPs/GTIMPs which will be administered to C&V UHB patients or handled and administered on C&V UHB premises. All staff members who are involved in the approval and use of GTMPs/GTIMPs must be aware of this policy, along with the responsibilities and requirements specified throughout.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.

Policy Approved by	Quality Safety and Experience Committee (QS&E)
Group with authority to approve procedures written to explain how this policy will be implemented	Genetic Modification Safety Committee
Accountable Executive or Clinical Board Director	Executive Medical Director

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	27.12.2021 Via Quality, Safety & Experience Committee Chair	30.12.2021	*new document,*
2			

Report Title:	**Surgery Clinical Board Assurance Paper – 2021/2022**								
Meeting:	**Quality, Safety and Patient Experience Committee**						**Meeting Date:**	22 February 2022	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Ruth Walker – Executive Nurse**								
Report Author (Title):	**Clare Wade- Director of Nursing for Surgery Clinical Board and Carolyn Alport Clinical Leader for Quality and safety**								

Surgery Clinical Board
Bwrdd Clinigol Llawfeddygaeth

SITUATION

This report provides details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2021. It will also highlight the actions and progress of the Surgery Clinical Board during the COVID pandemic.

BACKGROUND

Between January 2021 – December 2021 the Surgery Clinical Board had 5 Service Groups which provide a significant number of emergency and elective services to Cardiff and Vale residents which include Trauma and Orthopaedics and Breast, Spines, General Surgery and Urology, Head and Neck and Perioperative Care. The Clinical Board employs over 2209 wte staff and has a budget of £140 million.

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

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

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

The Surgery Clinical Board has a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly which is co-chaired by the Clinical Quality and Safety Lead (Consultant Anaesthetist) and the Director of Nursing for Surgery Clinical Board. This structure is formally replicated in each of the Clinical Directorates. The QSPE group has three key sub-groups that report to it; a Health and Safety group, Infection Prevention and Control group and the Thromboprophylaxis Thrombosis and Anticoagulation group.

Due to the COVID pandemic these groups have not met at such regular intervals due to the challenges of the environment and challenges of workload in 2021.

ASSESSMENT

Safe Care

Governance, Leadership and Accountability

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

The group met on the following dates during 2021

Jan 2021

Mar 2021

Jul 2021

Sep 2021

Nov 2021

The Clinical Board Covid Risk Register is monitored at Directorate and Clinical Board level on a regular basis locally. The top 4 current risks on the Covid Risk register as of January 2022 are:

Risks	Mitigation
Patient or staff harm due to insufficient deployable workforce (medical and nursing) and challenges to separate staffing amber and green zones and new additional capacity areas in both inpatients' areas and theatres on the back of COVID. There are also the impact staffing issues have or remaining staff in regard to, morale, sickness levels, training & development.	1. UHB wide multi professional approach is being utilised. 2. Ongoing efforts of the work force hub and public recruitment campaign for nursing 3. Allocation of workforce lead for Surgery Clinical Board for junior doctors .4. Micromanagement and contingency plans put in place on a daily basis by lead/senior nurses. 5. Staffing plans put in place for future wards (green Zone UHL) . No staffing plan currently for physio area if required. A detailed workforce plan is in place at Clinical Board level for Nursing recruitment. Regular recruitment events and campaigns

	undertaken. Substantive staff are rostered to risk areas on a daily basis. HB protocol for specialing patients adopted.
Increased morbidity and mortality to emergency surgical patients not presenting to hospital with significant medical illness due to Covid related fears. Lack of Surgical Assessment unit space due to social distancing requirement	1. Work undertaken by communications team to reassure the general public that hospitals remain safe places to present with acute medical illness. 2. Ongoing monitoring of non-covid mortalities/morbidity by Public Health. 3. Audit data on emergency patients has been collected since March 2020. Screening for Covid for every DTA patient. Clear zoning of Areas in UHW and UHL to ensure. Consultant triage of GS patients via dedicated hot line in SAU. TACU review for ambulatory trauma patients
Failure timely access to surgery which significantly affects the patient's quality of life and can in some cases exacerbate their condition. Increased risk to patients whose condition may deteriorate whilst waiting for surgery due to Covid	Development of Green Zones in both UHW and UHL to protect cancer and urgent patients who require surgery. Proactive Discharge Planning required to ensure bed availability in a timely manner and ensure. Quality assurance of patients waiting on list is undertaken and treatment expedited if GP requests urgent referral or if information received indicated urgent need of referral - this is overseen by a consultant. Weekly discussions to review longest waiters and the appropriate booking of them. Audit data on surgical patients has been collected since March 2020. If a patient's condition deteriorates whilst they are awaiting surgery or before their planned follow-up date they are able to contact us and we will book them into clinic for review with their consultant
There is a risk of suboptimal staff experience due to the unprecedented number of changes and departmental moves, at pace, over recent months and likely for over the next few months. This may lead to increased absence and decreased retention. Saunders,Nathan 02/16/2022 09:50:2	1.) Increased face: face Comms by Clinical Board Senior Leadership Teams with ward/departmental staff; (2.) Prospectively plan ward/dept moves in advance in order that good Comms can take place; (3.) Engage with Staff Wellbeing team should staff require enhanced support 4/ Early engagement with Union Colleagues. 3 times a week CB (Clinical Boards) meeting with Senior Teams - regular updates disseminated from meeting. Staff drop in sessions

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 (Quality and Safety Clinical Leader) 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.

Health Promotion Protection and Improvement

Covid Safe

Our IPC and H&S meetings over the last 12 months have focused on making all our clinical/ admin and communal areas as COVID safe for our staff and patients as we can. This has been a challenge, but we have been able to work closely with our IPC, Microbiology, Union and Health and Safety colleagues in managing and monitoring this and in supporting staff in making the right decisions.

H&S and IP&C dates 2021

Feb 2021

Apr 2021

Jun 2021

Oct 2021

National reportable incidents (NRI's) and No Surprise Incidents reported to Welsh Government

Between 01/01/2021 and 31/12/2021 the Surgery Clinical Board reported 9 NRI (National Reportable Incident) and 0 No Surprise events to Welsh Government.

Never events

There was 1 reported never event in this period where a robust RCA has been carried out

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

Table 1- Themes of the NRI's

	Total
Administrative Processes (Excluding Documentation)	1
Exposure to Environmental Hazards	1
Medication/Biologics/Fluids	1
Patient Accidents/Falls	3
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	2
Total	9

1943 patient incidents were reported by Surgery CB between 01.01.2021 to 31.12.2021

Table 2 - Top 10 themes

	Total
Pressure Ulcers/Moisture Lesions	630
Patient Accidents/Falls	524
Medication/Biologics/Fluids	105
Medical Devices, Equipment, Supplies	105
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	86
Documentation	66
Diagnostic Processes/Procedures	62
Communication	59
Infection Control Incident (Healthcare Associated Infection)	53
Administrative Processes (Excluding Documentation)	52
	1742

Falls

There were 3 injurious falls reported as National reportable incidents between 01.01.2021 to 31.12.2021. 2 were from T&O, 1 from General Surgery Directorate. No common themes were identified.

HM Coroner's inquests and regulation 28 reports

The Clinical Board has been involved in 3 inquests between 27/4/2021 and 29/9/2021 (where Surgery was the managing Clinical Board). Of these, none received a regulation 28 report.

Relevant Coroner and Ombudsman reports and recommendations are considered by the Directorate and Clinical Board Quality and Safety Groups.

IPC and Health Care acquired infections

Infection Type	01/01/21 – 31/12/21
Clostridium difficile	25
Methicillin Resistant Staphylococcus Aureus (MRSA) bacteremia	3
Methicillin Susceptible Staphylococcus aureus (MSSA) bacteraemia	10
Escherichia coli (E. Coli) bacteraemia	16
P.aeruginosa	3
Klebsiella spp	8

Clostridium difficile

Total 25 cases 01/01/21 – 08/12/2021
There has been a noticeable increase in C-Difficile over the past 12 months, this is a general trend throughout the UHB, the rationale for this is that patients are more unwell and sicker on admission, and as a consequence require multiple anti-biotics over a longer period of time.

The SCB have introduced the All-Wales medication anti- microbial charts (ARK (Antimicrobial Review Kit)) on all ward and are working with Pharmacy leads to monitor and audit anti-microbial prescribing. IPC are also working with nurses & doctors in targeted areas to increase education related to C-Difficile and the reduction of, and a task and finish group has been set up on B6 to audit and improve practice.

Methicillin Resistant Staphylococcus Aureus (MRSA) bacteremia

Total 3 cases 01/01/2021 – 31/12/2021
(11/03/2021, 16/06/2021 & 07/12/2021)

Methicillin Susceptible Staphylococcus aureus (MSSA) bacteraemia

Total 10 cases 01/01/2021 – 31/12/2021
8 cases from 02/02/2021 – 11/06/2021
2 cases from 11/09/21 – 21/12/2021

MSSA has shown a steady decline over the past 12 months with only 2 cases in the past 6 months

Escherichia coli (E. Coli) bacteraemia

16 cases 01/01/2021 – 31/12/2021

3 cases 02/02/2021 – 06/05/2021
6 cases 02/07/2021 – 05/11/2021

The general trend remains the same, but a reduction of infection is noted between the second quarter of the year between April to June 2021

P.aeruginosa

3 cases in total 22/07/21, 28/07/21 & 06/10/2021.

Klebsiella spp

Total of 8 cases from 01/01/2021 – 31/12/2021

There has been a notable reduction in the last 3 quarter of the year

Staff related incidents reported in 2021

	Total
Contact with Sharps	69
Contact with Potentially Infectious Materials	12
Contact/Collision with Objects/Animals (not sharps)	21
Entrapment	1
Exposure to Hazardous Substances	5
Exposure to Unhygienic Environmental Conditions	4
Exposure to Unsafe Environmental Conditions / Lack of Personal Protective Equipment	30
Inappropriate/Aggressive Behavior towards Staff by a Visitor	16
Inappropriate/Aggressive Behavior towards Staff by a Patient	76
Inappropriate/Aggressive Behavior towards Staff by Staff	16
Lifting/Manual handling	25
Other	1
Other	1
Slip/Trip or Fall	29
Unauthorised access/disclosure	1
Workplace Stressors/Demands	20
Total	327

RIDDOR related incidents reported in 2021

RIDDORS	**Total**
Total	9

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 and is well supported by the Corporate Health and Safety Team.

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 2021/2022. 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:

	Specialty	Tier 1 National Audit	Tier 2 Quality and Safety Priority (Local Audit)
Surgery	Dental		An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.
Surgery	Dental		Re-audit WHO (World Health Organization) checklist in oral and maxillofacial surgery
Surgery	General Surgery	National Oesophago-Gastric Cancer Audit	
Surgery	Urology		National Renal Colic
Surgery	general Surgery	National Audit of Breast Cancer in Older People	
Surgery	Urology		Monitoring of compliance with UAG guidance: Trans-ureteral resection of bladder tumour surgery
Surgery	Urology	National Prostate Cancer Audit	COVID stones
Surgery	Urology		Audit of Stress urinary Incontinence I Women
Surgery	Urology		Audit of Urethroplasty
Surgery	Urology		Audit of Cystectomy
Surgery	Urology		Audit of Nephrectomy
Surgery	Urology	Renal Registry (Renal replacement therapy)	
Surgery	Urology		Audit of Scrotal Pain Pathway Audit
Surgery	Urology		Audit of Consent for day of surgery admission patients
Surgery	Ophthalmology	National Ophthalmology Audit	
Surgery	Anesthetics		Obs Cymru
Surgery	Trauma and Orthopaedics		Fragility Fracture post-operative mobilisation.
Surgery	Trauma and Orthopaedics		Does the management of Pelvic Fractures in UHW

			adhere to BAST guidelines (joint T&O)
Surgery	Trauma and Orthopaedics		Re-audit of the spinal admissions pathway following the introduction of the Major Trauma Centre at UHW
Surgery	Trauma and Orthopaedics		The management of Fragility Fractures across Cardiff and Vale UHB (BOAS Standard)
Surgery	Trauma and Orthopaedics		Assessing the Quality of T&O operation notes (RCOS guidelines for documentation)
Surgery	Trauma and Orthopaedics		Spinal Venous Thromboembolism Audit - UHW Amber (NICE NG89)
Surgery	Trauma and Orthopaedics	National Joint Registry	Audit of Medical Record keeping on T&O (Joint with medical students
Surgery	Trauma and Orthopaedics	National Hip Fracture Database	
Surgery	Peri-operative services		WHO checklist
Surgery	General Surgery		National Audit of Pediatric Mastoiditis
Surgery	General Surgery		BAETS UK registry of endocrine and thyroid surgery
Surgery	General Surgery	National Oesophago Gastric Cancer Audit	PANC study (Pancreatitis: a National Cohort Study)
Surgery	General Surgery		PQUIP
Surgery	General Surgery	National gastrointestinal cancer audit	Audit of Appendicitis inflammatory response scoring
Surgery	General Surgery		SWORD pouch surgery database
Surgery	General Surgery		Pelvic floor national database (mesh rectopexy)
Surgery	General Surgery	National Vascular Registry	Peri-operative treatment of rectal cancer prior to and during COVID (NICE quality standard - 4)
Surgery	General Surgery	National Emergency Laparotomy Audit	Hepatobiliary Multi - disciplinary imaging review of colorectal cancer patients with intrahepatic metastases (NICE quality statement 6)

Perioperative Quality Improvement Programme

Since March 2019 we have been recruiting patients across the health board to PQIP (Perioperative Quality Improvement Programme) Perioperative Quality Improvement Programme This research project is multicentred and collects perioperative data on those patients undergoing major elective surgery. We recruit from the majority of surgical specialties and to date have collated data on 594 patients across the health board.
This project has been influential in providing data to improve perioperative care in our patients in areas such as anaemia management, improving starvation times, diabetes pathways and enhanced recovery.
PQIP has been supported by a fantastic team in the anaesthetic and R&D department and have managed to continue recruitment throughout the majority of the last year -despite pressures from the pandemic.

Dignified Care

Dignified care inspections and CHC inspections carried out in 2020-2021 have not identified any areas of significant concern specifically in relation to dignity. 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.
Surgery Clinical Board have worked closely with the Professional standards Senior Nurse on being a pilot site for this scheme are leading on this work and plan to have several Bronze accredited wards by Feb 2022 using the Perfect Ward digital app. Current audits include; Key Harms, IPC and Environment, Medication Management and Documentation. We hope to role this accreditation scheme out to theatre and outpatient settings

Timely Care

Ophthalmology Mobile Theatres

Since March 2019, a significant amount of Cardiff and Vale UHB's routine elective operating was cancelled or greatly reduced due to the Covid-19 pandemic. One such speciality that was affected as a result of this was ophthalmic surgery, specifically cataract surgery. This reduced ability and capacity to perform cataract surgery led to significant volumes of patients waiting, in some cases for over two years, for their surgery to be performed. The number of patients on waiting lists for treatment was significant and the Health Board recognised this.

Therefore, as part of the Health Board's recovery programme, it was decided that measures had to be implemented to reduce the volume of patients waiting for cataract surgery and decrease the amount of time that patients were having to wait for their surgery. In order to do this Peri-Operative Care Directorate needed to ensure that there was the capacity to perform more cataract operations than pre-covid and that the increase of the operating lists available was efficient and could cope with high volumes of patients.

A business case was written, which was approved by Welsh Government, which enabled the Health Board to have the funding for two mobile theatres, and also a bespoke modular admission and discharge unit to run extra high-volume cataract lists for 12 months. After going through a tender process, the company chosen to supply these theatres was Vanguard Healthcare Solutions. It was decided that the mobile theatres and unit would be positioned on the (now closed) disabled car park opposite Lakeside Wing at the University Hospital for Wales and that the additional disabled car parking that had been made available in car parks 8 and 9, would continue.

Peri-Operative Care have worked closely with the Ophthalmology Directorate and various stakeholders, such as Estates, Facilities, Resuscitation service, Health and Safety, Temporary staffing, Pharmacy, Security, IT (Information Technology) and many more Directorates to progress this project in a short time frame. The units started arriving on the site at the end of October 2021 and were officially handed over to Cardiff and Vale UHB on the 10th of January 2022. The Go-live date for the units is 7th February 2022. The plan once the theatres are operational is to operate on approximately 24 patients per day, this will greatly help to reduce patient waiting times and will be a significant step in our Health Board's recovery plans.

Validation Exercise

To support with ensuring new outpatient waiting lists are validated as accurately as possible a joint approach with Healthcare Communications was undertaken, initially targeting C&V patients waiting over 52 weeks.

Patients are contacted via SMS and/ or paper letter and are asked to complete an online digital or paper questionnaire to confirm if they wish to remain on the waiting list and an opportunity to update on their condition.

Patient eForm Record Details

Do you still require your outpatient appointment?

Yes

You have answered 'NO' to question 1. We would like to know the reason/s why you no longer want an outpatient appointment. Please tick all that apply:

Not Answered

You will be placed on a list for six months. If during this time your symptoms recur, you can contact the hospital for a review of your condition. You DO NOT need to be referred again by your GP. If you have not made contact in the six month period we will contact you to confirm removal from the waiting list. Please note that this ONLY applies to the condition/reason you were originally referred for. For all other conditions, please contact your referrer.

Not Answered

Please specify

Not Answered

You have answered 'YES'. You will be contacted for an appointment according to your clinical urgency. This may be a face to face, telephone or video consultation. In order to understand a little more about how your condition affects you, please complete

Other

C&V UHB Approach to New Outpatient Validation

Cohort Identified	Digital 1st Approach	Text and Letter Templates	Response	Non-Responses	Clinical Engagement	Non Compliant Patients
• Nationally agreed process to validate and liaise with new outpatients waiting over 52 weeks who have not been see for their first attendance • Our health board feel it is important to communicate with all patients waiting 4 months and over.	• SMS message sent to patients with link to online validation letter and questionnaire. Each message contained a unique PIN for patients **(see copy of letter attached)** • Any patients who had not responded within 48 hours or who could not be sent a SMS were sent a paper validation letter/ questionnaire	• Patients have an option to respond via online link or by letter with pre-paid envelope. • The questionnaire asks to check the patient demographics are correct, if they want to remain on the waiting list and if not why. We also ask how their condition is. Whether it is the same or has worsened **(using simple scale)**.	• Responses are collated and information shared with clinical teams. • Those patients who have responded stating appointment no longer required are removed and their details recorded.	• As an added governance measure if a patient has not responded within four weeks we send a reminder letter. • This requests that the patient provide a response within two weeks if they wish to remain on the waiting list.	• Clinical teams and primary care will be informed of change in plan by speciality. • Patients who have indicated that their condition has deteriorated greatly are flagged with the clinical team.	• Patients not responding to the prompt letter are removed per WG guidance. • Further letter is sent to patient and referrer outlining their removal from the waiting list with an option to contact within 2 weeks if they feel this was done in error.

June 2021 – December 2021 Validation Process

Total patients contacted – 21,239

Remain on waiting list – 14,402

- Removed (no response) – 4,497
- Removed (patient choice) – 1,738
- No response (not removed) – 273
- Reinstated after removal – 139
- Covid unavailability suspension (6 months) – 114
- Letters not received (remain on list) - 76

Prehab

The Prehabilitation Service started seeing patients with suspected or confirmed Colorectal, Hepatobiliary and Upper GI cancer in September 2021. The aim of the service is to get patients fitter, stronger and psychologically ready for cancer treatment. The service supports patients from across Cardiff and Vale and also those patients out of area who are having surgery within the organisation. The patients are referred by their own teams, at an early stage in their pathways and are seen within 5 days of referral by a senior therapist for Initial Assessment and Triage. The Prehabilitation therapies team consists of dedicated physiotherapists, dietitians, occupational therapist and prehabilitation support workers. They are supported by the project Clinical Lead, Macmillan AHP Cancer Lead, Lead Surgeon, Lead Anaesthetist and Lead Cancer Nurse. The patients are given a programme to improve their exercise, diet, and wellbeing according to their individual needs whether that be for one-to-one supervision, to join a group setting, or more independently with regular follow-up. The programme has seen 150 patients at the time of writing and will soon report on the initial measured outcomes prior to treatment, as well as monitoring perioperative outcomes in the postoperative period and those relevant to ongoing treatment.

HealthPathways in Surgery

Numerous pathways are active or in development within Surgery Clinical Board. Standard pathways have been localised in breast surgery, colorectal surgery, ENT, and urology and virtually all are complete in acute general surgery and paediatric orthopaedics. Pathway work is currently ongoing in ophthalmology and orthopaedics. We have asked all primary care clinicians, via a quarterly surgical update, to follow the HealthPathways to ensure that patients are referred who have a surgical solution to their condition and that those patients referred truly want a surgical procedure.

There is ever increasing utilisation of the HealthPathways by primary care, but this is not universal. The establishment and employment of Interface GPs within surgical departments to work across the traditional primary-secondary care divide is helping to embed HealthPathways and joint working. An area where development has been poor is in the triaging of the referrals received by secondary care against the localised HealthPathways. This has major implications on patient care, further magnified by the increased waiting times created by the pandemic. An example of this impact is seen in patients referred to an orthopaedic hip surgeon with lateral hip pain. There is no surgical solution

and patients referred can wait up to 2 years to be seen by a consultant to then be re-directed to physiotherapy services. Having established the lateral hip pain syndrome pathway with the appropriate triaging of orthopaedic hip referrals any patients sent down the wrong referral stream could be re-directed to the benefits of the referred patient and the hip orthopaedic waiting times.
Having reached a critical number of localised HealthPathways, to see the benefits, we must now use the agreed protocols to ensure the patient sees the right clinician by applying the pathways.

Future plans:

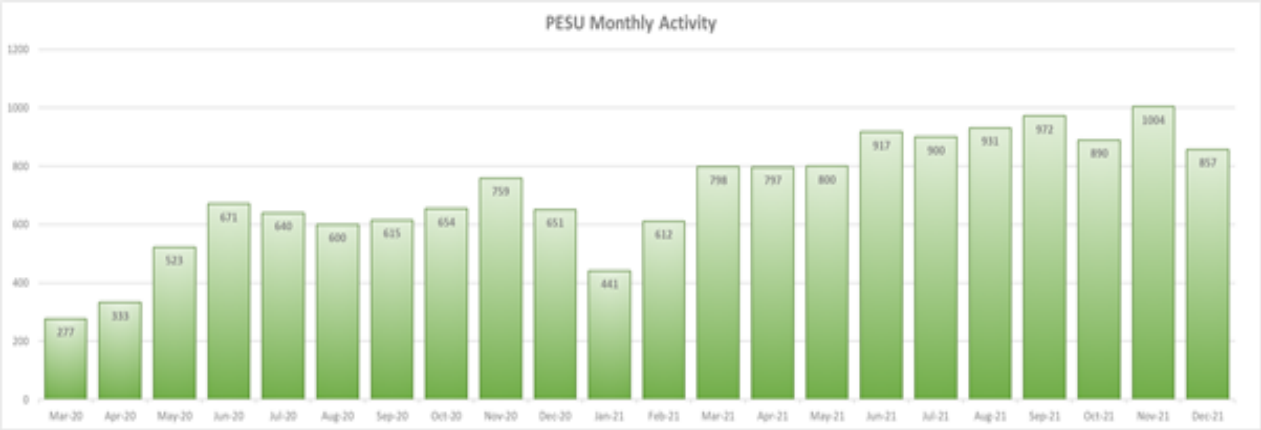
1. To create a physical and virtual space, the HealthPathways Development and Referral Centre (HDRC), where clinicians from both primary and secondary care can work together to finish localising HealthPathways, identify additional pathways within departments and modify current pathways as needed.

2. Create a multidisciplinary team, led by the interface GPs within individual departments, to triage all incoming referrals against the localised HealthPathways. Each department will require a unique mix of staff and time dependant on the number and type of referrals. Some departments will need daily reviews of referrals to identify urgent suspected cancer (USC) referrals where as others, without these demands, could undertake batched reviews. Audiologists, physiotherapists, nurses with experience in a department, nurse practitioners, podiatrists, hand therapists, GPs, senior trainees and consultants could all make up this multidisciplinary triaging team.

Protected Elective Surgery Unit

Extensive work continues in Surgery Clinical Board at University Hospital of Wales (UHW) and University Hospital Llandough (UHL) to create dedicated green zones to enable more patients to undergo urgent surgery. The green zone in UHW was enabled patients to undergo surgical procedures including neurosurgery, urology and general surgery, gynaecological, ear, nose and throat (ENT), and cataract surgery. At UHL, a green zone has been established to enable increased access to cardiac and thoracic surgery, orthopaedics and breast surgery.
Protecting patients, their families, and staff from COVID-19 is of vital importance, with the meticulous planning by the Surgery Clinical Board in conjunction with Children and Women, Specialist, CD&T and the support of estates and IPC allowing for an increased number of time sensitive surgeries to take place.
Patients due to have surgery are asked to self-isolate for 3 days prior to their procedure and take a COVID-19 test 72 hours before being admitted to hospital. When travelling to hospital, patients are asked to travel in a private vehicle avoiding public transport and the use of taxis. To further increase patient safety, the green zones have dedicated entrances and exits, and staff working in the green zones are required to remain in the dedicated zones for the entirety of their shift.
In order to support staff in this endeavour, new staff areas, changing rooms and showers have being constructed within these green zones. Any deliveries to the units are contactless using a “drop off” door system.

All of these measures are absolutely necessary so that staff are supported in their efforts to make patients as safe as possible as we continue to bring more of our services back online.



So far as of the 31st December 2021 we have operated on the following numbers via a Green Pathway:

Patients treated in PESU Green Zones		
UHW	UHL	External
9312	3585	2745

Vascular Centralisation

In spring 2022 the South East Wales Vascular Network will launch following a public engagement and investment in services across adult pathways of care covering four Health Board populations: Aneurin Bevan University Health Board (ABUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Powys Teaching Health Board (PTHB) and Cardiff and Vale UHB (CAVUHB). The aim is to ensure a unified service which will underpin the creation of a safe, sustainable, equitable service for the population that is in line with the rest of the UK.

The new model of care includes the implementation of a high volume vascular surgical service at the Major Arterial Centre (the hub) located at the University Hospital of Wales, whilst delivering appropriate local care for assessment and rehabilitation through local non-arterial centres (the spokes) at the Royal Glamorgan, the Grange University Hospital and University Hospitals Llandough. There will be an increase of around 530 vascular patients being transferred to the University Hospital of Wales per year from across the region.

The aim is to ensure equitable and timely access to surgery for all patients in SE Wales with care closer to home wherever possible.

Teams from across the region have come together to develop and plan for a new model of care that will ensure:

- A sustainable service that will be able to recruit the appropriate clinical workforce
- Improved patient outcomes through the delivery of a high volume Major Arterial Centre that meet the minimum population recommendations (VSGBI, NCEPOD, GIRFT, WAASP)
- Delivery in line with national standards and the rest of the UK
- Consistent achievement of all outcome measures to target levels (as defined by the VSGBI)
- Creation of a more resilient, skilled and sustainable workforce
- A focus on service development across care pathways
- Improved regional working
- Delivery of care in line with Health Board clinical strategies
- Improved opportunities in research and innovation
- Improved opportunities for training and education
- Improved patient experience
- Clear lines of accountability and clinical governance across the network

Trauma Ambulatory Care Unit (TACU)

TACU was relocated to UHL in September 2019, in which time a total of 4,130 patients have been seen and treated. The unit has allocated space within the Day Surgery Unit footprint, its current positioning on the UHL site has enabled more timely access to orthopaedic theatres and treatments, especially with hand, ankle and shoulder surgery. This has resulted in reduced waiting times, improved patient flow and enhanced patient experience.

In this time, the unit has successfully prevented **3,512** in-patient admissions.

The demand for this ambulatory service has increase during the past 27 months, which is clearly demonstrated in Table 1

Table 1

Sept 2019 – December 2019	393
January 2020 – December 2020	1480
January 2021 – December 2021	2257
Total	**4130**

This nurse led service is open 7 days a week, 12 hours a day, and run by a small team of dedicated experienced nurses and support staff working together with the Orthopaedic Consultants. The staff are committed to providing a high standard of patient centred care and regularly received positive feedback from patients who are extremely grateful for the care they have received, combined with the flexibility of being able to return home every day.

Previously patients who required IV antibiotic treatment would have normally been admitted to the ward. Since September 2019 with an average predicted 2 days bed occupancy, 939 patients needing IV have been managed via TACU, equating to a saving of 1,878 bed days.

On Thursdays there are now 3 dedicated slots for pre-surgical patients requiring iron infusion, resulting in a further saving of 156 bed days.
In June 2021 the unit began to accommodate patients on a Saturday & Sunday who required pin site wound care. Previously it was common for these patients to have long waits in CAVOC, but this is no longer the case, and from June - December 171 patients have been treated. As a result of TACU's success, Betsi Cadwallader have mirrored the service via the Bevan Commission.

The Following compliment has recently been received from a patient who was treated via TACU

I wanted to write to thank and commend you after my recent treatment in the TACU unit at Llandough hospital.

The care, treatment and human compassion I experienced while receiving treatment in TACU was not only world class, but I believe world leading. It's not exaggerating to say that I don't believe I could have received a higher standard of care had I employed each member of the team directly on a private basis.

I received a cat bite to my right hand on bank holiday Monday (3rd January) and was referred by Heath A&E to TACU unit in the early hours of Wednesday morning. Arriving at the unit at 8am after a 10 hour wait for treatment the night before, I was tired, emotional and for a number of hours in A&E had felt very small and insignificant compared to the queues of other patients waiting to be seen by the stretched service. It was a humbling experience.

*Upon arriving at TACU unit with my paperwork from the night before, despite having received no notification I was coming, ***** and *** welcomed me immediately. They got me set up in a seat, started IV antibiotics and explained exactly what was going to happen with my care every step of the way.*

*** told me that I would need antibiotics 3 times a day and that I could travel back and forth to the unit and leave after each treatment. When I confessed, quite embarrassed and a bit teary eyed, I wouldn't be able to arrange transport for 3 visits a day, he immediately reassured me the space could be found for me on the unit to wait there during the day.*

*I was seen within hours by Mr. ******** and his team for surgery for the first of 2 washout surgeries performed under local anaesthetic. Here too the quality of care was incredible, while Mr. ******* and **** (I'm so sorry I don't know Dr ****'s full name!) operated, another member of the theatre team talked to me throughout, immediately spotting my tattoos and finding a topic to discuss. Mr. ******** explained what he had done and discussed the operation he had performed with me.*

*My 2nd washout operation was performed on Friday by Miss ********* who after assessing me in hand clinic opened a new theatre for me to treat me within the hour. This surgery again, similar to the first, was performed under local anaesthetic while a member of the theatre team chatted to me like I the most interesting person in the room. It made what was a strange and scary experience so much easier and in don't think I'll ever forget the kindness of the theatre staff on both occasions.*

For the next 5 days my nursing care was overseen by the TACU nursing team . For my time on the unit, I was privileged to experience the team care for not only me but a number of patients as if there

were no more important people in the hospital. They offered human compassion and a nursing standard I didn't know could be possible in today's busy service.

So, without any adequate words to describe how grateful and impressed I have been by your unit, I wanted to say thank you. Thank you to each and every member of team for the exceptional care and for making me feel like my health mattered. It's been an experience I think will stay with me all my life.

Individual Care

Concerns received between 1st September 2020 to 30th September 2021,

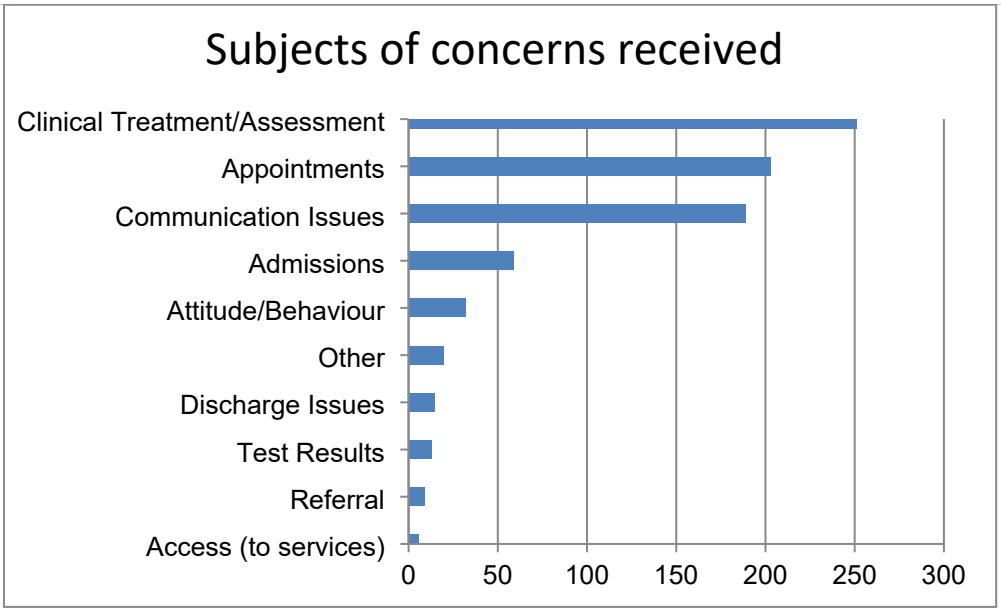
The management of concerns is a key priority for the Clinical Board. Surgery Clinical Board received 812 concerns during this period.

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.

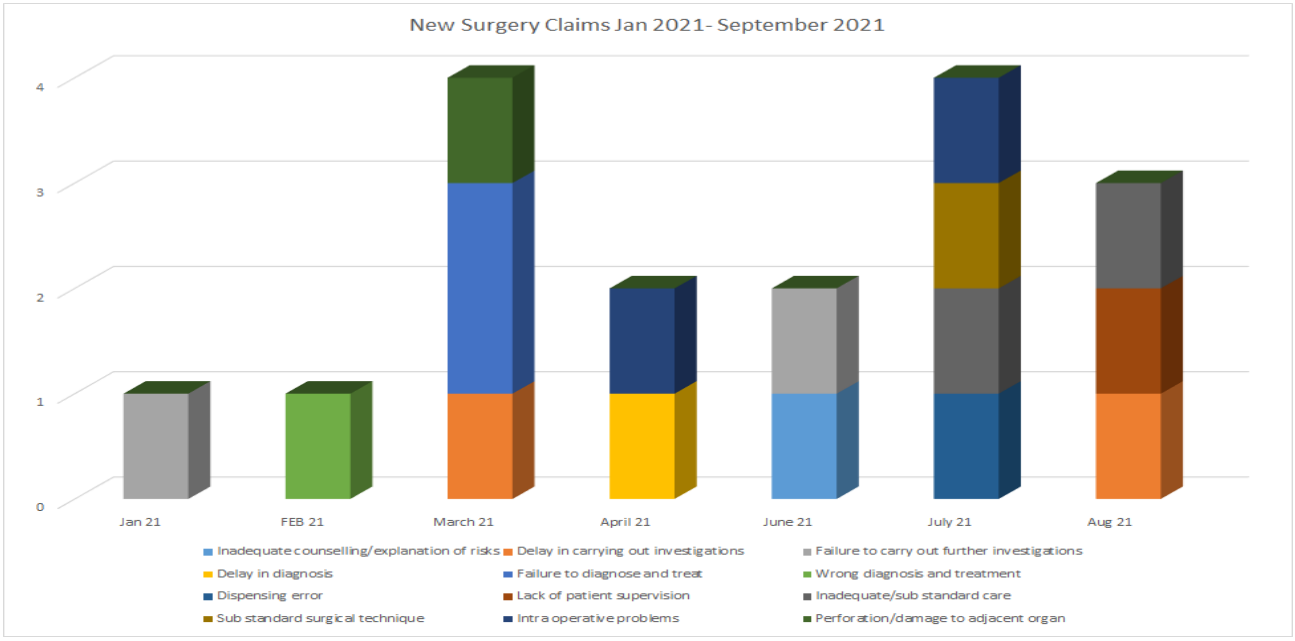
The Clinical Board aims to resolve all concerns (where appropriate) by early resolution with contact from the relevant Ward Sister/Manager, Senior/Lead Nurse or clinician. From 1st September 2020 to 30th Sep 2021 the Clinical Board responded to 788 concerns, 233 of these were resolved within 2 working days (including day of receipt).

The Welsh Government Target for responding to concerns within 30 working days is 75%, it is pleasing to note that during this period, Surgery Clinical Board closed 86% of concerns within 30 working days. The Clinical Board had good support from the corporate concerns team and are grateful for the enhanced support that they have offered via the pandemic.

Reasons of concerns are noted below:



Clinical Negligence Claims



Case reviews into any Claim 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.

Patient Feedback

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

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

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

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

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

Staff and Resources

Finance

Surgery Financial Position as of 31st December 2021

The Board has reported an overspend of £3.846m for the nine months ended 31st December. In line with WG requirements, the assessed impact of COVID 19 has been set out separately. The board need to ensure the process set out to record related expenditure for Gold Command review is followed. Expenditure reported is in line with staff payments and goods received.

	In-Month			To Date		
	COVID-19 £'000	Operational £'000	Total £'000	COVID-19 £'000	Operational £'000	Total £'000
Pay	550	9	**559**	3,334	-804	**2,530**
Non-Pay	35	166	**201**	-283	1,330	**1,047**
Income	46	36	**82**	47	222	**269**
Totals	**631**	**211**	**842**	**3,098**	**748**	**3,846**

Rather than report in the traditional manner of Pay, Non-pay and Income, the financial position above draws out the impact of COVID 19; both in terms of response and recovery expenditure

incurred. It is likely that some of the operational non-pay position is actually COVID related as the position is difficult to separate in some places.

Workforce

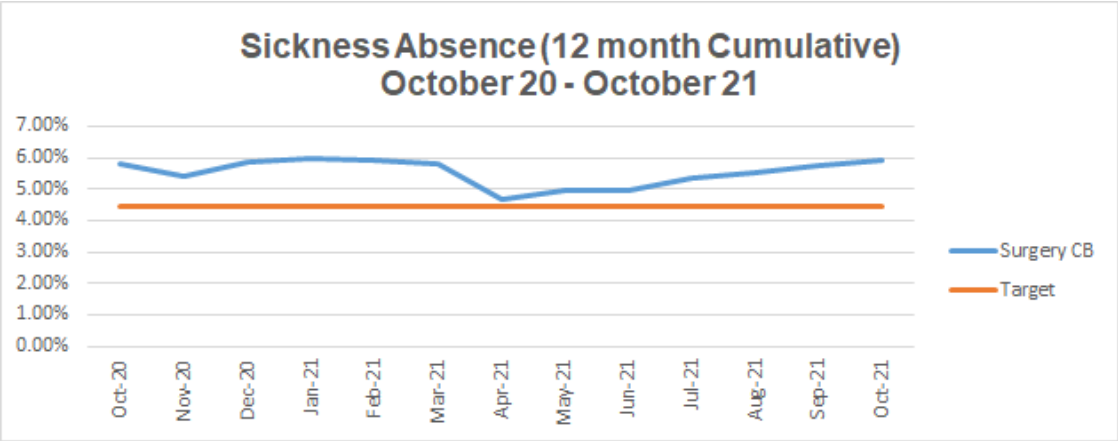
Surgery Clinical Board
Workforce Summary Report
November 2021 (October Data)

Key Performance Indicator	Cumulative 12 month as of October 2021	Comparison with Previous Month September 2021	Comparison with Previous Year October 2020	Target
Vacancy Rate (WTE)	5.63%	6.14%	6.49%	5.00%
Voluntary Turnover Rate (WTE)	5.18%	5.38%	6.85%	7%
Sickness Absence Rate	7.56%	5.73%	5.82%	4.47%
PADR Rate	21.84%	22.58%	27.75%	85.00%
Statutory and Mandatory Training Rate (Fire only) Statutory and Mandatory	54.48% 66.01%	51.44% 65.49%	54.61% 67.28	100.00%
Medical Appraisal	74.09%	71.72%	61.76%	81.55%

Improving Attendance, Clinical Board position as of October 2021

5.90% 12 month cumulative

October sickness absence currently 7.32%



Clinical Board Target 20/21 = 4.47%

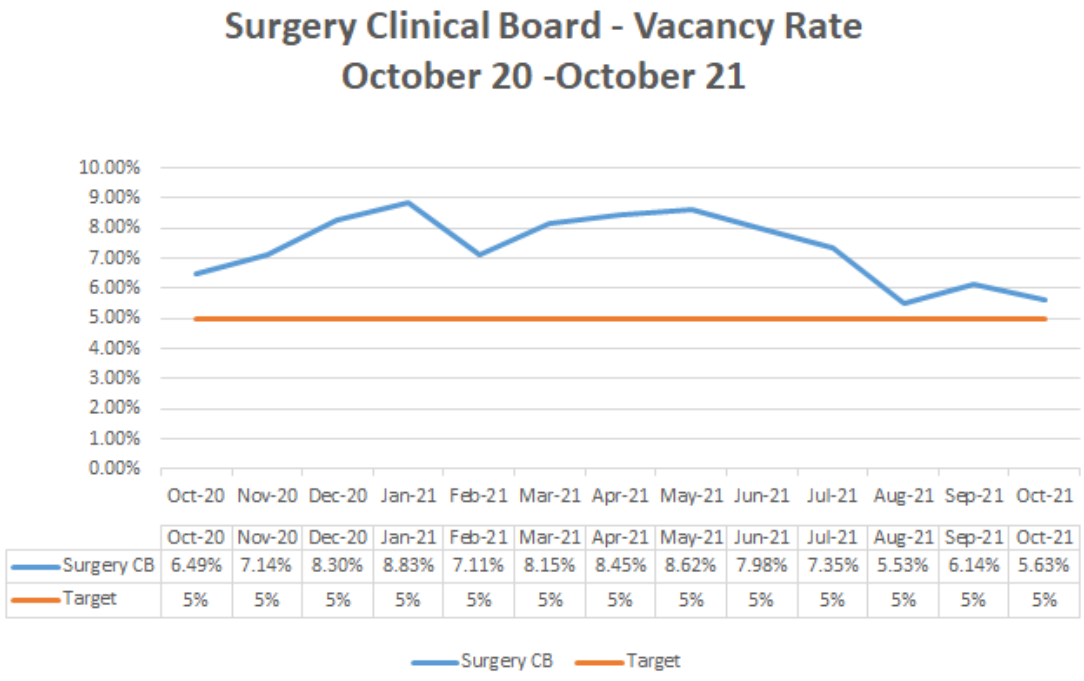
Recruitment

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

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

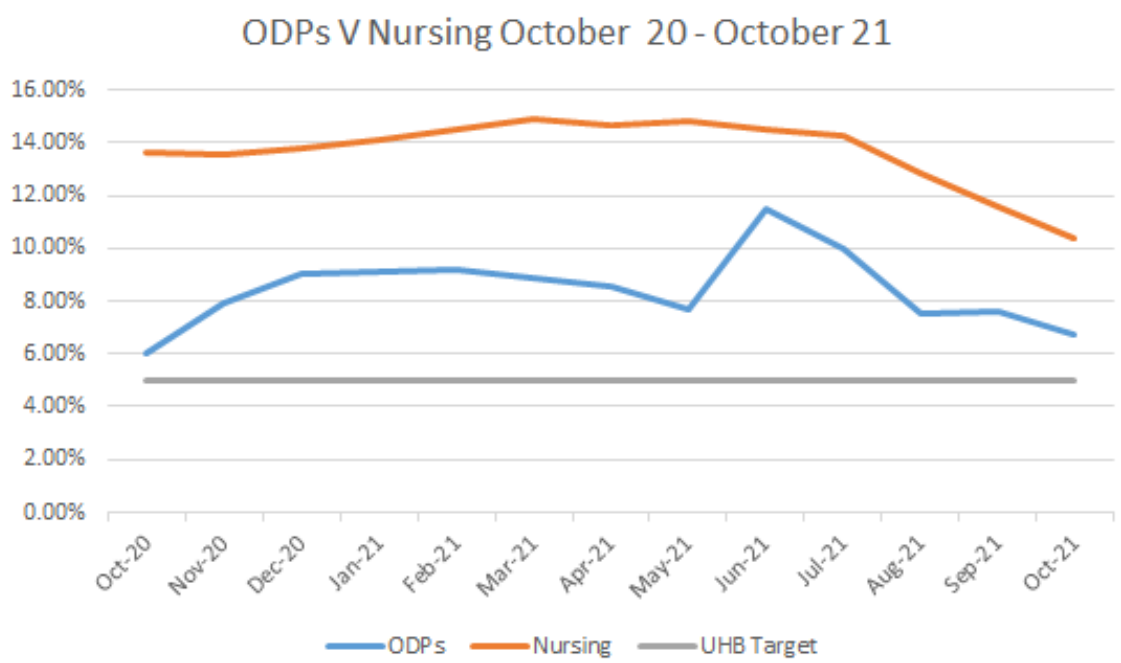
The main schedule of work for the Surgical the Clinical Board to progress with over the next 12 months is the Peri operative care workforce plan to modernize and streamline out Nursing and ODP workforce. A robust plan has already been developed and we have resources a project manager to help support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

Vacancy Position October 2021 5.63%



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Surgery CB	6.49%	7.14%	8.30%	8.83%	7.11%	8.15%	8.45%	8.62%	7.98%	7.35%	5.53%	6.14%	5.63%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

Vacancy Position October 2021
Theatre Practitioners - 6.77%
Nursing 10.40%



NB: these figures are based on ESR (Electronic Staff Record) data; we know they do not reflect the higher current position such as ward moves, and non-established wards being set up

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

Retention

Whilst we have a very comprehensive work plans and action plans to try and address nurse retention such as holding celebration events, surgery star awards, employee engagement events and trying to instil a feeling of being part of a bigger team such as via dedicated Facebook pages, it is still proving to be inadequate and further pressures from the COVID pandemic and staffing additional capacity have exaggerated this in 2021.

Staff engagement

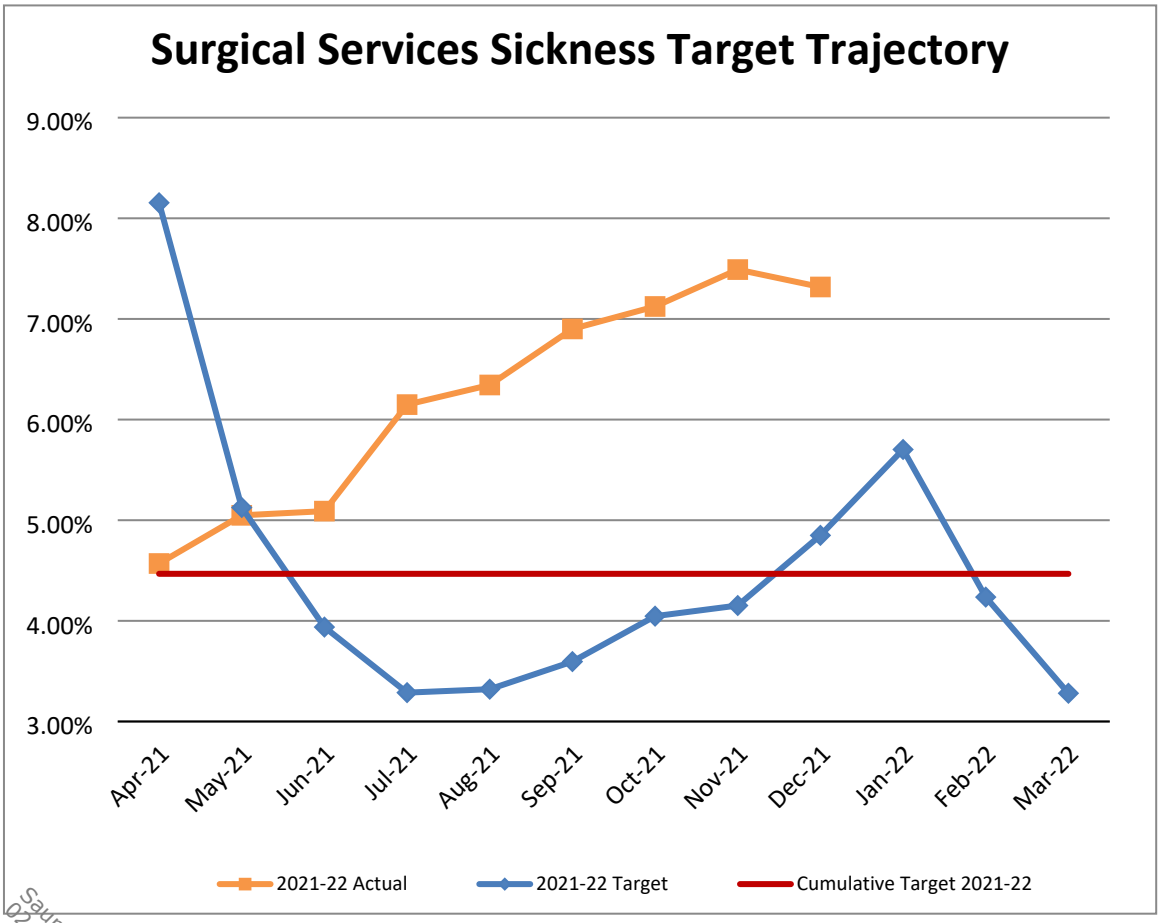
A significant amount of work has been carried out in the Clinical Board over the last 12 months to make this agenda a priority. The following are some of the highlights of the good work being done or being planned.

- OD work ongoing in Theatres and HSDU (Hospital Sterilisation and Disinfection Unit) to improve engagement
- Promoting the Health Board values and behaviours, including values-based recruitment

- Surgery Stars Celebration Event 2021
- Team Development
- Succession Planning
- Talent Management
- Leadership & Development Programme ongoing in Theatres and HSDU
- Keeping in touch days for New Starters
- Clinical Skills days for Nurses
- Professional Nursing Forums
- Registered and un-registered engagement groups
- Student Streamlining engagement sessions
- Perioperative Care Workforce plan

Sickness absence

Sickness absence has been a challenge due to the pandemic.



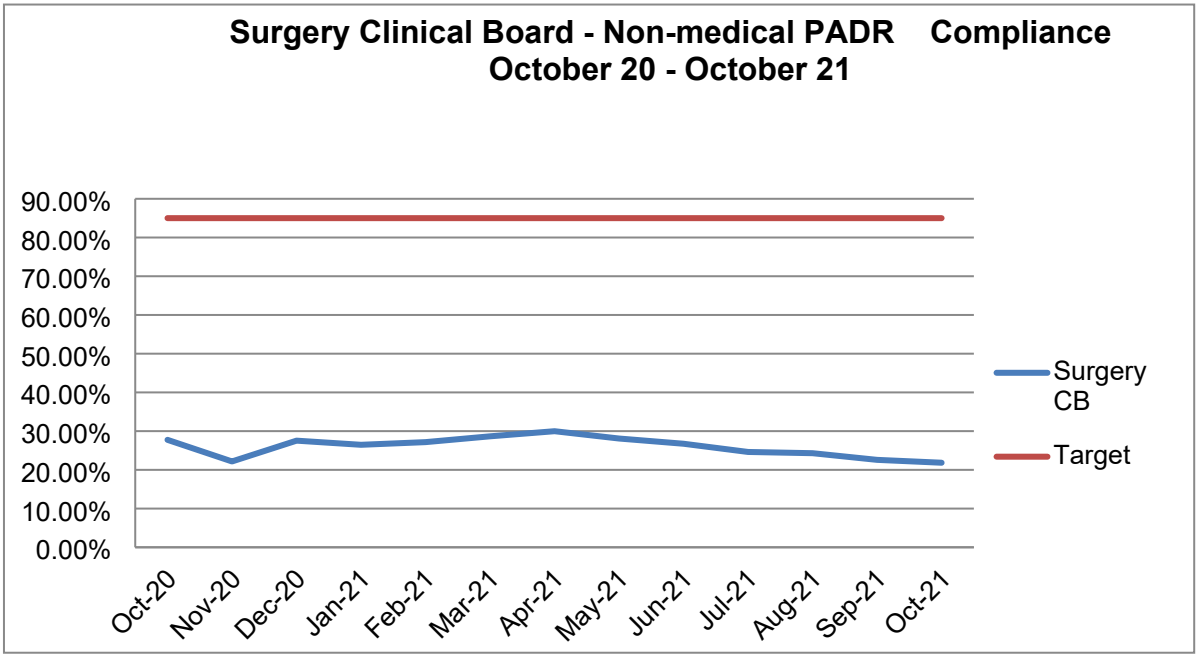
Actions that have been put in place to help support managers with this agenda are.

- Support for managers with both short- and long-term absence via:
  Bespoke training by the Workforce & OD Team
  Sickness Absence Surgeries with Line Managers, to discuss individual cases
- Compliance Against the Policy:
  Audit programme, focussing on hot spot areas to check.
- Health & Wellbeing Promotion via sickness surgeries and training
- Redeployment and return to work opportunities for staff in green areas

PADR compliance

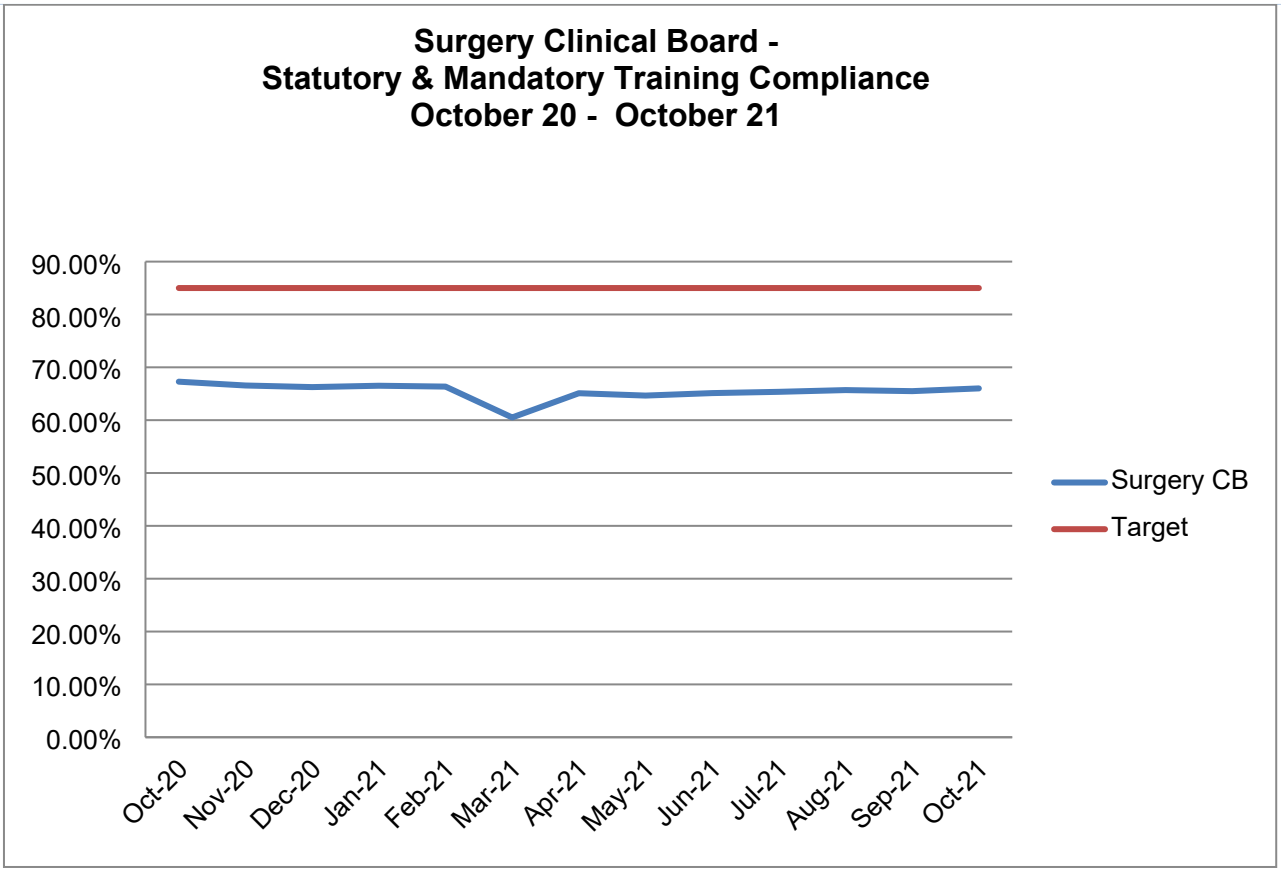
PADR compliance has decreased to under 30% in Sept 2021 with a marked deterioration since October 2020 due to the COVID pressures.

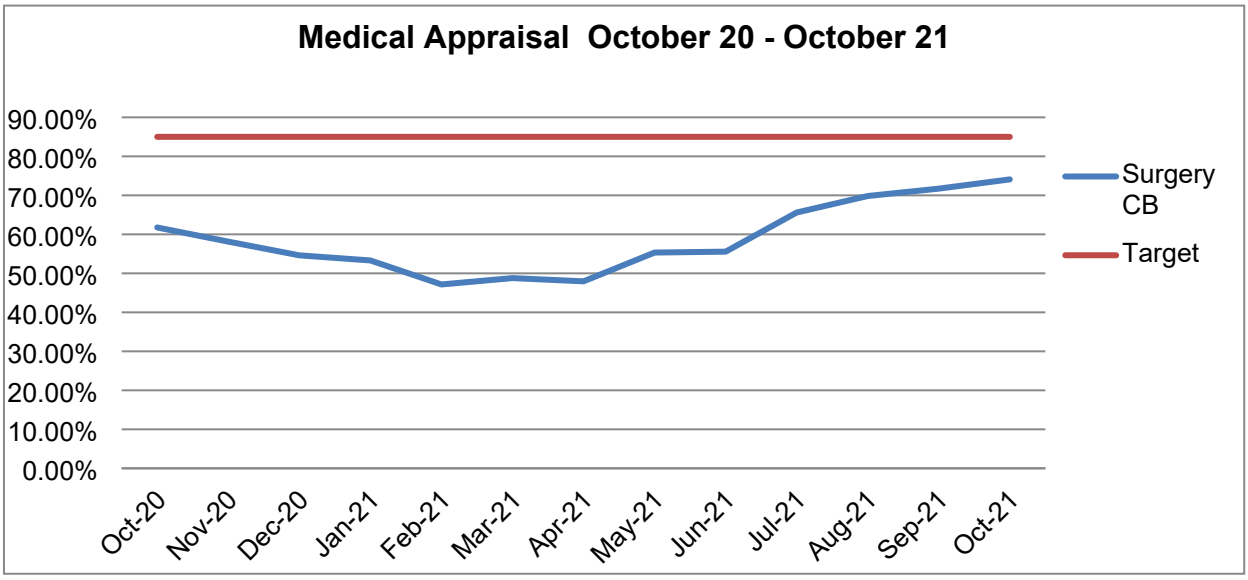
Surgery Clinical Board - non-medical PADR Compliance



Actions to enable sustained improvement:

- Managers are able to access training in how to retrieve their latest reports via the ESR team.
- Encouragement to use ESR database, not department database as the ESR data is what is reported upon
- Unfortunately enabling work has not delivered the level of improvement that the Clinical Board anticipated over the COVID pandemic period





Award winners

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

Sustainability
Nitrous oxide is a medical gas, with 265 times the global warming potential of CO2.
The Welsh public sector has set a goal to be carbon neutral by 2030 and the NHS Wales Decarbonisation plan has identified anaesthetic gas reduction as a key component of improving our sustainability footprint.
A collaborative project between anesthetic's, pharmacy, medical engineering and estates has identified that nitrous oxide consumption can reduced by 95% through using portable nitrous oxide cylinders rather than the current piped manifold supply.
Our goal is to transition from piped to cylinder supply and then decommission our nitrous oxide manifolds. A pilot project has been completed in the Childrens Hospital, and currently Llandough Hospital is being converted to cylinder supply with the rest of the UHW site set to follow by April this year. This project will save around 1 million litres of nitrous oxide per year, equivalent to approximately 535 tonnes of CO2.

This is a first for Wales and we are working with other Welsh health boards to implement a similar reduction in nitrous consumption across the country.
Dr Charlotte Oliver, Dr Steve Froom, Elaine Lewis (Continuous Service Improvement, Norman Mitchell (Estates), Ed Chapman and Joe Harris (Clinical engineering).

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

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

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

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

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

- Healthcare Standards
- Duty of Candour
- National Quality Framework
- Annual Quality Statement

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

Four principal areas:

- Duty of Quality;
- Duty of Candour;
- Establishment of a new Citizens' Voice Body; and
- Requirement for NHS Trusts to have vice chairs.

The Policy intent will be delivered through a mix of primary and secondary legislation, such as regulations and statutory guidance.

The Act was passed in March 2020 and received Royal Assent in June 2020.

Intention is to bring the Act into force in April 2023.

What is required to implement?

- Statutory Guidance.
- Regulations that will set the duty of candour procedure.
- Regulations to amend the PTR Regulations – to ensure they fit with the duty of candour.

Duty of Candour – Why have one?

- A culture of openness, transparency and candour is widely associated with good quality care.
- Builds on the non-statutory duties of candour.
- Enables learning and improvement.
- Strengthens the fundamental principles of ‘Putting Things Right’ and provides a robust process to support ‘Being Open’.

Duty of Candour – What will it mean?

- It places a duty on NHS bodies at an organisational level and will support existing professional duties.
- Duty of candour procedure.
- There is no element of fault or blame.
- Reporting requirements.

Duty of Candour – Impact

- Achieve a position of consistent and routine practice whereby openness and transparency with people in relation to their care and treatment becomes a normal part of daily healthcare practices.

- The key intention is to promote the ethos of openness, learning and improving, which must be owned at organisational level. The candour procedure and reporting framework encourages reflective learning and prevention of incidents occurring again.

Duty of Candour – Implementation

- Workshops.
- E learning packages .
- Public awareness campaign.
- Easy read information leaflets will be developed and comms engagement will take place across Wales.

Duty of Candour

A statutory duty of candour on providers of NHS services.
The duty to be placed on NHS bodies at an organisational level and will support existing professional duties.

The duty requires providers to follow a process when a service user suffers an adverse outcome during the course of care or treatment and suffers harm. A service user is treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that they could experience; any unexpected or unintended harm that is more than minimal.
There is no element of fault.

- A culture of openness, transparency and candour is widely associated with good quality care.
- Clarify a process to be followed by an organisation when something goes wrong or not as planned and people suffer harm.
- Enable a focus on learning and improvement, not blame.
- Builds on the 'Putting Things Right' expectations.
- Improves public confidence and organisational reputation

- Has a service user to whom healthcare is being or has been provided by the NHS body suffered an adverse outcome?
- i.e. Did the service user suffer any unexpected and/or unintended harm that is more than minimal, or are the circumstances such that the service user could suffer any unexpected and/or unintended harm that is more than minimal in the future?

Duty of Quality

- To date, the focus of quality in the health service has largely been on developing systems for quality assurance within local services. Quality, however, is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable care.

- New overarching duty will require Welsh Ministers and NHS bodies to exercise their functions with a view to securing improvements in the quality of services they provide to their service users.

- This duty will apply to all of their functions, not just clinical functions.

- NHS bodies will be placed under a duty to produce an annual report setting out how they have complied with the new duty.

Duty of Quality

- To date, the focus of quality in the health service has largely been on developing systems for quality assurance within local services. Quality, however, is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable care.

- New overarching duty will require Welsh Ministers and NHS bodies to exercise their functions with a view to securing improvements in the quality of services they provide to their service users.

- This duty will apply to all of their functions, not just clinical functions.

- NHS bodies will be placed under a duty to produce an annual report setting out how they have complied with the new duty.

- **Quality Planning?**
  - Are we assured that Quality Planning is correctly identifying common and special cause variation and working more effectively to match the service to the need of the customer? And what is the plan for each?
- **Quality Improvement?**
  - Are we assured that Quality Improvement is taking place and projects are strategically aligned?
  - Is there evidence of improvement?
  - Do we have the necessary capacity and capability to deliver improvement?
- **Quality Control?**
  - Are we assured we have the necessary systems in place to understand on a daily basis how the system is behaving?

- The Duty…
- seeks to achieve a system wide approach to quality in the health service to secure improvement and shift the focus away from simply quality assurance.
- requires NHS bodies to exercise their functions in a way that requires them to consider how they can improve quality on an on-going basis.
- aims for improving quality and therefore outcomes for service users to become an embedded and integral part of the decision making process for health boards, trusts and Welsh Ministers.
- It supports the ambitions set out in ‘A Healthier Wales’ and marks the next step in our journey of quality improvement, to be more open, transparent and learning services and better integrated working.
- Deliverables for Welsh Ministers and NHS bodiestatutory Guidance
- Compendium of good practice – case studies focused on embedding a culture of quality
- Suite of tools to support the Duty
- Digital handbook providing an overview of the Duty and tools

Citizens’ Voice Body

Will replace CHCs with a new, independent, national body that will exercise functions across health and social services.The new body will strengthen the voice of the citizen. It’s overarching function will be to represent the interests of persons to whom NHS or social services are being provided in Wales.

It will have powers to make reports and recommendations to organisations, such as health boards, trusts and local authorities, and to provide complaints advice and assistance to citizens when they have a complaint about NHS services and certain social services.

It will be independent with powers to employ its own staff and recruit volunteers.

NHS Trust Vice Chairs

Requires NHS Trusts in Wales to have a Vice Chair.

This will place NHS Trust Boards on the same statutory footing as local health boards in this respect and will strengthen their governance structure.

Impact on concerns

- .

Duty of Candour

The new law will mean that people who provide health services must tell people if they have or may have suffered harm

There will be an expected impact upon Complaints, Redress and Claims

Duty of Quality

Raising concerns

If an individual or group which has been adversely affected by the decision of a public body, and considers that the duty has not been properly complied with, they can resolve their concerns through the relevant body's formal complaints procedure. It is recommended that NHS bodies and Ministers ensure that information regarding raising a concern / complaint is readily available

Citizens Voice

The third part of the new law will make sure that people in Wales can say if they are happy or unhappy with health or social services they receive.

Raising concerns

If an individual or group which has been adversely affected by the decision of a public body, and considers that the duty has not been properly complied with, they can resolve their concerns through the relevant body's formal complaints procedure. It is recommended that NHS bodies and Ministers ensure that information regarding raising a concern / complaint is readily available.

HEALTH AND CARE STANDARDS

- The Health and Care Standards were introduced in 2015 to bring together and updated the Doing Well, Doing Better: Standards for Health Services in Wales (2010) and the Fundamentals of Care Standards (2003), and this provided an opportunity to align standards underpinning the planning and provision of healthcare services. The Health and Care Standards were designed to be implemented in all health care organisations, settings and locations, and by all teams and services.
-
- The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. Alongside the Framework for Assuring Service User Experience (2013), the standards help to ensure that people have positive first and lasting impressions, that they receive care in safe, supportive and healing environments, and that they understand and are involved in their care.

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

- As part of this work there will be a review of the existing standards with a future revision planned

AQS

- **3.3 For 2021-22, there will be no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report. Information on dealing with concerns, that complies with the requirements in the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, should be contained in the Performance Report, unless a separate report has already been developed.**

- For the 2021-22 reporting period the deadlines for submission are for the performance report :

  - Draft Accounts to be submitted to HSSG Finance and Audit Wales **Friday 29 April 2022;**
  - Draft Performance Report Overview, Accountability Report (including the Governance Statement), and Draft Remuneration Report to be submitted to HSSG Finance and Audit Wales by Friday 6 May;
  - Final Annual Report and Accounts to be submitted by Audit Wales to HSSG Finance by Wednesday 15 June 2022, as a single unified PDF document.

  An organisation's annual report (which includes the performance report) - must be presented at a public meeting no later than 29 July 2022.

Report Title:	**Quality Indicators – Progress Report – Item 2.3**						
Meeting:	Quality, Safety and Experience (QSE)				**Meeting Date:**	22/02/22	
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 Experience**						

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 Third 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. We have also included some Covid related specific measurements in this report

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

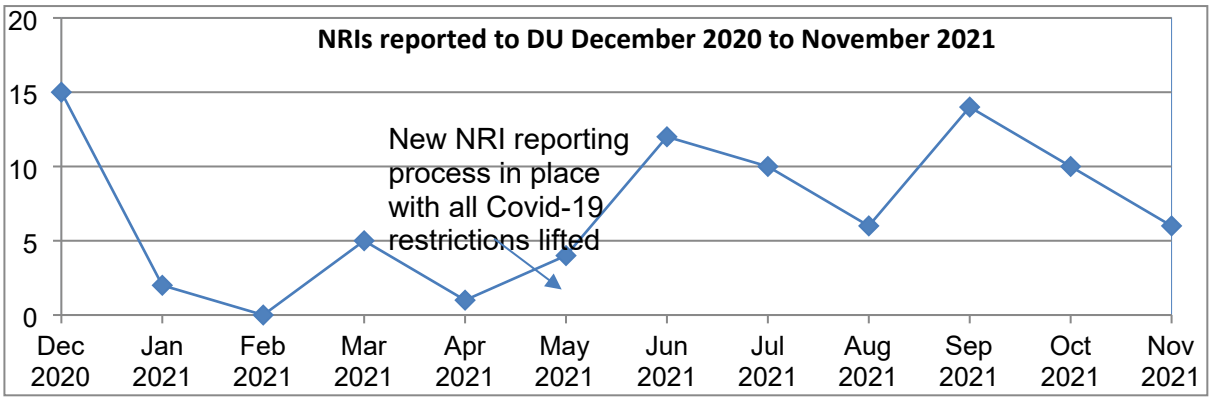
Work continues to develop the dashboard for presentation at the Quality, Safety and Experience Committee. This report provides the current position and progress in relation to theQSE indicators identified for review by the QSE Committee.

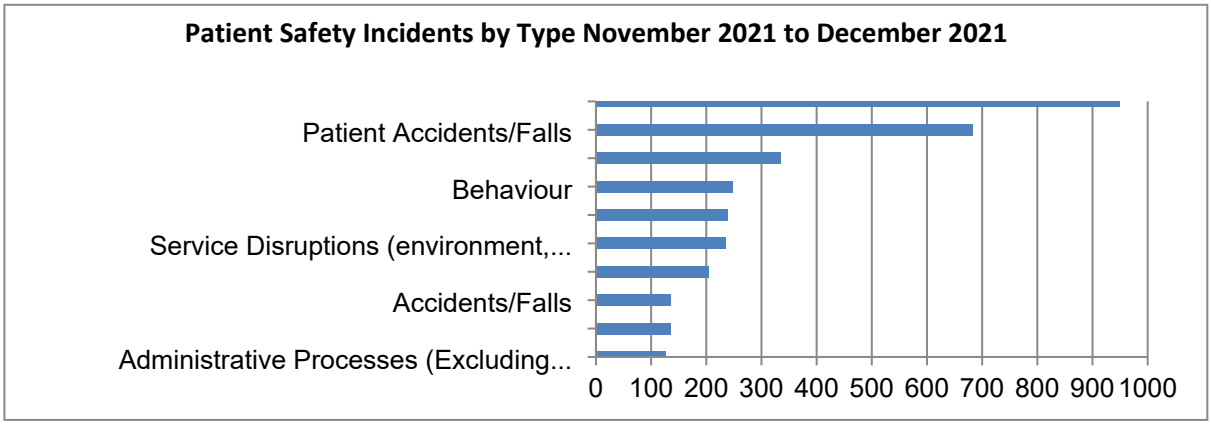
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Nationally Reportable Incident reported

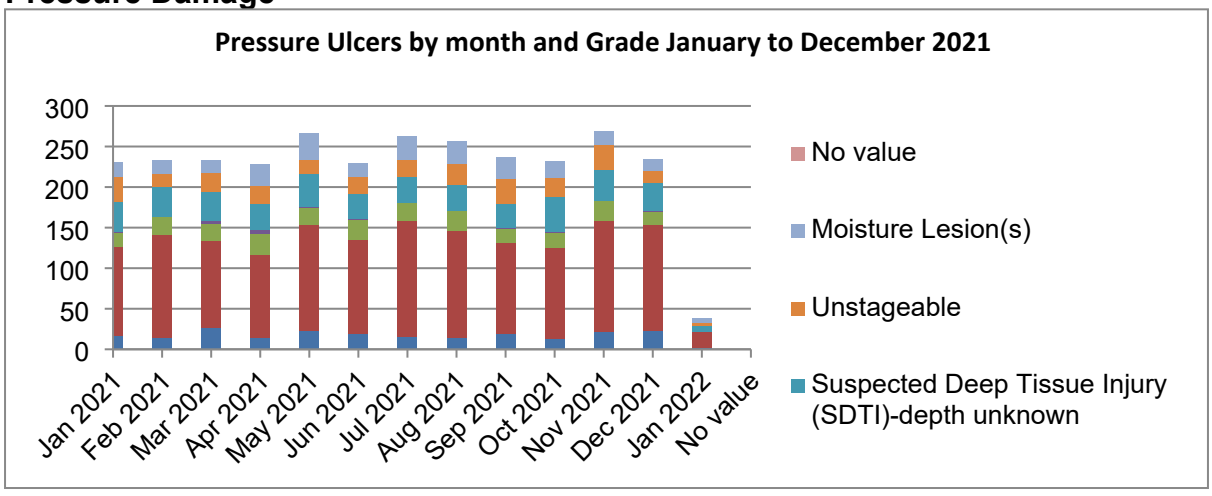
On average, Cardiff and Vale report more than 26,000 patient safety incidents a year; of those nearly 3000 are graded as moderate to catastrophic harm.

In 2021, 103 of those were nationally reportable to the Delivery Unit (constituting Serious Incidents, No Surprises and Never Events). Each Health Board is required to investigate and close an incident within a set time frame and this is a Key Performance Indicator that the Delivery Unit record. At the time of writing this – Cardiff and Vale have 76 open Nationally Reportable Incidents (the new term for SIs/Serious Incidents) – of these 41 (54%) were overdue for closure with the Delivery Unit.

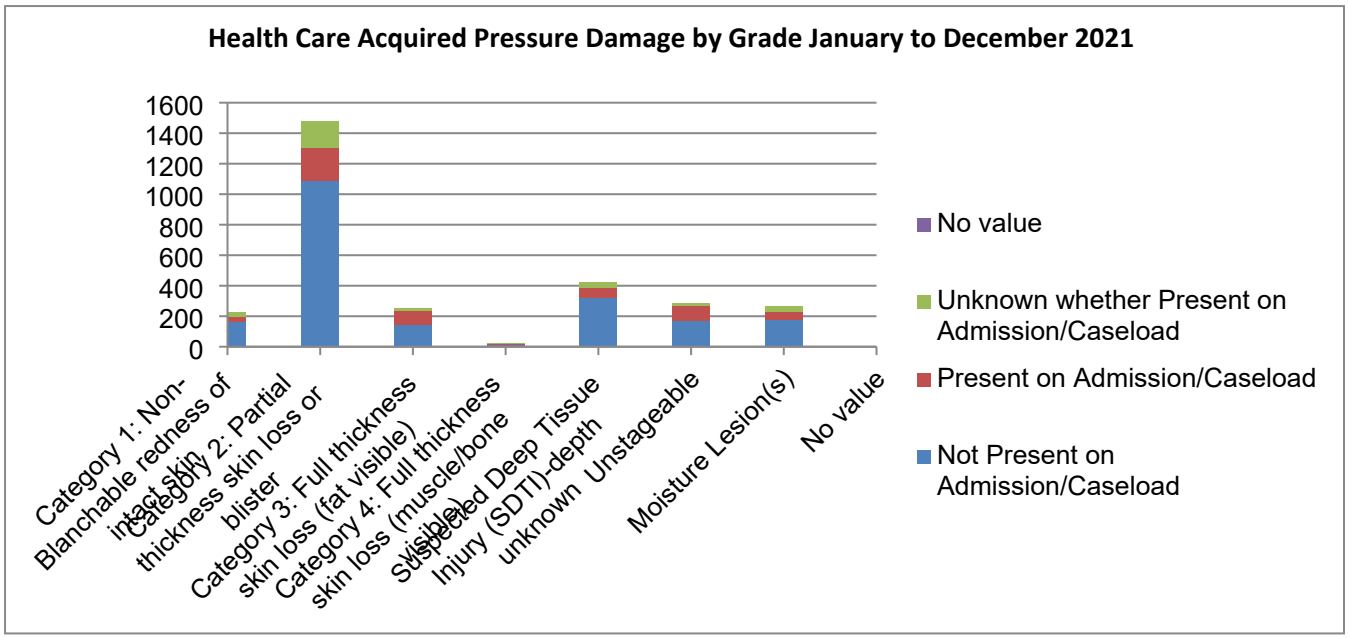




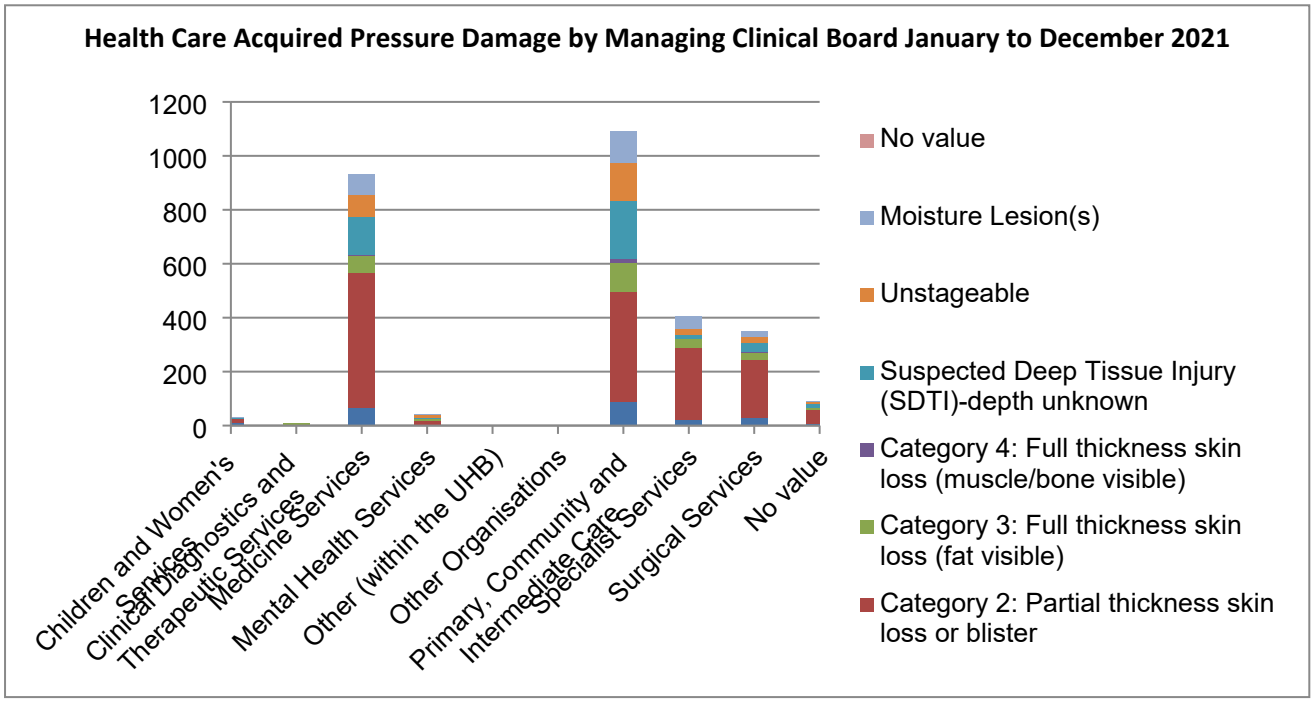
Pressure Damage



The previous chart shows category 2 partial thickness pressure damage is the most commonly reported. There had been a slight reduction in pressure damage reported from July to October, however there was then a spike in reporting in November. December reporting appears to show that figures had reduced back down to the numbers reported in October, however this data is still undergoing validation and so could change.

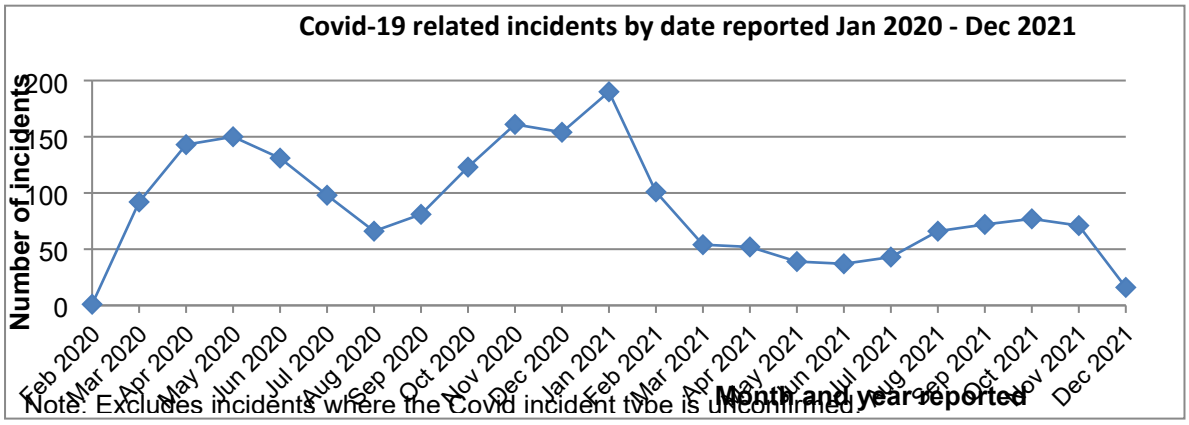


This demonstrates that the majority of those reported were not present on admission and as highlighted above, category 2 partial thickness are the most commonly reported health care acquired pressure damage.



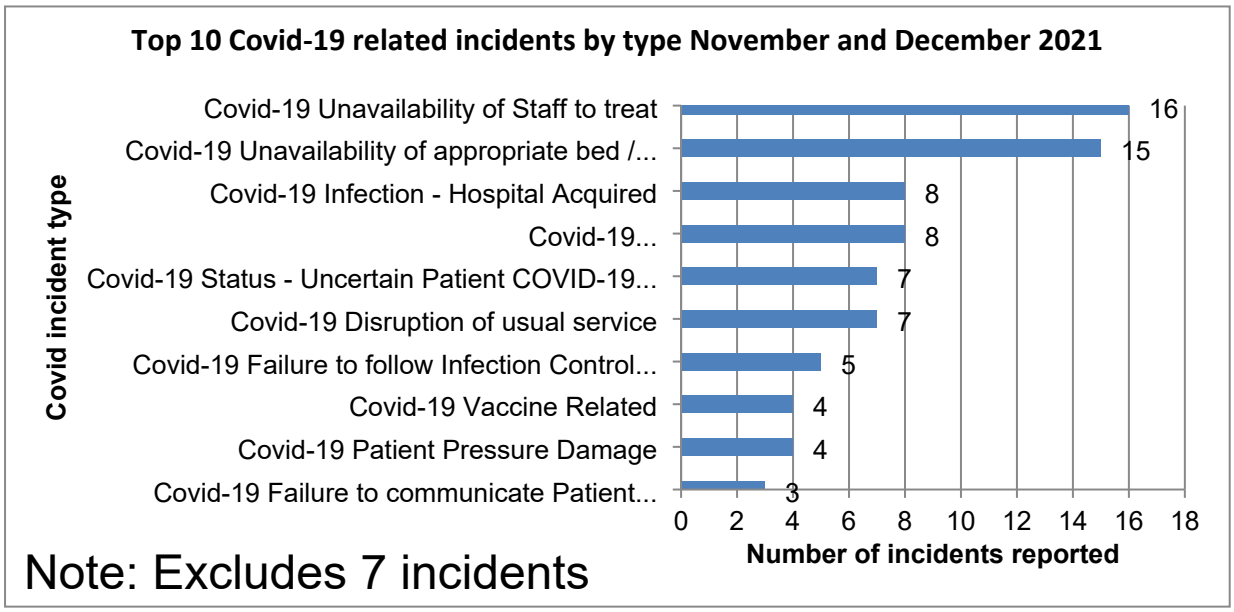
Medicine and Primary, Community and Intermediate Care are the highest reporting Clinical Boards for health care acquired pressure damage incidents. PCIC report higher numbers of unstageable and suspected deep tissue injury incidents.

Covid-19

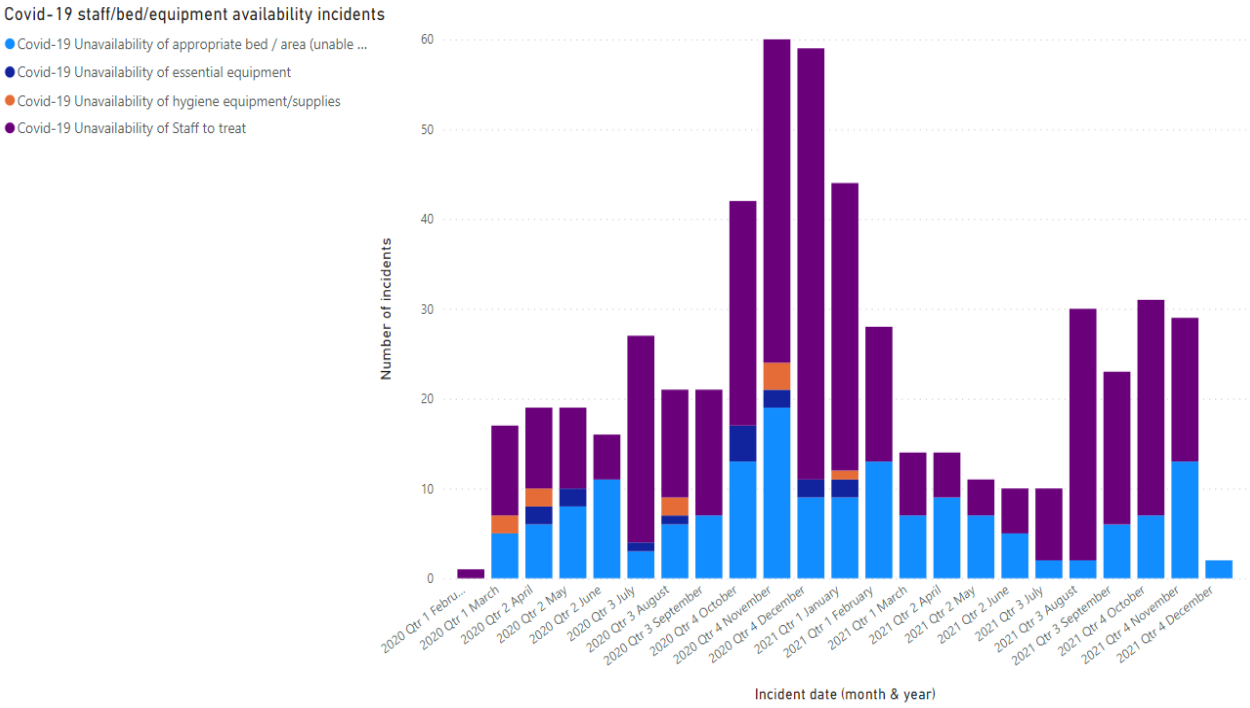


This shows a peak in Covid related incidents in the spring of 2020 and again from November 2020. Covid related incidents dropped significantly in the spring of 2021. Covid related incidents has not reached the numbers reported in the first wave.

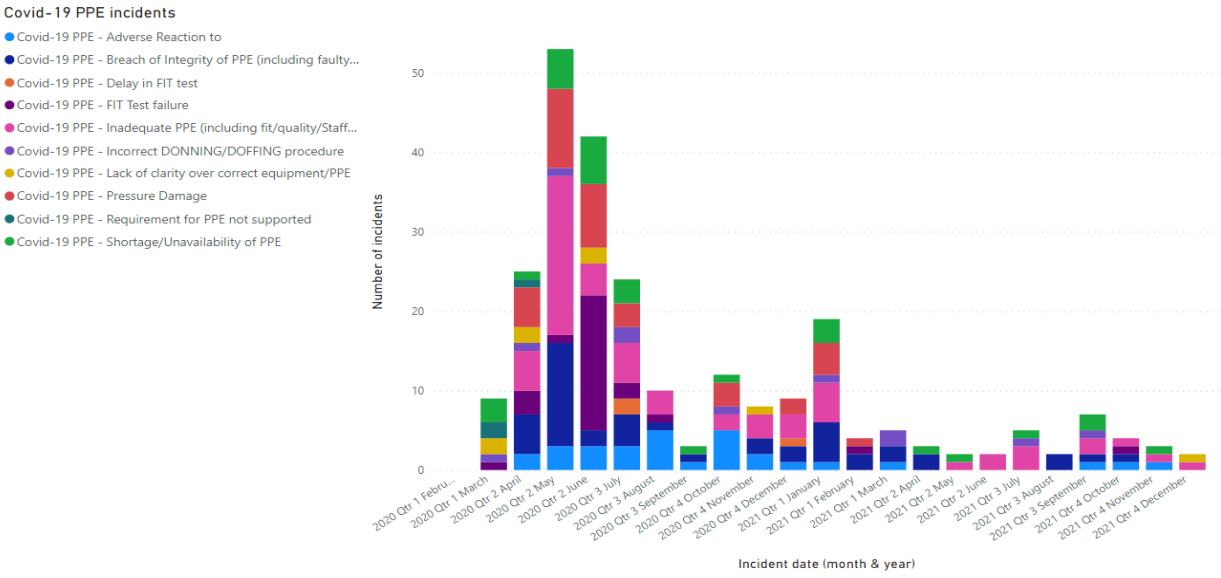
Covid-19 related incidents



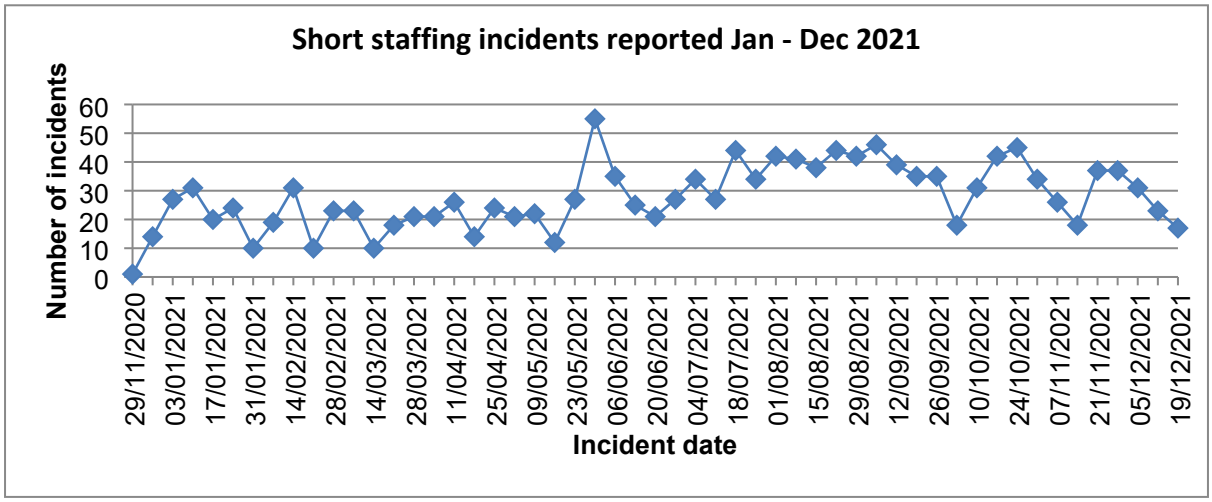
The major theme from incident reporting during the 3rd wave is availability of staff and beds:



PPE related incidents are much less common than in the 1st wave:



We know that short staffing is a significant challenge at present and it is likely that Datix reporting does not truly reflect the reality as staff struggle to have time to report.



The above shows peaks of short staffing reported incidents however, on average we can see that the numbers reported are higher than this time last year.

The top reported category of NRIs across Wales since June 2021 has been:

- Falls - 80
- Delayed Treatment – 59
- Pressure damage – 41
- Unexpected/unexplained death – 19
- Delayed diagnosis - 10

Within Cardiff and Vale, the top reported NRI categories within the 61 reported since June 2021, has been:

- Pressure ulcers – 20
- Patient Accidents/falls – 14
- Unexpected deaths – 8
- Delayed diagnostic processes/procedures – 5
- Delayed access/admission - 4

Pressure damage and falls continue to be the highest reported category of patient safety incidents. Significant work continues to address these high reported incidents. A detailed paper regarding the actions around pressure damage reduction through a collaborative was presented at the December 21 Quality, Safety and Experience committee

Link to papers

The Director of Nursing for Surgery Clinical Board is the Professional lead on this piece of work for the UHB that looks at reducing the occurrence of healthcare acquired pressure damage within Cardiff and Vale UHB. To ensure that there is a Multidisciplinary approach to this scheme of work a Collaborative was formed in June 2021. The goal of the Collaborative is:
 reduce the incidence of healthcare acquired pressure damage with the Health Board by 25% by July 2022
 speed up adoption of innovation into practice to improve clinical outcomes and patient experience

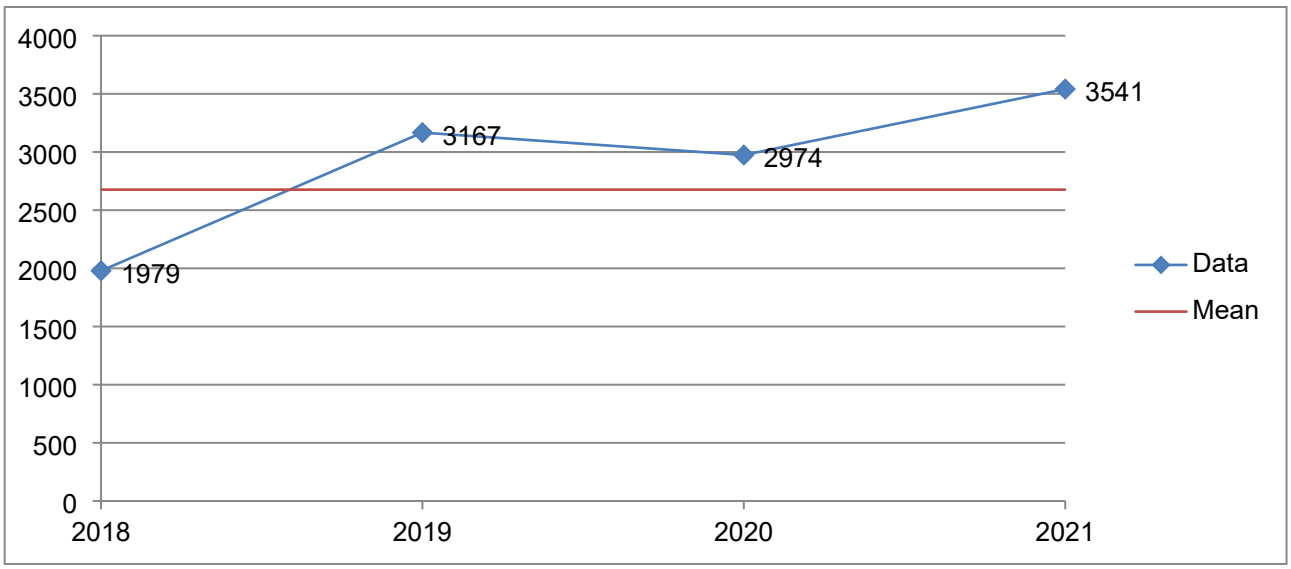
Never Events

There are curently two Never Events under investigation. 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.

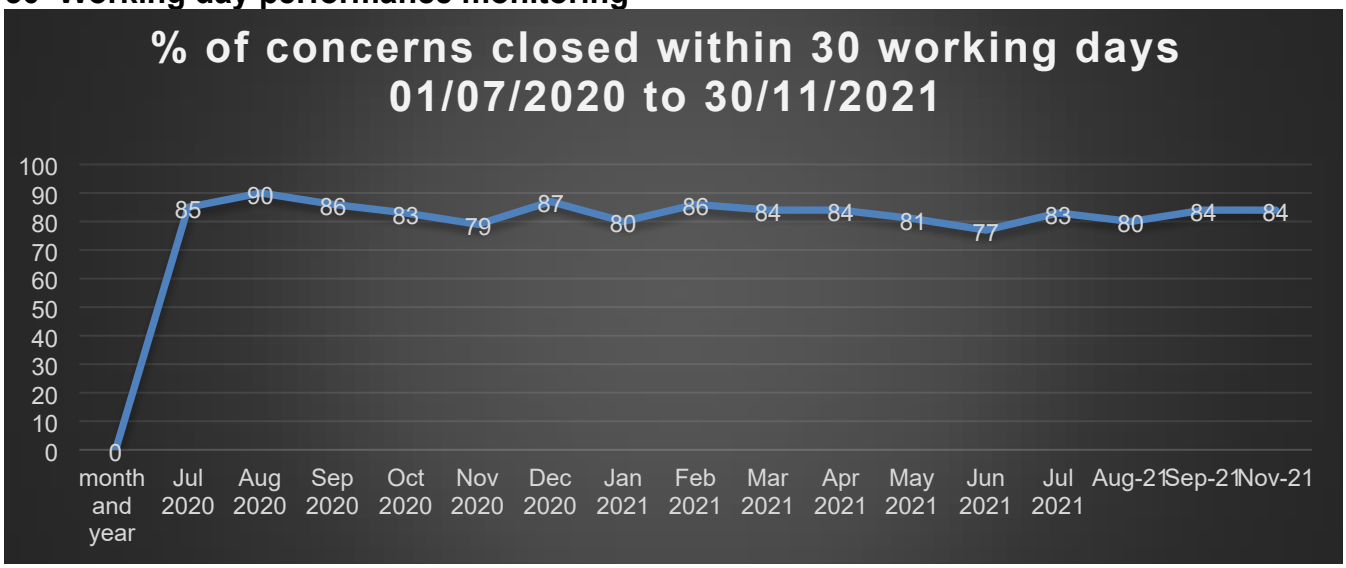
A campaign on Safety Culture is being planned and embedding a Human Factors and Systems based approach to safety will support the reduction of Serious incidents and Never Events.

Complaints –Concerns

Since 2018 we have seen a 100% increase in Complaints



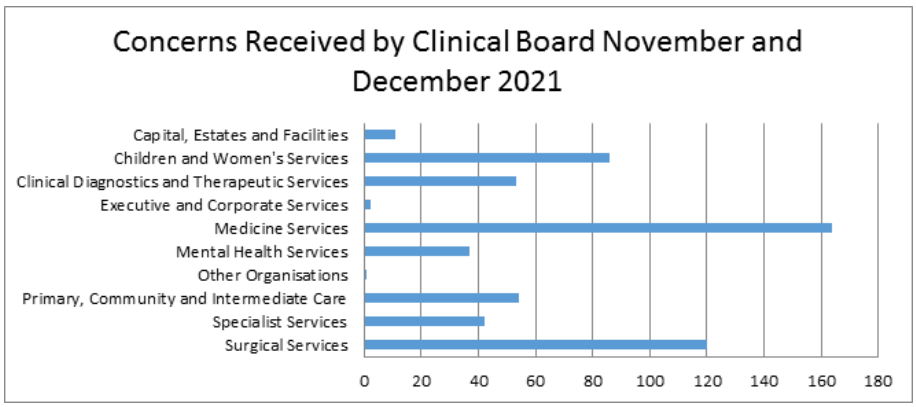
30 Working day performance monitoring



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%.

Concerns –Patient Experience
During November and December we received 579 concerns – as received by Clinical Board in graph below with a significant number of concerns in medicine both Emergency unit and integrated medicine



In order to support clinical board the central concerns team are processing as many concerns under early resolution as possible and this has maintained an overall 30 working day response time at 88%

The main themes remain as waiting times, communication and concerns regarding care and treatment.

We have noted a significant increase this year as we have already exceeded the number of concerns received in previous years and we still have another quarter

We continue to capture Patient Experience scores and the feedback in December through the kiosks only was

How would you rate the care you have received?

73%
1,500 resp.

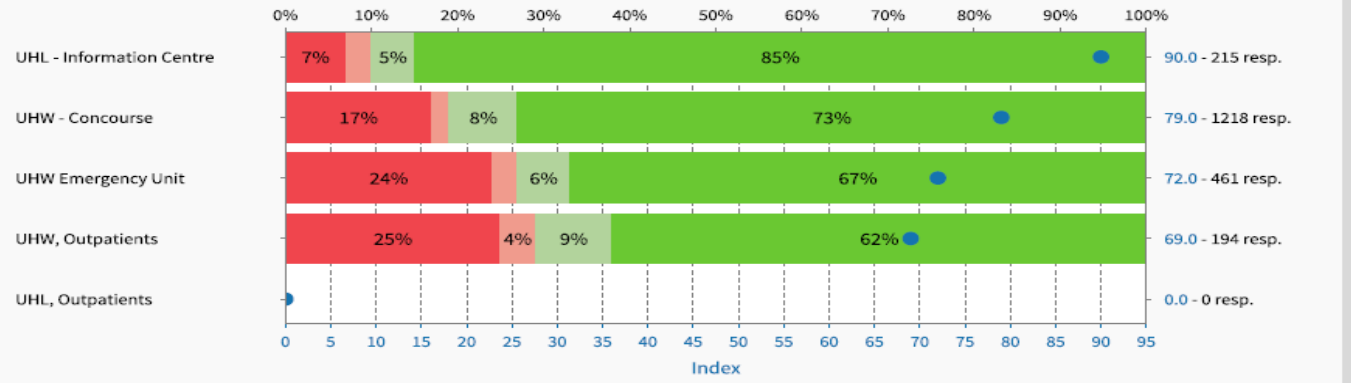
7%
150 resp.

2%
52 resp.

18%
386 resp.

Index: 77.0
Responses: 2,088

Comparison



Risers

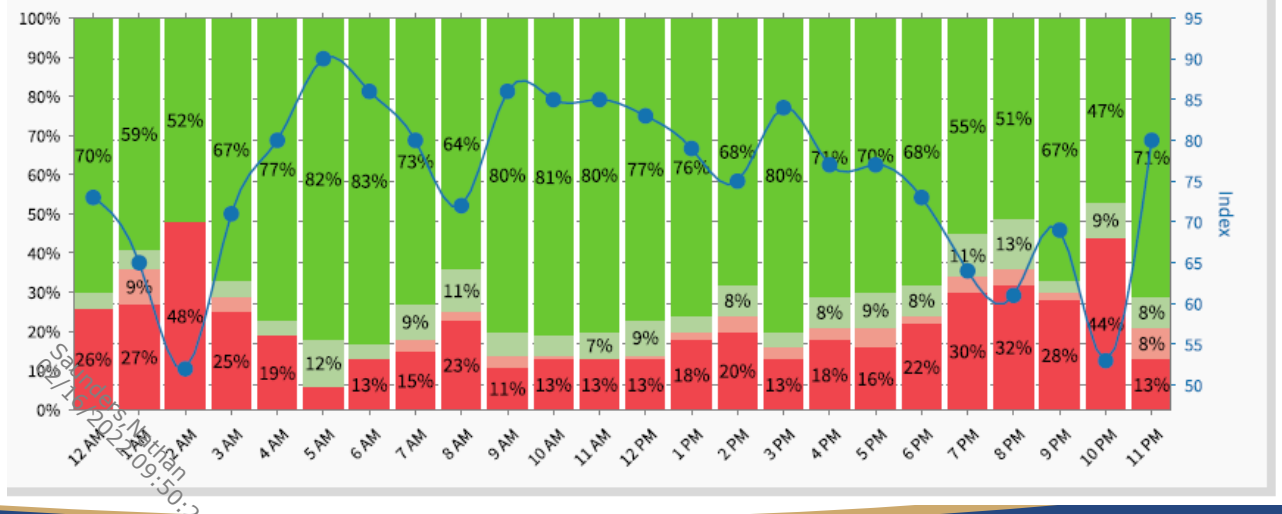
Survey	Index	Change
UHL - Information Centre	90	0% ↑

Fallers

Survey	Index	Change
UHW - Concourse	79	-0% ↓
UHW Emergency Unit	72	-2% ↓
UHW, Outpatients	69	-11% ↓

The hourly distribution shows a pattern of times when people are most unhappy with their experience in particular in EU at 2 am and 10 pm.

All units combined - hourly distribution

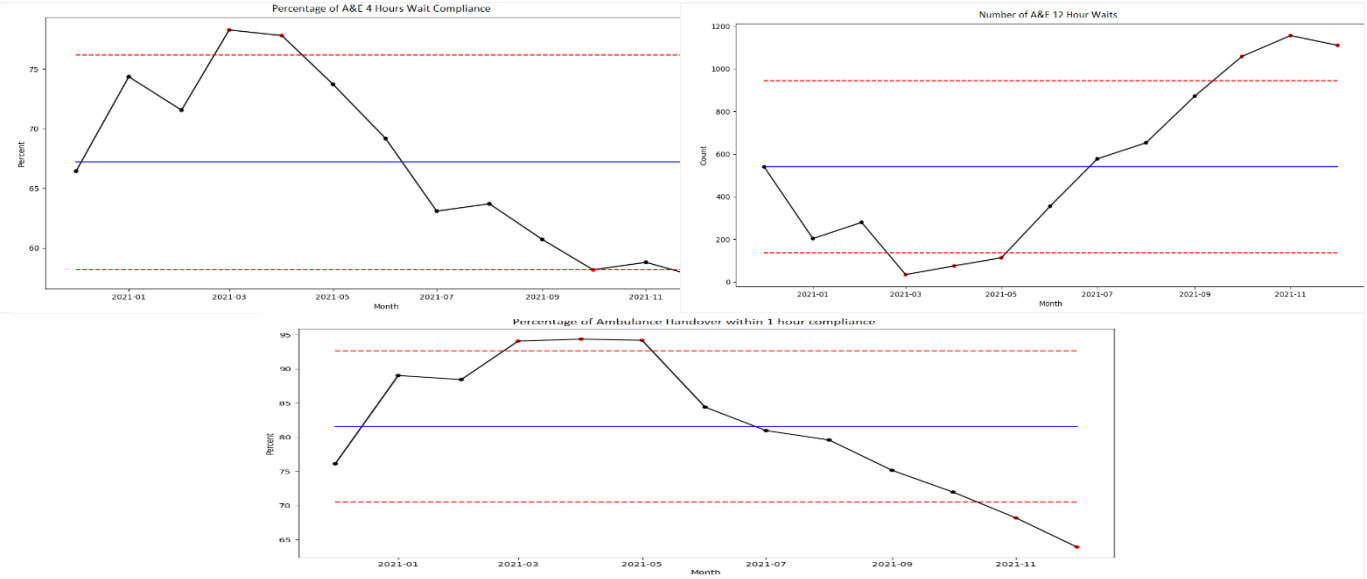


In-patient falls

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

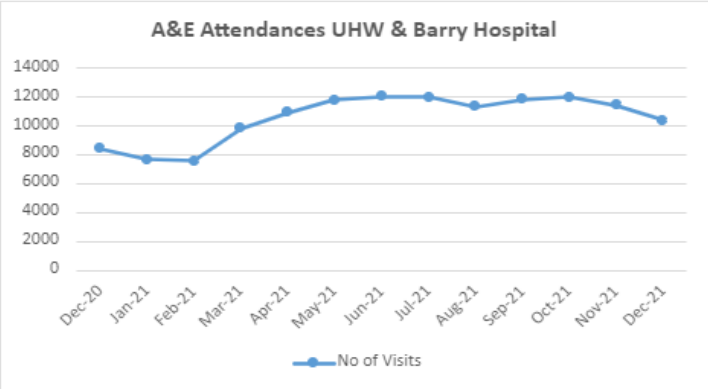
Unscheduled Care

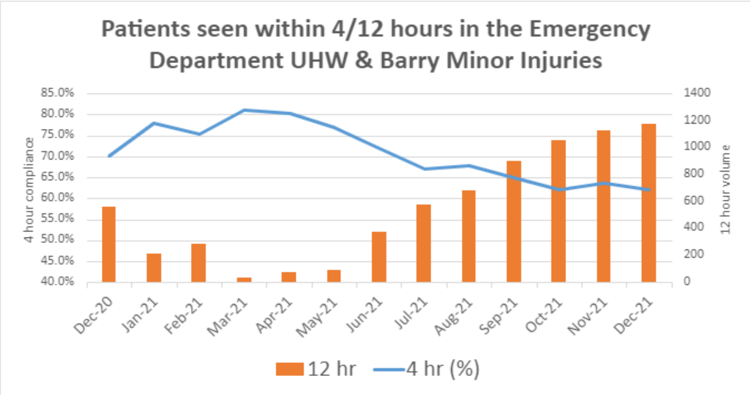
Attendances at our Emergency Unit department have increased since the first covid wave



- Emergency Unit attendances reduced slightly in December 2021 (10,379) from October 2021 (11,975) a decrease of 15%. This is 19% higher than 8,399 in December 2020.
- 4-hour performance in EU improved in November 2021 to 64% from October (62%) but deteriorated to 62% in December. This compares to 70% in December 2020. 12-hour waits have been high in the recent quarter and at their highest (1,177) in December 2021.
- 661 Ambulance handovers took place in over 1 hour in December 2021. This compares with 441 in October 2021.

The percentage of red calls responded to within 8 minutes has increased to 65% in December 2021 from 64% recorded in October 2021.





Mortality Indicators
Learning from Deaths/Mortality

The last Mortality Review Group was held on 9th November 2021. The easements put in place to manage death certification during COVID-19 will be maintained until March 2022. Whilst it was recognised that easements make things easier, not necessarily safer, there have been no obvious issues. A 'campaign' has been launched to maintain the current practices noting that our mortuary services will struggle without them.

A step-wise approach to introducing the Medical Examiner Service continues. People who have died with nosocomial COVID-19 are a priority to send to the Medical Examiner for independent scrutiny. This is an important aspect of our assurance for families who were not able to be present.

Engagement with doctors and bereavement offices has been good. Approximately 20% of patients sent to the Medical Examiner are referred back to the UHB for stage two review or other proportionate review.

The Chief Medical Examiner for Wales continues to recognise the evolving processes and progress made in the UHB for mortality reviews. Since the introduction of the Datix Mortality Module in October all referrals from the Medical Examiner (ME) have been entered on to the system. The next step is to enable Bereavement Office staff to have access to the system so that they can update families who have raised issues on actions taken by the UHB through the review process.

Primary Care colleagues are engaged and have commenced communication and engagement with GP practices as we gradually include primary care deaths and whole system reviews.

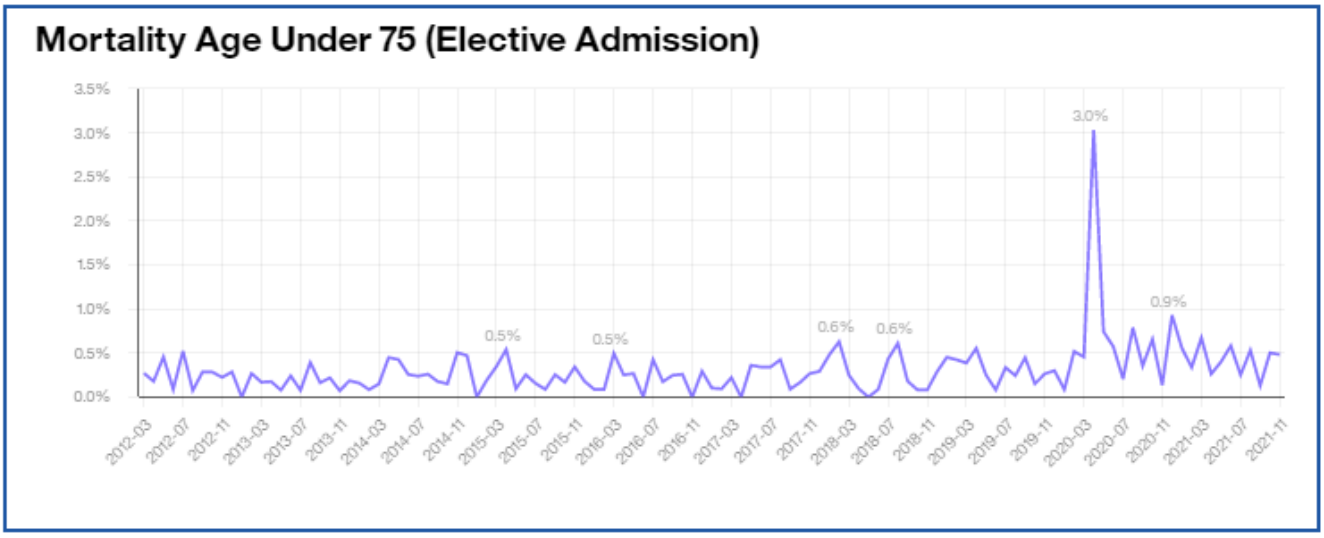
The quality of death certification is improving as the certifying doctors discuss the cause of death with the ME. This has enabled COVID-19 to be included on the right part of the death certificate.

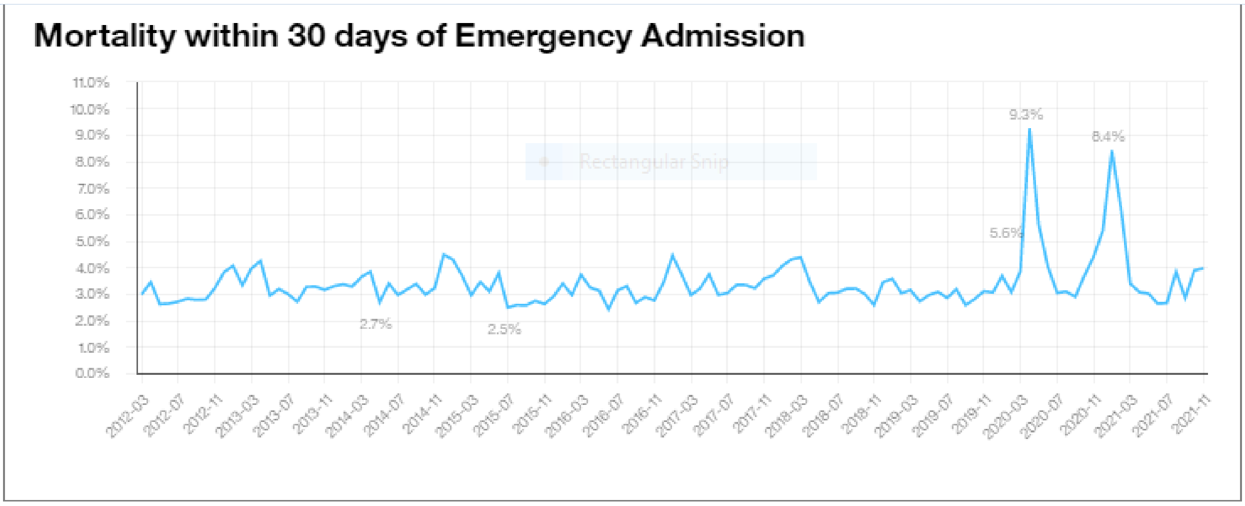
The ME may spot reasons to refer to HM Coroner that have been missed by the certifying doctor. And the Coroner may not issue a Regulation 28 if organisations recognise and act on safety issues.

The ME Service has identified some themes across Wales and can act as an alert system. Some deaths involving patients with diabetes were raised to the Executive Medical Directors in Wales.

In Cardiff and Vale UHB the emerging themes and solutions include:

- Lack of decision making on whether to resuscitate or not. This is being addressed with training for junior doctors.
- A Lead Nurse in Medicine took immediate action to signpost new staff to food/nutrition drinks for patients on special diets.
- Pressure damage - Work is ongoing across the UHB to reduce pressure damage.
- Where concerns have been raised about falls these patients are referred to the Falls Review Panel which has generated some useful learning.
- IPC – notably nosocomial COVID-19 - These patients are referred to the COVID Investigation Team for a targeted review.
- Communication has been the most frequent concern raised by families which has generated some actions to improve the situation. Medicine Clinical Board is working hard to address this by recruiting staff to actively ensure that relatives are communicated with and contacted in a timely fashion.

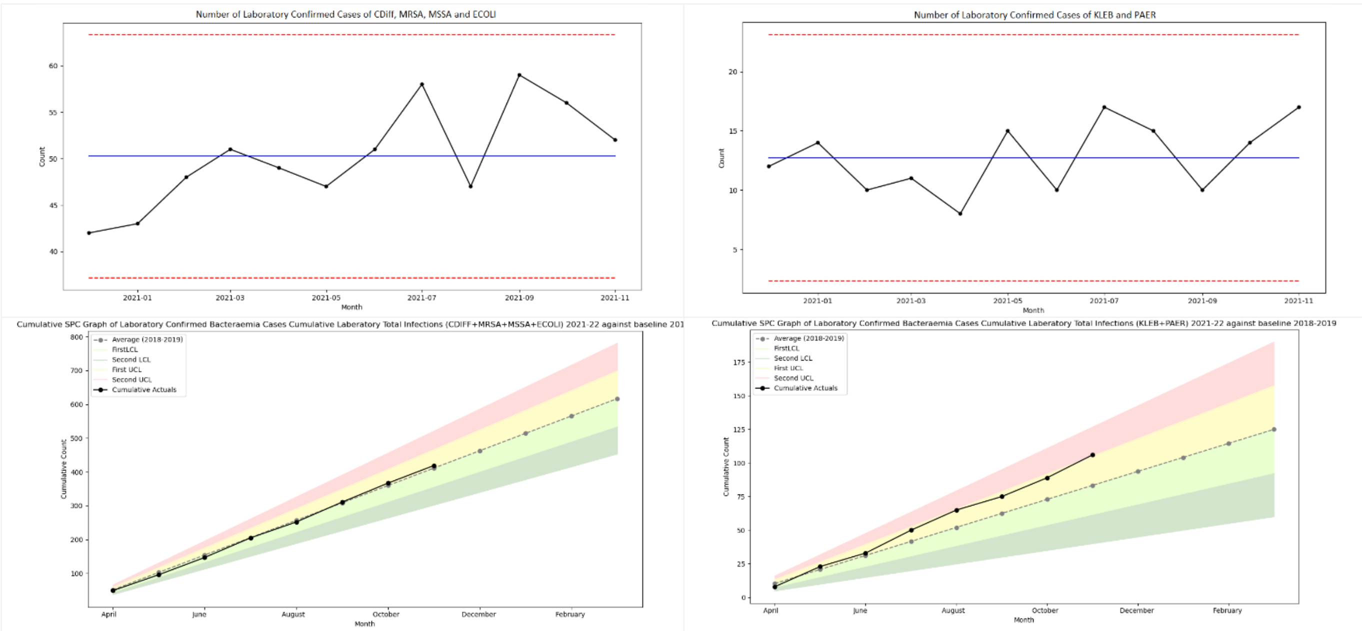




A detailed review of Mortality data is undertaken by the well - established Mortality Group.

Hospital Infections – As at November-21 the grouped total Cdiff**,** Ecoli, MRSA and MSSA infections is showing no in-year improvement against the 2018/19 baseline. However, Ecoli, MRSA and MSSA are demonstrating an in-year improvement whereas Cdiff in year has increased by 37% compared to baseline of Nov-18.

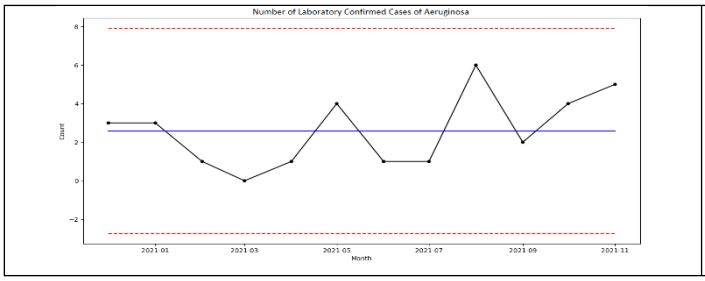
Similarly, as at November-21 Klebsiella has increased the in-year infections above the baseline year whereas P. aeruginosa is running below the 2018/19 baseline average.

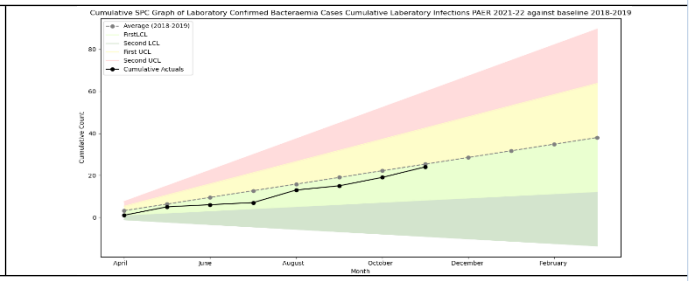


(For Individual Infection SPC Graph please see Appendix A)

We have some work to do and our main focus for the next 6 months is *C'diff* –
We will revisit the RCA process in PCIC, approximately half of our cases are related to the community therefore the RCA's will be piloted with some GP practices to ensure the tool used is robust enough to capture the required data and is in a usable format for the practices
MRSA/MSSA –

We have funded more staff in the IP+C team who will focus on audits of practice related to PVC insertion and ongoing management and review of the RCA's with the relevant teams in the Clinical Boards





Recommendation:

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

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

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

Report Title:	**HEALTHCARE INSPECTORATE WALES ACTIVITY**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**22.02.22**	
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 HIW position with regard to their assurance and inspection programme was published in the winter bulletin and remains unchanged in that it is driven by risk, whilst also seeking to support the response and recovery of healthcare services from the pandemic. The situation is continuously under review with a mixture of offsite and onsite assurance work to deliver their function is also unchanged.

HIW recognize that there is a range of indicators showing increased pressure on healthcare services due to COVID-19, broader respiratory conditions and pressure across the system, and will continue to risk assess every piece of work and engage Health Boards where appropriate. In recognition of feedback and reflection on recent inspections, HIW will now move away from

unannounced inspections for 'green' and elective, scheduled pathways. They will provide around 24 hours' notice for these inspections with the intention of ensuring teams have time to communicate with staff and allow time for arrangements to be put in place for the inspection. This is expected to be the approach for all inspections that fall into this category, however, HIW still reserve the right to operate in a fully unannounced way where they determine there to be an extremely high risk to patient safety as a result of the way a service is operating

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

No Inspections have been undertaken since the December QSE paper.

Update on Thematic Reviews

WAST
WAST thematic review actions for improvement is still ongoing. HIW acknowledges that a significant number of whole system activities are underway to address the recommendations in the report and are liaising closely with Wales' Chief Ambulance Commissioner regarding the response.
A copy of the report, patient survey and Terms of Reference is available here. (https://hiw.org.uk/local-review-welsh-ambulance-service-trust-delayed-handover)

Mental Health Crisis Prevention in the Community
The fieldwork for the National Review of Mental Health Crisis in the Community has been completed.
The main question the review will seek to answer is:

- Is mental health crisis being prevented in the community, through timely and appropriate care?

The review will explore:

- The experiences of people accessing care and treatment

It will also explore how services available within the community in each health board across Wales:

- Provide safe and effective services to help prevent mental health crisis
- Understand the strengths and areas for improvement to help prevent mental health crisis

The publication of the report had been delayed and is now expected to be published in spring 2022.The Terms of Reference can be found here (https://hiw.org.uk/sites/default/files/2021-01/20200120MentalHealthCrisisPreventionReview-TermsofReference-en.pdf)

National Review of Patient Flow (Stroke pathway)
HIW have commenced a National Review of Patient Flow (Stroke Pathway). A Stakeholder Advisory Group has convened to help steer the work. Information has been shared by Health boards in Wales to HIW regarding the services provided locally.
The review we will explore:

- The experiences of people accessing care and treatment for stroke, focussing on key aspects of patient flow, at each stage of care, from assessment through to discharge
- The impact that patient flow can have on outcomes for patients.

It will also explore:

- The processes in place for managing patient flow through healthcare systems
- The patient journey through the stroke pathway

HIW aim to share findings of the review as part of their series of Quality Insight Bulletins before concluding with a national report published late autumn 2022.

Review of Maternity Services in Wales – Remains on hold.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.
- **AGREE** that the appropriate processes are in place to address and monitor the recommendations.

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

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

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

Report Title:	**Board Assurance Framework – Patient Safety**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	22nd February 2022	
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 January 2022) 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 ten 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, increased demand of unscheduled care patients, sub optimal workforce skill mix, current EU pressures and inability to segregate patient'.

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 Meriel Jenney, Ruth Walker and Fiona Jenkins**

Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.

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 which is adding to the pressure within A&E. 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. Due to the ability to balance risk in the community in transferring patients to EU Due to the current pressure in EU and inability to segregate patients due to the volume in the department		
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. The Omicron variant is having a significant impact on staff availability (see separate risk on workforce)		
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 insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Implementation of Organisation and Transformation centres to focus upon patient flow within hospital sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21		

Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (2) • CAHMS position reviewed at Strategy and Delivery Committee (2) • Mental Health Committee aware of more people requiring support(2) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)		
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 Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since Nov 21
1. Recovery plan in place and constantly being reviewed	Caroline Bird	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. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Ruth Walker	31.03.22	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements
3. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Ruth Walker/ Caroline Bird	31.03.22	New Action
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

Report Title:	**Patient Experience Overview**	**Agenda Item no.**	**2.7**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	22/02/2022
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**
Lead Executive:	**Executive Nurse Director**		
Report Author (Title):	**Asssitant Director**		

Background and current situation:

This paper will provide an overview of the Patient Experience Team roles and regulatory function. We will provide more detailed reports regarding Complaints, Claims and redress themes and trends to committee in line with the QSE work Plan

The National statutory and regulatory Framework which governs much of what our department needs to deliver, is changing significantly. The recent **Health and Social Care (Quality and Engagement) (Wales) Act** 2020, places both an enhanced duty of Quality and an Organisational Duty of Candour in order to 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 Duty of Candour extends the circumstances in which disclosure to patients and families is required and there is currently a review of the **Putting Things Right** regulations in line with these requirements.

The Health and Care Standards, Putting Things Right regulations (PTR), Ombudsman standards, Health and Social Care (Quality and Engagement) (Wales) Act 2020, all include a duty to promote listening and learning from experience and feedback. They set out the criteria for all NHS Wales organisations to demonstrate how they respond to peoples and community experience to improve services and ensure feedback is captured, published and demonstrates learning and improvement.

People and community experience' is what the process of receiving a service is like. Whether this is in a hospital ward, outpatient appointment, GP practice (primary care), engaging with health promotion practitioners or at any event delivered by the 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 people all the way to how 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.

PATIENT EXPERIENCE TEAM – Covers several functions including those listed below

Complaints and PALS team

Regulatory requirements
Putting Things Right Regulations 2011 (PTR)-Guidance amended November 2013
Public Service Ombudsman Model Complaints Handling Policy

The UHB receives approximately 800 to 1,000 complaints each quarter (compared to 2018 where 600 concerns were received in each quarter). Under the PTR regulations, the Team are required to acknowledge all concerns within 2 working days. In addition to this, all complainants (where possible) are contacted by the appointed coordinator personally within 5 working days.

Coordinators are able to introduce themselves, building a rapport with complainants, offer initial apologies on behalf of the Health Board, and provides assurance to Complainants that their concerns are being taken seriously.

- Complainants have an opportunity to discuss their concerns in detail and agree the terms of reference and identify specific questions that they would like answered as part of the Health Boards investigation.
- This helps to ensure that responses are thorough and addresses all the issues agreed. Improving the quality of the responses provided, reducing the number of meetings requested and referrals to the PSOW.

It is pleasing to note that despite the current significant Clinical Pressures and staff availability, reported in the last Board Report, the Health Board has maintained an 81% 30-day performance in responding to concerns.

Since the beginning of April, the Concerns Team have been hosting a 7-day booking line (including Bank Holidays) for relatives to arrange a visit which is consistently extremely busy. We receive, on average, approximately 800 visiting requests a week, with approximately 70% of calls resulting in a visit being arranged. The Team work closely with the clinicians to provide advice regarding safe visiting practices and to collate the required contact information. Visiting on the UHL site was postponed for a short period due to rising Covid cases and this is reflected in the decrease in the number of visiting calls received.
We currently have 349 active concerns. Medicine Clinical Board have the highest number of active concerns, with Surgery having the second highest.

EU Directorate continue to receive a high number of concerns, however, this would be expected based on the significantly higher number of patient contacts and level of activity they experience in conjunction with the rest of Medicine Clinical Board during the pandemic.

As mentioned in previous reports, we continue to receive a high volume of concerns relating to follow up treatment, appointments and waiting lists and a number of actions have been taken by Clinical Boards to address some of these issues:

- Clinical Boards have been encouraged to contact patients to provide assurance that they have not been forgotten and to provide updates on services and current waiting times.
- Clinical Boards/Directorates have redesigned pathways to fast track patients that have not accessed care during the pandemic.
- Primary care services are being utilised so patients can be seen more timely.
- Some areas have introduced weekend clinics to catch up with the back logs.

Communication is a theme consistently identified in Concerns and this can be particularly distressing for relatives and patients when there is poor communication regarding diagnosis, treatment plans and discharge requirements. It is particularly difficult when visiting is restricted. One initiative being undertaken within Medicine Clinical Board is the implementation of the Safer Bundle which incorporates communicating with patients regarding their progress and making them active participants of their care.

The Health Board has also noted a high number of concerns relating to the environment and social distancing, particularly, within the EU Department.

In order to address these issues, we have as a Health Board:

- designed materials to help/encourage social distancing
- enhanced cleaning procedures and rota's
- brightened up areas with redecoration

However the impact of the increased activity in the department and the pressure on patient flow throughout the system is leading to examples of poor patient experience and an increase in concerns in the EU.

Inquests

Regulatory requirements: Coroners and Justice Act 2009 and Coroners (Inquest) Rules 2013

The numbers and complexities of inquests is an increasing demand Poor preparation and management of inquests provides a significant risk to the organisation. At the present time we have 224 open inquests.

Pre-inquest reviews (PIR) is a hearing before the Coroner where the Interested Persons and the Coroner seek to plan for the final inquest. In complex cases 2 PIR's are often held.

Staff support.

Part of inquest preparation is effective staff support prior, during and post inquest. It can be very distressing to provide evidence at an inquest in the presence of families, the media, and peers and to be questioned by the Coroner and cross-examined by legal representatives. As indicated, inquests can be subject to media attention and this needs to be managed sensitively whilst recognizing the open and transparent culture that is the philosophy of the organization The plan is to pilot a support framework for staff in these difficult inquests through signposting , peer support and/ or additional help if required.

Claims-Clinical, Negligence, Personal Injury and small claims

Supporting Procedures and Written Control Documents Other supporting documents are:
Responsibilities & Accountability Framework
Claims Handling Escalation Procedure
Standing Orders and Standing Financial Instructions
CN & PI : Claims Handling
CN & PI: Structured Settlements
NHS Indemnity – Arrangements for Handling CN Claims against NHS staff
Handling CN Claims: Pre-Action Protocol
Putting Things Right Regulations 2011 (Guidance amended November 2013)
Public Service Ombudsman Model Complaints Handling Policy

The Health Board is liable for the initial £25,000 paid in a settlement (unless under redress) and if the process is followed correctly and the learning is accepted by the **Welsh Risk Pool (WRP)** then financial settlement above £25,000 is reimbursed.

The aim of the regulation was to streamline the handling of concerns and under the '*Putting Things Right'* arrangements, all NHS Wales organisations should aim to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time around. We are committed to using the redress process when appropriate this enables a timely resolution for those people seeking an apology, remedial treatment and/or financial compensation to the value of £25,000. if we can demonstrate to the WRP that we have followed process, from an investigation and legal context, that we have evidenced the improvements needed to ensure that the learning is used to mitigate the risk of a case like this reoccurring then we can reclaim the £25,000 settlement and the expert fees incurred. However, the UHB will bear the costs of the claimant's legal fees, if they choose to engage a solicitor which under PTR are capped at £1,920

We will need to complete LFER-Learning from events forms for all Nationally reportable incidents to comply with Welsh Risk Pool reimbursement process. This is a significant increase in the litigation workload. However we are supportive of the process which is recognizing immediate learning and mitigation of risk throughout the investigation.

The WRP has issued several changes to their information requests and in order to obtain reimbursement the Learning from Events form must be robust, demonstrate effective claims management and most importantly learning. The investigation and learning from claims will be informing the Learning advisory panel through thematic analysis.

The Health Board faces significant financial risk from any missed deadlines or poor management of claims. The team want to be able to proactively share themes and learning across the UHB

Bereavement

In response to the isolating nature of the Covid-19 pandemic the Bereavement Lead Nurse developed a service whereby all next of kin of those who died a hospital setting are contacted by telephone. Working relationships were very quickly established with Third Sector organisations who were able to provide ongoing counselling The pandemic has caused people to become bereaved and grieve in an entirely new and unique set of circumstances. The isolation that Covid-19 enforced upon us was unsettling for everyone, but bereavement in addition to that solitude

proved truly devastating. The unfavorable outcomes of inadequate bereavement support are well documented with ongoing mental health struggles a considerable cause for concern.

The bereavement nurse and Patient Experience team colleagues have contacted over 3000 next of kin since March 2020. Just under 200 have required an immediate follow-up from the team following the initial support call and over 100 of those who are bereaved have required an immediate referral for counselling from Third Sector.

This is a hospital-based service at present, however, as we progress, links have been forged with Primary Care and Welsh Ambulance Service to discuss how this could be replicated for community bereavements. At present few Health Boards have a Bereavement Lead and, following the pandemic, are looking to set up a similar service. It has been recognised that bereavement support is crucial in improving long-term mental health outcomes and we have therefore become an example of good practice.

We wish to continue post pandemic to contact all those who are bereaved with investment we would like to adopt site based support across the UHB. In the survey with stakeholders we undertook to develop our QSE framework where we received over 1,600 responses one of the key requests was for bereavement training and support.

Chaplaincy

In response to the Covid-19 pandemic the Chaplaincy team comprehensive guidance for staff supporting patients at end of life care or are significantly unwell as a result of Covid-19 or other potentially life-limiting illnesses. This work was supported across the Patient Experience Team and has made such a difference to those who are bereaved.

Throughout the pandemic the Chaplaincy team, due to infection control measures, have had to adapt the way in which some of the services are provided. However, they continue offering spiritual and pastoral care to both patients and staff.

They have been key in supporting staff through the very sad death of colleagues, enabled funerals to be live streamed on multiple sites and sometimes in several places, to allow colleagues to observe the services and pay their respects in a safe, socially distanced manner. The relationships within our multi faith community have been strengthened in these difficult times and mutual support has been demonstrated. This was demonstrated through a multi faith day of prayer

It was particularly pleasing to note the children's memorial services which the team recorded and shared with families. The Chaplains placed the precious stars on the tree on behalf of the families who would normally place them, that symbolizes so much for these families and enabled this important memorial service to proceed despite the challenging times

Carers

The pandemic has impacted upon some of this work and we know that the numbers of carers has significantly increased during the pandemic

Cardiff and Vale University Health Board and Cardiff and Vale of Glamorgan Councils have worked with Carers Trust South East Wales (CTSEW) to commission the Young Carers in Schools Programme. This programme provides schools with the tools and resources to support young carers, giving them the same access to education, opportunities and future life chances as their peers. Schools are asked to produce, collate and submit evidence around five key themes which is reviewed by the Peer Review Panel.

The Young Carers in Schools programme reported that the impact of COVID-19 was subsiding however schools still had competing priorities due to staff and pupils having to isolate if they had a co outbreak. However, despite the challenges, the team has reported an increase in participation, 16 of the 18 schools in Cardiff (89%) are now participating in the programme and the Vale of Glamorgan have maintained 100% participation. They have also seen an increase in the numbers of young carers identified in schools.

The success of the Young Carers in Schools Programme was recognised nationally last year in the Patient Experience Network National Awards (PENNA).

The judging panel commented: "An outstanding school focused project which, through collaboration between the health board and community sector, enables the recognition, support and appreciation of the role of young carers. Addresses recognized concerns of young carers themselves

Moving forward Carers Trust South East Wales have been working with two primary schools across Cardiff and the Vale to understand how the YCiSA can be utilised in a Primary School setting.

Since 2016 Cardiff and Vale University Health Board and Cardiff and Vale of Glamorgan Councils have commissioned Carers Trust South East Wales to implement their Carer Friendly Accreditation throughout Cardiff and the Vale. The aim is to improve, share and recognize support for carers across a wide range of services. The Accreditation Scheme has grown from focusing solely on health and social care to including communities groups who want to support unpaid carers To date 12 areas have achieved the Carer Friendly Accreditation across health and social care, and Third Sector settings and 3 areas have achieved the Carer Friendly Advanced Accreditation. A further 5 are working towards their accreditation and 37 areas have expressed an interest in the Accreditation but, due to the pandemic, have yet to move forward with the portfolio.

GP Carers Champions

The aims of the initiative are to raise awareness of unpaid carers, improve access to information and up skill staff, within GP Surgeries, allowing them to support and signpost carers appropriately.

Engagement in the scheme has increased year on year and prior to the pandemic 80% of GP surgeries in Cardiff and the Vale of Glamorgan were engaging with the scheme at varying levels. Unfortunately, due to the COVID-19 pandemic and the pressures that GP surgeries have been under we have been unable to meet with the Champions face to face, however, there has continued to be collaboration between the Health Board and GP Champions / representatives via email and telephone.

Work has continued on developing the resources for the GP Champions including standardized paperwork, a Champions Manual and training programme, ready to re-launch the programme in the near future. Work has also been undertaken to develop a volunteer role here carers themselves will undertake the assessment of the GP Surgery to determine if it meets the criteria to receive their award

Carers Lead Role

Within Cardiff and Vale UHB, a Carers Lead was appointed in 2020, with the aim to aid a smooth transition for people on hospital discharge, back home with support to unpaid carers. Unfortunately, due to the pandemic the Discharge Pilot was placed on hold. However, the Carers Lead has been working in partnership with teams within and external to the UHB and has used this time to ensure that the carer's voice is represented on new initiatives moving forward. This has included, to highlight a few:

- Supporting the Human Resources Team in developing Guidance for Carers and their Managers. Helping to raise the profile of staff carers and the issues they face. This work also led to the Carers Lead being involved in the development of the Staff Well-Being Agenda ensuing staff carers issues are highlighted.
- Representing the UHB on the Young Carers ID Card Working Group, working with partners to raise the profile of young cares and the scheme.
- Undertaking a pilot of Attend Anywhere for virtual visiting to support Carers and relatives with increased virtual visiting during current hospital restrictions.
- Monitoring a dedicated email inbox for carers vaccination queries.
- Currently working with Head of Patient Experience Clinical Teams to look at starting a pilot to trial the Clinical Workstations App to support carers and relatives get daily text updates on how the patient is doing.
- Sitting on Minority Health Fair Committee to raise awareness of carers and the caring role within Black and Ethnic Minority Groups
- Involved in the development of a resource, created by those living with dementia and their carers, for professionals to help them understand the issues.

The Carers Lead continues to Support carers, including staff carers with information and advice. However they have also focused on developing working relationships across all sectors including both Local Authorities, Third Sector Organizations and carers themselves. This work has allowed the Carers Lead to raise awareness of not only carers and their role but also the support and information that the Carers Lead and wider Patient Experience Team can provide to carers and also the training that can be provided to staff. Moving forward the Carers Lead will be working with the newly appointed Digital Stories Lead to develop some visual resources for carers and gather their stories to be used for awareness raising and training purposes.

Volunteers

Regulations and frameworks

The Disclosure and Barring Service (DBS) established under the Protection of Freedoms Act 2012

WCVA/CVC Volunteer strategy WCVA/CVC AND Policy

As part of the QSE framework we anticipate roles for volunteers being considered in every business case and development at the outset so that we can recruit specific volunteer roles in collaboration with our staff side colleagues. During the first 3 months of the pandemic we received over 250 expressions of interest to help just through our volunteering email account. We opened

recruitment in May 2020, with the aim of recruiting a pool of volunteers who would be ready to start as soon as it was safe. Interviews were undertaken virtually and all individuals who got in touch when recruitment was on hold were contacted.

In December 2020 with the opening of the Mass Vaccination Centres, we also opened those areas for Meet and Greet Volunteers. This established a partnership with St Johns Ambulance Cymru and British Red Cross Wales for volunteers supporting at the centres. To date over 100 third sector volunteers have been recruited and are supporting alongside UHB volunteers at the centers. We have also facilitated online inductions for these volunteers as part of their recruitment process.

Transitional Care Unit

Our Volunteer Service Managers are currently working closely with Senior Nurses to suppor patients being transferred to the Transitional Care Unit TCU at St David's Hospital, to date they have met with staff and are planning the reintroduction of volunteers to the unit who will be able t support and facilitate activities both group and 1:1, help build and maintain social skills, support witl digital learning and virtual visiting, while befriending to improve wellbeing and help with boredon and isolation.

Vaccination Centers

Voluntary Service Team continue to support all vaccination center's including support at a loca medical center where volunteers will support the Aneurin Evans Pharmacy, West Quay Medica Centre, Barry from 4th October - 14th November roll out of patient vaccine booster clinics.

Return of Existing Volunteers

The Team have been working closely with Health and Safety/ Occupational Health and IPC t develop risk assessments and enhanced induction processes to support volunteers who ar returning from being on hold since the pandemic began. All volunteers will undergo specific Covi safety training and volunteer inductions before starting in public facing volunteer roles only. Th team are also engaging with various wards to discuss the safe return of volunteers to wards areas

Horatios Garden

Horatio's Garden – A Memorandum of Understanding has been agreed between the Health boar and the Charity to implement a volunteer placement at the new Spinal Unit specifically in th Garden. Horatio's Garden Volunteers will be recruited to support with planting and maintaining th garden and eventually supporting and joining patients in the garden.

People Experience/ digital support

As part of the QSE framework we will be supporting the collation of Patient and Carer stories. We will train a number of volunteers to also collate stories and utilise the civica People experience system being implemented across wales to develop a digital feedback platform.

The Digital Stories Programme will:

- create environments that provide positive experiences for patients and staff
- contribute to people's wellbeing through facilitating participation in the Arts
- lead directly to service improvement across the Health Board

People Experience Feedback system. CIVICA

In line with our Health Boards across Wales we will be introducing and embedding a once for Wales People Experience System developed by CIVICA. The system will enable timely collation of feedback via a plethora of methods including text messaging, QR codes, feedback machines, digital upload. Staff want timely feedback so that they can contextualize comments to activity and action any immediate improvement. The development of a compliment's portal will enable us to learn from what goes well and why in a timely way. Through the system we can monitor actions and undertake more effective thematic and sentiment analysis.

KEY Achievements

The Patient Experience Team were successful in two PENNA categories this year. The firs category 'Support for Families and Care Givers' we were successful runners up , this work involve the Bereavement Team undertaking and ensuring that all bereaved families are contacted after a death of a loved one and offered telephone support and signposting during a very difficult time Watch the video here.

Secondly the whole team were winners in the category of 'Team of the Year' for the work they hav undertaken throughout the pandemic. Cardiff and Vale Health Board are the first Welsh Healt Board to have achieved this winning status in the Team of the Year category which is an enormou achievement for the whole team.
Watch the video here.

Help force Volunteers Awards

The Help force Annual Volunteer Awards were announced on Friday the 29th of October, the Patien Experience Team were successful in three groups receiving the Highly Commended awards in th following categories,

Partnership and Systems Working in volunteering- Mass Vaccination Centre Volunteers - Cardiff & Vale University Health Board, British Red Cross, and St John Ambulance Cymru

Outstanding Staff Champion for Volunteers. - Sarah Davies - Cardiff and Vale Health Board

Outstanding Volunteering Team of the year - Hospital Runner Team at Cardiff and Vale Universit Health Board

Our volunteers provide so much support, time and care for our services, staff, patients an communities and this is a fantastic recognition of their contribution during the pandemic.
https://helpforce.community/connecting/awards-2021

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

The significant increase in Concerns being received for this year in comparison to others

The requirements to meet the financial reimbursement arrangements for WRP demonstrating both management of the redress case/ Claim and evidence the learning from the investigation.
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.): Risk of financial and reputational risk across the portfolio
Recommendation: To note the the increase in concerns numbers and the increased workload from the Welsh Risk Pool

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:	**Work Plan 2022/23 – Quality, Safety and Experience Committee**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	22.02.22	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the Quality, Safety and Experience Committee Work Plan 2022/23 prior to presentation to the Board for approval.

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

The Work Plan for the Quality, Safety and Experience Committee was last reviewed in February 2021.

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

The work plan for the Quality, Safety and Experience Committee 2022/23 has been based on the requirements set out within Quality, Safety and Experience Committee Terms of Reference which requires the Committee to meet six times a year in addition to a 'special' meeting in October. There are still some area of the Quality Framework which are 'under development' and these will come on line and report into the Quality, Safety and Experience Committee when appropriate to do so.

The Work Plan should be kept under review to ensure appropriate reporting requirements are met and it should be noted that it may require further updating as the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which is due to come into force in Spring 2023.

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

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

Recommendation:

For Members of the Quality, Safety and Experience Committee to:

(a) Review the Quality, Safety and Experience Committee Work Plan 2022/23
(b) Ratify the Committee Work Plan for 2022/23 and
(c) Recommend approval to the Board on 31st March 2022.

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

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

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

Quality Safety and Experience Committee Work Plan 2022 - 23								
App -Approval Ass- Assurance Inf - Information	**Exec Lead**	**12-Apr**	**14-Jun**	**30-Aug**	**11-Oct**	**29-Nov**	**10-Jan**	**07-Mar**
Agenda Item					Special			
Standing Items								
Quality, Safety and Experience Implications arising from IMTP	MJ/RW	Ass						
Quality Indicators	MJ/RW	Ass	Ass	Ass		Ass	Ass	Ass
Quality, Safety and Effectiveness Assurance Reports from Clinical Boards	CB	Ass	Ass	Ass		Ass	Ass	Ass
Sub Groups to Quality, Safety and Experience Committee : **Clinical Effectiveness Committee** (consent MCA, DoLS, National Clinical Audit, NICE, NCEPOD, Patient Information, EOL Care, Dementia and delirium, Transition, Organ Donation, Peer Reviews.)	MJ/RW	Ass				Ass		
Concerns Group (concerns and complaints, incident reporting, Duty of candour, patient/user experience and feedback in line with National Clinical Services Framework: A Learning Health and Care System, claims, datix system.)	MJ/RW		Ass				Ass	
Clinical Safety Group/Committee (when established)(Consent MCA, DoLS, Patient Information, Dementia and delirium, Transition, Organ Donation, IP&C, Pressure Damage Group, IRMER, End of Life Care, Falls Delivery Group, JAG, Medicines Management Group, Mortality Review Group, Blood Transfusion, patient Safety Solutions, Medical Devices Group. Nutrition and Hydration, RADAR)	MJ/RW			Ass				Ass
Learning Committee (when established)	MJ/RW	Ass				Ass		
Operational Groups by Exception (IP&C, Cleanliness, Decontamination, Medicines Management, Safeguarding, Research, Patient Safety Solutions, Medical Devices, Nutrition and hydration, Falls, Health Records, Blood Transfusion, Resus, VTE, Pressure damante, Mortality, Suicide Prevention, Point of Care Testing)The operational groups will feed into the Clinical Safety Group when established with exception reporting only to QSE Committee	MJ/RW	Inf	Inf	Inf		Inf	Inf	Inf
Patient Story	RW	Children and Women; Mental Health	CD&T	Medicine		PCIC	Surgery	Specialist
Quality Governance								
Quality, Safety and Experience Framework -effectiveness review	MJ/RW	Ass				Ass		
Health Care Standards Strategy and Action Plan	MJ/RW		App				App	
Policies	MJ/RW	App	App	App		App	App	App
Health and Social Care (Quality and Engagement) (Wales) Act 2020- Annual Compliance	MJ/RW							
Key External Reports from CHC, Internal Audit, Audit Wales	MJ/RW	Ass	Ass	Ass		Ass	Ass	Ass
HIW Activity Overview	RW	App	App	App		App	App	App
HIW Primary Care Contractors	RW		App			App		
Health Promotion Protection and Improvement								
Public Health Promotion activities	FK	Ass						
Quality, Safety and Experience of Public Health Services	FK					Ass		
Quality, Safety and Experience Committee Governance								
Chairs Action	SE	Inf	Inf	Inf		Inf	Inf	Inf
Annual Work Plan	NF						App	
Review of Meeting	NF	Ass	Ass	Ass		Ass	Ass	Ass
Self assessment of effectiveness	NF	Ass						
Review Terms of Reference	NF						App	
Produce Committee Annual Report	NF						App	
Minutes of Quality, Safety & Experience Committee Meeting	NF	App	App	App		App	App	App
Action log of Quality, Safety and Experience Committee Meeting	NF	Ass	Ass	Ass		Ass	Ass	Ass

Report Title:	**Terms of Reference – Quality, Safety and Experience Committee**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	22.02.22	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

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

The Terms of Reference for the Quality, Safety and Experience Committee were last reviewed in February 2021.

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

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

It should be noted that they are fit for purpose but may require further updating as the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 come into force in Spring 2023. The Act will strengthen the existing duty of quality on NHS bodies and extend this to the Welsh Ministers in relation to their health service functions and establish an Organisational duty of candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong.

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

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

Recommendation:

For Members of the Quality, Safety and Experience Committee to

(a) Review the Terms of Reference;
(b) Ratify the Terms of Reference and
(c) Recommend them for approval to the Board on 31st March 2022.

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

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

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

Quality, Safety and Experience Committee

Terms of Reference

Reviewed by Quality Safety and Experience Committee:

22nd February 2022

Approved by Board:

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

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

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

2. PURPOSE

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

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

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

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

- oversee the initial development of the UHB plans for the development and delivery of high quality and safe healthcare and health improvement services

consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;

- consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board;
- consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;
- consider the outcomes for patient feedback methodologies in line with the National Clinical Services Framework: A Learning Health and Care System.
- review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements;
- consider and approve policies as determined by the Board.
- Review ~~Approve~~ and monitor the implementation of the Quality, Safety and Experience Framework and oversee the necessary developments to deliver the seven identified workstreams:
  - Organisational Safety Culture
  - Leadership and the prioritisation of quality, safety and experience
  - Patient experience and involvement in quality, safety and experience
  - Patient safety learning and communication
  - Staff engagement and involvement in safety, quality and experience
  - Patient safety, quality and experience data and insight
  - Professionalism of patient safety, quality and experience

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

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

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

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

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

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

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

Authority

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

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

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

Access

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

Sub Committees and Groups

3.8 Within the Quality, Safety and Experience Framework the Board has approved the following Sub-Committees shall report into the Quality, Safety and Experience Committee:

- 7 Clinical Board Quality and Safety Sub-Committees
- Clinical Effectiveness Committee
- Clinical Safety Group
- Learning Committee
- Concerns Group
- Operational Groups (by exception)

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

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

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

4. MEMBERSHIP

Members

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

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

Attendees

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

- Executive Nurse Director (Joint Lead)
- Executive Medical Director (Joint Lead)
- Executive Director of Therapies and Health Sciences
- Chief Operating Officer
- Executive Director of Public Health

- ~~Executive Director of Finance~~
- ~~Executive Director of Strategic Planning~~
- Director of Corporate Governance
- Associate Medical Director for Safety and Governance
- Assistant Director of Patient Safety, Quality and Improvement
- Assistant Director of Patient Experience

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

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

4.3. By invitation:

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

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

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

7.3 The Board Secretary/Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees

established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

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

Report Title:	Draft Quality, Safety & Experience Committee Report 2021/22						
Meeting:	Quality, Safety & Experience Committee				**Meeting Date:**	22.02.2022	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Background and current situation:

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

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

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

The Quality, Safety and Experience Committee achieved an attendance rate of 70% so far (80% is considered to be an acceptable attendance rate) during the period 1st April 2021 to 31st March 2022 as set out below – This would increase to 86% if 100% attendance is observed at the February meeting.

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

The attached Annual Report 2021/22 of the Quality, Safety & Experience Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Audit and Assurance Committee is asked to:

- **REVIEW** the draft Annual Report 2021/22 of the Quality, Safety & Experience Committee.
- **RECOMMEND** the Annual Report to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2.	Deliver outcomes that matter to people	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	
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.*

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

Annual Report of the Quality, Safety and Experience Committee 2021/22

1.0 INTRODUCTION

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

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members, one whom must be a member of the Audit and Assurance Committee. During the financial year 2021/22 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Executive Nurse Director (Executive Lead for the Committee) and the Director of Corporate Governance. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS AND ATTENDANCE

The Committee met five times during the period 1 April 2021 to 31 March 2022 one of which (26 October 2021) was a special meeting. This is in line with its Terms of Reference.

The Quality, Safety and Experience Committee achieved an attendance rate of 70% so far (80% is considered to be an acceptable attendance rate) during the period 1st April 2021 to 31st March 2022 as set out below – This would increase to 86% if 100% attendance is observed at the February meeting.

	13.04.21	15.06.21	15.09.21	26.10.21	14.12.20	22.02.22	Attendance
Susan Elsmore (Chair)	✓	✓	X	✓	✓		67%
Ceri Phillips (Vice Chair)	X*	X*	✓	✓	✓		75%
Michael Imperato	✓	✓	X**	X**	X**	X	100%
Gary Baxter	✓	✓	✓	✓	✓		83%
Akmal Hanuk	X*	X*	✓	X	X		25%
Mike Jones	✓	✓	X	✓	✓		67%
Total	**100%**	**100%**	**60%**	**80%**	**80%**		**70%**

*The Vice Chair of the Committee and Akmal Hanuk were approved to post in August 2021.

** Michael Imperato was a member of the Committee during the period April 2021 until June 2021.

Mike Jones and Ceri Phillips are also Members of the Audit and Assurance Committee.

4.0 TERMS OF REFERENCE

The Terms of Reference will be reviewed and approved by the Committee on 22nd February 2022 and are to be approved by the Board on 31st March 2022.

5.0 WORK UNDERTAKEN

This Committee's focus is on ensuring patient and citizen quality and safety including activities traditionally referred to as 'clinical governance'. In particular, the Committee should seek and provide assurance to the Board or to escalate areas of concerns and advise on actions to be taken in relation to the seven identified work streams:

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

During the financial year 2021/22 the Quality, Safety and Experience Committee reviewed the following key items at its meetings:

1. Impact of Covid-19 on Patient Safety
2. Themes and Trends in Never Events
3. Gosport Review
4. Quality, Safety and Experience Framework
5. Waiting Lists and Cancer Services
6. Pressure Damage
7. Falls Group
8. Perfect Ward
9. Update Report on: Healthcare Standards, Duty of Candour, National Quality Framework and Annual Quality Statement

PRIVATE QUALITY, SAFETY AND EXPERIENCE COMMITTEE

APRIL, JUNE, SEPTEMBER, DECEMBER 2021 AND FEBRUARY 2022

1. Pandemic Update & Any Urgent/Emerging Themes
2. Corporate Risk Register
3. Review into working practices of CMHT's in C&V UHB
4. Nosocomial Investigation Position
5. Cardiac Surgery Report

PUBLIC QUALITY, SAFETY AND EXPERIENCE COMMITTEE – SET AGENDA ITEMS

April 2021 - March 2022

Clinical Board Assurance Reports

The Committee discussed a number of Clinical Board Assurance reports received throughout the year. These reports provided details of the clinical governance arrangements within the Clinical Boards in relation to Quality, Safety and Patient Experience (QSPE). The reports identified the achievements, progress and planned actions to maintain the priority of QSPE.

By way of example, in April the Committee received a report in relation to the Children and Women's Clinical Board. That report had provided the Committee with an update of the continued progress made regarding the Quality Safety and Patient Experience Agenda. The report had also highlighted the considerable pressures faced by the Clinical Board and the

concerns of clinicians as the country emerged from the second wave of the pandemic, in particular, the emotional well-being support that will be required for our children and young people.

Quality Indicators Report

In June 2020, the Committee agreed a range of quality indicators that would be routinely monitored at each meeting. To enable this, work was undertaken with the Information Department to develop a QSE dashboard.

The reports provided an overview of current performance against those quality indicators that were available within the dashboard.

Exception Reports

The Committee received five Exception Reports (including February 2022):

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

COVID-19

At the April meeting, the Committee were provided with information regarding the impact of Covid-19 on Patient Safety which covered:

1. Progress on COVID-19 Mass Vaccination
2. COVID-19 related incident reporting
3. COVID-19 Patient Experience Response
4. COVID-19 Assurance on reporting of deaths

A Special Meeting of the Quality, Safety and Experience Committee 26th October 2021

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

1. Hot Topics
2. Quality, Safety and Experience Themes and Trends 2020-2021

Policies and Procedures

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

1. Thromboprophylaxis Policy
2. Swab, Instrument and Sharps Count Policy and Procedure
3. Prevention and Management of In-Patient Falls Policy
4. Patient Falls Policy
5. Incident, Near miss and Hazard reporting Policy
6. Patient Identification Policy
7. National Patient Safety Incident Reporting Policy
8. Gene Therapy Medicinal Products & Gene Therapy Investigational Medicines Products Policy & Procedure.

Inspections, Peer Reviews and Other Reviews

Eleven Inspections, Peer Reviews and Other Reviews were received and approved over the course of the year and included:

1. Health Inspectorate Wales Update Review
2. Health Inspectorate Wales Activity Overview
3. Health Inspectorate Wales Primary Care Contractors
4. Terms of Reference Annual Review (February 2022)
5. Patient Experience Overview (February 2022)
6. Committee Effectiveness Survey 2020-2021

Corporate Risk Register

At all meetings, the Committee received the Corporate Risk Register. Each risk within the Register is linked to a Committee of the Board and the Board Assurance Framework. The Committee noted those operational risks, which were linked to the Quality, Safety and Experience Committee together with the work being undertaken to address those risks.

Plans

Two plans were presented to the Committee and are as follows:

1. Health Care Standards Strategy and Action Plan
2. Annual Committee Workplan (February 2022)

Quality, Safety and Experience Framework

In September, the Committee received and approved the Health Board's draft Quality, Safety and Experience Framework 2021 to 2026. The Framework had been developed through extensive engagement with a great number of stakeholders over the previous twelve months and set out the Health Board's priorities in delivering safe, effective services that deliver excellent user experience.

Other Reports

Over the course of the year a number of other reports and presentations were presented to the Committee. They included the following items:

1. **Blood Inquiry Update**

The Committee received an update with regards to the Infected Blood Inquiry. That update had included the following points: -

- on 2 July 2018, the Independent Public Inquiry into Infected Blood and Blood Products (the Infected Blood Inquiry) was launched.
- The inquiry will examine the circumstances in which men, women and children treated by the NHS in the UK were given infected blood and blood products, in particular since 1970.
- Since responding to the Inquiry on 12th September 2018, the Health Board has continued to work with Haemophilia Wales, Welsh Blood Service, Public Health Wales, Velindre NHS Trust and other Health Boards across Wales.

- Following a six-week suspension of the Blood Inquiry hearings from 31st March 2021 until 18th May 2021 for Easter, hearings recommenced the week commencing 17th May with additional hearings scheduled until August 2021.

2. Patient Safety Solutions

The Health Board regularly receives alerts and notices from Welsh Government which cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according to the complexity of the actions required. By the specified deadline, the Health Board must report a position of compliance, non-compliance or not applicable.

In December the Committee received a report in relation to Patient Safety Solutions. Amongst other matters, the report provided details of a business case which had been submitted for additional resource within the team and for the implementation of AMaT software, both to provide further assurance with regards to this area.

Perfect Ward Presentation.

At it's September meeting, the Committee received a presentation in relation to the "Perferct Ward. The presentation had highlighted that ward Accreditation was the development of a set of standards to enable areas for improvement to be identified and areas of excellence celebrated.

It was noted that Ward Accreditation was used quite frequently in England and highlighted that the Health Board was the first Health Board in Wales to introduce it.

The Committee had noted that the framework could be utilised in both Primary and Secondary care settings and that the aim would be to achieve a Bronze, Silver or Gold accreditation.

3. Health Care Standards Strategy Plan and Action Plan

The Committee was advised that work had been undertaken with specialist leads in the Health Board in order to make sure their improvement plans had been implemented.

4. Board Assurance Framework – Patient Safety

At its meetings, the Members of the Committee are provided with the opportunity to review the Patient Safety risk on the Board Assurance Framework. The purpose of the same was to provide an extra level of assurance to the Committee.

5. Patient Falls

In-patient falls are the most frequently reported incident for the Health Board (and this is true throughout the UK). With the Health Board's patient population increasing in age and complex multi-morbidity, the challenge to reduce the number of falls and injuries from falls is significant. The Committee was briefed upon the significant amount of work that has been done to date and to describe the proposed approach to falls prevention in Cardiff and the Vale of Glamorgan.

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

The Falls Policy was last ratified in 2016 and was reviewed and updated for approval at the June meeting.

6. **Pressure Damage**
   In order to provide assurance, the Committee received a report which set out the proposed multidisciplinary approach to reduce health care acquired pressure damage. The Committee recommended that the pressure damage update was shared at full Board.

7. **Ombudsman Annual Letter and Report**

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

6.0 COMMITTEE GOVERNANCE

Reports submitted to the Committee for review and approval in February 2022.

1. Committee Annual Report 2021/22
2. Committee Terms of Reference
3. Committee work plan

Also presented to the Committee at each meeting were the minutes from the:

1. Clinical Board QSE Sub Committees
2. Clinical Effectiveness Committee

7.0 REPORTING RESPONSIBILITIES

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

8.0 OPINION

The Committee is of the opinion that the draft Quality, Safety and Experience Committee Report 2021/22 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

SUSAN ELSMORE
Committee Chair

Saunders.Nathan
02/16/2022 09:50:23

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 29TH NOVEMBER 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Bolette Jones	Head of Medical Illustration
Sandeep Hemmadi	Clinical Board Director
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Robert Bracchi	Medical Advisor to AWTTC
Louise Long	Public Health Wales Microbiology
Rhys Morris	CD&T R&D Lead
Sian Jones	Operational Service Manager
Alicia Christopher	General Manager, Radiology and Medical Physics/Clinical Engineering
Emma Cooke	Clinical Director of AHPs
Becca Jos	Deputy Director of Operations
Mathew King	Assistant Director of Therapies/Head of Service Podiatry
Kim Atkinson	Acting Head of Occupational Therapy
Judyth Jenkins	Head of Dietetics
Jo Fleming	Quality and Safety Lead, Radiology
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Timothy Banner	Head of Patient Services
Seetal Sall	Point of Care Testing Manager
Scott Gable	Laboratory Service Manager, Cellular Pathology
Alun Roderick	Laboratory Service Manager, Haematology
Jacqueline Sharp	Acting Head of Physiotherapy
Debbie Jones	Patient Safety Facilitator
Tracy Wooster	Sister, Outpatients
Nigel Roberts	Laboratory Service Manager, Biochemistry

Apologies:

Jonathan Davies	Health and Safety Adviser
Lesley Harris	Professional Head of Radiography UHL
Nia Came	Head of Adult Speech and Language Therapy
Paul Williams	Clinical Scientist, Medical Physics
Jamie Williams	Radiology Nurse

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/340 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 21/341 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/342 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 29th October 2021 were **APPROVED.**

CDTQSE 21/343 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 21/283 Reusable Respiratory Guidance

Emma Cooke to check if the guidance has been implemented in Physiotherapy.

Action: Emma Cooke

CDTQSE 21/309 Therapies Equipment in Short Supply

It was noted that the supply chain position has now stabilised.

CDTQSE 21/326 Air Handling Issues

Meetings are being held with Estates, focusing on Haematology and Blood Bank. A meeting to discuss air handling issues within regulatory areas has also been arranged.

The air conditioning in Clinical Engineering is still not working and requires action from Estates for this to proceed. Matt Temby will escalate.

Action: Matt Temby

Alicia Christopher reported that a useful meeting has been held with the Estates team to discuss issues that need addressing within the Radiology and Medical Physics/Clinical Engineering directorate. The situation has improved and Estates have agreed to hold further briefing meetings with the directorate.

CDT QSE 21/328 Support and Resources Relating to Staff Behaviours

Work is being taken forward relating to behaviours and staff resilience and Sian Jones will provide an update at the next meeting.

Action: Sian Jones

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/344 Introduction to Chloe Evans, UHB Mental Capacity Act and Consent Lead

Chloe Evans was welcomed to the meeting. She advised that training will recommence in the New Year and bespoke training for groups of staff that would benefit with training in specific issues can be provided.

DoLS (deprivation of Liberty Safeguards) is being replaced with Liberty Protection Safeguards (LPS). This will be a 3-stage process and the UHB is currently awaiting the code of practice and Welsh Government standards that will sit alongside this. DoLS will continue to run for existing applications prior to being phased out.

CDTQSE 21/345 Feedback from UHB QSE Committee Minutes June 2021

This Clinical Board presented its assurance report to the UHB QSE Committee meeting in June.

Work on the QSE Framework is in the final stages of development. The Clinical Board will produce its own quality work plan based on this framework and also from submissions to the IMTP.

It was noted that the UHB QSE minutes contained a number of reports relating to falls, pressure damage and the pandemic recovery information and directorates were encouraged to read these reports.

CDTQSE 21/346 Risk Register – Review and Revision

Alun Roderick reported that the server for the coagulation service is run on Windows 7 and requires an upgrade. Matt Temby advised that he has escalated this issue however it is still unresolved. He requested that Alun Roderick forward the latest correspondence to him and he will follow this up.

Action: Alun Roderick/Matt Temby

The Coagulation Service has been instructed by Procurement that the offsite storage facility it utilises is no longer permissible. Sion O'Keefe and Alun Roderick to discuss outside of the meeting.

Action: Sion O'Keefe/Alun Roderick

Ed Chapman noted that the Clinical Engineering offsite storage unit is being handed over to the WEQAS service and he raised his concerns that this will impact on space within the department.

Judyth Jenkins reported that the supply chain for nutrition support products has transferred to Dietetics from Pharmacy and there are issues with the Oracle system. Orders of feeds are not arriving and suppliers are not providing the products. The issues have been raised with Procurement and Shared Services but there is currently no resolution.

Sue Bailey provided an update on the national shortage of blood tubes. Supplies of blood tubes have now returned to normal and the business continuity process has been stood down. She thanked all the teams involved for their hard work. Sion O'Keefe and Alun Roderick are undertaking a proof of concept for hubs to be utilised to address the backlog of patients requiring blood tests to be taken.

CDTQSE 21/347 Exception Reports

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/348 Initiatives to Promote Health and Wellbeing of Patients and Staff

Seasonal Flu Staff Vaccination Update

As of 15th November 2021, the Clinical Board is reporting 54.4% of frontline staff having received the flu vaccination. It was noted that in the same period last year the Clinical Board was reporting 70% and Sue Bailey emphasised that it is equally important to receive the vaccination this year. Pharmacists, Healthcare Scientists and AHPs are the professions reporting the highest uptake of the vaccination.

The question was raised that in light of the changes in Government Covid guidance relating to travel, whether updated information will be circulated in the Health Board. It was noted that the Health Board is unlikely to react until guidance from Welsh Government is firmed up.

SAFE CARE

CDT QSE 21/349 Concerns and Compliments Report

In October 2021 the Clinical Board reported an Amber status. It received 23 concerns and 7 compliments. There were 3 breaches in response times and a 35% early resolution rate.

Departments reporting a Red status were Radiology and Laboratory Medicine. Radiology reported 8 concerns and resolved 50% through early resolution. However, there were 2 breaches in response times.

Laboratory Medicine received 1 concern in Phlebotomy and Phlebotomy also reported 1 breach in its response times.

Departments reporting good concerns management are dietetics which reported 0 concerns and 1 compliment.

Podiatry received 1 concern which it resolved through early resolution and it received 2 compliments.

Difficulties arranging appointments remains the key theme for formal concerns. In October there were a cluster of concerns relating to services in Physiotherapy. A response to the concerns has been produced.

CDTQSE 21/350 Patient Safety Incidents

NRI Report

There are 2 open NRIs:

In143602 is an ongoing investigation relating to the quality of ultrasound imaging and concerns relating to a trainee.

In92837 relates to a patient who needed to access Neuroradiology. The closure form has been submitted to Welsh Government and a request has been received for an update in terms of the outstanding action and a response will need to be submitted.

CDTQSE 21/351 New NRIs (National Reportable Incidents)

There are no new NRIs to report.

CDTQSE 21/352 Patient Safety Alerts

PSN060 Oral Meds Wrong Route

The alert has been circulated across the Clinical Board for information and awareness.

ISN 2021 029 Rubber Fragments in IV Meds

Tim Banner reported that Pharmacy is linking in with All Wales work that is being undertaken in relation to this alert which may result in further addendums being issued.

Radiopharmacy reported this issue a number of years ago and have learning that can be shared with Pharmacy from the work they had undertaken to address this.

CDTQSE 21/352 Medical Device Risks/Equipment and Diagnostic Systems

A Healthcare Safety Investigation Branch Report has been produced relating to treating Covid patients using CPAP outside of a Critical Care Unit. Ed Chapman will circulate the report.

Action: Ed Chapman

An alert has been circulated to Dietetics for awareness relating to inclusion alarms on Freego pumps. The alert was produced following a serious incident in England whereby the alarm was not activated due to its design and resulted in a patient not receiving nutrition. The alert advises users of the pumps to carefully follow the instructions.

Clinical Engineering have produced a poster reminding individuals to use the Yellow Card system for medical devices in addition to drugs.

CDTQSE 21/353 IPC/Decontamination Issues

New simplified IPC guidance relating to PPE is being produced, however in light of the current Covid situation this is likely to change further.

CDTQSE 21/354 Point of Care Testing Issues

Seetal Sall reported that a free allocation of new rapid Abbott ID Now devices that facilitate Covid, influenza and RSV have been issued to the Health Board from the DHSC to test. These devices will be deployed to the Emergency Unit, MEAU and Surgical Assessment Unit. She enquired how she can check if the delivery has arrived at Lakeside. She was advised to contact Darren Holloway in Procurement.

CDTQSE 21/355 Key Patient Risks

Safeguarding Update

The UHB Safeguarding Meeting was held on 25th November. The Clinical Board is reporting an increase in the uptake of Level 2 Adult Safeguarding training and is reporting 73.8% compliance. Level 2 Child Protection training compliance is 70.03% and Violence and Aggression Against Women and Domestic Abuse training compliance is 67.5%. All are above the UHB average.

The meeting received a Domestic Homicide Review which highlighted the issue of individual accountability for robustness and legibility of documentation. The review has also led to work being undertaken in terms of responsibilities of bystanders.

The Violence and Protection Unit Team based in the Emergency Unit provided an update. The team deal with violence related injuries and reported that they have a team in the community working with under 25 year olds. They also reported that there has been an increase in attendances relating to spiking and work is ongoing in terms of the management of these patients.

Georgina Davies, UHB Safeguarding Nurse has offered over the next few months to assist this Clinical Board with any referrals and help with the completion of paperwork.

Mental Capacity Issues

Nothing further to report.

CDTQSE 21/356 Health and Safety Issues

Nothing to report.

CDTQSE 21/357 Regulatory Compliance and Accreditation

Sue Bailey congratulated the Blood Transfusion team for closing their MHRA actions, one of which was a very challenging action. UKAS inspection dates have been received for April 2022.

UKAS is inspecting the Biochemistry department in December.

CDTQSE 21/358 Policies and Procedures

A number of policies are currently out to consultation including:

Falls Policy
PPE Policy
CoSHH Policy
Manual handling Policy
Violence and Aggression Policy

It was noted that the Pharmacy department is linking in with national work relating to the sustainability agenda in terms of medicine waste and deliveries.

The Physiotherapy Non-Medical Prescribing Policy was **RECEIVED**. It was noted that further amendments are required to the policy. Tim Banner queried whether this policy is needed as there is a UHB Non-Medical Prescribing Policy already in place. He will link in with the author George Oliver to discuss further.

Action: Tim Banner

Sue Bailey suggested this document may be more appropriate as an SOP as opposed to a policy.

EFFECTIVE CARE

CDTQSE 21/359 Clinical Audit Update

Nothing to report.

CDTQSE 21/360 Research and Development

Rhys Morris reported the main issues discussed at the Clinical Board R&D Group relate to funding. The HCRW are removing funding for directorate R&D leads for the second half of this year and the R&D pump priming funding that had been offered to the Clinical Board has been withdrawn. Rhys Morris will discuss with Matt Temby.

Action: Rhys Morris/Matt Temby

An open Clinical Board R&D Forum will be set up in January. The purpose of the forum is to discuss actual research.

CDTQSE 21/361 Information Governance/Data Quality

CD&T Digital leads have been undertaking a baseline assessment to understand the current maturity of this Clinical Board in terms of its digital position. They have held a number of sessions for digital champions and will collate information received. A Sharepoint page has been set up and the aim is to share good practice and provide an opportunity for areas to request support. Departments are requested to encourage interested staff to take on the role of digital champion.

Sion O'Keefe reported that the Health Board held its first working group to discuss health records for Trans patients and consider options that the Health Board can consider for policies and procedures relating to Trans patients' health records. The Health Board will work with the community and there will be work around education of staff. On a local level the group is seeking representation from Radiology and Laboratory Medicine.

Discussions are underway with digital colleagues around creating a single demographic service where patient details can be updated and fed back into UHB systems.

DIGNIFIED CARE

CDTQSE 21/362 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

The HIW Inspection Report relating to the inspection in Radiology has been received. A robust improvement plan was produced in response to the report and this has been fully accepted by the HIW.

The Clinical Board has been working with the Welsh Audit Office on a follow up review to their audit of Radiology in 2017. The draft report will be shared in due course. The outcome was satisfactory with one action relating to the backlog following the pandemic.

CDTQSE 21/363 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory loss

Nothing to report.

CDTQSE 21/364 Initiatives Related to the Promotion of Dignity

Nothing to report.

CDTQSE 21/365 Equality and Diversity

A bespoke training session was provided to the Clinical Board by Keith Wilkinson, UHB Equality Manager which focused on allyship. The Clinical Board is replicating the work of the Executive Team by allocating the 9 protected characteristics to members of the senior management team. This work is at an early stage whilst the management team and Executives start to understand the roles allies and develop shared learning with other Clinical Boards.

Specific work is also being undertaken linking with the LGBQT Network and mentorship. The aim is to encourage this work at service level. Sion O'Keefe will share the list of who is leading on which protected characteristic following the meeting.

Action: Sion O'Keefe

TIMELY CARE

CDTQSE 21/366 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Patients waiting 8 weeks or more for diagnostics is 2902. This is an increase of 118 from the previous months.

Patients waiting 14 weeks for Therapies is 644. This is an increase of 93 from the previous month.

INDIVIDUAL CARE

CDTQSE 21/367 National User Experience Framework

Patient Experience feedback is currently not being collated. The Lead Nurse role for the Clinical Board will prioritise this work next year.

STAFF AND RESOURCES

CDTQSE 21/368 Staff Awards and Recognition

Dietetics were awarded a prestigious award from the British Dietetic Association on the work of the Model Ward as part of a multidisciplinary project and outstanding feedback was received. Judyth Jenkins thanked and praised the CEDAR team for the support they provided with data, clinical information and analysis of results. A clinical paper has been produced on this work which will go to publication in the New Year.

Medical Illustration were also celebrating success at the Annual Medical Illustrators Awards hosted by the Institute for Medical Illustrators. The team were awarded 8

Bronze, 7 Silver and 1 Gold Award. Bolette Jones personally received the Norman Kay Harrison Award for promoting the profession. Examples of the winning images were illustrated in the Chief Exec Connect newsletter.

Beverley Holdcroft was successful at the Advancing Healthcare Awards and won an outstanding achievement for being an outstanding rehabilitation coach. The Physiotherapy Team were highly commended for the acute redicular pain pathway in Physiotherapy.

CDTQSE 21/369 Monitoring of Mandatory Training and PADRs

Donna Davies will be providing clarification on the requirements for clinical staff with regards to undertaking face to face or online fire training.

The results of the staff survey will be shared when available.

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

The following minutes were **RECEIVED:**

Biochemistry QMS Minutes November 2021
Clinical Board R&D Group Minutes November 2021

ANY OTHER BUSINESS

An agenda item will be added to future meetings on Waste and Sustainability. The Clinical Board is keen for sustainability to be considered by services in all decision making going forward.

Sian Jones and Sue Bailey attended the Environmental Management Steering Group last week. The outcome of the Nitrous Oxide Project was shared and Sue Bailey will arrange for the presentation to be brought to a future meeting.

Action: Sue Bailey
Departments were encouraged to adhere to appropriate segregation of waste.

It was noted that the Park and Ride is up and running which will help address the new parking arrangements.

The Next Bike service has been suspended to allow for repairs and replacement of bikes.

The Health Board has established a Cycle to Work Group to support staff who cycle to work.

Work will be taking forward in the Clinical Board around carbon literacy and more information is being gathered on this.

Matt Temby reiterated that any requests for decisions submitted to the Clinical Board Formal Board meeting from April at the latest, will require a statement on sustainability.

Tim Banner reported that Pharmacy is involved in national sustainability work relating to trying to reduce medicines waste and with community pharmacy in terms of deliveries.

Matt Temby reminded directorates of the request sent out last week from the Clinical Board on the wider staffing challenges and different approaches that can be used, including a request for activity that can be stood down to release staff. Becca Jos will be contacting departments this week to follow this up.

Tim Banner reported that EPMA (Electronic Prescribing and Medicines Administration) is on the horizon for Cardiff and Vale. This is a Welsh Government nationally led scheme that will replace all manual paper prescribing processes with an electronic solution. A national procurement exercise will be commencing.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 17th December 2021 at 10am 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 17TH DECEMBER 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Debbie Jones	Patient Safety Facilitator
Bolette Jones	Head of Medical Illustration
Gareth Jenkins	Deputy General Manager, RMPCE
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Robert Bracchi	Medical Advisor to AWTTC
Louise Long	Public Health Wales Microbiology
Sian Jones	Operational Service Manager
Jonathan Davies	Health and Safety Adviser
Mathew King	Assistant Director of Therapies/Head of Service Podiatry
Kim Atkinson	Acting Head of Occupational Therapy
Jo Fleming	Quality and Safety Lead, Radiology
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Alun Roderick	Laboratory Service Manager, Haematology
Jacqueline Sharp	Acting Head of Physiotherapy
Alicia Christopher	General Manager, Radiology and Medical Physics/Clinical Engineering

Apologies:

Sandeep Hemmadi	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Rhys Morris	CD&T R&D Lead
Emma Cooke	Clinical Director of AHPs
Becca Jos	Deputy Director of Operations
Lesley Harris	Professional Head of Radiography UHL
Judyth Jenkins	Head of Dietetics
Timothy Banner	Head of Patient Services
Nia Came	Head of Adult Speech and Language Therapy
Paul Williams	Clinical Scientist, Medical Physics
Jamie Williams	Radiology Nurse
Scott Gable	Laboratory Service Manager, Cellular Pathology
Tracy Wooster	Sister, Outpatients
Nigel Roberts	Laboratory Service Manager, Biochemistry
Seetal Sall	Point of Care Testing Manager

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/370 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 21/371 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/372 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 29th November 2021 were **APPROVED.**

CDTQSE 21/373 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 21/283 Respirator Guidance

Emma Cooke to check that the reusable respirator guidance has been implemented in Physiotherapy.

Action: Emma Cooke

Air Conditioning Issues

Sian Jones reported that a meeting was held with Estates and all the air handling issues were discussed. Contact has been made with managers to complete forms to request funding for equipment to be replaced. A follow up meeting will be held in the New Year.

CDTQSE 21/326 Behaviours and Staff Resilience

Discussions will be held in the New Year on how the videos will be used and the appropriate timing for these to be shared.

CDTQSE 21/346 Server in Coagulation Service

No progress has been made. The server issues have been escalated to Genmed, the service provider for a resolution.

CDTQSE 21/346 Offsite Storage Facility for Coagulation

Alun Roderick noted that the coagulation service will be using the same records storage process as blood transfusion.

Jo Fleming commented that there are storage requirements for Radiology and she was advised to link in with Keeley Baker.

CDTQSE 21/358 Non-Medical Prescribing Policy

Tim Banner to discuss Non-Medical Prescribing Policy with George Oliver.

Action: Tim Banner

CDTQSE 21/360 R&D Funding

Matt Temby and Rhys Morris to discuss the Clinical Board's R&D funding issues.

Action: Matt Temby/Rhys Morris

CDTQSE 21/365 Protected Characteristics

Sharing information with the Clinical Board is currently being paused whilst the Clinical Board Team obtain more knowledge on the protected characteristics.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/374 Patient Story

Angela Cleaver was welcomed to the meeting to present information on how the dietetics service helps patients manage Irritable Bowel Syndrome with dietary and FODMAP advice.

In 2019 this service formed part of a Bevan Spread and Scale Project. 85 patients were referred, of which 69 attended an initial appointment and 42 patients attended a follow up appointment. Patients completed a food diary and their different food groups were categorised with a colour to flag up the main foods that were causing problems and identify which food groups were lacking from diets.

A lot of the patients required first line advice to explain why diet matters in managing IBS and how it impacts on the bowel. Some patients referred to the service were underweight and need nutritional support advice. The majority were eating FODMAP foods, which are simple sugars and complex carbohydrates fermenting in the bowel. For some patients these result in a more pronounced reaction that causes bloating and pain and they were advised to follow a low FODMAP diet.

It emerged that half of patients had tried to follow low FODMAP diets themselves but had failed. This is a complicated diet which is wheat and lactose free and requires avoidance of certain groups of fruit and vegetables. The dietetic support that patients require to follow this diet is much greater than a leaflet from the internet.

There is a potential risk that there is an increased risk of bowel cancer when following this diet if followed over a long period of time due to changes in microbiome. There is also a potential for macro and micro nutrient deficiencies. It is therefore important that people have dietitian involvement and receive good advice for following this diet.

Patients referred to the service were scored on a range of symptoms at their initial appointment and they are scored again at follow up. Data shows a large decrease in their symptoms score at follow up.

The story was presented of a 33-year old lady who experienced pain, bloating and was alternating between constipation/urgent loose stools for 15 years. She tried a low FODMAP herself with limited success. She was anxious throughout her life through school and work life as she could never be sure when she would need to use the toilet. Many people suffering with IBS find this very difficult to talk about openly.

On assessment, this lady had thought she was following a low FODMAP diet but was still eating high FODMAP foods. She moved to the low FODMAP diet strictly for a maximum of 2 weeks. The service ensured she was eating the right amount of fibre and fluids. Time was taken to explain to her how the gut works and advice and reassurance was given on what is normal and not normal. This lady followed the advice and noted a reduction in pain and bloating and she moved to a regular pattern. She was then given advice and knowledge on how to reintroduce some FODMAPs whilst being able to continue to manage and control her condition.

The benefits of seeing a dietitian to manage IBS include:

- Reducing the impact on waiting lists on other services and the need for GP visits and medication.
- The service shows results in resolving patients' symptoms.
- Dietary advice is individualised and the patient feels listened to and empowered to manage the condition themselves.
- Patients receive advice to prevent long term issues of following diets incorrectly.

Angela Cleaver was commended on the individualised care that the service provides to patients and demonstrates a prudent care approach.

Deborah Jones asked if the presentation could be shared with other Clinical Boards. Angela is willing to deliver the presentation but is concerned that services may be keen to refer their patients into the Fodmap service which is very limited in terms of staffing resource, and the service will not be able to cope with the volumes.

CDTQSE 21/375 Risk Register

Alun Roderick raised concerns on staffing levels particularly over the festive period. This will be a major constraint across services.

Guidance states that contacts of Omicron cases need to isolate for ten days and the question was asked that for staff wearing the appropriate PPE, whether they are classed as a contact. IPC advice was given that if there is no breach in PPE then the staff are not classed as a contact. The IPC team can be contacted for advice and in certain circumstances Microbiology are willing to be contacted to discuss a specific case.

Gareth Jenkins flagged a longstanding issue that the corridor leading to Medical Physics from Physiotherapy has water/damp is coming through the ceiling and patients have commented on this. Physiotherapy have previously raised the issue with Estates. Gareth Jenkins and Jackie Sharp to provide Sue Bailey with the MR numbers and she will escalate.

Action: Jackie Sharp/Gareth Jenkins/Sue Bailey

Jonathan Davies reported internal temperature issues within a laboratory in Cellular Pathology. It was noted that Sian Jones has been engaged with the team.

CDTQSE 21/376 Exception Reports

Nothing further to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/377 Initiatives to Promote Health and Wellbeing of Patients and Staff

Nothing to report.

SAFE CARE

CDT QSE 21/378 Concerns and Compliments Report

In November 2021, the Clinical Board reported an Amber status. It received 22 concerns and 23% were resolved through early resolution. There were 2 breaches in response times. 16 compliments were received.

There were no areas reporting a Red status.

The 2 breaches were reported in Physiotherapy, however the department resolved 14% of the 7 concerns it received through early resolution and it received 4 compliments.

Most services reported a green status. Areas to highlight are dietetics, which received 1 concern which it resolved through early resolution and also received 1 compliment.

Pharmacy received 1 concern which it resolved through early resolution.

Occupational Therapy reported 0 concerns and received 5 compliments.

Difficulties arranging appointments continues to be the key theme of the formal concerns raised.

CDTQSE 21/379 Patient Safety Incidents

NRI Report

There are 2 open NRIs:

In143602 is an ongoing investigation relating to the quality of ultrasound imaging and concerns relating to a trainee. The report is in progress.

In92837 relates to a patient who needed to access Neuroradiology. The closure form has been submitted to Welsh Government.

CDTQSE 21/380 New NRIs (National Reportable Incidents)

There are no new NRIs to report.

CDTQSE 21/381 Learning from Events Report

Sue Bailey shared a report relating to a claim made to the Welsh Risk Pool and the learning from this event. The report involved a gentleman who was admitted in 2019 following a fall. He had sustained several falls prior to this and he was referred for occupational therapy. He was able to independently move from a chair and toilet but struggled to move from a lying position to sitting up.

There was a plan for an Occupational Therapist to take the patient for an assessment for provision of a bed lever. The Occupational Therapist took a wheelchair to his bedside with the intention of transporting him to the assessment with the wheelchair. As she arrived alongside the patient she noted that another patient in the opposite bed was trying to get out of bed and was at high risk of falling, she therefore left the wheelchair and went to assist the other patient. She did not apply the brakes to the wheelchair and whilst assisting the other patient who was about to fall, the patient who she was meant to be assisting tried to get into the wheelchair himself. The wheelchair rolled back and the patient fell on the floor and he sustained a fracture. The internal investigation found that the failure to apply the brakes amounted to a breach of duty.

The patient was appropriately managed and he recovered well and is now independent with his daily mobility.

The case highlights the need to ensure the patient being dealt with is safe prior to assisting another patient.

CDTQSE 21/382 Patient Safety Alerts

PSN060 Oral Meds Wrong Route – Amended Version

The amended version was shared and noted.

PSN061 Phenobarbital Oral Medication

The alert was shared and noted.

Field Safety Notice ENfit Nasogastric Feeding Tubes

The Field Safety Notice is applicable in Dietetics and good measures are being taken.

CDTQSE 21/383 Medical Device Risks/Equipment and Diagnostic Systems

Nothing to report.

CDTQSE 21/384 IPC/Decontamination Issues

It was reported that staff rooms are proving difficult for staff to social distance and the query was raised whether further staff havens will be set up. The IPC cell is meeting today and Carla English will raise this. She commented that it is ill advised for services that were planning to move to one metre social distancing to continue with this given the Omicron variant.

CDTQSE 21/385 Point of Care Testing Issues

Nothing to report.

CDTQSE 21/386 Key Patient Risks

Safeguarding Update

Nothing to report.

Mental Capacity Issues

Nothing to report.

CDTQSE 21/387 Health and Safety Issues

Sue Bailey had raised a concern with estates around the lack of footpath around the new eye theatres area. This has now been resolved and there is appropriate lighting and a safe route to walk around the building.

Ed Chapman escalated the lack of lighting in the car park at Field Way and is awaiting a response from Estates. Security have visited the area and the department is awaiting quotes for CCTV.

CDTQSE 21/388 Regulatory Compliance and Accreditation

UKAS inspected the Biochemistry department in early December. Good feedback was received and the department has successfully maintained its accreditation.

EFFECTIVE CARE

CDTQSE 21/389 Research and Development

Nothing to report.

CDTQSE 21/390 Service Improvement Initiatives

A lot of work is progressing around digital service improvements, particularly within Therapies. Digital Champions have been identified and they are linking in with the Improvement and Innovation Team.

CDTQSE 21/391 Information Governance/Data Quality

Nothing to report**.**

CDTQSE 21/392 Waste and Sustainability

Sue Bailey advised that services can arrange for an environmental impact audit to be undertaken on their departments.

The Academic Centre UHL requested to receive a crisp packet recycling bin. Sue Bailey will try to source a bin.

Action: Sue Bailey

Ed Chapman noted that he has not received a response on the capital bid submitted for charging points. There is a risk that the electric cars will have no chargers. Sian Jones will follow this up.

Action: Sian Jones

DIGNIFIED CARE

CDTQSE 21/393 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

Nothing to report.

CDTQSE 21/394 Equality and Diversity

As discussed earlier, the communication on the roles of the protected characteristic allies is being held whilst the senior management team obtain a greater understanding of how to support services. The Clinical Board is sharing this work with Surgery and Medicine.

Keithley Wilkinson is leaving the UHB and the Clincial Board thanked him for the support he is provided to the Clinical Board.

TIMELY CARE

CDTQSE 21/395 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Patients waiting 8 weeks or more for diagnostics is 2853. This is a reduction by 49 on the previous month.

Patients waiting 14 weeks or more for Therapies is 658. This is an increase of 14.

INDIVIDUAL CARE

CDTQSE 21/396 National User Experience Framework

Happy or Not reports are being collated in Outpatients. Feedback received has been very positive.

Radiology is in the process of developing a bespoke patient feedback survey. Sion O'Keefe asked if this could be shared with him when completed for shared learning with Outpatients.

STAFF AND RESOURCES

CDTQSE 21/397 Staff Awards and Recognition

Nothing to report.

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

The following minutes were **RECEIVED:**

Clinical Board Health and Safety Group Minutes December 2021.

ANY OTHER BUSINESS

Sue Bailey requested that all staff are encouraged to undertake their mandatory training.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 10th January 2022 at 10am via Teams.

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 23rd November 2021, 8am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJones), Interim Director of Nursing Angela Jones (AJ), Senior Nurse Resuscitation Service Louise Waughington (LW), Associate CNS, IP&C Clare Rowntree (CR), Clinical Board Director Anthony Lewis (AL), Lead Pharmacist Debbie Jones (DJ), Patient Safety Facilitator Matthew McCarthy (MM), Patient Safety Facilitator Paula Davies (PD), Lead Nurse Children Young People & Family Health Services Martin Edwards (ME), Asst Clinical Director, CHFW Ashleigh Trowill (AT), Asst Service Manager, Children Young People & Family Health Services Suzanne Hardacre (SH), Head of Midwifery, Obstetrics & Gynaecology Abigail Holmes (AH), Deputy Head of Midwifery Obstetrics & Gynaecology Emma Davies (ED), Interim Risk Manager Obstetrics & Gynaecology Rhodri John (RJ), Directorate Manager Obstetrics & Gynaecology **In Attendance** Kirsty Hook (KH), Interim Risk Governance & Patient Experience Facilitator Emma Bramley (EB), Paediatric Flow Co-ordinator (shadowing Karenza Moulton) Lucie Lewis (LL), Advanced Nurse Practitioner, NICU Claire Francis (CF), Consultant Obstetrician/Clinical Lead for Obstetrics	
1.2	**Apologies for absence** None noted	
1.3	**To approve the Minutes of the previous Q&S meeting held on 02nd November 2021** The minutes were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 02nd November 2021** The action log was updated and updates were provided. All actions were closed by exception.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – Forced Discharge CHFW** 15yr old young person in the CHFW, was a delayed discharge for CAMHS as there was not a suitable place to discharge. Planned discharge was undertaken, supported by Social Services however the patient refused to leave, and was very verbally aggressive. A place of safety had been sought with Social Services and an escort arranged, but she continued to refuse to leave. Contact made with Safeguarding and advice was provided that patient can be forced to leave legally, however this was difficult to physically remove due to her being a 15yr old vulnerable child. Security were asked to attend, and then patient eventually agreed and left with the Social Worker.	

	Discussions ensued with regards to difficulties due to the fact that mum still had parental rights, which was difficult as next steps would have been for a court order to be arranged for Social Services, however this would have caused further delays and this was a very difficult situation. It was agreed that feedback and thanks would be provided to Security for their help and support in managing this very difficult situation. This situation highlights the significant complexities of managing such situations with a very vulnerable patient without compromising care. Thanks, were expressed to all staff for how this was managed, ensuring the correct outcome for the patient.	**KM**
2.2	**Clinical Lead for Obstetrics Report January 2021** Claire Francis was welcomed to the meeting and provided an update on the Obstetric Report which was completed as a "stock take" and benchmarking exercise against national maternity targets. Slow and steady decline of stillbirths. Neonatal deaths are slightly higher than expected, however it was noted that a that a more detailed review needs to be undertaken to better understand the reasons for this, acknowledging that numbers are quite small, with fetal medicine cases contributing to approximately half of the neonatal deaths being reported. Options are also being reviewed with regards to addressing neonatal death and national reporting through the perinatal mortality review tool for a joint proposal to increase the resources around this area. Attain Study is coming in to reduce unexpected neonatal term admissions and review of trends is regularly completed in order to reduce these cases as much as possible. It was noted that this is an excellent piece of multidisciplinary work and it was agreed that a more detailed presentation would be provided at a future meeting. Cora Doherty and Pina Amin are the leads for this study across Neonatal and Obstetrics. Introduction of Antenatal Care toolkit is being taken forward which is part of a national drive that the department will be taking part in. Fetal Monitoring in labour has been a challenge within the Covid pandemic, and this is a target to reintroduce the face to face training for all medical and midwifery staff. There is big drive towards PROMPT training and work is continuing to take this forward. Succession planning for CTG training is progressing. Increase of transitional care capacity on the post-natal ward is being worked through in order to try and avoid any unnecessary admissions to the Neonatal Unit. It was agreed that this is a very informative report which clearly outlines the goals for the coming year and it was agreed that this would be very helpful to see going forward. Succession planning for sonographers are progressing, however there remains a challenge with regards to an independent external moderator on the stillbirth national forums and whether support could be provided via the Clinical Board and Patient Safety team to take this forward. AJ and MM agreed to discuss potential way to progress this.	**AJ/MM**
2.3	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues & Business Continuity Update)** **CYPFHS Directorate Report** • Ongoing issues with regards to data input for School Imms and work is ongoing to resolve this. • First MVC for Fluenz undertaken and this was a positive uptake session. Some concerns regarding possible duplication but safety measures have been implemented to manage this. • Accommodation pressures continue. Work continues to source appropriate accommodation but this is proving difficult at present.	

	• SBAR for CAMHS/Emotional Mental Health Waiting Lists regarding young people who are unlikely to be seen before their 18th Birthday and how these can be managed as they transition to adult services. Agreed that the number of patients would be shared for information in order to understand the risks associated with these patients. • Inquests ongoing, concerns regarding waiting lists and young people being admitted to adult mental health units • Review options for phlebotomy sessions at St David's Hospital and also a mobile resource within the special schools as required. • Staff shortages within Ty Hafan and respite care may be cancelled at short notice. • Blended Diet policy has been updated and further discussions are needed with CHFW prior to ratification of the policy. • Melatonin management switch is being progressed • Draft pathways have been developed in conjunction with safeguarding for children attending ED with mental health issues. • Safeguarding group supervision audit has been completed and concerns have been identified that there is no benefit of the current model, and work is ongoing to discuss with the safeguarding team. • Complex Needs Care Group – risk assessment is being undertaken with regards to the fragility of the safeguarding rota. • Escalation of concerns regarding nursing support provision in Ty Gwyn and Woodlands School campuses. Discussions are ongoing with Education with regards to the changes in the case mix and the need of nursing support required. Current provision is not enough, and need to identify the gaps in service and the requirement going forward which will require a business case. • Recruitment event held within Emotional Mental Health which was very positive. • Cardiff Parenting request has been received for access to PARIS records and ongoing discussions are taking place with Information Governance as to what is proportionate. An SBAR will be shared with the Clinical Board once this is finalised. • Risks within the Continence Service at present which is requiring the need to recruit into a nurse led service, however this will impact the waiting lists whilst training needs are met. **CHFW Directorate** • Work undertaken on resus trollies to ensure that they are in line with current guidance • Work has commenced on the PICU Ceiling and is on track • SOP for Charity visitors has been completed for implementation to outline the requirements. This has been discussed and agreed at the last Directorate Meeting for implementation. KM agreed to share with AJones for sharing corporately. • Hydrotherapy pool to reopen for inpatients in the next few weeks. • New consent form for Oncology children received and is part of the National Oncology Network for implementation. • X2 environmental audits for Neonatal and Rainbow. Both good audits and action plans are in place to progress. • Safeguarding training Microsoft team's links have been shared in order to look to improve the momentum and attendance at mandatory training sessions for all staff. • X4 NRI's which are being progressed. • Governance support within the Directorate has been advertised and Emma Bramley has been appointed for 6months to help support the clinical governance agenda within the Directorate. • Observation charts, printing is progressing following agreement with EU and a chart has now been agreed for implementation. • TB Clinics have been supported within the Outpatients Department and has been a significant piece of work and has been very positive. Clinics will stop in December due to staffing, but will be recommenced in January 2022.	**PD** **KM**

	• Rotation of staff from Cwm Taf UHB NICU is progressing and it is anticipated that this rotation will commence at the end of January 2022 and honorary contracts will be implemented in order to help upskill the staff in improving neonatal care. • Directorate Newsletter is being progressed to share information to all staff of winter plans • X3 formal concerns which are being progressed • Executive Walkabout undertaken in Outpatients department and feedback received has been very positive. • MMBRACE report feedback received and a further report will be shared with the Clinical Board when ready. • Recruitment continues across all areas; however, sickness continues to impact the rotas. • Pheonobarbital Standardised Liquid Patient Safety Notice received and areas are fully compliant. This has been shared widely for onward dissemination. • Peer review in Oncology Services is being undertaken in January 2022, and further information will be shared as this review progresses. **O&G Directorate** • Estates work to repair Maternity roof is progressing and hopes this will resolve ongoing leaks. • Staffing pressures despite recruitment continue, and covid related absence is a significant issue which causes delays with PCR Testing and awaiting return. • Minimal handling compliance is being progressed for a bespoke training package for midwives to be developed, different to that of Adult nursing. • Move to T2 progressing from recovery end this week. • Visit to the Directorate from the new Chief Executive and Stuart Walker has been undertaken and was very well received. Visit also held with the Chair and Caroline Bird following some concerns raised on the pressures experienced in August. • Clinical Audit meeting has taken place reviewing the themes of risk. Presentation on civility saves lives provided and work continuing on civility, values and behaviours and psychological safety work in future audit sessions. • Face to face and online antenatal sessions are being progressed • Induction of Labour pathway being launched at the end of the month to help manage activity. • MMBRACE report being prepared and will be presented at a future meeting. • Business case for Lucamed Sorbact is being progressed to ensure NICE compliance. **Cancer Services** • Wales Cancer Patient Survey has been received, and initiated Quality Health. Concerns regarding patients receiving questionnaires even though they haven't had cancer, this has been escalated and is being investigated.	
2.4	**Waiting Times Update (including Long Waiting Patients)** **CYPFHS Directorate** • Some stabilisation in the ND Waiting List with the longest wait at 134weeks. • PMH – under 90 patients waiting. Part 1a Compliance for PMH has been a significant improvement however there remains constraints in the service. • Increase in patients waiting for a choice assessment within CAMHS and expansion of Helios is being explored to help with the waiting list. • Continence Service – longest wait 126 weeks and continues to grow at present. • Therapies – 528 patients waiting at the end of October, longest wait is for OT at 27 weeks which is a breach against the RTT target. **CHFW** 518 patients awaiting Paediatric Surgery with over half that have been waiting over 36weeks. 141 waiting over 52 weeks. Longest wait is 131weeks, but this patient has a date surgery for December 2021. Ongoing discussions are taking place with WHSSC with regards to the backlog	

	and how this can be improved, and possible alternative providers to help with the backlog being considered. ***Outpatients*** General Paediatrics numbers continues to be steady at circa 2500, however there are now 143 waiting over 36 weeks and this has been included within the IMTP as part of COVID recovery. For endoscopy, there are regularly 35-40 children waiting over 8 weeks for diagnostics. Sleep service continues to be a growing waiting list and a business case is being progressed with WHSSC in order to review options to manage this backlog. Neurology service pressures continue and discussions are ongoing as to how the risks can be mitigated with a consideration of a joint rota going forwards. There are x2 weeks in December where there is no cover, and this is a priority to be addressed, and discussions are ongoing to ensure that a robust plan is in place. Support for Q&S is being reviewed in order to see how the nursing team can be supported going forwards. **O&G** Benign gynae inpatient WL at 1231 patients waiting, the pre covid average was 786 and likely to continue increase due to current theatre capacity. Benign gynae outpatients – 1300 patients awaiting an appointment and 793 patients who have appointment between now and January. Average wait is circa 30weeks across all specialties. Cancer breaches for November was reported at 5 breaches, and business cases for investment across Obstetrics, Oncology and the emergency stream. With regards to the IPWL Letter, this is being sent out this week. There are concerns that there will be some issues raised from primary care as the letter is advising patients to go back to their GP, however there is a need to inform patients. Increasing number of complaints with regards to gynaecology being received, and work is ongoing to review how this can be supported. It is understood that the issues with the lifts has reduced, however if issues start to increase, this will be escalated appropriately.	
2.5	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **Assurance Mapping Reporting** Corporate Governance department are taking forward an Assurance Mapping Exercise as part of the recently approved Assurance Strategy across C&V UHB. The work is progressing and information being gathered, which will provide clarity on the types of assurance currently being provided and further updates will be provided in due course.	
SAFE CARE		
3.1	**Update on Serious Incidents** X3 new NRI's reported. X1 NRI due to close within CYPFHS and work is progressing. There has been an increase within CHFW with regards to incidents awaiting review. Work continues across all areas within the Clinical Board to review and action incidents as appropriate. **POCT Update** No further issues highlighted and it was agreed that this can be closed by exception.	
3.2	**DATIX Open Incidents** The group were asked to ensure that all open incidents are being reviewed and necessary actions being undertaken to close where possible, in readiness for the new Datix system being implemented.	**ALL**

	Thanks, were expressed to all for their ongoing work in ensuring that these incidents are actioned and ongoing reviews are being undertaken where required.	
3.3	**SI's/RCA's/Closure Forms for discussion** **RCA Baby D – In344486** Background to the case was provided and it was noted that during the observation process, some results were low and led towards the commencement of a sepsis screen. Further bloods were required and it was decided that due to the difficulties in gaining blood previously, a hot glove was used and a heel prick was undertaken. A superficial burn was identified and mum was informed immediately. Advice was sought and contact made with Morriston Hospital for appropriate treatment to be provided. ***Notable practice*** Midwife acted quickly and first aid was administered immediately. Appropriate services were involved, and parents were updated at every point and apologies were provided. ***Changes in practice*** • Learnt practice of hot glove is not acceptable and appropriate. Noted that this training was not provided in this UHB, and the Dr had not received appropriate training. • Safety alert to BAPM and other Neonatal Units was undertaken and the practice was ceased immediately and heel warmers have been implemented across all areas. • Update guidelines for heel warmers is being completed • Roll call for training is being implemented to ensure that all staff have received appropriate training. • Taps are being checked with regards to the irregular temperature, and all staff have been informed not to use the sluice for water for patients. Excellent RCA, and agreed that a presentation would be provided at the O&G Directorate Q&S Meeting to ensure learning is shared widely and actions are embedded into practice. Video demonstration to be considered as part of the guidelines for ease of review of procedures as part of teaching and training. Within recommendations on the systematic cochrane review it was noted that venuous sampling should be considered instead of heel pricks, however this would be difficult in community setting, however should be given to implement this for hospital settings. It was agreed that any changes that are implemented will be shared with the Clinical Board **SBAR & RCA DC** Deferred to the next Extra Ordinary Q&S Meeting.	
3.4	**Infection Prevention Control Update Report** The report was noted for information. X1 new MSSA reported within PICU and the RCA is being progressed. Staph Capitus has been closed with no ongoing issues. Increase in COVID numbers across CHFW and O&G which are being managed appropriately. Learning on IPC RCA's will be shared as part of the newly implemented Clinical Board IP&C Meetings. All were asked to review any outstanding IPC RCA's for completion as soon as possible.	**ALL**
3.5	**Safeguarding** **Ending Physical Punishment in Wales** Shared for information and onward sharing. Further details will be shared as this work progresses.	

3.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • **Public Health Wales Briefing: Increase in reports of enterovirus D68 respiratory illness in Wales, and reminder on reporting of Acute Flaccid Paralysis/Myelitis (AFP/AFM)** This is being monitored as there are high numbers reported within the community. Discussion ensued with regards to increases of infectious diseases and currently there is no funding for an infectious diseases service. It was agreed that this data can be shared as part of the IP&C processes. It was agreed that support could be provided by IP&C also. • **DCMO Letter -HSIB report- re Missed detection of lung cancer Oct 2021** Noted for information. No specific exceptions noted. • **PSA 014 Inappropriate anticoagulation of patients with a mechanical heart valve** Noted for information. No specific exceptions noted. • **ISN 2021 Oct 028 Zoll Defibrillators** Noted for information. Imperative that all equipment is checked to ensure that equipment is working appropriately. No specific exceptions noted. • **Internal Safety Notice ISN/2021/Nov/029 Rubber Fragments in IV Meds** Ongoing local and national investigation is being progressed. There have been a number of problems reported, and any further incidents to be reported through to AL for onward reporting. All alerts were noted for information and onward dissemination. All compliance forms to be completed and submitted to KH for Clinical Board compliance to be submitted.	**AL**
3.7	**Best Practice guidelines for the use of Equipment that Restricts Movement for Children and Young People** The guidance was shared for information and covers the best practice processes for the use of equipment that restricts movement. There is clear documentation that is regularly revised and updated to ensure that harm is reduced. PD agreed to share with Safeguarding service for onward sharing.	**PD**
INDIVIDUAL CARE		
4.1	No items to note.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**Children's Commissioner for Wales: Using a children's rights approach to transform how Cardiff and the Vale safeguard children's mental health and wellbeing: progress and next steps** Noted for information.	
5.2	**Panacea Evaluation Report June 2021** Noted for information.	
5.3	**Promotion of National Safeguarding Week - Programme of Events** Noted for information.	
5.4	**Health & Safety Dashboard October 2021** Noted for information.	
5.5	**Minutes from the Mortality Review Group – November 2021** Noted for information.	
5.6	**To note the New 2222 Reporting Form** Noted for information.	
5.7	**To note the New SBARD Form** Noted for information.	
ANY OTHER BUSINESS		
	Paediatric Resus Practitioner Discussions are ongoing and AJones agreed to provide an update as this work progresses.	**AJones**
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for **Tuesday 21st December, 8.30am, Microsoft Teams**		

2022 Meeting Dates

The meetings for 2022 will follow the same pattern as this year and will take place on the **4th Tuesday of each month (unless otherwise stated below) between 8.30 – 10.30am unless otherwise stated**. All meetings will be held via Microsoft Teams – links will be circulated.

Tuesday 25th January (H&S Focus)
Tuesday 22nd February
Tuesday 22nd March
Tuesday 26th April (H&S Focus)
Tuesday 24th May
Tuesday 28th June
Tuesday 26th July (H&S Focus)
Tuesday 23rd August
Tuesday 27th September
Tuesday 25th October (H&S Focus)
Tuesday 22nd November
Tuesday 20th December

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 21st December 2021, 8.30am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJONES), Director of Nursing Sarah Davies (SD), Governance Midwife, Obstetrics & Gynaecology Directorate Louise Waughington (LW), Associate CNS, Infection Prevention & Control Paula Davies (PD), Lead Nurse CYPFHS Directorate Angela Jones (AJ), Senior Nurse, Resuscitation Service Matthew McCarthy (MM), Patient Safety Facilitator Debbie Jones (DJ), Patient Safety Facilitator Rhodri John (RJ), Directorate Manager Obstetrics & Gynaecology Directorate Abigail Holmes (AH), Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Ashleigh Trowill (AT), Assistant Service Manager, CYPFHS Directorate Gareth Simpson (GS), Estates Manager Suzanne Hardacre (SH), Head of Midwifery, Obstetrics & Gynaecology Directorate Kylie Hart (KHart), Senior Nurse CHFW Directorate **In Attendance** Kirsty Hook (KH), Interim Risk Governance & Patient Experience Facilitator	
1.2	**Apologies for absence** Clare Rowntree, Martin Edwards, Becci Ingram, Anthony Lewis, Annette Beasley, Emma Davies	
1.3	**To approve the Minutes of the previous Q&S meeting held on 23rd November 2021** The minutes of the meeting held on 23rd November 2021 were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 23rd November 2021** The actions were noted and closed as appropriate. An update was provided on the open actions as follows: **Access to PARIS – Cardiff Parenting Request** This action is ongoing at present. An SBAR will be shared with the Clinical Board once this is finalised. **Datix Incidents** Time is a concern at present, however all acknowledged that this will continue to be prioritised and incidents reviewed for closure where possible. **Best Practice guidelines for the use of Equipment that Restricts Movement for Children and Young People** PD agreed to share with Safeguarding service for onward sharing.	**PD** **PD**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Update on RCA Case – Patient AJJ**	

	Deferred to next extra ordinary meeting.	
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **CYPFHS Directorate** • Risk Assessment raised by CITT Service regarding capacity in the service at present. This is impacting on flow through the CITT service and CAMHS. Regular cross service meetings are taking place to manage the cases across the service. No new referrals can be accepted at present but are managing the most complex cases within the CITT team, continuing to review all referrals received. This will need to be added to the Directorate Risk Register. • X1 SI for DC which is now ready for closure and is part of the agenda today for sign off. • Number AM concerns, x1 Ombudsman Investigation regarding a Community Paeds Waiting List case, clinical reviews have been undertaken however the child remains on the waiting list. Consultants have increased their sessions to try to address the waiting list, however this remains an issue at present. This case is being progressed to local resolution and reply to the Ombudsman will be completed. • Care Groups Timeout session arranged for the New Year to ensure robust governance processes are in place. • No H&S lead within the Directorate at present, but this is being reviewed and will be a representative in each of the care groups. Any action plans will sit within the care groups for local resolution and escalated to the Directorate Q&S as appropriate. • Transcribing risks continue, whilst measures have been put in place there is a need for a more robust process to be implemented. Further discussions will take place outside of the meeting and an SBAR will be shared with the Clinical Board for consideration of potential solutions. • Safeguarding concerns with regards to Orbis (independent provider) and work is ongoing with regards to this. Regular monitoring is taking place to continue to mitigate any specific risks. UHB Safeguarding are aware of this and engaged in the process. • MJ Case – this will be a safeguarding investigation and providers have withdrawn care. Further discussions to take place outside of the meeting. • RTT position is much the same, however it was acknowledged that there have been significant improvements specifically within Primary Mental Health and work is ongoing across all areas. Thanks were expressed to all for their hard work. **O&G Directorate** Report noted for information. Key highlights noted; • BFI Assessment due in March 2022 and work is ongoing to ensure that all requirements are met • Ongoing promotion of COVID 19 vaccinations for women and work taking place with Mass Vaccination Centres. • Fetal surveillance midwife and patient safety lead preparing an action plan following the standard report to return to welsh risk pool by 01/02/2022 • Number of ongoing RCA's specifically within Obstetrics – 14 in Obstetrics (x4 are SI), x4 within Gynaecology, x10 Obstetric detailed timelines and x2 Gynaecology detailed timelines and x6 Birth Injury Tools outstanding. The ongoing issues regarding allocated obstetric time which is delaying processes which could adversely impact learning is included as part of the risk register. • Ongoing issues with Maternity Lifts which continues to be escalated and remains on the directorate risk register. • No reported tissue damage within October and November 2021. • X3 Falls reported for November within Gynaecology. There were no adverse outcomes for all cases and appropriate actions have been undertaken.	**PD**

	• Walkabout with IP&C on T2 and move for Gynae Outpatients should be able to progress in January 2022 • Guideline for Hyponatraemia is being progressed. In the interim, measures are in place to provide advice to patients in the late stages of labour • Medicines Management – no adverse outcomes, and midwife has undertaken a reflection. – check • Safeguarding referrals have increased and a number of disclosures of domestic abuse has been noted. • New multiagency referral form for Social Services which will be a more streamlined approach for all agencies. • Asked to commend on a draft National Patient Safety alert on the risk of oxytocin dose in labour which is progressing. • Patient Safety Walkabouts undertaken. Increasing pressures on staff highlighted, and support being provided for all staff. • T2 services open for elective caesareans and recovery. • Safety notice shared widely regarding fragments of rubber bung in IV antibiotic solutions • Ongoing focus for CTG Training. Training dates shared email so that all training dates can be accessed. National CTG Study Day by Professor Phillip Steer on 11/01/2022 and an holding a free study day on the 15/01/2022 for all midwives and doctors with Dr Edwin Chandraharan. • Funding for ISVA received. Referrals remain high but referrals continue to be managed within the timeframe. Operational Sotario commencing in the New Year which will increase joint working with CPS and the Police. • Research projects have recommenced and a number of projects are ongoing. Audit undertaken on shoulder dystocia and recommendations for consent are being taken forward. This has been presented at the Audit Meeting in December for sharing of lessons learnt. • Digital self-booking referral system now embedded which has increased the numbers of women booked prior to 10 weeks' gestation and is working well. Text messages for clinic appointments is also being set up. • Attend anywhere – staff trained on use and using it for postnatal discharges and workshops will be used on it also. • Letter to all gynaecology patients regarding waiting lists. Visiting concerns are increasing again • Recruitment ongoing across a number of areas • Post-natal debriefing service was suspended due to activity; however, this is hoped to be formally restarted in January 2021. • Number of recent awards within the Directorate, which is very positive and congratulations were noted. • The Research Team have got through to the next stage of the Cardiff based designed by us Feasibility Study for Midwifery Led Pathway which is very positive news. Further detail will be shared when available. **CHFW Directorate** Report was noted for information. Key highlights noted; • Commenced the new Paediatric Observation Charts which will be used from the front door, right through to CHFW. Re-evaluation will be undertaken in 6 weeks' time, but feedback to date has been positive. It was agreed that this would be shared with Resus practitioners for onward dissemination. • X4 NRI's that are ongoing and progressing through the governance process.	**KHart**
2.3	**Waiting Times Update (including Long Waiting Patients)** Updates taken from Directorate reports	

CYPFHS Directorate

- There has been a slight increase in the Neurodevelopment waiting list in November to 1175 patients waiting at the end of the month. Weekly assessment activity is increasing week on week, and clinic capacity has also been increased from 2 patients to 3 patients. Some of the longest waiters are now starting to be removed from the waiting list and at the end of November, the longest wait for the service was 137 weeks, however this now sits at around 125 weeks.

- The Primary Mental Health waiting list continues to see a decrease as a result of a waiting list initiative with Healios. At the end of November, there were 118 patients waiting for an assessment and the longest wait was reported as 5 weeks. However, the average wait is now approximately 24 days and the team are consistently achieving the Part 1A target with November's overall performance reported at 86%.

- There has been some stabilisation in patients waiting for CAMHS, at the end of November there were 453 patients recorded as waiting. There continues to be reduced capacity in the team as a result of a significant number of vacancies within the team. We are still waiting for the go ahead from Procurement to start the second iteration of Healios which will help reduce the waiting list. The longest wait at the end of November was reported as 34 weeks.

- At the end of October, there were 802 patients waiting for an assessment within the Continence service. The longest wait was recorded as 123 weeks. There are significant concerns around the staffing of this team as the Team Leader is leaving for another role within the NHS and the consultant is due to retire next year.

- Referrals for therapy services are increasing significantly at the moment and at the end of November there were 742 patients waiting. The longest wait was for OT at 27 weeks and there were 164 patients waiting for the service 14 weeks and over.

O&G Directorate

Cancer

Av. No. breaches per month: 0 – 2

Breaches October 21: 5 November 21: 5

- Directorate has submitted a paper to the Clinical Board to recruit an additional Gynae Oncology consultant and secure additional theatre capacity

Benign gynae outpatients

Pre-covid Av. No. pts without appointment 1971

Av. weeks wait without appointment 28 weeks

Current position

Av. No. pts without appointment 1333

Total on waiting list with and without appointment 2028 - the majority of those with an appointment to be seen by the beginning of February 2022

Av. weeks wait without appointment 14 weeks

- Routine referrals are currently being seen in a timelier manner than pre-covid.

Inpatients

No. pts on IP waiting list: 786

Longest waiter: 39 weeks

Current

Number of patients on waiting list 1251

Longest waiter 127 weeks

	• The Directorate still has a reduction in theatre sessions compared to pre – covid which has been well documented • The directorate has chosen not to write to all patients on the IPWL (also on advice from GP interface lead) instead a UHB response on theatre waiting times is required. Additional funding is being sought for clinics to validate patients who have been waiting on the IPWL for over 12 months. **CHFW Directorate** Paeds Surgery – currently have 10.5 paediatric surgery lists per week, compared to 13.5 pre COVID. This has supported the directorate in ensuring all priority level 2 patients are treated. All patients waiting over 52 weeks continue to be reviewed ensuring all quality and safety monitoring is completed for each patient. There are currently 238 children waiting over 36 weeks of which 141 children have been waiting over 52 weeks. The number of children waiting over 52 weeks has not increased. There are 4 children waiting over 36 weeks for an outpatient appointment. General Paediatrics – there are currently 143 patients waiting over 36 weeks for an outpatient appointment, with 124 children without an appointment. This is a deteriorating position. Additional out-patient clinics can be delivered but there is limited capacity within the out-patient footprint to deliver additional clinics. Paediatric Endoscopy – there are 50 patients on the waiting list of which 40 are waiting over the 8 week target. The Directorate have had additional funding to deliver additional endoscopies but this is limited due to theatre capacity. Any vacant Paediatric Surgery lists are backfilled with additional endoscopy lists. However, there have been a number of cancelled lists, therefore the additional lists that have been secured has not improved the position, but prevented it from deteriorating. Sleep studies – There are currently 162 children waiting for a sleep study, with the longest wait being 110. The Directorate is currently reviewing the activity that can be delivered within the current infrastructure to address the long waiters. A case will be submitted to WHSSC to request additional resources to increase the sleep studies we can deliver. Work is being undertaken within the directorate to look at Paediatric MRI lists. The Health Board had significant investment for additional GA lists. A business case was agreed for 2 additional paediatric GA lists, however due to covid there continues to be 6 baseline sessions which has led to an increase in waiting times and less throughput. Work is ongoing with the paediatric and radiology directorate to review the service and allocated sessions. To date these lists have yet been made available.	
2.4	**Business Continuity / Escalation Cards** Business continuity plans have been received from both CHFW and CYPFHS. It was noted that the CYPFHS will need to be reviewed as this will need a further update and this is progressing. It was agreed that the plan and escalation cards for O&G would be shared following the meeting.	**PD** **AH**
2.5	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** No items to note for this meeting.	
SAFE CARE		
3.1	**Update on Serious Incidents**	

	Report was noted for information. There has been a recent decline in reporting across all Directorates at present, however reporting should be encouraged where possible to ensure that all risks can be monitored. Retained Swab incident within Maternity is being investigated and further information will be shared as this investigation progresses.	
	Estates Update Maternity Lifts – the order has gone to the manufacturer and this is being progressed as soon as possible, however there are currently delays with supplies Rainbow Ward – work completed last week and yesterday and as soon as the update report is received on the findings, this will be shared for information.	**GS**
3.2	**DATIX Open Incidents** Discussed as part of item 3.1. Work continues to review all open incidents to progress to closure where appropriate, acknowledging that due to operational pressures this is difficult at present, but is being actioned when possible.	
3.3	**SI's/RCA's/Closure Forms for discussion** **SBAR – DC (SI – Incident Number 119370)** Background to the case was provided. Following a number of events, mum brought the patient to ED and she remained in hospital whilst a CAMHS assessments was carried out. Multi agency referral was made, a safety plan provided and patient was discharged. Further admission followed and a second assessment took place, and the patient was admitted to CHFW with mum's consent. A safety plan was implemented, and patient was discharged home again. Fourth admission in September, and further CAMHS crisis assessment was undertaken. LA were contacted and a social worker was allocated. Patient was discharged home following a further safety plan being agreed with the patient and her family. X2 further admissions followed. On the 7th admission, the patient was assessed and a Tier 4 assessment was requested, it was felt that a tier 4 admission was not required at that time and an intense care package was put into place with the CITT team. The patient absconded from St David's Hospital in January 2021 when attending an appointment with the Psychiatrist and CITT Team and was found by the police who detained her under a section 136 (risk of harm) and was taken to hospital and following assessment was detained under Section 2 of the Mental Health Act. Following this the patient was admitted to Ty Lydiard for a period and was discharged in March 2021 into the care of her family and the CITT Team. In April 2021 the patient was found again threatening to end her life, was assessed under section 136 and then again discharged to the care of her family. On 1st July, the patient was found hanged in her bedroom by her mum. She was resuscitated and remained in hospital until 7th July 2021. The patient had a history of self harming behaviours from the age of 10. The psychiatrist felt that there was a lot of behaviours that were hidden with lots of disclosures and the psychiatrist was trying to work with her engage her in a trusting process. Moved to Cardiff from London at the age of 6, and moved from Cardiff to Pontypool and back to Penarth and offered a place in St Cyris School into Year 10 (a year below her age) with 1:1 support on a limited timetable. The young person had anxieties with returning to education. It was noted that engagement with the family was difficult when the patient was in hospital. **Key Findings & Recommendations** Correct procedures were followed and carried out throughout access to Mental Health Service, including appropriate use of the Mental Health Act, including offer of an advocate. Communication with partner agencies, and assessments were all carried through.	

There were no significant missed opportunities within Cardiff & Vale CAMHS Services however noted that there were missed opportunities regarding numerous multiagency referrals submitted to local authority highlighting safeguarding concerns including several changes of social worker noting lack of consistency in managing the case.

Areas of good practice
Continued support from CITT Team, sharing of information between agencies was substantial. Home visits were offered in this case as patient was not engaging with online appointments, however the family declined due to concerns regarding COVID impact.

With regards to the absconding incident when attending the Emotional Mental Health Clinic in St David's, it was noted that this has been reviewed and procedures have been implemented to ensure that there is appropriate supervision for any patient left in the waiting room, and a standard operating procedure is being developed to outline this. No further investigation is required for C&V, however the pathway for Tier 4 assessment can be challenging and this continues to be a factor, specifically if surge beds are full.

Recommendations
- Discuss with Head of UHB Safeguarding re: escalation process for staff completing multiple MARF'S for same patient with considerable risk.
- Develop clear process within SCAMHS for notification of MARFS and outcome.
- Develop guidelines for SCAMHS re keeping CYP safe when attending SDCC for clinical assessment.
- Review SCAMHS Clinical Supervision Structures and processes. To include process for staff, debrief following significant incidents

All actions are being progressed, this information has been shared through the Directorate and Care Group forums for shared learning, and consideration being given for further sharing with the Safeguarding forum.

It was noted that the patient has recovered well with no long-term brain injury and to date, currently remains in a Mental Health placement in North Wales and is doing very well.

The case was agreed for closure. **PD/MM**

RCA – Patient RK (Datix Ref 335841)
Term baby born in poor condition and was admitted to Neonatal Unit. The baby was treated for grade 2 hypoxic ischaemic encephalopathy (HIE). The baby has had regular follow ups and is making excellent progress, assessment will continue until the age of 2yrs. Mum was physically healthy, however did have significant mental health issues and was referred to the perinatal mental health service for support. Care plan was agreed and followed throughout.

Root cause identified a missed opportunity to deliver baby following a deterioration in fetal heart rate. On reflection an attempt of a rotational forceps delivery in the presence of an abnormal fetal heart rate pattern was the wrong decision. However, it was noted that there was good documentation about decisions made, however there was no documentation to support opportunity for early delivery. Instrumental delivery was performed. Maternal sepsis proforma was not used. Completion of the proforma has been highlighted as part of a thematic review that was undertaken and actions are being taken forward.

Recommendations were noted as;
- Continued multidisciplinary CTG teaching with continued emphasis on assessing the full clinical picture and not the CTG in isolation. Case to be used in this teaching.

	• PROMPT teaching to emphasise the importance of completing actions on the maternal infection and sepsis proforma. • Case to be used as a case study for future courses/teaching on operative vaginal delivery. • Case to be presented at departmental audit day to aid shared learning across the department. • All clinicians involved to reflect on the case. It was noted that mum has been significantly unwell as a result of this case, specifically with regards to her mental health, however it was noted that she is now starting to make good progress in her recovery. The report was agreed and will now be shared with the patient and an opportunity to meet will be offered in the New Year.	**SD**
3.4	**Infection Prevention Control Update Report** No bacteraemia since the last meeting. Daily walkarounds are being undertaken across the UHB and Safe to Start is being reinforced. Safe to Start is to check all staff are well before starting work. It has been highlighted that some staff are swabbing in hospital just before shifts, and requests were made that this is undertaken prior to coming in to shift. Communication regarding lateral flows will be shared later today, however it was noted that LFT need to be completed the evening before shift to ensure that those requiring PCR can be completed as soon as possible. Omicron isolation advice was noted and concerns were raised with regards to the TTP advice on the necessity to isolate, regardless of wearing PPE. Further discussions are taking place and a further update will be provided as this is received. On call system for IP&C over the Christmas and New Year period will be shared for information.	
3.5	**Safeguarding** • Adult at Risk Safeguarding Training • Safeguarding Team Alignment 2021 • SBAR Contextual Safeguarding • SBAR Nov SSG Training • Safeguarding Maturity Matrix Improvement Plan 2021-22 • Cardiff and Vale UHB commits to working collaboratively to prevent suicide and self-harm with new strategy All items were noted for information and onward sharing as appropriate. There were no specific exceptions to note.	
3.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Letter from CNO/ DCMO- HSIB report CPAP - 2021-11-19** Noted for information and onward dissemination. **CEM/CMO/2021/35 Update on Covid-19 Variant B.1.1.529** Noted for information and onward dissemination **PSN061 Phenobarbital Oral Medication** Noted for information. The Clinical Board are compliant with the PSN for Phenobarbital liquid and that there is work going on locally and nationally to make the supply of liquids safer for children – mainly the standardisation of strength.	
3.7	**Covid-19 Risk Assessment for contact with Positive Cases** Noted for information and onward dissemination.	

3.8	**WMNN Maternity and Neonatal Services COVID and Winter Plan** Noted for information.	
INDIVIDUAL CARE		
4.1	No items to note for this meeting.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**Returning from International Travel – Guidance for Health & Social Care Staff** Noted for information.	
5.2	**Official: sensitive COVID-19 vaccination in pregnancy report November 2021** Noted for information. Some issues have been highlighted with regards to access to booster vaccinations, however there is a plan in place to refer and monitor these referrals.	
5.3	**Safety & Quality Sessions 2023-2024** Noted for information.	
5.4	**CMO Letter - JCVI Advice on Omicron Variant** Noted for information.	
5.5	**Medicines Management Safety Newsletter – November 2021** Noted for information.	
5.6	**H&S Dashboard – November 2021** Noted for information.	
ANY OTHER BUSINESS		
	None noted.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 25th January (H&S Focus), 8.30am, Microsoft Teams**

2022 Meeting Dates

The meetings for 2022 will follow the same pattern as this year and will take place on the **4th Tuesday of each month (unless otherwise stated below) between 8.30 – 10.30am unless otherwise stated**. All meetings will be held via Microsoft Teams – links will be circulated.

Tuesday 22nd February
Tuesday 22nd March
Tuesday 26th April (H&S Focus)
Tuesday 24th May
Tuesday 28th June
Tuesday 26th July (H&S Focus)
Tuesday 23rd August
Tuesday 27th September
Tuesday 25th October (H&S Focus)
Tuesday 22nd November
Tuesday 20th December

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

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Ceri Phillips (CP), Lead Nurse Cardiac Services
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Claire Mahoney (CM), CNS Infection Prevention & Control
Ben Jones (BJ), Consultant, ICU
Lisa Simm (LS), Interim Directorate Manager, Neurosciences
Laszlo Szabo, (LSz), Consultant in Transplant Surgery
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Keith Wilson, (KW), Consultant Haematologist
Emma Swales, (ES), Senior Nurse, Nephrology & Transplant
Sharon Daniels, (SD), Directorate Support Manager, Nephrology & Transplant
Lisa Higginson, (LH), Interim Lead Nurse, Nephrology & Transplant
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Suzie Cheesman, (SC), QSE Facilitator
Hywel Pullen, (HP), Head of Finance, Specialist Services
Rachel Barry, (RB), Lead Nurse, Neurosciences
Khalid Hamandi, (KH), Clinical Director, Neurology
Sarah Lloyd, (SL), Interim General Manager for Critical Care & MTC
Sian Williams, (SW), Senior Nurse, Cardiology
Tom Hughes, (TH), Consultant Neurologist

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting.	
1.2	Apologies for absence Received from Cath Wood, Guy Blackshaw, Gayle Sheppard, Hywel Roberts, Judith Burnett & Tessa Northmore.	
1.3	To review the Minutes of the previous meeting 27 August 2021 The minutes of the last meeting were agreed as an accurate record. Matters Arising • 1.3 Issues with the office accommodation in Haematology remain on-going. • 2.1 Serious Incident relating to patient CJ, CMain reported that this incident is being investigated by the Surgery Clinical Board and any developments in this case are being relayed to the team as	

ACTION	appropriate. • 2.2 Alerts / Patient Safety Notices •Principles for Safe Patient Placement, Carla English is unable to make the meeting today but it is hoped she will be able to attend a future meeting. •ISN Ref 2021/Aug/018 Histopathology Results this is an on-going discussion with IT, updates will be provided when available. • 3.3 Exception Reports • Critical Care incidents with ophthalmology doctors not reporting prescribing drugs which dilated the eyes of patients. CMain said that RP had linked in with the Surgery Clinical Board and Ophthalmology to resolve this issue. SC reported that these incidents were considered as IRMER breaches and information was requested from the Radiation Protection Service, however, because at the time of requesting the CT scans were considered justified they weren't considered reportable as IRMER breaches, an internal investigation will be required which Surgery Clinical Board will be leading. • Haematology new guidance has been issued from HR regarding the management of staff working with vulnerable patients who have been contacted via Track & Trace. • Neurosciences reported challenges with the new build in UHL, this will be discussed later in the meeting. • Nephrology and Transplant the HTA report has been issued and shared accordingly.	CMain
PART 2: SAFE CARE		**Action**
2.1	Open Nationally Reportable Incidents RP reported that there are 6 NRI's open, 2 are completed and awaiting final confirmation before being closed. In108123 - The investigation is complete and an improvement plan is required, the case predominantly involves ABHB. All documents have been shared with ABHB to review and report back by a deadline. The family have raised a concern with ABHB, RP has asked the HB if they would like to share the report with the family in response to their management of that concern. If ABHB decide not to do this RP informed that it may become incumbent on C&V to contact the family and share the report. ABHB have been slow in responding to date. In136398 - The investigation is complete and the improvement plan in progress, it is hoped to submit the closure form at the next QS&E meeting. In137783 – The investigation is complete and the improvement plan in progress. Elements of this case sit within Surgery. It is hoped to submit the closure form at the next QS&E meeting. In146473 – A falls investigation has been completed and initial meetings have raised no concerns regarding the care of this patient. Investigations are underway to determine whether neurological changes preceded the fall or if they occurred as a result of the fall. KW asked whether audits are undertaken on improvement plans in order to determine the efficacy of the plans? CMain replied that the new model should ensure that the improvement plans will be audited. SC added that	

ACTION	Datix can be used to set reminders. CB said that part of the work of the Mortality and Review Group is to try to improve communication with the reviews that occur across Clinical Boards. CB reiterated that the push to use Datix as a formal system to keep track is very much what the HB would like and also to use the Stage 2 template. CB added that in regards to IN146473 there is probably enough evidence available to suggest that this was a case of a traumatic brain injury rather than a brain injury causing trauma. There were multiple pathologies present on the initial scan which would suggest trauma. All scans have been formally reported on by a neuroradiologist. <u>Open Inquests</u> RP reported that there were no issues with the Inquests listed. SC reminded that a recent inquest has an outstanding action to feed back to the Coroner on the Heparin Protocol. SC informed that this would be her last QS&E meeting CMain thanked Suzie for all her support over the past 5 years. CB added her thanks for all the help that Suzie has provided to her especially over the last year.	CMain/RP
2.2	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group. • Clinell Universal Wipes – Urgent recall – UPDATE CMain said that given the quantities used, the stock would have been used before the recall was issued. • ISN Ref 2021/Aug/021 Clexane – 2 Types of Pre-filled Syringes with DIFFERENT Administration Instructions To note, nothing further to discuss. • ISN Ref 2021/Sep/024 Sodium Citrate Coagulation Tube To note, nothing further to discuss. • ISN Ref 2021/Sept/023 3ml EDTA European Tubes To note, nothing further to discuss. • Resuscitation Procedure for Basic Life Support for all Adult Patients during the COVID-19 Pandemic To note, nothing further to discuss. • SBAR Chest Compressions and Aerosol Generating Procedures To note, nothing further to discuss. • ISN 2021 Sep 025 Hydrogen Peroxide To note, nothing further to discuss. • ISN 2021 Sep 026 Human Albumin Solution To note, nothing further to discuss. • PSN 060 Liquified Phenol To note, nothing further to discuss.	

	• PSN 060 Oral medication by the wrong route To note, nothing further to discuss. CMain reminded all that confirmation replies are required to these notifications when they are circulated.	
2.3	<u>Closure Forms</u> In122976 – RP reported that this was not a serious incident but was an IRMER reported by CD&T and has been discussed at the Neurology Q&S meeting. RP gave a brief overview of the case as detailed in the closure form. An improvement plan has been completed. KW said that this case represents the difficulties with not having an electronic patient record and the necessity to have to trawl through letters to try to find the relevant information, also the problems associated with staff changes and new-comers being unaware of the past incidents and keeping the systems safe, he suggested that procedures of this sort need a checklist which would remove ambiguity when the patient attends. KH asked if patients were provided with details of any device that has been implanted? RB replied that now this information is provided. RB said that it would be useful to take this case back to the next Neurology Q&S meeting to discuss along with the suggestions given today. Further discussions were held around possible solutions to this problem. CG added that it is part of the UHB Medical Equipment Strategy that this sort of information is available electronically to whoever needs it, whenever it is needed. CB commented that Cardiology have kept robust system for logging pacemakers etc for a long time and suggested that Neurosciences contact Cardiology to determine whether there is any shared learning that could be developed. CMain thanked all for their suggestions.	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report September 21 CM had produced the attached report which gives details of the current situation but had been called away from the meeting. SC informed the group that there have been changes to the visiting for UHL.	
2.5	<u>Health Care Standard 2.9 Medical Devices</u> Prior to the meeting CG had sent the following report. “I attended the Clinical Board MDSO’s meeting on Wednesday (15.09.21) at which I raised the issue of reporting medical devices related incidents to the MHRA. The feedback that I had was that the pending new versions of Datix and the MHRA Yellow Card reporting systems will make it much easier to ensure that such reports get to the MHRA than currently. It was agreed that Datix training will need to be updated accordingly and that incident reporting processes and responsibilities will be included in the next iteration of the UHB’s Medical Equipment Management Policy and Procedures. At the meeting, Mark Campbell provided an update on compliance with the WHC Policy on Single-use and Reusable Laryngoscopes: WG have agreed to the phased approach and extended timescale and the UHB’s	

	implementation plan is underway. The upcoming WG slippage money opportunity for capital purchases of medical equipment was also discussed. The UHB MDSO Group has been tasked with prioritising the bids so if I can provide any help or support for bids to be submitted by the Clinical Board then please let me know. Finally, the UK Government Consultation on the future regulation of medical devices in the United Kingdom was published on 16.09.21 and is open until 25.11.21. The UHB's response will be discussed at the next MEG meeting on 11.10.21." CMain thanked CG for his update. CB commented that it has taken 3 weeks to report a device problem via the MHRA website to discover that the website doesn't seem to work via the UHB IT system and wondered if this needed to be checked out. CG said that there have been a number of issues lately and added that as a failsafe there is a phone line where faults can be reported verbally. CMain asked if this problem is being picked up formally, CG didn't think so at the moment.SC said that there had been a query as to whether the MHRA Yellow Card system could be included in the Datix training, however it is not possible to include everything in the Datix training so Suzie had advised that Clinical Engineering contact Pharmacy to get some ideas on how they have informed staff of medication Yellow Card reporting over the years.	
2.6	Vaccination Update RB reported that the Flu vaccinations are now available with a series of mini mass vaccination sessions held at UHW and UHL which were very successful. There were approximately 1200 vaccinations administered at UHW and approximately 800 at UHL. Flu vaccines are now being co-administered with Covid boosters, at the moment the UHB have given approximately 4,500 flu vaccinations. The data around which CB's the staff belong to will be available shortly. The flu vaccines will now be made available to the Flu Champions, Specialist Services have in excess of 50 of these and they will hold individual, local sessions. There is a strong push for all to take up the flu vaccine this year. Currently waiting for clarity on the vaccination of in-patients in terms of Flu and Covid booster. CMain thanked Rachel for the update and acknowledged that this was a huge amount of additional work this year and asked that Rachel let her know if she needed any additional support.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing to report	
3.2	Mortality Review CB reported that the Mortality Review Group meeting was held a few weeks ago, the Medical Examiner role was not made statutory in September as was anticipated. There is no firm date for this, a tentative date is Summer 2022. The UHB has agreed to refer all Covid-related deaths to the Medical Examiner, CB asked that all ensure that all deaths	

	within 28 days of a positive Covid result is reported to the Medical Examiner. CB and KW have been working on the Stage 1 mortality review form, CB encouraged all who have any comments on the form to contact her in order to compile all comments / suggestions before the next meeting scheduled for early November. CB gave a brief update on work being undertaken by Dr Rhian Morse in designing a cause of death form that would be completed by the consultant on the ward and would accompany the patient notes to the Bereavement Office. It has been suggested that once the form has been designed it would be shared to all departments for comments. CB reminded all of the importance of using the Stage 2 template and asked that all forms be copied to CB and RP in addition to Ann Jones and Joy Whitlock. A request has been made for a representative from each Clinical Board to sit on an All Wales Review panel, CB is happy to do this and asked that if anyone else would like to do this to please contact her to discuss further.	
3.3 ACTION	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> KW reported that the situation with the offices continues. The offices have received a "deep clean" but Estates could not guarantee that the situation would not arise again, due to the nature of the infrastructure. Staff are currently working in premises unfit for human occupation, he added that the UHB has a statutory responsibility to provide safe working conditions and is failing to do so at present. CMain replied that CW is working with Estates to try and find solutions to these problems. <u>Nephrology and Transplant</u> LS reported that a few weeks ago a kidney offer had to be declined due to lack of beds available because patients were moved into the beds reserved for Transplant patients. He said that this would have to be reported to NHSBT, the Commissioner, WHSCC and the renal network. This scenario was clarified with the clinical director as detailed in the attached document, and on those occasions the kidney offers would have been declined because of capacity, however the events have been reviewed and recorded in Datix as such: That organs were offered as part of a "fast track" process, so multiple units had the opportunity to accept or decline. Three units were ahead of Cardiff so WG and WHSCC were not notified of a missed organ due to bed shortages. However, it did raise the need to review the escalation policy on the ward when beds were full and this is underway from the directorate. This will be shared with QSE when complete. <u>Neurosciences</u> RB reported that there were no specific issues and that the pool is now open <u>Major Trauma</u> Nothing to report <u>Cardiac</u> CP reported that the DMT have met to discuss the acute nursing shortages	RE Minutes from the last clinical boar N&T Directorate

	Pharmacy No significant issues to report. SG asked all if they were aware of the search function on as found this useful.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	• Update from Learning Disability Liaison Team For information only.	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Nothing to report CMain thanked all for their hard work particularly over the past few weeks with challenges due to staffing issues, volume and acuity of patients coming through.	
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Friday 29 October 2021 8am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 19 November 2021
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Cath Wood (CW), Interim Director of Operations, Specialist Services Board
Ceri Phillips (CP), Lead Nurse Cardiac Services
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Claire Mahoney (CM), CNS Infection Prevention & Control
Ben Jones (BJ), Consultant, ICU
Mathew Price (MP), Interim Directorate Manager, Neurosciences
Lisa Simm (LS), Interim Directorate Manager, Neurosciences
Laszlo Szabo, (LSz), Consultant in Transplant Surgery
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Keith Wilson, (KW), Consultant Haematologist
Lisa Higginson, (LH), Interim Lead Nurse, Nephrology & Transplant
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Hywel Pullen, (HP), Head of Finance, Specialist Services
Rachel Barry, (RB), Lead Nurse, Neurosciences
Khalid Hamandi, (KH), Clinical Director, Neurology
Daniel Jones, (DJ), Assistant General Manager for Critical Care & MTC
Cath Evans (CE), Patient Safety Facilitator
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology & Metabolic Medicine
Joanne Bagshawe (JB), Senior Nurse, Haematology, Immunology & Metabolic Medicine
Gareth Harris (GH), Nurse, Critical Care
Carla English, (CEng)

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting. CMain introduced Cath Evans to the Group, Cath will be taking over the role of Patient Safety Support for Specialist Services.	
1.2	Apologies for absence Received from Guy Blackshaw, Judith Burnett & Joanne Clements.	
1.3	To review the Minutes of the previous meeting 8 October 2021 Matters Arising • 3.3 Nephrology and Transplant LSz asked for clarification on the reply provided to CMain by the Clinical Director regarding the declined offers of organs for	

ACTION	transplantation. The events have been reviewed and recorded in Datix as such: That organs were offered as part of a “fast track” process so multiple units had the opportunity to accept or decline. Three units were ahead of Cardiff so WG and WHSSC were not notified of a missed organ due to bed shortages. The Directorate is working on an escalation policy which is due to be brought back to QS&E for sign off. • 2.1 There is no update on the outstanding action to feed back to the Coronor on the Heparin Protocol, RP confirmed that this is due by the end of November. • CB asked if all documentation could be uploaded onto the Teams link	
1.4	<u>Principles for Safe Patient Placement</u> Carla English, Head of Covid Investigations, delivered her presentation Nosocomial Covid-19 Investigations. CMain thanked Carla for her presentation. LD added her thanks to Carla and said that she had only received positive feedback from the nursing staff since implementation of the new processes. CP added that Cardiac Services have found the support from Carla and her Team invaluable. Carla replied that Cardiac and Renal have been two of the areas most engaged in this change.	
PART 2: SAFE CARE		**Action**
2.1	<u>Open Inquests</u> INQ/In146473 patient SB. RP reported that this case is currently under investigation, there are no current grounds to believe that there were any breaches in care provided. The review is near completion. CE informed that there is a new process for the management of inquests within the Patient Safety Team, Matt McCarthy, patient safety facilitator will be managing all inquests that were also NRI’s. All other inquests will be managed by the Inquest Team based within the Concerns Team. <u>Open Nationally Reportable Incident’s</u> Patient LP – this is a complete investigation, waiting for completion of items on the Improvement Plan and submission to the Delivery Unit. Inquest has been completed. In108123 – this case has been fully completed, waiting for clarification of actions on the Action Plan, there is a complication with this case as a number of the actions were for ABUHB, in order to progress this case, it has been decided to submit C&VUHB actions to the Delivery Unit directly. A decision has to be made regarding who from C&VUHB should contact the family in order to share the report with them. In116055 - This is an NRI related to Covid on Cardiothoracic which has been closed and will close when the Review Panel are satisfied with everything. In136398 – This case has been fully investigated waiting to confirm the	

	actions on the Improvement Plan before submission. In137783 - This case has been fully investigated waiting to confirm the actions on the Improvement Plan before submission, there are 1 or 2 elements relating to Peri-operative which also need to be chased. In152962 – This is a patient from ALAS from the Swansea area who was provided with a powered wheelchair. The NRI fact finding investigation took place 18 November 2021, further updates will be provided in due course.	
ACTION	CP and RP agreed to meet outside the meeting to discuss the NRI's related to Cardiothoracic	RP/CP
2.2	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group. • ISN Ref 2021/Oct/027 Checking Resuscitation Equipment To note, nothing further to discuss • ISN Ref 2021/Oct/028 Zoll Defibrillators To note, nothing further to discuss. • PSA Ref PSA014/October 2021 Inappropriate anticoagulation of patients with a mechanical heart valve SG reported that this issue was discussed in the Executive Patient Safety Meeting and reported as being dealt with. • PSN Ref 2021/Nov/029 Fragments of rubber bung in intravenous solutions SG reported that the product affected is the Tazocin generic equivalent this problem has been recognised nationally and is being investigated. SG reminded all to check all reconstituted infusions as the problem seems to have spread to other infusion products where people are noticing particulate matter.	
2.3	<u>Closure Forms</u> There were no closure forms to discuss.	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report October 21 CM had submitted the attached report for noting, highlights from this include that the MDRO Klebsiella has been closed with no new cases for a considerable time, the remaining positive patients are cohorted on West 8, with segregated gym equipment, monthly screening to continue for the next 6 months for surveillance. There is one on-going Covid incident, related to B1 where a patient tested positive on their 72-hour screen. The patient was on a 9-bed ward and all contacts were cohorted. One of the remaining contacts is in a cubicle on B1 and the remaining two patients are in 9-bedder on C3N.	

ACTION	Isolation ends 21 November 2021. HCAI comparison to last year 12% rise in C. Difficile infections 55% reduction in E.Coli infections 60% reduction in P.Aeruginosa infections 58% rise in Klebsiella infections KW asked if the figures could be presented using denominator data. CM replied that she would ask if this could be provided for Specialist Services. CMain added that there is an investigation of a patient death with C.Diff the patient had passed through Critical Care, it is hoped that the investigation will be undertaken as quickly as possible. CMain will share the information with CB after this meeting	CMain
2.5	<u>Health Care Standard 2.9 Medical Devices</u> Prior to the meeting CG sent the following summary I attended the Clinical Board MDSO's meeting on Wednesday (20.10.21) at which we prioritised the slippage money capital bids. Over £7m of bids were received for the £1m of internal capital slippage money was available. Since then, WG have agreed to fund an additional £5.2m in slippage money capital bids thus the majority of bids have been funded. CG asked for as much information as possible on any bids in advance of the meetings as the MDSO's are asked to speak in support of any bids for the Clinical Board. CG would also be keen to support anyone in the writing up of any bids. CW asked if there was any possibility of any further slippage money being made available in the New Year, CG replied that he believes that this may relate to the additional £5.2m that was made available at this round. HP confirmed that there is additional capital monies going to be made available to all Health Boards connected with slippage, which may be used to consider other bids that were unsuccessful in this round. The <u>UK Government Consultation on the future regulation of medical devices in the United Kingdom</u> is ongoing with WG collating responses from the NHS across Wales prior to submission by the deadline of 25.11.21.	
2.6	<u>Vaccination Update</u> RB reported that to date within the HB just under seven thousand staff have received their flu vaccination which seems to be a higher rate than in previous years. There are fifty Flu Champions within Specialist Services who are actively trying to vaccinate as many of our staff as possible. Just under 43% have received their flu vaccine, this is believed to be higher than at the same time last year. It is hoped to run a Specialist Services vaccination session on the UHW site, details will be sent out shortly. Occupational Health do hold vaccination sessions every Friday morning no appointment required.	

ACTION	Patients can be vaccinated as required, if there are any patients who need either flu or Covid booster could everyone let either the Directorate Senior Nurse or RB know and a vaccination will be arranged. CB said that there are some members of staff who work across HB's and may have received their vaccination with another HB, CB asked if data is being captured regarding this group. RB said that the process of reporting has changed this year and anyone who has had their vaccination within the HB will be recorded. For those staff who have received their vaccination elsewhere there is a form available which will help capture this information. RB will send via this group. RB added that there is a comprehensive Flu page on the C&V Intranet site with lots of useful information.	RB
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing to report	
3.2	Mortality Review CB reported that the Covid mortality going through the Medical Examiner process is an aspiration at the moment rather than being enforced but we are trying for 100% compliance as it is a useful method of testing the system. From 6 December 2021, it will be a requirement that all HB deaths go through the Medical Examiner process aside from those being referred to the Coroner instead. CB needs to discuss this with Raj as Critical Care have experienced problems this week with the process in place, at present the scanning process within Bereavement limits the number of ME referrals to 3 per day and there have been in excess of 3 Covid deaths / day over the past week resulting in an unfortunate backlog. Critical Care have had cases with a clear cause of death for which they have been unable to issue the bereavement paperwork. CB added it does not feel that a process about to be implemented in 3 weeks' time will be sufficiently supported by the HB infrastructure to enforce. This situation causes concern as there is a statutory requirement for families to register deaths within 5 days.	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups ALAS Nothing to report Cardiac CP said that other than the daily challenging staffing problems for which considerable support was received there was nothing further to report. Critical Care BJ reported that Critical Care are experiencing staff shortages and problems with capacity. The blood bottle shortage is also a perpetual crisis. CB gave details on a TAVI patient who was transferred from ABHB CCU where he was receiving CPAP to C&V CCU, unfortunately this resulted in a downgrading of level of support available to him due to the constraints	

ACTION	within CCU and not being able to use CPAP there. The patient was transferred to Critical Care but sadly died before he could have his procedure done. The main problems of providing CPAP on CCU are around aerosol generation and lack of side-room capacity and also a lack of equipment, in the small number of cases where Critical Care have been able to help by providing a machine this lack of infrastructure and equipment does need addressing. CMain confirmed that this case had been raised through Datix and a fact-finding investigation is being undertaken. CE asked if the staffing issues and not being able to provide CPAP affect the outcome of the patient, CB replied that she thought that it might. Discussion was held around information on the Datix. CP was not aware of the incident and asked for information to be shared. CP agreed that there is significant challenge in terms of the environment on CCU with no cubicle capacity on CCU. In terms of equipment, there is an older machine and there are 2 new machines which staff are currently being trained on. However, this does not take away from environment problems with lack of cubicles. CB reported that the use of high flow nasal oxygen in Covid patients is being restricted to only support food and hydration breaks. CB gave details of a case where an NG tube had to be inserted because there were no high flow nasal oxygen machines. Therefore, Critical Care are not able to support food and hydration breaks, part of the problem is because the machines have been loaned out to other areas of the hospital for the same reasons i.e. to give respite from CPAP machines. CB asked if monies could be made available to purchase additional machines. CMain said that she would discuss this outside of the meeting and orders would be placed accordingly. <u>Haematology</u> JP reported on the on-going Estates issues and said that a workplace inspection of the BMT offices was undertaken earlier this week, the outcome is awaited. CMain said that CW is working to progress this. <u>Major Trauma</u> DJ reported that a meeting has been set up with TARN to discuss the quality and consistency of the data, he will update as necessary. <u>Neurosciences</u> RB reported that since the last meeting the Telemetry Service has been reconvened, the situation isn't ideal but some positive steps have been made. KH added that the general footprint of Neurology at the UHW site was lost since Covid which is having an impact, in particular the Day Unit which has been moved to Rookwood Hospital, where the accommodation is not ideal resulting in increasing problems in delivering the day care services. The Day Unit needs to be on a Neurology ward space at UHW and the OPD back on the UHW site. CMain said that the Operational Performance and Transformation Service headed by Scott McLean would be the correct forum to review the whole of the footprint to ensure that services are clinically aligned and appropriately placed. CB reported that there has been a significant increase in patients with groin haematomas after neurological vascular interventional procedures, work is being undertaken to review each of the cases to identify whether this might be a cross Clinical Board problem. <u>Nephrology and Transplant</u> Currently undergoing a peer review for Vascular Access Service this self-assessment was submitted to the Welsh Renal Network 18 November,	CE CMain

	feedback will be fed back when received. <u>Pharmacy</u> No significant issues to report.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4	For information only.	
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> KW reported that due to extreme staff shortages it was deemed safer for the service to undertake risk assessments and contravene the NICE guidance relating to Covid contacts and return to work and asked that this be noted in the meeting. CMain thanked KW and said that all risk assessments should come through the CB Office in order to escalate accordingly. CMain reported that Hywel Roberts will be standing down from his role of QSE Lead for the Clinical Board, Claire thanked Hywel for all his support and work during his time in this role and asked for any expressions of interest in taking up this position. CMain reminded all of the Specialist Services Staff Recognition Event on 16 December and asked that nominations are sent through by the deadline.	
PART 6: DATE OF NEXT MEETING		
6.1	<u>Next Meeting</u> Friday 10 December 2021 8am via Teams - cancelled	

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

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
21st OCTOBER 2021 VIA TEAMS

Present: Neil Jones, Clinical Board Director Mental Health (Chair)
Jayne Bell, Consultant Nurse for Complex Clinical Risk MH
Paul Cantrell, Consultant Forensic Psychiatrist, Interim Clinical Director, Adult MH
Suzie Cheesman, Patient Safety Facilitator
Mark Doherty, Lead Nurse MHSOP/Neuro
Gail Evans, Lead Nurse Practitioner
Nicola Evans, Head of Workforce & OD Mental Health
Victoria Gimson, MHCB Pharmacist
Mark Jones, Directorate Manager, Adult Mental Health
Robert Kidd, Consultant Clinical & Forensic Psychologist
Tara Robinson, Lead Nurse, Adult Mental Health
Vince Saunders, Infection Prevention and Control Nurse
David Seward, Acting Mental Health Act Manager
Melanie Smolinski, Service Lead Cynnwys

Apologies: Claire Humphries, Safeguarding Nurse Advisor
Andrew Vidgen, Consultant Psychologist, Assistant Clinical Director, Adult MH
Mark Warren, Director of Nursing Mental Health
Julian Willett, Transformation & Innovation Lead
Joanne Wilson, Directorate Manager MHSOP/Neuro

Minutes: Joyce Fox

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed Suzie Cheesman, Patient Safety Facilitator for Mental Health to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 19th August 2021 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

Risk Register

Neil Jones wanted to emphasise risk assessment and that it is a good idea for Directorates to contact Timothy Davies, Risk & Regulation Officer.

Incidents and Support for Staff

Neil Jones said that they had previously talked about support for staff with regard incidents and having reflective space.

Rob Kidd said he had identified a suitably qualified counsellor who works for another Clinical Board in Cardiff & Vale UHB. However, she is not full-time and we are working up a proposal for her to work an additional day, and that day would provide reflective spaces for Adult and MHSOP Directorates.

Tara Robinson said she appreciated that Rob has organised the reflective day. There is a Compassion Circle on 29th November in the Seminar Room, Hafan y Coed for the Clinical Board and Directorates to get a better understanding of how that may feel for staff and to see if that is something we want to take forward.

Neil Jones said there had been further Care Aims training and wanted to see practice embedded.

Suicide Awareness training

Jayne Bell gave an update on Suicide Awareness training. We have had week four of our six week roll out. We did five sessions with 20 slots each so that was 100 sessions offered. We had 90 attendees but in the afternoon of week 4 we did not have many attendees therefore it was agreed with them not to continue unless there was a good mix of professionals. Jayne acknowledged the staffing challenges. It did evaluate really well. Jayne knew of one person who was using it but had not heard from any other staff; they were invited to contact Jayne or Miranda if they wanted support. At the end of the first session they are able to complete a safety plan with the patient; once they had done all three sessions they are able to use a risk mitigation tool so at this point our staff have only gone as far as the safety planning session. It is paused at the moment and we need admin support.

Risk Assessment

Neil Jones reported that there had been a number of discussions and meetings regarding the assessment we use and it has been decided to retire Form 4 next year. We will move to WARRN as our first line risk tool. Train the Trainer training is being rolled out followed by Practitioner training.

Tara Robinson said that Train the Trainer courses have been arranged for 5th and 8th November 2021. Nine senior staff are attending. Tara will share her thoughts on how to take the training forward to achieve the maximum number of people trained by Summer 2022 and would value comments on this. Gail Evans said on 4th November, the day before the coaching, she will be going through the presentation with MHSOP staff and would be welcome Adult MH staff to join them so that they are prepared for the coaching days.

Jayne Bell wanted to Minute that the Risk assessment Policy is out of date and therefore we are working to an out of date document until such time as the pilot with WARRN/SAFEtool is finished and the document is re-written.

Neil Jones asked staff to flag up any discrepancies with existing Policy, to allow update.

136

In relation to 136, the decision is that we are going with Richard Jones's latest advice in that the clock starts ticking in A&E unless the person has gone there for treatment completely unrelated to their mental disorder. The 136 Policy is out of date and will be updated.

Neil Jones will update on this at the next meeting. **Action: Neil Jones**

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

Minutes of the UHB Quality, Safety and Experience Committee meeting dated 15th September 2021:

Perfect Ward Report

The Perfect Ward presentation was received. The Director of Nursing for the Medicine Clinical Board advised the Committee that the Ward Accreditation was the development of a set of standards so that areas for improvement could be identified and areas of excellence celebrated.

Mark Doherty confirmed that MHSOP and Adult Directorates are working with Aron and it is being populated and developed. Mental Health is engaging with this.

Quality, Safety and Experience Framework

The Assistant Director of Patient Experience advised the Committee that the team had taken a year to ensure that all of the stakeholder involvement had been recorded.

The framework could be formally launched on World Patient Safety Day, 17th September 2021.

It was noted that to further strengthen the Quality Governance arrangements two additional Committees would be established:

- The Clinical Safety Group –Chaired by the Executive Medical Director
- The Organisational Learning Committee – Chaired by the Executive Nurse Director

Neil Jones referred to the two meetings above. Neil would contact the Medical Director regarding the Clinical Safety Group.

2.2

Regulatory compliance

No report.

2.4 Risk Register

Mark Doherty said that MHSOP had very few staff on the wards for obvious reasons and that put them in a position of having new recruits who have only been employed for a few weeks and who have not worked their way through all competencies, their medication administration and management. Our normal practice would be that they do not do the drug round or hold the keys

until they have been through all competencies but we cannot carry this out unless we ask new staff to hold the keys. The advice we have been given is that it is permissible to do this as long as the nurse feels confident and comfortable to do so, and we should put it on the risk register.

Tara Robinson said that Adult MH have not had this issue to date. Neil Jones agreed that it should be put on the risk register. Nicola Evans said the availability of workforce, vacancies etc should be reviewed.

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Meeting dated 29th September 2021.

Adult – Tara Robinson

Staffing

Tara Robinson said staffing was an issue, especially as staff have to isolate when a family member has Covid. This has had particular impact on the shift co-ordinator and night site manger role and left us in the vulnerable position of seeking cover. We have moved to Silver but they may be a need for us to have Band 7s on call, going back to Bronze, to have another tier of staff support. This will cost about £10,00 for a year but would not be long term.

Beds

Elm 1 ward is currently closed. Elm 2 ward is the covid area.

Paul Cantrell, Consultant Forensic Psychiatrist, Interim Clinical Director, Adult MH

Covid

Paul Cantrell reported that currently Adult Directorate had 4 Consultants awaiting PCR Covid tests. Paul raised his concern regarding workforce being away from work in the Winter months awaiting Covid test results which could pose a huge risk.

Neil Jones confirmed that (at the time of the meeting) the latest guidance instructed that if someone in your household tested positive staff could not return to the workplace until a negative PCR result was received.

Staffing

Paul Cantrell said, in the Adult Directorate, full establishment of Senior Medical and Middle Grades had never been achieved. Locums have been the order of the day. Paul commented that medical workforce recruitment was difficult and for risk register purposes wanted to raise the shortage of medical staff in this, and other Health Boards, meant that hiring costs may rise.

Neil Jones and Nicola Evans both agreed that this was a problem that should be considered and to look at current and future workforce planning.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY** Meeting dated 6th September 2021.

Staffing

Mark Doherty said that staffing issues are equal to Adult MH whereas staff have to isolate with Covid. We function by creating pop up wards It should be noted that the rest of UHB are having the same experience and the DoNs have collectively formally written to Ruth Walker, Executive Nurse Director and Ruth has taken it to the Executive Board.

Nursing Expenditure

Currently 250K overspent, due to temporary staffing/vacancies. We are working on nursing establishments which should be signed off soon.

Inquest

MHSOP have an inquest at the end of November relating to a suicide in 2019.

The **PSYCHOLOGY & PSYCHOLOGICAL THERAPIES QUALITY & SAFETY** Meeting dated 6th October 2021:

Robert Kidd said that isolation due to Covid does not have such a knock-on effect in Psychology and Psychological Therapies because lots of people work remotely in the counselling service.

For risk register purposes, over the last few months there has been a very high level of staff on maternity leave.

Robert said that there had been a real improvement with the 1A target with PMHSS but may not be sustained due to the number of staff away.

PHARMACY

Valproate

Vicki Gimson said a there was national and UHB work regarding Valproate being prescribed to women of childbearing age. There were actions to be completed by the end of October, these are comparing primary care audit data with our Mental Health database to identify patients not known to speciality teams, and we are also contacting all patients not currently engaging with specialist teams to ensure the annual review and annual risk acknowledgement forms are completed.

Covid

Pharmacy are having discussions with Paul to see where pharmacists can support CMHTs to help fill some of gaps with the medics.

MENTAL HEALTH ACT

The MHLAGG meeting was held on 7th October 2021. Section 140 responsibilities under the Act. Informing section assessments that the hospital is full.

Paul Cantrell volunteered to work short term with David Seward to look at the definition and clarity of special urgency work regarding Section 140. **Action Paul Cantrell/David Seward**

COLLABORATIVE EVENT

Jayne Bell explained that the Collaborative is a meeting held once a year to learn from incidents. It's across all mental health services in Wales and is coordinated by those that set the national serious and untoward incident steering group. This year it was held online on 6 October 2021.

Sue Tranka, the new chief nursing officer for Wales, attended.

Louis Appleby presented figures and summarized the most recent report. Wales and nationally we normally have four inpatient suicides a year across Wales but in fact we have had three in Cardiff already in six months. We tend to think that men commit suicide more often because they do no access services. But in this year's most recent report, 67% of the men who died by suicide had been in touch with services in the three months prior to their death, and a third of those were in touch with services in the week prior to their death.
Professor Michael Coffey was commissioned to write a report on person centred safety planning.

Neil Jones referred to the NCISH tool kit. Tara Robinson and Gail Evans were looking at this and Neil requested feedback in two months' time.

HEALTH PROMOTION, PROTECTION AND IMPROVEMENT

No report.

SAFE CARE

4.1 Patient Safety Incidents

Neil Jones recognised that there is a lot of good work going into the SI process, and confirmed that it needs to be done sensitively. Communication needs to be good at this point and he urged If anyone is concerned about any problems with the pathway, communication etc, it needs to be picked up quickly, flagged and acted on, particularly where it involves communication with family members.

4.2 Patient Safety Alerts

No Alerts.

4.3 Key Patient Safety Risks

Safeguarding

Tara Robinson said all safeguarding referrals, whether local authority written or health, should go to our centralised safeguarding hub. There has been some concern within CMHTs of duplication so Tara would like a reminder to go through our safeguarding hub. An e mail has been circulated to remind everyone.

EFFECTIVE CARE

5.1 Clinical Board Clinical Audit Plan

No report.

NICE Guidance

Neil Jones referred to Nice Guideline NG205 "Looked-After Children and Young People" published 20th October 2021. Claire Humphries is Safeguarding Nurse Advisor for Mental Health; Claire will be asked to look at this guideline and make us aware of any MHCB action to comply.

5.3 Research and Development

Neil Jones informed the Committee that Emily Harrington is the Interim MHCB R&D Lead – our thanks to Emily.

There is a Mental Health Research & Development Conference virtual on Teams tomorrow, 22nd October 2021.

DIGNIFIED CARE

Nicola Evans said that Workforce have an Equality, Diversity and Inclusion Group, and will bring the data and information to the next MHCB Q&S meeting. To agenda under Dignified Care 6.3, titled "Equality, Diversity and Access".

TIMELY CARE

7.1 Access to Services

Neil Jones said there has been further training on Care Aims. It is important that people use Care Aims within their teams.

Neil said that IMTP sessions will be held in the coming weeks. This is a three year plan.

INDIVIDUAL CARE

8.1 Surveys

Mark Doherty said there have been discussions in Adult and MSHOP Directorates regarding Service User feedback as the current process does not seem to be working. We have discussed alternative ways of seeking this information with Nexus.

Robert Kidd mentioned that Julian Willett hosts a regular drop-in outcome measures group and within that there is some patient experience measures.

8.2 Compliments

Compliments received for:

MHSOP and Neuropsychiatry – Plaudits September 2021.

STAFF AND RESOURCES

9.1 Disciplinary Trends

Nicola Evans informed the Committee that there are 14 live disciplinary cases; 12 of which are for registered nurses and two for healthcare support workers. Four of the cases are over 12 months, two are over 6 months and the rest are less than 6 months. The cases are 11 in MHSOP and 3 in Adult.

Nicola said that there is also an Employment Tribunal, one Appeal and one Personal Injury case.

9.2 Staffing Levels

Vacancies:
According to the ESR data we've got 126.93 whole time equivalent gaps, so that's working out at 9%.

Sickness:
The sickness reported rate for September 2021 was 9.03%.

Staff Survey:
Results in December 2020 are positive. Staff said there is improvement in reflection and learning.

PART 2 : ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

10.0 Did Not Attend Guidance (Draft) - MSHOP

This guidance relates to the issue of non-attendance at individual scheduled appointments by patients.

Tara Robinson said she would arrange for this draft guidance to be formatted in template form and shared for agreement at the next MHCB Q&S meeting.

Neil Jones referred to two documents:

Second Opinion Guidance

This guidance is largely meant for medical staff but may have applicability for other groups. It also makes reference to what to do if there is any turmoil or disagreement between you and the second opinion person, or where you have asked for the input of another clinical area and you have disagreed with the decision making.

Out Patients

This is what to do if you must cancel your Clinic within six weeks.

Neil would welcome any comments on these two documents.

DATE OF NEXT MEETING

Thursday, 16th December 2021 at 9.30am
(next Clinical Board Q&S Lessons Learned Meeting is on 25th November 2021)

Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
21 October 2021 14:30 – 16:00, via MS Teams

Attendees:
Aled Roberts, Clinical Board Director, MCB
Rebecca Aylward, Director of Nursing, MCB (Chair)
Kath Prosser, Quality & Governance Lead, MCB
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Sharon Jones, Consultant, Rheumatology
Jane Morris, Senior Nurse, PaRT
Angela Pugh, Lead Asthma CNS
Annie Burrin, Patient Safety Org Learning, Patient Safety & Quality Team
Angela Jones, Resuscitation Senior Nurse
Gemma Taylor, Practice Development Nurse, Integrated Medicine
Sam Baker, Practice Development Nurse, Integrated Medicine
Sam Barrett, Deputy General Manager, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Lisa Green, Senior Nurse, A&E
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Geraldine Johnston, Director of Operations Sarah Follows, General Manager, Acute & Emergency Medicine Derek King, Clinical Nurse Specialist, Infection Prevention & Control Sian Brookes, Senior Nurse, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.0	**Minutes of the previous meeting** – received and accepted.	
1.1	**Maters arising** – none discussed.	
1.2	**Patient Story** delivered by Angela Jones, CNS, Asthma Service. Jane was diagnosed with asthma when aged 45, whose sister had died of an asthma attack. Now 60 years old, Jane had attended the Emergency Unit (EU) on 9 occasions. In 2019 Jane attended the asthma clinic as she was struggling emotionally and physically with asthma. Jane was quickly linked to a clinic Psychologist. The asthma clinic staff kept in contact with Jane during the pandemic and sought to see if she would benefit from biologic therapy. In June 2020 it was decided to start biologic therapy, which is given as an injection. Jane was then transferred onto a homecare system. There have been no further exacerbations or admissions to hospital due to her asthma. Jane advised since starting the biologic therapy and seeing the Psychologist, it has given her life back to her. She now leaves the house, socialises, has been on holiday and keen to link into	

	Asthma UK. She has open access to the clinic and has follow ups every 3 weeks, seeing a consultant annually. As an Asthma service reflection, this story has highlighted the importance of biologic therapy in asthma care. There are currently 100 patients on biologic therapy for asthma, although more fit the criteria. If patients frequently attend the EU secondary to asthma, the asthma service should be advised. Jane was happy to have her story shared at QSE. New biologics are being introduced by NICE at present. Angela Jones is the only full time CNS in the Asthma Service. Averaging 4–5 patients per month. Biologics is a fast-moving area for keeping patients well. All GPs are aware of the service. Wales has the highest incidents of asthma deaths. NACAP Adult Asthma National Clinical Report Currently seeking to ensure 90% of patients received respiratory specialist review during their hospital admission. Ensure 95% of patients who have not been administered steroids as part of pre-hospital care are administered this treatment within 1 hours of arrival. Six elements of good practice care are undertaken as part of discharge. People are four times less likely to be admitted into hospital if they have an asthma plan. Key themes of the audit: Captured more patients for audit in UHL than UHW. Need to target the first hour and improve information on peak flow. Increasing time for respiratory review. Looking at the discharge bundle. The asthma service requires engagement of all ED staff and the pathway will follow. Angela Jones will share her presentation.	AJ
1.3	**Feedback from UHB QSE Committee** – no issues raised.	
1.4	**Directorate QSE minutes – exception reporting** Minutes received from Rheumatology; Dermatology; Clinical Gerontology.	
1.5	**MCB Quality Paper for Executive QSE Committee September 21** All to read the report. MCB is doing a good job.	ALL
1.6	**Significant Nurse Staffing Risk** – no issues raised.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.0	**Healthcare acquired Covid investigations update** KP to add this item to the next meeting agenda.	KP
2.1	**Influenza/Covid investigations update** Flu season has started and is challenging. To date 7,000 staff have been vaccinated. Trying to set up additional clinics. Staff can have their Covid booster and flu jab at same time.	
2.2	**Falls Review Panel September Learning and Feedback** Thanks to staff using the new injurious falls templates. Still seeing omissions. Staff to revisit the use of bed rails so they are not used inappropriately. Generally, injurious inpatient falls are reducing. It is expected that there will be a revision of the NICE guidelines regarding falls.	
2.3	**NHS Wales Annual Report Safeguarding Network** – not issues raised.	

2.4	**Learning Disability – Once for Wales** – no issues raised.	
2.5	**NACAP Adult Asthma National Clinical Report** – no issues raised.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.0	**Serious Incidents for Closure: Integrated Medicine** **In147702** – Injurious Injury. This was a witnessed mechanical fall whilst mobilizing independently resulting in a catastrophic left sided intraventricular haemorrhage. The investigation concluded that the patient had attempted to mobilize unsupervised around the bed area. Post falls procedures were completed in line with UHB post falls procedures and NICE 2015 post falls guidance. The investigation highlighted that although lying and standing blood pressure was not completed on admission, the patients blood pressure had been stable since admission and this omission would not have contributed towards the fall. The ward have implemented lying and standing blood pressure for all patients admitted to the ward if able to comply with the process. In addition, Practice Development Nurses in conjunction with the UHB Falls Lead are in the process of developing a falls resource folder for all areas across the Clinical Board. This incident is subject to an inquest. **In148531** – avoidable healthcare acquired bilateral unstageable pressure damage to the heels. The investigation concluded there were missed opportunities to accurately define the correct category of the pressure damage to the heels. In addition, some of the patients risk assessments and car plan to inform the patients care were not updated in line with UHB best practice. An AS1 referral has been submitted to the UHB safeguarding team. It was highlighted over a weeks period within Safety Briefings the importance of Intentional Rounding and clear concise documentation, particularly a patients care plan and risk assessments to inform safe and effective care. **In146660** – avoidable healthcare acquired bilateral Category 3 pressure damage to the heels not on weight bearing areas. The investigation identified that the Category 3 pressure damage was as a result of ill-fitting slippers secondary to leg dressings which were changed on alternate days. These were changed to looser slippers balanced against the patients falls risk. All staff were reminded that patients with complex leg dressings and tight slippers should be reviewed daily to ensure this is not contributing towards pressure areas evolving. In addition, new slippers should be sourced, balanced against the risk of loose slippers increasing a patients falls risk.	
3.1	**Infection Prevention and Control update** 347 days since last MRSA bacteraemia (UHW C5) 29 days since last MSSA bacteraemia (SADH Rhydlafar) 17 days since last *C difficile (UHW A1)* 16 days since last E. *Coli* bacteraemia (UHL SRC) 336 days since last Pseudomonas bacteraemia (UHW B7) 34 days since last Klebsiella bacteraemia (UHW A7) **Outbreaks/ Incidents** – there were 5 incidents or outbreaks in September affecting 27 patients, 8 staff and resulting in 74 bed days lost. There are no current incidents or outbreaks. **C4C scores** – all wards within MCB are compliant for the 4-week period. All achieved >97%. **HCAI reduction goals** - on target for Pseudomonas, MRSA and E. *coli*. **Outstanding RCA's** – there are 9 Outstanding RCA's. **MCB position based on the same period 2019:** C.*difficile* (+90%), SAUR (+63%) E.*coli* (-48%) Klebsiella sp. (+68%) Psuedomonas (-1). Due to the effects of COVID last year, comparisons are now be made with 2019.	

	There have been a number of issues will faulty macerators not being repaired for extended time periods (A7, C6). BBE slipping on C5 again. Clutter appearing on wards again.	
3.2	**Point of Care Testing** - any actions required following circulation of information from POCT team	
3.3	**Medical devices/equipment issues** – no issues raised.	
3.4	**PSN/ISN/MDA's** CAPA-2021-07 – Customer comm – recall Clinell Universal Wipes update ISN 2021 Aug 021 Clexane different supplier ISN 2021 Sep 024 – Glass Sodium Citrate Tubes ISN 2021 Sept 023 – 3ml EDTA European Tubes PSN060 Oral meds wrong route SBAR Chest compressions and AGP ISN 2021 Aug 018 Histopathology ISN 2021 Sept 026 Human Albumin Solution ISN 2021 Sept 025 Hydrogen Peroxide PSN058 Ingestion of super strong magnets PSN062 Liquified Phenol	
DIGNIFIED CARE		
4.0	**Feedback from Internal Medical Examiner UHL** – positive feedback shared via the ME from patients families regarding the excellent care provided.	
TIMELY CARE		
5.0	**Patient at Risk Team (PaRT)** KP to ensure Jane Morris is allocated an agenda slot for the next meeting.	KP
5.1	**Datix Queues** The datix system is changing from April 2022 and prior to this taking place, the datix queues must be significantly reduced to at least 170 in progress, otherwise they will have to be manually transferred across. Datix training is available if required. Some staff who cannot be clinical/ patient facing at present could assist with reducing these in EU & IM.	
INDIVIDUAL CARE		
6.0	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans	
6.1	**DTOCs** – no issues raised.	
6.2	**Compliments** – none discussed.	
6.3	**Safeguarding** – no issues raised.	
6.4	**Concerns update** – no update at present due to operational pressures. Over 100 concerns open at present.	
6.5	**LFE update** **LFE 3546 AB** – dermatology, staff member sustained a cut from a scalpel blade not disposed of properly. New system now set up and a check list put in place. £2,500 awarded to staff member as a result.	

	LFE 3858 BM – pressure sore to a patient in 2015. C&VUHB had to admit documentation did not reflect if the patient was on the correct mattress. Patient awarded £10,000 in damages. All to evidence that patients are on the correct mattress and to take this message back to teams. Pressure damage has increased; however, this could be because the bed base has increased. Multitude of reasons for increase in pressure damage. Pressure damage collaborative – the Execs have requested a 25% reduction in pressure damage areas and to take avoidable cases through redress. Report from PHW on result of Covid on older patients – people are more deconditioned than in the past. Currently there is nothing to replace the intentional rounding chart.	ALL
Staff and Resources		
7.0	**Staff well-being** – conversation about the significant risks across the MCB. Running with significant gaps and sickness is very high. Last night opened up another 8 beds in LSW and had to find staff to staff the area. A discussion took place on how best to support staff. - Employ a team of staff at Band 6 level, wellbeing champions, to walk around the wards, talk to staff, pastoral support and this has been well received in the Children and Women Clinical Board. It was agreed this would be a positive way to support staff. - Look at psychology support as there is more violence and aggression at the front door. Someone with counselling skills, compassionate person, however, it is critical that this is not a nurse. This will be a positive message back to staff that they are very much cared for. - Buddy system could be introduced. - Staff haven could be used more. - Zoom session for staff could be re-introduced (as was in place after the 1st wave). - Staff appreciated the chaplaincy staff calling in. It is tough on the wards and RA thanked everyone for all they are doing.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Date and time of next meeting** – 2.30pm on 18/11/21.	

Report Title:	**Corporate Risk Register**						
Meeting:	Quality Safety and Experience Committee				**Meeting Date:**	22/02/2022	
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 and above to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.

Each of these risks are 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 the September 2021 Board meeting 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 to 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 January 2022 Board meeting a total of 10 (from a total of 16 scoring 20 or above) 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	3	
PCIC		
Specialist Services	4	
Surgery		
Digital Health		
Estates		
Children and Women		
Mental Health		
Capital Estates and Facilities	**3**	
Total:	**10**	**-**

It should also be noted that the entries shaded grey on the attached register remain live within Clinical Board directorates but will not, due to their current risk ratings, continue to be recorded on the Corporate Risk Register (unless their scores increase prior to the next update).

An updated Register will be shared with the Board at its March 2022 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 Risk Management development work which is now progressing with Clinical Boards and Corporate Directorates.

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 - BOARD MEETING JANUARY 2022

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			
Capital Estates and 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	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	2	Mar-21	**Obsolete Medical Gas Delivery Equipment** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete in Barry. Medical Gas (Nitrous Oxide) manifolds are obsolete in UHW Maternity (manifolds 1&7), UHW A&E, UHW Dental (manifolds 4&10). In addition the UHW Medical Gas Pressure reducing set is obsolete. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety. quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	3	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**	Feb-22	Quality, Safety & Experience Committee	Patient Safety Capital Estates

Medicine CB	7	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.	5	5	25	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. Update December 2021: Investigations are being undertaken by the Covid team (Corporate) whihc is supporting the CB identify common themes and trends.	5	3	16	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.	5	3	15	Feb-22	Quality, Safety & Experience Committee	Planned Care Capacity
	8	01/03/2019	Patients are remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	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. All non paramedic crews are assesseed by the Triage Nurse/Majors Assessment Nurse to ensure a patient clinical assessment is conducted.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. Update December 21: Joint CB/ WAST partnership meetings in place to focus on improvements. The Clinical Board is engaged with the NRI process for reporting incidents where WAST delays have resulted in major patient harm. Update Transformational work being undertaken across Acute and Emergency Medicine to support flow, including RATZ, virtual ward.	5	4	20	Daily review and risks noted within Safety Huddles and EU Controller reports. Escalated to MCB Hub and Patient Access Services. Evaluation of Standard Operating Procedure to reflect any changes required. WAST Immediate Release Standard Operating Procedure in use to support 'Red' calls in the community. Update December 2021: OPAT accross both UHW and UHL to support WAST and patient flow.	5	2	10	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety
	9	01/01/2021	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.	5	4	20	Medical staffing reviewed as part of the daily LCC meetings with ongoing planning to ensure safe staffing.	5	2	10	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety and Workforce
	10	01/12/2021	There is a risk of overcrowding with the Emergency and Acute Medicine footprint secondary to no flow or lack of UHB capacity. This results in the inability to provide and maintain key quality standards as patients are being nursed in inappropriate areas affecting timely access to treatment and discharge.	5	5	25	UHB and local escalation policy and implementation led by MCB HUB and Patient Access Services working in partnership with the EU Controller and Senior Floor Cover to improve flow. Escalation of all constraints to all Directorates. Internal escalation to key clinicians/staff to assist with flow across the department. All vulnerable patients escalated to ensure timely bed allocation. Standard Operating Procedure in place for all ambulatory areas. Implementation of Internal Professional Standards to deliver prompt specialist review within agreed timeframe	5	4	20	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow.	5	3	15	Feb-22	Quality, Safety & Experience Committee	Patient Safety

Children & Womens CB	11		Delay and interuption to induction of labour due to staffing levels. This has the potential risk of poor outcomes for mothers and babies. This also effects the women's experience. Approx 30 DATIX submitted 27.10.21 - 8.12.21 (6 week period as on August risk register	4	5	20	1.Undertaking an in depth review of our that there is continued assurance that sickness is being managed according to the policy. 2. Introduced a weekend planning meeting each Friday at 12pm so that we have assurance that weekends are covered 3. Introduced a postnatal / newborn spot screening clinic at UHW on the weekends. This means that women will attend ANC at UHW or UHL for their care rather than a midwife visiting. This will release a community midwife to come in to support the hospital setting but keep the home birth service going. 4. Operational Ward Managers – while they have a clinical component to their role, we have requested that they roster one clinical shift per week so that they're included in the overall numbers 5. Midwives offered bank / additional hours and overtime 6. Elan midwives to provide on call support to wider community teams with home birth service 7. Digital Midwife, Practice Education Facilitator, Fetal Surveillance Midwife & Women's Experience Midwife – to provide at least one clinical shift per week. 8. Research and Development Midwives to be temporarily redeployed back to providing frontline clinical care until the staffing situation improves 9. Clinical Supervisors for Midwives to be redeployed 50% back into clinical practice. 50% CSfM to continue to provide ongoing support to clinical practice / capability / action learning	4	4	16	1.Band 6 vacancies to be filled - interviews scheduled 2. 24 midwives have been offered 27 hrs each upon qualification in September.3. continues to be escalated to clincal board and executative leve	4	2	8	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	15	Sep - 21	**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	25	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	20	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	10	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety and Planned Care Capacity
	16	Jan-16	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	5	25	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently. The unprecedented demand during the current Covid19 Pandemic has resulted in a temporary increase in the unit footprint and capacity which has ameliorated this issue whilst at the same time exacerbating the Crtitical Care workforce risks detailed elsewhere.	5	4	20	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	10	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Planned Care Capacity
Specialist Services CB	17	Jul-20	**Critical Care - Clinical Environment** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and also compromises the care of patients where temperatiure is a critical concern. The well being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dedydration. 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 program and business case developed to address this need.**	5	2	10	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets

19	Aug-21	**CARDIOTHORACIC** Deaths on Cardiac Surgery waiting list Provision of Cardiac Surgery - including ability to meet 36 week RTT, ability to treat urgent patients, impact of staff shortages (theatre and CITU staff), impact of lack of access to inpatient beds leading to increased mortality and morbidity of patients on the WL	5	4	**20**	Daily validation of cardiac surgery waiting lists by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly cardiac surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Standardised communication processes for patients on the waiting list for cardiac surgery. Forward planning for Cardiac surgery. Recruitment and retention of theatre personnel. Obtain anaesthetics	5	3	**15**	Theatre staff shortages, limited flexibility on CITU beds. Inability to undertake weekend working Limited assurance due to significant establishment gaps in both theatre scrub staff and anaesthetics Commisioning review of potential outsoucing contract. Recruitment of anaestheic and theatre personnel. Daily flow monitoring to ensure timely transfer between CITU and Ward C5	5	1	**5**	Feb-22	Quality, Safety & Experience Committee	Patient Safety Planned Care Capacity
21	Jan - 2010	**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**	**Risk specific policies, protocols, and guidelines.** **Cleaning schedules.** **Installation of air pressure gauges outside BMT cubicles to measure positive air pressures.** **Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green).** **HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved.**	5	4	**20**	**New dedicated Haematology facility required.** **Escalated to Clinical Board, estates and WHSSC.** **Bid for Lakeside Wing is to be submitted for consideration.**	5	1	**5**	Feb-22	Strategy and Delivery Committee and Quality, Safety and Experience Committee	Planned Care Capacity Patient Safety