



CARDIFF AND VALE UHB Patient Safety & Quality

**3rd Edition
Summer 2019**

NEWSLETTER

ANNUAL QUALITY STATEMENT



The Annual Quality Statement (AQS) was published on 31 May 2019 in accordance with Welsh Government guidance. This report provides Cardiff and Vale UHB with an opportunity to show the public in an open and transparent way how it is performing and the progress being made to ensure that all services we provide meet the high standards required.

A copy of the AQS can be viewed [here](#)

INFECTED BLOOD INQUIRY

In July 2018 The Independent Inquiry into Infected Blood and Blood Products was launched, to examine the circumstances in which men, women and children treated by the NHS in the UK were given infected blood and blood products, particularly since the 1970s. Cardiff played an important role in the treatment and care of individuals with inherited bleeding disorders and cared for patients across Wales. The UHB is supporting the Inquiry by providing evidence relating to the provision of services and the treatment of individuals during this period. We have, and continue to provide copies of medical records to individuals who are contributing to the Inquiry.

An email account Blood.Inquiry@wales.nhs.uk is available as a general point of contact for individuals who wish to contact the UHB to discuss anything that relates to the Inquiry. Those either infected or affected will be giving evidence in Cardiff from July 23rd—26th. The UHB is engaging fully with the enquiry.

RETIREMENT NEWS



On 13th June 2019, Kathy Morris will be retiring from the Clinical Audit Department, having enjoyed an extraordinarily long career in the NHS.

On leaving school, she initially joined the Civil Service for a short time, before starting Nursing Training in Llandough Hospital, where she still maintains strong connections through the Nurses Association.

Throughout Kathy's career she has contributed enormously to the UHB quality assurance agenda; supporting and facilitating National Audits in COPD, Asthma, Major Trauma and MI. She has also provided clinical audit advice and support to clinicians across a number of directorates throughout her career.

We would all like to wish Kathy a long, happy and very active retirement. No doubt this will enable more opportunities for walking with the Ramblers Association, more bowls matches, more holidays and other enjoyable pastimes.

DATES FOR YOUR DIARY

Clinical Audit Workshop dates:
Monday 24th June UHW—FULL
Thursday 7th November UHW
[More information](#)

Next Safety and Quality session date:
16th July 2019
[More dates](#)

Action Planning Workshops:
Please contact the [Patient Safety Team](#) for training dates.

DATIX Manager Training:
Please contact the [Datix email helpdesk](#) for a full list of dates available.



Our staff can all be found on the [Global email list](#) or alternatively call 46991 for Patient Safety queries or 42963 for Audit queries



CORONER REG 28 UPDATE

The Coroner has a legal duty following an inquest, to consider if there is a risk of other deaths occurring in similar circumstances. If the Coroner considers that future deaths could be prevented, they can write a report under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. During 2018-2019 the Coroner has issued 5 Regulation 28 reports to the UHB. These related to:

- A delay in carrying out surgery on a patient who had fallen at home and fractured his hip
- A patient who had suffered a head injury at home following a fall and needed to be transferred to England for interventional radiology
- A delay in the ambulance response to a patient in the community. The Coroner was concerned about ambulance handover delays at the major hospitals
- The in-patient death of an elderly gentleman who took a deliberate overdose on a general ward. The Coroner was concerned about the security of medications
- The care of a patient in a mental health setting following a fall and head injury.

The UHB has to respond to the coroner within 56 days to confirm the actions being taken. The reports are published on the Chief Coroner's website. For further detail on any of these Regulation 28 reports please contact the Patient Safety team.

The South Wales Central Coroners Service now has a [website](#). The site contains useful information for bereaved families and witnesses attending an inquest.

DID YOU KNOW?

"All emails sent across the majority of public sector organisations in Wales are now secure and encrypted following a significant piece of work between NHS Wales Informatics Service and Public Sector Wales. It means emails sent between organisations such as local government, police, fire and NHS Wales are now encrypted between all parties."

However this does not prevent the sender emailing the wrong recipient. Do be extra careful especially when dealing with Person Identifiable Information.

[More information](#)



TARN UPDATE

Every year across England and Wales, 16,000 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life. The Trauma Audit and Research Network is a national organisation that collects and processes data on moderately and severely injured patients in England and Wales allowing organizations to benchmark their performance with other providers across the country. Some of C&V UHB recent results include:

81.4% of patients that met the NICE criteria had a CT scan within 60 minutes of arrival at the trauma unit. This is above the national average (52.9%) by 28.5%.

82.1% of patients with severe injuries with pre alert/trauma team according to NICE criteria were seen by a Consultant within 30 minutes of arrival. This is above the national trauma unit average (44.9%) by 37.2%. To find out more visit [TARN](#)

MENTAL CAPACITY

Consent to treatment/examination training

Consent training sessions have been organised with LED for the following dates – 19th September and 20th November 2019.

This course is aimed at all clinical staff who provide treatment and care to patients, including nurses, doctors and allied health professionals. For further information, including how to book, please go to page 64 in the training prospectus [here](#).

NICE has produced some guidance on the use of Mental Capacity Act 2005 this can be found [here](#).

Independent Mental Capacity Advocacy (IMCA) service

There are times when clinicians **must** (legal duty) instruct IMCA, when the patient lacks capacity to make a decision for themselves. For further information about IMCA, please see the UHB's [Independent Mental Capacity Advocacy Procedure](#) and the [Mental Capacity Act 2005 Code of Practice](#)

The IMCA service is still coming across clinicians who do not know about the service, even though the Mental Capacity Act has been in force for over 11 years.

Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act has been amended to replace DoLS with the Liberty Protection Safeguards (LPS), which will come into force sometime in 2020. For a summary of what the changes will mean, please see [this](#).



FALLS UPDATE

Cardiff and Vale UHB Falls Framework: Reducing risk and harm launched

At the clinical senate on the 8th March 2019 there were a number of presentations on pieces of work underway as part of the transformation of falls services in Cardiff and Vale UHB. These included the launch of the UHB's new falls framework, the Cardiff and Vale Community Falls Prevention Alliance, Stay Steady community falls clinics in Cardiff, inpatient falls simulation training, community strength and balance class updates and the Staying Steady Schools scheme.

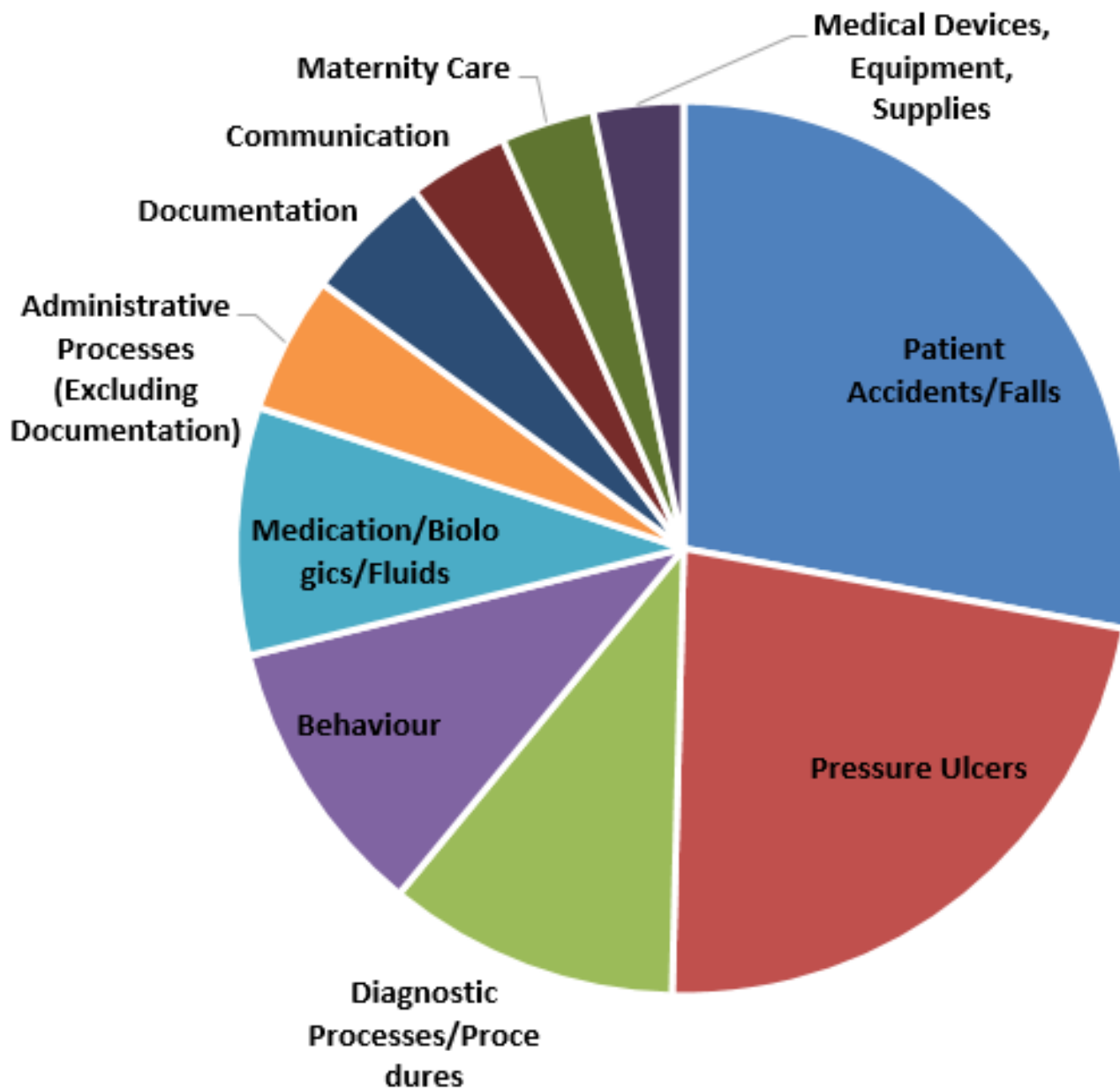
The new falls framework is available for [download](#) on the UHB website.



PATIENT SAFETY INCIDENTS

17,665 Patient Safety Incidents were reported during 2018. The majority of these incidents were graded as no harm, minor or moderate harm. Even if no harm is reported to a patient it is still important to report near misses. We can learn and identify common themes and trends which can help improve patient safety.

The pie chart below displays the 10 most common type of incidents reported:



ITEMS OF INTEREST

Here are some links to recent reports that may be of interest to you:

[Quality Care Commission review on Never Events](#)

[Royal College of Surgeons Analysis—Learning from Invited Reviews](#)

[Healthcare Quality Improvement Partnership: The Learning Disabilities Mortality Review – Annual Report 2018 – HQIP](#)

