Quality, Safety & Experience Committee

Tue 10 January 2023, 09:00 - 12:00

Agenda

09:00 - 09:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 29.11.22

Ceri Phillips

1.4 Public QSE Minutes 29.11.22 JR.MD.NF. SE.pdf (11 pages)

1.5. Action Log – Following the meeting held on 29.11.22

Ceri Phillips

1.5 QSE Action Log MD NF.pdf (3 pages)

1.6. Chair's Action taken since last meeting

09:10 - 10:55
105 min

2. Items for Review & Assurance

2.1. Surgical Clinical Board Assurance Report (including a Patient Story)

Jason Roberts / Clare Wade / Tina Bayliss / David Scott-Coombes

9.10am: *25 minutes*

2.1 QSE Surgery Clinical Board Assurance Report.pdf (29 pages)

2.2. COVID Investigations

Jason Roberts

9.35am: *15 minutes*

2.2 QSE Covid Investigations.pdf (5 pages)

2.3. Quality Indicators Report

Jason Roberts

9.50am: *10 minutes*

2.3 QI Report January 23.pdf (29 pages)

2.4. HIW Activity Overview

Jason Roberts / Meriel Jenney

10am: *10 minutes*

- 2.4 HIW Update.pdf (3 pages)
- 2.4a Opthamology thematic review action plan.pdf (18 pages)

2.5. CHC Reports - Verbal

Jason Roberts

10.10am: *5 minutes*

2.6. Internal Audit reports

Nicola Foreman

10.15am: *5 minutes*

2.7. Pressure Damage Update – Verbal Update

Jason Roberts

10.20am: *5 minutes*

2.8. Maternity Services – Verbal Update

Jason Roberts

10.25am:

i) HIW Review - ***5 minutes***

ii) Ockenden Review - ***5 minutes***

2.9. BREAK 10.35am – 10 minutes

2.10. Board Assurance Report – Patient Safety

Nicola Foreman

10.45am: *5 minutes*

- 2.10 BAF Patient Safety Covering report.pdf (3 pages)
- 2.10 BAF - Patient Safety Risks.pdf (21 pages)

2.11. Corporate Risk Register

Nicola Foreman

10.50am: *5 minutes*

- 2.11 Corporate Risk Register - QSE Update January 23.pdf (4 pages)
- 2.11a - QSE - Detailed Corporate Risk Register.pdf (5 pages)

10:55 - 11:10
15 min

3. Items for Approval / Ratification

3.1. Committee Annual Report 2022/23

Nicola Foreman

10.55am: *5 minutes*

- 3.1 QSE Annual Report Cover.pdf (2 pages)
- 3.1a DRAFT Annual Report QSE 2022-23MD.pdf (10 pages)

3.2. Committee Terms of Reference 2023/24

Nicola Foreman

11.00am: *5 minutes*

- 3.2 QSE Committee Terms of Reference - NF.pdf (2 pages)
- 3.2 QSE ToR 23.24.pdf (8 pages)

3.3. Policies for ratification including:

Emma Cooke

i) Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331)

- 3.3 Policies Cover Report Q&S 10.01.23.pdf (2 pages)
- 3.3a Referrals By Non-Medical Practitioners Policy.pdf (3 pages)
- 3.3b Referrals By Non-Medical Practitioners Procedure.pdf (12 pages)

11:10 - 11:25
15 min

4. Items for Noting & Information

4.1. Joint Research Governance Group Report

Meriel Jenney / Colin Dayan

11.10am: *5 minutes*

- 4.1 JRO report formation of JRGG.pdf (2 pages)
- 4.1a JRO proposed committee governance structure.pdf (1 pages)
- 4.1b ToR Cardiff Joint Research Office JRGG.pdf (5 pages)

4.2. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

1. CD&T Clinical Board & Patient Experience Sub-Committee - 17.10.22

2. Medicine Clinical Board – 20.10.22

3. Specialist – 01.09.22, 13.10.22 & 31.10.22

4. Surgical – 20.09.22

5. Children & Women's Clinical Board -

6. PCIC - 08.11.22

- 4.2.1 CDT QS Minutes 17.10.22.pdf (12 pages)
- 4.2.2 Medince CB QS Minutes 20.10.22.pdf (7 pages)
- 4.2.3a Specialist QS Minutes 01.09.22.pdf (6 pages)
- 4.2.3b Specialist QS Minutes 13.10.22.pdf (7 pages)
- 4.2.3c Specialist QS Minutes 31.10.22.pdf (8 pages)
- 4.2.4 Surgical CB QS Minutes 20.09.22.pdf (12 pages)
- 4.2.6 PCIC QS Minutes 08.11.22.pdf (7 pages)
- 4.2.6b PCIC QS Minutes 30.11.22.pdf (6 pages)

11:25 - 11:25
0 min

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

Ceri Phillips

11:25 - 11:25
0 min

6. Agenda for the Quality, Safety & Experience Private Meeting:

i) Private Minutes -

ii) Any Urgent / Emerging Themes – Verbal

iii) Inpatient Suicides

iv) Acute Pressures - UHB Response

11:25 - 11:25
0 min

7. Any Other Business

Ceri Phillips

i) Acute Pressures - UHB Response

11:25 - 11:25
0 min

8. Review of the Meeting

Ceri Phillips

11:25 - 11:25
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

Tuesday 11 April 2023 at 9am via MS Teams

11:25 - 11:25
0 min

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]"

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 29 November 2022 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 Cardiff and Vale University Health Board
In Attendance		
Paul Bostock	PB	Chief Operating Officer (in attendance until 10am)
Barbara Davies	BD	Lead Nurse in Specialised Medicine
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director (in attendance until 11am)
Mathew King	MK	Interim Assistant Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Jane Murphy	JM	Interim Director of Nursing – Medicine Clinical Board
Suzanne Rankin	SR	Chief Executive Officer
Aled Roberts	AR	Clinical Director for Medicine Clinical Board
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director
Observing		
Timothy Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Beth Jones	BJ	Senior Nurse for Specialised Medicine
Katherine Prosser	KP	Interim Quality and Governance Lead – Medicine Clinical Board
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Louise Platt	LP	Director of Operations for Medicine Clinical Board
Catherine Phillips	CP	Executive Director of Finance

QSE 22/11/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/11/002	**Apologies for Absence** Apologies for absence were noted. The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting. The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group.	
QSE 22/11/003	**Declarations of Interest** No declarations were noted.	
QSE 22/11/004	**Minutes of the Committee meeting held on 30 August & 11 October 2022** The minutes of the meeting held on 30 August 2022 and 11 October 2022 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 30 August 2022 and 11 October 2022 were approved as a true and accurate record of the meetings	
QSE 22/11/005	**Action Log following the Meeting held on 30 August 2022** The Action Log was received, and all ongoing actions discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 30 August 2022 was noted	
QSE 22/11/005	**Chairs Actions** The Chairs Action around the Approval of the Research Governance Policy (UHB 099) was received. **The Committee resolved that:** a) The Chairs Action was noted.	
QSE 22/11/006	**Medicine Clinical Board Assurance Report (including a Patient Story)** The Clinical Director for Medicine Clinical Board (CDMCB) introduced the Lead Nurse in Specialised Medicine (LNSM) who presented the Committee with a Patient story. It was noted that the Patient Story reflected the complex experience of a Patient at the University Hospital of Wales (UHW) and their extended length of stay. The LNSM advised the Committee that the Patient's case was very complex and identified a number of areas in which the Health Board had input into the care of the Patient and the actions taken around: • Patient admission • Interventions • Early MDT approach • Discharge Planning • Re-Admission • Further Discharge Planning It was noted that a number of lessons had been learnt which included: • Failure to engage GP in the MDT approach added to the Patient's readmission • Access to psychology was limited • Acute care environments did not support the therapeutic interventions required for Patients with multi-faceted complex needs The Independent Member – University (IMU) noted that the Patient within the story had a very complex case and that the issues seen around psychology had offered another interesting aspect to the complex case in terms of holistic management. The Vice Chair of the University Health Board and Committee (the Vice Chair) asked if the lessons learnt could be pooled across the Organisation with regards to how Patients with complex needs were managed because there were currently Patients inappropriately located in care settings for a number of reasons but those areas did not necessarily address their Clinical or emotional needs. The CDMCB responded that the ward in which the Patient had been admitted was no stranger to complex cases and noted that a Patient whose length of stay exceeded the expected length of stay was usually due to the Patient's needs falling between services and that attention was required as to why a Patient's length of stay was so high. The LNSM added that in terms of sharing the complexity of the learning across the Organisation, it should be looked at and shared effectively between Clinical Boards.	

The Chief Executive Officer (CEO) noted that they had been discussing the need for psychological therapy to be embedded as an element of the Health Board's "universal offering" as opposed to an "as and when" required approach.

The Medicine Clinical Board Assurance Report was received.

The Executive Nurse Director (END) advised the Committee that in relation to the National Reportable Incidents (NRI) management, the Medicine Clinical Board (MCB) had undertaken a lot of work to close down the NRIs.

It was noted that the Medicine Clinical Board (MCB) was investigating 8 NRIs and that 5 of the investigations were being progressed for closure and 3 were subject to His Majesty's Coroners inquests.

The CDMCB advised the Committee that maintaining safe and timely Patient flow across the Clinical Board continued to be a significant risk to the MCB, especially within the Emergency Department (ED).

He added that the MCB had received a lot of support from the Health Board around areas which included:

- A frailty zone - a 6-day Frailty service in the Assessment Unit had commenced in November 2022

- Right bed, first time - Ward A1 was reset to ensure Patients with a predicted length of stay under 72 hours were admitted and Ward C5 had introduced a Clinical led flow model with respect to Board rounds and noted that the small change in the timings of Board rounds had seen a big impact on communication and team working in relation to Patient discharges and flow.

The Interim Director of Nursing – Medicine Clinical Board (IDNMCB) advised the Committee that the biggest risk for the MCB was staffing.

She added that the lack of a consistent workforce impacted on standard of care and added that staff were expressing their concern with regards to not having enough nurses to look after Patients.

It was noted that different models of healthcare were being looked at with other Health Boards in Wales, as well as gaining valuable insights via Tendable.

The IDNMCB advised the Committee that the MCB was trying to build its workforce around the Patient rather than looking at the traditional model of care and had recognised the huge amount of work that was needed.

The Vice Chair asked what actions were in place to increase the percentage of MCB staff undertaking their Values Based Appraisal (VBA), as the current level stood at 22.20% which was poor.

The IDNMCB responded that the MCB and Directorates were working hard to review and improve compliance with VBAs and pay progression.

She added that the paperwork had been looked at and reduced to encourage a more streamlined approach which would help to make the process more discussion based.

The Assistant Director of Patient Experience (ADPE) advised the Committee that the MCB had a high level of activity but had remained very focussed on the QSE agenda and that as a Clinical Board they were always receptive to trying any innovation that could support and improve experience.

The END concluded that with regards to the staffing and remodelling work, the Committee could not underestimate the challenge to the MCB. He added that there was a Quality Framework that had to be followed and so work would be undertaken to look at that Framework to ensure safety within the system.

The QSE Committee resolved that:

	a) The assurance report provided by the Medicine Clinical Board Report Medicine Clinical Board QSE was noted; and b) The mitigation being taken to improve quality, safety and experience and reduce harm was agreed.	
QSE 22/11/007	**Quality Indicators Report** The Quality Indicators Report was received. The ADPE advised the Committee that she would take the report as read and would highlight key areas for noting. It was noted that one of the areas picked up within the report was around information collated through the Tendable platform which enabled the team to analyse some of the best use of resources questions. It was noted that one of the questions included was: • Are Nurse Staffing Levels Appropriate vs Are you undertaking a task that a non-clinician could to? It was noted that the more nurses felt that staffing levels were inappropriate, the more they reported doing tasks that could have been undertaken by a non-clinician. The ADPE advised the Committee that the correlation was, in part, contributing to the consistent reduction in staff wellbeing scores. It was noted that the over the next 12 months, a more electronic format of the Quality Indicators Report would be received by the Committee to provide a live database and real-time reporting. The END advised the Committee of the Health Board's Infection, Prevention and Control (IPC) position and noted that the grouped total Cdiff, Ecoli, MRSA and MSSA infections had shown no in-year improvement against the 2018/2019 baseline. He added that the Cdiff rate in-year had increased, compared to baseline of December 2018 and noted that the Board had received that information at their last meeting in November. It was noted that the END and the Deputy Medical Director (DMD) co-chaired the Cdiff group and that the root cause analysis would be undertaken and learnings shared with the relevant areas. The IMU asked where the Health Board was in relation to pressure damage and noted that the report tried to discern pressure damage correlation with staffing. The ADPE responded that pressure damage management was difficult because so many variable factors came into it which included: • Patient waiting a long time in ambulances. • Delays in admission to beds on wards for Patients with a "decision to admit". She added that the collated data was used to examine whether there was any correlation between short staffing incidents and pressure damage and falls reporting, and to examine the theory that short staffing incidents led to a reduction in falls, as there were not enough staff to mobilise the Patients, and therefore an associated increase in pressure damage as a result. It was noted that the data did not suggest that, but it was also noted that the data did not account for rates per 1000 bed days. The END added that pressure damage had remained on the agenda for a long time and noted that it would most likely always be there because it was a constant risk for Patients and safety and that constant validation was essential.	**JR/RS**

	He added that there was a pressure damage collaborative group which looked at all of the data and reported back to the team for use in the Quality Indicators Report. It was noted that the END had requested permission from the CEO to contact Health Boards in NHS England to understand what their collaborative was working to and they noted that by early 2023 there should be benchmarking data to provide to the Committee. The IMU asked if the Clinical areas using the HappyOrNot feedback systems received the positive feedback as noted in the report because one area had not received the feedback when the IMU had undertaken a Patient Safety walkaround. The ADPE responded that all Clinical areas should receive their feedback and noted that she would send the relevant Clinical area their feedback for the one that was missed. The Vice Chair concluded that it was pleasing to read within the report that the approach was to focus upon improving the overall system, and ensuring that 'as few things as possible go wrong' and 'as many things as possible go right'. Further, that there was a focus upon the whole system shift in which the Health Board's QSE priorities in Community and Primary Care carried equal attention to that in the Secondary and Tertiary care services. **The QSE Committee resolved that:** a) The content of the report and the developing process to monitor Quality Indicators was noted.	**AH**
QSE 22/11/008	**Maternity Services Update - Verbal** The verbal Maternity Services Update was received. The END advised the Committee that an unannounced visit from the Health Inspectorate Wales (HIW) had been undertaken in November 2022. He added that from that visit, further correspondence had been received regarding significant improvement plans which had been worked through to complete the assurance plan. It was noted that the Health Board was awaiting further correspondence and that more details could be provided in the Private session of the Committee. The END concluded that as soon as the final report was published and the Health Board had completed the action plan, it would be received by the QSE Committee for assurance in 2023. **The QSE Committee resolved that:** a) The verbal Maternity Services Update was noted.	
QSE 22/11/009	**HIW Activity Overview Including:** ***a) HIW Report regarding the Emergency Unit*** ***b) HIW Report from visit to Stroke Centre*** ***c) HIW Report regarding Cardiothoracic services*** The END advised the Committee that he would take the paper as read and that he had a good relationship with the HIW. The purpose of the report was to provide the Committee with an overview of the reviews and inspections carried out by HIW. It was noted that unannounced inspections undertaken by HIW had allowed HIW to see the services in the way they usually operated. The inspections had focused on 4 themes which included: • Quality of the Patient experience • Delivery of safe and effective care • Quality of management and leadership • Delivery of a safe and effective service The END advised the Committee that HIW had undertaken unannounced visits in 5 areas which included:	

	• Cardiothoracic Services UHL: It was noted that no immediate concerns were identified and that an update had been provided to HIW on completion of the Improvement Plan and that all actions had been completed, with the exception of relocating Cardiothoracic Surgery to UHW (planned for May 2023). • Emergency Unit and Assessment Unit UHW: It was noted that HIW had acknowledged that staff were working extremely hard in very challenging circumstances and that they had welcomed the inspection team. A number of immediate improvements were identified by HIW, and an action plan was developed and submitted to provide immediate assurance. It was noted that good progress had been made with regards to the implementation of the Improvement Plan, but some actions remained in progress. • Stroke Services: The END advised the Committee that a national review of Patient flow in the Stroke pathway had commenced in 2021 and that throughout the review HIW were considering how Health organisations in Wales addressed access to acute care at the right time and considered if care was received in the right place. It was noted that the report and associated recommendations and improvements would be reported to the Committee upon publication. • Maternity Services: The END advised the Committee that as previously mentioned, a number of immediate assurances recommendations were issued following the inspection and that the report and associated improvements would be presented to the Committee upon publication by HIW. • Nuclear Medicine Department UHL It was noted that an IRMER compliance inspection was undertaken in UHL in October 2022 and that initial verbal feedback was overall positive, with no immediate concerns identified. The END concluded that the report and any associated improvements would be presented to the committee upon publication by HIW. **The QSE Committee resolved that:** a) The assurance provided by the progress made against the improvement plans was noted b) The recent inspections in Maternity and Nuclear Medicine that were yet to be published were noted.	**JR** **JR** **JR**
QSE 22/11/010	**Community Health Council Reports** The Community Health Council Reports were received. The END advised the Committee that he would take the reports as read and noted that the Committee had made the decision that the Health Board would start reporting on visits that the Community Health Council (CHC) had undertaken. It was noted that the main themes highlighted by the reports included: • Lack of Day Room and TV facilities • Improvement required to showering facilities for patients with mobility issues • Improvement required to storage facilities • Improvement required to parking availability The END concluded that the CHC reports provided great emphasis on Patient feedback and that the Clinical Boards would progress the required actions, and all improvement plans were approved	

	by the END, the Executive Director of Strategic Planning (EDSP) and were signed off by the CEO prior to submission to the CHC. **The QSE Committee resolved that:** a) The contents of the report and the CHC feedback and recommendations were noted.	
QSE 22/11/011	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Director of Corporate Governance (DCG) advised the Committee that there were a number of new risks linked to Patient Safety which were received by the Board last week. She added that the new risks included: • Maternity • Critical Care • Cancer • Stroke • Planned Care. Further, that the 2 risks were already on BAF, namely: • Patient Safety • Urgent and Emergency Care It was noted that the highest scoring net risks were: • Patient Safety with a score of 20 • Maternity with a score of 20 • Critical Care with a score of 20 The DCG concluded that the risks had been linked to the END, the EMD and the COO and they would be jointly responsible for the risks going forward. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	
QSE 22/11/012	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Committee that the risks on the CRR were the risks held corporately across Clinical Boards and Corporate Directorates. It was noted that at the Health Board's November 2022 Board meeting a total of 17 extreme risks were reported to the Board and they had related to Patient Safety and were linked to the Quality, Safety and Experience Committee for assurance purposes. The DCG noted that at the November Strategy and Delivery Committee meeting, it was confirmed that whilst the Haematology risk had remained on the Haematology Risk Register since 2010, it was certainly not the case that the risk had been left unmanaged and that detail had now been added to the CRR to reflect the actions and work which had been undertaken in order to address that risk. The IMU thanked the DCG for presenting a fuller picture with regards to the Haematology risk and for capturing all of the proposals that had been attempted in the past to manage that risk, so that anybody coming afresh to the Health Board could receive assurance that the risk had been actively managed as best at it could be. **The QSE 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 22/11/013	**Safeguarding Annual Report** The Safeguarding Annual Report was received. The END advised the Committee that the Safeguarding Annual Report was received by the Committee every year and that it provided a backward look at the significant amount of work that the Safeguarding team had achieved each year. It was noted how diverse the agenda of the Safeguarding Report was. It included the introduction of two significant Acts of law in Wales which had impacted on the safeguarding workstream across the Health Board and had required significant changes in process, additional training and supervision as well as the relocation of existing resources. The END added that further legislation from the Home Office had also defined the need to raise awareness of Domestic Homicide and Female Genital Mutilation (FGM) and Modern Slavery. He added that it was important to note the implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) which had determined much of the safeguarding work undertaken across Wales. It was noted that the report captured all of that work implemented and provided assurance to Committee that the onward focus of the team was to continue to maintain the safety of adults and children in Cardiff and the Vale. The CC noted that the QSE Committee meeting fell at the beginning of the white ribbon campaign which was a campaign to eliminate violence against women and girls and noted there was a lot of activity around the campaign. She asked if there was anything else the Committee needed to be aware of as the reporting period was from April 2021 until March 2022. The END responded that the only other area to mention was that safeguarding formed part of the Health Board's mandatory training. He highlighted the challenges and difficulties for staff to maintain their mandatory training, although he added that the safeguarding modules tended to be the highest completed within the Health Board because staff recognised the importance of safeguarding. The Vice Chair asked to what extent since March 2022 had Liberty Protection Safeguards (LPS) featured in discussions. The END responded that the Health Board was trying to ensure that safeguarding was aligned to LPS whilst noting that LPS had been "on the horizon" for a long time and it was unknown when it would come into effect. He added that safeguarding would be the fundamental bedrock of LPS moving forward The IMU asked to what extent did the Health Board oversee and capture the mandatory training of independent contractors, such as dentists and GPs. The END responded that as part of All Wales contracts, external contractors were expected to complete their mandatory training in line with the Health Board's requirements. The DMD added that under the contract between those independent practices and the Health Board, there was an obligation upon the contractors to maintain training and that they were also subject to reviews as part of that contract. **The QSE Committee resolved that:** a) The assurance provided by the Annual Report 2021/22 was noted	

QSE 22/11/014	**Mortality Indicators Update** The Mortality Indicators Update was received. The EMD introduced the paper and noted that the report described the development of a more mature reporting structure for mortality. The Assistant Director of Quality and Patient Safety (ADQPS) advised the Committee the Learning from Death Framework set out three tiers of mortality indicators: • Organisational Mortality It was proposed that the Health Board adopted a crude all cause and inpatient mortality as a tier 1 mortality indicator • Clinical Board Mortality It was noted that the identification of Clinical Board mortality indicators would further support the proposed approach to mortality oversight and learning from death could be achieved by identifying trends in mortality data that supported additional actions and scrutiny. • Speciality Mortality It was noted that once Tier 2 indicators (Clinical Board Mortality) were established, work would progress to identify appropriate indicators in each Directorate. The ADQPS noted that there were multiple clinical databases in use across the organisation and mortality data was included in many of those resources and the Specialties that benefited from those included: • Emergency laparotomy surgery • Neonatal Unit • Intensive Care • Interventional cardiology • Renal • Trauma and orthopaedics It was noted that the Learning from Death Framework would support an approach of systematic Ward to Board reporting and monitoring of mortality, robust and accurate mortality data which needed to be made readily available. The CEO advised the Committee that benchmarking would be important and consideration would be required as to how to embed that into the system. Her concern was that a rate could mask the numbers, hence why reporting the numbers was important. The Executive Director of Public Health (EDPC) advised the Committee of the work done carried out in relation to fatal drug poisoning and suggested that it would helpful to link the work with the Mortality Framework in the Health Board. She added that she would welcome a discussion with the EMD offline The DMD advised the Committee that as a Health Board, Cardiff and Vale had always been information rich and noted that what the ADQPS had proposed was a way of looking at the mortality information in a structured way. **The QSE Committee resolved that:** a) The approach proposed as part of the Learning from Death Framework and the assurance it would provide was noted. b) The proposed Tier 1 Mortality Indicators were approved c) The proposed Tier 2 Indicators were noted.	**FK/MJ**
QSE 22/11/015	**Policies for ratification including:** 1. Concerns, Complaints, Claims Policy (UHB 332) 2. Medical Equipment Policy and Procedure (UHB 082)	

	3. Ionising Radiation Policy (UHB 344) 4. Exposure of Patients to Ionising Radiation Procedure (UHB 345) 5. Radioactive Substances Risk Management Policy (UHB 463) and Procedure (UHB 464) 6. Exposure of Staff and Public to Ionising Radiation Procedure (UHB 465). 7. Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365) The END advised the Committee that all of the policies had been received by their appropriate clinical groups and noted that the purpose of the Committee was to ratify each one and to recommend the Concerns, Complaints, Claims Policy to the Board for approval. **The QSE Committee resolved that:** a) The Medical Equipment Management Policy (UHB 082) and Management of Medical Equipment Procedure (UHB 082) was ratified b) The Radioactive Substances Risk Management Policy (UHB 463) was ratified. c) The Radioactive Substances Risk Management Procedure (UHB 464) was ratified. d) The Exposure of Staff and Members of the Public to Ionising Radiation Procedure (UHB 464) was ratified. e) The Ionising Radiation Risk Management Policy (UHB 344) was ratified. f) The Exposure of Patients to Ionising Radiation Procedure (UHB 345) was ratified g) The Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365) were ratified. h) The Concerns, (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy (UHB 332) was recommended to Board for approval	
QSE 22/11/016	**WHSSC QPSC Chair's Report** The WHSSC Quality & Patient Safety Committee Chair's Report was received. The DCG advised the Committee that WHSSC had requested that the Committee note the report and that any questions raised could be referred back to WHSSC. The Vice Chair advised the Committee that he was the Chair of the WHSSC QPSC and noted that he could answer any questions that were raised. No questions were raised. **The QSE Committee resolved that:** a) The WHSSC QPSC Chair's Report was noted.	
QSE 22/11/017	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. The CC asked when the Clinical Effectiveness Committee (CEC) would meet next. The ADQPS responded that the next meeting of the CEC was 13 December 2022. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 22/11/018	**Items to bring to the attention of the Board / Committee** The ADPE advised the Committee that the Concerns, Complaints, Claims Policy needed to be received and approved by the Board.	

QSE 22/11/019	**Agenda for Private QSE Meeting** i) Minutes of the Private Committee Meeting held on – 30.08.22 ii) Any Urgent / Emerging Themes – Verbal iii) Maternity Services Update – Ockenden Framework Review iv) DNAR Orders at St David's Hospital – Update	
QSE 22/11/020	**Any Other Business** No other business was raised.	
QSE 22/11/021	**Review of the meeting.**	
	Date & Time of Next Meeting: Tuesday, 10 January 2023 via Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 10 January 2023
(Following the meeting held on 29 November 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/06/006	**Clinical Diagnostics & Therapies Clinical Board Assurance Report**	The CBDCDT to meet offline with the IMTU to discuss mitigation measures in relation to the risk rating of 16 for the backlog and waiting lists.	**29.11.2022**	Meriel Jenney/Sue Bailey	**COMPLETED** **Updated on 29 November 2022** Agenda - item 2.7
QSE 22/06/008	**Mortality Indicators**	Update to be provided to the Committee in November, to include RAMI in Intensive Care.	**29.11.2022**	Meriel Jenney	**COMPLETED** **Updated on 29 November 2022** Agenda – item 2.10
QSE 22/06/008	**Mortality Indicators – format of report paper**	The Executive Medical Director to consider the format of the RAMI report paper in time for the next RAMI update to the Committee.	**29.11.2022**	Meriel Jenney	**COMPLETED** **Updated on 29 November 2022** Agenda – item 2.10
QSE 22/06/010	**HIW Activity Overview**	HIW Report from visit to Stroke Centre Committee to receive copy of the HIW Report regarding Cardiothoracic services HIW Report from visit to EU	**29.11.2022**	Jason Roberts	**COMPLETED** **Update on 29 November 2022** Agenda – item 2.5
QSE 22/11/007	**Quality Indicators Report –**	The Assistant Director of Patient Experience to send the HappyOrNot		Angela Hughes	**COMPLETED**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
	HappyOrNOt feedback	feedback to the Clinical area that had not received the same.			Sent out following QSE meeting on 29.22.22
Actions in Progress					
QSE 22/11/007	**Quality Indicators Report – Cdff**	The Executive Nurse Director and the Deputy Medical Director to undertake a Cdiff root cause analysis and share their learnings with the relevant areas	**10.01.2023**	Jason Roberts/Richard Skone	**Update on 10 January 2023** Agenda item 2.3
QSE 22/11/009	**HIW reports**	Once published, copies of the HIW reports relating to (i) Stroke Services, (ii) Maternity Services, and (iii) Nuclear Medicine, to be reported to the QSE Committee.	**10.01.2023**	Jason Roberts	**Update on 10 January 2023** Agenda item 2.4
QSE 22/11/014	**Mortality Indicators Update**	The Executive Director of Public Health asked the Executive Medical Director if the work done around fatal drug poisoning could link the work with the mortality framework in the Health Board and that a conversation would be required offline.	**10.01.2023**	Meriel Jenney / Fiona Kinghorn	**Update on 10 January 2023** via Action log discussion
QSE 22/08/013	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response**	Progress had been made and would be presented to the Committee.	**07.03.2023**	Nicola Foreman	**Update on 7 March 2023**
Actions referred to Board / Committees					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 22/06/008 **QSE 22/02/008**	**Board Development**	The Chair asked for a future Board Development to have sight on the information discussed on: • Healthcare Standards • Duty of Candour • National Quality Framework • Annual Quality Statement	23 February 2023	Jason Roberts/ Nicola Foreman	**Update on 23 February 2023** Original Board Development Session date of 25 August has been postponed. Now scheduled to go to the Board Development Session in February 2022.
Actions referred FROM Board / Committees					
UHB 22/09/011	**Integrated Performance Report**	The IMU asked at the Board meeting for the management approach to mitigating the pressure damage issues be explored further, at the Quality, Safety and Experience Committee.	10 January 2023	Jason Roberts	**Update on 10 January 2023** **See agenda item 2.7**

Report Title:	QSE Surgical Clinical Board Assurance Report				Agenda Item no.	2.1
Meeting:	QSE Committee Meeting		Public	X	Meeting Date:	10th January 2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Nurse Director Jason Roberts					
Report Author:	**Clare Wade- Director of Nursing for Surgery Clinical Board and Carolyn Alport Clinical Leader for Quality and safety**					

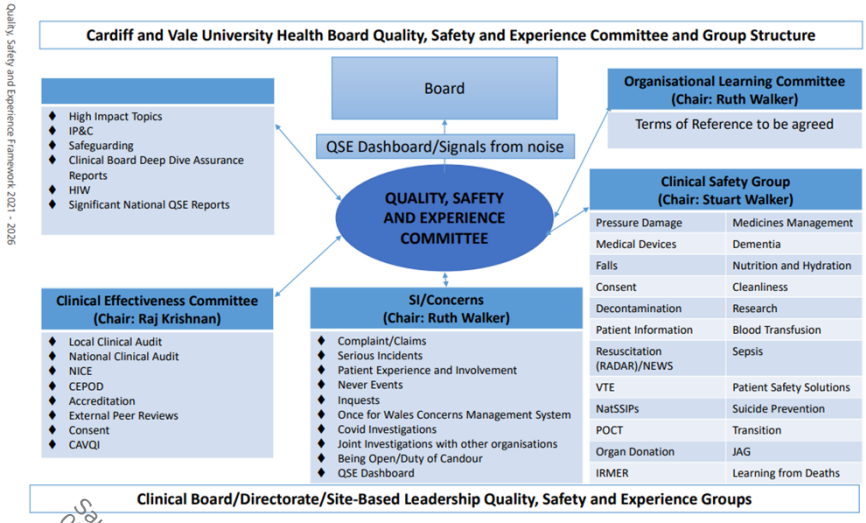
Main Report

Background and current 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 2022.

We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services that deliver excellent user experience. These eight key areas are:

- Safety Culture
- Leadership and the Prioritisation of QSE
- Experience and Involvement
- Patient Safety Learning and Communication
- Staff Engagement and Involvement
- Data and Insight
- Professionalism of QSE
- Quality Governance Arrangements



Between January 2022 – December 2022 the Surgery Clinical Board had 6 Service Specialities 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, Dental and Perioperative Care. The Clinical Board employs over 2209 whole time equivalent (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 and Sterile Services.

Whilst many 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 newly appointed Asst Director for QSE and Value based health care 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 recovery and operational pressure these groups have not met at such regular intervals due to the challenges of the environment and challenges of workload in 2022

The plan for 2023 is to revisit the agenda for the QSPE meeting using the UHB QSE framework as a guide to driving the agenda forward

Safe Care

Patient Safety Alerts/Internal Safety Notices

The Surgical Clinical Board has a robust process for cascading all Patient Safety Alerts. The designated Quality and Safety Clinical Leader is responsible for maintaining and updating the local surgical Safety Alerts database containing the details of all safety alerts which have been released over the past 12 months together with the evidence to support actions which have been taken. Currently there is 100% compliance.
All notices are shared at the SCB QSE meetings and at the local Directorate Q&S meeting within the SCB.

NRI Management

There has been one reported Never Event since January 2022.

- Wrong side implant – right side knee joint replacement placed in left knee

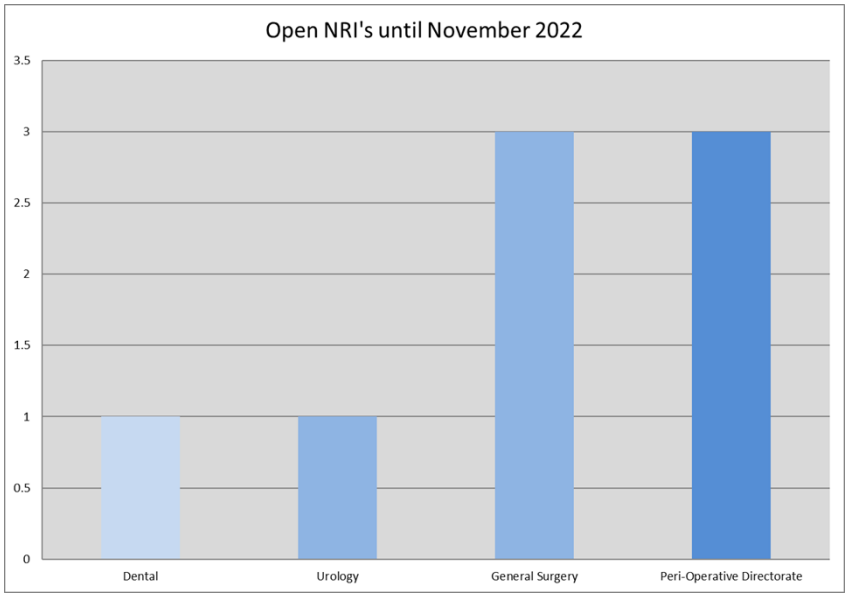
There have been 6 National Reportable Incidents (NRI) recorded between the dates 01/01/2022-31/12/2022 and 1 No surprises events submitted to Welsh Government.

All NRI's are fully investigated and shared with the appropriate clinical teams and Directorate Quality & Safety Groups for learning. Implementation plans are developed and actioned appropriately.

The SCB has been work in partnership with the audit team to promote the use of AMaT to all medical and nursing staff within all Directorates. Surgery have welcomed the opportunity to be one of the first CBs to utilise AMaT and recognises the potential of this system to enable the storage of all NRI investigation action plans and supporting evidence.
This will ensure all lessons learnt from investigations and clinical audits will be stored securely in one place and can be accessed to give assurances and demonstrate service improvement.

A total of 9 closure forms have been submitted since January 2022

Current open NRI's



Themes of NRI

	Total
Assessment investigation and diagnosis	4
Medication, IV fluids	1
Treatment procedure	3
Total	8

Current investigations

- Omission of thromboprophylaxis assessment; patient did not receive pre-operative anti-thromboprophylaxis, and developed a post-operative Pulmonary Embolus (PE)
- Omission of anti-coagulants on discharge for the treatment of a diagnosed PE resulting in the death of the patient
- Missed oncology histology reporting resulting in delay in follow up and diagnosis

- Oncology patient lost to follow up, resulting in delayed diagnosis and treatment
- Peri-operative Hypoglycaemic episode
- Patient had additional procedure due to missing instrument
- Failure to follow up echo report
- Nerve damage during dental procedure

3 incidents are on target to be closed by the end of December 2022.
2 are subject to His Majesties Coroners Inquests. 1 hearing, planned in November 2022 from a case in 2021 was postponed and has been rearranged for 16th of January 2023

When the predicted closures are submitted on time there will be a total of 2 overdue closures,
and 5 outstanding NRI's outstanding.

The failure to provide anti-coagulant treatment on discharge of a patient resulted in the immediate circulation of a memo to all medical staff signposting them to the policies and guidance for anti-coagulation therapy in cancer patients diagnosed with a Pulmonary Embolus.

With reference to the coroner's hearing in January 2023. The importance of inter-directorate working, and shared learning has been demonstrated when lessons were learnt for both the Emergency Unit, Patient Access and General Surgery following a patient death in 2021.

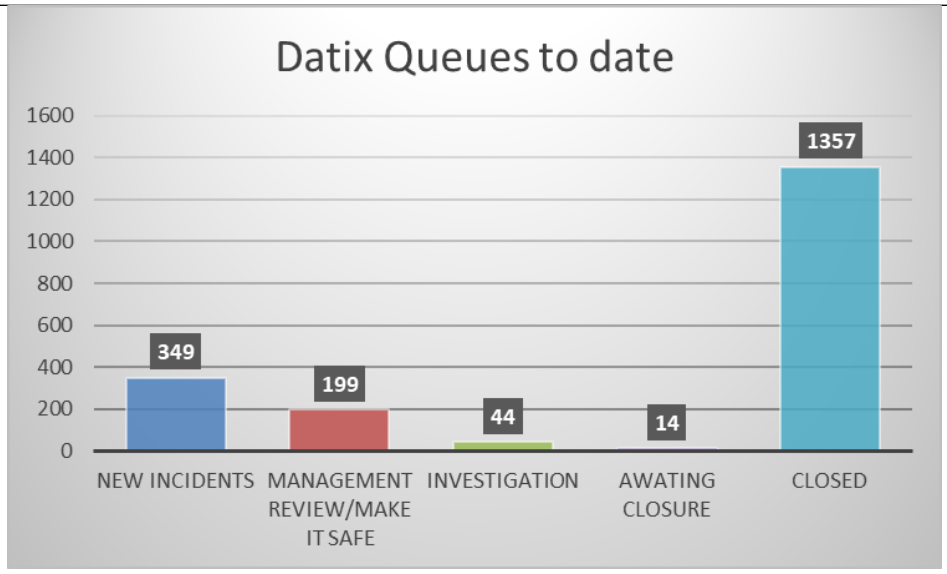
Due to the lack of recognition of this patient's need to continue receiving non-invasive ventilation (NIV) after admission, the home oxygen team, and medical teams have succeeded in their application for NIV flags to be added to Workstation, which will highlight existing patients with NIV needs to ensure their specific needs are escalated and to make it safer for patients who are admitted through the emergency stream.

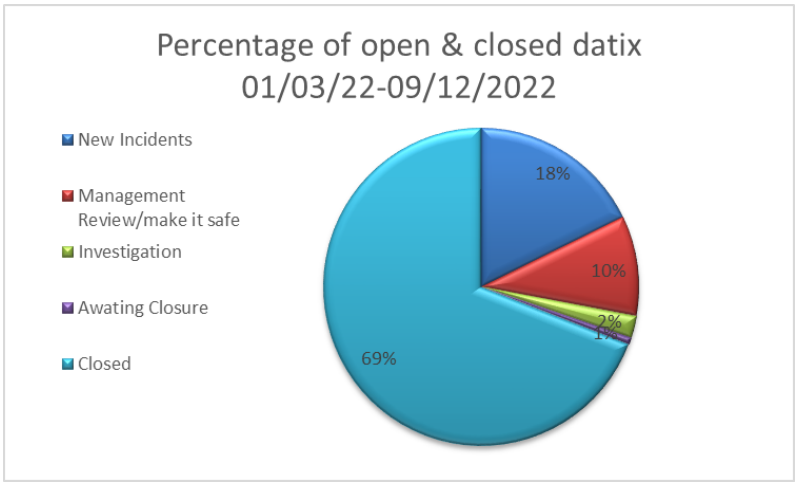
Staff have received further training and placement guidance has been updated to ensure patients are admitted to the safest wards for their primary needs.

Patient Safety Incident Management

The Surgical Clinical Board seamlessly transitioned over to the new Datix Cymru reporting system on the 1st of March 2022. Although the system continues to throw up many challenges with regards to what reports can be pulled there has not been any noticeable reduction in reporting since its implementation. Considerable Support and training have been given to the staff to manage the reported incidents, with a total
of 167 staff having completed incident manager training. Continued support is given by the Quality & Safety Leads within the SCB

The current open Datix totals 619, with a closure rate of 68% (table 3& 4). Queues are reviewed regularly by the Quality & Safety Leads, and plans are in place to expedite closures and reduce queues, however there are still several challenges due to staff workloads, although the clinical board remain confident that this is possible with support and education

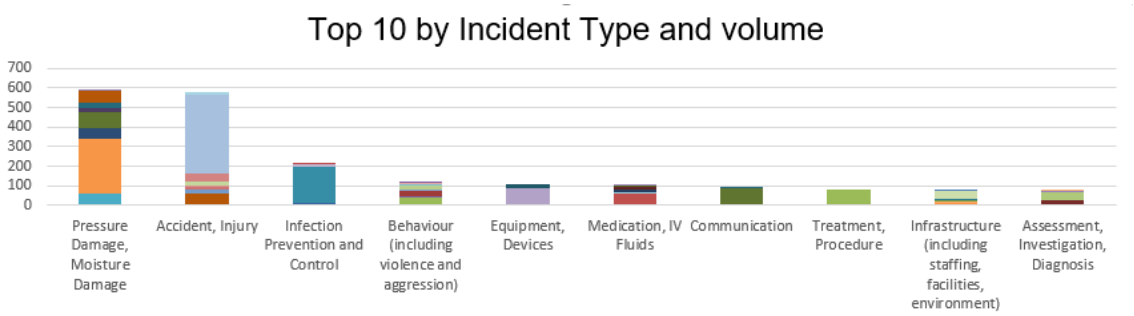




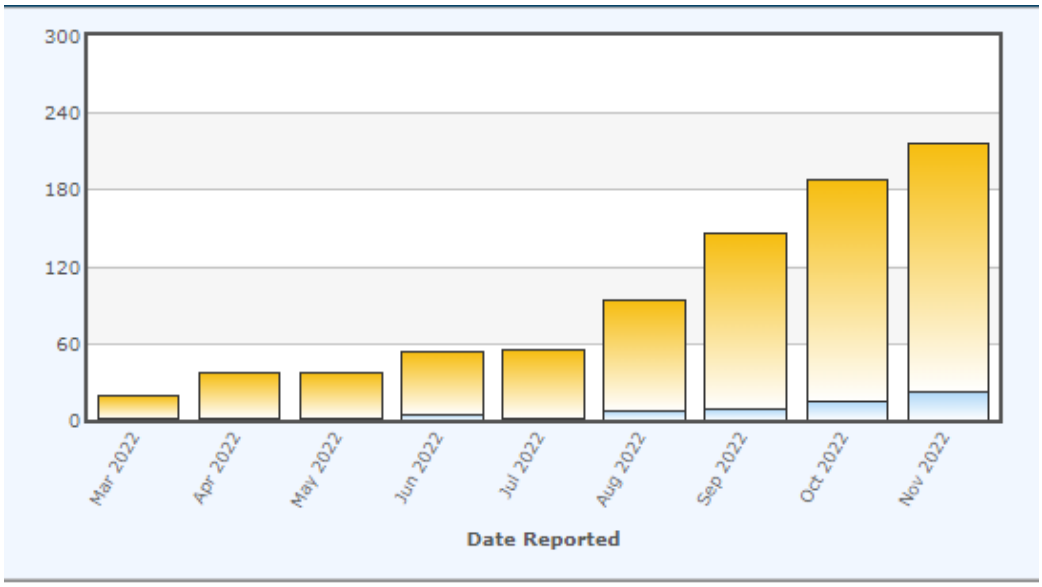
The SCB has representation at the Patient Safety Datix Cymru Group meetings, in which overall Datix progress can be monitored against expectations and issues and or glitches can be raised, shared, and resolved with other Clinical Boards.

Due to this joint working, bespoke Datix Dashboards were created for each CB and surgery can monitor its KPI's immediately.

Top 10 incidents

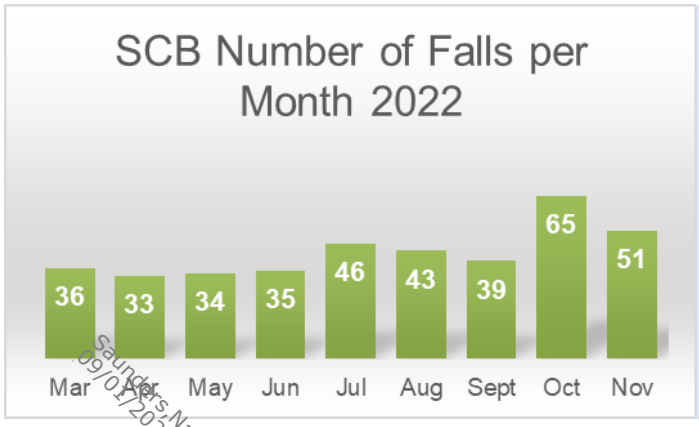


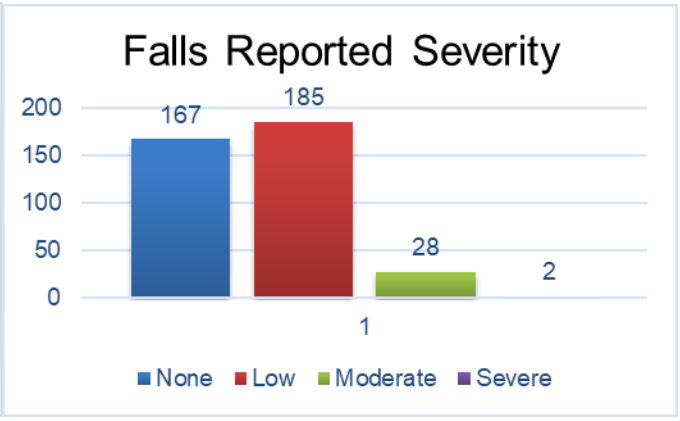
Open incidents by the end of the month



Falls

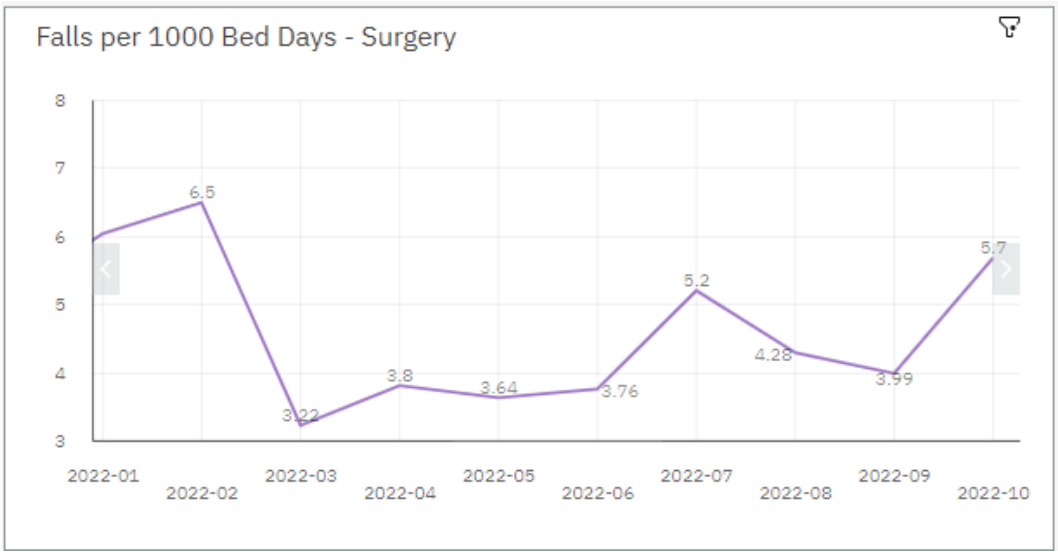
Falls remain in the top three reported incidents within the Surgical Clinical Board. From 01/03/2022-30/11/2022, there were 382 reported falls. The total number of falls are broken down into monthly reports with reported severity as demonstrated in table 7 below.





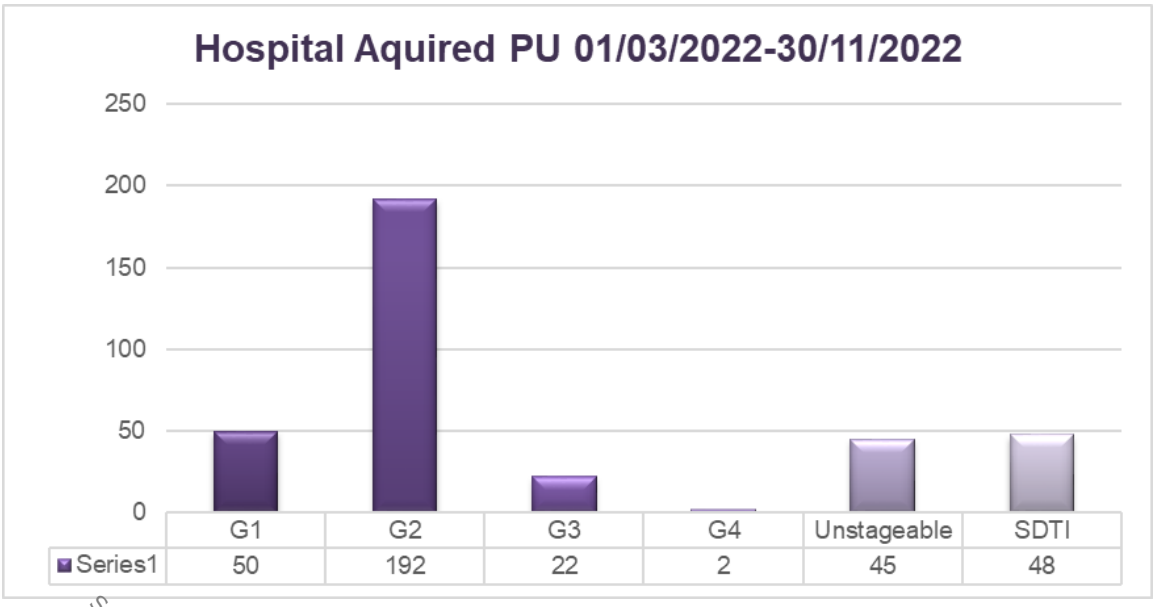
There have been 5 reported injurious falls. 3 in general surgery, (1 Aug, 1 Sept,1 Nov 2022) and 2 in T&O in Sept 2022. All were investigated using the focused review tool and escalated to the senior nurse teams, after review, all were concluded as unavoidable. All injurious falls are discussed at scrutiny panel with the Patient Safety Team, to date the falls discussed have not met the National Reporting criteria as set out by the Delivery Unit.

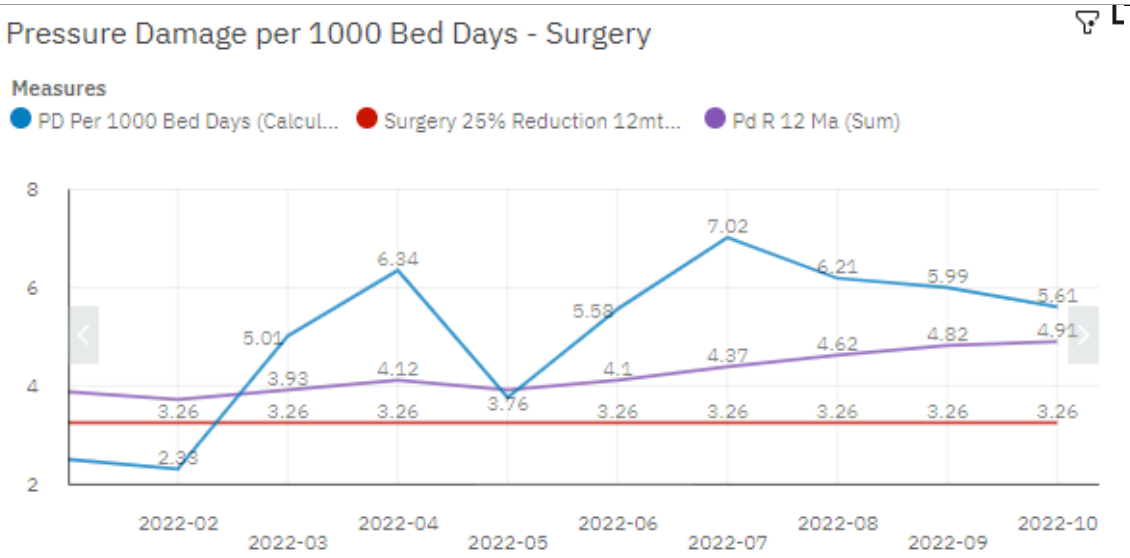
Falls per 100 bed days



Pressure and tissue damage reduction and prevention

Between 01/03/2022-30/11/2022 a total of 359 hospital acquired pressure ulcers were reported and are broken down into categories as below -





Pressure Ulcer prevention and reduction is a priority for the SCB. The Director of Nursing Leads the pressure damage collective, the most recent meeting took place on10/11/2022. In particular it has been noted that the Purpose T tool is poorly completed, so there is ongoing work to educate staff in its use. As we move forwards after covid there has been a noticeable increase in face-to-face training, also in support of the staff repose product representatives are attending wards to undertaking training in heel offloading devices.

The Director of Nursing has requested the setting up of a pressure ulcer scrutiny panel within Surgery, and measures have been taken to facilitate this. The panel is expected to be in place by the end of January 2023, the Surgical scrutiny panel will mirror other Clinical Boards giving a robust approach to reviewing reported pressure ulcers and giving managers an opportunity for discussion and learning in a supportive forum.

As one of our vascular wards, B2, has been singled out as a model ward for assessing and managing pressure ulcers, our intention would be to use B2 as the pilot ward, followed by a roll out to all other wards within 2 months.

In addition, Pressure Ulcer collaborative Advisory Member training (PAM) has been piloted on specific wards within the UHB, including B2 vascular. With link nurses at ward level, good practice will be embedded and promote an early intervention culture to reduce pressure ulcers in the ward areas.

Safeguarding

All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals, with appropriate actions taken and shared more widely if required.

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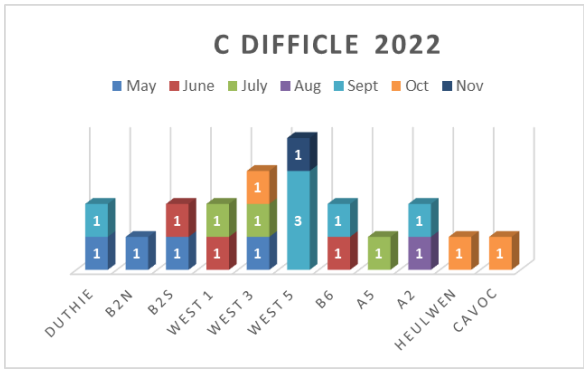
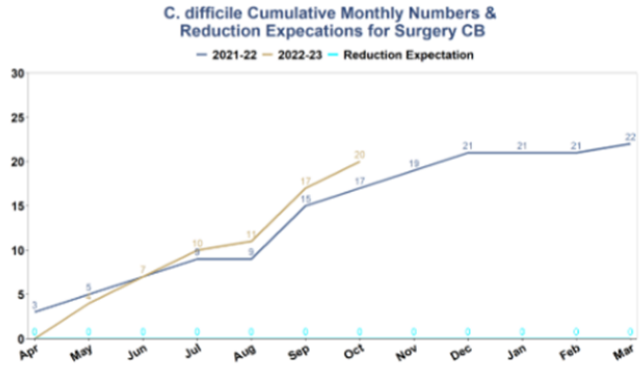
Infection, Prevention and Control

C Difficile

C- Difficile cases are increasing compared to November 2021. There have been 23 reported cases from April-November 2022, compared to 17 cases at the same period in 2021. 3 cases reported on West 5 in September 2022 were identified as an outbreak, the IPC CNS has worked with the staff to investigate and look at practice.

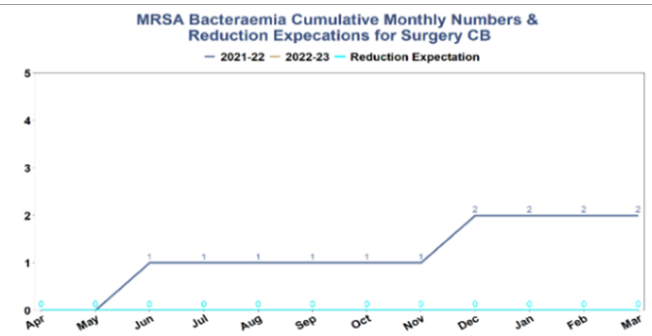
Regular meetings are held with the ICP CNS to understand root causes, there are no current concerns and assurance has been given that all cases of C-Diff are being managed appropriately. RCAs are undertaken and lessons learnt are shared with teams at the Ward Manager's Professional Nurses meetings. Common themes have been identified as - elderly age groups, with several co-morbidities, and complex histories, presenting very unwell, requiring several different antibiotics, in line with microbiology guidance and prescribing.

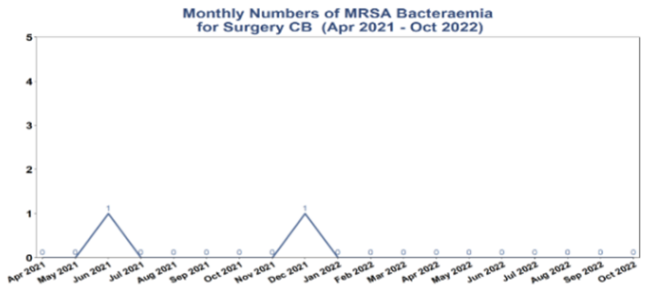




MRSA

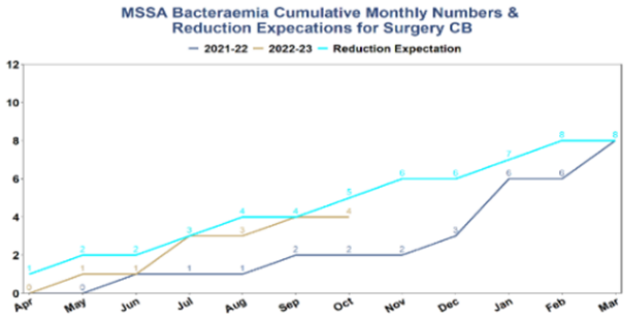
The SCB are pleased to report there have been zero cases of MRSA since January 2022.





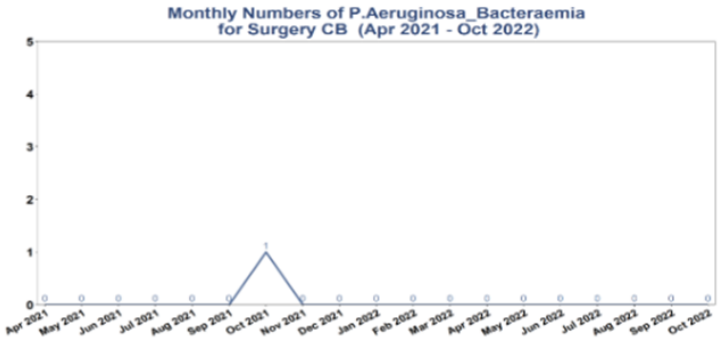
MSSA

The overall accumulative up until October 2022 totals 4 cases. 1 case in May, 2 cases in June and 1 case in September. The sources of infection have been categorised as - skin / wound infection, PVC/CVC, epidural site, and one unknown.



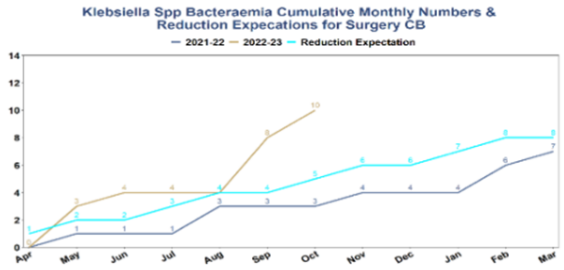
Pseudomonas

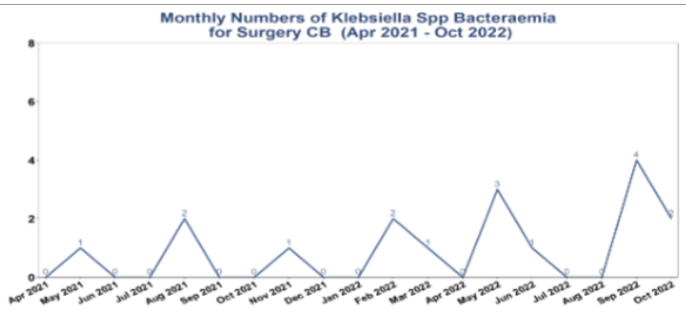
There have been no reported cases of pseudomonas A since October 2021



Klebsiella

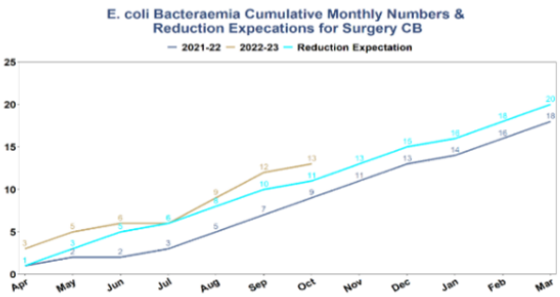
10 cases of klebsiella have been reported between April 2022 – October 2022, this is 2 less in comparison to last year at the same point in time. The reported cases were classified as – 2 urinary / renal, 1 bone, I biliary, 1 skin / wound, 4 GI tract, with 1 unknown.

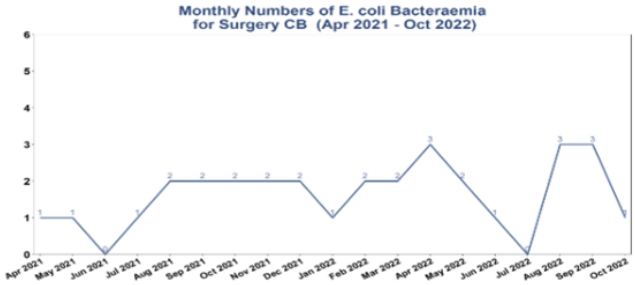




E Coli

13 cases of E coli have been reported between April 2022 - October 2022. Sources reported as 3 urinary/renal,1 biliary, 1 wound, 1 upper GI and 7 unknowns.





Tendable has been set up in all surgical ward areas and demonstrates that regular IPC audits are being undertaken by the staff, which can be immediately visualised and shared with their teams. Hot spots can easily be identified and actioned. The improved version will now allow wards to enter their action plans, against the audit which can then be monitored for improvement.

In addition, Nursing Dashboard training is being rolled out to all Senior Nurses and Q&S Leads. This dashboard is easy to use and captures all ICP data from various sources enabling a real time overview of all areas.

Workforce

Data based on Sept 2022 information

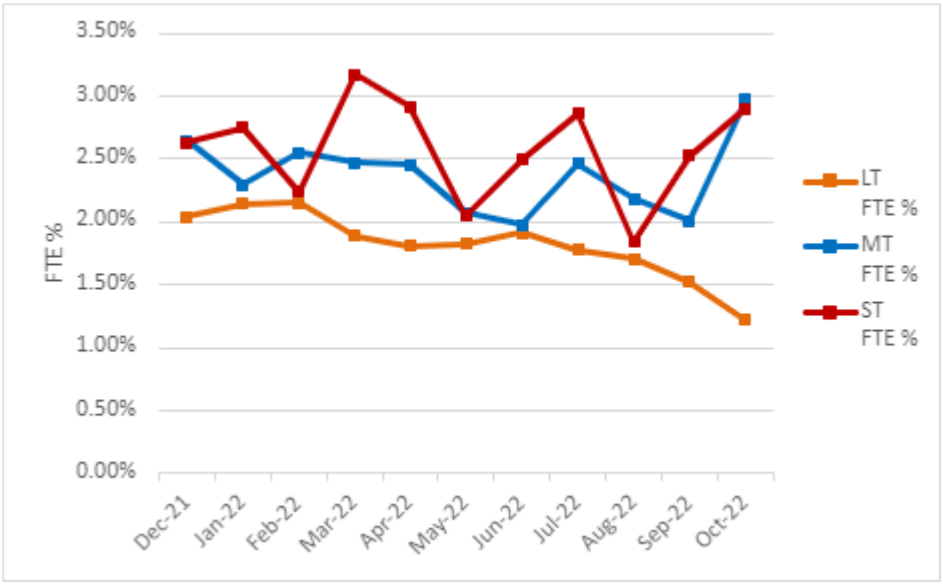
	Performance -September 2022													
Clinical Board	Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical appraisal	e-Job Planning	Stat and Mand	Disciplinary cases	Organisational change projects	Formal R&R cases	Formal UPSW cases	ET cases
Surgical Services	5.22%	£634,358	£1,489,403	10.92%	6.77%	39.19%	86.44%	53.58%	68.76%	1	3			2

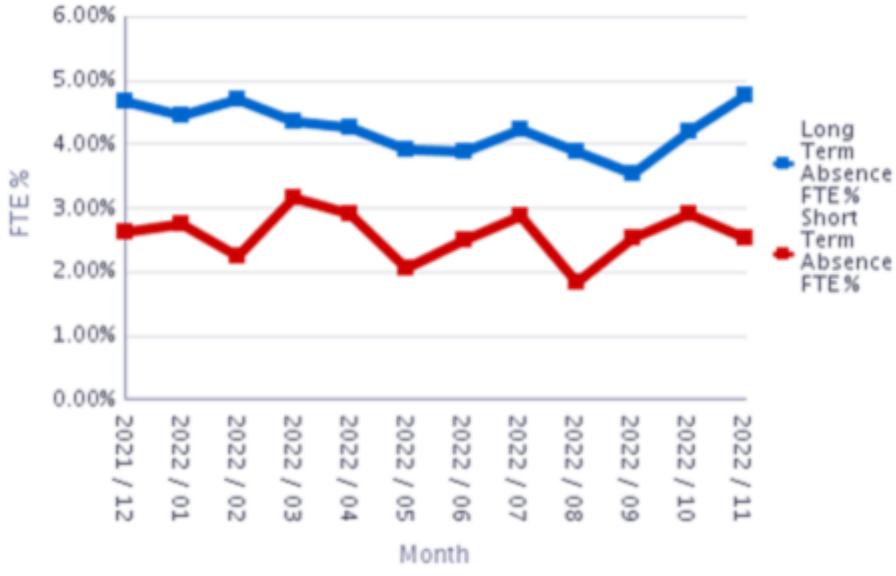
Sickness

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:

- 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 proactive return to work opportunities for staff





Clinical Board	Competence Name	Sum of Assignment Count	% Compliance
⊟Surgical Services	NHS|CSTF|Dementia awareness - No Specified Renewal|	1762	87.91%
	NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	2426	70.73%
	NHS|CSTF|Fire Safety - 1 Year|	2426	59.93%
	NHS|CSTF|Health, Safety and Welfare - 3 Years|	2426	69.04%
	NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	2426	70.94%
	NHS|CSTF|Information Governance (Wales) - 2 Years|	2426	70.94%
	NHS|CSTF|Moving and Handling - Level 1 - No Specified Renewal|	2426	79.18%
	NHS|CSTF|Resuscitation - Level 1 - 3 Years|	2426	65.46%
	NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	2426	66.41%
	NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	2426	65.46%
	NHS|CSTF|Violence and Aggression (Wales) - Module A - No Specified Renewal|	2426	76.83%
	NHS|MAND|Mental Capacity Act - 3 Years|	477	70.65%
	NHS|MAND|Mental Capacity Act - No Renewal|	76	76.32%
	NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	2426	59.52%
Grand Total		29001	69.81%

Resources

Surgery Financial Position as at 30th November 2022

The Board has reported an overspend of £2.342m for the first eight months of the year. COVID related expenditure reported within the summary position relates only to response as the approved recovery schemes are funded each month in line with expenditure incurred.

Response and PPE expenditure have been funded in line with forecast at month 06 in line with WG's funding confirmation.

	In-Month				To Date			
	COVID-19	PPE	Operational	Total	COVID-19	PPE	Operational	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	318		316	**634**	2,545		756	**3,301**
Non-Pay	11	38	128	**177**	96	353	1,707	**2,156**
Income	-143		100	**-43**	121		-66	**55**
Allocation					-2,817	-353		**-3,170**
Totals	**186**	**38**	**544**	**768**	**-55**	**0**	**2,397**	**2,342**

Key Actions

- Plans required from General Managers to deliver the year end control total of £2.277m
- Confirmation that Cancer and Waiting Time profiles to 31st March align to the financial forecast
- Plans required to address the recurrent savings target shortfall alongside progress for 2023/24

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Staff engagement

On October 12th, 2022, the SCB was proud to hold the 'Surgical Stars Awards' in recognition of the extraordinary lengths our staff go to when making a difference for patients. The nominations confirm that the SCB is surrounded by truly compassion and inspirational teams, and individuals who consider going that extra mile 'just doing their job.' Every year we are humbled to read the nominations and stories, and it is always near impossible to separate out the winners.

The night was shared and enjoyed by all in the beautiful setting of Cornerstone, in Charles Street.
The SCB values their staff and is committed to providing them with every opportunity to develop themselves, their teams, and the services; celebrate their success, and reward them for their achievements.
It is hoped that all the positive feedback and stories from the winners will bring inspiration to their teams who we know work exceptionally hard every day to improve and maintain services for all of our patients.

Categories	Winner	Runner-up	Highly Commended
Values	Tracey Parsons - UG	Debbie Stewart - HCSW	Kelly Brown -memory link
Team	B2 Vascular	Duthie	Anne Marie Goggin & Sarah Davies - ENT
Performance	Khitish Mohanty - T&O	Matthew Walley - Theatres	Denise Cars -WBC West 3
Leader	Ceri Chinn -Lead Nurse Peri-op	Heather Woodward - opth	Gayle Williams & Liz Mosca PSEU
Wellbeing	Gemma Saxeby - Audiology	Linda Tilley - SSSU Deputy Ward Manager	Angela Connelly -HCSW West 3
Hero	Gail Callaghan - T&O	Cheryl Chiplen - Medical Records	Laura Jones - PA

VBA's

We are pleased to report an improving continuing picture with VBA's in Surgery Clinical Board

Surgical Services	2075	42.94%
ENT & Dental Hospital	414	71.01%
General Surgery	356	36.24%
Ophthalmology	84	57.14%
Surgery Management	13	69.23%
Theatres, Anaesthetics, SSU & Sterilisation Services	755	31.39%
Trauma and Orthopaedics	399	34.84%
Urology	54	64.81%

Actions to enable sustained improvement:

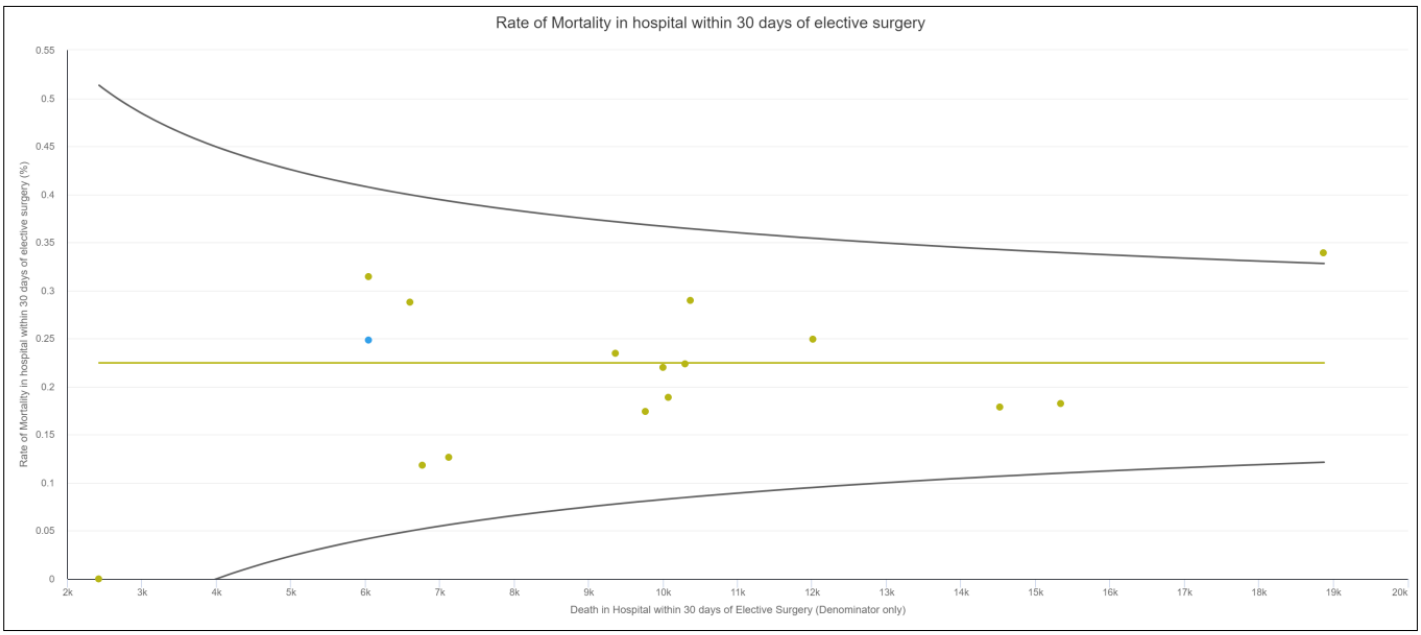
- Managers can access training in how to retrieve their latest reports via the ESR team.
- CB continue to meet with Senior Nurses and Clinical Leaders from Theatres in UHW to give a clear message regarding improvement. The same will happen with Senior Nurses and Clinical Leaders in UHL.
- Encouragement 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 due to operational pressures

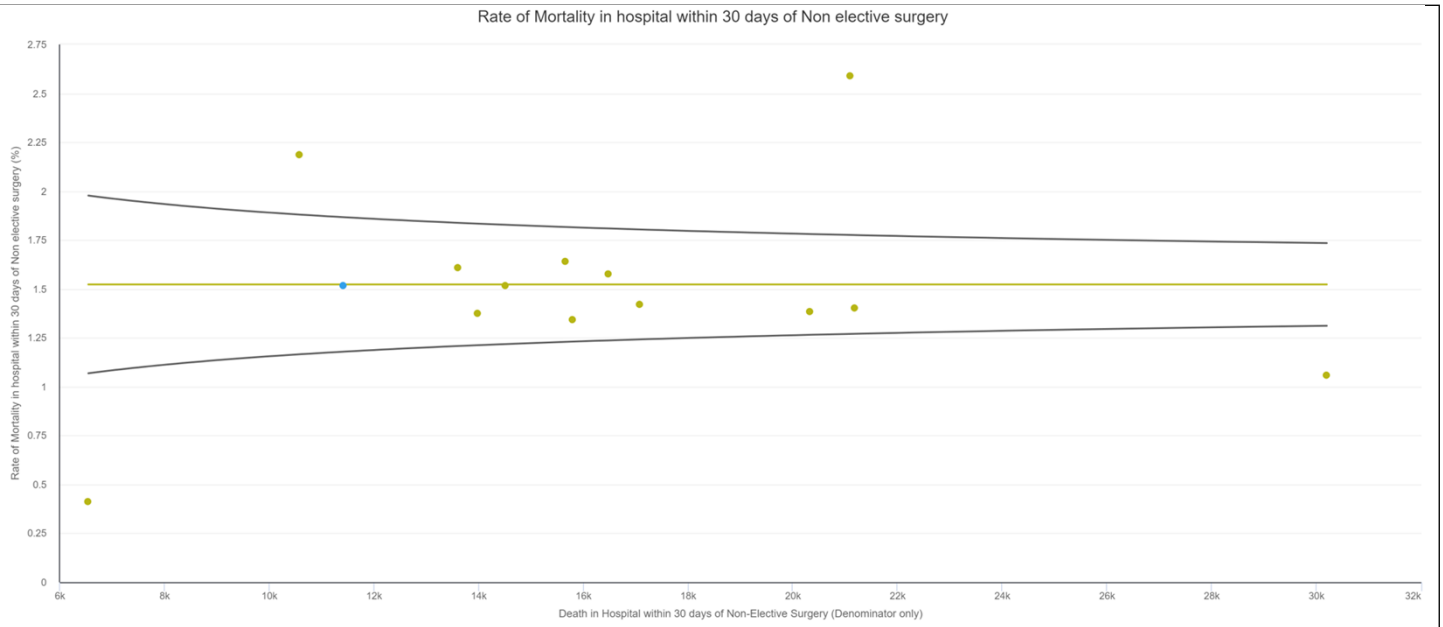
Effective Care

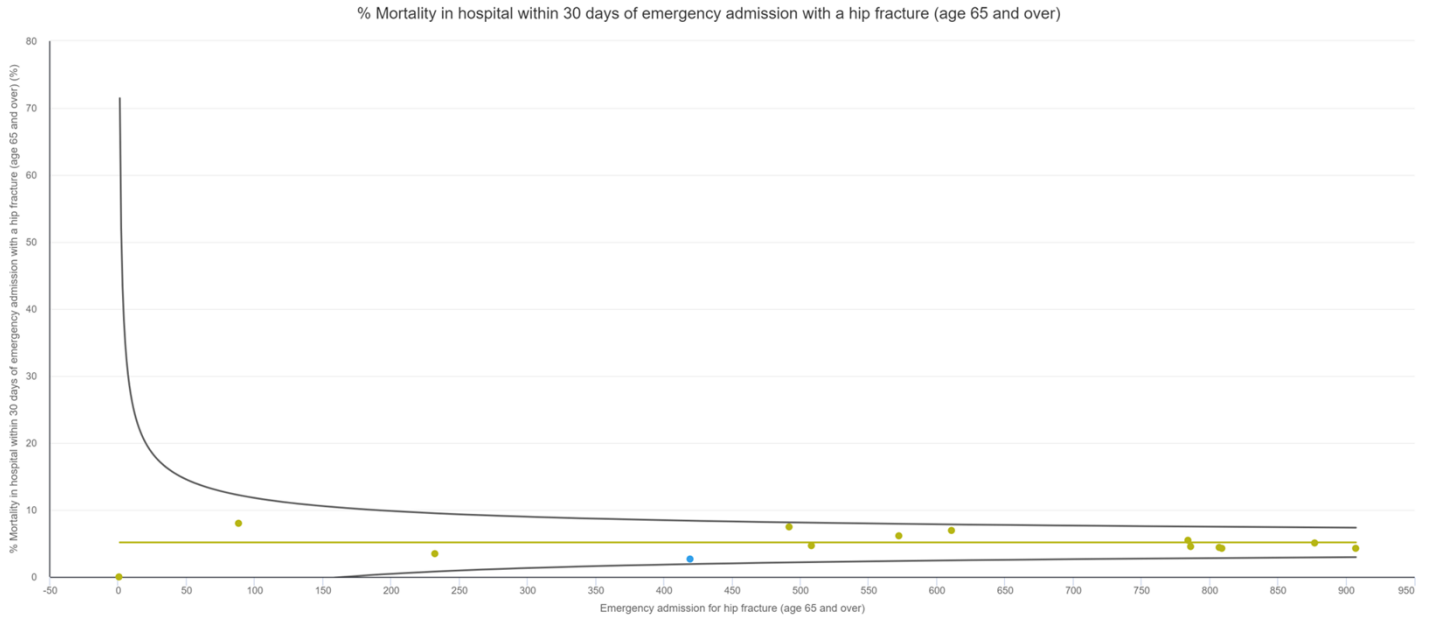
Mortality reviews

Mortality reviews are routinely undertaken as part of Directorate QSPE (Quality, Safety and Patient Experience) meetings in line with the All-Wales Checklist. Mortality Level 2 reviews are undertaken with a proportion shared at Directorate QSPE meetings as a means of discussion and shared learning. The Clinical Board is fully engaged and supportive of the Independent Medical Examiner reviews and form part of the UHB Mortality Group with feedback shared at Clinical Board QSPE meetings.

The below graphs confirm that Surgery Clinical Board are within the 95% percentile for Elective surgery, emergency surgery and hip fracture surgery







National Audit

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 2022/ 2023 . The Clinical Board would welcome the introduction of AMaT (Audit Monitoring and Tracking) to support accurate and timely audit programmes and compliance and so far, 25 Clinical Board Audits have been logged on the AMaT system

5 Steps to Safer Surgery

The WHO 5 Steps to Safer Surgery checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's perioperative journey.

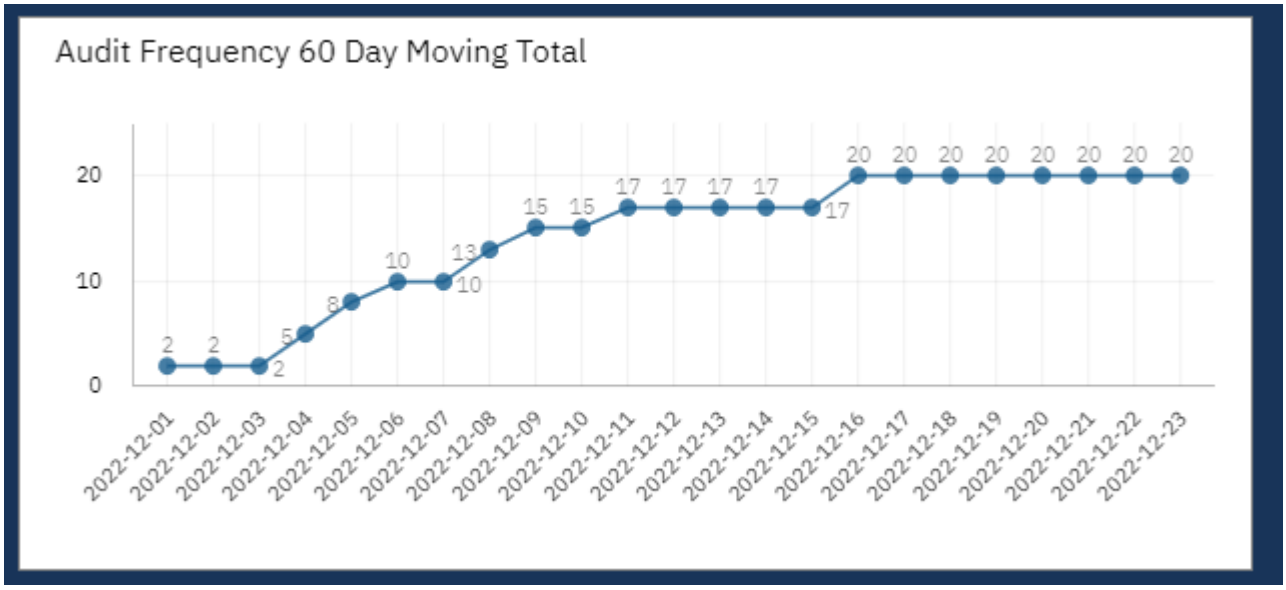
In February 2022 we integrated the checklist into the Theatreman programme in order to be able to accurately audit and monitor compliance and data. Intergrating the system into a programme that was already being used and familiar to theatre staff enabled the process to be embedded into practice in a timelier manner. The programme is set up so that progression through each part of the checklist cannot be achieved before all the

essential criteria has been completed for each of the 5 steps. The Peri-operative Directorate now receive weekly informatics from the IT department which allows areas of non-compliance to be identified and if any support or development is required. The data is providing us with information for each area, speciality, and team. Data has shown that compliance is very good, the majority of areas with non-compliance that have been highlighted to date are those where the Theatreman programme is not currently used, these are areas outside of the Peri-operative Directorate such as Emergency Unit and Interventional Radiology where certain surgical procedures take place. These areas continue to use the paper based approach to the checklist. Recent data for the week of 04/12/2022 shows that out of 1,808 surgeries conducted there were only 4 areas of non-compliance, these related to procedures performed in Interventional Radiology or under local anaesthetic outside of theatre environments.

The 5 Steps to Safer Surgery Procedure has also been updated in line with the new programme, allowing managers and clinical leads to clearly identify the way in which to deal with non-compliance, offering transparency and fairness for all.

Tendable

Tendable allows clinical areas, Senior/Lead Nurses and Infection Prevention and Control, to undertake Core Standard Audits. This is linked to a Nursing Dashboard within Business Intelligence System providing the Clinical Board and Directorates with key Quality and Safety, Patient Experience, Staff Experience/Workforce, and Improvement data. As of the 23rd December there are 19 inspection types logged on Tendable and 20



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 many 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 last year

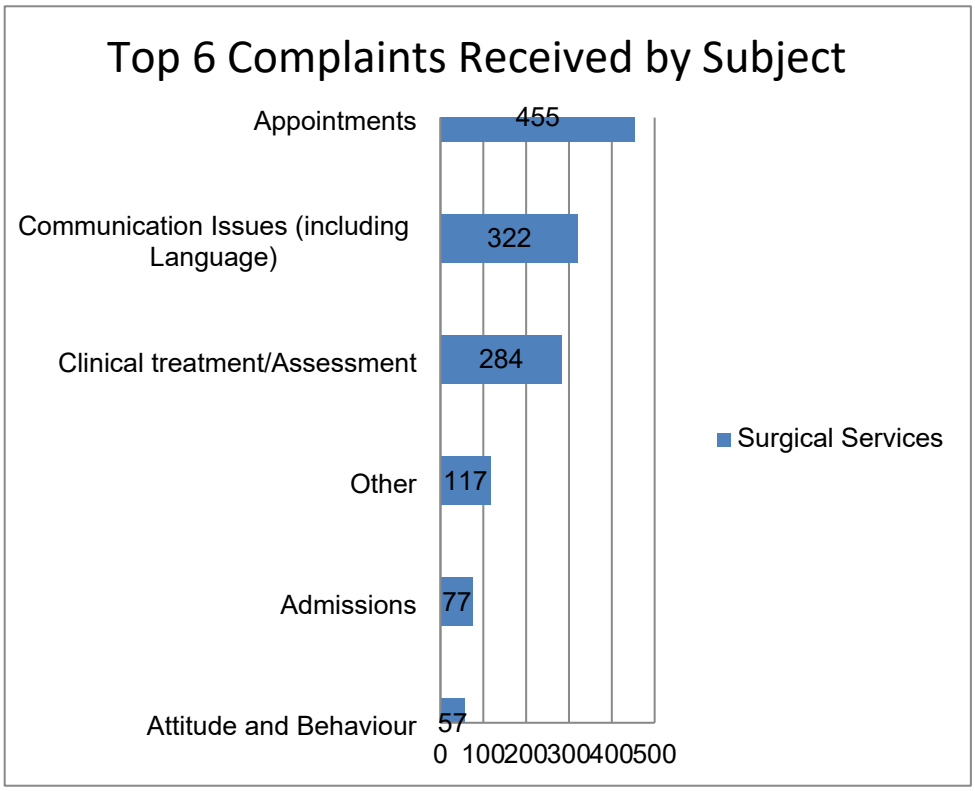
Person centered Care

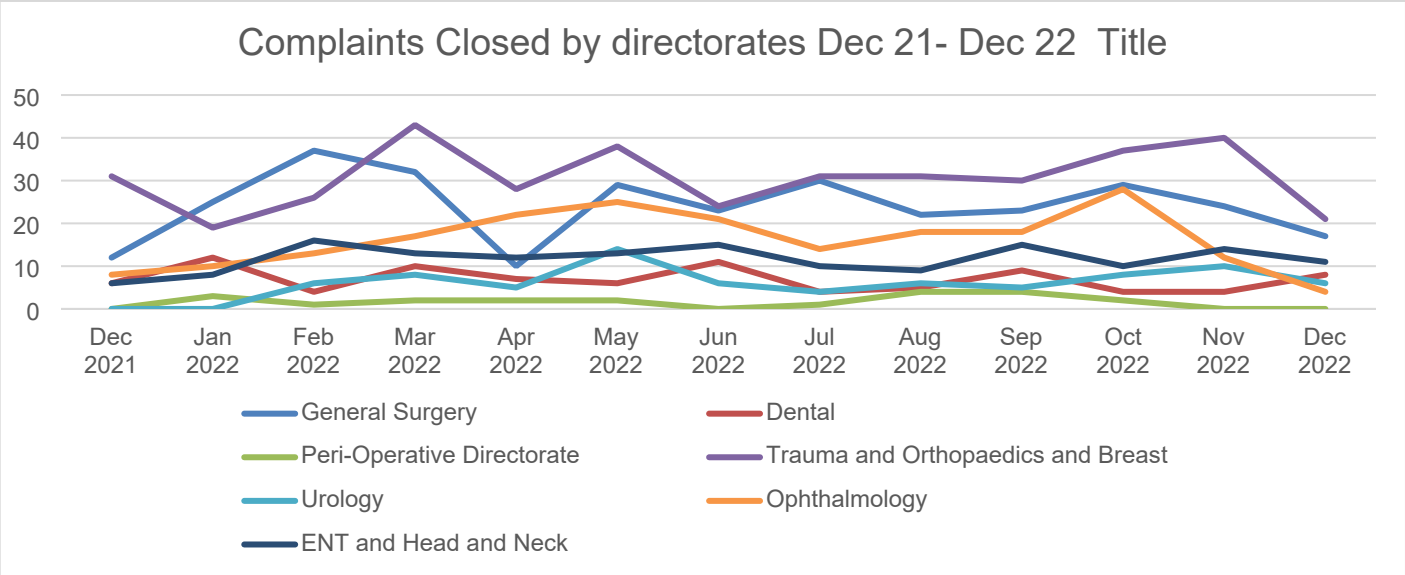
Concerns

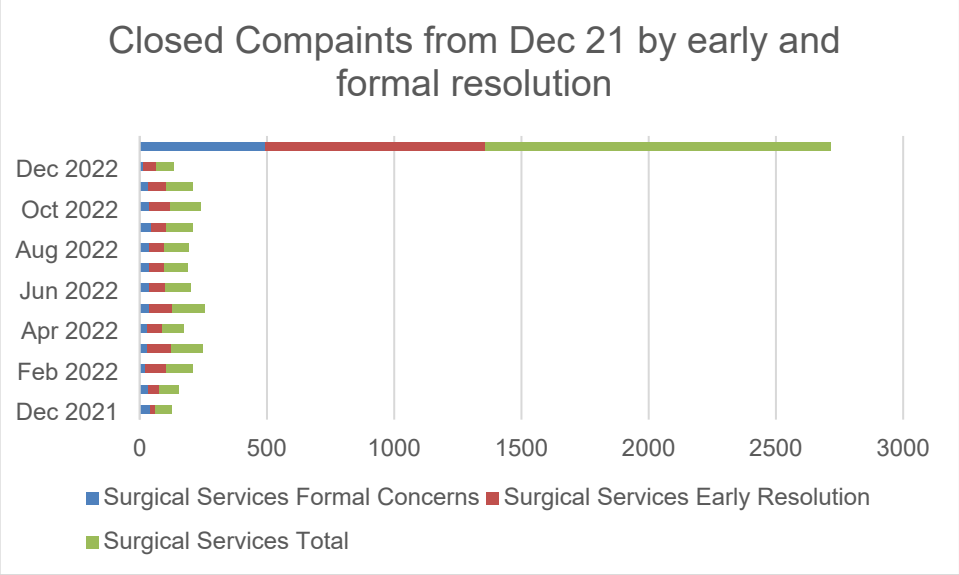
The management of concerns is a key priority for the Clinical Board.

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

The Clinical Board aims to resolve all concerns (where appropriate) by early resolution with contact from the relevant Ward Sister/Manager, Senior/Lead Nurse, or clinician.
Reasons of concerns are noted below:







Surgery Clinical Board received continue to receive a high number of concerns and have received 1207 concerns within the last 12 months .

Active number of concerns as at 23rd Dec is 83.

Surgery managed 66% of concerns via Early Resolution (within 2 working days whereby the complainant was satisfied with the outcome) this is an excellent achievement and ensures that complainants receive a timely response. Last Key Performance Indicators show that 84% of the total number concerns received a response within 30 working days (including ER)

Trauma and Orthopaedics closed the highest number of concerns followed by General Surgery.

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Claims

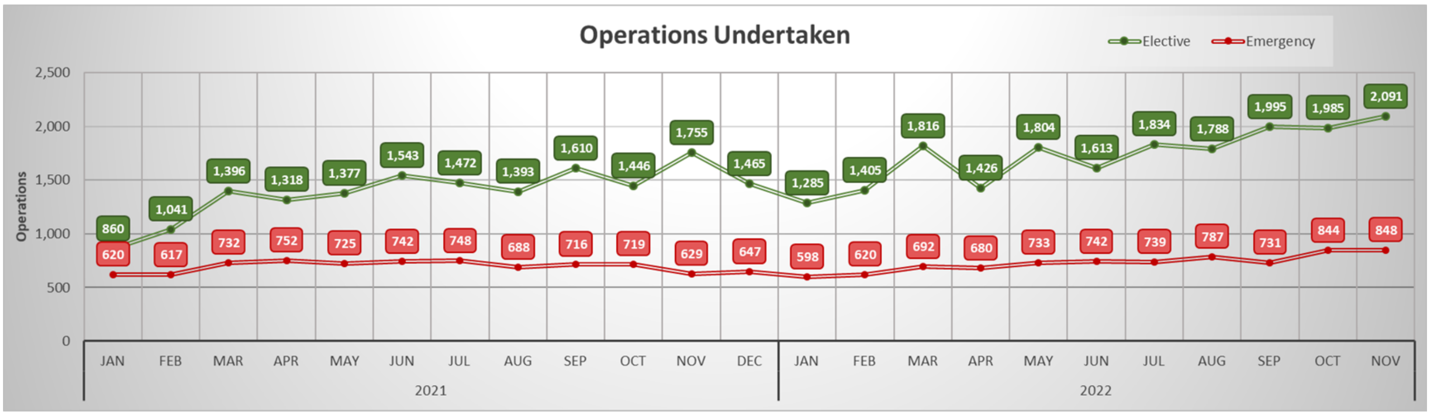
There are currently 30 active Clinical Negligence claims and 2 Personal Injury claims

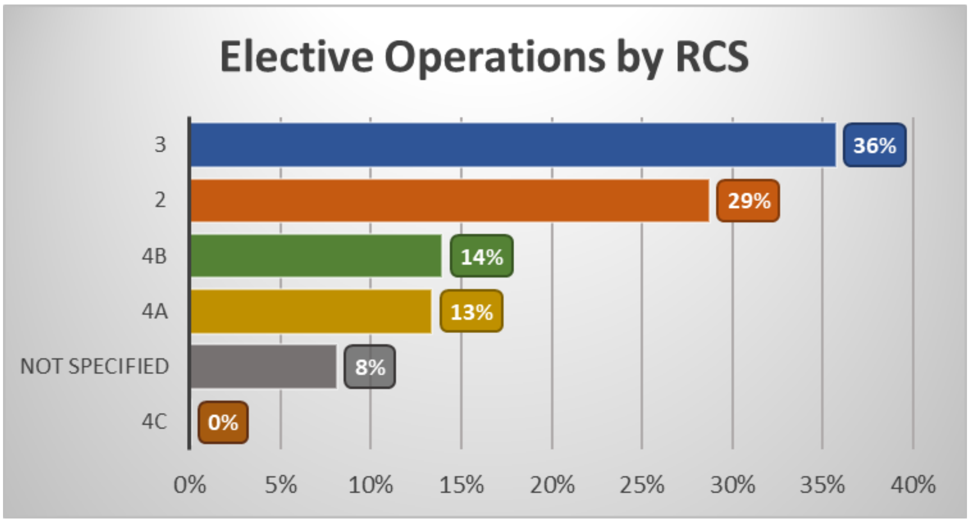
Patient Experience

Surgery have received 53 compliments since 1st October 21

Timely Care

The Surgery Clinical Board Recovery Plan has concentrated on improving the efficiency of theatres over the last year to address the capacity gaps within specific specialties to prevent further growth in waiting list volumes.





SSDEC

Surgery Clinical Boards new SSDEC model opened in July 2022. An SDEC (Same Day Emergency Care) is a model of care that enables patients referred to the acute surgical service to undergo senior assessment, investigation, treatment, and discharge without the need for overnight admission, (which would previously have been the default option).

Our SSDEC unit which accommodates Gen Surg, Urol, ENT, MaxFax & Ophthalmology pts comprises of:

- 45 chairs in waiting room
- 2 triage rooms
- 2 observation rooms
- 4 clinical assessment rooms
- 8 reclining/ambulatory chairs
- 3 Procedure Rooms

It has an attached unit known as the Surgical admissions Care unit (SACU) comprised of

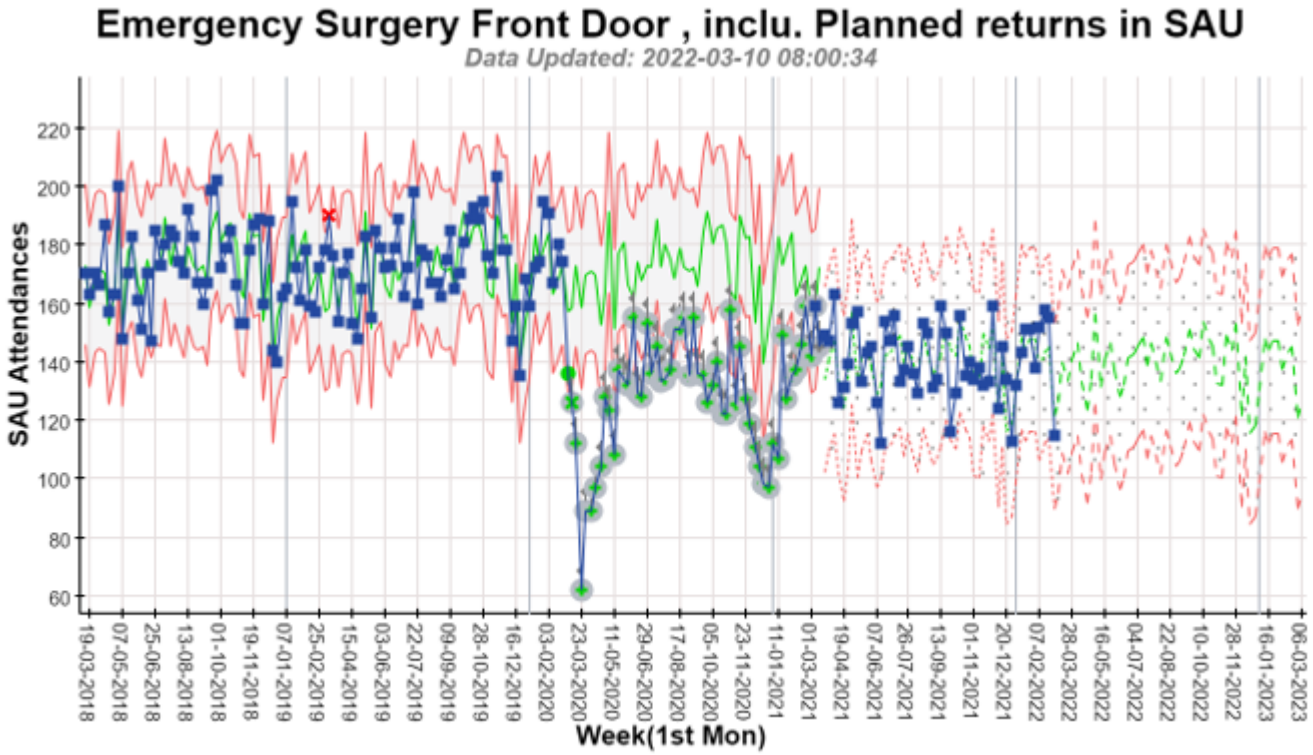
- 10 beds (2 side rooms) for patients having short stay emergency surgery

Our SDEC Theatre Lists are protected for quick turn over patients such as

- Lap Cholecystecomy
- Appendicectomy
- Abscess
- Or any patient who is ambulatory and likely to require less than 24 hour stay

Improvements seen:

Persisting Reduction in Acute Attendances from 180 per week to 140 per week which is a 22% reduction

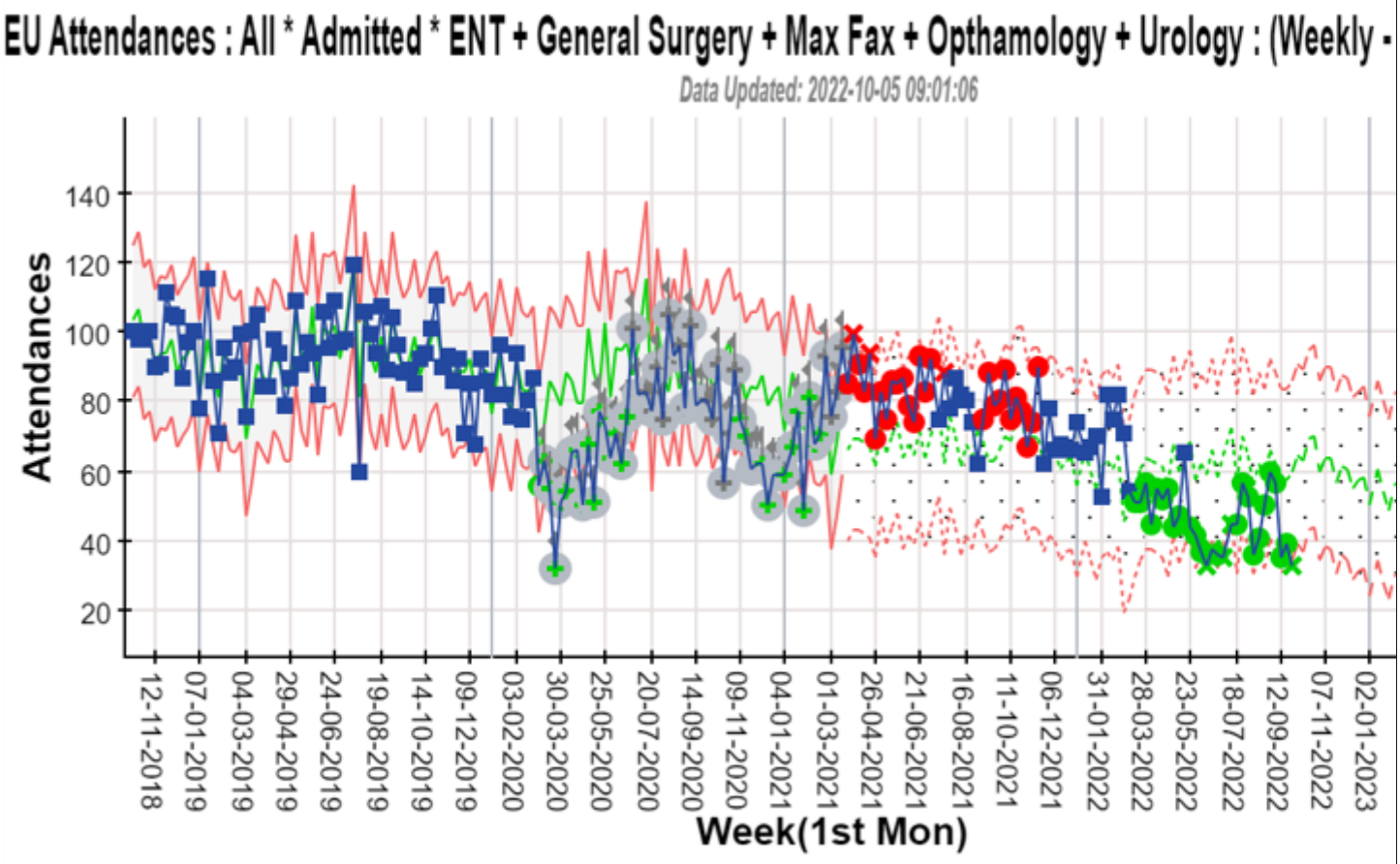


Since July 17th 2022 (sSDEC opening) there has been increased Clinical Conversations (Consultant Connect) Resulting in

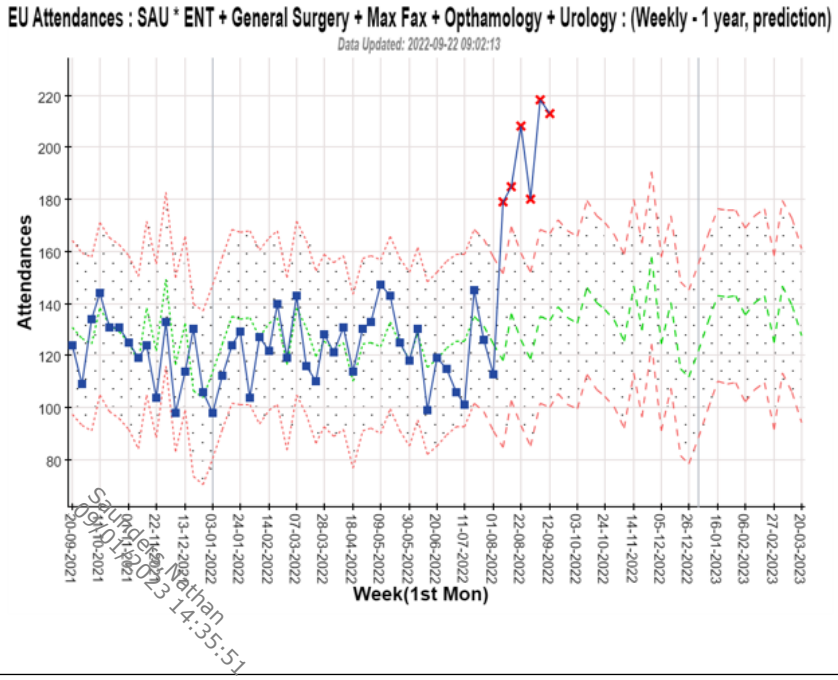
- Acute Surgery Referral Calls = 1035

- 90% 1st time Connection rate
- 30% Navigated away from an acute attendance (outcome data only available for 11%)

Weekly Admissions sSDEC Specialities

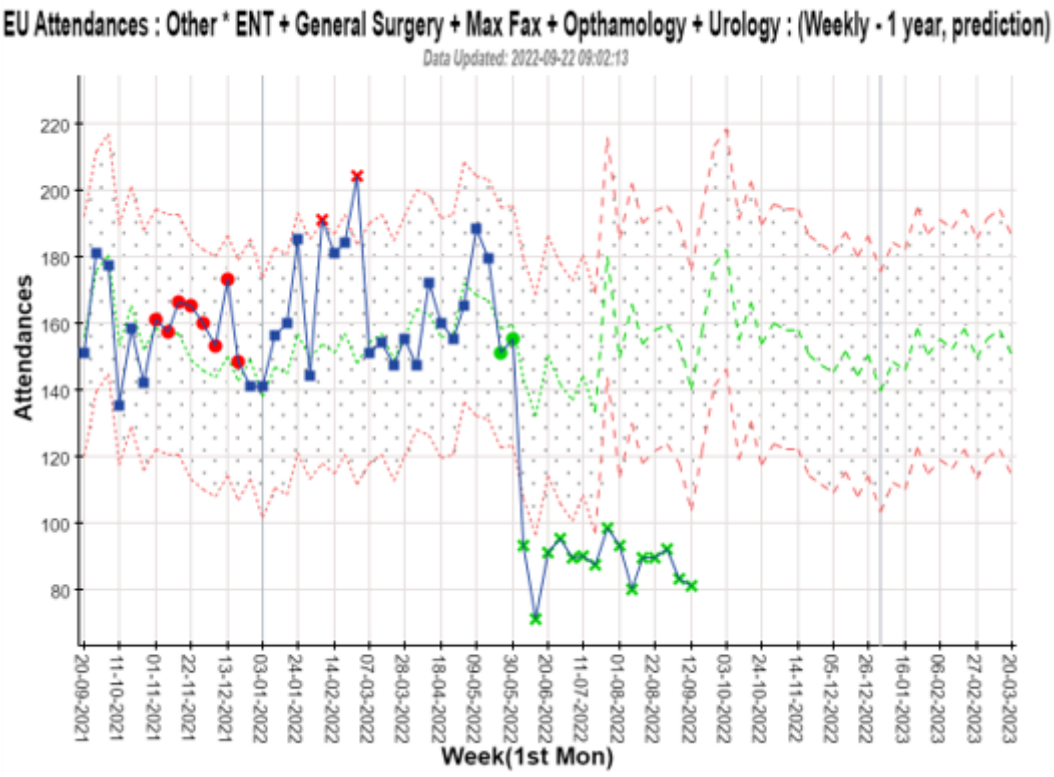


Number of emergency surgical patients seen in SDEC

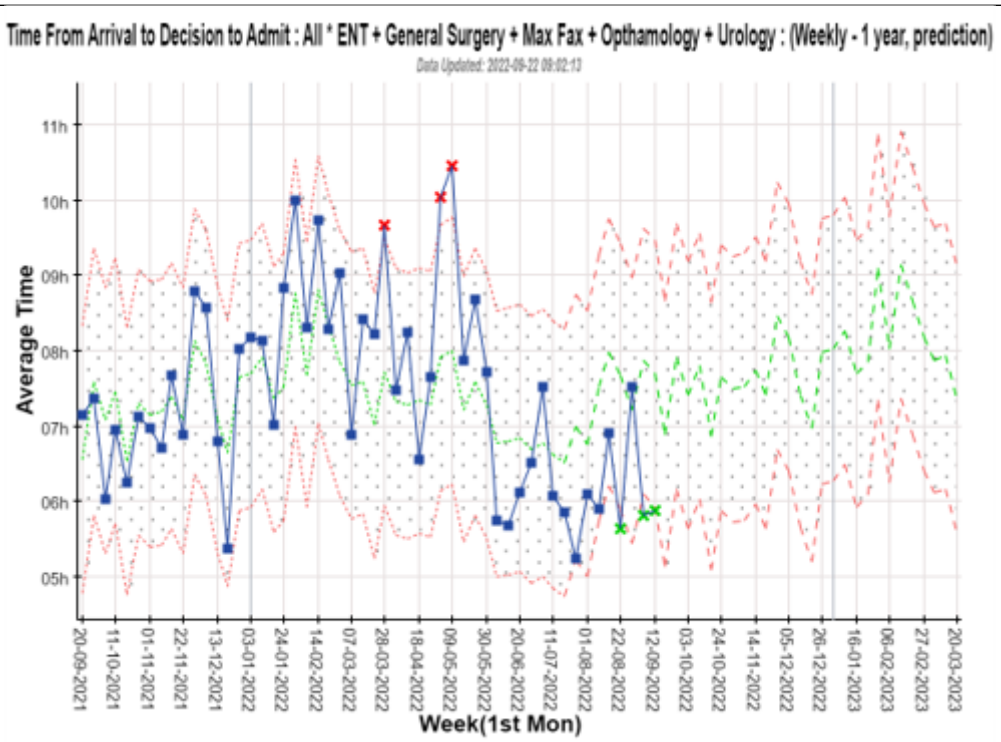


There has been an Increase of 60 patients per week seen in SDEC compared to SAU (Surgical Assessment Unit) since SDEC opened
Currently 66% or 2/3 of all surgical emergency attendances are being seen in SDEC compared to 43% pre SDEC leading to a 47% reduction in Surgical EU Attendances

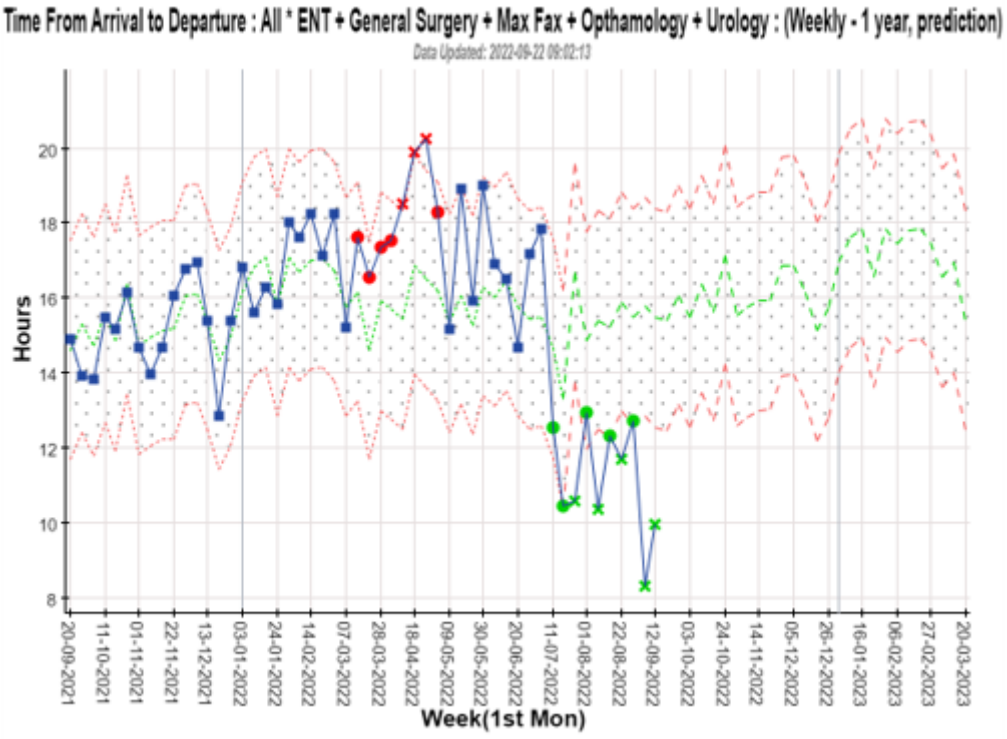
Number of emergency attendances seen in A&E/ EU



Time from arrival to decision to admit has reduced by 150 minutes



Time from arrival to discharge sSDEC Specialities -median time from arrival to discharge reduced for surgical patients by 7 hours



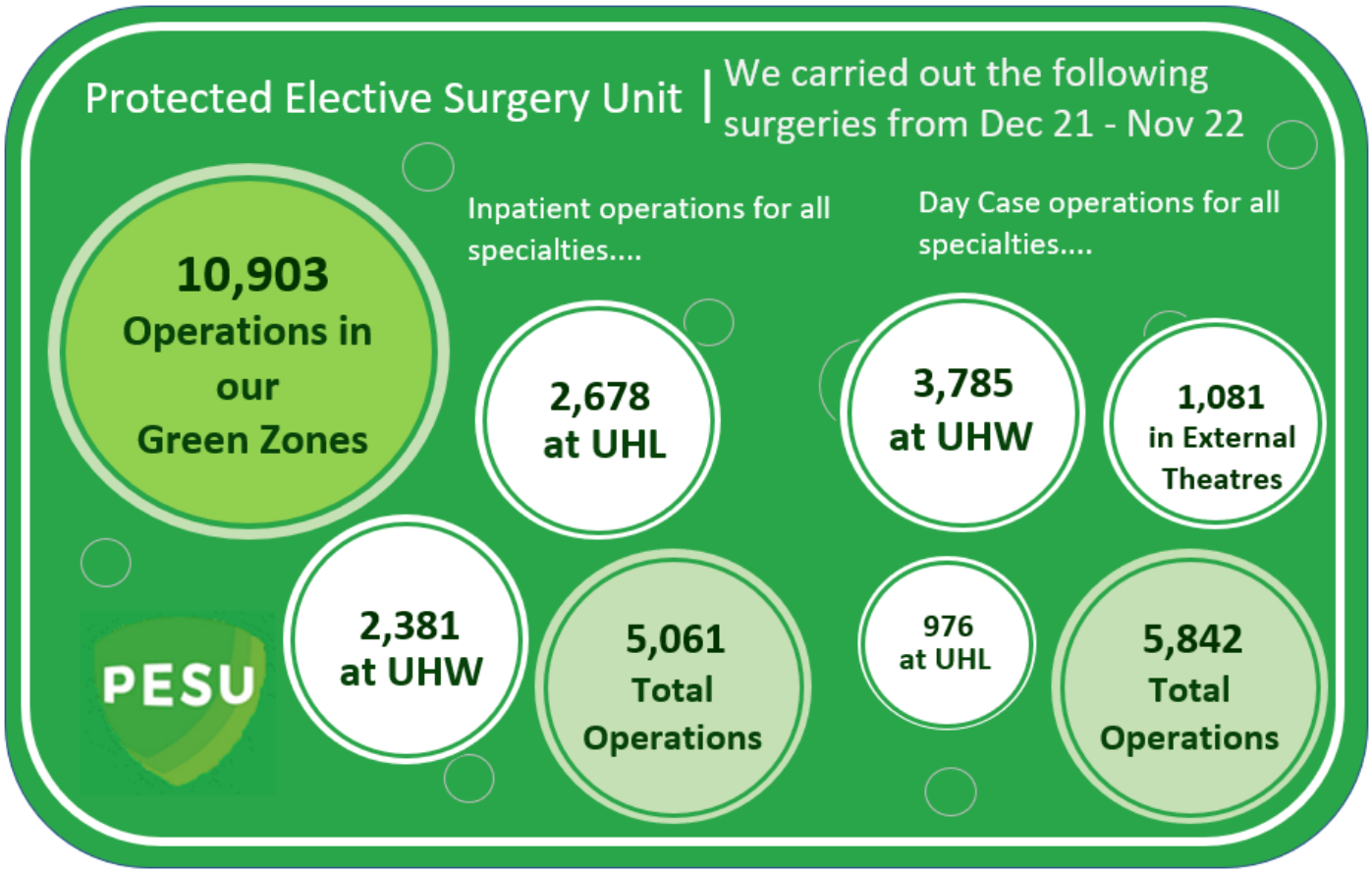
Impact of SDEC Operating lists

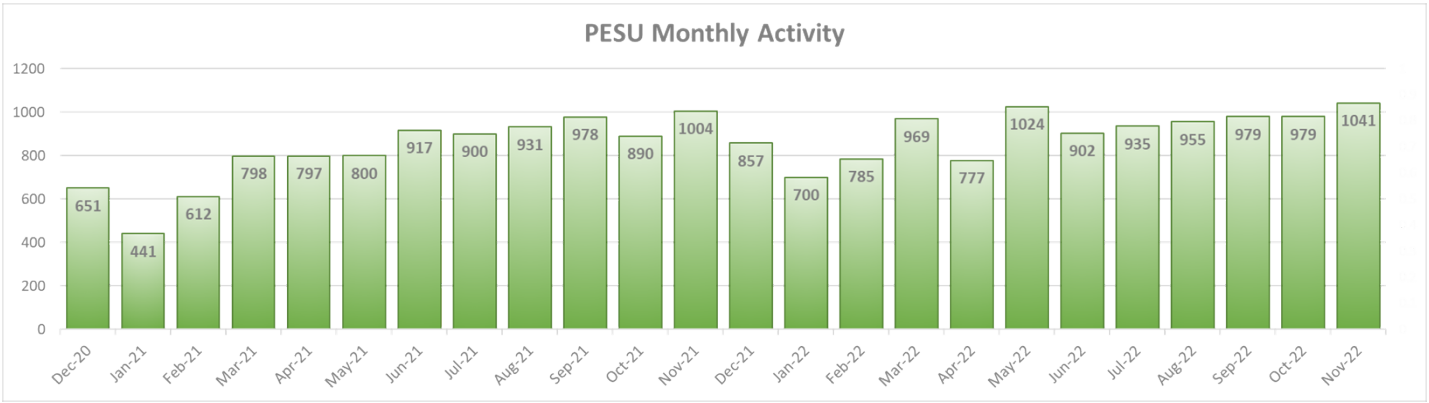
- 50% of all emergency lap cholecystectomies going through SDEC lists rather than CEPOD
- For uncomplicated biliary disease patients stay on average 2.25 days less in hospital when operated on the SDEC list compared to CEPOD.

Areas to develop

- Acute Surgical Ward collocated near SSDEC
- Virtual inpatient system/ early supported discharge
- SDEC Flow Coordinator in EU (Emergency Unit) (minimising missed opportunities for SDEC)
- Acute Oncology/ Palliative Care pathway
- In-house data viewers(previously reliant on 3rd party Data reporting)

Efficient Care





The success of the Protected Areas within Surgery Clinical Board Continue with nearly 11, 000 operations carried out in our protected areas in the last year

Vascular Centralisation

On July 18th 2022 the Regional Vascular Centralisation unit opened in Cardiff and Vale UHB

Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board worked closely to establish robust plans for the implementation of the South East Wales Vascular Network. Vascular services in South East Wales have faced a growing number of challenges which made them unsustainable in their original format – this presented growing risks for our populations. The configuration has been discussed at length for many years and several options were explored.

In early 2021, Health Boards worked closely with local Community Health Councils to facilitate an 8-week public engagement on the future of vascular services. Our populations agreed with the national evidence and clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes. Following independent reviews of the findings, Community Health Councils and partner Health Boards supported the case to move forward with implementing the hub and spoke model. This model is endorsed by the clinical community across South East Wales and The Vascular Society of Great Britain and Ireland as the preferred model of care for vascular services, and has been successfully implemented across the UK.

“It is widely acknowledged that NHS services are under severe pressure nationally due to operational and workforce challenges. The South East Wales Vascular Network has considered the timing of the implementation and is confident that the timing is favourable in the interest of sustaining high-quality, safe and effective care.

The Implementation Board will remain in place for at least the first 6-months to ensure a smooth transition takes place. Formal quarterly reviews will also take place in the first year. The network is confident in the planning and wider support mechanisms established to ensure the South East Wales Vascular Network provides exemplary care to patients across the region.

Equitable Care

Two of our areas (Duthie Ward and the Stoma Care department) have recently become accredited Autism aware areas following an ombudsman's case where there was concern raised about communication with a patient who had autism.

All-Wales National Robotics-Assisted Surgery Programme

The aim of the All-Wales National Robotics-Assisted Surgery Programme (NRP) is to rapidly implement the NRP (the first of its kind worldwide) for Colorectal, Upper Gastrointestinal, Urological and Gynaecology Oncology across four health board, Cardiff and Vale UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB and Swansea Bay UHB.

The aim of this funding is to ensure that coordination and implementation of the NRP is supported via a national programme manager. Employed by Cardiff and Vale UHB and providing programme management across all the programme, the Programme Manager will be responsible for the effective delivery and development of the NRP across Wales.

The Welsh Government will support the network with funding of £4.2m over five years, alongside £13.35m provided by health boards over 10 years.

Trauma SDEC

In June 2022 due to the ongoing pressures within in EU the trauma team were tasked with looking at developing an SDEC approach to a core group of patients to provide an equitable service to our ambulatory Trauma patients . The aim of the SDEC Trauma Unit was

- To ensure that suitable ambulatory trauma patients receive rapid efficient assessment and treatment.
- To avoid hospital admission and improve the time to surgery
- Supporting the local healthcare economy to be more effective and efficient in its use of the hospital of the bed base.
- To focus on returning the patients home early, to recover patients in a timely manner, to improve patient satisfaction and avoidance of admission and bed requests.

The SDEC trauma unit was designed to manage the needs of ambulatory trauma patients who require minor and major operative procedures which result in the need to be recovered post operatively for a maximum of 24 hours. The post-operative period is managed entirely within the SDEC Trauma footprint whilst maintaining the recognised theatre pathway.

The directorate identified the requirement for 4 trolley spaces to accommodate the needs of the service, although during times of high demand we have seen this increase to 8 spaces. Using a small nursing workforce of one registered nurse and one HCSW per shift to manage admission, post-operative recovery and discharge of the patient.

During this very short operational period data has shown between 1-2 bed day savings by operating this pathway.

The unit will be operational throughout winter with a view to funding long term.

Fracture clinic

The health system has had to adapt and change its shape over the last two years as we have tackled COVID admissions, more stringent infection prevention and control measures, less capacity for normal services, increased mortality, self-isolation for our patient's protection and many more service constraints. The services have been redesigned to best protect our workforce and patient population as well as maintain as much core activity as possible for our most sick patients.

Fracture clinic is running out of Llandough Hospital in the space previously used for planned care orthopaedic outpatient work. This change was essential to allow additional Emergency Department space in the University Hospital of Wales (UHW) to separately stream COVID and non-COVID patients at the height of the pandemic.

The aim is to move our fracture clinic back to UHW thereby creating the space needed to see patients with musculoskeletal conditions waiting for their first appointment. Work commenced on the new fracture clinic at UHW on the 28th November with a provisional completion date of May 2023.

ASSURANCE AND RECOMMENDATION S

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
- Monthly review of Clinical Board Risk Register by Clinical Board Team
- 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

RECOMMENDATIONS:

The Quality Safety and Experience Committee is asked to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: **Yes**/No

Risks are highlighted in the main report.

Safety: **Yes**/No

Safety issues and action taken or planned is included in the main report.

Financial: Yes/**No**

This report does not have specific finance implications.

Workforce: **Yes**/No

Workforce issues and associated actions are included in the main report.

Legal: Yes/**No**

There are no legal implications.

Reputational: **Yes**/No

There could be reputational implications if risks are not appropriately managed but this report includes action taken or planned in order to mitigate this.

Socio Economic: **Yes**/No

The actions taken or planned referenced in this report relate to the provision of services and how they can be improved. There are a range of services provided by SCB which aim to improve access or quality of services

Equality and Health: Yes/**No**

No requirement as a result of this report for an EHIA to be undertaken.

Decarbonisation: **Yes**/No

Not applicable in relation to the content of this report.

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Saunders,Nathan
09/01/2023 14:35:51

Report Title:	Covid Investigations				Agenda Item no.	2.2	
Meeting:	Quality, Safety & Experience Committee		Public	x	Meeting Date:	10 January 2022	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Head of Covid Investigations						

Main Report
Background and current situation:

The publication of the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (the framework) supports the Communicable Disease Outbreak Plan for Wales (2020) by providing a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

These reviews are under the umbrella of the final 'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021) which supports the Communicable Disease Outbreak Plan for Wales (2020) by identifying, reviewing and reporting patient safety incidents, complaints or claims relating to nosocomial transmission of Covid-19 in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

On the 26th January 2022, the Welsh Government announced £9 million investment over 2 years to support delivery of the framework.

The associated funding conditions were that all Health Boards:

- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial COVID-19. Investigation work must be completed in line with the framework. This includes investigating cases where a person has acquired nosocomial COVID-19 in a care setting while receiving NHS funded care and when individuals were transferred from hospital into a care home and subsequently contracted COVID-19, within 14 days of transfer. The national framework is currently being updated to provide further clarity of these requirements for NHS funded care.

- Establish relevant internal assurance mechanisms such as scrutiny panels. Proactively engage with patients and families who have been affected by incidents of nosocomial COVID-19, including advocacy through the Community Health Council.

- Put in place the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.

  - Develop robust governance structures, including internal mechanisms to ensure the Board is fully appraised of progress with investigations; and
  - reporting mechanism to update NHS Wales Delivery Unit (DU) on progress. Monthly reporting against an agreed reporting framework will be required.

- Engage with colleagues in the DU who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.

- Work with the DU to develop the national learning plan which will incorporate the lessons learned throughout the pandemic.

Cardiff and Vale UHB have a fully established Covid Investigation Team and are implementing all aspects of the National framework. The investigations into indeterminate, probable and definite Health Care Associated Covid -19 Infections (HCAI) are fully underway with current activity focused on patients who contracted covid during Wave 1 of the pandemic and cases where the patients or their families have raised concerns about the care provided.

Definitions for the surveillance of HCAI have been agreed by the 4-Nations HCAI Surveillance group and are shown below.

HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission
Probable healthcare-associated	Positive specimen date 8-14 days after admission
Definite healthcare-associated	Positive specimen date 15 or more days after admission

Criteria for determining if COVID-19 infection is healthcare associated following post discharge is shown below.

HCAI category	Criteria
Community onset **Possible** healthcare-associated*	Positive specimen date ≤14 days post-discharge, or within 2 days after hospital admission, with discharge from hospital in 14 days before specimen date.

As of 14th December 2022, there are 3229 patients who fit into the indeterminate, probable and definite categories of nosocomial Covid-19, with 630 of those who have sadly died in Waves 1, 2, 3 and 4. A further 657 cases that have occurred since 1st of May are being added to the investigation work, these are classified as 'live' cases by the Delivery Unit.

As of the 19th December the Covid Investigation Team have undertaken 1191 proportionate investigations and reviews.

	Wave 1 (27th Feb '20- 26th July '20)	Wave 2 (27th July '20- 16th May '21)	Wave 3 (17th May '21- 19th Dec '21)	Wave 4 (20th Dec '22- 30th April 22)	Live Cases (01/05/2022-)
Outbreaks	7	86	30	25	
Number of Pts assoc	554	1314	355	1006	657
Clinical Review	*348*	*748*	*215*	799	639
Clinical review completed	*128*	287	21	29	1
Req a full tool (death <28 days)	*185*	*328*	*35*	82	18
Subtotal of Full tools	*72*	*117*	*27*	19	1
Downgrade/recategorised	*21*	*238*	*105*	125	0
% Clinical review & Full tools completed.	***39.89%***	***48.86%***	***43.10%***	**17%**	**0.30441400304414%**

Scrutiny panels for each Clinical Board have commenced. The purpose of the scrutiny panel is to consider all elements of the covid investigations, to agree the level of harm and to establish if there was any breach of duty of care in the context of the pandemic at the time. To date 87 patients have gone to scrutiny panel with a further 32 waiting to be reviewed.

Progress is reported to the UHB Nosocomial C&V UHB Programme Board. This is chaired by the Executive Nurse Director who is the Programme Senior Responsible Officer. As well as Health Board representatives the Community Health Council is an active stakeholder on the Programme Board.

Further scrutiny of progress is provided on a monthly basis to the Delivery Unit via submission of data capture reports and a high light report.

Communication with patients and families has begun, with a focus on contacting bereaved families from Wave 1. To date initial contact has been made with all bereaved families from Wave 1. Communication consists of a phone call first with a follow up letter. The outcome of the investigations will be communicated via a letter. On contact all patients and families are made aware of our dedicated single point of contact phone number, our generic email address and our Web page which has further information on it, including advocacy details for the CHC.
Bereavement support is available for all families via a direct referral from the Covid Investigation Team or there is signposting on our Web page to bereavement support services.

The emerging themes from our communication with families have been surrounding communication with staff and their loved ones, and visiting during the pandemic.

The availability of patient records is the main risks impacting on the ability to progress the investigations. Additional medical records staff hours are being funded from the covid investigation budget until the end of the financial year.

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

There are 3229 patients in waves one to four of the pandemic whose care requires investigation through the framework

There are a further 657 cases since May 2022 that require consideration to establish if they are HCAI.

1191 investigations have been undertaken to date.

Recommendation:

The Committee is requested to: **NOTE** the assurance provided by the progress against the framework.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
09/01/2023 14:35:51

Report Title:	Quality Indicators – Progress Report			Agenda Item no.	2.3
Meeting:	QSE Committee	Public	✓	Meeting Date:	10/01/2023
		Private			
Status *(please tick one only):*	Assurance	✓	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assistant Director of Patient Experience				

Main Report

Background and current situation:

In June 2020, the QSE Committee agreed a range of quality indicators that would be routinely monitored at each meeting. This paper provides an overview of current performance against those quality indicators that are available

There have been significant operational pressures across the Organisation, made more challenging with the ongoing staffing pressures and periods of industrial action.

The QSE framework continues to be embedded and the committees/groups established in 2022 will support the acceleration of the implementation of the framework with particular emphasis in 2023 on

Psychological safety as part of the safety culture

We will also focus upon empowering people in decisions about their healthcare

Patient Experience and Involvement

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

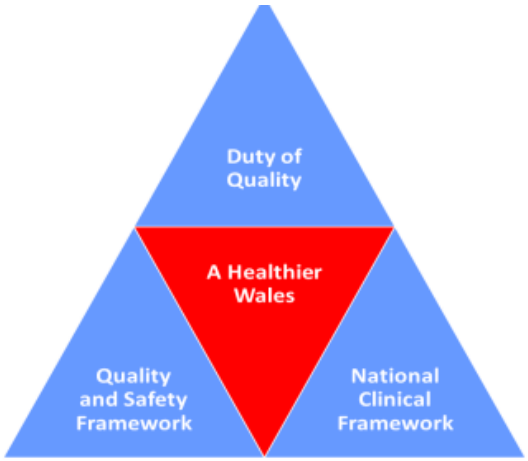
Many patients would like more control of, or say in, the decision-making process, so their views and preferences are taken into account. It can sometimes be hard to judge where an individual patient lies on this spectrum. The best solution is to ask the patient and this can start with the question -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

OUR PRIORITIES for 2021 - 2026

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

The report is being presented in line with the Duty of Quality Act

- The six **domains of quality** and five **quality enablers**.
- Quality-driven **decision-making**.
- Demonstrate improved quality with **evidence**.
- **Quality Standards** 2023 will replace the Health and Care standards



Key messages

- We must put the quality and safety of our health services above everything else
- The duty of quality influences many health-related policies and frameworks
- In turn, these also affect how we approach delivering quality in healthcare services
- Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services

Cardiff and Vale University Health Board Quality, Safety and Experience Committee and Group Structure

Board

QSE Dashboard/Signals from noise

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

- High Impact Topics
- IP&C
- Safeguarding
- Clinical Board Deep Dive Assurance Reports
- HIW
- Significant National QSE Reports

Organisational Learning Committee (Chairs-Executive Medical and Nurse Director)

Terms of Reference to be agreed

Clinical Safety Group (Chair: Executive Medical Director)

Pressure Damage	Medicines Management
Medical Devices	Dementia
Falls	Nutrition and Hydration
Consent	Cleanliness
Decontamination	Research
Patient Information	Blood Transfusion
Resuscitation (RADAR)/NEWS	Sepsis
VTE	Patient Safety Solutions
NatSSIPs	Suicide Prevention
POCT	Transition
Organ Donation	JAG
IRMER	Learning from Deaths

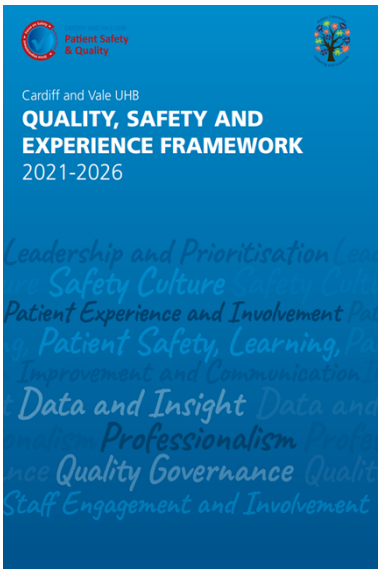
Clinical Effectiveness Committee (Chair AMD for Quality and Safety)

- Local Clinical Audit
- National Clinical Audit
- NICE
- CEPOD
- Accreditation
- External Peer Reviews
- Consent
- CAVQI

NRI/ Concerns (Chair: Executive Nurse Director)

- Complaint/Claims
- Serious Incidents
- Patient Experience and Involvement
- Never Events
- Inquests
- Once for Wales Concerns Management System
- Covid Investigations
- Joint Investigations with other organisations
- Being Open/Duty of Candour
- QSE Dashboard

Clinical Board/Directorate/Site-Based Leadership Quality, Safety and Experience Groups



The structure above is our QSE framework - the final committee being established is the Learning Committee to progress the whole systems approach to learning across Cardiff and the Vale.
We believe that in focusing on these 8 key priorities, we can aspire to provide safe, effective services, that deliver an excellent user experience, equal to the best healthcare organizations in the world.

These eight key areas are:

- Safety Culture
- Leadership and the Prioritization of QSE
- Patient Experience and Involvement
- Patient Safety Learning and Communication
- Staff Engagement and Involvement
- Data and Insight
- Professionalism of QSE
- Quality Governance Arrangement

The last committee to be established will be the Learning and Improvement committee, as we needed to have all of the other groups in place and these have been established in the weekly NRI/concerns meeting, The Clinical Effectiveness Committee, Clinical Safety Group and then the Learning Committee

The Learning Committee will be where the thematic reviews will be considered, to ensure that sustainable and measure improvements are put in place, utilising tested quality improvement methodology. Each of the Clinical Board Directors of Nursing will have a key area to concentrate upon through multiprofessional engagement, such as reduction in injurious falls, reduction in avoidable pressure ulcers, psychological safety etc.

Duty of Quality

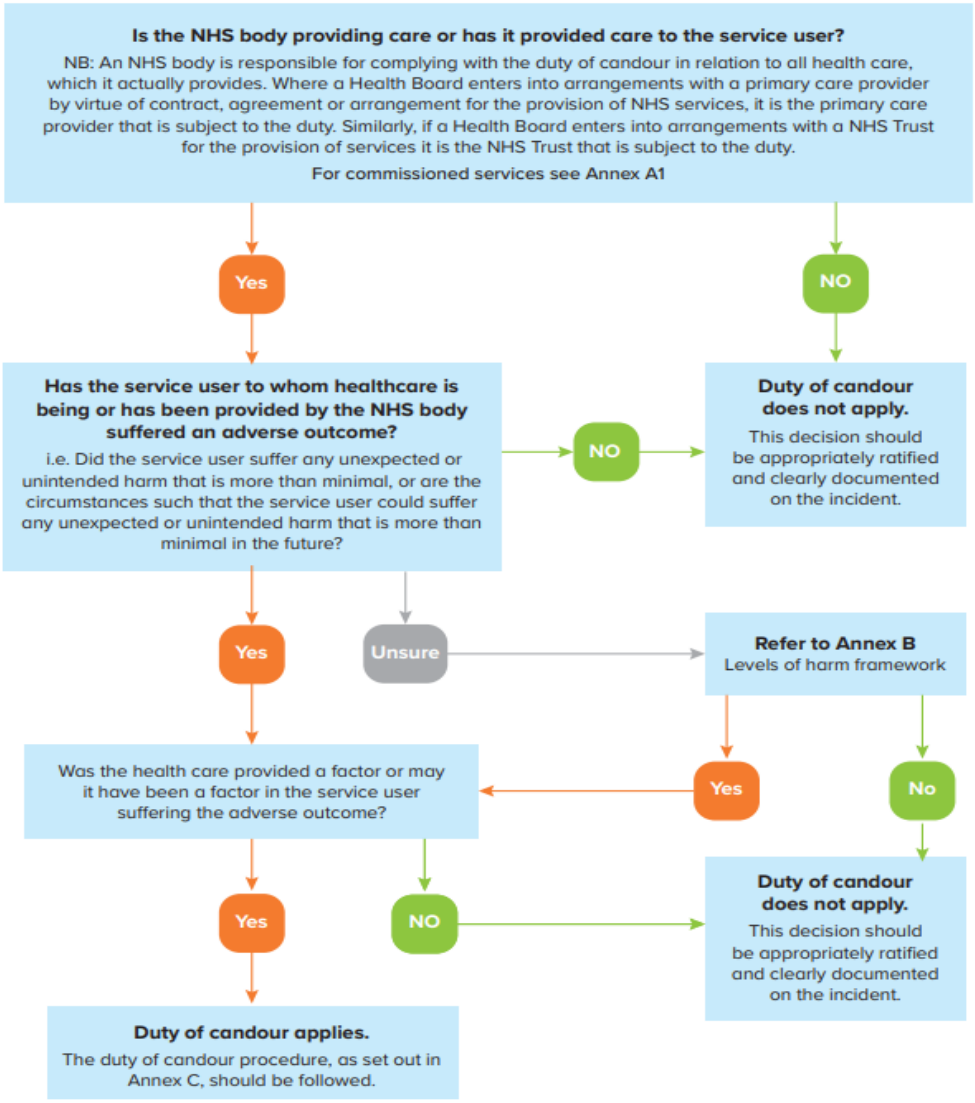
The duty of quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will come into force in April 2023. It is a lever for improving and protecting the health, care and wellbeing of the current and future population of Wales. It aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country. The Act is intended to have positive benefits for everyone in Wales, supporting a culture and the conditions needed to drive improvements in health care. The duty of quality requires the Welsh Ministers with regards to their health-related functions and NHS bodies to think and act differently by applying the concept of “quality” across all functions. They will need to consider quality within the context of the health service and health needs of their populations. The duty of quality requires quality driven decision making and planning to ultimately deliver better outcomes for all people who require health services. It requires involving people in decisions that affect them, balancing short-term needs with planning for the longer-term, with action to prevent problems occurring or getting worse. The prevailing intention is to build on the positive culture of quality at the heart of the Welsh health system, enacting a broader system-wide duty of quality which strengthens decision making, action, improvement and ultimately, improved outcomes for the population. The duty of quality guidance document is currently undergoing public consultation. The guidance sets out a definition of quality alongside six domains of quality and five quality enablers. It is proposed that these become our Quality Standards 2023 which will replace the Health and Care Standards (April 2015). NHS bodies will be required to take these new standards into account for the purpose of discharging the duty of quality

Duty of Candour

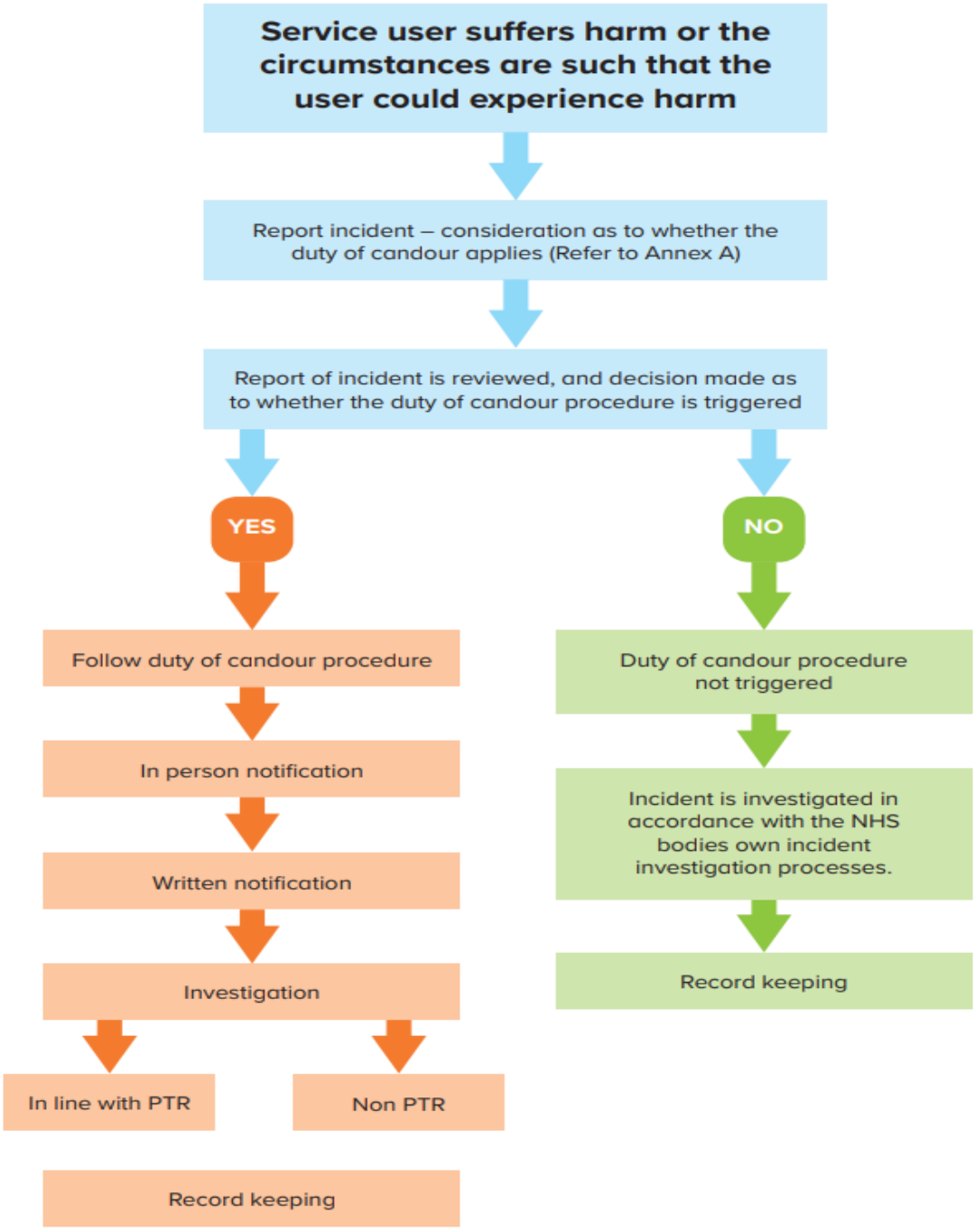
The Duty of Candour will be in force from April 2023. The duty applies to NHS bodies in Wales and requires them to be open and transparent with people when they come to harm whilst using services. The duty will be triggered when there is an incident that causes harm that is more than minimal, the harm is unexpected or unintended and health care was or could have been a factor in causing the harm. When this type of incident occurs, the duty requires NHS organisations in Wales to notify the person involved offering a sincere apology for the harm and detailing what investigations will be done to learn from the incident. It also requires NHS bodies to produce an annual report on Duty of Candour incidents summarising the number, type and learning from those incidents.

Annex A - Duty of Candour

Trigger review process



Review process and record keeping



In practice this means - The trigger process for duty of candour essentially forms another gateway into existing investigation and PTR processes. It does not require additional investigation work.
Organisations will have existing processes in place whereby incidents are reviewed and it is that this point that a decision is made as to whether the duty of candour procedure is triggered.
Once confirmed that duty has been triggered, this will be the duty of candour procedure start date, also known as the day the 'NHS body first becomes aware'. The organisation will then have 30 working days to undertake their investigation as per PTR timescales.
There must be a gateway to redress if appropriate

Quality statements

A Healthier Wales and the National Clinical Framework confirmed the introduction of a series of quality statements for specific clinical services. These describe the outcomes and standards expected to be delivered for those services. Quality Statements focus on what is important to deliver consistently across Wales for any given clinical service. It is important that NHS bodies demonstrate where the quality attributes are relevant for specific clinical services and throughout their wider planning, embedding the published service specifications and pathways that underpin those quality statements for example in cancer and heart conditions.

The quality statement for cancer | GOV.WALES
The quality statement for stroke | GOV.WALES
The quality statement for heart conditions [HTML] | GOV.WALES
Care of the critically ill: quality statement [HTML] | GOV.WALES
The quality statement for palliative and end of life care | GOV.WALES
The Quality Statement for women and girls' health [HTML] | GOV.WALES
Quality statement for kidney disease [HTML] | GOV.WALES
Quality statement for respiratory disease [HTML] | GOV.WALES
The quality statement for liver disease [HTML] | GOV.WALES
The quality statement for neurological conditions [HTML] | GOV.WALES

Safe

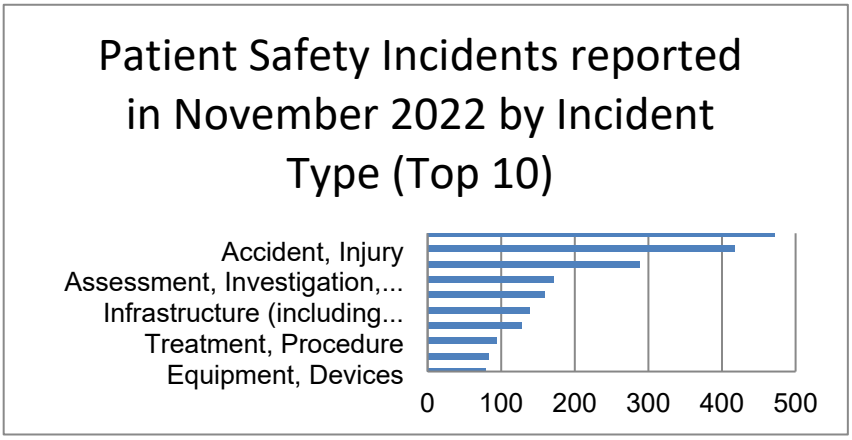
Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce,

Incident reporting

The chart below illustrates patient safety incidents reported in November 2022 by incident type. A total of 2321 incidents were reported in November 2022, again, the most commonly reported incident relating to the development of pressure or moisture damage.

Pressure damage is subject to investigation to establish if there were any modifiable elements or omissions in healthcare. Avoidable pressure damage that is deemed to be associated with healthcare provision are subject to national reporting requirements.

Accident/Injury (falls) is the second most commonly reported incident; these 2 categories often alternate in terms of most prevalent.



Nationally Reportable Incidents (NRIs)

The table illustrates performance of Nationally Reportable Incidents until 30th November 2022. The position has improved over the last month, the open NRIs have increased however the number of overdue NRIs has reduced; reducing overdue NRIs each month has been a trend over the last few months and reflects the focus and hard work of the Clinical Boards and Patient Safety Team. This progress is reflected in the table below. Recognising the number of open NRIs has increased, it is important to maintain focus so that these are investigated and closed within time.

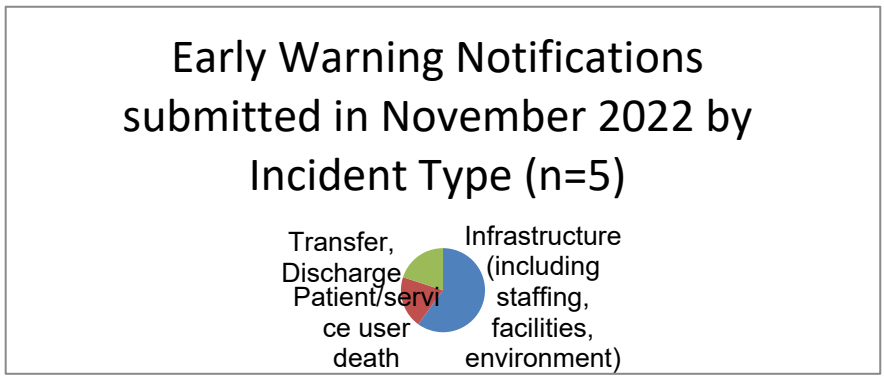
	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26

This demonstrates a reduction of overdue NRIs by **24%** since September 2022.

The Exec and Corporate incidents relate to delays in ambulance conveyance (Appendix Bs). A new process has now been developed building on the Joint Investigation Framework making the process more robust and ensuring wider learning across Health Boards.

Clinical Board	**Open NRIs as of 31.10.22**	**Overdue NRIs as of 31.10.22**
Children and Women	12	5 ⟷
CD&T	0	0 ↓
Executive	3	2 ↓
Medicine	7	5 ↓
Mental Health	10	6 ↑
Surgery	8	5 ⟷
PCIC	2	2 ⟷
Specialist	8	1 ↑
Total	**51** ↑	**26** ↓

CD&T, Exec and Medicine have all seen a reduction in their overdue NRIs, Specialist (who had no overdues last month) and Mental Health have had an increase in their overdue closures.

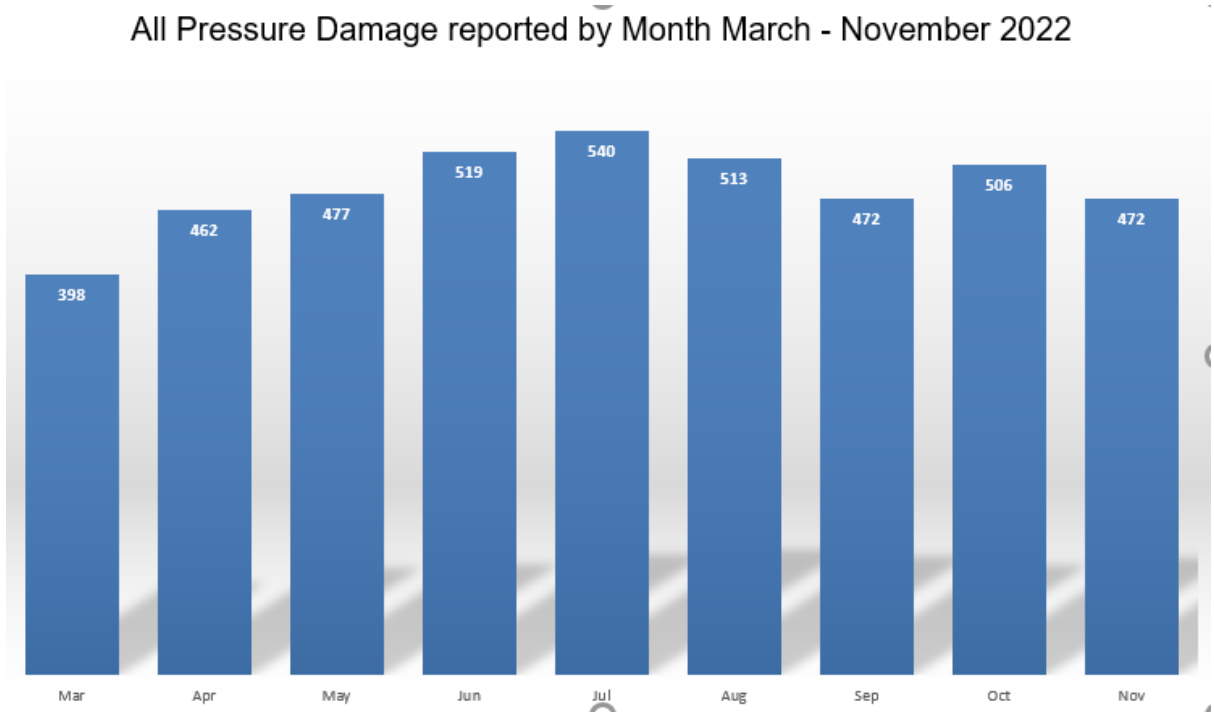


The above illustrates the Early Warning Notifications reported to Welsh Government in November 2022 by incident type; 5 were reported in September, October and November.

No Never Events were submitted during November 2022.

Current reported Delivery Unit All Wales Position as above

Pressure Damage



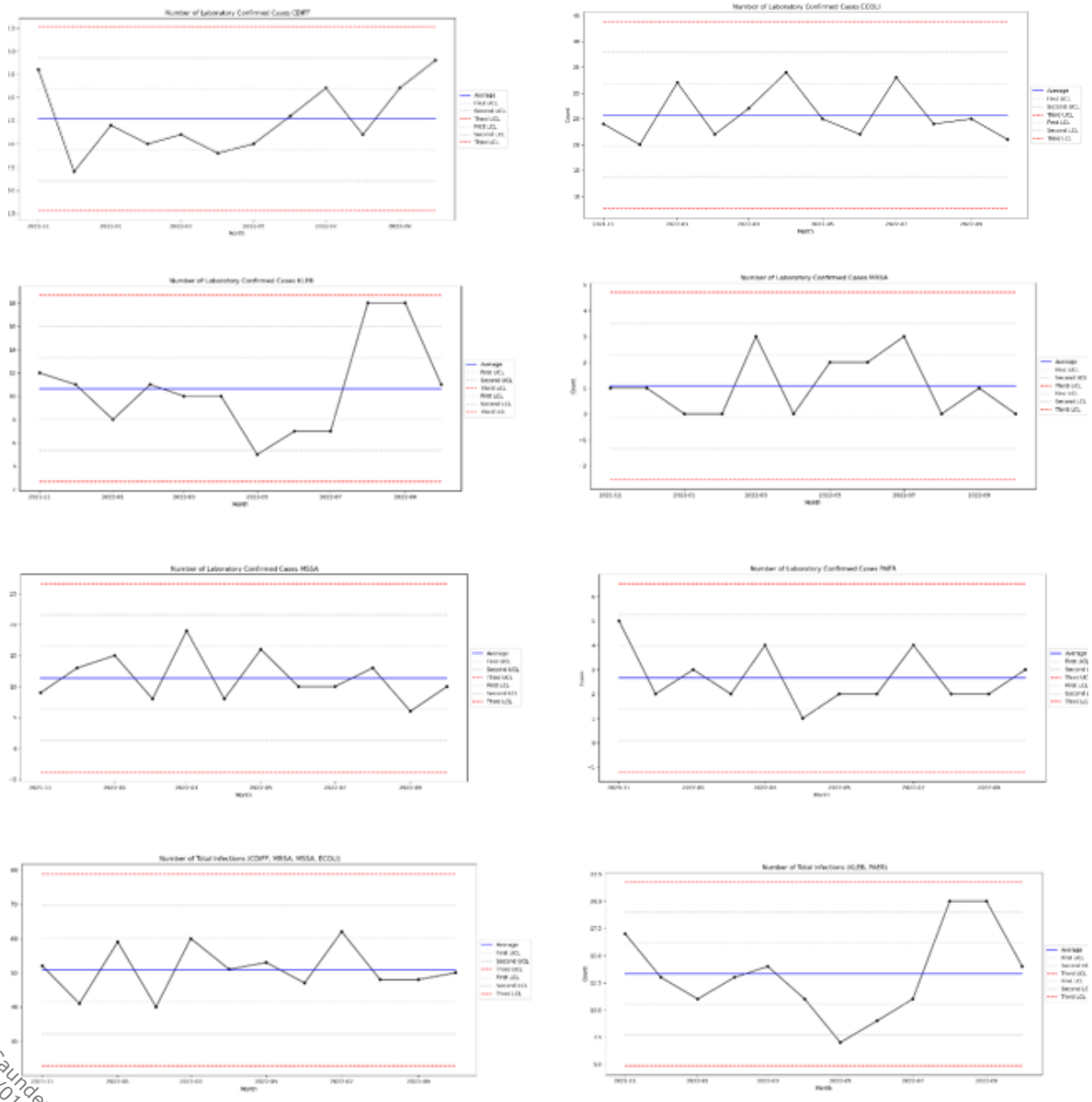
The above shows the reporting trend for ALL pressure damage entered onto Datix between 1st March 2022 and 30th November 2022. The level has remained fairly constant. A more detailed paper will be provided to QSE committee in February.

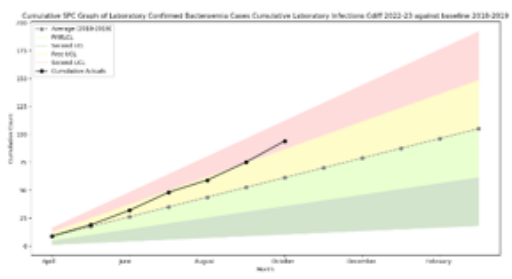
Infection Control

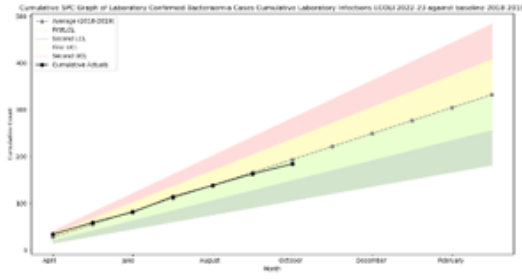
Hospital Infections – the grouped total Cdiff, Ecoli, MRSA and MSSA infections, is showing no in-year improvement against the 2018/2019 baseline. However, Ecoli, MRSA and MSSA are demonstrating an in-year improvement, whereas Cdiff in-year has increased, compared to baseline of December 2018.

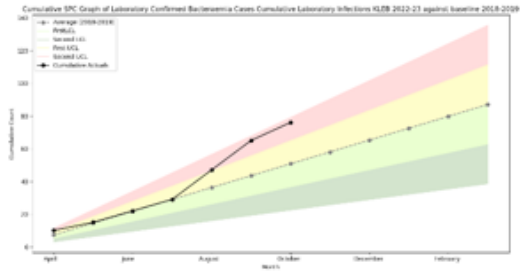
Cdiff rates were observed to be high across the UK after the first and subsequent waves of Covid, all community cases are now subject to investigation to understand the cause of the infection.

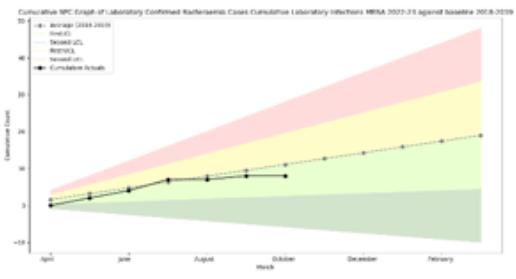
There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

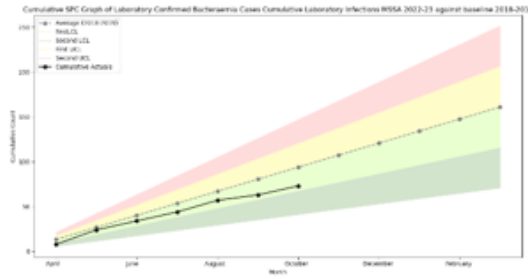


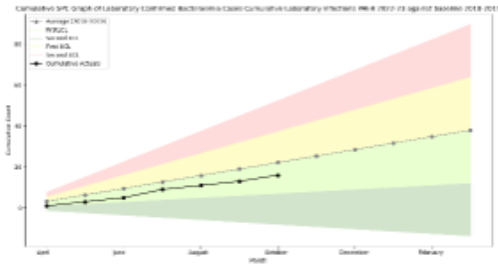


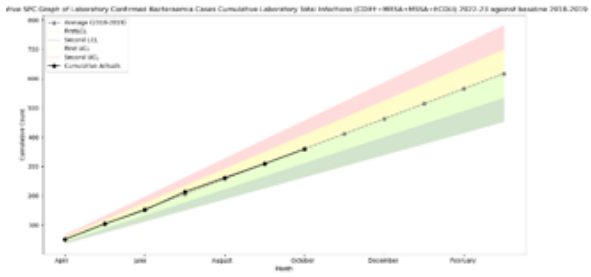


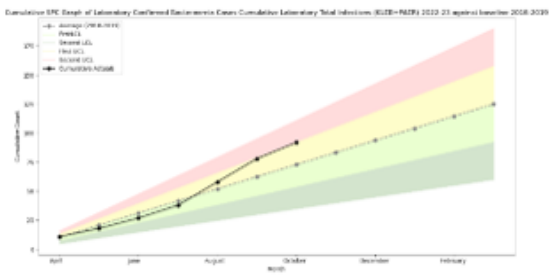










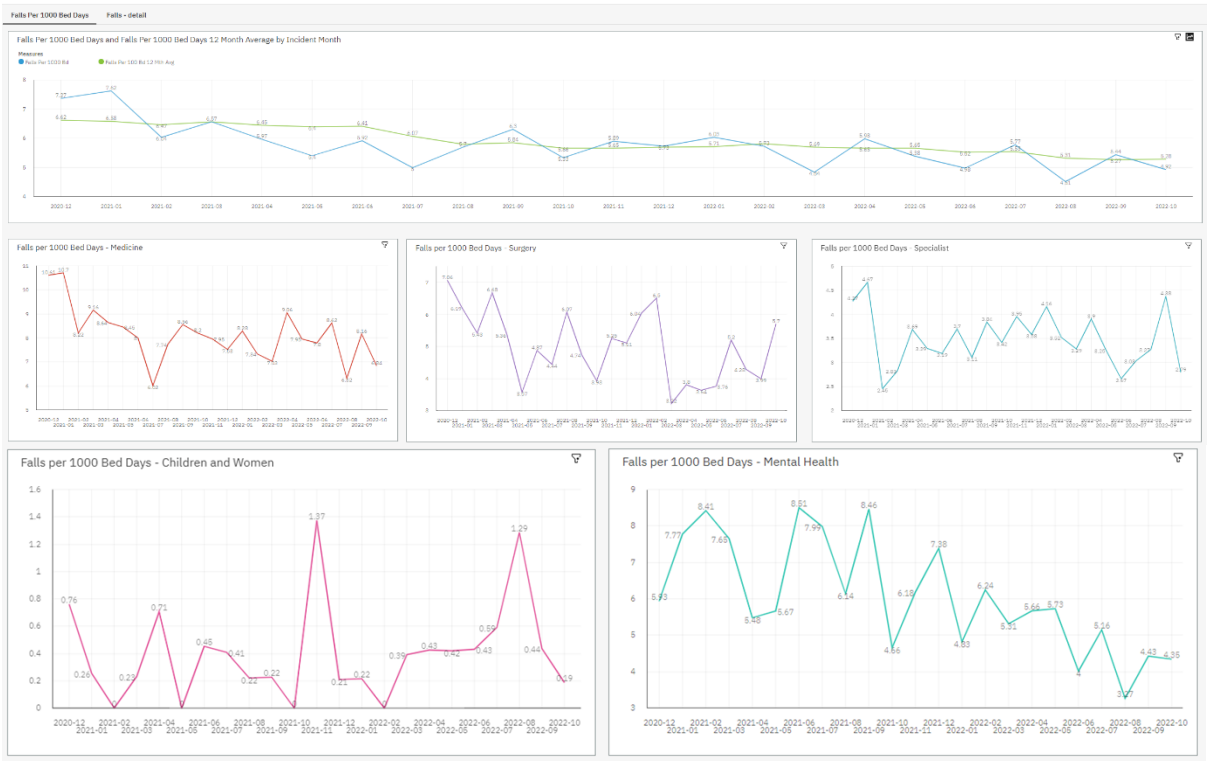


Actions to progress the improvement trajectory

- Weekly Cdiff/SAUR meeting with IP&C, Micro, AMR specialist pharmacists ongoing
- Plan to reinstate MDT review rounds with the above
- MRSA RCA review meetings with the EMD, EDON, IP&C and clinical teams
- IP&C audit plan for 2022/23 includes increased audits of PCV/CVC bundle compliance and insertion pack usage
- ICNET SSI surveillance to begin within the next month
- Working with clinical teams to further standardize products/procedures including IV access teams
- Regular audits of clinical environments and equipment
- Working with Capital/Estate/Facilities teams to improve clinical environments
- Build on the existing Education programme to widen staff groups included

Falls

The charts below show inpatient falls per 1000 occupied bed days (blue line) with the rolling annual falls per 1000 bed days (green line) continuing to show a sustained reduction. Falls per thousand bed days reported by clinical boards show normal variation but Mental Health Clinical Board shows statistically significant reduction. The improvements in Mental Health attributed to the delivery of falls management training and increased scrutiny from the Senior Nurse for Physical Health Care.



All serious and catastrophic injurious hospital falls are reviewed by a multi-professional panel to identify modifiable factors that could have prevented the fall. Learning, including good practice, is fed back to the individual reporting teams and high-level lessons learnt are shared in an infographic.

A multi professional and multi-agency Falls Delivery Group oversees the implementation and monitoring of the Cardiff and Vale UHB Falls Framework which is based on the NICE Guidelines for Falls and other key documents. A new falls lead has recently been appointed to take this work forward.

Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

The Health Board is currently developing the – RELEASING TIME 2 CARE

RT2C is a framework combining 6 elements of change, each covering a multitude of tools, techniques and resources

Key principles of the framework include:

1. Identifying problems.
2. Developing solutions.
3. Testing ideas.
4. Using visual queues to focus performance.
5. Embedding strong communication between teams.

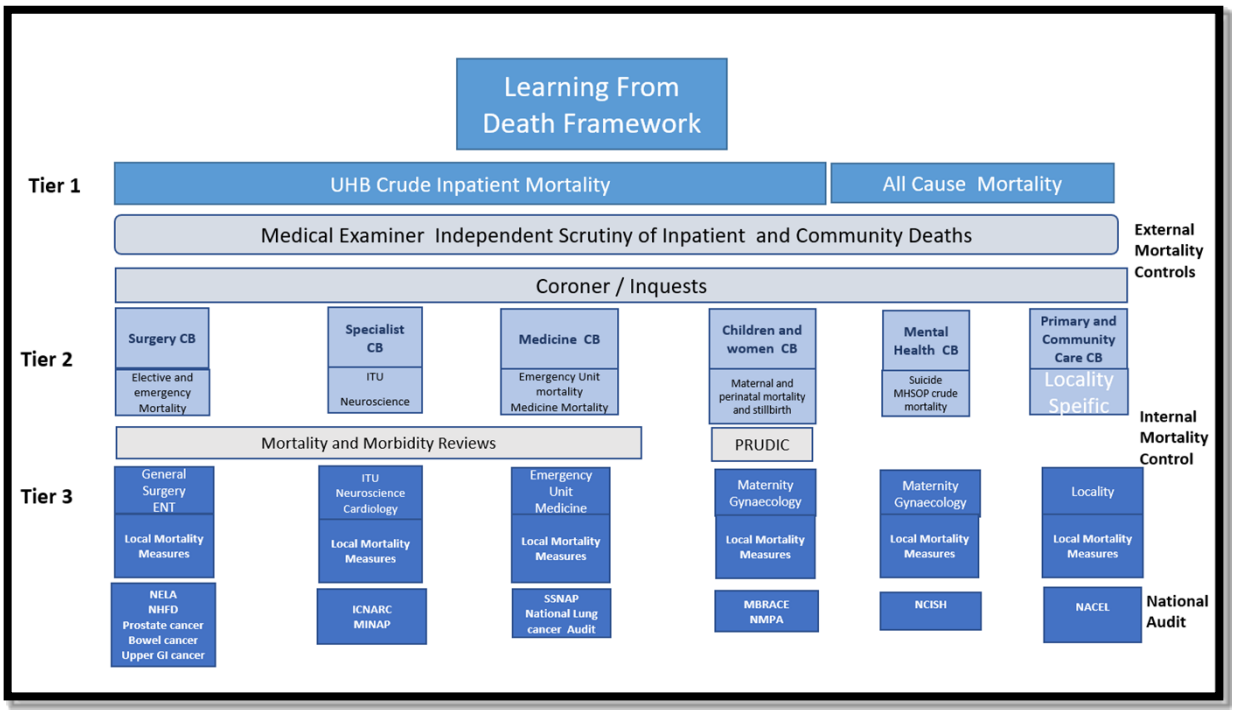
Expected benefits of the approach:

- Improve experience for staff working on wards.
- Better organisation of ward processes.
- Smoother discharge planning and organisation – reducing length of stay.

Mortality

To support an approach of systematic ward to Board reporting and monitoring of mortality, robust and accurate mortality data needs to be made readily available to allow the identification of trends and the subsequent triangulation of condition specific mortality data with information from the Medical Examiner. A stratified model of mortality data sub-divided into three tiers will allow oversight at:

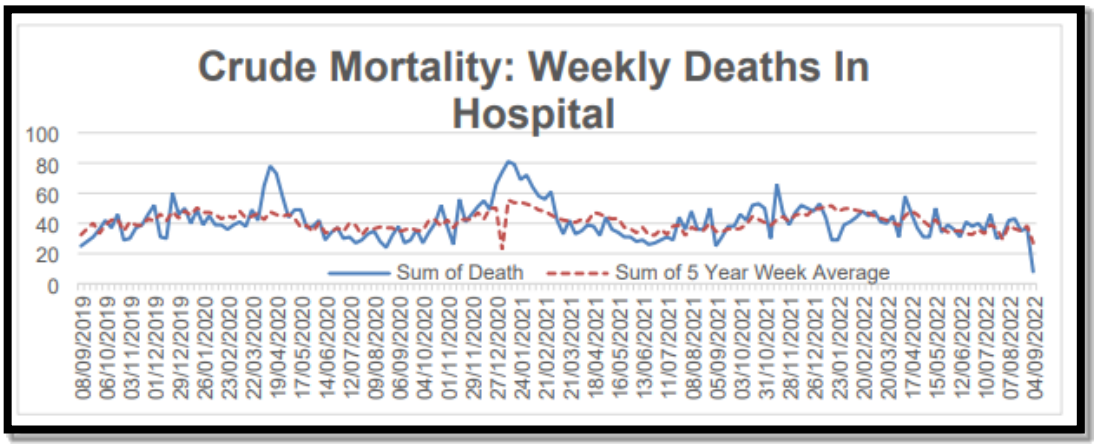
- Tier 1 - Health Board level
- Tier 2 - Clinical Board level
- Tier 3 - Speciality level



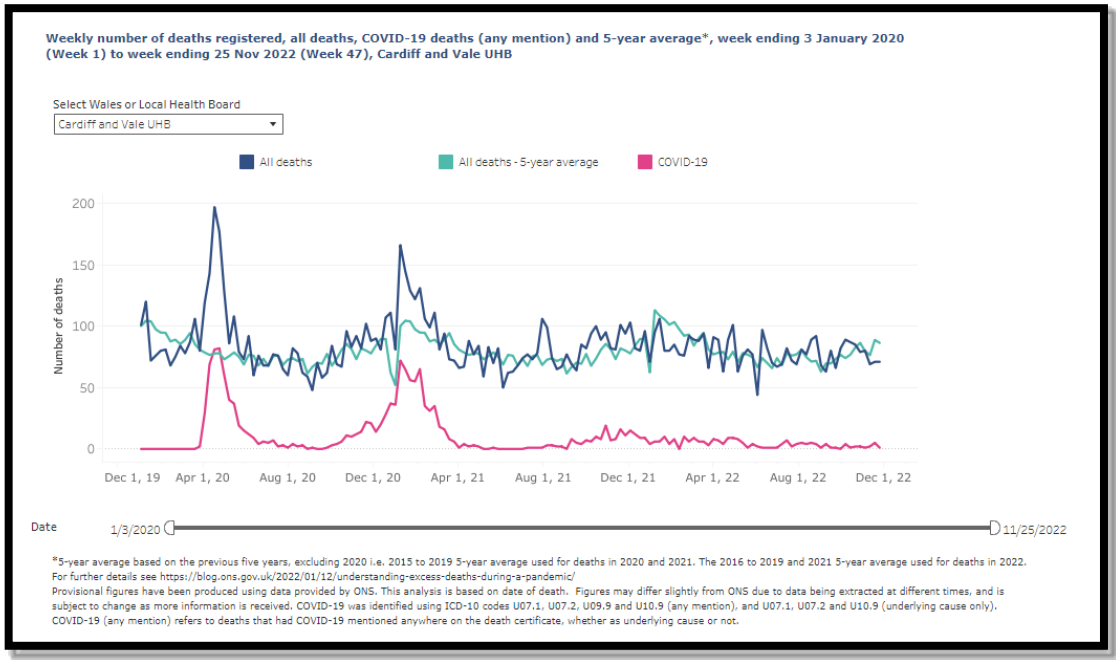
Tier 1 Mortality

Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart below demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week with the exception of March 2020 and December 2020 to February 2021, the first and second waves of COVID-19 where inpatient deaths rose above the 5-year average.

Crude Inpatient Mortality



Crude all-cause mortality demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan regardless of where they occurred. COVID-19 deaths the pink line illustrates the number of deaths where COVID-19 features on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had COVID-19 on their death certificate.



Tier 2 Mortality Indicators

The identification of Clinical Board mortality indicators will further support the proposed approach to mortality oversight. Learning from death can be achieved by identifying trends in mortality data that supports additional actions and scrutiny. These measures will include:

- Systematic reporting of mortality at Clinical Board Quality and Safety meetings or a similar forum.
- Triangulation of information from the Medical Examiner where increases in mortality rates are noted, e.g. if stroke deaths are observed to increase, thematic reviews of Medical Examiner referrals relating to this specific patient group should be undertaken to identify any contributory factors.

- Case note reviews will be considered to provide assurance in the absence of other patient specific clinical reviews.

- Presentation of mortality themes and trends at the Health Board Mortality Review Group to support organisational learning.

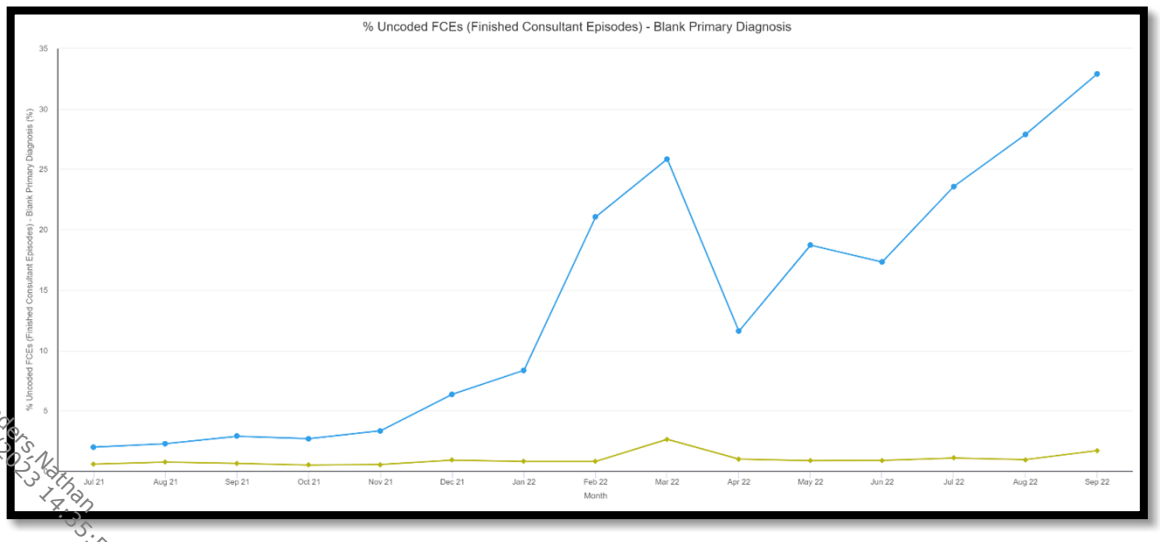
Work is underway to support the ongoing and systematic reporting of all Tier 2 mortality indicators but some have been included in body of the report.

For the purpose of this report condition specific mortality is reported as funnel charts. All funnel charts demonstrate the Health Board's mortality rate for September 2021 to September 2022 and compares our performance with the 2021 Acute Trust Peer group, which includes:

- Manchester University NHS Foundation Trust
- University Hospital Bristol and Western NHS Foundation Trust
- Royal Free London NHS Foundation trust
- University Hospital Southampton NHS Foundation Trust
- Sheffield Teaching Hospital NHS Foundation Trust
- Guys and Thomas' NHS Foundation Trust
- University Hospital of North Midlands NHS trust
- Homerton health Care NHS Foundation Trust
- University Hospital Birmingham NHS Foundation Trust
- The Newcastle Upon Tyne NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- North Bristol NHS Trust
- University Hospital of Leicester NHS Trust
- Nottingham University Hospitals NHS Trust
- Imperial College Health Care NHS Trust

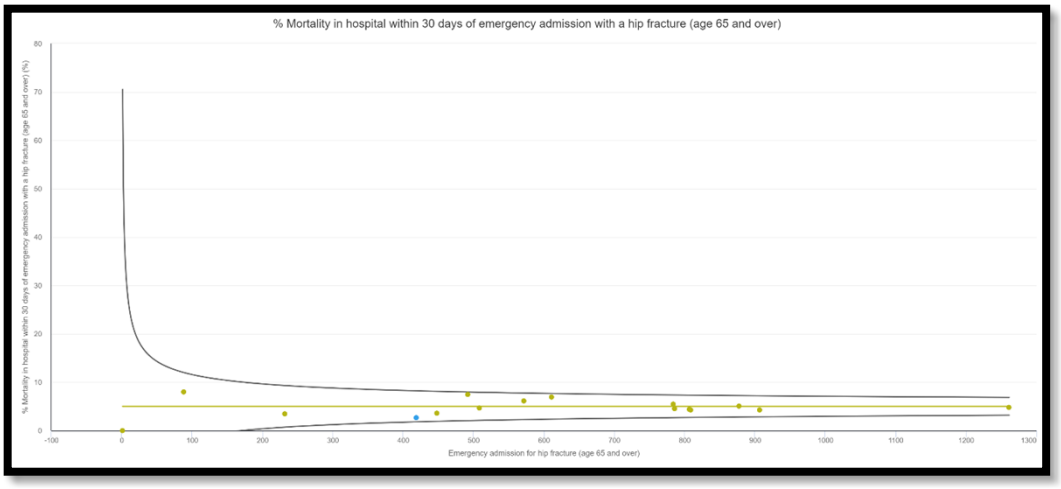
Funnel plots demonstrate distribution of performance per organisation within the Acute Trust peer Group. C&V UHB is illustrated in each as a blue dot. The X axis (bottom line) on each chart is the number of cases seen by the organisation and the Y axis (vertical line) is the % mortality.

The completion of clinical coding is vital to support the generation of accurate mortality data. The % of uncoded primary diagnosis was 11.58 % in April 2022 and has increased to 32.89% in September 2022. The prioritisation of coding of mortality cases can lead to an over representation of mortality across the case mix and increase the reported mortality rates.



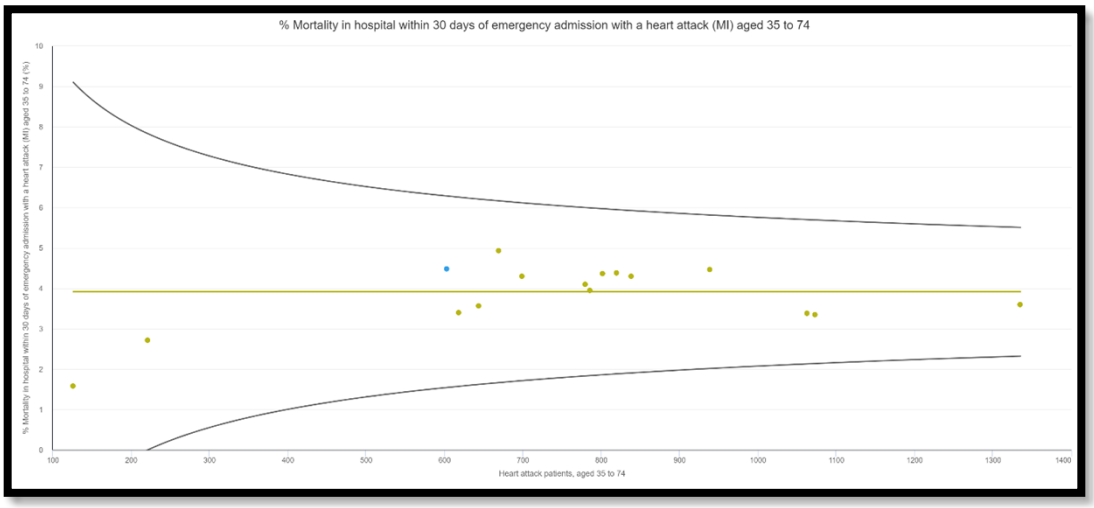
Fractured neck of femur

The Funnel Plot illustrates 2.62% in hospital following an emergency admission with a hip fracture compared with a mean rate of 5% on the 2021 Acute Trust Peer Group and is within the 95% confidence interval. This data does not include patients who die within 30 days of the hip fracture but following discharge or those patients who were transferred back to mental Health wards following hip fracture and subsequently die on these wards within 30 days of the hip fracture. The National Hip Fracture Database has previously provided case adjusted mortality benchmarked against UK organisations. The mandate to submit data to the NHFD was relaxed in 2020 and as a result this data is not available from December 2020 onwards.



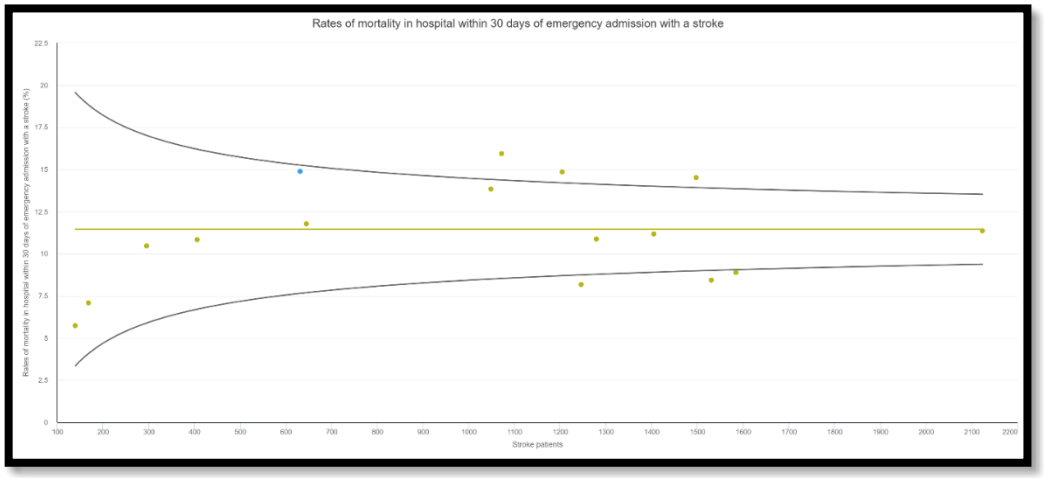
Myocardial Infarction

The funnel plot below illustrates Cardiff and Vale % in hospital within 30 days of an emergency admission with an MI (age 35-74). Performance is compared to the 2021 Acute Trust Peer Group for the period of September 2021-September 2022. Cardiff and Vale mortality rate is 4.478% which is within the 95% confidence interval and just above the national mean of 3.9%.



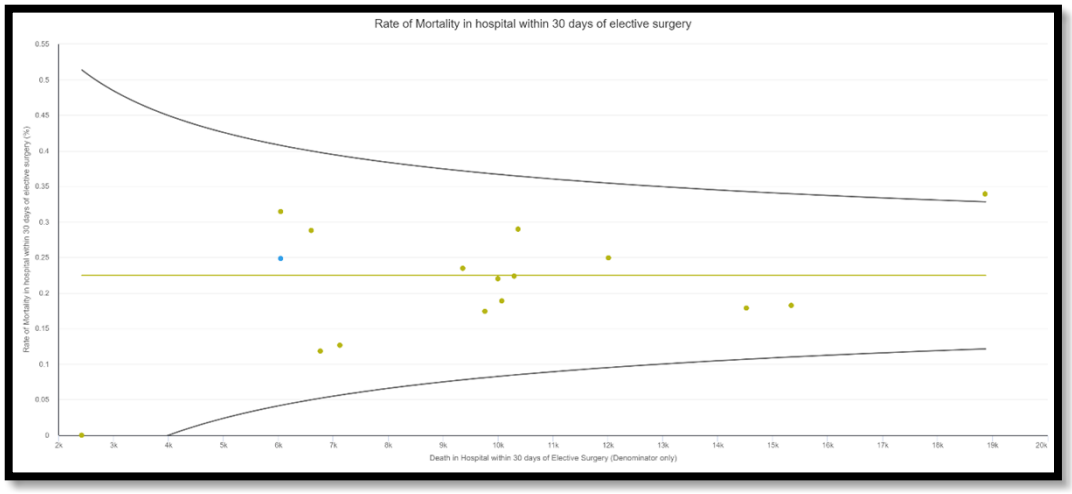
Stroke

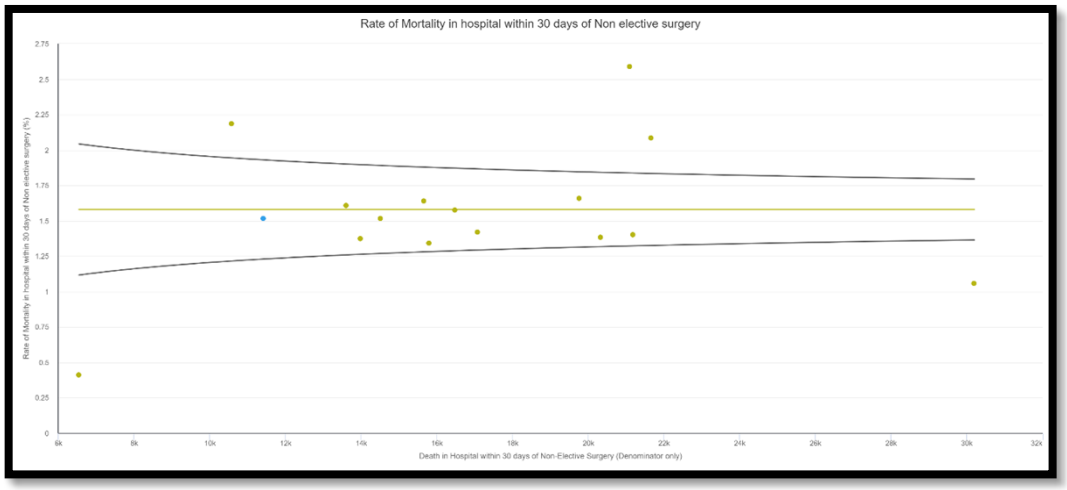
The funnel plot below shows mortality within 30 days of emergency admission for stroke between September 2021 and September 2022 compared with peers. The % mortality is higher that the peer average but remains just within the 95% confidence interval. Cardiff and Vale mortality rate is 14.89% compared to the top hospital peers at 11.73%.



Surgery

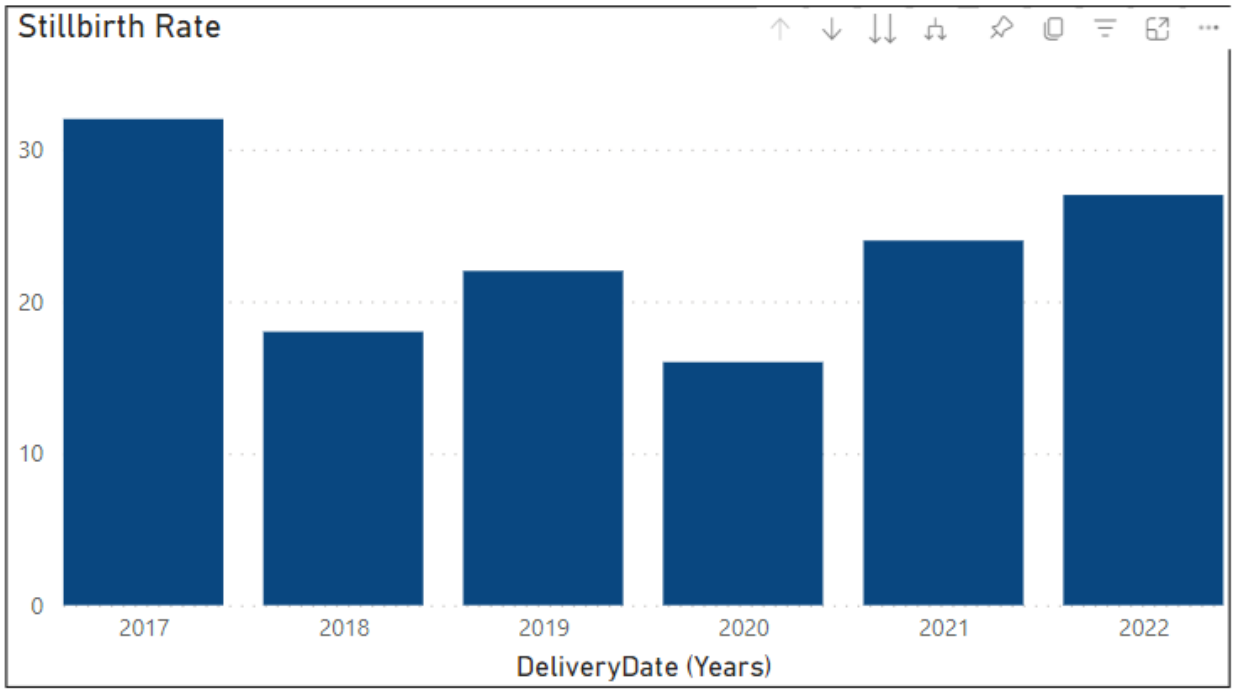
The two charts below illustrate % mortality within 30 days of elective and non-elective surgery. Both remain within the 95% confidence interval, and close to the peer group mean.





Stillbirth rate

Stillbirth data for 1st Jan 2017 - to 30th Nov 2022 is presented. We use a 5-year range within the dashboard but in 2016 we had 43 stillbirth which demonstrates the reduction over the subsequent 5 years following the Gap and Grow and Safer Pregnancy initiatives.



The rate per 1,000 births is as follows:

2017	5.61			
2018	3.21			
2019	4.13			
2020	2.98			
2021	4.39			
2022	5.58	(December Data not included)		

Over the last 5 years in total - our stillbirth rate has been 4.30 per 1,000 registerable births.

Further data regarding ethnicity and smoking data will be available shortly.

Person-centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

Concerns –Patient Experience

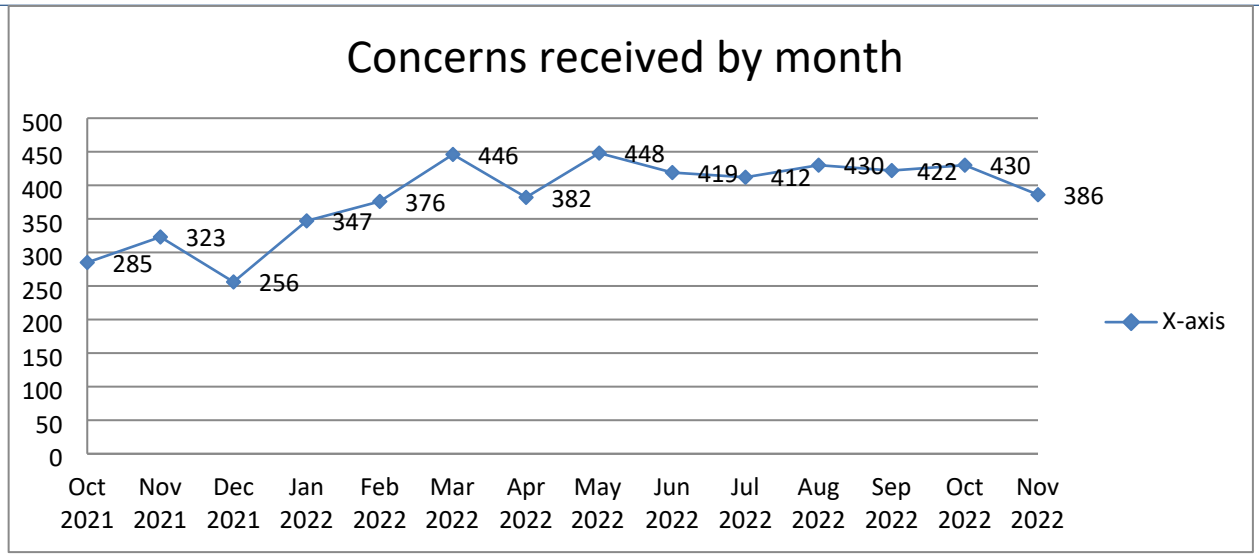
During October and November, we have maintained an overall 30 working day response time for all concerns, of 80%. However, we are concerned at the 8% decrease in November which is due to the operational pressures being experienced by the clinical teams to undertake the investigations.

August 30 day performance 80%
September 84 %
October 85%
November 77%

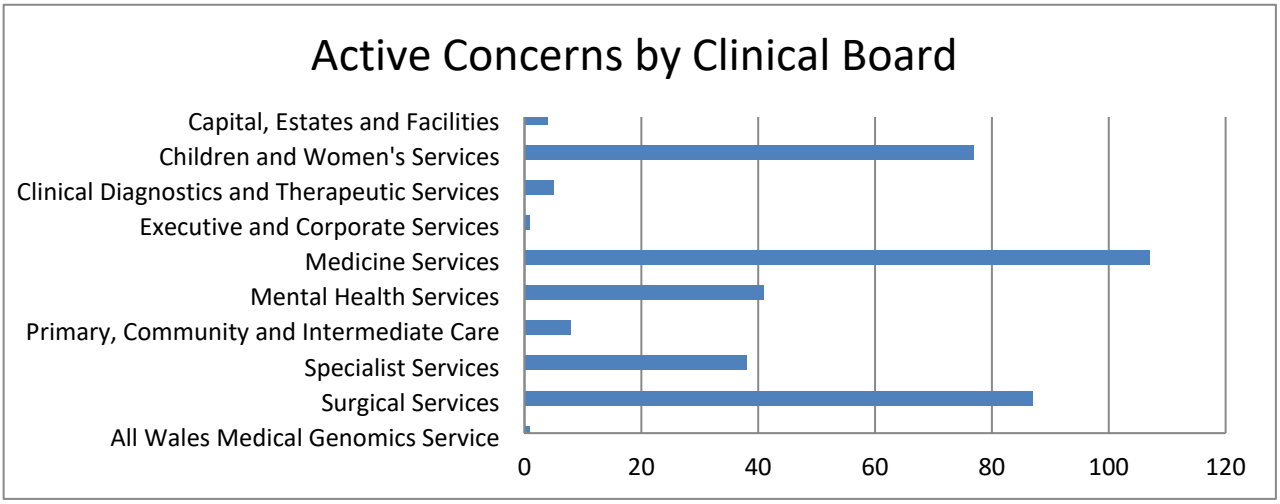
In October and November, we processed **60%** of concerns in line with Early Resolution (*this process can be utilised dependent upon the nature of the concern*) Early Resolution aims to ensure a response is received within 2 working days, if however, we cannot issue a satisfactory response to a concern then the formal process must be used.

It should be noted that previously we have been able to process up to 80% of concerns via the Early Resolution route but it is dependent upon timely response to enquiries and ensuring that a satisfactory resolution for the complainant is achieved.

Due to the current demands on the service the volume of concerns is increasingly challenging and it is appreciated that failure to answer concerns in a timely way is not acceptable and we continue to be focused upon improving the response times whenever possible and addressing the underlying themes.

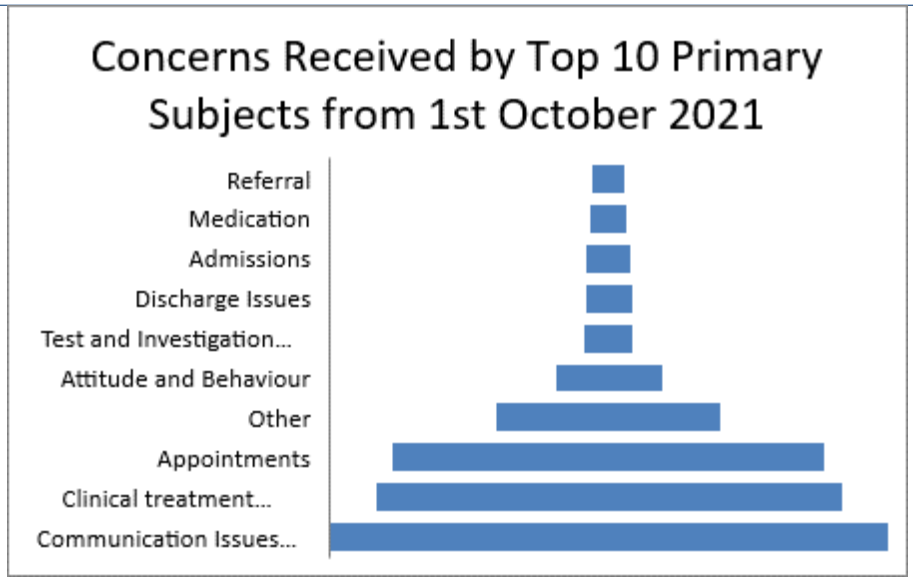


We currently have 369 active concerns. Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, the high volumes of concerns received in Medicine and Surgery Clinical Board is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of necessary cancellations and delays due to Covid and the significant increase and demand on services like EU.



The graph below demonstrates the 10 main themes noted in Concerns.

Communication and Clinical treatment continue to be the primary subject noted in concerns, however, it should be noted that the number of concerns that also highlight the environment, facilities and attitudes and behaviours are emerging as a theme and increasingly statistically significant in number



Whilst performance is important as a quantitative measurement another quality metric is the number of cases referred to the Public Service Ombudsman for Wales and the number that they investigate.

The Welsh Risk Pool, at the request of Welsh Government, have undertaken a validation exercise of the 2022-23 Q2 quarterly complaints data prepared for submission by each health body.

The validation exercise was intended to provide support to each health body in relation to the assurance of local processes for the application of the requirements of the Putting Thing Right regulations, published definitions and guidance and the maintenance of accurate and consistent information within the Datix Cymru system

The validation exercise consisted of verifying source data provided by the health body and comparing this to the prepared proforma, addressing variances or queries through liaison with staff within the organisation.

The validation report is presented using the standard approach to audit assurance ratings and contains recommendations to enhance local processes

Validation Report – Complaints Data

V1: 31st October 2022

Health Body	Cardiff and Vale University Health Board

Assurance Report

This assurance report is provided following analysis of a draft Proforma and the provision of source data which has been used to complete the proforma.
The assurance rating is **not** based on analysis of live data within Datix Cymru systems.

Substantial Assurance		All data provided on the proforma is validated following analysis and enquiries made. Few matters require attention and are minor in nature. The organisation can take substantial assurance in relation to local complaints data processes.
Reasonable Assurance		The majority of data provided on the proforma is validated following analysis and enquiries made. Some matters require management attention and are minor in nature.
Limited Assurance		Some of the data provided on the proforma is validated following analysis and enquiries made. More significant matters require attention.
No Assurance		**None of the data provided on the proforma is validated following analysis and enquiries made. Action is required to address the whole complaints data framework / process.**
Assurance Not Applicable		The health body is not required to submit complaints data or has no complaints data to submit. Validation has not bee possible or appropriate.

Based on the information provided, the health body can take **substantial assurance** regarding the preparation, scrutiny and submission of data for the Welsh Government Complaints Proforma.

Assurance Rating	SUBSTANTIAL ASSURANCE
Proforma suitable for submission to Welsh Government?	YES – Submitted to WG by Welsh Risk Pool

As an organisation it was pleasing to receive substantial assurance regarding our data collation and performance information.

Information from each organisation was shared with the Public Service Ombudsman for Wales to provide a national picture

The national data shows that between April and September 2022 Welsh Health Boards and Trusts received over 10,500 complaints. This is the equivalent of 6.84 complaints for every 1,000 residents of Wales

The data collected by us shows that 28% of complaints recorded by Health Boards and Trusts were about clinical treatment or assessment, 18% were about appointments, and 17% were about communication issues.

Welsh Health Boards and Trusts closed just over 9,700 complaints within the relevant period – 76% within the target of 30 working days.

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to Public Services Ombudsman for	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Aneurin Bevan University Health Board	591,225	1,656	5.60	1,568	80.29%	83	5.29%	70	22.86%	10.00%	10.00%
Betsi Cadwaladr University Health Board	698,369	1,786	5.11	1,473	61.98%	114	7.74%	102	35.29%	23.53%	9.80%
Cardiff and Vale University Health Board	496,413	2,509	10.11	2,357	83.03%	65	2.76%	61	19.67%	14.75%	4.92%
Cwm Taf Morgannwg University Health Board	445,190	1,676	7.53	1,558	87.61%	77	4.94%	65	16.92%	9.23%	7.69%
Hywel Dda University Health Board	385,615	1,269	6.58	1,164	75.00%	43	3.69%	45	51.11%	37.78%	13.33%
Powys Teaching Health Board	132,447	76	1.15	82	40.24%	15	18.29%	13	23.08%	15.38%	0.00%
Swansea Bay University Health Board	389,372	1,066	5.48	986	65.82%	68	6.90%	57	26.32%	15.79%	8.77%
Velindre University NHS Trust	-	84	-	73	98.63%	3	4.11%	3	100.00%	33.33%	33.33%
Welsh Ambulance Services NHS Trust	-	619	-	289	57.79%	22	7.61%	26	15.38%	3.85%	3.85%
Wales	3,138,631	10,741	6.84	9,704	75.89%	490	5.05%	413	28.09%	17.92%	8.72%

It is pleasing to note that the percentage of concerns referred to the Ombudsman is the lowest across all Health Boards. We feel that direct engagement with complainants and the offer of a meeting to discuss their response is a factor.

The total number of concerns raised is high which does demonstrate a healthy culture where people feel able to raise issues but we must interrogate the data for themes and trends to ensure that we are not receiving concerns due to a lack of learning or mitigation being put in place.

Patient Experience Feedback **HappyOrNot feedback** (All locations)

In relation to the 'HappyOrNot' feedback, those reported as being satisfied are respondents who when asked: How would you rate the care you have received? chose the 'Very happy' or 'Happy' button options i.e. gave a positive response.

A breakdown of the feedback for October and November is:

Summary values	October	November
Surveys completed	**1810**	**1975**
Response: Very happy button (Excellent/Very positive)	64%	66%
Response: Happy button (Good/Positive)	9%	8%
Response: Unhappy button (Fair/Negative)	5%	5%
Response: Very unhappy button (Poor/Very negative)	22%	22%
Respondents satisfied	**73%**	**73%**

Civica 'Once for Wales' platform

The CIVICA 'Once for Wales' software platform enables Health Boards to collect and report on feedback. This could be feedback from patients, staff or the wider public. This initiative is currently being implemented across all Welsh Health Boards.

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS,

The table and figures below give some of the summary information received so far:

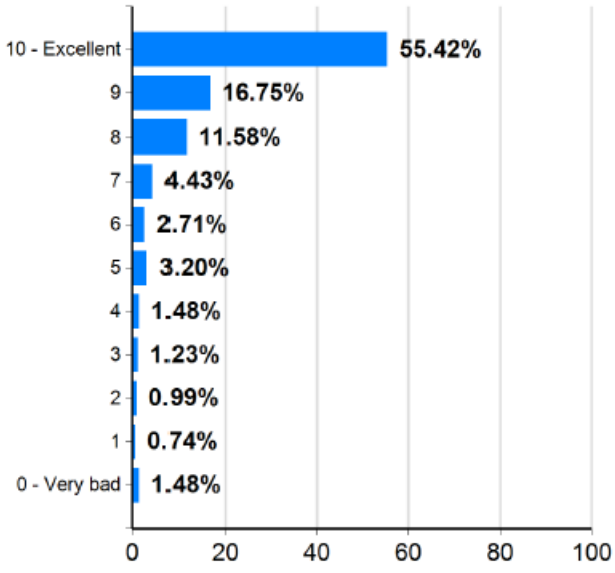
Summary values	**Oct / Nov**	**Dec** (to 14/12)
Surveys completed	1722	422
Respondents satisfied	**88%**	**88%**

For the above, the 'Respondents satisfied' figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

Table below Gives a detailed breakdown of December's rating question feedback.

Question 5: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Available Answers	Responses	Score (%)
0 - Very bad	6	1.48%
1	3	0.74%
2	4	0.99%
3	5	1.23%
4	6	1.48%
5	13	3.20%
6	11	2.71%
7	18	4.43%
8	47	11.58%
9	68	16.75%
10 - Excellent	225	55.42%
Total	**406**	**100%**

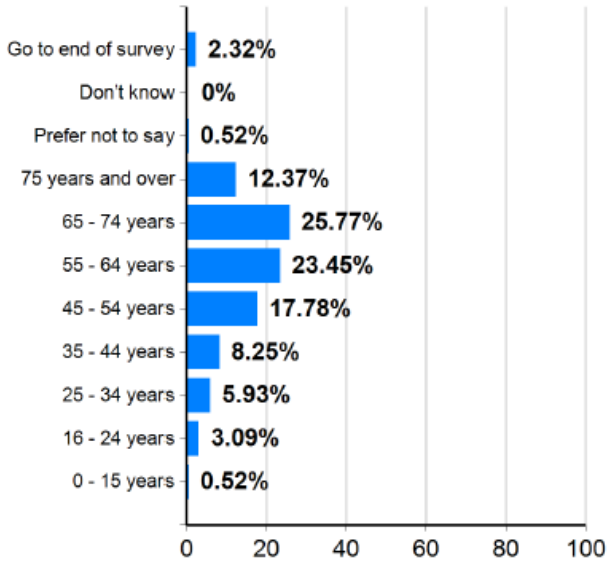


Create new action

Table below Gives December's feedback, broken down by age group of respondents.

Question 9: What is your age? Please give the patient's age, if completing this questionnaire on their behalf.

Available Answers	Responses	Score (%)
0 - 15 years	2	0.52%
16 - 24 years	12	3.09%
25 - 34 years	23	5.93%
35 - 44 years	32	8.25%
45 - 54 years	69	17.78%
55 - 64 years	91	23.45%
65 - 74 years	100	25.77%
75 years and over	48	12.37%
Prefer not to say	2	0.52%
Don't know	0	0.00%
Go to end of survey	9	2.32%
Total	388	100%



Create new action

The reports available via the Civica platform are quite detailed and include:

- Survey response breakdown
- Heat map
- Comment report
- Custom reports

The plan is not only to give staff access to their own data and reports, but to also set up regular push reports to users.

It is hoped that in coming months the platform will act as our main 'hub' to collect and collate feedback from various sources e.g. SMS, paper, other links, tablets and kiosks. The system will also enable users to create and deploy their own survey designs and analyse their feedback.

Bespoke project examples

We are also currently involved in numerous bespoke projects, for example:

- BSL survey
- National health visiting questionnaire
- Radiology questionnaire

Key messages

- Quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve
- Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable and person-centred**
- These quality dimensions (so-called STEEEP) provide a framework to assess quality and guide improvement
- Quality enablers have been identified which underpin and influence a blueprint to ensure a system-wide approach to improving quality
- The quality enablers are **leadership; culture and valuing people; data to knowledge; learning, improvement and research and whole-systems perspective**
- Maturing and embedding the quality management system takes time, vision, ambition, and an active commitment to learning and improving

Executive Director Opinion and 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 these indicators identified for review by the QSE Committee.

Recommendation:

The Committee is requested to:

Note the content so the report and the developing process to monitor Quality Indicators

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention		Long term		Integration		Collaboration	✓	Involvement	✓

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Quality indicators should help to identify areas of concern.
Safety: Yes
Delays in investigations presents a delay in identified learning and mitigation being put in place at the earliest opportunity the Quality Indicators should help when viewed collectively to pre-alert to areas of concern.
Financial: Yes
Failure to identify learning from themes will lead to increased harm and litigation.
Workforce: No
Legal: Yes
We need to adhere to the relevant legislation.
Reputational: Yes
There is media interest in QSE.
Socio Economic: Yes/No
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the quality indicators to the level of low super output areas of social deprivation in comparison to areas of affluence.
Equality and Health: Yes
Many quality indicators when reviewed in detail demonstrate equality and health inequalities.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Healthcare Inspectorate Wales Activity			Agenda Item no.	2.4
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	10 January 2023
		Private			
Status *(please tick one only)*:	Assurance	X	Approval		Information
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Angharad Oyler, Head of Quality Assurance and Clinical Effectiveness				

Main Report
Background and current situation:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews and inspections carried out by Healthcare Inspectorate Wales (HIW). 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

Activity Since November 2022 QSE Committee Report

Unannounced Inspections

There have been no unannounced inspections since the last QSE committee meeting, Publications of the following reports are awaited.

Maternity Services were subject to an unannounced Inspection by HIW on the 9th, 10th 11th November 2022. A number of immediate assurances recommendations were issued following the inspection. The report and associated improvements will be presented to the Committee on publication by HIW.

IRMER Inspection

An IRMER compliance inspection was undertaken in Nuclear medicine Department at UHL on the 11th and 12th of October, Initial verbal feedback was overall positive, there were no immediate concerns identified. The report will be presented to the committee following publication by HIW along with the associated improvement plan.

National Review of Patient Flow (Stroke Pathway)

HIW aim to publish the final Patient Flow (stroke pathway) report in Spring 2023. No immediate assurance recommendations were issued following on from the Cardiff and Vale UHB site visit.

Ophthalmology Thematic review 2015-16

In 2015-16 HIW completed a thematic review relating to ophthalmology, focusing on wet age-related macular degeneration (Wet AMD) services. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing the care and support required by patients. The aim of the review was to assess how effectively health boards have been utilising service integration as a means of making the best use of the breadth of expertise and resources available. The review consisted of two phases. Phase one involved interviews with senior representatives from all health boards. Phase two involved additional interviews with operational staff from three selected health board areas namely Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board and Hywel Dda University Health Board.

The UHB submitted an improvement plan in response to the recommendations made by HIW. In December 2022 the Health Board were asked to provide an update on progress made in delivering the improvement plan. The updated action plan is included in appendix 1.

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

There have been no further HIW inspections since the November QSE committee

The UHW maternity report is yet to be received from HIW, however the Health Board has responded in relation to immediate assurance recommendations made following the inspection.

HIW have received an update on the improvements and actions implemented to address the recommendations made following the 2015-16 Ophthalmology Thematic Review. The majority of improvements have been completed with one actions remining for the Health Board to ensure that patients are provided with adequate information about their condition and treatment. An audit of compliance with the GMC consent standards in planned for February 2023 and work is underway to develop a bespoke ophthalmology patient experience survey which will be complete by February 2023.

Recommendation:

The Committee are asked to:

NOTE the assurance provided by the response to HIW inspections and progress against existing improvement plans

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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*									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
09/01/2023 14:35:51

Appendix 1

Thematic Review: **Improvement Plan: 2017-18** **CARDIFF AND VALE UHB**

Department: Opthamology

Date of inspection: 2015/16 **Updated 14/12/22**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
MD 1/1	Issues relating to patient referral process (Patient Referrals - Referral Process)	All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	1 i)The UHB requested NWIS select Specsavers Cardiff as their pilot site for e-referrals as this our highest referrer to secondary care services (rather than Boots who were selected by NWIS and who are a very low referrer and are not engaged with the programme) NWIS have declined this request (20 Jan 17) . Therefore the UHB is exploring other options	Technical Development Manager/ Executive Director of Therapies and Health Science	March 17	**Completed**
			1ii) In addition work has been commenced by the national eye care steering group to look at developing an EPR for eyes, though implementation is not expected until 2018.	National eye care steering board/NWIS	April 18	**Partially complete:** There has been good engagement and progress is being made. Funding has been awarded by Welsh Government

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
						to develop open ERS enabling optometrists across Wales to submit electronic referrals for all eye care pathology pathways. we anticipate in early 2023 that the application will go live in Cardiff and Vale in preparation for roll out across Wales to be fully operational 2023
MD 2/1	The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process)	Health Boards via Local Eye Care Groups should work with optometrists to ensure that patients are provided with adequate and accessible information regarding the reason for their referral to secondary care and ensuring that all patients feel listened to and involved in decisions made around their care.	2. Optometric lead will review current arrangements and develop an action plan to address gaps working with patient groups and third sector	Optometric Advisor	June 17	**Completed** A review of arrangements has resulted a quarterly meeting which has been established and in place to ensure that service user feedback considered. There is representation from Optometrists, 3rd sector RNIB, consultants a, service managers and CCH.
MD 3/1	Quality of referrals being sent to rapid access pathway	3 A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate	3 A) Pathway redesign and audit as part of Big 3 service improvement	Optometric Advisor/	Nov 16 – June 17	**Completed**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
	(Patient Referrals – Quality of Referrals)	care pathway in a timely and efficient manner, avoiding unnecessary visits.		Improvement Manager		Cataract referrals have been regularly audited by optometric advisor, conversion rate now >90%. Other sub-specialties will be timetabled for action. Further addressed with the implementation of open ERS to enable consultants to return a referral if inappropriate for treatment in the acute sector
		B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways	3 B) Training sessions with optometrists	Optometric advisor	Commenced Nov 16 with an on-going scheduled training programme	**Completed:** Optometric advisor had commenced programme of education. Cardiff and Vale UHB in collaboration with Cardiff University School of Optometry have opened and is operational the NHS Wales eye care centre supporting the training of more than 50 optometrists across Wales

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
		C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	3 C) Training sessions with optometrists	Optometric advisor	Commenced Nov 16 with an on-going scheduled training programme	**Completed:** Optometric advisor had commenced programme of education. In addition the e-referral module is being rolled out via the open eyes electronic patient referral system, anticipated to be in place in 2023.
MD 4/1	Lack of feedback provided to optometrists following referral and discharge of patients. (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information)	A)Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral	4A) Exploring potential for patient management system to enable communication back to referring optometrist, (rather than just GP) to give timely feedback. If this is possible to develop implementation plan to progress. If development work needed to develop a plan for this work.	Technical Development Manager/	March 17	**Completed** Cardiff and Vale UHB are the lead authority for the implementation of the national eye care digital programme, already operational in Cardiff and Vale withy National Role out in 2023 across Wales

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
		B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible	4 B) To be included in training (Action 3 B & 3C)	Technical Development Manager/	Commenced Nov 16 with an on-going scheduled training programme	**Completed** Optometric advisor had commenced programme of education
		C) Health boards/welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care	4Ci) LHB action included in Action 4 A	Technical Development Manager/	March 17	**Completed** Optometrists will also be able to access the open eye digital patient care notes.
			4Cii) WG action included in enabling procurement and deployment of EPR (Action1ii)	WG/NWIS	April 18	**Completed**
MD 5/1	CHC reports concerns around lack of information provided within	Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to	5. C&V UHB has good information for patients. However Audit will be undertaken to ensure that patients feel informed about their care plan and treatment and this conforms to GMC guidance on informed consent	Ophthalmology Consultant/ Audit Lead	Updated timescale 20.12.22	**Partially completed**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
	secondary care prior to treatment (Patient Referrals – Communication Following referral)	any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	Patient experience Team captures some Ophthalmology patient feedback through the Civica 'Once for Wales' system, These patients either receive a link to the generic 'Tell Us in 2' or National survey.			There is an agreement between the General Manager and Clinical Director to undertake an audit of compliance with the GMC informed consent standards. February 2023 There is also work underway to develop a bespoke patient satisfaction survey specifically around patient information. This will be distributed to patients in a paper format and/or electronically e.g. as hyperlinks, QR codes, via tablet and/or kiosk and fed back through the directorate Q&S meeting and will be led by the Outpatient Senior Nurse. February 2023
MD 6/1	Concerns around set monitoring for follow-up patients	A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data	6 A) Ophthalmology to work with IT team to determine whether PMS can deliver this functionality	Directorate manager	March 17	**Complete-** Our PMS IT system has a follow up tracking capability, which is available to

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
	(Treatment Timescale – Targets)	on clinician recommended follow-up interval and actual follow-up interval by care pathway.				ophthalmology. However, Data needs to be consistently inputted by clinical and OP admin teams, Denis Williams leading work to ensure a SoP is developed for this, and data quality monitored. Cardiff and Vale are operational with open eyes system for its eyecare services
		B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	6 Bi) Work being led by C&V UHB on a national basis on behalf of the medical directors, to address this recommendation with regard to prioritisation.	Medical Director	Dec 16- June 17	**Complete** Cardiff and Vale UHB is the first in the UK to create an operational ODTC in 2019 and has been operational since and the development of the new NWUECC to address the perfect storm in ophthalmic services today and have received numerous awards nationally and Globally for this work.

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
			6 Bii) In addition developing ODTC and nurse led initiatives to increase capacity for consultants to see those patients in most clinical need of seeing a consultant	Directorate Manager & PCIC	Jan 17- Sept 17	**Complete** In addition to this work the training of nurses is also a priority, in 2022 7 nurses were supported with training for ophthalmic academic qualifications, another 8 nurses booked on the training for the next academic year.
		C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan	6 C) Being captured through Consultant outpatient module of PMS, but also requires additional outpatient service improvement, which will be managed by surgery clinical board as part of the eye care improvement programme (BIG 3)	Directorate Manager	Sept 17	**Complete** Follow-up management plans and imaging also being recorded on Medisoft or Open Eyes. The national digital programme for ophthalmic services is open eyes is already operational in Cardiff and Vale and planned for operationalisation across Wales in 2023
MD 7/1	Lack of incident reporting relating to WG patient harm policy (Incident Reporting)	A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures	7A) Remind staff of incident reporting requirements and ensure incidents are reviewed as part of quality and safety agenda for surgery clinical board	Director of Nursing for Surgery Clinical Board	May 17	**Complete** Dedicated time is set during audit to discuss incidents reported which feeds in to the monthly audit session

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
		B) Health Boards must ensure on the occasions where any incidents occur, in line with the WG policy related to patient harm, that these are reported as Serious Untoward Incidents (SUI's).	7B) Ensure ophthalmology incident reporting to WG complies with SUI policy	Assistant Director Nursing	Jan 17	**Complete** The Quality and Patient Safety team support the Ophthalmology Directorate to adhere to the Nationally Patient Safety Incident reporting Policy and the patient safety facilitator reviews all incidents resulting in serious harm or above as well as those that require external reporting .
MD 8/1	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity)	A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	8A) Workforce plans developed in line with IMTP plans for eye care and also as part of national work on eye care workforce planning – looking to adopt prudent workforce principles)	PCIC and Surgery Clinical Board workforce leads	Jan – March 17	**Complete** Workforce planning undertaken as part of IMTP process, will be on-going as service requirements develop and change Workforce Task and Finish Group established within PCIC and an information tool has been sent to Optometrists.

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		B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	8B) Developing plans for ODTC and maximising primary care element of pathways as part of eye care plan implementation and BIG 3 workstreams	Directorate Manager /Head of Dental and Optometry. Optometric advisor/PCIC	Feb 17- Sept 17	**Complete** Regular and sustained engagement between primary and secondary care in several fora, including managers and clinicians. Strategic leadership from Executive and Clinical Board level to ensure on-going relationship development. Team development session scheduled for April 17. A working group has been established between primary and secondary care, of which the purpose is the delivery of the revised eye care delivery plan, HIW report and CHC report. This groups meets monthly.
MD 9/1	Health boards should learn from the experiences following progress made in other areas	A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared	9A) C&V now have senior attendance at National Planned Care Boards including CB representation by the Director of Operations Directorate manager and Optometric advisor	Directorate Manager / Optometric advisor	Jan 2017	**Complete**

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	(Treatment – Initiatives to improve Capacity)	learning from/with staff in other areas.				
		B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	9B) WG action, but will be addressed by national planned care board eye heath group where all LHBs are represented. Possibly also an action for OSAG	WG action	Sept 17	**WG Action**
MD 10/ 1	Importance of the AMD Coordinator role (Service Support Staff – AMD Coordinators)	Due to the demands of the role and the importance of providing continuity of cover, consideration should be given by Health Boards as to whether one AMD Coordinator is sufficient for the eye care service	10. AMD co-ordinator is employed. Additional resource has been provided to ensure continuity during times of leave	Directorate Manager	Jan 2017	**Complete** Have had an AMD coordinator in post for more than 3 years, support for periods of leave managed by Directorate
MD 11/ 1	ECLO – lack of utilisation of the role from other staff (Service Support Staff – Eye Care Liaison Officer)	Health Boards must ensure that all staff are aware of the availability of the local ECLO service. Ensuring patients have access to relevant advice and support.	11. Good engagement with ECLO, office accommodation within main outpatients setting. Involvement in Audit/Directorate meetings.2017	Directorate Manager	Jan 2017	**Complete**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
MD 12/ 1	ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer)	Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	12. 2017-18 Funding for ECLO requires securing	Director of Operations	March 2017	**Complete** Clinical Board have agreed to fund ECLO post on an ongoing basis
MD 13/ 1	Concerns raised by staff in relation to a lack of processes in place to submit comments/suggestions to health board management. (Service Support Staff – Eye Care Liaison Officer)	Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should to ensure that feedback is routinely provided to individuals	13 i) UHB has a programme of staff engagement (Values into Action" which has gathered input from 3000 sources. Feedback sessions are in place as well as tools to aid speaking up. Via feedback lead by UHB OD team.	OD team	Jan – Feb 17	**Complete** Freedom to speak up psychological safety in QSE framework
			13 ii) In addition the BIG 3 principles include engagement with clinicians and encouraging feedback to improve services.	Continuous engagement via Surgery clinical board, Clinical Director/ Operations Director/ and Directorate manager	Feb 17	**Complete** Regular and sustained engagement Team development session scheduled since April 2017
	More clarity required in relation to evolving role of optometrist	To enable more effective utilisation of optometrists, Welsh Government must provide clarity to health	14. WG action. And subsequent UHB implementation	WG action	Await WG timescale	**WG action**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
MD 14/ 1	(The role of optometrist)	boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.				
MD 15/ 1	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists)	Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	15 i) Will develop capacity and demand plans and identify capacity gap, and the skills mix required to fill any identified gap.	Surgery clinical Board and PCIC	March 17	**Completed** As part of IMTP and Eye care sustainability plan, capacity and demand planning completed and skill mix reviewed. Most prudent development of ODTC at this stage is to use LHB employed optometrists for ODTC work. Using optometrists as part of other pathway work and good uptake of cataract follow up
			15ii) Will seek clarity from WG re indemnity, financing and other elements as required (Action 14 above)	Executive Director of Therapies	April 17	**Completed** As in Action 14
MD 16/ 1	Patients not always being referred for their initial low vision assessment	Health Boards must ensure that staff are reminded of the importance of referring all eligible patients are referred to an accredited	16. As part of demand and capacity and service redesign work is underway with the optometric lead to develop further the use of optometrists in the service	Optometric Advisor	Jan 2017	**Partially completed** We have 2 optometrists who work alongside the Glaucoma

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	by secondary care staff. (Utilisation of optometrists)	optometrist for a low vision assessment.				clinics. Submission through our IMTP 2023 to seek approval for the development of a secondary care service to support this work. preliminary discussions have taken place with the Surgery Clinical Board held 29th November at an IMTP away day. The Directorate will formerly provide a project on a page to outline the requirements for this development, expected January 2023.
MD 17/ 1	Issues in relation to poor relationships between primary and secondary care staff impacting on progress to service developments (Primary and Secondary Care Relationship)	Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.	17.This is currently happening. Regular meetings, minuted and attended by both Primary and Secondary care clinicians and managers. Last was held on 13/01/2017. Next scheduled for 10/02/2017. Exec Chair of the C&V eye care group is also Chair of the national group. Team development session scheduled for April 17.	Executive Director of Therapies/ PCIC and Surgery Clinical Boards and partners	Scheduled quarterly meetings.	**Completed** Regular and sustained engagement between primary and secondary care in several fora, including managers and clinicians. Strategic leadership from Executive and Clinical Board level to ensure on-going relationship development.

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						Team development session scheduled since April 17.
MD 19/ 1	Concerns raised about different criteria being used by different consultants, which subsequently means some patients are being followed up unnecessarily or treated with little chance of benefit. (Discharging Patients – Criteria)	Health Boards must ensure their AMD service has a policy setting out criteria for discharging 'wet' AMD patients in line with Royal College Guidance. The aim being to ensure that patients do not remain within the service longer than required. Maximising capacity for patients most likely to benefit. Adherence to the policy could form part of the annual service audit.	18.BIG3 AMD workshop being held on 20/01/2017 looking at pathway redesign. These criteria will be discussed. AMD revised pathway commenced March 17 and ongoing. SOP signed off December 2017	Improvement Manager	April 2017	**Completed**
MD 20/ 1	Inadequate IT systems to capture useful date. Limited awareness of capacity and demand data. (Information Management Systems - planning)	Improvements must be made to information management systems within health boards to enable accurate capturing of capacity and demand (performance) data to allow for more informed workforce planning and to ensure resource provisions are based on patient need.	20i) Review of PMS ability to track follow ups will be undertaken (Action 6A above).	IT management team	Mar 17	**COMPLETED** Functionality in place
			20ii) Use of WPRS to enable e referral will support improvements in capturing demand. However this requires optometry to be enabled to refer electronically, which is being picked up as action in actions (1iand 1ii)	National eye care steering board/NWIS	April 18	**Partially complete** e-optometry ongoing with approximately 15 practices and plans to expand further This is replaced by the implementation of open ERS which will be live

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						in Jan 2023 and rolled out nationally across
			20 iii) However a significant part of the issue is NHS Wales coding requirements for outpatients – this needs further exploration via the planned care Board.	Planned CB	June 17	As above Welsh Government has implemented for its ophthalmic waiting lists that R1, R2 and R3 coding structure against the clinical need of the patient against irreversible harm. There is a required for all Health Boards in Wales to monthly report on these codes against their patients planed next appointment date against that of the attended appointment date
	Issues in relation to information sharing (Information Management Systems –sharing information)	Improvements must be made on improving the access to/sharing of patient information within health board areas to improve efficiency of services	21. Specific issues will be highlighted by clinicans, and issues that can not be resolved and needing IG sharing advice to be raised with corporate information governance.	Ophthalmology Consultant lead	April 17	An essential component to deliver the Welsh Government initiative of shared ophthalmic care to address the perfect storm in our nation today involves sharing agreements

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						between all health boards and optometry practices. Cardiff and Vale are leading this for Wales and are currently in consultation with all health boards in developing and having signed agreements. This work is being addressed via the Eye Care Digitisation Programme (All Wales Ophthalmic electronic patient record). which will be live in Jan 2023 and rolled out nationally across
22	Lack of public awareness in relation to general eye care (Public Awareness)	Welsh Government , Public Health Wales and Health Boards need to consider how the general public can be made more aware the importance of regular eye checks, general eye care issues, as well as the symptoms to look out for which are associated with the more serious eye conditions and the	22.This is an action for Public Health Wales as part of the national plan	PHW	Dec 2017	**PHW Action**

	Recommendation	Recommendation Info	Health Board Action	Responsible Officer	Timescale	Update on actions 14/12/2022
		importance of seeking healthcare advice quickly. More information needs to be provided on the different services/professionals available to see/treat patients in relation to their eye care conditions.				

Health Board Representative:

Name (print): **Fiona Jenkins**

Title: **Executive Director Therapies and Health Science and Chair Cardiff and Vale Eye Care Group**

Date: **14/12/22**

Report Title:	**Board Assurance Report – Patient Safety & Workforce**				Agenda Item no.	2.11	
Meeting:	Quality, Safety and Experience		Public	x	Meeting Date:	10th January 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
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 risks on the Board Assurance Framework (BAF) which impact upon Patient Quality, Safety and Experience.

At the Board Meeting held on the 24th November 2022 the following risks were reported on the BAF which impact upon said areas:

- Patient Safety
- Maternity
- Critical Care
- Cancer
- Stroke
- Urgent and Emergency Care
- Planned Care.

With the exception of Patient Safety and Urgent and Emergency Care these were all new risks to the BAF.

These risks will be reported to each meeting of the Quality, Safety and Experience Committee going forward to ensure that they are being appropriately managed and/or mitigated, so the Committee can provide assurance to the Board that this is the case.

The highest scoring net risks (which is after controls are in place) from the above are Patient Safety (20), Maternity (20) and Critical Care (20). Further details including cause, impact, controls and assurances are also detailed in the attached risks.

Executive Director Opinion and 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, Quality and Experience Risks (last considered by the Board in November 2022) are considered to be key risks to the achievement of the organisation's Strategic Objectives.

There are also a number of risks on the Corporate Risk Register which relate to Patient Safety.

Recommendation:

The Quality, Safety and Experience Committee are requested to:

Review the attached risks in relation to Patient Safety, Quality and Experience to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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	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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No
Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Board	24th November 2022

1. **Patient Safety – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

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 the Emergency Unit (EU). 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 in a larger clinical footprint in relation to post Covid 19 recovery. Due to the ability to balance within the health community and the challenge 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 since the onset of the COVID 19 pandemic creating both longer 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, with an impact on patient outcomes Post Covid recovery sickness 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 Private Partner facilities. • 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 • Quality and Safety and Experience Framework Implementation underway • health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented •		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position reviewed at Strategy and Delivery Committee (1)		

	• Mental Health Committee aware of more people requiring support [1] • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives [1][2] • . [1] • Recent Executive review with Clinical Teams for understanding and review of front door pressures. [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 and domiciliary care settings. 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 Sept 2022
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.	Jason Roberts	30.04.23	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 with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Paul Bostock	31.03.23	Choice framework continues to be utilised
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog	Paul Bostock	31.03.23 Review October 22	Programme currently been reviewed by COO
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 High)**

2. Maternity Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockendon requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.

The background to, and summary of the Ockenden report, is best understood in the quote from Donna Ockenden below

> **"This final report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives. "**

The report details 89 recommendations that should be enacted to improve maternity services across the UK. An immediate self-assessment of the service was undertaken against the requirements, which noted that 45 of the requirements were already met, 27 partially met, and 17 not met at all. The detail of where we are currently not meeting recommendations and the proposal to close that gap has been completed (appendix 1). The recommendations that we currently fail to meet can largely be grouped into 3 categories, patient safety, quality and experience, training, and workforce.

Whilst underlying actions to progress the plans to achieve the recommendations have developed and presented to Execs, UHB agreement of circa £2M recurrent funding is required to deliver progress.

In addition, the service has sustained pressure across Obstetrics and Maternity care system, mainly due to reduced workforce availability, increased interventional birthing as a result of NICE guidance, backlogs on critical incident investigation etc

Risk	We are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports. We have a backlog of investigations, RCA's and concerns and as a result LFE delays Workforce concerns and adverse media
Date added: 3/11/22	

Cause	• In England 180 million pounds of funding was released to support each Trust in complying with all of the Ockenden Recommendations. Welsh Government have invested £1 million in to the Mat Neo Safety Programme across Wales, which is currently in its Discovery phase for circa 12 months, next steps of which are yet to be communicated. The operational view is that it is unlikely any further investment will be made available by Welsh Government to support implementation of the recommendations. • NICE clinical guidance Intrapartum care for healthy women and babies resulting in increased instrumental birthing practices. Patients presenting and subsequently admitted have a higher acuity and complexity, particularly in light of NICE guidance. • We continue to experience challenges in our ability to deploy sufficient workforce to cover community, Midwifery-Led and Obstetric-Led care setting services. We struggle with sustained workforce challenges from sickness, maternity leave, resignations, retirement and challenges of retention and recruitment. • One out-take of newly Qualified Midwives and Paediatric Nurses each year from Welsh Universities causing a limited flow of Midwives/Paediatric Nursing staff • Restricted Neonatal capacity continues to add an increased layer of complexity in managing patient flow. • T2 new area opened during Pandemic, but with no increase in staffing (loss of 6 beds on Delivery Suite, 14 opened on T2). • Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and MSWs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the New-born and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. • With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks' gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife. • Constraints accommodating the increased number of Inductions of Labour (IOL) and instrumental deliveries within current footprint. • Good level of incident reporting but insufficient resources to complete investigations, action plans and learning from events actions. • Independent external Birth-rate+ re-assessment has been undertaken and verbal findings are circa 16 Midwives short.
Impact	• Closure of Community Home Birth Services and Maternity Led Unit due to lack of staff. • Delays in allocating IO's to investigations, subsequent delays in completing investigations, action plans and LFE • Rise in instrumental deliveries • Delays in IOL and constraints in accommodating elective caesarean sections due to lack of NICU capacity • Congested department and long waits for IOL & ECS • Insufficient consultant cover for labour ward, NCEPOD readmission reviews • Lack of specialist roles; labour ward leads, Foetal surveillance, bereavement, transitional care nursing. • Lack of training in Human factors, CTG, labour ward coordinator leadership. • Poor staff morale and retention due to the sustained pressures in the system

	• Worsening patient experience and outcomes (see separate risk on patient safety) and run of adverse incidents.		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Induction of 27 Newly qualified Midwives (NQM) and 43 Newly Qualified Paediatrics nurses from Student Streamlining • Introduction of daily clinical huddles between each days Lead Midwife, Lead obstetrician, lead neonatologist and lead neonatal nurse each day • Rollout of 3 extra consultant sessions for obstetric governance and 1 extra consultant session Neonatology governance to enable allocation of IO's to investigations • RAG rating of position against national report recommendations, presentation of gap analysis to executives and to senior Leadership Board for support of required resources • Continued recruitment actions • Escalation of concerns to HEIW re single out-turn of midwives and paediatric nurses • Establishment of Ockenden Oversight group meeting on fortnightly basis • Team continue to support recruitment and retention, submission of request for oversea recruitment. • Daily SiteRep reporting introduced into maternity and Neonates and DoNM/HoM daily catch up		
Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	Lead	By when	Update since September 2022
1. Ongoing recruitment above establishment, increasing training places	AJ	31/03/23	New action
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	01/01/23	New action

3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives		AJ	31/03/23	New action
4. Continued maternity / Neonatology oversight meetings with Executive lead		JR/AJ	31/03/23	New action
5. Ongoing review of job planning and consultant establishment		CR/AT	31/03/23	New action
Impact Score: 5	Likelihood Score: 3	Target Risk Score:		**15 (high)**

3. **Critical Care Capacity – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable critical care capacity.		
Cause	• There is a progressively deteriorating problem with access for critically ill patients to ICU in Cardiff as a direct result of capacity. This now means patients who would benefit from ICU admission and care are not able to have this. • Gap of 15 ICU beds in CAV (2014 unmet needs study WG) • Funded increase in tertiary workload has increased the overall demands on critical care services in CAV • Poor infrastructure within the critical care unit – limited access to cubicles • Patient at Risk Team (PART) only operate during daytime hours (7am-7pm)		
Impact	• Adverse impact upon the Emergency Department and theatre flow • Untimely patient access • Inequity of patient access • 15% of referrals not admitted to critical care • Impact other operationally e.g. anaesthesia and theatres • Impact tertiary development e.g. ECMO • Patient outcomes worse • Reputation, Professional & Legal risk • Workforce - Reduced Recruitment & Retention • Poor staff morale and retention due to the sustained pressures in the system • Delayed admission and discharge from critical care leading to poor patient experience and outcomes		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Strengthened site-based leadership and management • Strengthened OPAT oversight and support for DTOCs • Workforce plans in place to support recruitment and retention • Registered nursing recruited to establishment • Local escalation plan in place and utilised when appropriate to support operational pressures • PART team provide daytime support patients not admitted to critical care • Ringfenced PACU to protect elective urgent and cancer surgery • Winter escalation plan in place to support delivery of critical care to the sickest patients during the winter months		
Current Assurances	• Operational position reported into OPAT (1) • Key operational performance indicators and progress against plans reported into the clinical board 6 weekly (1) • ICNARC audit to provide assurance on outcomes (2) • Plans in development to increase level 3 bed capacity by three beds during 2023/24.(1) • Project team established to address medium term infrastructure constraints.(1)		

Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	Development and implementation of a capacity plan to address the 15-bed gap Achievement of standard to step down patients from ICU within 4 hours to improve efficiency and patient flow 24/7 PART team Development of a fit for purpose critical care unit (UHW2)		
Gap in Assurances	Able to meet the needs of the sickest or highest priority cases. Un-met not fully understood across the organisation.		

Actions	Lead	By when	Update since September 2022
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/11/22	Funding not confirmed as at 03/11/22. Focus remains on utilising existing resource to rollout out to further clusters
2. Implementation of 24/7 PART team	PB	31/03/23	Plan developed. Funding not confirmed as at 03/11/22 and implementation on hold.
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL	AH / PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions. Awaiting decision from WG on funding of stage 1 of the infrastructure programme
4. Ongoing development of recruitment and retention strategies	JR / RG	31.03.23	

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

4. **Cancer Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments to see elective patients in a timely manner has also impacted on those waiting on a cancer pathway. • Referral demand for cancer is now greater than pre-Covid levels and our planned care system has struggled to respond to this increase in demand and carve out sufficient capacity for cancer at outpatients, diagnostics, and treatments stages • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff • Weaknesses in the central cancer team in terms of changes of leadership, structure, vacancies and temporary staffing leading to lack of clarity and consistency		
Impact	• Long waiting times for first contact and diagnostics contributing to lengthening of the overall pathway for cancer patients • Overall PTL has grown 3-fold since pre-Covid • Significant volumes of patients now waiting >62 days and >104 days • Potential for harm e.g. missing the window of opportunity for surgical intervention, delays to starting chemotherapy/radiotherapy • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Strengthened governance and oversight • COO is now Executive Lead for Cancer • Cancer is one of the delivery programmes in the 2022/23 Operational Plan • SOP in place to support tracking process • Roles and responsibilities redefined • Training being rolled out to refresh understanding of SCP guidance • Workforce team continue to support recruitment and retention • Ambition clearly stated – first contact by day 10, diagnosis by day 28, treatment by day 62 • Two cancer summits held with senior leadership teams, directorate management teams and tumour site clinical leads • Demand/capacity work commenced		

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements[1] • Executive Cancer Board meets quarterly[1] • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan [1] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [1] • Breach reports produced for every patient treated >62 days [1] • Harm reviews conducted for every patient treated >146 days [1] • Cancer reported as part of the Board Integrated Performance report [1]		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed		

Actions	Lead	By when	Update since September 22
1. Continue to develop and iterate the demand/capacity work	HE/JC	31.3.23	D&HI team are engaged in the work
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	RL	31.3.23	Support from the WCN to undertake a number of deep dives – focus on lung and urology initially
3. Establish a weekly PTL meeting with General Managers/Directorate Managers	JC	30.11.22	Terms of reference being drafted
4. Finalise the Cancer Strategy and develop a workplan	RL/BW	31.3.23	Draft strategy completed and is on the agenda for Exec Cancer Board in November
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5 / Likelihood Score: 2	Target Risk Score:		**10 (High)**

5. Stroke Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint.

In addition to thrombolysis treatment rates, there has been improvement in thrombectomy assessment, referral and procedures delivered both internally and referred to Bristol. There has also been focused training for acute medics on stroke assessment, thrombolysis and thrombectomy. The Stroke CNS role is being protected where possible; recognised that this team are the drivers and facilitators of the thrombolysis pathway.

Investment is needed for increased Stroke resource at the front door – allowing patients to be seen, diagnosed and treated in a timely manner, ultimately reducing mortality and improving outcomes for patients. The aims are to improve Tier 1 performance and most importantly, safer care for our Stroke patients

Risk **Date added:** **01/11/2022**	Poor compliance with SSNAP – currently a D grade centre.
Cause	• An increasingly busy ED (double the number of patients) has seen a high demand upon the Stroke Service. Patients are often self-presenting which may result in an initial delay to be triaged resulting in (i) delays to Stroke calls being put out (ii) delays to patients receiving CT scans within 1-hour (iii) delays in the recognition and subsequent delivery of thrombolysis to patients. • The Stroke Unit at UHW regularly runs at 100% occupancy. Every effort is made to ensure there is a bed available for new stroke admissions. The large volumes of patients in the ED mean there is often a delay in patients being triaged and assessed within 4 hours, making it difficult to get the patients to the acute ward within a timely manner. Patients awaiting admission to the stroke unit in September between them spent almost 70 days in the ED. • Pressures across the system mean that Stroke beds are often used for non-Stroke patients. These short-term gains have long term impact on Stroke affecting the ability to admit new stroke patients within 4 hours, which has knock-on impact on specialist MDT assessments, commencement of rehabilitation and supportive discharge planning. • Since additional capacity beds which were collocated with stroke closed in August 22, performance against the 4 hours admit target improved to 20% in September. Support is needed to protect stroke beds for patients on the stroke pathway • Stroke CNS being pulled into ward numbers due to poor staffing levels

Impact	• Delays in patients receiving their CT scans within 1 hour • Delays in patients being recognised as potential Stroke patients • Delays in patients receiving timely treatment such as thrombolysis • Delays in patients being recognised as potential thrombectomy patients • Patients not receiving swallow screening in a timely manner (<4 hours) • Delays in patients being admitted to the acute Stroke ward in a timely manner (<4 hours) • Delays in patients leaving the acute Stroke ward (long lengths of stay, non-stroke patients being admitted due to ambulance waits) • Poor patient outcomes • Lack of available CRT slots or inappropriate CRT slots meaning patients in SRC are unable to be discharged in a timely manner		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20**
Current Controls	• Awareness raising on the importance of early swallow screen assessment – investment in training over the summer needs reinforcement with the timing of swallow screen and its urgency. • Taking any golden opportunities, we can – whenever there is capacity on the stroke unit, the stroke team are driving and pushing the ED stroke pathway to achieve the 4 hours admit wherever we can. The stroke team are real champions of the principles of 'Think Thrombolysis, Think Thrombectomy' and are pushing the imaging pathway to reach diagnosis as early as possible and ensure all patients are considered and assessed for urgent treatments which could reduce the disabling impact of the stroke. • Stroke Service Manager in post since July; Clinical Director for stroke in post from October. Dedicated resource for focused work with ED, radiology and medicine to ensure the optimal stroke pathway is in place and applied for all patients. • Seeking investment for uplift of CNS resource and dedicated stroke medical resource to support the front door for stroke. • Wider programme of works is needed to continue momentum of a stroke service improvement programme, particularly given future requirements for regional network service delivery and for UHW to become the regional thrombectomy centre		
Current Assurances	• Operational position reported into MCB (Monthly) (1) • Mechanisms in place to monitor key schemes in Stroke Operational Group and MCB SMT/IM DPR (1) • Monthly touch point meeting with the Delivery Unit (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Lack of consistent cover to the ground floor by a dedicated Stroke Medic CNS cover not 7/7 Stroke beds not ringfenced SRC capacity		
Gap in Assurances	Competing demand on regional, thrombectomy and clinical board priorities		

Actions	Lead	By when	Update since September 2022
1. Recruit and appoint a dedicated Service Manager for Stroke (8a) to form part of the triumvirate to lead the service	SB	01/07/2022	Completed and member of staff now in place

2. Recruit and appoint a new dedicated Clinical Director for Stroke Services	AR/NT/SB	01/10/2022	Completed and member of staff now in place
3. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support	DP/NW/NT/TH	31/01/2023	
4. Medical Extend locum SHO for SRC in backfill of specialist middle grade moving to UHW front door (Mon-Fri 9-5) Collaboration with other specialities (e.g. neurology) to improve stroke junior doctor out of hours cover. May incur cost to medicine. Contribute 4 locum consultant sessions to a new post with ITU for a neuro critical care specialist with 4 stroke sessions **Benefits** Cross speciality working - more sustainable OOH model and offers training opportunities. Reviewing the structure of the out of hours rota will offer further support to the medical on call team. Specialist middle grade and uplift of consultant sessions would support TIA clinic reconfiguration and front door senior decision making. Improved selection of patients for C4 beds, improved management of mimics in ED, acceleration of stroke assessment and diagnostics, improvement in 4 hours admit. This model offers the service an interim solution for winter demands, reducing the urgency of consultant uplift, allowing for planned succession and recruitment. **Interdependencies / Risks** Uplift is needed both in and out of hours. Locum posts are expensive but it is unknown if the workforce is there for external middle grade or consultant recruitment.	TH/NT/SB	31/01/2023	Locum SHO secured which will allow 6 sessions of front door Stroke cover (likely beginning middle of November)

5. Capacity C4 beds only to admit those patients on the stroke pathway with a protected minimum of 4 beds. Until additional capacity Winter beds open the ask is to cap medical outliers to 4 on the ward at any one time. **Benefits –** median number of admissions per day = 3 in September. 4 beds protected should offer admission capacity for most new stroke patients and we would hope to see the 4 hours admit performance >50%. When necessary to relieve pressure across the system medical outliers would be admitted; the cap would attempt to minimise the impact of these admissions on stroke performance. **Interactions/Risks** – Ability to create 4 beds each day once used is uncertain. Exit strategy needed for any medical outliers and stroke mimics. Flow needed across whole stroke pathway; community services to be approached re options to prioritise stroke beds in CRT slot allocation if possible.	NT/DP/NW/SB	31/01/2023	SOP being produced for the ringfencing of beds Agreement being sought at Clinical Board and Health Board level for ringfencing of beds "Golden days" where beds are available at the beginning of the day to show the art of the possible
6. Diagnostics Daily imaging 'hot slots' for carotid dopplers/ MRIs/ CTA for stroke patients. **Benefits –** Timely diagnoses and treatment for both stroke patients and stroke mimics. Improved discharge profile to support protection of beds. **Interactions and Risks –** hot slots may not be needed every day (would be booked by 10am and released back to radiology if not needed). Ideally would operate over 7 days.	NT/TH		Ongoing discussions with radiology to create slots Use of the CD&T escalation email to prioritise Stroke patients for discharge dependent MRIs, etc.
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

6. **Urgent & Emergency Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23.

Risk **Date added: 09/05/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable urgent and emergency care as close to home as possible.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the urgent and emergency care system. Five factors have combined to cause current operational challenges: (i) Non-covid occupancy remains at a high level and we continue to experience challenges in our ability to achieve timely discharge of patients (ii) Covid continues to add an increased layer of complexity in managing patient flow (iii) Patients presenting and subsequently admitted have a higher acuity and complexity (iv) We have sustained workforce challenges (v) Social Care are experiencing similar workforce and demand challenges • Sustained pressure in Primary and Community Care, including an increased number of GP practices operating at a higher level of escalation, temporary list closures and practice closures • Poor consistency in referral pathways, and in care in the community leading to significant variation in practice • Rollout of multi-disciplinary team cluster models only in limited number of clusters • Lack of co-ordination and / or streamlined services across Health and Social care to ensure a joined-up response is provided and the patient gets the right care, in the right place, first time • Poor response times in the community from WAST due to significant delays in ambulance handovers • Longer length of stay for both medically fit patients and clinically unfit patients, significantly above pre-covid levels		
Impact Saunders.Nathan 09/01/2023 14:35:51	• Long waiting times for patients to access a GP • Patients attend the Emergency Department because they cannot get the care or timely care they need in Primary and Community Care • Referrals and admissions into hospital because there are no alternative options or staff are unaware of alternative options • Congested ED department and long waits for patients to be seen • Increase in ambulance handover delays and challenges in timeliness of ambulance response to community demand • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.2500 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and transition to NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and being implemented • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee. Specific focus on Six Goals for Urgent & Emergency Care on 12th July 2022. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**

Gap in Controls	Actively scale up multidisciplinary cluster models Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce) Developing an effective, high quality and sustainable Acute Medicine model Reconfiguring our in-hospital footprint to improve efficiency and patient flow
Gap in Assurances	Whilst an Urgent & Emergency Care Delivery Group is in place, the Six Goals Integrated Urgent & Emergency Care Transformation Board is yet to be established

Actions	Lead	By when	Update since Sept 2022
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	30.11.22	Utilisation of CAV 24/7 funding to support interim model as larger scale redesign developed for Health Board
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals Saunders.Nathan 09/01/2023 14:35:51	PB	31/10/22	Clinical Director appointed. Associated director for transformation and delivery appointed. Support for key urgent and emergency models of care developed and to be implemented in Quarter 3.

3. Introduce Medical Same Day Emergency Care Unit moving to new area whilst introducing senior clinical triaging and hot clinics	PB	30.11.22	New action
4. Introducing frail assessment service in emergency and assessment area UHW	PB	30.11.22	New action
5. Develop SOP for A1 (medical short stay ward) and SOP for Zero four-hour ambulance handovers	PB	30.11.22	New action
6. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents 7. Develop acute admission protocols	PB PB	30.11.22 30.11.22	New action New action
8. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs	AH / PB	31.03.23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME with new IMT introduced bi-weekly chaired by SR to increase focus on actions
9. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.	PB	31.10.22 - 31.01.23	New action
10. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU	PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions.
11. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5 / Likelihood Score: 2	Target Risk Score:		**10 (high)**

7. **Planned Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)**

One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable planned care services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments for urgent/emergency care has impacted on those waiting to access the system for planned care. • Referrals for planned care are at pre-Covid levels overall, however there is significant variation between specialities. Whilst our planned care system (outpatients, diagnostics, treatments) is almost back to full capacity, it has been challenging to achieve activity levels significantly above pre-Covid activity. • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff		
Impact	• Significant volumes of patients waiting for new outpatient appointments, diagnostics and treatment • Some patients are tipping over into waits of more than 3 years, some of these are still at the outpatient stage • Potential for harm in terms of clinical deterioration whilst patients are waiting, particularly at the outpatient stage where patients have yet to be seen by a secondary care clinician and priority determined • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) • Organisational/reputational harm due to political and media interest and scrutiny		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	• Planned Care is one of the delivery programmes in the 2022/23 Operational Plan • Demand/capacity work undertaken to model expected delivery against the ministerial measures • Additional capacity schemes funded through WG planned care monies are in place and delivering e.g. independent sector, mobile ophthalmology theatres, 2nd gynae treatment room commissioned, spinal unit commissioned, mobile endoscopy unit in place • Workforce team continue to support recruitment and retention • Suite of reports and dashboard created by the Digital and Healthcare Intelligence team to support Directorate teams and Clinical Board in terms of managing the planned care position		

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting [(1)] • Operational position reported into daily/weekly 'hot' reports[(1)] • Elective Care Delivery Group in place monthly; suite of metrics reviewed at every meeting [(1)] • Monthly meeting with the Delivery Unit on Planned Care[(1)] • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan [(1)] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [(1)] • Planned Care reported as part of the Board Integrated Performance report [(1)]		
Impact Score: 4	Likelihood Score: 3	Net Risk Score:	**12 (High)**
Gap in Controls	• Further demand/capacity work required together with an indication of the ministerial targets to inform the plan for 23/24 and assess deliverability • Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Since the Operational Plan Delivery Group meeting has been stepped down, there is a need to consider the governance mechanisms by which key risks and messages from the Elective Care Delivery Group are escalated • Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update since Sept 22
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	D&HI team are engaged in the work
2. Establish key priorities and a work plan for the supporting patients sub-group	EC	31.12.22	Group is meeting fortnightly initially
3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group	JC	Weekly	Meetings in place
4. Agree formal reporting mechanisms from the Elective Care Delivery group through to SLB	PB/HE	31.12.22	Under consideration as part of review of COO meeting structures
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 4 / Likelihood Score: 2	Target Risk Score:		**8 (High)**

Report Title:	**Corporate Risk Register**			Agenda Item no.	2.11
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	10/01/2023
		Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Cardiff and Vale UHB (the Health Board) 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 only those risks scoring 20 and above.

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.

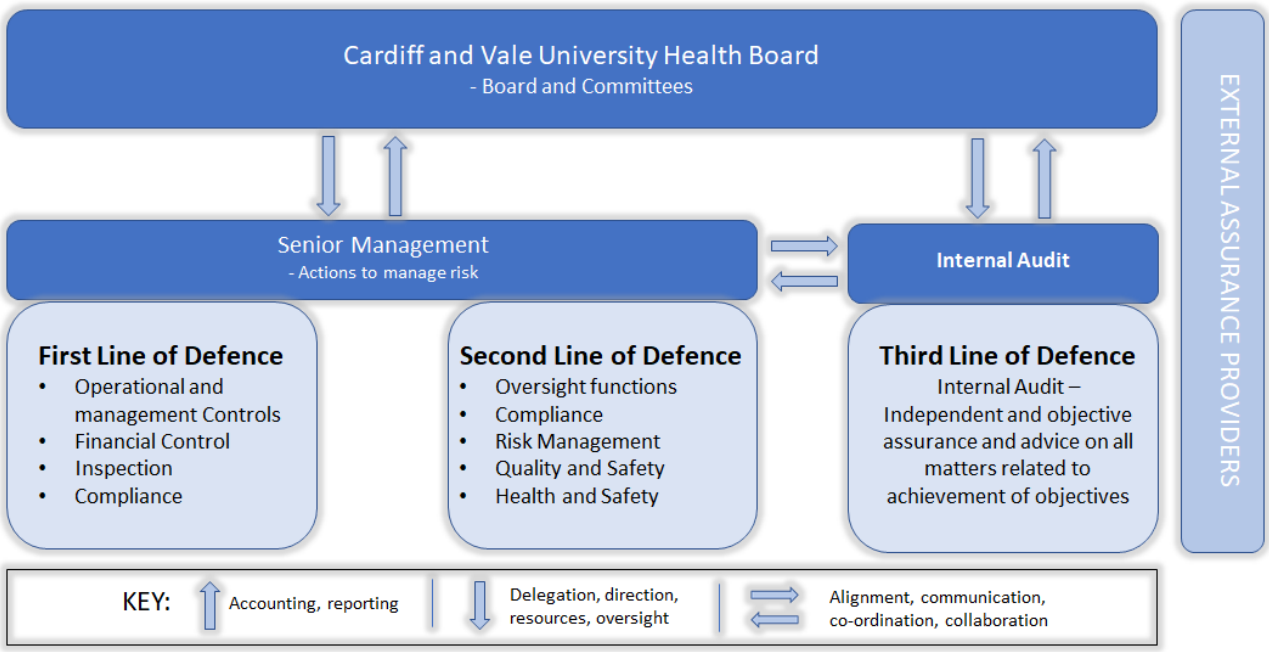
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

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. During November and December 2022, the Head of Risk and Regulation has also met with Risk Leads within Clinical Board Triumvirates and Corporate Directorates to provide additional support and guidance in advance of submission of updated risk registers for the January 2023 Board meeting.

Within these meetings discussions have also been had regarding the implementation of the Health Board Assurance Strategy and the population of an Assurance Map in relation to those risks recorded within the Corporate Risk Register. The Assurance Map will, once populated, articulate what assurances and controls are in place within the Health Board's 'Three Lines of Defence' (see below) for each risk within the Corporate Risk Register. It is hoped that this document will provide a useful point of reference to demonstrate that risks are being proactively managed and will also identify where there are gaps in assurance so that additional support and resource can be provided.



At the Health Board's November 2022 Board meeting a total of 17 (from a total of 22 risks 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 A but can be summarised as follows:

Risk Score (1 to 25) - Clinical Board	20/25	25/25
CD&T		
Medicine	6	1
PCIC		
Specialist Services	4	
Surgery		
Digital Health		
Estates		
Children and Women	2	
Mental Health		
Capital Estates and Facilities		
Workforce and OD	4	
Total:	**16**	**1**

An updated Register will be shared with the Board at its January 2023 meeting. It should also be noted that each Clinical Board shares the detail of their Extreme Risks with Executive and Operational colleagues bi-monthly at Clinical Board Operational Meetings to ensure that they are continually monitored and proactively managed.

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 requested 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.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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	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		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*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
Yes – The ongoing management and review of the Health Board's Corporate Risk Register involves a review of all Extreme Risks held by Clinical Boards and Corporate Directorates.
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a

Decarbonisation: Yes/No	
n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	24th November 2022

CORPORATE RISK REGISTER NOVEMBER 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	**Obsolete Medical Gas and Air Delivery Equipment and Plant** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete at UHW Maternity (manifolds 1&7), In addition the UHW Medical Gas Pressure reducing set is obsolete. Helipad and Ambulatory Care Medical Air Plant areare non compliant to HTM02-01 MGPS Standards. **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	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	2	Mar-21	**Risk/Issue**: UHW Tunnels corroded Main O2 Pipeline due to building leakage **Impac**t: 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**	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	3	Mar-21	**Risk/Issue**: UHL Main Boiler F&E TANKS are badly corroded and require renewing **Impact**: Corrosion causing tanks to leak and loss of Heating throughout Hospital	5	4	20	No controls in place as cleaning tanks may result in leakage	5	4	20	Renew or reline tanks to prevent leaks.	5	1	5	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	4	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW ITU A3N, UHW ITU B3N North, UHW Cardiac ITU C3 Link does not comply with HTM's for Ventilation. **Impact:** Adverse impact on the safety of staff working in these areas, faiulre to comply with HTM regulations.	5	4	20	System is subject to statutory testing and inspection in line with legislation and HTM regulations. Regular maintenance.	5	4	20	Preparing plans to renew the AHU. Look at improving the sytem to comply with current HTMs	5	1	5	Dec-22	Quality, Safety & Experience Committee	Workforce Patient Safety Capital Assets Staff Wellbeing
	5		**Risk/Issue**: Energy Cost pressures. Energy Markets are very unstable which is resulting in dramatic tariff increases for the remainder of 21/22 and for the entire 22/23 financial year. **Impact**:Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million).	4	5	20	Energy spend monitored and reported to Finance department monthly and is further supported by monthly meetings.	4	5	20	Assurances are through monthly reporting and meetings with finance.	4	4	16	Dec-22	Finance Committee	Financial Sustainability
	6	08/2022	There is a risk of physical and emotional harm to patients and staff due to the number of nursing vacanies across the Clinical Board. Secondary to this is the risk of failure to comply with regulatory staffing requirements (Nurse Staffing Levels (Wales) Act 2016).	5	5	25	Posts advertised in a timely manner. Authorisation of vacancies reviewed efficiently. Maximsation of medical ward float staff. Dedicated recruitment officer in post. Bimonthly recruitment events held. Engagement with Project 95, overseas recruitment, adaptation programmes, student streamlining and staff return to practice. Risk staff framework completed daily by the Clinical Board and shared at daily OPAT UHB meetings	5	5	25	Ongoing support and escalation via OPAT. Overseas nurses coming on board October 2022 to support staffing shortfalls. Focused work on staff exit questionairres and engagement with established staff to protect establishment.	5	3	15	Dec-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Workforce Patient Safety Staff Wellbeing Urgent and Emergency Care
	7	08/2022	Patients with suspected (Basal cell carcinoma) BCC are added to a routine waiting list, due to this there is a risk that these patients may actually be unusual presentation of a higher risk Squamous cell carcinoma (SCC). Secondary to existing RTT waiting times for routine referrals (target 36 weeks) there is a risk that increased waits could impact on a patients prognosis.	5	5	25	Ongoing work within the Directorate with Clinical Board oversight to reduce waiting times	5	4	20	Waiting list initiatives ongoing as part of recovery plan to reduce overall waiting position. Triage system in place for referrals: teledermatology review of photographs to support clinical prioritisation	5	1	15	Dec-22	Quality, Safety and Experience Committee	Patient Safety Cancer Planned Care
	8	08/2022	There is a risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit.	5	5	25	Engagement across Clinical Board specialities to review patients within 30 minutes of referral and make a plan within 60 minutes. Implementation of internal escalation cards within Emergency Medicine. Delays documented within EU Safety Huddles Report.	5	4	20	To facilatate seven day 12 hour per day presence of an Acute Medicine Consultant as per Royal College of Physician guidelines	5	3	15	Dec-22	Quality, Safety and Experience Committee	Patient Safety, Urgent and Emergency Care

Medicine Clinical Board	9	08/2022	There is a risk of Patient Harm due delays in the delivery of patient care and subsequently NRI's reported to the Delivery Unit for delayed cancer diagnosis secondary to the accumulation of therapeutic and surveillance backlog for Endoscopy and due to Covid restrictions. Change in the local lower GI pathway has shifted all USC priority CT pneumocolon requests into secondary care. Implementaton of FIT stool testing into pathway now requires result for some patient groups delaying decision making and waiting times for USC referral.	4	5	20	Clinical validation of lists. Corporate risk stratification cub available in BIS to pull through surveillance patients based upon individual risk vs chronological waiting times. NEP also provided documentation for risk stratification. High risk surveillance patients started to be listed for procedures.	4	5	20	Directorate to utilise BIS risk surveillance to prioritise patients and reduce potential harm. Administrative team to send patient risk letters for delayed surveillance cases to manage patient risk. Directorate to consider use of FIT stool test as per BSG to manage risk of overdue lower GI surveillance. Clinical validation continues risk assessing using a clinical tool recommended by steering group. Table top exercises undertaken to ensure all actions aligned and updated and will continue to be reviewed.	4	2	8	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Planned Care Cancer
	10	01/03/2019	There is a risk to patient safety and wellbeing due to patients remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	**25**	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patients condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assessed by the Triage Nurse/MAN to ensure a patient clinical assessment is conducted. Concern by either party about the length of any dealy or volume of crews being held is escalated to the Senior Controller/EU nurse in charge to Patient Access for usual UHB escalation procedures, or by WAST via 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. Standard operating procedure in place within EU to support 'immediate release' requests by WAST. Joint CB/WAST partnership meeting in place to focus on improvement. The CB is engaged with the NRI process for reporting incidents where WAST delays have resulted in major harm. The Clinical Board work with OPAT and the completion of 'on boarding' and FCP when ambulances have been held for 3 hours. Transformational work undertaken across Acute and Emergency Medicine to support flow including RATZ, virtual ward and speciality hub. The appointment of two Band 7 registered nurses to work with Patient Access to support patient flow.	5	4	**20**	Daily review and risks noted within Safety Huddles and EU controller reports. Escalation via MCB HUB and Patient Access Services. Evaluation of Standard Operating Procedure to reflect changes required. WAST immediate release Standard Operating Procedure in use to support 'red' calls in the community. OPAT across both UHW and UHL sites to support WAST and patient flow.	5	2	**10**	Dec-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Urgent and Emergency Care
	11	01/01/2021	There is a risk of patient and staff harm due to an inability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment, 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 OPAT meeting with ongoing planning to ensure safe staffing. Work ongoing with Medi Team and Locums to support the Emergency footprint. Ongoing recruitment into F3 posts	5	2	**10**	Dec-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety Staff Wellbeing Workforce
	12	01/12/2021	There is a risk of patient harm due to overcrowding within 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. Clinical Board engaged and supportive of 'on boarding' to facilitate flow. Change in the Emergency Unit footprint to support flow, eg speciality hub.	5	4	**20**	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow. Introduction of two Band 7 nurses to support flow and patient access.	5	3	**15**	Dec-22	Quality, Safety & Experience Committee	Patient Safety Capital Assets

Mental Health Clinical Board	13	Aug-20	**Young People in Adult Mental Health Placement** Young people with complex needs require admission to adult mental health services as no suitable alternative available. There is a risk that the patients will be in a sub-optimal clinical environment which will adversely impact on their safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.	5	5	**25**	Additional staff allocated to the care of these patients.	5	3	**15**	Safeguarding discussions ongoing with private care providers with no realistic placement available for the forseeable future. Away day to plan alternatives to admission with C&W CB. Earmarked area in HYC to allow impact of Sanctuary to be evaluated while reducing impact on Cedar ward and CAMHS patients.	5	2	**10**	Dec-22	Mental Health &Capacity Legislation Committee	Patient Safety
Children and Women CB	14	16.08.21	There is a risk of patient and staff harm due to an inability to discharge or place medically fit children and young people with severe behavioural problems who are inpatients in acute paediatric settings.	5	5	**25**	1. Daily huddles and deployment of nursing resources based on risk and using bank and agency staff where possible 2. Regular discharge planning meetings 3. Regular communication with Local Authority and enhanced staffing from LA sources 4. Daily medical ward round, and review by junior doctors throughout the day as required 5. Use of physical and chemical restraint to manage violent behaviour 6. Relocation of children as necessary across wards to maintain safety 7. Signposting to Healthboard wellbeing services for staff	-	-	-	1. Arrange 'safe holding' training for staff who care for these patients 2. Increased numbers of suitably trained staff on wards, in collaboration with community teams. 3. Provision of appropriate Local authority accommodation for these C&YP 4. Earlier provision of psychological and other (eg educational and social) intervention whilst admitted 5. Proper engagement and timely input from the Local Authority 6. Increase targeted support for staff (physical and emotional wellbeing) 7. Assurances from the medical director and executive board regarding risk management and governance of these patients	5	2	**10**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee Mental Health, Capacity and Legistaltion	Patient Safety Maternity
	15		Due to Fetal Medicine capacity shortfall and breach of ASW 5 day referral standard, there is an increased risk of harm to compromised fetuses and reduced options for termination of pregnancy if delayed beyond 21+6 weeks	5	5	**25**	Fetal medicine lead is keeping accurate data regarding breach figures, along with demand and capacity data. Clinics are being overbooked to absorb urgent referrals and active triage to allow joint shared care with local delivery where possible.	5	4	**20**	The fetal medicine service is actively triaging on a daily basis and managing patients locally where possible and declining to accept referrals when safe to do so. A locum consultant with appropriate experience is providing 2 clinic sessions a week. Extra additional clinics are being put on where possible and will continue to be explored, however this is not always possible due to consultant availability and there still not being enough sessions available to meet the demand on the service. The fetal medicine service will continue to try manage the risk by vigilant triaging to pick off the highest risk cases and trying to manage joint care with local units when possible. Additional clincial space (current antenatal phlebotomy room) is being prepared to reduce crowding in clinics and improve efficiency.	5	1	**5**	Dec-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Maternity
	16	01.05.22	Due to staffing levels within Maternity services there is a risk that: - there will be delay and interruption to induction of labour and the potential risk of poor patient experience and poor outcomes for mothers and babies. Home Birth Services will be withdrawn resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board. - the Midwifery Led Unit will have to close resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board	5	5	**25**	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. Midwives offered bank / additional hours and overtime Enhanced overtime approved	5	4	**20**	1.Band 6 vacancies to be filled. Band 5 vacancies have been filled. On going request to PHW to facilitate rapid Covid testing for maternity staff. Improved sickness review in place. Weekend planning meetings continue.	5	2	**10**	Dec-22	Quality, Safety and Experience Committee	Patient Safety Workforce Maternity

CD&T	17		**Estates and Medical Equipment** There is a risk to the delivery of of modern, safe and sustainable healthcare due to suboptimal estate. Significant aggregated risks acorss the Clinical Board Directorate risk registers including: 1. Mortuary - failure to meet HBN20 with potential for improvement notice or closure from the regulator (HTA) 2. Radiopharmacy - failure to meet the requirements of the regulator (MHRA) with potential for improvement notices or closure from the regulator - regional impact on delivery of diagnostic services 3. Stem Cell Processing Unit - inadequate accommodation, compressor failures, failure of supply of liquid nitrogen from the external tank, impact - failure to deliver liquid nitrogen to the cryogenic freezer holding patient stem cells for transplantation. 4. Health Records - inadequate storage capacity, security of the Health record, potential for data loss, health and safety risks 5. Clinical Engineering - inadequate accommodation for the equipment library, Fieldway, and mechanical engineering UHW, no space to clean returned equipment 6. Insufficient accommodation for a number of clinical board services including - Occupational Therapy, Speech and language Therapy, Pharmacy, POCT, physio, Cedar 7. Air tube for lab specimens sitting under contract for maintenance with CD&T, regular breakdowns and damage resultig in unable to use the system to deliver specimens ina timely manner 8. Air handing and chiller units - not in place, subject to regular breakdowns, impact on temperature sensitive services such as Blood Transfusion/drugs, impact on temperature sensitive equipment such as blood analysers, CT scanners leading to loss of service 9. Repeated examples of water or sewage ingressing into clinical and non-clinical areas, leading to inability to deliver services 10. UHL Main Occupational Therapy Department - Fabric of building is deteriorating , room unusable , leaks throught the area .Patient records damaged as a result . Poor condition of outpatient portacabins	5	5	**25**	Capital planning programme Discretionary capital programme Escalation routes to Estates Business Continuity Plans Managed service contracts Maintenance service agreements Medical equipment governance framework	5	4	**20**	Further work with Capital and Estates to develop prioritised timetabled plans to address known risks Continue to seek funding through WG for replacement equipment and HTF funds to substitute old technologies Engage with TRaMS project for proposed regional solution to Radiopharmacy Engage with Capital Planning with regards to Mortuary refurbishment project	5	2	**10**	Dec-22	Strategy and Delivery Committee	Capital Estates Patient Safety
Specialist Services Clinical Board	18	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**	Dec-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Staff Wellbeing Workforce Critical Care
	19	08/2022	**Critical Care - Bed Capacity** Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care present a risk of avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.	5	5	**25**	Currently the directorate are occupying the use of a surge ICU area (C 3 Link) to provide 10 additional physical beds. Capital Planning are in the design process for refurbishment and expansion of Critical Care.	5	4	**20**	Undertake Design work to produce an outline cost for refurbishment and expansion of Critical Care beds, overseen by Program Board.Seek funding for expansion and refurbishment. Clarify commissioning arrangements	5	2	**10**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Critical Care
	20		**Critical Care - Estates** There is a risk of patient and staff harm due to aging and obsolete estates and equipment coupled with reduced capacity within the Critical Care Directorate. Aggragated Risk following risk of harm in the following areas: - HCID Level 2 and 3 (Reduced Capacity) - Sub-standard Heating, Ventilation and Air Circulation - Isolation Facilities - LTV unit	4	5	**20**	Prioritisation of clinical need, use of neighbouring facilities and acquiing temporary mobile structures.	4	5	**20**	Business cases to be developed to secure renovation and replacement funding.	4	2	**8**	Dec-22	Quality, Safety and Experience Committee Strategy and Delivery Committee	Capital Assets Patient Safety Critical Care

	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. A number of options for the relocation of the service have been explored over the past 10 years but have not been successfully adopted. The directorate and Clinical Board are currently working with Estates and Operational Colleagues as part of the Health Board's Acute Sites Master Plan work to develop plans for relocation to the current Outpatient site at UHW.	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**	Dec-22	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Capital Assets
Finance	22	Apr 22	Risk: The submitted IMTP has a planned deficit of £17.1m for 2022/23 and The Health Board does not have a plan to achieve its revenue statutory breakeven duty without reliance on WG financial support. There is a risk failure to have a three year IMTP approved by the Welsh Ministers due to an inability to achieve its revenue statutory break even duty.	5	4	**20**	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board	5	4	**20**	Development of plan to address the deficit in line with WG expectations in 2022/23 and continue to plan to break even in FY24 and FY25. Submission of IMTP to WG at end of Q1.	5	2	**10**	Dec-22	Finance Committee	Financial Sustainability
	23	April 22	Risk: Due to a planned deficit of £17.1m for 2022/23 there is a risk of failure to achieve an Approved Three year Financial plan (IMTP) with potential for additional escalation and intervention arrangements following Enhanced Monitoring arrangements being imposed by Welsh Government.	5	4	**20**	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board Work continues to address the recurrent deficit in the UHB's financial position. WG have note but not approved the IMTP submitted in June 2022 and are approaching the plan on a one year basis.	5	4	**20**	Developing a plan to address the £20.8m deficit is underway. The work will be completed to inform submission of IMTP at end of Q1.	5	2	**10**	Dec-22	Finance Committee	Financial Sustainability
Digital Health	24	06/08/2011	Cyber Security - Due to prevailing national and international Cyber Security threats there is a risk that the Health Board's IT infrastructure could be compromised resulting in prolonged service interuption and potential impacts on the safety of patients due to an inability to access electronically stored data.	5	5	**25**	The UHB has in place a number of Cyber security precautions. These include the following: - The implementation of additional VLAN's and/or firewalls/ACL's - Segmenting and an increased level of device patching. - The use of Monitoring and Vulnerability Softare - Health Board wide Mandatory Cyber Security Training and Phishing Campaigns.	5	4	**20**	The requirements to address the resourcing of Cyber Security Management have been acknowledged in an approved but unfunded UHB Business Case. (May 2022: Successful business case bid made to BCAG to ensure appointment of dedicated Cyber resources. Roles are currently being advertised and recruited to. Continued efforts need to be made to improve compliance with the Health Board's Cyber Security Mandatory Training and to increase awareness of and engagement with the Health Board's Phishing Campaigns. Compliance with/completion of Cyber Resilience Unit Recommendations.	5	3	**15**	Dec-22	Digital Health Intelligence Committee	Capital Assets Digital Strategy and Road Map

Report Title:	Draft Quality, Safety & Experience Committee Report 2022/23			Agenda Item no.	3.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	10.01.23
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Senior Corporate Governance Officer				

Main Report
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 and Key Issues to bring to the attention of the Board/Committee:

The Quality, Safety and Experience Committee achieved an attendance rate of 80% so far (80% is considered to be an acceptable attendance rate) during the period 1st April 2022 to 31st March 2023 as set out in the annual report.

Recommendation:

The Board / Committee are requested to:

- **REVIEW** the draft Annual Report 2022/23 of the Quality, Safety & Experience Committee.
- **RECOMMEND** the Annual Report to the Board for approval.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
09/01/2023 14:35:51

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Annual Report of the Quality, Safety and Experience Committee 2022/23

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 2022/23 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Executive Nurse Director and the Executive Medical Directors (Joint Executive Leads for the Committee), the Executive Director of Therapies and Health Sciences, the Executive Director of Public Health, the Assistant Director of Patient Experience, the Assistant Director of Patient Safety, Quality and Improvement, 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 seven times during the period 1 April 2022 to 31 March 2023 one of which (11 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 ?? (80% is considered to be an acceptable attendance rate) during the period 1st April 2021 to 31st March 2022 as set out below.

Commented [NS(aVU-CG1]: To be updated following January and March meetings

	12.04.22	15.06.22	30.08.22	11.10.22	29.11.22	10.01.22	07.03.22	Attendance
Susan Elsmore (Chair)	✓	✓	X	✓	✓	X	?	
Ceri Phillips** (Vice Chair)	✓	✓	✓	✓	✓	✓	?	
Gary Baxter	✓	✓	✓	✓	✓	X*	?	
Akmal Hanuk	X	X	X	✓	X	?	?	
Mike Jones**	✓	✓	✓	✓	✓	?	?	
Total	**80%**	**80%**	**60%**	**100%**	**80%**			

*Gary Baxter was a member of the Committee until 31 December 2022.

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

4.0 TERMS OF REFERENCE

The Terms of *Reference were reviewed and recommended for Board approval by the Committee on 10th January 2022. The Terms of Reference are due to be approved by the Board on 30th March 2022.*

Commented [NS(aVU-CG2]: To be reviewed at January's meeting

5.0 WORK UNDERTAKEN

As set out in the Committee's Terms of Reference, the purpose of the Committee is to provide:

a) Evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regards to quality, safety and experience of health services;
b) Assurance to the Board on the setting of local organisational Quality and Safety standards and supporting organisational safety culture;
c) 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;
d) Assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services; and
e) Assurance to the Board in relation to improving the experience of patients, carers and citizens and all those who come into contact with our services.

In addition and amongst other matters, the Committee reviews and monitors the implementation of the Quality, Safety and Experience Framework and oversees the necessary developments to deliver the following 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 course of the year, there were a number of standing agenda items which are received by and discussed at each Committee meetings which included: -

an assurance report and Patient Story from each Clinical Board, a Quality Indicators Report, an Overview of the Health Inspectorate Wales (HIW) activity and any HIW reports received by the Health Board, a report on the Community Health Council (CHC) inspections undertaken/reports received, the Board Assurance Framework in relation to the Patient Safety Risk and the Workforce Risk.

The Public Quality, Safety and Experience Committee also reviewed a number of key items at its meetings which included:

1. Quality, Safety and Experience Framework
2. Maternity Services
3. Pressure Damage
4. Mortality Data

PUBLIC QUALITY, SAFETY AND EXPERIENCE COMMITTEE – STANDING AGENDA ITEMS

April 2022 - March 2023

Clinical Board Assurance Reports

The Committee discussed Clinical Board Assurance reports and Patient Stories received throughout the year from each of the Clinical Boards, namely:

- Mental Health Clinical Board
- Clinical Diagnostics and Therapies (CD&T) Clinical Board
- Primary, Community and Intermediate Care (PCIC) Clinical Board
- Medicine Clinical Board
- Surgical Clinical Board
- Children & Women's Clinical Board

Commented [NS(aVU-CG3]: To be received in March 2023

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 which had arisen during the previous twelve months.

By way of example, in April the Committee received a report in relation to the Mental Health 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 as the number of adverse incidents had increased during the period. The Medicine Clinical Board Assurance Report which was received by the Committee in November had highlighted the significant risk being seen with regards to maintaining safe and timely Patient flow within the Emergency Unit (EU) together with some of the measures that had been taken to address the same. By way of example, a new Frailty zone / service had been set up in the Assessment Unit.

At its September meeting, the PCIC Clinical Board presented a Patient Story which showed care home residents talking about their experiences with Covid-19 lockdowns and how it had affected them.

Quality Indicators Report

At each meeting, the Committee received an overview of the Health Board's current performance against a range of agreed quality indicators (which included Patient concerns, Patient Safety, Nationally Reportable Incidents, Pressure Damage, and Hospital infection).

In August, the Committee was advised that the number of concerns, in particular in relation to the EU, had increased, and that the hospital infection measurements were showing an in year improvement. The Quality Indicators Report had also informed the August Committee meeting of a number of significant challenges which included (i) ongoing staffing pressures, (ii) an increased presentation of Patients with complex mental health and behavioural needs, and (iii) an increased volume and complexity of maternity cases coupled with ongoing staffing pressures that had contributed to the Maternity Services being under significant pressures.

HIW Activity Reports

The Committee received a report, at each meeting, which provided an overview of the reviews and inspections (unannounced and announced) which had been carried out by HIW. Each report also detailed the actions that were being implemented in response to the findings of the inspections and how those actions were being monitored.

During the past year the Committee received reports in relation to a number of inspections, which included the following: -

Cardiothoracic services at UHL

Mental Health Services at Hafan y Coed

Emergency Department at UHW

Maternity Services

Stroke Services

Nuclear Medicine Department at UHL

Community Health Council Reports

The Community Health Council (CHC) had suspended its announced scrutiny visits during the pandemic. Those visits recommenced during this year and, consequently, the Committee received a number of reports which related to visits which had been carried out by the CHC, which included: -

- Midwife Led Unit, UHW.
- Island Ward Children's Hospital for Wales, UHW.
- East 4 Medical, UHL.
- Spinal Rehabilitation, UHL.
- Mental Health Service
- Veterans Survey Report
- The Impact of Covid restrictions on people receiving care and their families and care for people living with long Covid.

The Committee noted that there were a number of common themes highlighted by those reports, namely: -

- Visiting restrictions
- Lack of Day Room and TV facilities
- Lack of Quiet Room
- Improvement to showering facilities for patients with mobility issues
- Improved storage facilities

Board Assurance Framework – Patient Safety

At its meetings, the Members of the Committee was provided with the opportunity to review the Patient Safety risk on the Board Assurance Framework (BAF) and to ensure that the same were being appropriately managed. During the year, a number of new risks which related to Patient Safety were added to the BAF. This included (i) Maternity, (ii) Critical Care, (iii) Cancer, (iv) Stroke and (v) Planned Care.

As at March 2023, the highest scoring risks which related to Patient Safety were xxxxxxxxxx.

Commented [MD(aVU-CG4]: To be added.

Corporate Risk Register

At all meetings, the Committee received the Corporate Risk Register (CRR). 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.

In November, the Committee was advised that 17 of the extreme risks on the CRR were linked to, or had Patient safety elements associated with them

Exception Reports

The Committee received one Exception Report which covered 2 areas:

1. Pressures in the Emergency Department
2. Overall System Pressures

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. **Maternity Services**

At its meeting in June, the Committee was advised that there had been a strained environment regarding National Maternity Services over the past few years with issues raised in Telford, Cwm Taf and the subsequent Ockenden Report.

It was noted that the Health Board had carried out its own thematic review in response to the Ockenden Report, and that WG had put an assurance template together so that there was a standard template across Wales for all health boards.

It was noted that the Health Board had provided assurance against that template and that it had been submitted to the Chief Nursing Officer (CNO) and WG for validation.

In November the Committee was advised that Health Inspectorate Wales (HIW) had undertaken an unannounced visit in November 2022. The Health Board was working on an improvement plan which could be received by the Committee as soon as the HIW report has been published.

January 10th 2023 – To be updated

Commented [NS(aVU-CG5]: Information to be added following January's meeting

2. **Mortality Indicators**

In June, the Committee was advised that there had been concerns about the Risk Adjusted Mortality Index (RAMI) being high which had led to the Medical Team wanting to explain to the QSE Committee what that meant and what was being done about it.

At its meeting in November 2022, the Committee received an update on the Mortality Indicators, in particular with regards to the development of a more mature reporting structure for mortality. The Committee was advised that the Learning from Death Framework set out three tiers of mortality indicators:

- Organisational Mortality
- Clinical Board Mortality
- Speciality Mortality

3. Quality, Safety and Experience Implications Arising from IMTP:

In April the Committee was advised that the key focus for the 2022/23 period was laid out within the received report and aligned to the Framework for Quality, Safety and Experience.

It was noted that the Framework had identified eight key areas and all the actions were aligned to those areas.

It was noted that there were no key performance indicators (KPIs) identified within the report because the Health Board was waiting for those to be received from WG. Once received, they would be brought back to the QSE Committee.

4. Recommendations from The Nuffield Trust Report:

In April The Committee received a report which set out the background to the Velindre University NHS Trust (VNHST) commissioned report by the Nuffield Trust to provide independent advice on the proposed model for non-surgical tertiary oncology services in South East Wales.

The report made a number of recommendations which were accepted by the Velindre Board and its partner organisations (including Cardiff and Vale Health Board.

5. Blood Inquiry Update:

The Committee received an update with regards to the Infected Blood Inquiry. That update had included the legal proceedings timetable from which it was noted that the final hearings were scheduled for December 2022 with conclusions and findings to be presented approximately 6 months later.

6. Implementation of Datix OfWCMS:

The Implementation of Datix Once for Wales Concerns Management System (OfWCMS) report was received by the Committee.

7. Duty of Candour:

The Duty of Candour report was received by the Committee where it was identified that the Health Board was against All Wales information and it was noted that it would be taken to the Board when the process developed further.

8. Dental Services

The Committee received an update with regards to Dental Services at its meeting held in June. In particular, the Committee was advised that the impact of the Pandemic had resulted in a significant backlog and reduced access to all types of dental services where all areas had been prioritising patients with the highest need resulting in increased pressure on access to urgent care. As part of Recovery, investment had provided additional capacity for both routine and urgent dental care across all providers of services.

9. Ultrasound Clinical Governance Position

In June the Committee was advised that following an internal audit of Ultrasound Governance across the Health Board, several shortcomings had been identified. Those had centred around a lack of assurance of appropriate governance in the correct and safe use of ultrasound across the Health Board and insufficient communication and escalation pathways.

The Committee was advised that a number of actions had been taken or were in progress to address the short fallings which had included (i) a review of the Ultrasound Clinical Governance Group (UCGG) with a new set of Terms of Reference, (ii) new members being added to the to include all areas of diagnostic and therapeutic ultrasound across the Health Board, and establishment of a clear reporting pathway for the UCGC.

10. 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. At its meeting in August the Committee noted that this year's Annual Letter was positive.

Safeguarding Annual Report

The Committee received and discussed the above report at it meeting in November. The Safeguarding Annual Report provided detail on the significant work that had been undertaken by the Safeguarding Team during the last twelve months.

Policies and Procedures

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

1. Interventions Not Normally Undertaken (INNU) policy and intervention list.
2. Medical Equipment Policy and Procedure
3. Exposure of Patients to Ionising Radiation Procedure
4. Radioactive Substances Risk Management Policy and Procedure
5. Exposure of Staff and Public to Ionising Radiation Procedure
6. Venepuncture for non-clinically qualified Research Staff Policy and Procedure
7. Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure.

Commented [NS(aVU-CG6]: To be reviewed at January's meeting

At its meeting in November, the Committee recommended that the Concerns, (Complaints), and Claims (Clinical Negligence, Personal Injury and Redress) Policy was recommended to full Board for approval.

In addition, the Committee reviewed and endorsed the Unpaid Carers Charter during its meeting in August.

A Special Meeting of the Quality, Safety and Experience Committee 11th October 2022

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

1. Maternity/Neonatal Services
2. Mental Health Services
3. The Five Harms
4. Quality, Safety and Experience Themes and Trends

6.0 COMMITTEE GOVERNANCE

Reports submitted to the Committee for review in January 2023.

1. Committee Annual Report 2022/23
2. Committee Terms of Reference 2023/24

Reports submitted to the Committee for review in March 2023

3. Committee work plan 2022/23

Commented [NS(aVU-CG7]: To be updated in following January's meeting

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

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

PRIVATE QUALITY, SAFETY AND EXPERIENCE COMMITTEE

APRIL, JUNE, AUGUST, NOVEMBER 2022 AND JANUARY, MARCH 2023

Commented [NS(aVU-CG8]: Any further agenda items to be added following agenda setting

1. Pandemic Update & Any Urgent/Emerging Themes
2. Cardiac Surgery
3. Maternity Services
4. HIW report relating to the Emergency Unit at UHW
5. Cardiac Surgery Report
6. DNAR Orders at St David's Hospital
7. Inpatient Suicides

REPORTING RESPONSIBILITIES

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

7.0 OPINION

The Committee is of the opinion that the draft Quality, Safety and Experience Committee Report 2022/23 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

CERI PHILLIPS
Committee Vice Chair

Report Title:	**Terms of Reference – Quality, Safety and Experience Committee**				Agenda Item no.	3.2
Meeting:	**Quality, Safety and Experience Committee**		Public	x	Meeting Date:	10 January 2023
			Private			
Status *(please tick one only)*:	Assurance		Approval	x	Information	
Lead Executive:	**Director of Corporate Governance**					
Report Author (Title):	**Director of Corporate Governance**					

Main Report
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 2022.

Executive Director Opinion and 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 the Terms of Reference are aligned to the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which 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:

The Committee is requested to:

(a) Review the Terms of Reference;
(b) Ratify the Terms of Reference; and
(c) Recommend them for approval to the Board on 30th March 2023.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: N/A
Safety: N/A
Financial: N/A
Workforce: N/A
Legal: N/A
Reputational: N/A
Socio Economic: N/A
Equality and Health: N/A
Decarbonisation: N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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09/01/2023 14:35:51

Quality, Safety and Experience Committee

Terms of Reference

Reviewed by Quality Safety and Experience Committee:

10th January 2023

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 and monitor the implementation of the Health Boards Quality, Safety and Experience Framework and oversee the necessary developments to deliver the ~~seven~~ eight key areas~~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
  - Quality Governance Arrangements
- Ensure that the Health Boards Framework aligns to the Welsh Government Quality and Safety Framework 2021: Learning and Improving and that the organisation functions as a quality management system to ensure that care meets the six domains of quality; care that is safe, effective, patient centred, timely, efficient and equitable.

3.2 The Committee will, in respect of its ***assurance role***, seek assurances that quality 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~~organisation, 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~~ organisation's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the ~~organization~~organisation, 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~~ organisation has effective systems and processes to meet the Health and Care Standards;

Commented [NF(aVU-EH1]: These are mentioned in WGs Quality and Safety Framework 21 so I have left it in the ToR

Saunders,Nathan 09/01/2023 14:35:51

- 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~~organisation;
- 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~~organisation;
- 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~~ organisation – 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.

Commented [NF(aVU-EH2]: Not sure if this will be part of end of year arrangements for this year as it has not been the last couple of years due to Covid.

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.

Saunders.Nathan 09/01/2023 14:35:51

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~~ 'task and finish' 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
- Director of Corporate Governance
- Associate Medical Director for Safety and Governance
- Assistant Director of Patient Safety, Quality and Improvement
- Assistant Director of Patient Experience

Commented [NF(aVU-EH3]: Meriel/Jason can you please confirm who you want from your respective Directorates to attend each meeting of QSE.

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 of the Committee: 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.

Commented [NF(aVU-EH4]: These will be moving to monthly from April 2023 due to the ongoing quality issues

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~~organisation, 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:	Policies for Ratification			Agenda Item no.	3.3
Meeting:	Quality & Safety Committee	Public	X	Meeting Date:	10/01/2023
		Private			
Status *(please tick one only)*:	Assurance		Approval	X	Information	
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences.				
Report Author (Title):	Emma Cooke, Deputy Director of Therapies and Healthcare Sciences.				

Main Report
Background and current situation:

The Following Policy and Procedure is for review:

1. Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331)

The policy and procedure have been reviewed within the relevant professional meetings and have been agreed there.

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

No significant changes have been made to the policy and procedure. However, a verbal briefing will be provided in the Quality, Safety Committee for each of the policies by the Deputy Director of Therapies and Healthcare Sciences,

Recommendation:

The Committee is requested to:

Ratify the following attached policy and procedure: -

(i) Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331)

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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		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	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*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
None
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
09/01/2023 14:35:51

Reference Number: UHB 330 **Version Number:** 3	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** Ref No: 173

Referrals By Non-Medical Practitioners For Diagnostic Imaging Investigations (Excluding Clinical Trials And Research) Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage the application process for Non Medical Referral (NMR) status and governance of practice in order to facilitate safe, appropriate pathways of care within the UHB.

A Non-Medical Referrer (NMR) is defined as a registered healthcare professional other than a Medical or Dental professional, e.g. Nurse practitioner, extended scope therapist, etc. who has been entitled by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Employer to act as a Referrer in compliance with the Regulations according to the specific responsibilities of that role.

Policy Commitment

We will

- Only support applications for NMRs within Cardiff and Vale UHB where approval has been given by their Directorate and it can be demonstrated that it is a requirement of the role.
- Provide information that Directorates are aware of their responsibility that NMRs employed within their Directorate are competent to fulfil their clinical role as a referrer and provide governance to their practice in this role.
- Receive a clear audit framework with each NMR application to ensure a governance of practice process exist for NMRs within individual Directorates.
- Ensure all non-Medical/Dental healthcare professionals who act as referrers are identified, agreed and recorded in a local register.
- Have arrangements in place that only healthcare professionals registered with an appropriate Regulatory Body are enabled to refer as a NMR.
- Demonstrate a specified Scope of Practice and Scheme of Work for each NMR.
- Ensure NMR's have undergone suitable radiation safety training appropriate to clinical imaging.
- Manage a review programme where compliance against NMR authorisation is assessed.

Supporting Procedures and Written Control Documents

This Policy is supported by:

- Referrals By Non-Medical Practitioners For Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Procedure
- Statement of Authorisation, Scope of Practice and Scheme of Work for NMR

They describe the following with regard to Non-Medical Referrers referral to DII:

- Application process for NMR entitlement
- Responsibilities of Directorates supporting the practice of NMR's
- Management of referral practice of NMR's against their defined Scope of Practice and dealing with instances non-compliance
- Duties associated with the practice of NMRs

Other supporting documents are:

- Ionising Radiation Risk Management Policy
- Exposure of Patients to Ionising Radiation Procedure
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed. This procedure aligns to IR(ME)R regulatory requirements

Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed. This procedure aligns to IR(ME)R regulatory requirements
Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Radiation Protection Group
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Sciences

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	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2	13/09/2016	07/10/2016	New policy format with supporting document. Removal of information relating to the resources supporting the implementation.
3	XXXXX	XXXXX	Reflection of update to legislative policy, Name change to supporting documents

Reference Number: UHB331 **Version Number:** 2	**Date of Next Review:** **Previous Trust/LHB Reference Number:** UHB331

Referrals By Non-Medical Practitioners For Diagnostic Imaging Investigations (Excluding Clinical Trials And Research) Procedure

Introduction and Aim

Developments within the NHS have led to an increase in the role of non-medical health care professionals in the delivery of care for patients; this includes referral to diagnostic imaging investigations (DII).

The UHB has a Referral by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy, whose aim is to ensure that we manage the application process and referral practice to be compliant with responsibilities under The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017), in order to protect the UHB, the public and staff.

This Procedure supports the policy and translates its aim into practical implementation measures.

Objectives

We will achieve our aim by:

- Giving clear direction to Professional Heads/ Service Managers which procedures, training and resources that must be in place prior to the use of NMR's referring for DII.
- Providing a framework for professional heads/service managers to develop services that utilise NMRs, which are safe, effective and compliant with current legislation in order to protect the UHB, the public and staff
- Ensuring all applications come through the formal NMR application process
- Applying the requirement all NMRs are Health Care Professionals with professional registration status.
- Receiving evidence of NMR training in appropriate radiation safety as part of the application process
- Audit of referral practice against scope of practice by the Radiology, Medical Physics and Clinical Engineering (R.M.P.C.E.) Directorate
- Applying responsibility to the NMR employing directorate for appropriate professional supervision of practice and systems to ensure safety and quality.
- Appropriate dissemination of information relating to new NMRs within the R.M.P.C.E. Directorate
- Providing feedback to the NMR on any inappropriate requests from the imaging operator or practitioner

- Ensuring employing directorates are aware of their responsibility for the local operational procedures under which NMRs will operate

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed. This procedure aligns to IR(ME)R regulatory requirements
Documents to read alongside this Procedure	• Referrals By Non-Medical Practitioners For Diagnostic Imaging Investigations (Excluding Clinical Trials And Research) Policy • Non-Medical Practitioner Referrals for Diagnostic Imaging Investigations Policy • Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Consent to Examination or Treatment Policy • Patient Identification Policy
Approved by	Radiation Protection Group

Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Science
Author(s)	Radiographer Professional Head

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*13/09/16*	*07/10/16*	Radiographer Professional Head
2			Changes to policy names noted Changes to legislation reflected References updated Appendix 2 updated

Contents

Non Medical Referrer: defined as a registered healthcare professional other than a Medical or Dental professional, i.e. Nurse practitioner, extended scope therapist, etc who has been entitled by the IR(ME)R Employer to act as a Referrer in

compliance with the Regulations according to the specific responsibilities of that role.

Diagnostic Imaging investigations: broad scope definition to encompass any and all diagnostic imaging examinations normally provided by a radiology and medical physics department.

Plain Film Radiographs: this is a specific definition for a range of examinations of the axial, appendicular skeleton, thorax and abdomen that do not require further enhancement through the introduction of contrast media or advanced imaging technology.

Magnetic Resonance Imaging (MRI): this is a specific definition to encompass all investigations and /or interventional examinations that are produced through the use of computer aided nuclear magnetic resonance imaging.

Computerised Tomography: this is a specific definition to encompass all investigations and /or interventional examinations that are produced through the use of computer assisted tomographic

Nuclear Medicine: this is a specific definition to encompass all investigations and /or interventional examinations that are produced through the use of radiopharmaceuticals.

Sonography: this is a specific definition to encompass all investigations and /or interventional examinations that are produced through the use of Ultrasound wave form.

Fluoroscopy: this is a specific definition to encompass all investigations and /or interventional examinations that are produced through the use of real-time fluoroscopic image intensification.

Dual Energy Absorptiometry (DXA): Investigation to measure the bone mineral density using dual energy X-ray absorption.

Ionising Radiation: radiation that is sufficiently energetic to cause ionisation through the release of inner in atoms of high atomic number.

Major Incident: broad definition to encompass any event that is of an untoward nature, which would cause abnormal pressure upon the services of the local NHS facilities i.e. Train crash, terrorist bomb etc.

Radiotherapy planning: A specific term to describe acquisition of images to target Radiotherapy treatments.

Operator: Any person who is entitled, in accordance with the employer's procedures, to carry out practical aspects associated with the conduct of a medical exposure to ionising radiation .

Practitioner: a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the employer's procedures to take responsibility for an individual medical exposure.

Scope

This procedure applies to Cardiff and Vale UHB and relates to referral for appropriate DII listed in Appendix 1

All NMRs who refer for DII must be identified on the Radiology Information System (RIS) or relevant departmental IT system and have access to electronic reporting in order to ensure IR(ME)R compliance[1-2]

Any referrer completing a request for DII does so in the knowledge that there must be a record of diagnostic findings or therapeutic outcome in the patient's case notes. The referrer is required to adhere to the R.M.P.C.E. directorates' standard operational procedures [2, 3].

The term NMR refers to all Health Professionals who are currently registered with a regulatory body but not registered by the General Medical Council / General Dental Council and have been entitled to refer to diagnostic imaging investigations [6]. (Appendix 2)

Exclusions

The following areas of clinical practice are excluded from this procedure

Major Incident
Clinical Trials and Research
Radiotherapy Planning

Individual departmental/service procedures will include any exclusions specific to that area of clinical practice.

Responsibilities

Professional heads and service managers who employ NMRs that refer for DII are responsible for the implementation of these procedures and are accountable for any non-compliance [5-7,].

New services that require NMRs to refer for DII will not be approved unless the professional head/ service manager of that area can submit evidence that there is a requirement of the post to refer for DII; this should be within the role profile. [3, 8-9] .

Directorates employing NMRs are responsible for developing local operational procedures for their referral practice and ensuring that all aspects of this have been complied with [1, 3, 5-6].

All registered healthcare professionals who have the role of NMR specified within their job description will be required to adhere to this policy and draw to the attention of the professional heads/ service manager / UHB any deviation or incidents which affect compliance [5-8, 10].

The NMR has responsibility for providing sufficient medical and patient identification data relevant to the referral [1-2, 7, 11-13].

NMRs are personally accountable to their Professional Body and have an individual professional duty to practice within the limits of their education, training and competence [6-7,11] .

It is the duty of the Clinical Director of Radiology, Medical Physics & Clinical Engineering (R.M.P.C.E) to entitle NMR status within Cardiff and Vale University Health Board; on behalf of the Executive Director for Therapies and Healthcare Sciences, to registered healthcare professionals whose application fulfils the requirements set by the Imaging directorate [6].

The R.M.P.C.E. Directorate will ensure that all referrers are made aware of any relevant changes in radiation legislation, or any other issues affecting the referral process [6, 14]

Unexpected or Incidental Findings

Non-medical referrers have a duty to ensure that unexpected or incidental findings from the imaging examinations they request are managed appropriately. The non-medical referrer must communicate unexpected or incidental findings to the medical practitioner responsible for the patients care, unless they are an autonomous healthcare professional responsible for their own case load; in such cases NMR is responsible for ensuring the patient is referred onto an appropriate pathway of care [3, 5, 7, 10, 12].

Training

All NMRs who have been identified by the UHB as required to refer for DII are required to successfully complete training appropriate to their defined role which must include evidence of:-

- An understanding of the necessary legislation and UHB documentation
- Attendance at appropriate Consultant led clinics/ward rounds or multidisciplinary team meetings, to observe initial referral and follow-up of patients.

Training is required to be documented and will form part of the Knowledge and Skills profile for this role and be reflected within the individuals' personal development plan [1-2, 8, 10, 15-16]. Audit and review of referrals made will occur as part of this procedure and will drive the requirement for update in training of individual NMRs [1, 5-6, 10]

If a NMR has not referred to DII for more than 12 months, a review will be undertaken to ascertain whether the service is still required and if appropriate, the individual NMR will be required to repeat the initial training programme

Clinical Governance

The professional head/ service manager for the NMR will be responsible for undertaking an annual audit of their service to test compliance with the procedure. They can be approached at any time to provide evidence of their audit processes and operational procedures. The directorate could also be subject to external review by a variety of statutory bodies [5-6, 10, 17-18].
The line manager/supervisor will undertake an audit of the individual NMRs clinical/referral practice as part of the annual IPR process. Action will be taken where the suitability and impact of referrals may compromise the overall quality of patient care [1,].

The regularity of the audit process may alter subject to the needs of the individual procedure but should be no less than annually.

The R.M.P.C.E. directorate will undertake an annual audit of a selection of DIIs requested, and assess the appropriateness and quality of the referrals received. Where concerns are raised following audit; suspension of NMR entitlement will be employed until evidence of further training and/or governance is in place. Failure to comply with this requirement will result in the NMR entitlement being withdrawn [2, 5-6, 17].

The imaging operator or practitioner will feed back to the NMR on any inappropriate requests. If on the basis of this feedback the NMR feels they require further training or they do not understand

the feedback they will discuss the matter with their professional supervisor in order to identify possible further training needs[7,10].

All referrals for examinations performed by the R.M.P.C.E directorate are included within this policy, both those involving the use of ionising radiation and those not, such as Ultrasound.

Consent

It is the responsibility of the referrer to ensure that valid informed consent is obtained for the procedure they are requesting. This includes where appropriate, discussing the risk vs. benefit of an examination. The NMR has the responsibility to address any issues arising from the patients' mental capacity to consent as set out in the Mental Capacity Act 2005 [10, 19,]. This does not absolve the healthcare professional undertaking the diagnostic investigation from their responsibility with regard to patient consent.

References:

1. Ionising Radiation (Medical Exposure) Regulations 2017 (Statutory Instrument 2017 No. 1322, London, HMSO
2. A guide to understanding the implication of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology. *Clinical Radiology*, The Royal College of Radiologists (2015)
3. Department of Health (2003), The Chief Health Professions Officer's Ten Key Roles for Allied Health Professionals, Department of Health: London
4. National Health Service Reform and Health Care Professions Act (2002), Office of Public Sector Information (OPSI)
5. Ionising Radiation (Medical Exposure) Regulations 2000: Notes on good practice. Department of Health (DoH)

6. The regulatory requirements for medical exposure to ionising radiation (2001), Health and Safety Executive.

7. Standards of conduct, performance and ethics, HCPC (2022)

8. Health and Social Care Review for Wales (2003) Advised by Derek Wanless, National Assembly for Wales

9. The NHS Improvement Plan, Putting People at the Heart of Public Services , 2004

10. The Health and Social Care Act 2012

11. Clinical Imaging Requests from Non-Medically Qualified Professionals (2021 3rd Ed), The Royal College of Nursing in conjunction with SCoR, RCR,CSP,

12. iRefer Making Best Use of Clinical Radiology 8th edition (2017), The Royal College of Radiologists

13. HIW activities and enforcement under the Ionising Radiation (Medical Exposure) Regulations 2000- Annual Report 2014-2015. Health Inspectorate Wales 2015.

14. Work with Ionising Radiation, Ionising Radiation Regulations 2017, approved Code of practice and guidance. (HSE) 2018

15. Management of Policies and Other written Controlled Documents (2017), Cardiff and Vale UHB

16. Allied Health Professionals Service Improvement Project, Improving Quality and Productivity (DOH) (2011)

17. Medical and dental Guidance Notes: A good practice guide on all aspects of ionising radiation protection in the clinical environment. Institute of Physics and Engineering in Medicine (2002).

18. Health and Social Care Act 2008 (Chapter 3 Quality of Health and Social Care).

19. Consent to Examination or Treatment Policy (and guidance for independent contractors working in primary care), 2015. Cardiff and Vale University Health Board.

APPENDIX 1.

Plain Film Radiographs
Magnetic resonance imaging (MRI)
Computerised tomography (CT)
Nuclear medicine (NM)
Fluoroscopy
DXA

APPENDIX 2.

Registered Allied Health Professionals
- Arts Therapists
- Clinical Physiologists
- Clinical Scientists
- Dieticians
- Occupational Therapists
- Orthotics
- Paramedics
- Physiotherapists
- Podiatrists
- Diagnostic Radiographers
- Speech and Language Therapists
- Registered Midwives
- Registered Nurses
- Physiological Measurement Technicians
- Operating Departmental Practitioners

Report Title:	Joint Research Governance Structure and Terms of Reference			Agenda Item no.	4.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	10.01.2023
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	x
Lead Executive:	Executive Medical Director				
Report Author Title):	Director of the Joint Research Office				

Main Report
Background and current situation:

The CVUHB Research and Development Office has had a long-standing commitment to report pertinent issues to the QSE Committee (via the Medical Director) to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services for subjects involved in research studies. This function was previously undertaken by the CVUHB Research Governance Group.

In October 2018, Cardiff University and Cardiff and Vale University Health Board committed to establish a joint service for research and development activity on the University Hospital of Wales site. An integrated team model has been adopted, which allows for joint working, in a single location, whilst staff continue to work for their current employer under the same terms and conditions. This has resulted in the formation of the **Cardiff Joint Research Office (JRO)**, which represents a partnership between Cardiff and Vale University Health Board (CVUHB) and Cardiff University (CU) to support the development, set up and approvals for health research in Cardiff. The JRO was launched in August 2021.

In order to support the integrated team model within the JRO, it was agreed that the Research Governance Group would be disbanded in July 2022, and a new Group, reporting to both CVUHB QSE Committee and Cardiff University would be established, entitled the **Joint Research Governance Group (JRGG)**. The purpose of this new group is to facilitate joint working between Cardiff & Vale University Health Board (CVUHB) and Cardiff University (CU) in order to ensure robust Research Governance arrangements are in place for research which falls under the remit of the Joint Research Office (JRO) and the UK Policy Framework for Health and Social Care Research. The inaugural meeting was held on 18 October 2022 and the Terms of Reference were accepted by the Group. The Group noted the reporting structure and operational oversight. The Terms of Reference have been deposited in the JRO's document control system and will be reviewed in 3 years.

The attached Organogram indicates the extent of the Joint Research Office Group reporting structure and operational oversight and highlights, by solid lines, where groups report and by dotted lines, where information is required. 2 groups will report directly to the Joint Research Governance Group:

- The Quality Assurance group will develop and review Standard Operating Procedures
- The Clinical Trial Governance Group will overview the governance of higher risk studies especially drug trials – so-called Clinical Trials of an Investigational Medicinal Product (CTIMPs) which are regulated by the UK Medicines and Healthcare products Regulatory Agency (MHRA). CTIMP trials may incur statutory inspections by the MHRA. The Clinical Trial Governance Group will overview both CVUHB and Cardiff University sponsored studies involving CVUHB subjects as well as overviewing the support provided for these studies by University's Centre for Trials Research.

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

- the establishment of the Joint Research Governance Group, to ensure that robust Research Governance arrangements are in place for research which falls under the remit of the Joint Research Office (JRO) and the UK Policy Framework for Health and Social Care Research.
- the Joint Research Office reporting structure and operational oversight

Recommendation:
The Committee is requested to: **a) To note the establishment of the Joint Research Governance Group, which will report to the QSE Committee as necessary; and** b) **To note, the Group's Terms of Reference and Organogram.**

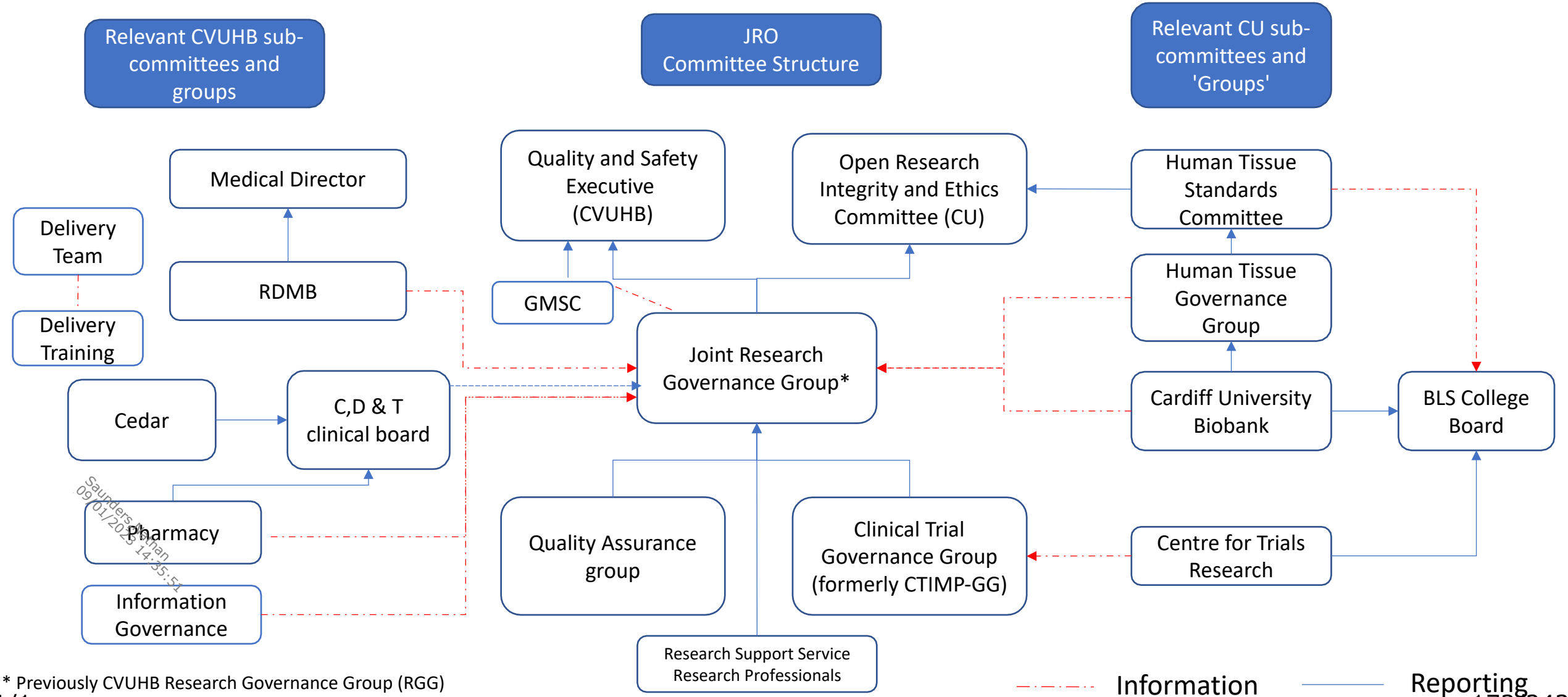
Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	Y	7. Be a great place to work and learn	
3. All take responsibility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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration	Y	Collaboration	Y	Involvement	Y

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: No
n/a of the report, please confirm)

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Joint Research Office
Committee reporting structure and operational oversight



* Previously CVUHB Research Governance Group (RGG)

Cardiff Joint Research Office

Joint Research Governance Group (JRGG)

Constitution and Membership (July 2022)

1. **PURPOSE:**
To facilitate joint working between Cardiff & Vale University Health Board (CVUHB) and Cardiff University (CU) in order to ensure robust Research Governance arrangements are in place for research which falls under the remit of the Joint Research Office (JRO) and the UK Policy Framework for Health and Social Care Research.

2. **Composition and Administration:**

2.1 There shall be a Cardiff Joint Research Governance Group which shall report to:

(i) The Cardiff and Vale University Health Board (CVUHB) Quality, Safety and Experience (QSE) Committee. A Chair's report will be received by QSE

(ii) The Cardiff University (CU) Open Research Integrity and Ethics Committee (ORIEC). A Chair's report will be received by ORIEC

2.2 The JRGG will be composed as follows:

(i) The Joint Research Office (JRO) Director, who shall be Chair
(ii) The College of Biomedical and Life Sciences Dean of Research
(iii) Associate Medical Director for R&D for CVUHB or delegate(s)
(iv) The three CU School Directors of Research of Dental, Medic and Healthcare
(v) The CVUHB Clinical Board/Directorate R&D Leads
(vi) Governance Lead for Cardiff University Centre for Trials Research
(vii) Governance Lead for Cedar
(viii) The JRO Senior Management Team
(ix) Chair of Clinical Trials Governance Sub-Group or delegate
(x) Chair of Quality Assurance Sub-Group
(xi) The Research Support Service Manager

2.3 Quorum shall be 8 members. 4 members need to be external to JRO. Members encouraged to send an appropriate delegate if unable to attend.

2.4 Officers who support this activity will be invited to the Group as follows;

(i) Two representatives of the JRO Sponsorship and Quality Assurance Team
(ii) CVUHB Pharmacy representative
(iii) Biobank/HTA representative
(iv) CVUHB Research Delivery Team representative
(v) Training lead/representative
(vi) Representative from Genetic Modification Safety Committee (CAV)
(vii) Information Governance Officer (CAV)

3. **Duties and Terms of Reference:**

3.1 JRGG will oversee and provide assurance of robust Research Governance arrangements within CVUHB and Cardiff University (CU) relating to research which falls under the remit of

the Joint Research Office (JRO) and the UK Policy Framework for Health and Social Care Research (2017).

3.2 JRGG will facilitate joint working in research endeavours between CVUHB and CU, focusing on solutions to any potential governance issues which arise.

3.3 JRGG will oversee the development and review of Joint Research Governance Policy which covers all research falling within the remit of the JRO

3.4 JRGG will monitor compliance with legislative requirements relating to Research Governance, including (but not limited to) the UK Policy Framework for Health and Social Care Research (2017), the Mental Capacity Act (2005), the Medicines for Human Use (Clinical Trials) Regulations (2004) and the associated Amendment Regulations, Human Tissue Act (2004) (from the CVUHB perspective) and the General Data Protection Regulations (GDPR) and Data Protection Act (2018)

3.5 JRGG shall receive update reports from the Clinical Trials Governance Sub-Group

3.6 JRGG shall receive update reports from the Quality Assurance Sub-Group and receive any documents where advice is sought from JRGG

3.7 JRGG shall receive Governance reports from CVUHB Clinical Boards and CU Schools to demonstrate that mechanisms are in place to discuss and deal with research governance issues at a Clinical Board and School level

3.8 JRGG shall receive Research Governance Audit reports and approve the JRO annual Research Governance audit plan

3.9 JRGG shall receive a report on research related incidents and breaches relating to work under the remit of the JRO

3.10 JRGG shall receive updates for information from the following:

i. Cardiff University Biobank
ii. Research Delivery Management Board/ Delivery Service
iii. Pharmacy
iv. C D & T Clinical Board/Cedar
v. Centre for Trials Research
vi. Genetic Modification Safety Committee
vii. Information Governance

3.11 JRGG shall integrate consideration of equality and diversity issues in all matters falling within its remit

3.12 JRGG shall ensure that sustainability issues are fully considered in all matters falling within its remit

4 Meeting Frequency:

4.1 JRGG will meet quarterly

Joint Research Governance Group: Membership

Session 2022-23

(i) The Joint Research Office Director, who shall be Chair

Professor Colin Dayan

(ii) The College of Biomedical and Life Sciences Dean of Research

Professor Andrew Lawrence

(iii) The three CU Schools Director of Research for Dental, Medic and Healthcare

Professor Aled Clayton, Medic
Dr Kate Button, Healthcare
Dr Elaine Ferguson, Dental

(iv) The CVUHB Clinical Board R&D Leads

Professor Aled Rees – Medicine
Professor Phillip Connor – Children and Women's
Dr Julie Cornish - Surgery
Dr Guru Naik- Primary, Community, Intermediate Care and Older Person Services
Dr Emily Harrington -Mental Health
Dr Richard Anderson - Specialist Services
Dr Ian Tully - Clinical Genetics
Dr Rhys Morris – Clinical Diagnostics and Therapeutics/Cedar Director

(v) Associate Medical Director for R&D/RDMB Chair – Professor Matt Wise.

(vi) Governance Lead for Cardiff University Centre for Trials Research

Dr Claire Johnson

(vii) The JRO Senior Management Team

Mrs Cerys Phillips
Mr Chris Shaw
Mrs Lucy Jenkins
Dr Anna Hurley
Dr Ellie Rad

(viii) Chair of Clinical Trials Governance Sub-Group

TBC

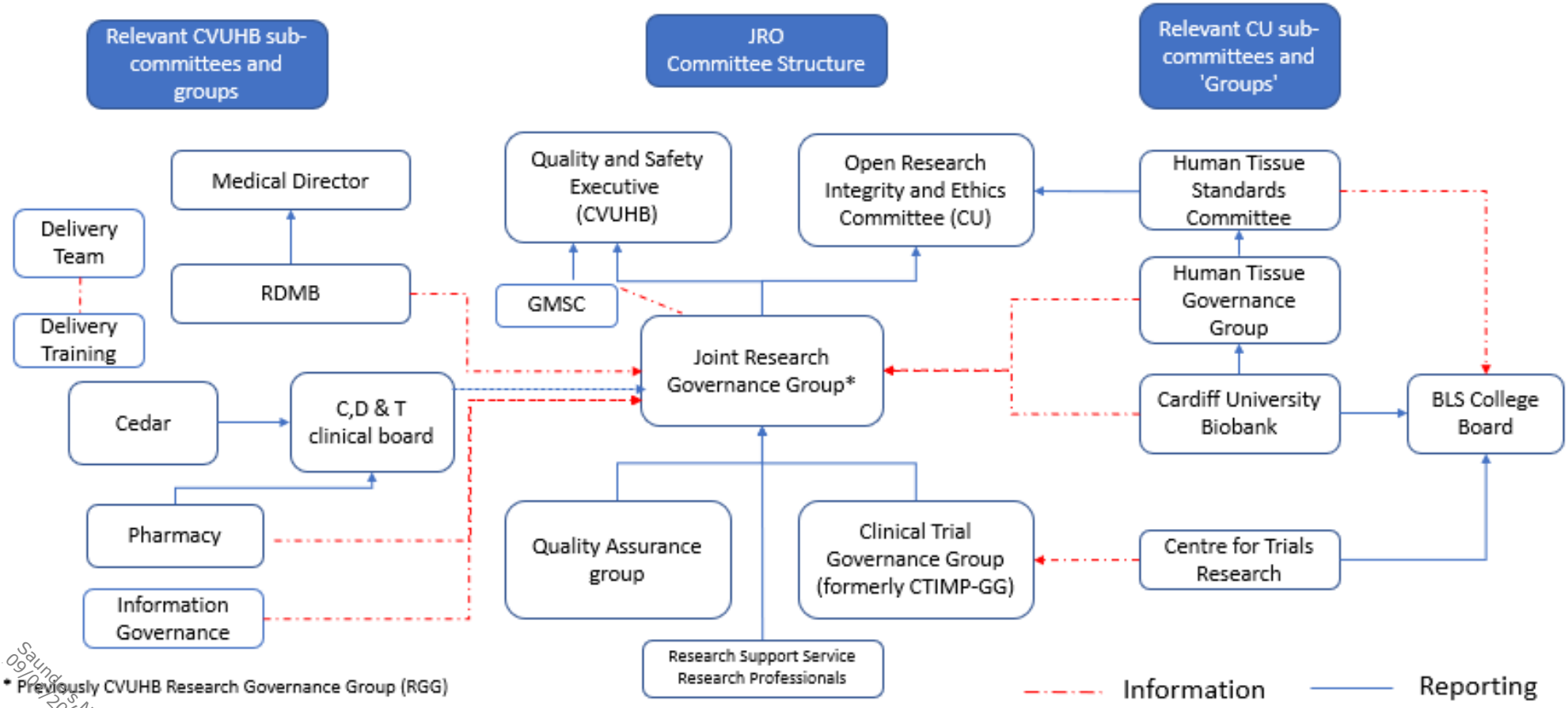
(ix) Chair of Quality Assurance Sub-Group

TBC

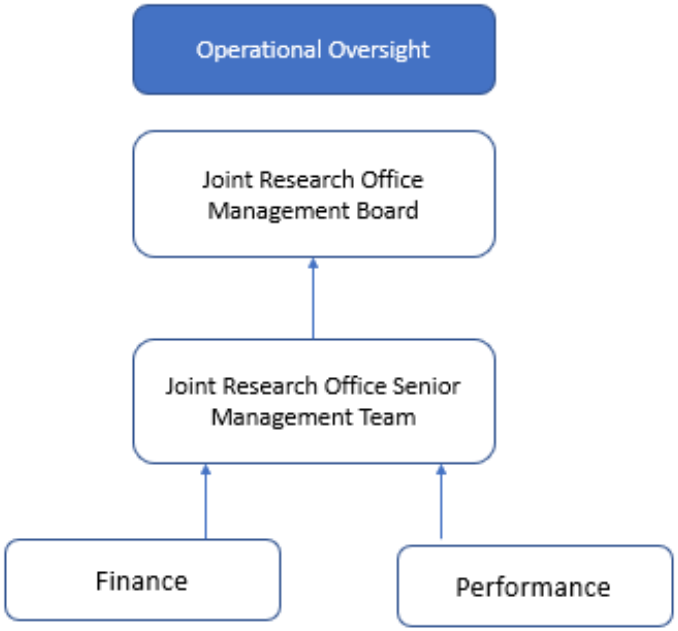
(x) Manager of Research Support Service (TBA)

Secretary: Mrs Jemma Cross/Mrs Kim Mears

Joint Research Office
Committee reporting structure and operational oversight



* Previously CVUHB Research Governance Group (RGG)



Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held On 17th October 2022
Via MS Teams

Present:		
Sue Bailey (Chair)	Chair	Director of Quality, Safety and Patient Experience
Sandeep Hemmadi	SH	Clinical Board Director
Becca Jos	BJ	Deputy Director of Operations
Rachel Hunt	RH	Biomedical Scientist Biochemistry (for Nigel Roberts)
Jo Fleming	JF	Quality Lead, Radiology
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Richard Thomas	RT	Biomedical Scientist Haematology (for Alun Roderick)
Jenna Walker	JW	Pharmacist, Pharmacy
Robert Bracchi	RB	Medical Advisor to AWTTC
Edward Chapman	ECh	Head of Clinical Engineering/ Medical Devices Officer
Louise Long	LL	Public Health Wales Microbiology
Bolette Jones	BoJ	Head of Medical Illustration
Seetal Sall	SS	Point of Care Testing Manager
Paul Williams	PW	Clinical Scientist, Medical Physics
Jonathan Davies	JD	Health and Safety Adviser
Jamie Williams	JWi	Senior Nurse, Radiology
Sian Jones	SJ	Directorate Manager, Laboratory Services
Cath Marshall	CM	Physiotherapy Representative
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Claire Constantinou	CC	Senior Dietitian (For Helen Nicholls)
Claire Fudge	CF	Strategic Lead Occupational Therapist (for Kim Atkinson)
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Helen Luton	HL	Director of Nursing, CD&T Clinical Board /Multi-professional Teams
Matthew Temby	MT	Clinical Board Director of Operations
Catherine Evans	CE	Patient Safety Facilitator
Rhys Morris	RM	CD&T R&D Lead
Emma Cooke	ECo	Clinical Director of AHPs
Tracy Wooster	TW	Sister, Outpatients
Kim Atkinson	KA	Head of Occupational Therapy
Suzanne Rees	SR	Lead Nurse, CD&T
Helen Nicholls	HN	Head of Nutrition and Dietetics
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Alun Roderick	AR	Laboratory Service Manager, Haematology
Mathew King	MK	Head of Podiatry

Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Timothy Banner	TB	Clinical Director, Pharmacy
Nia Came	NC	Head of Speech and Language Therapy
Lesley Harris	LH	Head of Radiography UHL

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 22/316	**Welcome & Introductions** SB welcomed everyone to the meeting.	
CDTQSE 22/317	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 22/318	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 20th September 2022 were accepted as an accurate record.	
CDTQSE 22/319	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/*158 *NICE guidance relating to rehab following a traumatic injury* SH and SB to consider the requirement for a risk assessment to be completed. *CDTQSE 22/213 CAV Connect* There is no update relating to the implementation of the UHB CAV Connect App. When this is launched, the Clinical Board will set up a comms group on the app for senior managers, as a communication tool in an emergency. *CDTQSE 22/243 Maintenance to Toxicology Lift* No update to report. *CDTQSE 22/247 Rehab Estates Issues* ECo is producing an SBAR of all Therapies Rehab estates issues.	**SH/SB** **HJ** **RB** **ECo**

	CDTQSE 22/254 Wall Brackets Work in conjunction with Estates is progressing across the UHB to ensure there are no issues with wall brackets in departments. *CDTQSE 22/264 Digital Therapies Work* To be presented at a future meeting. **The Group resolved that:** a) An update on the outstanding actions will be provided at the next meeting.	**SO/MK**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CDTQSE 22/320	**Presentation: AMAT Rollout** Debbie Jones was welcomed to the meeting to raise awareness of the AMAT (Audit Management and Tracking) system to the meeting. It was noted that this Clinical Board has shared the details of the demonstration of the AMAT system widely across its services. The demonstration will provide an overview of the whole system. This will be a central system that will allow monitoring of all clinical audit activity, inspections, NICE guidance assurance and it will also have a service evaluation module and a quality improvement module within it. An internal audit last year that was undertaken on clinical audit demonstrated very limited assurance. AMAT is a system that allows the logging of audit activity and sharing this across the whole Health Board. The system is designed for all staff to use. Different individuals will have more activity within the modules than others. The system will provide live data and reports. A Teams channel has been set up. This includes a training calendar for the system which is running over 3 weeks in November. Specific training sessions can also be accommodated for a group of staff with specific needs. The training sessions can also be accessed through the Clinical Audit Sharepoint site. Almost every Health Board in Wales is using AMAT but are at different stages of rollout. At present individual Health Boards can only access their own internal audit data. The AMAT system does not store patient identifiable information. Audit data can be restricted for viewing as tightly as necessary. **The Group resolved that:** a) Interested individuals will attend the demonstration of the system tomorrow. b) Departments will book onto the training sessions.	

CDTQSE 22/321	**Feedback from UHB QSE Committee** The UHB QSE Minutes 30th August 2022 are not yet available. **The Group resolved that:** a) The minutes of the UHB QSE Committee will be discussed at the next meeting when available.	
CDTQSE 22/322	**Health and Care Standards** **The Group resolved that:** a) There was no update to report.	
CDTQSE 22/323	**Risk Register – Review and Revision** **The Group resolved that:** a) There were no new risks to escalate.	
CDTQSE 22/324	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** **The Group resolved that:** a) There were no issues or exception reports to escalate.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
CDTQSE 22/325	**Initiatives to promote the Health and Wellbeing of Patients and Staff** Staff should now be aware that Covid-19 and flu vaccinations are available. Dates of pop-up sessions throughout October have been circulated and flu champions will be offering vaccinations from November. Medicines Safety Week is being held 7th-13th November. The theme this year is how patients and healthcare workers make safety work. Numerous events will be held during that week. Becca Jos noted that a UHB group has been set up to discuss the cost of living crisis and how to support staff. SO is attending on behalf of the Clinical Board. **The Group resolved that:** a) The vaccination programme was noted. b) Any ideas relating to supporting staff with the cost of living crisis to be submitted to SO who will feed this back to the group.	**All**

SAFE CARE		
CDTQSE 22/326	**Concerns and Compliments** In September 2022, the Clinical Board reported an Amber status. It received 31 concerns with 61% resolved through early resolution. There were 2 breaches in response times and 11 compliments. Areas reporting a Red status were Laboratory Medicine which reported 4 concerns and 1 breach in response times. Pharmacy reported 2 concerns and resolved both in early resolution timeframes but reported a breach in responding to a concern received in the previous month. All other departments reported a Green status. The main theme of the formal concerns received relates to difficulties arranging and cancelling appointments. **The group resolved that:** a) Overall, good concerns management was reported within the Clinical Board for September 2022.	
CDTQSE 22/327	**National Reportable Incidents (NRIs)** The Clinical Board is currently reporting 2 open NRIs: 4123 – an incident relating to the breakdown of a Radiology machine during a neuro interventional procedure. The patient experienced ill effect following the procedure. A draft report has been produced and awaiting final comments. 5670 – this incident relates to a delay to the reporting of a CT scan, where the patient suffered harm as a consequence of the delay. The final draft is currently being reviewed by the Redress Team. NHS Blood and Transplant shared learning from a Never Event relating to an organ donation and transplantation. The summary of the incident was shared with the Group. PW shared the learning from a negligence case relating to an ultrasound scan. The patient claimed there was a delay in diagnosis and treatment of a deep vein thrombosis in the claimant's thigh that led to a pulmonary aneurysm in July 2018. The claimant suffered a fall in May 2018 and experienced calf pain and attended A&E. A d-dimer was performed and the claimant returned for a review on 25th May and was diagnosed with a DVT in the calf and commenced on Clexane with a view to having a doppler scan a few days later. The claimant was noted to have had five plus months of history of shortened breath and	

	chronic cough. A chest x-ray's findings were normal which excluded a PE at the time. The claimant had a DVT scan on 29th May 2018 which was positive for a DVT of the calf. There was no extension into the popliteal vein which is at knee level and the patient declined anticoagulation and opted for a follow up doppler scan. A doppler scan was conducted on 5th June which showed no changes from the previous scan. On 3rd July the claimant phoned the DVT clinic with pain in the thigh and had a scan on 5th July which showed thrombus was still evident in the calf but no extension above the knee. The doppler report did not indicate whether the thigh was scanned and there was no image of thigh veins. The claimant was hospitalised on 10th July 2018 with shortness of breath and investigations confirmed that a PE remained and the patient remained as an inpatient until 23rd July. The claimant alleges that the negligence was due to a failure of adequately examining the proximal leg veins. At the time it was not clear that the thigh veins were not scanned nor evidence that they were scanned. It is also unclear if there was a repeat scan. The learning outcomes from this are: Anyone who is performing a scan needs to be clear on the extent of the scan from the request form, as this is the only documentation of what is requested. It needs to be ensured that the request form is clear. The importance of keeping images of scan results for the appropriate scan areas that match what has been requested. **The Group resolved that:** a) The update on the open NRIs were noted. b) The learning from the negligence case in Ultrasound will be shared with Ultrasound Governance Group.	
CDTQSE 22/328	**New NRIs** **The Group resolved that:** a) No new NRIs have been reported.	
CDTQSE 22/329	**Patient Safety Alerts (internal/external)** **The Group resolved that** a) There were no alerts to report.	

CDTQSE 22/330	**Medical Device/Equipment Risks** Repairs of Arcomed PCA pumps are still a problem with software and lack of engagement with company initially. Raised at national level and company are now engaging. **The Group resolved that:** a) The update on medical devices was noted.	
CDTQSE 22/331	**IP&C/Decontamination Issues** A Field Safety Notice has been issued around the inadequate instructions for cleaning and disinfecting Phillips oesophageal/ rectal/skin temperature probes. The probes should be disinfected using an enzymatic solution before disinfecting or sterilising them. **The Group resolved that:** a) The alert will be shared at the UHB Decontamination Group this week.	
CDTQSE 22/332	**Point of Care Testing** POCT are overdue a contract review for pregnancy testing equipment and require input from Procurement to progress this. SJ reported that she has a meeting with Procurement this week and will escalate the issue. An EU consultant is keen to utilise more Point of Care testing in the EU as part of service transformation work. This will lead to innovative workstreams in the next few months. This will overlap to other medical devices and ultrasound. PW and SS will discuss further outside of the meeting. **The Group resolved that:** a) The Point of Care Testing updates were noted.	**SJ** **PW/SS**
CDTQSE 22/333	**Safeguarding Update** **The Group resolved that:** a) There was no safeguarding update to report.	
CDTQSE 22/334	**Health and Safety Issues** Learning was shared at the last Health and Safety meeting relating to a staff trip in the Critical Care Pharmacy room that resulted from poor storage arrangements of stock which led to a claim. The Health and Safety Staff Representative has offered to support departments with workplace inspections.	

	The Group resolved that: a) The minutes of the meeting were shared for information.	
CDTQSE 22/335	**Regulatory Compliance and Accreditation** HIW have undertaken an inspection against IRMER regulations and Health and Care Standards in Nuclear Medicine at UHL. This was a successful inspection with only a few minor improvements to be made noted. The Home Office inspected SMPU against their controlled drug licence, with a successful outcome. The department has raised concerns with Estates around the lack of CCTV and security issues at SMPU and whilst the Home Office were satisfied with the measures taken to mitigate this, the issues relating to security need to be addressed. A focused review is being undertaken of the Blood Transfusion Laboratory regulatory compliance metrics to support the department with improvement ahead of any inspection. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group held on 6th October 2022 were received and noted.	
CDTQSE 22/336	**Policies and Procedures** **The Group resolved that:** a) The Ionising Radiation Policies and Procedures are out to consultation.	
EFFECTIVE CARE		
CDTQSE 22/337	**NICE Guidance** **The Group resolved that:** a) No guidance has been received.	
CDTQSE 22/338	**Clinical Audits** **The Group resolved that:** a) There are no relevant clinical audits to report.	
CDTQSE 22/339	**Research and Development** The Clinical Board R&D Group was held last month and a discussion was held on the requirement for an Information Governance review of data in cloud storage platforms for new trials in Medical Illustration and Podiatry. Sarah Hiom informed the Group on the Pharmacy Research Wales Network Research Strategy. There was also discussion on	

	the impact of TrAMs on research, particularly involving ATMPs (Advanced Therapy Medicinal Products). The Autumn Research Forum is planned for the 17th November with Sarah Hiom and Judith White speaking, and all are welcome. **The Group resolved that:** a) The minutes of the Clinical Board R&D Group held in September were shared for information.	
CDTQSE 22/340	**Service Improvement Initiatives** **The Group resolved that:** a) There was no update to report this month.	
CDTQSE 22/341	**Information Governance/Data Quality** **The Group resolved that:** a) There was no update to report this month.	
CDTQSE 22/342	**Waste and Sustainability** The Clinical Board Green Group was held last week. A presentation was given from Calum Shaw in the Planning team on the UHB Decarbonisation Programme and Strategy. It was noted that the meeting was poorly attended and it was requested that each directorate is represented at the meeting. At the next meeting there will be a discussion on sustainable travel and ideas for a sustainable Christmas. **The Group resolved that:** a) Each department will ensure they are represented. b) Members will bring along any suggestions for a sustainable Christmas.	**All**
DIGNIFIED CARE		
CDTQSE 22/343	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** **The Group resolved that:** a) As discussed earlier, an inspection from HIW was undertaken in Nuclear Medicine UHL.	

CDTQSE 22/344	**Any initiatives specifically related to the promotion of dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/345	**Equality and Diversity** The UHB Equality and Diversity and Welsh Language Strategy Group is being held this morning. The Clinical Board has representation on the Group. The Clinical Board Inclusion Ambassadors continue to meet monthly. Consideration is being given as to how best use these individuals. **The Group resolved that:** a) Directorates to inform Sion O'Keefe of any equality and diversity work taking place at a local level that he can include in the Clinical Board dashboard that reports into the UHB Equality and Diversity and Welsh Language Strategy Group.	**All**
TIMELY CARE		
CDTQSE 22/346	**Initiatives to Improve Access to Services** **The Group resolved that:** a) There was no update to report.	
CDTQSE 22/347	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Radiology waiting list performance has slipped in month and the team are working hard to mitigate a capacity shortfall and prevent any further slippage. Therapies have reduced their breaches in month for September. Physiotherapy were commended in particular for reducing their breaches by 570 in month. **The Group resolved that:** a) The waiting time position for diagnostics and therapies is monitored in detail in the Directorate Performance Reviews.	
INDIVIDUAL CARE		
CDTQSE 22/348	**National User Experience Framework** The national questionnaires are not currently being undertaken. HIW noted in their inspection of Nuclear	

	Medicine that they are are keen for patient experience feedback to be collated. Radiology are working on a departmental survey for capturing patient feedback. Pharmacy started producing a questionnaire to capture service user feedback prior to Covid and will now be resuming this work. Therapies are looking at mechanisms for capturing outcome measures. **The Group resolved that:** a) Approaches for capturing patient and service users' feedback and outcome measures are being considered in services.	
STAFF AND RESOURCES		
CDTQSE 22/349	**Staff Awards and Recognition** Medical Illustration were successful at the Annual Institute of Medical Illustrators Awards. The department won 2 Gold Awards, 12 Bronze Awards and 4 Silver Awards. **The Group resolved that:** a) The team are congratulated on their success.	
CDTQSE 22/350	**Monitoring of Mandatory Training and PADRs** **The Group resolved that:** a) The monitoring of mandatory training and PADR trajectories are discussed in detail at the Directorate Performance Reviews.	
	ITEMS TO RECEIVE/NOTE FOR INFORMATION	
CDTQSE 22/351	Clinical Board Health and Safety Group Minutes 4.10.22 Regulatory Compliance Group Minutes 6.10.22 R&D Group Minutes 22.9.22 Equality and Diversity and Welsh Language Steering Group Minutes 15.8.22 **The Committee resolved that:** a) The above items were received and noted.	
	ANY OTHER BUSINESS	
CDTQSE 22/352	SB is retiring and this is her last meeting. The Group and SH thanked her for her significant contribution to the Clinical Board's Quality and Safety agenda over the years. HL will be taking over the role as Chair of the Group.	

CDTQSE 22/353	**Date & time of next Meeting** 24th November 2022 at 10am via Teams.	

Minutes of the Medicine Clinical Board

Quality, Safety & Experience Committee Meeting

Held on 20 October 2022 14:30 – 16:00, Via MS Teams

Present:	
Diane Walker	Deputy Director of Nursing, MCB (Chair)
Suzie Cheesman	Patient Safety Facilitator, Patient Safety & Quality Team
Kath Prosser	Quality & Governance Lead, Medicine
Sam Barratt	General Manager, Integrated Medicine
Vicci Page	Deputy General Manager, Specialised Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Gemma Taylor	Professional Practice Development Nurse, Integrated Medicine
Sam Hughes	Professional Practice Development Nurse, Integrated Medicine
Barbara Davies	Lead Nurse, Specialised Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
David Pitchforth	Lead Nurse, Integrated Medicine
Cath Morris	Senior Nurse, Acute & Emergency Medicine
Lisa Green	Senior Nurse, Acute & Emergency Medicine
Ruth Cann	Senior Nurse, Integrated Medicine
Daniella Bridgman	IM Service Manager, Gastroenterology
Craig Dyer	Respiratory Consultant
Angela Jones	Senior Nurse, Resuscitation Service
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Aled Roberts	Clinical Board Director, MCB
Jane Murphy	Director of Nursing, MCB
Lyndsey MacDonald	Consultant, Emergency Medicine
Sharon Jones	Consultant, Rheumatology
Marianne Jenkins	Consultant Nurse Practitioner

Item No	Agenda Item	Action
MCBQSE/2022/0063	**A1. Welcome & Introductions** – were undertaken.	
MCBQSE/2022/0064	**1.1 To receive the minutes of the previous meeting** The group resolved: that the minutes were agreed and accepted.	
MCBQSE/2022/0065	**1.2 Matters arising:** **Blood sugar audit** – DW will liaise with Angharad Oyler to add this to the clinical audit schedule. No need to discuss further here. **Infusible therapy drug** - DW will follow up with Tracey Williams to see if she has checked if there are flags on the system for the patient records regarding the infusible therapy drug they take. **Directorate QSE –** Maitrayee Choudhury to email AR to enquire if the morning directorate QSE meetings could be held in the afternoon. AR will then forward the email to Raj for comment. **Action: SG to follow up with AR/MC.** **Tendable**– please send any queries/ suggestions to Ceri Dalimore.	Diane Walker Sheryl Gascoigne ALL

	Hoverjack – SBAR was taken to DoN's on 27/9/22. Sam Skelton is progressing this and also looking to get the Hoverjack training added to ESR, which will then be a central area to confirm training. **Action: CR-T/DP to follow up with Sam Skelton.** **DNA CPR audit results St David's** – no concerns highlighted. The independent audit will be shared when completed. **Administration of Prescribed Intravenous Medications in Endoscopy** – this has gone through robust scrutiny and to go to NMB for information. The group resolved: the above will be actioned. **Action from discussion:** as above.	Ceri Richards-Taylor/ Dave Pitchforth
MCBQSE/2022/0066	**1.3 Patient Story, Acute and Emergency Medicine** delivered by C Morris The patient came into Resus on 18/5/21 following a significant head injury from a fall. She had 12 days in intensive care. After being discharged, the patient requested to return to the department to thank staff who looked after her in Resus and this was arranged. She thanked the resus team and also Jamie the HCSW who helped her and her family. The group resolved: this had a positive impact on the team. **Action from discussion** – none.	
MCBQSE/2022/0067	**1.4 Feedback from UHB QSE Committee** Minutes from June are available on SharePoint. The Point of Care testing is noted on the risk register for CD&T. A Point of Care committee is being formed. DP has spoken to Seetal Sal about point of care governance. Awaiting feedback from CD&T as to current status. The group resolved: it is important to capture core skills records, although there are competing priorities at present. **Action from discussion** – none.	
MCBQSE/2022/0068	**1.5 Directorate QSE minutes – exception reporting** **Acute & Emergency Medicine Minutes** – received **Rheumatology Minutes** – received. The group resolved: minutes were received from the above. **Action from discussion** – none.	
2. HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
MCBQSE/2022/0069	**2.1 C&V pneumothorax pathway, Pleural procedures** – presented by Craig Dyer (CD) Jade Smitherman and Sofia de Oliveira are Pleural Nurse Specialists at UHW. New BTS guidelines have been issued and the BTS pathway now allows more people to be managed conservatively. The new equipment is a pleural vent, put in the patient with two stitches on the chest wall. The patient can then go home with the device, and reviewed in clinic after three days. Training will be given. CD will start teaching in the ED and ensure staff are aware of the new pathway. Patients must meet the criteria, so that this procedure is carried out on the correct people. Information will be given to patients advising who to contact in case of difficulties. Annually, this may be used for twenty patients. The group resolved: **Action:** CD to speak to AR to ensure AR is sighted on this. **Action:** CD to email Cath Morris to be put in touch with people in the ED.	Craig Dyer Craig Dyer
MCBQSE/2022/0070	**2.2 Healthcare acquired Covid investigations update** Scrutiny panels are still taking place. The team have moved onto contacting families regarding the outcome of the investigations. The group resolved: this may increase concern numbers.	

	Action from discussion – none.	
MCBQSE/2022/0071	**2.3 Learning and Education Plan** The group resolved: no further items have been added at present. **Actions from discussion** – none.	
MCBQSE/2022/0072	**2.4 Tendable feedback** New audit programmes are in place. Lead/Senior Nurses are encouraging audits to be undertaken. Lead and Senior Nurse audits take 2-3 hours. The group resolved: staff should diarise time to undertake audits. **Actions from discussion** – none.	
MCBQSE/2022/0073	**2.5 Hospital acquired thrombosis** The Welsh Risk Pool audited a few Health Boards in Wales looking at the risk assessments for VTE, risk assessments and prescribing. C&VUHB came out well regarding prescribing. The All Wales policy and risk assessment has not been fully adopted by C&VUHB. The group resolved: Recommendations are being worked through. **Action from discussion** – a medic from the front door is required to join the group. DW will follow up on this and liaise with AR.	Diane Walker
MCBQSE/2022/0074	**2.6 Winter Vaccination Programme** From 7/11/22 onwards Champions will be asked to vaccinate, however, it is hoped to have as many staff as possible vaccinated prior to this. Need to plan to vaccinate long-stay patients. The group resolved: Winter roadshow presentations are taking place, discussing staffing, winter plans and getting through winter. **Action from discussion** – none.	
3. SAFE & CLINICALLY EFFECTIVE CARE		
MCBQSE/2022/0075	**3.1 NRI's for closure:** **Acute and Emergency Medicine** **In150089/ID5564** A 63-year-old lady was conveyed to the Emergency Unit (EU) by WAST following a collapse and a head injury. The Unit was extremely busy, the patient left the Unit, collapsed and hit her head on the forecourt of the department. The patient was then brought into resus and where a CT head scan identified a significant head injury. The patient died the following day. **Learning**: when brought back into resus, on review of the patients history on clinical portal, the patient had a history of excessive alcohol intake. This was not disclosed to staff by the patient which may have prompted staff to place in a more observable area of the department. The lady made the decision herself to leave the EU. Red Cross is now re-established in the department to support patients. Radiology found that the majority of the injury would have come from the second fall. **Integrated Medicine** **In137655/ID5549** A lady from an EMI home was referred to hospital by her GP. She was independent and got agitated/aggressive with any interactions with her. Her 'Read about me' was not brought into hospital with her. During her stay her behaviour was challenging. She became restless and wanted to walk unaided to the toilet, staff tried to assist her by offering a steady or a commode. The patient became agitated, fell and hit her head. The patient had an immediate medical assessment, however, would not let nursing	

	staff fully complete observations. Her condition deteriorated, a CT head scan showed a significant bleed. The patient died several hours later. **Learning** – the patient would not comply with observations. CT scanning was not undertaken within 8 hours of the fall secondary to the patients agitation post fall. The patient's behaviour chart and falls risk assessment paperwork was not completed fully in line with best practice. Study days for violence and aggression and dementia training are in place. This is now subject to a Coroners enquiry. This has been discussed at redress, as there were elements of breach, but not causative of her fall. This took place at East 2, UHL at a time where the nursing team was struggling with vacancies. Overseas nurses have been recruited to East 2 and lots of mentoring is required. **ID7152** A gentleman came into UHW following a fall in the community and he also had a chest infection. The patient developed seizures with a normal CT head scan, so was kept in as an in-patient. He had a background history of dementia, hypertension and bronchiectasis. He was transferred to A1 link, and was noted to be restless and agitated overnight. The decision was made to allocate a HCSW as a 1-2-1 with him. The patient fell before the HCSW got to him. The patient was diagnosed with a fractured neck of femur which required surgery. His condition deteriorated post operatively, with heart failure, acute kidney injury and sadly died a month later. This case has been referred to the Coroner. **Learning** – the falls risk assessment was completed; however, agitation and restlessness was marked as 'no' on admission to A1 link and post fall. If the agitation and restlessness had been recognised, this may have prompted closer monitoring. Staff were delayed in the safety briefing, so not visible in the area. Safety briefing procedures have now changed in line with if patients require enhanced monitoring then staff are sent out to patients during the briefing and the staff are later updated regarding the safety briefing information. This case has been discussed at re-dress and an M&M review will take place in December 22 to support decision making. **ID9058 & ID5719** (will discuss both these together) Both cases had avoidable category three pressure damage. Intentional-rounding did not support the prescribed re-positioning the patient needed. There was a lack of individual pressure damage care plans and timeliness of mattress selection. **Learning** – the pressure damage task and finish group are looking at the algorithm to support staff to consider the correct mattress selection. The group resolved: all agreed these incidents may now be closed. **Actions from discussion** – none.	
MCBQSE/2022/0076	**3.2 Infection Prevention and Control up-date** 80 days since last MRSA bacteraemia (UHL E7) 7 days since last MSSA bacteraemia (UHW A7) 2 days since last *C difficile (UHW A7)* 20 days since last E. *Coli* bacteraemia (UHW C7) 193 days since last Pseudomonas bacteraemia (UHW LSGF2) 42 days since last Klebsiella bacteraemia (UHW LSGF 1) There are two ongoing outbreaks, one on A1 Link and the other on Lansdown Ward, St David's Hospital. Outbreaks have affected 10 patients'; 3 staff and 3 bed days were lost. • DMT scores – All wards within MCB are compliant for the last 4-week period.	

	• MCB position based on the same period 2020-2021: *C. difficile* - 32% reduction, *Klebsiella* 10% increase, 18% increase with *E. coli*, 31% increase with SAUR and +1 increase with *Pseudomonas*. • 22 RCA's remain outstanding. • Bare Below the Elbow. All UHW MCB wards audited. Only 35% of wards achieved compliance. • Monkey pox. A Further case was admitted in the last month. • Ebola. Attended a meeting with EU, inventory of PPE undertaken on EU and A7, Action cards and symptom checker disseminated to EU. Currently sourcing order no's for PPE stock and attending UHB Ebola meeting tomorrow. • Influenza-Confirmed influenza cases are increasing. RSV confirmed have also increased in recent weeks. The incidence of Influenza increased last week, there is now the highest number of confirmed influenza cases within a week since the 2019-20 • Awaiting reduction goals for 2022-2023. **On target to achieve the E.coli and C.*difficile*** • RCA's remain outstanding (since beginning of this year). • MCB catheter bundle audit ongoing. Results available soon • Monkey pox. cases now identified in wales. • Community case rate for COVID-19 increased by % in the last week. Hospital acquired cases also risen. • Confirmed influenza case numbers - The group resolved: the above was noted. **Actions from discussion** – DK will update on DMT scores following the 'walkabouts' being undertaken.	Derek King
MCBQSE/2022/0077	**3.3 Point of Care testing: any actions required** The group resolved: the action below will be carried out. **Actions from discussion** – during winter with off ward nurses being on multiple wards, Seetal has agreed that they will be activated on every machine for 6 months in MCB. GT will email DW regarding this decision and this email will then be shared.	Gemma Taylor
MCBQSE/2022/0078	**3.4 Medical devices/equipment issues** An NRI was reported regarding a procedure which took place where a non-medical-accredited LED bike light was used for quite a time, to illuminate a baby's vein and it caused a burn. There have been a few incidents reported on Datix recently regarding insulin needle stick injuries. The group resolved: **Actions from discussion** – Lead Nurses will check to ensure that correct medically accredited devices are used. Regarding the insulin needles, Lead Nurses to check if the datix incidents relate to individual pens or other needles.	Lead Nurses
MCBQSE/2022/0079	**3.5 LFE PI/UHW/DCIQ/606 PI/UHW/435** This relates to a patient from HM prison who was admitted to hospital with TB. The claim has come from the prison officers who stated they were not advised of the correct PPE to wear and were handcuffed to the patient 12-hours at a time. Liability has been admitted and a joint payment made between primary care/ prison/ health care. Patients being admitted to A7 or B7 should have it clearly documented in their notes regarding the appropriate level of PPE to be worn around them and remind visitors/ custodians of this. Be mindful that people are visiting hospital sites for a	

	range of reasons, need to be mindful of the advice given to visitors and people staff work alongside. Yvonne Hester will update the TB policy. The group resolved: these were noted for sharing. **Actions from discussion** Action 1: need to look at how to manage visitors. BD/ DW will discuss further due to historic information on such areas. **Action 2:** LG will update EU staff regarding clearly documenting on patient notes the appropriate level of PPE to be worn around the patient.	Diane Walker/ Barbara Davies Lisa Green
4. DIGNIFIED CARE		
MCBQSE/2022/ 0080	**Patients Safety/Quality Care** **Medicines Recall** – Mexiletine, cardiology drug. **4.1** The group resolved: to note the above for information. **Actions from discussion** – to be noted regarding awareness regarding under-dosing and over-dosing.	ALL
MCBQSE/2022/ 0081	**4.2 Mortality Group feedback** CR-T now receives mortality review feedback which allows CR-T to feedback to the group regarding what is being done in response to that. The group resolved: **Actions from discussion** – CR-T will look at how to best prepare the feedback for sharing with ward teams.	Ceri Richards-Taylor
MCBQSE/2022/ 0082	**4.3 HIW Report Emergency and Acute Medicine. Clinical Board update** The department is being painted. The chairs on the south side have been replaced with trolleys. Working on de-congesting the speciality hub. Additional showers will be completed by 30/11/22. **Unannounced Health Ministers visit** – the Minister never spoke to staff as they were so busy. Patients had all been triaged appropriately. The group resolved: The ED team fully supported the inspection. **Actions from discussion** – none.	
MCBQSE/2022/ 0083	**4.4 Respiratory Acute Oncology** – not discussed. The group resolved: item to be carried over to next month's meeting. **Actions from discussion** – none.	
5**. TIMELY CARE**		
MCBQSE/2022/ 0084	**5.1 Integrated Medicine** The group resolved: this item to be carried over to the next meeting. **Action from discussion** - KP to add to next month's agenda.	Kath Prosser
MCBQSE/2022/ 0085	**5.2 4-hour and 12-hour performance update, Emergency Medicine** The group resolved: this item to be carried over to the next meeting. **Action from discussion** - KP to add to next month's agenda.	Kath Prosser
6. INDIVIDUAL CARE		
MCBQSE/2022/ 0086	**6.1 National User Experience Framework - Feedback from 2 minutes of your time survey – relevant improvement plans** **6.2 Deprivation of Liberty Compliance in MCB** **6.3 Safeguarding** The group resolved: these items were not discussed. **Actions from discussion –** KP to add to next month's agenda.	Kath Prosser
MCBQSE/2022/ 0087	**6.4 Concerns update** There are 102 open concerns. Performance is 85%.	

	The group resolved: Thanks to all for work on concerns. **Actions from discussion** – none.	
MCBQSE/2022/0088	**6.5 Compliments** **B7** – compliment received from a person regarding the care of their relative who died on B7. They advised the patient care was phenomenal. **Endoscopy Unit, UHL** – praise was given for the Unit staff. The patient received wonderful care. Staff were kind and caring and made the patient feel at ease. **Lakeside Wing** (LSW) – thanks were given for the care and attention given to a patient, during his long stay in hospital. LSW 2 is the best ward the patient has been on. Deep gratitude was given to the nurse in charge who was with the patient when he died. **Acute & Emergency Department** – thanks to the department who are an amazing and undervalued team. The group resolved: compliments should be shared, not just to focus on complaints. **Actions from discussion** – all should share with their teams the appreciation for the outstanding care given to patients.	ALL
7. STAFF AND RESOURCES		
MCBQSE/2022/0089	**7.1 Any updates to share** The group resolved: no issues were discussed. **Actions from discussion** – none.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
MCBQSE/2022/0090	**7.2 Any other business** The continuing operation of additional capacity areas is having an adverse impact on safe staffing on wards and affecting the quality of care given to patients. Ward staff are under stress and some are tearful. Staff are raising significant concerns regarding patient safety and patient wellbeing. Concern has been raised regarding point of care arrangements when only one person on a nightshift can undertake point of care testing for 30 patients, with incredibly high acuity. Staff are concerned of the risks. There is significant concern about 'safe staffing' if strike action takes place. **Community Hospitals** – the issue continues regarding transferring patients to community hospitals at weekends. There have been two incidents recently when staff have gone off sick as a result of being attacked by patients. This is on the IM risk register. Even though controls are in place, community hospitals are still having inappropriate patients transferred to them out of hours when fewer people are around to ensure screening is robust. The group resolved: all incidents should be reported/logged. **Actions from discussion** – DW and RC to discuss transferring patients to community hospitals at weekends.	Diane Walker/ Ruth Cann
MCBQSE/2022/0091	**7.3 Date & time of next Meeting –** 2.30pm to 4pm on 15/12/22	

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee
Held Thursday 1 September 2022 at 9:30am
Via MS Teams

Chair:		
Claire Main	CMain	Interim Director of Nursing, Specialist Services Clinical Board
Present:		
Mat Davis	MD	Consultant Nephrologist, Quality and Safety Lead for Specialist Services
Gayle Sheppard	GS	Assistant Service Manager Cardiac Services
Claire Mahoney	CM	CNS Infection Prevention & Control
Tom West	TW	Critical Care Consultant
Gareth Jenkins	GJ	Interim Directorate Manager for Haematology, Immunology and Metabolic Medicine
Hayley Valentine	HV	Quality Lead for Critical Care
Cath Evans	CE	Patient Safety Facilitator
Nicola Carter	NC	Service Manager for Malignant Haematology
Richard Parry	RP	Q&S Facilitator
Rachel Long	RL	Directorate Manager for Nephrology and Transplant
Ceri Phillips	CP	Lead Nurse, Cardiac Services
Alannah Foote	AF	Directorate Support Manager for Nephrology and Transplant
Jordan Wilmer	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Kirsty Britton	KB	Senior Nurse, Nephrology & Transplant
Angela Jones	AJ	Senior Nurse Resuscitation
Alexandra Scott	AS	Assistant Director of Quality and Safety
Jo Bagshawe	JB	Interim Lead Nurse for Haematology, Immunology and Metabolic Medicine
Sian Williams	SW	Senior Nurse, Cardiac Services
Secretariat		
Mandy McGee		
Apologies:		
Caroline Murch	CB	Health and Safety Advisor
Guy Blackshaw	GB	Clinical Board Director, Specialist Services
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Colin Gibson	CG	Consultant Clinical Scientist, ALAS
Bev Oughton	BO	Senior Nurse, Cardiac Services
Nick Gidman	NG	Directorate Manager, Cardiac Services
Beth Ingram	BI	Lead Nurse, Haematology

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed everyone to the meeting and introduced Dr Mat Davies, Consultant Nephrologist as the new Quality and Safety Lead. MD invited comments from those present on their expectations from this meeting going forward. CMain added that it is intended to have a quarterly Health and Safety focussed meeting as part of this rolling timetable.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Minutes of the Meeting Held 8 August 2021** **The Committee resolved that:** The minutes were recorded as a true and accurate record. **Matters arising** 3.3 Exception Reports Critical Care CMain has shared the draft HB document on standardisation of storage of documentation and asked for comments. Marcia Donovan, Head of Risk and Regulation, will present to a future QS&E meeting. 2.1 Safe Care ALAS will present the findings from a recent NRI to a future meeting of the Group. 2.6 Health and Safety CMain has met with Caroline Murch and work has started on determining key H&S priorities for Specialist Services Clinical Board.	
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP reported that there is currently only one NRI in progress, the transfer of patient HN from Critical Care at UHW to Nottingham. Sabine Grundler is the Investigating Officer, there is a further NRI meeting scheduled for 16 September at which it is hoped to review a completed RCA. RP informed the Group that it is intended to hold closure meetings for future cases as part of the development of the NRI process.	

	The GROUP resolved: a) MD to be invited to follow-up meetings. b) MD to meet up with RP to gain an understanding of the NRI process **Potential NRI's** RP reported on the following potential NRI's: IN154137 - this was not a serious incident but has raised questions on how the pathway should work, Melissa Rossiter is looking at this case, it is not expected that this will become an NRI but will remain on the potential NRI list until the process is completed In157256 this case is under investigation but is not expected to progress to a Serious Incident. 6960 Timeline is currently being compiled, it is unknown at present if there was a breach in care, this is being investigated, once the investigation is completed a decision will be made as to whether the incident is reportable or not. **The GROUP resolved:** a) It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** Nothing to report	
2.2	**Closure Forms** Nothing to report	
2.3	**Alerts / Patients Safety Notices** The following notices have been disseminated to the Group, to share as appropriate, nothing further to discuss: • Adrenaline SBAR • Amiodarone SBAR • Urgent Field Safety Notice – Smith and Nephew IV3000 dressing • Internal Safety Notice Ref 2022/August/003/ SGLT2 Inhibitors and Euglycemic Acidosis AS informed the Group that it has been agreed to use a standardised pH strip with NG tube placement, this will be implemented from 3 October. AS will give further details to DoNs next week, it is expected that there will be a swap out day 3 October when all old equipment will be removed and replaced with new. There is a small training	

	resource required to be undertaken before going live. Further communication will be sent out in due course. **The GROUP resolved:** a) All documents shared at this meeting to be shared within the Directorates b) Directorates to ensure all clinical areas are prepared for swap out day 3 October	
2.4	**Healthcare Associated Infections** CM reported the following Days since last MRSA Bacteraemia - 157 Days since last MSSA Bacteraemia - 14 Days since last *C. difficile* - 25 Days since last *E.coli* -17 Days since last *Klebsiella* Bacteraemia - 13 Days since last *Pseudomonas* Bacteraemia – 13 **Outbreaks / Period Increased Incidence** CCD – *C.difficile* – 12 cases of *C. difficile*. First case identified 25.01.22. 4 cases have been identified as the same type, some single cases. Last linked case was 24 June. Next meeting 13/09/22. West 8 UHL – MDRO – nothing new to report, next outbreak meeting tba. **News / Issues / Concerns** Decreasing COVID rates, currently no outbreak or incidents within UHW.	
2.5	**Health Care Standard 2.9 Medical Devices** Nothing to report	
2.6	**Health and Safety** Nothing to report	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** CW reported that World Patient Safety Week is 12 to 18 September, information on events relating to this will be sent next week. **The GROUP resolved:**	

	a) Directorates to share and promote this event this with their teams	
3.2	**Mortality Review** AS reported on a recent presentation made to the Board regarding the Learning from Death Framework. Recent focus has been on looking at RAMI data but this can sometimes be misleading and is very reliant on having all coding up to date. Looking to implement a systematic approach to mortality at every level of the organisation, to achieve this a clear understanding is needed of what information is required and to ensure that this is made available in an accessible format. This work will be undertaken in collaboration with all Clinical Boards **The GROUP resolved:** a) To continue to engage with the process b) AS and CB to keep Group updated of developments	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** <u>Cardiac Services</u> CP reported that there was nothing further to add other that the on-going workforce challenges and the continued risk associated with working over both sites. <u>Critical Care</u> TW reported that there are on-going issues with delays in admissions to Critical Care due to insufficient bed and nurse numbers, with patients having to sit in Recovery, ED or the wards awaiting admission. There are also delays in transfer of care for patients who are ready for discharge which impacts on admissions. TW highlighted the recent case of a patient, medically fit for discharge who attempted suicide while awaiting a psychiatric review. The incident had significant impact on staff involved. CMain said that she would escalate this up through the Clinical Board to ensure that there is an appropriate response. AS added that there is a meeting in October looking at themes and trends across the year. This topic would be one of the clinical risks to present at the meeting, AS will contact CMain to discuss further. <u>Nephrology and Transplant</u> RL reported the potential risk associated with the retirement of Chemo CNS, there have been on-going discussions on the management of the situation. KB reported that a nurse has been signed off recently but that there will be a gap in training in the short-term. CMain said that she will be meeting with BI later to discuss interim plans for the service until this post can be recruited into. RL said that work is due to be undertaken to produce data on patient flow. MD suggested that it may be useful to have a conversation	

	within the CB on how data is collected and lessons learned from previous exercises. <u>Haematology</u> JB reported that there are on-going concerns with nursing workforce gaps and added that there has been a significant improvement on recruitment with the introduction of a new Band 5 rolling rotation programme. <u>PaRT</u> Nothing to report other than the planned expansion of the service, supporting data has been collected and it is hoped to escalate this over the next few weeks. <u>Neurosciences</u> CMain reported that C4N has now reverted to Neurology, C4S remains the Acute Stroke Area. The Telemetry Service has been reinstated. Work continues on relocation of services. Nothing further to report <u>ALAS</u> Nothing to report The GROUP resolved: a) Information on Critical Care delays to be sent though to MD. b) AS to contact CMain to discuss clinical risks	
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	**Statutory Medical Examiner System**	
5.1	**Any Urgent Business**	
	CMain asked all to let her know if there are views on the format of future meetings	
6.1	**Date & time of Next Meeting**	
	Thursday 13 October 9:30am via Teams	

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee
Held Thursday 13 October 2022 at 9:30am
Via MS Teams

Chair:		
Claire Main.	CMain	Interim Director of Nursing, Specialist Services Clinical Board
Present:		
Angela Jones.	AJ	Senior Nurse Resuscitation
Caroline Burford.	CB	Consultant in Critical Care
Cath Evans.	CE	Patient Safety Facilitator
Claire Mahoney.	CM	CNS Infection Prevention & Control
Gareth Jenkins.	GJ	Interim Directorate Manager for Haematology, Immunology and Metabolic Medicine
Guy Blackshaw.	GB	Clinical Board Director, Specialist Services
Hayley Valentine.	HV	Quality Lead for Critical Care
Helen Thomas.	HT	Lead Pharmacist for Specialist Services Clinical Board
Jo Bagshawe	JoB	Interim Lead Nurse for Haematology, Immunology and Metabolic Medicine
Jordan Wilmer.	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Judith Burnett.	JB	Senior Nurse Critical Care
Julia Teconi.	JT	Senior Nurse, Critical Care
Kathryn Bourdeaux.	KB	Senior Nurse Inherited Blood Disorders
Kirsty Britton.	KB	Senior Nurse, Nephrology & Transplant
Laszlo Szabo.	LSz	Consultant Transplant Surgeon
Lisa Higginson.	LH	Interim Lead Nurse, Nephrology and Transplant
Lisa Simm.	LS	Service Manager Neurology & Rehab
Mat Davies.	MD	Consultant Nephrologist, Quality and Safety Lead for Specialist Services
Nicola Carter.	NC	Service Manager for Malignant Haematology
Rachel Long.	RL	Directorate Manager for Nephrology and Transplant
Richard Parry.	RP	Q&S Facilitator
Shannon O'Callaghan.	SO'C	Service Manager for Critical Care & MTC
Sharon Daniels.	SD	Directorate Support Manager for Nephrology and Transplant
Sian Williams	SW	Senior Nurse, Cardiac Services
Tracey Skyrme.	TS	Head of Inquests
Secretariat		
Apologies:		
Alex Scott	AS	Assistant Director of Quality and Safety
Beth Ingram	BI	Lead Nurse, Haematology
Colin Gibson	CG	Consultant Clinical Scientist, ALAS
Tom West	TW	Critical Care Consultant

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed all to the meeting.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Minutes of the Meeting Held 1 September 2021** CMain noted the new format of the minutes using a UHB template and asked that each directorate adopt this in order to standardise across the HB. **The Committee resolved that:** The minutes were recorded as a true and accurate record. **Matters arising** 2.3 Alerts / Patient Safety Notices The roll-out date for the changeover for pH strips was 3 October, but subsequently delayed. 3.3 Exception Reports <u>Critical Care</u> CMain has discussed with the Mental Health Clinical Board, the incident involving a medically fit patient waiting for psychiatric assessment. The case will be moved across to MHCB for investigation but overseen by Specialist Services CB. It is anticipated that there will be some actions arising from this case which Critical Care will work through.	
1.4	**Learning from Events** Postponed until a later date	
1.5	**Audit Management and Tracking (AMaT)** Debbie Richards reported that AMaT will be rolled out across the HB from 7 November. C&WCB have piloted the system with positive results. Debbie gave a brief overview of the Teams Channel through which training can be accessed. AMaT are providing two training days for C&V UHB on 18 and 28 October, further information will be sent out to the Group via email.	

	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP updated the Group on the following NRI's IN13127 MJ – discharge advice letter was not sent, leading to the patient not being anti-coagulated after cardiac intervention and suffering harm as result. It is expected that IT will be leading this investigation but awaiting clarification at present. It is clear that no Cardiothoracic staff are directly involved, it appears that this is a wider issue across the HB whereby it is thought that letters have been sent out to patients when they have not. HN – Patient HN, investigation is in the end phase, meeting arranged for 27 October where it is hoped that the final report will be available. Since the NRI report was generated the following incidents have been reported • New incident of a complex cardiac arrest in the Cath Lab, investigations are on-going. • A private patient was referred for pacemaker insertion, subsequent assessment showed that this was not indicated but the admission proceeded. After reflection of the incident the patient has raised a concern, an investigation will be necessary. Uncertainty around the boundaries between CAV care and Private care. • Two incidents of maternal death which are under investigation by C&W CB, it is expected that Neurology will be involved in the investigations as both patients were known to have epilepsy. **The GROUP resolved:** a) RP and the Patient Safety Team will keep updated on the NRI process. **Potential NRI's** RP reported on the following potential NRI's: IN14831 - Patient suffered cardiac arrest in Cath Lab. Investigations identified that the initial intubation had been attempted by a trainee paramedic, currently on placement in CCU, who is not authorised to undertake airway management within C&V without direct supervision. This has prompted a review for organisational learning in conjunction with Swansea University and WAST	.

	IN11860 Patient JD passed away on West10, it is believed that the patient was palliative, awaiting further information. CE asked if this case could be reviewed by Neurology as soon as possible. IN11699 Patient ES, awaiting a meeting to review the evidence. IN12119 Patient EC, awaiting a meeting to review the evidence IN2663 Patient KS, investigation is completed and the case is in the closing phase IN5458 Patient DS, Major Trauma pathway to be reviewed **The GROUP resolved:** a) It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** TS had sent Specialist Services NRI Inquests report. MD noted that the date of death for Ref 744 (JW) is given as 25/05/2005 and asked that this be corrected. **The GROUP resolved:** a) The list of all Inquests relating to Specialist Services would be sent through for information.	
2.2	**Closure Forms** Nothing to report	
2.3	**Alerts / Patients Safety Notices** The following notices have been disseminated to the Group, to share as appropriate, nothing further to discuss: • Letter from Prof Chris Jones re All Wales Perioperative Anaemia Pathway • All Wales Perioperative Pathway • BHNOG Anaemia Strategy • ISN Ref 2022/Aug/003 Sodium-Glucose Co-Transporter2 SGLT) Inhibitors • pH Strips SBAR for Clinical Boards • CEM/CMO/2022/22 Ebola virus outbreak in Uganda MD reported that a letter had been sent out to each Directorate regarding the SGLT Inhibitors, not all Directorates have confirmed receipt to date.	

	The GROUP resolved: a) All documents shared at this meeting to be shared within the Directorates	
2.4	**Healthcare Associated Infections** CM reported on the attached document CMain announced that two leads for Infection Prevention and Control have been appointed for Specialist Services to work alongside Claire Mahoney. Meetings will be arranged in the near future. **The GROUP resolved:** a) To engage with IPC meetings.	Specialist IPC report September 2022.doc
2.5	**Health Care Standard 2.9 Medical Devices** CG is on annual leave but sent the attached documents. CG had sent the following report ahead of today's meeting *An urgent field safety notice (attached) has been issued by Medtronic relating to the Gold coated Cobalt CRT-D device (model DTPA2D1) recently approved for humanitarian use locally with a cardiac patient. The issue relates to some of the devices not delivering sufficient energy to the heart under certain circumstances, however, the problem can be averted by reprogramming the device (now underway in relation to the patient concerned).* LH confirmed that this has been discussed in the N&T Q&A meetings and formal notification been sent out to clinical areas and through the staff media channel. **The GROUP resolved:** a) To review Medical Device Bidding.	Capital Medical Devices Bidding For Declaration of Interests Form Procu Medtronic FA1225 Urgent Field Safety
2.6	**Health and Safety** CMain asked that each team look at the reportable incidents on the attached report and where possible finalise and close off on Datix. RP reported that one of the incidents on the report had been investigated and closed off in August. CMain said she will discuss system errors with Caroline. **The GROUP resolved:** a) To review RIDDORs and update as needed.	UHB Op group RIDDOR report sept

	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** Nothing to report	
3.2	**Mortality Review** CB reported that it has been confirmed that the ME process will be statutory from April 2023 when all non-coronial deaths will be referred to the Medical Examiners for independent review. From 3 November it is anticipated that all non-coronial deaths in Critical Care will be sent to the ME to test the system. The biggest problem envisaged is the increased workload for the Bereavement Services due to the large number of paper records which will need to be scanned. Currently the ME is looking at approximately 130 cases / month from C&V UHB, by April it is expected that this figure will rise to 900 to 1,000 deaths / month, including Primary and Secondary Care. The outcomes from the reviews show that approximately 20 to 25% are triggering a Coroner's referral. The themes that the ME have identified are around communication and Covid.	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** <u>Haematology</u> GJ reported that the Directorate are currently experiencing a number of workforce gaps which are presenting a number of challenges. The Lead Nurses are currently working on a recruitment plan to resolve this. CMain thanked the Team for their work through the recent outbreaks to keep the Service running with as little impact as possible. <u>Nephrology and Transplant</u> RL reported that the Department are currently experiencing difficulties with one patient who is refusing to attend the Dialysis Unit for his treatment. KB said that there had been some progress with this situation and would update RL and CMain outside of this meeting. RL said that there is currently a high demand but limited capacity for dialysis in the units across SE Wales, SW Wales also have an on-going problem with capacity which C&V support partially by treating those patients east of SWUHB. RL added that C&V are not in the position of having to make difficult medical decisions at present and are currently co-ordinating a meeting to explore medium to long-term solutions to this situation.	

	Neurosciences LS reported that the Day Unit had relocated to the area previously occupied by SSSU, LS thanked the Team for facilitating the move at short notice and reported that there had been positive feedback from patients using the Unit. Critical Care HV reported that the Department are experiencing difficulties due workforce capacity, patient flow, the C. Diff outbreak and cubicle availability. CMain thanked HV and said that there has been some on-going work to support flow and that discussions are taking place within the Executive Team to support capacity and flow through Critical Care going into the winter. Cardiac Services Nothing to report MTC Nothing to report PaRT Nothing to report ALAS Nothing to report	
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	Changes to Community based secondary care anticoagulation service - UPDATE	
4.2	EIDO Healthcare Update	
4.3	Identifying Patients on the Single Cancer Pathway	
5.1	**Any Urgent Business**	
	Nothing to report	
6.1	**Date & time of Next Meeting**	
	Monday 31 October 9:30am via Teams	

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee
Held Monday 31 October 2022 at 9:30am
Via MS Teams

Chair:		
Claire Main	CMain	Interim Director of Nursing, Specialist Services Clinical Board
Present:		
Alex Scott	AS	Assistant Director of Quality and Safety
Bethan Ingram	BI	Lead Nurse, Haematology
Bethan Owen	BO	Senior Nurse, Neurosciences
Beverley Oughton	BOu	Senior Nurse, Cardiac Services
Carly Simpson	CS	Lead Nurse, Neurosciences
Clare Smerdon	CSm	Senior Nurse, Neurosciences
Gareth Jenkins	GJ	Interim Directorate Manager for Haematology, Immunology and Metabolic Medicine
Gayle Shepperd	GS	Assistant Service Manager, Cardiac Services
Guy Blackshaw.	GB	Clinical Board Director, Specialist Services
Jane Morris	JM	Senior Nurse, PaRT
Jo Clements	JC	Lead Nurse, Critical Care
Jordan Wilmer.	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Keith Wilson	KW	Consultant Haematologist
Kevin Nicholls	KN	Service Manager, Cardiac Services
Laszlo Szabo	LSz	Consultant Transplant Surgeon
Lisa Higginson	LH	Interim Lead Nurse, Nephrology and Transplant
Mat Davies	MD	Consultant Nephrologist, Quality and Safety Lead for Specialist Services
Nicola Carter	NC	Service Manager for Malignant Haematology
Richard Parry	RP	Q&S Facilitator
Stephen Fernandez	SF	Senior Nurse, Critical Care
Tracey Skyrme	TS	Head of Inquests
Secretariat		
Mandy McGee		
Apologies:		
Caroline Murch	CMu	Health and Safety Adviser
Cath Evans	CE	Patient Safety Facilitator
Claire Mahoney	CM	CNS Infection Prevention & Control
Colin Gibson	CG	Consultant Clinical Scientist, ALAS
Hayley Valentine	HV	Quality Lead for Critical Care
Jo Bagshawe	JoB	Interim Lead Nurse for Haematology, Immunology and Metabolic Medicine
Tom West	TW	Critical Care Consultant

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed all to the meeting.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Minutes of the Meeting Held 13 October 2021** The minutes of this meeting were not available, these will be sent to the Group as soon as possible **Minutes of meeting held 13 October to be sent out as soon as available**	
1.4	**Learning from Events** BOu presented details of an incident which occurred in 2017 involving a patient and two members of staff from T4. **Summary:** A patient was admitted via a local hospital to the Neurosurgical Unit following a traumatic head injury. The post-surgical patient became aggressive and fled the Unit. The security team and site manager were called to assist and he was followed by the Claimant (registered nurse) and a colleague in an attempt to persuade the patient to return to the Unit for his own safety. On following the patient and assault took place. The Claimant sustained a head injury due to the assault. Later the patient was reassured and he returned to the Ward with the Security Team. **Learning:** Staff are advised to follow the guidelines of the violence and aggression training and consider the risk assessment. Also, staff have been reminded of the use of on-going dynamic risk assessments in their daily assessment and practice. Staff are reminded through ward meetings and peer support that it is recommended that staff do not follow patients who have absconded but inform security and site managers an await their response. Discussions were held around the learnings from this event. CMain thanked BOu for her presentation and asked that if anybody had any further thoughts or wanted to discuss anything to get in touch.	

1.5	**Learning from Events** ALAS case postponed.	
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP updated the Group on the following NRI's IN5007 HN - meeting held 27 October draft report awaited. AS added that RP let her know if there are any constraints sitting with her team and if there was any additional support the team could provide. IN13127 MJ – IT lead has been appointed for this investigation and RP will be providing support. An initial meeting is planned for 3 November IN14869 WH – Mental Health Clinical Board will be investigating this case which will technically sit under Specialist Services for the time being. A meeting will be held 14 November regarding the incident of a complex cardiac arrest in the Cath Lab, Cardiology have been gathering statements in advance of this meeting. A meeting has been held to discuss the case of a pacemaker insertion on a patient who initially didn't appear to require it but subsequently it has emerged that the pacemaker had been required, this case has been downgraded from a Never Event to an NRI. An IO in Cardiac Services is investigating this. Children & Women Clinical Board are investigating two incidents of maternal death. The cause of death is SUDEP. RP will produce a report for these two cases to be incorporated into the C&W investigation once approved by Neurology. **Potential NRI's** RP reported on the following potential NRI's: IN14831 – a meeting has been held in conjunction with WAST and Swansea University, RP and BOu are in the process of producing a detailed timeline, gathering statements and seeking documentation from Swansea University regarding general governance. RP is reviewing the case of a Renal patient with Pseudomonas sepsis given as a 1A on cause of death, there are no apparent breaches in care.	

	The GROUP resolved: a) It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** CMain informed the Group that following the last QS&E meeting TS had sent through the full list of inquests, in addition to those being reviewed from an NRA process. Decisions will be made on how this information is disseminated. **The GROUP resolved:** a) To review inquest information as appropriate	
2.2	**Closure Forms** Nothing to report	
2.3	**Alerts / Patients Safety Notices** The following notices have been disseminated to the Group, to share as appropriate, nothing further to discuss: • WHC: Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning CMain reported that Kirsty Britton is the Vaccination Lead for the CB and will be providing regular updates at this meeting. Currently within the HB 45.5% of staff are vaccinated for COVID in terms of the latest round of COVID vaccinations and 27.2% vaccinated against flu. The vaccination figures for Specialist Services CB staff are 41% and 25% respectively. CMain said that a new email address and on-line form have been introduced in addition to the COVID telephone line for staff to arrange their vaccinations. Walk-in mass vaccination sessions have been arranged, details will be circulated. **The GROUP resolved:** a) All documents shared at this meeting to be shared within the Directorates	
2.4	**Healthcare Associated Infections** CM sent apologies. Prior to the meeting she had sent the following report Specialist IP&C Report September/October 2022 completed 27 October 2022	

	Days since last MRSA Bacteraemia - 52 *Days since last MSSA Bacteraemia - 11* *Days since last C. difficile – 18* *Days since last E.coli -25* *Days since last Klebsiella Bacteraemia - 25* *Days since last Pseudomonas Bacteraemia – 7* ***Outbreaks / Period Increased Incidence*** *West 8 UHL – MDRO – nothing new to report, next outbreak meeting tba.* *Haematology – 3 cases of C.difficile in the past week, all 3 patients have had recent admission to B4 Haem, A5 and attended Haem day centre, typing awaited.* *CCD – 2 cases of C.difficile in a week, does not appear to be an epidemiological link, typing awaited.* ***News / Issues / Concerns*** *Numbers of Covid outbreaks improving.* *Starting to see increasing cases of Influenza*.	
2.5	**Health Care Standard 2.9 Medical Devices** Nothing to report.	
2.6	**Health and Safety** CMu had sent the following update *Myself and Sam Skelton (manual handling adviser) have met with Hayley Valentine (Critical Care) offering support with incidents.* *Also, Carl Ball has been actively involved with V&A incidents.* *There has been some progress on investigations closed, a few still need following up*	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** Nothing to report	
3.2	**Mortality Review** AS reported that with regards to mortality a revised national framework has been published and that in the past, C&V have not followed the national framework, this is going to be re-visited to ensure that the necessary governance is in place around all of the ME referrals that come in.	

	It also looks likely that a Mortality Screening Group is going to be formed the purpose of which will be to oversee the more complex, clinical concerns raised by the ME, to establish how further investigations are commissioned rather than burdening CB's with undertaking extensive second reviews. Work will also be undertaken to look at how M&M reviews are utilised and some of the existing processes such as PTR and NRI's. AS informed the Group of the development of a Learning from Death Framework and said that she would be looking to engage with each of the CB's to establish some quality indicators to support the CB in their governance of mortality. <u>pH Strips</u> AS informed the Group that the planned roll-out for the swapping of pH strips did not take place on 3 October due to a supply chain issue. It is hoped that the swap over will now take place 9 November, with communication in relation to this being sent out shortly. <u>DAL's</u> There has been a further issue around DAL's on CAV Clinical Portal only. The adverse reaction is not being uploaded onto the CAV Clinical Portal DAL, staff are being asked not to use that information for medicines reconciliation at present. It is hoped that Digital Healthcare Wales will put a fix in place this week to allow us to rectify this problem. If this is not the case we may need to rethink how we mitigate any risk associated with that and may have to consider withdrawing access to those DALs on CAV Clinical Portal. Information is available on how many of the DALs with information missing have been accessed by clinicians who will be advised that they have looked at a DAL which is not complete. <u>Implementation of Neuraxial Equipment</u> A Task & Finish Group has been set up with a plan to swap to NR Fit compliant equipment in April 2023 with a final decision being made based on supply chains. The project outline document will be presented to the Senior Leadership Board on December 1st, AS will share with the DoN's. There will be a requirement for each Directorate impacted by this to appoint a responsible officer to ensure all necessary actions are undertaken to allow a safe implementation in April. Further updates will be provided nearer the date.	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** CMain informed the Group that it is planned to re-arrange the Agenda and possibly extend the meeting to ensure that appropriate time is allocated for exception reporting. More information will be sent out before the next meeting	

	Haematology KW asked if there is a date planned for the decanting in order to facilitate the cleaning of the air handling system. The system was turned off at the start of COVID but now needs to be restarted before the winter gets underway. KW recently attended a Coroner's inquest and asked that he present the learning from this at a future meeting. CMain agreed that this would be a good topic to bring to this meeting at a future date. With regard to the "deep-clean" CMain explained that she and SL will be contact KW as soon as possible to discuss the decant move. Nephrology and Transplant LH reported that the Team would be happy to share the work currently being undertaken around Recruitment & Retention at a future meeting. MD related an incident which occurred over the weekend and asked if it would be possible to set up a meeting discuss the Plasma Exchange rota. CMain replied that a meeting has been arranged for next week with some of the overall commissioners to look at how the service can be evolved across South Wales and where the best place to deliver the service would be. There is also a meeting organised with WBS looking at ways forward to deliver more complex treatments. It is also planned to look at the core work for plasma exchange with a view to developing the service. Neurosciences CMain welcomed Carly Simpson who has joined the Team today as Lead Nurse for Neurosciences. Critical Care Nothing to report. MTC Nothing to report PaRT JM reported still waiting for the 24/7 bid to be considered.JM informed the Group that as a part of the National Framework for Outreach Services it has been suggested that relatives and patients can contact PaRT directly if concerned about their condition. She asked if the Team could present this suggestion at the next QS&E meeting to gain the opinions of the Group. JM told the group that PhD student Shalini Gasson, has joined the team and will be on the wards. Shalini is studying resilience in rapid response systems and teams.	

	Cardiac Services KN informed the Group that the main area of concern at present is the Cardiac Surgery waiting list with the reduction in capacity recently due to theatre staffing and some anaesthetics problems. ALAS Nothing to report **The GROUP resolved:** a) PART will present at the next meeting scheduled for Thursday 24 November	
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	Wound Care Autumn Chronicle	
4.2	TVN Question Time Poster	
4.3	Winter Respiratory Vaccination Programme 2022	
5.1	**Any Urgent Business**	
	Nothing to report	
6.1	**Date & time of Next Meeting**	
	Thursday 24 November 9:30am via Teams	

Minutes of the SCB Q&S Meeting
Held On 20TH September 2022
Via MS Teams

Present:		
Richard Hughes	RH	Consultant Anaesthetist (Chair)
Clare Wade	CW	Director of Nursing
Alex Young	AY	Speciality Manager T&O Spines
Antonio Riccioli	AR	Orthopaedics Recovery Manager
Barbara Jones	BJ	Educational Lead
Carly Podger	CP	Finance Business Partner CDT Surg
Catherine Evans	CE	Patient Safety Facilitator
Ceri Chinn	CC	Lead Nurse Peri-operative care
Christopher John	CJ	Clinical Governance Lead
Debbie Jones	DJ	Patient Safety
Denis Williams	DW	Directorate Manager
Emma Thomas	ET	Senior Nurse
Gemma Roberts	GR	Interim Senior Nurse
Haley Dixon	HD	Director of Operations
Laura Hodges	LH	Lead Nurse T&O
Naomi Goodwin	NG	Consultant Anaesthetist
Rafal Baraz	RB	Consultant Anaesthetist
Richard Coulthard	RC	Consultant Urology
Rowena Griffiths	RG	Governance & Quality Lead Manager
Sandeep Berry	SB	Consultant Otolaryngologist
Susan Mogford	SM	Senior Nurse
Terry Stephens	TS	Procurement Nurse
Tracy Johnson	TJ	Practice Development Nurse
Yvonne Hyde	YH	Head of Nursing for Infections Prevention & Control
Secretariat		
Genessis Viola	GV	Surgery Quality and Safety administrator
Apologies:		
Carolyn Alport	CA	SCB QSE Lead
Catherine Twamley	CT	Interim Lead Nurse
Julie Cornish	JC	Colorectal consultant and Hon senior lecturer
Michelle Able	MA	CNS Infection Prevention & Control
Rachael Barlow	RB	Clinical Lead
Siene Ng	SN	Ophthalmology Consultant

Item No	Agenda Item	Action
SCB/QS: 22/92	**1. Welcome & Introduction** The Chair welcomed everyone to the meeting.	
SCB/QS: 22/93	**2. Apologies for Absence** a) The apologies given were noted.	
SCB/QS:	**3. Amat**	

22/94	**DJones** presented AMaT verbally to the Group and discuss the followed: - AMaT is an audit management and tracking system; it's an essential system to capture all audit activity. An internal audit took place last year and the result concluded very limited assurance and as a Health Board it raised some governance concerns because all order activity should be registered. A survey identified that members of staff were unsure of how to register it. Equally, members of staff were unsure of who the audit team were or what they did and they weren't sure how to undertake an audit and also trying to understand who the Clinical Audit Leads are. DJ advised that there's three tiers to the audit process, these being: - • Tier one is our national audits. It was noted that these were being captured although there are ongoing and not fully concentrating on those just yet. • Tier two, which are patient safety priorities. It was highlighted that this tier needed focus. • Tier 3, which is the local priority interest so everybody has to focus on patient safety priorities and so anyone with an NHS email will be able to access the system. **The group resolved that:** a) The AMaT System Update was noted and no actions to implement **GOVERNANCE, LEADERSHIP AND ACCOUTABILITY** **4. Patient Story** **ET** presented the following Learning from events Ref: CN/UHW/3786 What Happened? • Patient had a Sub Total Colectomy • The surgeon inserted a Rectal Catheter in theatre • The surgeon requested that the Rectal tube needed flushing, this would be to maintain patency • This was prescribed on the drug chart and nursing staff were informed • This task was never recorded or monitored on a surveillance chart, this form of documentation didn't exist on any of our surgical wards • The only way that we would know if this was carried out, would be if the nursing staff recorded it in the medical notes What was the concern? • The patient highlighted to the nursing staff that she believed that a nurse had incorrectly flushed the wrong port of the tube	
SCB/QS: 22/95		

- It was noted that the nurse had flushed the port that inflates the balloon, which she believed had damaged her remaining Rectal Stump
- Patient stated that she made the nurse aware that she felt that she was doing the procedure incorrectly; however, there was no evidence to support this.
- There was only one entry in the medical notes, whereby a nurse has correctly identified that she has flushed the catheter.

Analysis of events

- It is difficult to assess or prove if the nurse in question did or didn't follow correct procedure
- Without documentation, we cannot correctly assess the events
- At the time of this event, there was no formal education in place to teach this skill
- How often do nursing staff nurse patients with a Rectal Catheter to ensure continuity and safe practice of this skill?
- Did the nursing staff understand the rationale for this practice?

IN CONCLUSION

- Plans to add teaching of this skill to amber areas as well as elective areas
- Discussions around make the care plan available throughout the surgical clinical board
- Looking to make colorectal teaching readily available to staff
- Plans to improve access to teaching resources on our Surgical Training Platform
- Aiming to modernise access to education resources within the surgical clinical board

The GROUP resolved:

a) Followed from the learning from events the group agreed on education and teaching needs to be implemented.

5. BOA Elective Care Review Update

LH reported verbally to the group and shared an Action plan for BOA recommendation.

a) The Actions where discuss and no urgent recommendations were considered necessary to ensure patient safety is protected

	6. Feedback from UHB QSE Committee It was noted that **AS** hadn't attend any meetings yet to be able to give a feed back to the group. a) No actions were implemented.	
SCB/QS: 22/96	**7. Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** **Peri-operative** **CJ** reported the following and give a verbal update to the group **UHW Main Theatres**	
SCB/QS: 22/97	In155105. Arterial line retained in patient following dressing removal. Investigation completed. Report sent to patient by recorded delivery. Meeting conducted with family to discuss report findings 31/08/22.	
SCB/QS: 22/98	ID 8548. Retained swab. Fact finding meeting 07/07/22. Fact finding Investigation underway. ID 3612. Anaesthetic awareness. Concerns department received complaint. Redress has forwarded cheque in order for patient to receive private phycological support following incident. Timeline and Action Plan uploaded to Datix-Cymru. Concerns department dealing with solicitor regarding incident. Theatre 7 sluice floor needs repairing. Estates aware and dealing with issue. Plans recommenced to build new theatres off the back of theatres 5+6. Visits from trade people expected over the coming weeks. **PESU** No new incidents reported. Several issues with the Vanguard Ophthalmology Theatre units. The ceiling has had several issues with leaks and water ingress causing damage to stock. A list of damaged stock being compiled. Vanguard aware of issues and are repairing leaks as and when identified. **UHL** In149722. A patient sustained a burn following the use of Hydrogen Peroxide Solution. RCA complete, improvement plan nearing completion and sharing of information to take place upon completion.	

In160082. Never event reported. Wrong side implant used for a primary knee replacement. Investigation and improvement plan complete. Follow up meeting conducted 15th July. Incident has been shared for learning. Incident now closed.

Lights in CAVOC 1 not working, estates are aware and are planning the repair and logistics as the lights are difficult to access.

HSDU

Workforce concerns raised, however work is in progress to improve staff shortages in-order to maintain service.

CHFW

ID 7106. Child received morphine overdose. Fact finding meeting 11/07/22. Investigation complete. No surprises form submitted to Welsh Government. Investigation report sent to parent 09/09/2022. Investigation report and outcome sent to mother.

Historic incident involving skin burn following the use of prep solution. Recommendations from Ombudsman put in place and procedure changed to accommodate these changes.

1. Chloroprep (Chlorhexidine 2%) sponges should be used for all CVP and Arterial lines.
2. Chlorhexidine 0.5% spray should be used for all Neuraxial and nerve blocks.
3. Must allow skin to dry before applying drapes.
4. If incontinence pad is used, it must be removed immediately after the anaesthetic procedure.

Ombudsman has now received the relevant information and has closed the incident.

Staffing
Anaesthetic practitioner shortages, could impact upon utilisation of future lists.

Significant improvement of paediatric anaesthetic availability due to support from Swansea anaesthetics teams.

ALL AREAS

Audit for the “5 Steps to Safer Surgery” has been revisited and now completed. All outstanding actions and recommendations have been completed and the audit team are happy with all outcomes. Audit complete and finalised.

Staff sickness increased due to COVID-19. Possible impact upon future theatre utilisation and ability to run lists effectively.

a) No Actions were implemented from the group.

General Surgery & Urology

ET verbally shared the following with the group

It was reported that an injurious fall occurred during the period, within General Surgery - Ward B2. It was noted that the gentleman came in with worsening foot pain and discoloration; and following an X-ray a hip fracture was confirmed which required operating on.

The Group were informed that reports had been completed and an injurious falls investigation was carried out and the patient had been transferred back over to YYF.

The IPC, currently have an outbreak on B2 and it's currently closed, the Ward Manager linking in with and infection control today to try and get at least 1/2 up and running for the network. B6 have also got two confirmed cases as well. In general surgery it's in and COVID is on the increase unfortunately.

It was highlighted that SSSU had ongoing issues with poor lighting; CW reported that CA had agreed to pick this up with patient safety QSE as two incidents had been raised in relation to patients sustaining injuries, within this area

Suite18 Clinic have had a power electrical outage on the weekend, and that is an ongoing and with the water geyser still leaking.

An update was given on ward changes- Heulwen ASW was moving to A5N and A5S would become a medical winter ward staffed and ran by SCB

ENT/H&N

No representative at the meeting

a) No actions to implement

T&O

LH reported the following updates to the group

- Incident on A6, DW. Timeline complete, meeting at end of the month to discuss.
- One case C.difficile reported on West 3, in August. RCA to be completed
- Patient safety alerts shared with teams.
- Injurious fall West 1 10th September. RCA to be completed. High levels of enhanced supervision
- BOA draft action plan under completion.
- LFE for missed Lisfranc fracture
- LFE miss managed fracture

- CHC visit 2 weeks ago on west 1, a/w final report.
- IPC audit plus Tenable app launch

a) No actions were implemented

Anaesthetic

RB reported the following

M+M case presented July 2022: Difficulty measuring BP during surgery of a neonate causing hypoxic damage

•Day 67 Neonate for Tunnelled line and closure of prolapsed stoma

•Complex neonatal course

•Problems measuring BP

•All monitoring satisfactory but not able to get consistent BP reading

•Multiple attempts, size and locations tried to obtain BP reading

•Fluid boluses and adrenaline given once tunnelled line secured

•Proceeded to Laparotomy •BP trending downwards but not worryingly so

•No further issues during laparotomy

•On attempted waking had abnormal movements/fitting therefore MRI arranged: Widespread Hypoxic damage on MRI

•SUI report –something happened under anaesthetic but not due to breach of care

•Recommendations: ensure communication of risk is adequate and explicit.

•Couple of incidents related to CVP line insertion presented in anaesthetic Q+S July 2022

•Incident related to inappropriate catheter length and robust documentation at insertion

•The department aims to standardise lengths. 16cm for RIJ and 20cm for femoral and LIJ veins.

•Recommended use of pre-printed labels to capture all required information.

M+M presented in Sep 2022 anaesthetic Q+S:Chlorhexidine causing skin burns in a baby

•Patient store in July SCB meeting

•RCA following a complaint from a parent of a child (6-week-old)

•Skin burns caused by pooling of chlorhexidine

•**Actions:**

- Email circulated to the anaesthetic department on 18thAug 2022

- Q+S presentation on 13thSep 2022for shared learning

•Recommendations:

- ChloraPrep 2% sponges for CVC and art lines
- Chlorhexidine Spray 0.5% for neuraxial blocks
- Must be allowed to dry before proceeding
- If incontinence sheet used must be removed as soon as possible

•Paediatrics policy exists from 2017:

- Use an incontinence sheet to avoid pooling
- Then remove the sheet
- This policy could be safely applied to adults

•Further actions:

- Policy needs updating
- RB will update and circulate to anaesthetic department for comments
- RB updated the policy heavily following the anaesthetic Q+S in line with AAGBI recommendations. RB suggested changing the title to include adults. The policy will be reviewed by the pads anaesthetists then will be sent to the general consultants for further review.

-Also, to report: the shortage of the Smith-Medical Epidural minipacks has eased off. However, there is shortage of the Bodyguard Micro set which is a crucial giving se for all epidurals, ESP catheters and rectus sheath catheters. This may cause disruption in both maternity and acute pain service. There is no alternative to this giving set as it is specific to the BD pumps we have in CAV.

Dental

RG had technical problems and wasn't able to present the report.

No actions implemented

Pharmacy

No representative on the meeting

a) No actions were implemented

Prehab

No representative present on the meeting

a) No actions were implemented

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

8. Initiatives to promote health and wellbeing of:

SCB/QS: 22/99	**Patients** **SCB H&S/IPC meeting update** **CA** wasn't present in the meeting; no verbal update was given. Report was noted a shared with the group. a) No actions were implemented **Decontamination group update** **BJ** explained to the group that she hasn't attend any meeting since last Q&S meeting so nothing to report. a) No actions were implemented **Water safety Group Update** **BJ** gave a verbally update to the group, highlighting the main key points raised. It was noted that extra flushing was continuing to be carry out at UHL. BJ reported that concerns were raised around the number of flushing being carried out, but not recoded. Equally, this function was not being picked in the absence of the responsible member of staff when on sick or annual leave. Areas had been asked if this can be looked at and also raised at safety briefings to ensure flushing is on the agenda and the audit tool has changed. a) No actions to record **SAFE CARE** **9. Patient Safety Incidents** **CW** gave a verbal update, reporting that the information provided demonstrated that seven of the long standing NRI had been closed. With eight open and five overdues, which were due to be closed in 60 days, which is a really tight ask, but lot of progression has been made over the last couple of months, so the plan would be to close them over the next month or two hopefully. Action There is a plan in place over the next month to try and support staff in closing some of the non NRIs DATIX. So, some of the Datix queues and supporting managers going forward in closing them in a timely manner. A system is in place within the clinical board that made aware it quite timely if there are any incidents that need to be aware of. **10. Patient Safety Alerts (internal/external)**	
SCB/QS: 22/100		

	RH Discussed about cannulation packs if has been used and what departments. CC to look at possibility of using cannulation packs in Periop and to bring back to next meeting **11. Health Care Associated Infections**	
SCB/QS: 22/101	**HCAI rate** **YHyde** Discussed the rates with the group. It was also discussed the rates in all departments. a) No actions where implemented	
SCB/QS: 22/102	**12. Any key patient safety risks** **Q&S performance data** **CW** shared with the group a data report and discussed the following. this is the data that were shared for last performance review. It was acknowledged that this data was quite limited compared to previous data a) No actions implemented	
SCB/QS: 22/103	**Falls reduction and Pressure and tissue damage reduction and prevention** **CW** show both spreadsheets to the group that highlighted that there had been two injuries falls within the clinical board With regards to hip fracture patients, plans are in place to speed up the new hip fracture pathway. It was noted that, pressure damaging incidents had increased without really understanding the reasons behind it; staffing issues was raised as a constraint, Discussions had taken place around how to track patients prior to admission to check if any damage caused before patient is admitted to the hospital or ward To progress via Pressure damage Collaborative chaired by CW **Medicines management issues/incidents/audit findings** No representative at the meeting to update the group **Medical Equipment Group** **RH** stated the software for medical equipment is becoming more and more complex and linking in as well with the network increasingly.	

	Blood management **CJ** explained to the group that he couldn't attend the last meeting held but he shared that was brought to his attention that staff are returning the white part of the label following blood transfusion and that is an incorrect process, Blood bank actually need the fully completed blue part of the label for traceability **Zero Tolerance Report** . **Q&S Workplan 2022-2023** It was highlighted that ENT/ Ophthalmology is due to present at the next meeting. **13. Mortality data analysis** No representative currently implemented for this group **Effective care** **14. Monitoring of CB Clinical audit plan** **CW** highlighted the importance of AMaT and how implementing it would be very beneficial.	
SCB/QS: 22/104	**15. Implementation of key Nice Guidance** **NICE Spreadsheet** **CW** discussed verbally with the group the following: - A lot of the clinicians get nice guidance sent to the medley from the audit team. This is a function that may well be picked up by AMaT going forward as well.	
SCB/QS: 22/105	Quite a lot of the clinicians are chased regularly with regards to feeding back on NICE guidance. Some of the guidance iis not always sent out to the correct person and some are quite wide ranging covering several CB's	
SCB/QS: 22/106	**16. Research and development update** No representative on the meeting **Dignified Care** **17. HIW/CHC, Deci (dignity and essential care inspections) reports and improvement plans**	

SCB/QS: 22/107	**CW** reported verbally to the group CHC are back visiting areas HIW also recently attend EU and the report is due to be shared shortly with the Health Board **Timely Care** **18. Initiatives to improve access to services/ management of risks**	
SCB/QS: 22/108	**DW** had to leave the meeting before had the chance to update the group about it. **Individual Care** **19. Concerns news letter** **CW** shared on the screen and invited the group to read through the newsletter **Staff and Resources**	
SCB/QS: 22/109	**20. Staffing levels** **CW** Mentioned that the senior lead nurses will be going through the processes with the ward managers again now over the next couple of weeks to sign off their safer staffing levels for each inpatient area, which will then come to the Clinical board for sign off and then go to the exec review for sign off. So, this is a triangulated approach which brings together the skills of the ward manager, finance and their quality and safety indicators.	
SCB/QS: 22/110		
SCB/QS: 22/111		
SCB/QS: 22/112	**4. Date & time of next Meeting** Tuesday 15th November 2022 at 08:00 -10:00	

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 8TH NOVEMBER, 2022
Venue: MS TEAMS

Attendees	
Anna Llewellin (AL)	Director of Nursing (Chair)
Rachel Armitage (RA)	Quality and Safety Manager
Clare Clement (CC)	Head of Medicines Management
Anna Mogie (AM)	Deputy Director of Nursing
Carol Preece (CP)	Lead Nurse, South & East Locality
Lynne Topham (LT)	Locality Manager, South and East Locality
Andrea Rich (AR)	Lead Nurse, Palliative Care
Helen Kemp (HK)	Deputy Clinical Board Director
Rhys Davies (RD)	Locality Manager, North & West Locality
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Lisa Waters (LW)	Senior Nurse for Quality and Education
Sarah Griffiths (SG)	Head of Primary Care
Rachel Thomas (RT)	Assistant Director of Operations
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Debbie Jones (DJ)	Patient Safety Facilitator
Niamh Sully (MS)	Patient Safety Facilitator
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Amy Worrell (AW)	Interim Team Leader, North Cardiff District Nurse Sister
Nicola Jobs Davis (NJD)	Acute Care and Leadership Advisor
Louise Thomas (LTh)	Quality & Safety Officer

Apologies	None received.

ITEM NO.	TITLE	ACTION
11/22/01	AL welcomed everyone to the meeting.	
11/22/02	No apologies of absence were received.	
11/22/03	No declarations of interest were raised.	
11/22/04	Minutes The minutes of the meeting held on 6th September, 2022 were approved. AL requested that members should forward any comments to LTh if they have not read the minutes as yet.	
11/22/13	Nursing Workforce Standards Item 13 on the agenda was brought forward. NJD explained that the UK wide RCN Nursing Workforce Standard was developed in 2021 and she is the lead for Wales. NJD has mapped the legislation and the issues of 25B to see what the difference is. (25B is the safe nurse legislation in Wales; Wales was the first country in Europe to legislate against numbers). The standards fit into the Primary Care element. The 14 Nursing Workforce Standards were presented; NJD will share the presentation with the group. We have our own Welsh Board looking at these standards and the workforce standards fitting into them. NJD presented a case story of a respiratory ward illustrating how the standards were applied to support staff. The presentation talked about shared decision making with staff and included a mental health audit that showed 90% of the ward's staff were struggling and felt unwell. Wellbeing Tuesdays was developed as a result of this and a member of staff was made available (charity funded) to support staff. Staff learnt how to develop their coping skills. The presentation also looked at the supporting tools developed and methods of engagement. NJD will share the tipping point model which explains when a situation should be declared unsafe along with the checklist used by the hospital referred to in the case story. AL queried how PCIC is translated to clinical areas and its diverse range of services ranging from HMP to district nursing and was informed that the legislation does not directly impact upon PCIC in the community, but the impact of not having staff in place on the wards will. HEIW have adopted some of the standards for inspection. The legislation has come directly from WAG and HEIW. AM noted that Georgie Hill, HEW is supporting some of this work to roll out to LED staff. NJD has had conversations with other nursing directorates, has formally written to them and provided presentations in order for the standards to be recognised by other Health Boards. AM encouraged NJD to include our independent sector nursing colleagues and to have a conversation with CIWS. NJD left the meeting. She is happy to be contacted should anyone have any questions.	NJD NJD

11/22/05	Action Log 11/21/006 Medicines Management: action remains outstanding. AM continues with her efforts to schedule a meeting with Jo from AB HB. She may need to escalate if necessary but understands how busy Jo is. 09/22/08 Workforce risk. AL to pick up in NE's absence. Completed items to be removed.	
11/22/06.1	OOH Business Report HE ran through item 6.1 and highlighted that OOH has been operating in business continuity since 11.08.2022 following on from an Adastra cyber-attack. It is hoped that the system will be live by Christmas. A WAG peer review was undertaken looking at OOH's overall performance. Positive feedback was received on the day; the final report is awaited. 111 press 2 for mental health service will soon sit under the CAV247 and PCIC Clinical Board umbrella instead of the Mental Health Clinical Board. PADR rates are increasing.	
11/22/06.2	N&W Locality Business Report RD ran through item 6.2. Recruitment issues continue for the District Nurse and CRT Therapies posts. Health and Social Care with carer's situation is a block booking contract which will come online in November and will make a difference to the number of patients we are able to accommodate and discharge from hospital. Parking issues continue at St David's. PADR rates are increasing.	
11/22/06.3	Vale Locality Business Report The report is included as item 6.3. Please raise any queries via email in KR's absence.	
11/22/06.4	South and East Locality & HMP Business Report RD referred to item 6.4 and highlighted the HMP nursing workforce depletion due to sickness and vacancies. A meeting has been scheduled to discuss how to cover these positions. CP is linking in with Comms in order to raise awareness of the vacancies with a variety of shift patterns via Twitter.	
11/22/06.5	Medicines Management CC ran through item 6.5. A new risk has been added to the register in relation to patient discharge and the potential delay of patients requiring their medication in the monitored dosage system on discharge. It is not a new risk but was not on any other risk register within the Health Board. AL noted that we need to look at patient education and how it is embedded within our CRT teams. There should be education on rehabilitating patients with their medication so that MDSL is not required. £300k has been spent on domiciliary care support to go into homes to prompt patients to take their medication. Workforce is moving in the right direction.	

	It is Medicines Safety Week; the team had a slot with Ask Suzanne last week and a different theme is being discussed every day this week via Comms. C&V continue to perform well on the national prescribing indicators and are the best or second best performing Health Board across the majority of the indicators. There is a consultation underway with regard to unlicensed medicines. The associated document aims to improve communications between health professionals and patients.	
11/22/06.6	<u>Palliative Care</u> AR referred to item 6.6. A huge number of Hospice referrals are being received and we are struggling to admit patients. The Hospice has just 12 beds open. WAG recently released a new quality statement (what good quality palliative care looks like). The first end of life Board meeting is scheduled this month. Following on from this meeting we will have a framework as to what the UHB should be working towards. The family project (a service improvement project) has restarted, improving education for families of patients being discharged for end of life care. AM has met with both Local Authorities and the hospice. It was noted as an aside that 12 beds are open instead of 20 as a consequence of staffing and recruitment issues which will be picked up in this week's SLA meeting. There has also been a delay with regard to discharge out of the hospice in terms of local authority support.	
11/22/06.7	<u>Primary Care</u> Since item 6.7 was produced, a further sustainability report has been received from a Cardiff practice asking for financial support for onward sustainability. One list has been closed in South West Cardiff as a result of the practice going down to singlehanded management. It is anticipated that the list will reopen in 3 months' time. Two practices are classed as very high risk due to premises issues and also being run/about to be run singlehanded. The team is meeting regularly with the contractors discussing how they will make their business robust enough to move forward. The team is undertaking practice visits; every practice should be visited by the end of December, looking at contractual assurance and how they can support. Details have been received of a new unified contract coming into force moving many enhanced services into core GMS services. The notice period for practices run singlehanded will be the same as that of partnerships, i.e. 6 months. The regulations which were negotiated between WAG and the professional group will be in place by October 2024 bringing optional elements of the contract into a mandatory contract. Primary Care decision making now goes via the Primary Care Panel. SG is in discussions with Lisa Dunsford as to how these decisions will be fed through to Corporate level.	

11/22/06.8	Mass Vaccination Centre (MVC) report The new modular build went in on time. The booster campaign is underway and on track to meet its set target. Workforce is a key issue and is being managed with temporary staffing. Following on from a recent incident, some patients chose to be re-immunised whilst some did not due to side effects suffered. The findings of the investigation will be brought back for future learning. Noise levels within the modular build are being looked at. It is a construction issue posing a risk in terms of patients not hearing what they are being told. Minimising noise levels will help with patient confidentiality; the curtains do not promote Information Governance. There are rooms that patients can be taken to if necessary. VW continues to work with Estates.	
11/22/07	Risk Register The highest risks on the register are presented to the Exec team every second month. We are generally commended for the way in which our risk register is managed and used to drive business decisions.	
11/22/08.1	PCIC Quality Report Staffing continues to be an issue due to vacancies and sickness. There are currently 4 NRIs; an NRI meeting will take place later today to progress the report and to look at the closure of one NRI. A report has been sent to the family following on from the unexpected death of their child; a closure form has also been submitted to DU and the team is working closely with the GP practice. A report has been completed regarding the diabetic eye problem and the action plan is being progressed. There are 6 ongoing concerns and there were 76 informal resolutions in September/October. In comparison to this, there were 34 informal resolutions the previous month. There are 394 open datixes of which Sarah Higgins (DN) is supporting and 83 interface incidents from GPs (the datix system is not active in GP practices as yet; roll-out plans are ongoing). Sarah Higgins has been asked to carry out a focused piece of work looking at individual areas to see if certain localities report higher numbers of pressure damage. If so, we will look if this could be demographic related. There was one avoidable pressure damage incident in the last month across the Clinical Board. There are 13 safeguarding cases, 9 of which relate to pressure damage. There is one professional concern. AM noted that a patient turned off his/her electric bed due to his/her worries relating to electricity costs. Any potential power outage could have a significant impact on pressure damage.	

	Cdiff incidents increased over the summer but this was a national trend. Usual figures have resumed. The mortality review process will be implemented in April 2023. CC will work with LW on some of the report wording around the medication areas. Not all of the reported incidents reported by Community Pharmacy will be errors, some of these 'errors' refer to dropped tablets or stock discrepancies, etc. CC will pick up with LW for the next report. HK thanked LW for the report; she is aware of the huge amount of work being undertaken by her team. RA thanked everyone for their support. The team has gone through a very difficult phase due to capacity issues.	
11/22/08.2	<u>Ty Coch compliment</u> Item 8.1, a compliment received from Ty Coch Nursing Home was referred to. AW explained that a patient was routinely visited at his home address until the end of July when he deteriorated and was fast tracked to a Nursing Home. One month later the DN team received a referral from the Nursing Home asking for support with the patient's syringe pump drive. Nursing Home staff had previously received training but their competency levels had dropped due to lack of practise and the DNs were asked to support. Unfortunately, the gentleman passed away two days later. The manager of the Nursing Home emailed the DN team to thank the team for their professionalism when supporting their staff and making the patient's death very peaceful and settled. He also thanked the team for working alongside them and providing support in these situations. AL thanked AW for attending today's meeting and presenting the compliment. Please send any compliments to LW, RA and LTh. Compliments should be noted by Business Unit Managers on the quadrant spreadsheet.	
11/22/09	<u>National Reportable Incident Update</u> Nothing to note in addition to item 11/22/08.1.	
11/22/10	<u>Pressure damage</u> Nothing additional to note.	
11/22/11	<u>AMaT roll out</u> DJ explained that AMaT is an internal audit piece of software; it is a system where audits can be centralised and will be a platform to share the Clinical Board's good work. The system has been implemented in every Welsh Health Board other than Powys. The AMaT system is welcomed but it must be recognised that there will be significant resource implications. The team has not yet worked out how the system will be used by PCIC: Business Units are encouraged to log into the training to look at how the system can effectively be used in their area. The system has a functionality where risk registers can be communicated with other Health Boards. It is a platform where evidence can be uploaded and shared. It does not encourage duplication and is not intended to be additional work. A proforma can be developed within the system enabling a link to be shared with staff who are not Health Board employees.	

	CC queried if information will be sent to contractors informing them that the Health Board will be using their information in a collated way. DJ will come back to CC. Training sessions will be held over the next three weeks and can be booked via Teams.	DJ
11/22/12	<u>Quality Services, Delivering what matters</u> To be discussed at the next meeting.	
11/22/AOB	<u>Any Other Business</u> Thought to be given about mitigations of the striking workforce. Business Continuity plans will be put in place ensuring that the Clinical Board is not put below safe minimum levels even though it is recognised we are already at that threshold. Areas of derogation will be identified. Centralised direction will be waited on before planning commences. It was noted that the strikes will also involve administrative and clerical staff. RT will email all BU leads to highlight areas that need flagging to SMT. Type 1 diabetes NICE guidance has been implemented. Please see the supporting documents located on the Teams channel. Discussions to be held regarding potential power outages. ED has drawn up a PCIC Tier 1 report; LTh will circulate. This will be made a standard agenda item and AL, AM and ED will discuss. ED is welcome to attend the Senior Nurse meetings if she would like to do so.	RT LTh
PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 17th January, 2023 at 11.00 am.		

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

AGENDA

PCIC Clinical Board
Primary Care Quality and Safety Group Meeting
Date and time: Wednesday 30th November 2022 14:00-15:30
MS Teams Meeting

Attendees:
Dr Gneeta Joshi (GJ) (Chair) Community Director for Governance
Louise Allen (LA) Head of Community Pharmacy
Jane Brown (JB) Head of Dental and Optometry
Clare Clement (CC) Lead Pharmacist for PCIC
Sue Friis-Jones (SFJ) Primary Care Support Manager
Sarah Griffiths (SG) Head of Primary Care, Contractor Services
Carole Murphy (CM) Primary Care Contract and Development Manager
Sian Powell (SP) Primary Care Contract and Development Manager
Jennifer Pugh (JP) Primary Care Support Manager
James Rugg (JR) Primary Care Contract and Development Manager
Lee Virgo (VS**)** Senior Primary Care Manager
Richard Baxter (RB) Community Director for Primary Care Improvement and CD for Quality Improvement
Charlotte Williams (CW) Community Director Primary Care Improvement
Rachel Armitage (RA) Quality and Safety Manager
Josie Smith (JS) Primary Care Contract and Development Manager
Scott Davies (SD) Primary Care Support Manager
John Webber (JW) Primary Care Support Officer
Francesca Lado (FL) Optometric Advisor
Louise Thomas (LT) Quality and Safety Officer (minutes)

Apologies:
Lisa Dunsford (LD) Director of Operations
Clare Evans (CE) Assistant Director of Primary Care
Ceri Walby (CW) Community Director for Primary Care Improvement
Rebecca Gill (RG) Senior Nurse for Primary Care Improvement
Kate Wakeling (KW) Senior Practice Nurse
Maria Dyban (MD) Community Director

ITEM NO.	TITLE	ACTION
11/22/01	**Welcome and Introductions** GJ opened the meeting by welcoming the group.	
11/22/02	**Apologies for absence** Apologies for absence were noted as above. **Declaration of Interest** No Declarations of Interest were received.	
11/22/03	**To receive the minutes of the last meeting** The Minutes of the meeting held on 28th September 2022 were reviewed and approved by the group but it was noted that:	

	The first paragraph of item number 09/22/04 (page 2) should refer to the 'RAG rated dashboard', not the 'rag rated dashboard'. The first paragraph of item number 09/22/07 (page 4) should refer to the 'Clinical Board risk register', not the 'Corporate risk register'. CC will email LT in relation to the updating of job titles. **Action log** Please refer to item 03b.	CC
11/22/04	**Sustainability Practice Support Issues/Update** **General Medical Services - Current sustainability issues** There is one closed list in Cardiff which is due to reopen in January following on from the resignation of a partner, leaving the practice to be run singlehandedly. The practice is undertaking a recruitment exercise to fill the vacant GP position. An application has been received for the sustainability framework; the Primary Care panel will consider the paper on 15th December. The practice has previously been offered significant sustainability support following on from a decline in student numbers as a result of Covid restrictions. There are 12 practices reporting at level 3 and 4; these practices continue to be contacted regularly. Other practices are currently being supported with sustainability issues relating to the premises and partnership succession arrangements, following retirement of one of the partners of a two-partner practice. **Practice visits** The practice visit programme is underway; all practices will be visited by the end of December. Visits will provide us with intelligence as to how the team can support sustainability as well as provide assurance on contractual matters. **Offer to Practices** LV described the offer to practice which has been sent out inviting interest from practices on a number of key interventions to improve sustainability; setting out the role of the team and what practices can expect from their intervention. Practices should contact the primary care team for further information. This has been discussed with the LMC and also at CD Forum. **Community Pharmacy - Current escalation position** Item 4D, Management of Community Pharmacy Contractual and Regulatory requirements will be sent to all GMS practices. **Contractual breaches** Temporary closures are the most common contractual breach at present. The dashboard could refer to a Community Pharmacy half hour closure or a full day closure. Three Community Pharmacies have been presented with a breach notice (closures are often due to staff sickness). Four or five temporary closure notices were received on 29th November 2022 and twelve were received for September. Temporary closures have never been witnessed in this capacity before. RA noted that the documents discussed should be headed with the UHB logo otherwise they are invalid.	

	RA believes LD's title to be incorrect on the paper; LA will clarify her title even though the paper has already gone through the Primary Care panel. It was noted that LD does have delegated authority to chair the panel. **Contract monitoring programme** Contract monitoring visits will commence in quarter 4 (January – March) provided that the new staff member is in post.	LA
11/22/05	**GMS Contract Agreement 2022/3 – Final Outcomes** The GMS contract is negotiated between GPC and WAG each year. The upcoming changes being made for 2022/3 are the most fundamental changes made since 2004. The aim is to have a unified contract in place in 2023 when the majority of services will be part of the core contract. There are challenges ahead to ensure the contract is managed appropriately. An assurance framework for Health Boards will be implemented to ensure things are being done properly as of 1st October 2023. Groups will be set up to work through the new contract in order to help practices move forward.	
11/22/06	**HIW Inspection Reports** **Update on visits undertaken** The report details one practice visit that took place in the last quarter; there were no actions. JR, JB and the Dental and Optometry Contract and Service Development Manager met with Angharad Oyler, Head of Patient Safety and Quality Assurance who uses a new system for managing HIW inspection reports; it was suggested that there was a possibility of implementing the same system to manage practice visits/inspection reports and actions. A potential share point of information may be offered. **Reports update/Actions to follow up** Nothing to note for GMS.	
11/22/07	**PCIC Risk Register Update** There are currently 17 active risks as per the below: • 2 risks scoring 20 • 7 risks scoring 16 • 2 risks scoring 15 • 3 risks scoring 12 • 3 risks scoring 9 Risks will be moved over to Share Point when capacity allows. **Teams** RA urged the group to be mindful when sensitive issues are discussed over Teams meetings. **Records Management Code of Practice** We will be unable to meet the Records Management Code of Practice requirements due to capacity, especially in relation to destroying/the disposal of records. This will affect the whole organisation and has been added to the Clinical Board risk register. There is potential for unlimited financial penalties.	
11/22/08	**Immunisation Update** **Flu programme**	

	• **GMS** No practices have hit target as yet in relation to the Under 65 at Risk category but figures are slightly higher than this time last year. 15 practices hit target in relation to the Over 65 category but are running slightly lower than this time last year. No practices hit target for the 2-3 year old category; this is an area of concern as figures are running at approximately 10% lower than this time last year. Work is being carried out with the immunisations coordinators to identify what support can be offered to practices. A process is in place for practices to access contingency stock; contingency supplies are available if needed. JS and SC continue to work with the mass immunisation coordinators to manage the process. • **Community Pharmacy** 23k vaccines have been delivered to date and will continue to be delivered until March. 50% of the vaccines delivered are within the 50 – 64 age group. Data anticipated to be available next week will allow us to look at the statistical breakdown. QIVe vaccine: one individual over 65 has been identified who had received the incorrect vaccine (they should have been given QIVc). **Booster programme** • **Primary Care update** General Practice has completed the autumn booster rollout; 6k vaccines were given. There is currently no further GMS ask for a spring booster. • **Community Pharmacy** The Community Pharmacy booster programme ceased on the week commencing 05.11.2022. Just over 10k vaccines were delivered over 13 sites.	
11/22/09	**Safeguarding** One GP safeguarding report is being managed with the support of the safeguarding team.	
11/22/10	**MPL Update** There are two cases involving GPs in managed services. Two GPs have been referred for a behavioural assessment. The Governance team is also looking at a case brought to light via whistle blowing.	
11/22/11	**Cold Chain Breach Report** Item 11 details any cold chain breaches between 22.09.2022 – 18.11.2011. There were 3 incidents during this period involving 3 different practices. One of the incidents involved 4 doses of Gardasil – Human papillomavirus which had expired; the value of the doses was £346. There were 2 fridge failure incidents resulting in an expense of £7567. A reduction in breaches has been seen over the last 8 weeks which could be associated with the data logger rollout or possibly a more robust system being implemented. The team is confident that practices are doing all they can in order to save vaccines in the event of a fridge failure.	

	RB suggested this issue is discussed at CPET and was advised to liaise with the Community Director on the Health Pathways team.	RB
11/22/12	**Learning from events** Item 12 is a document sent by NHS Wales Delivery Unit which relates to an incident following on from when a patient spoke with a nurse working in OOH. The patient highlighted her allergy but could not remember which antibiotic worked best for her. She suffered an allergic reaction to the antibiotic prescribed and attended EU for 9 hours. The action plan offered as a result of the incident included a discussion in the nurse's appraisal, more usage of the BNF and reminding the practitioner that patient records can be accessed on the clinical portal. CC pointed out that the drug in question is an old drug that has been brought back into the system and the allergy it can give is being discussed in pharmacy meetings.	
11/22/13	**NICE Update** Please refer to the written update (item 13) provided by SFJ. SFJ will continue to email the NICE updates until the SharePoint page has been set up. Consideration to be given to adding Health Pathways to the agenda. Members were asked to consider this and let GJ know if this is something that would be beneficial.	ALL
11/22/14	**CPET Update** Three webinars have been provisionally booked (COPD update, Paediatric cancer and Medicine management hot topics). The next CPET session is scheduled on 1st March 2023.	
11/22/15	**Compliments** Compliment included for noting.	
11/22/16	**Access to in-hours GMS Standards – Final Internal Audit Brief** The Primary Care Team is being audited on their processes of the in-hours access standards. This work is almost complete. Initial findings will be published shortly.	
11/22/17	**End of year report: In-hours Access Standards 2021/2 and Q1 and Q2 reporting for 2022/3** The Access Standards were required to be implemented by all practices by 31.03.2022. The Health Board reviewed compliance at the end of March 2022 and payment was awarded at 30.06.2022, based on achievement at this time. Practices were not assessed at 31.03.2022 on Standard 2 or Standard 8. Achievement for both was assumed with Standard 2 counting towards Group 1 payments and Standard 8 counting towards Group 2 payments. The GMS Contract agreement for 2021-22 included an Access Commitment to be introduced from 01.04.2022. The Access Standards accordingly now have 2 phases. Phase 1 – the Access Standards introduced in April 2019 remain as pre-qualifiers. All practices are expected to achieve, maintain and embed those working practices in order to make any claim for achievement or the Phase 2 Standards. Phase 2 is the reflective phase. This is to allow practices time to reflect, listen to patient experience and make improvements to access.	

11/22/18	**Optometry update** JB introduced FL to the group. FL is one of the new optometric advisors and is looking forward to working with and supporting JB and her team. Rukaiya Anwar, optometric advisor has also recently joined the team. The new optometry contract will come into effect on 01.04.2023.	
11/22/19	**New recruits and vacancies** • **Primary Care Team** Jonathon Campbell worked his last CD session on 29th November 2022; the vacant 2 day session is out to advert. The band 7 project manager post is being shortlisted. The Practice Manager Consultant post is out to advert for a further 2 sessions. Elizabeth Green has been recruited into the band 6 GMS vacancy and will take up post in January. Caitlin Gall, PC Support Officer took up post on 07.11.2022. Welcome Caitlin. • **Governance Team** Laura O'Connor, Quality and Safety Officer has left. Louise Thomas was recruited into the 4 month secondment post and has been permanently appointed following interview. • **Community Pharmacy** Interviews for the Community Pharmacy Advisor post are scheduled on 05.12.2022.	
11/22/21	**Items to be recorded as received and noted for information by the Committee** Items 21 a, b, c, d and e were referenced.	
	Date and time of next meeting – 25th January 2023, 2 – 3.30pm	