Quality, Safety and Experience Committee

Tue 12 April 2022, 09:00 - 12:00

Agenda

09:00 - 09:10

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the QSE Committee Meeting held on 22 February 2022.

Susan Elsmore

1.4 Public QSE Minutes 22.02.22MD.NF.SE.pdf (12 pages)

1.5. Action Log – Following the meeting held on 22 February 22

Susan Elsmore

1.5 Draft Public QSE Action LogMD.NF.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

09:10 - 10:40

2. Items for Review & Assurance

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

Ruth Walker / Mark Doherty / Neil Jones / Daniel Crossland

30 minutes

2.1 MHCB Assurance Report QSE - Formatted for final review.pdf (16 pages)

2.2. Quality, Safety and Experience Implications arising from IMTP

Ruth Walker / Abigail Harris

10 minutes

2.2 IMTP - Quality Safety Patient Experience QSE Paper FINAL.pdf (10 pages)

2.3. Feedback from the Clinical Effectiveness Committee

Meriel Jenney

10 minutes

2.3 CEC QSE April 2022 V3 final.pdf (11 pages)
2.3a CEC -April QSE.pdf (11 pages)

2.4. Quality Indicators Report Update on Falls in Lakeside Wing

Ruth Walker

10 minutes

2.4 Lakeside Falls Briefing Paper for April 2022 QSE v3.pdf (5 pages)

2.5. HIW Activity Overview

Ruth Walker

10 minutes

2.5 HIW Update on Activity - QSE Paper.pdf (4 pages)

2.6. Board Assurance Framework – Patient Safety

Nicola Foreman

5 minutes

2.6 BAF Patient Safety Covering report - 2022.NF.pdf (2 pages)
2.6a Patient Safety - BAF Risk.pdf (3 pages)

2.7. Recommendations from the Nuffield Trust Report

Meriel Jenney

15 minutes

2.7 Nuffield report update_03_22.pdf (3 pages)
2.7a Nuffield Trust report update_annex 1 and 2.pdf (6 pages)

10:40 - 10:40

3. Items for Approval / Ratification

No Items

10:40 - 11:20

4. Items for Noting & Information

4.1. Exception Reports (Verbal)

Ruth Walker / Meriel Jenney

10 minutes

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

5 minutes

4.2.1. Children & Women's Clinical Board Minutes 25.01.22

4.2.1 C&W Minutes 25.01.22.pdf (10 pages)

4.2.2. CD&T Clinical Board Minutes 10.01.22 & 15.02.22

4.2.2a CDT Minutes 10.1.22.pdf (9 pages)
4.2.2b CDT Minutes 15.2.22.pdf (9 pages)

4.2.3. Medicine Clinical Board Minutes 17.02.22

4.2.3 Medicine minutes 17.02.22.pdf (6 pages)

4.2.4. Specialist Clinical Board Minutes 11.02.22

4.2.4 Specialist Minutes 11.02.22.pdf (8 pages)

4.2.5. Clinical Effectiveness Committee Minutes 18.01.22 & 15.02.22

4.2.5a CEC Minutes 18.01.22.pdf (9 pages)
4.2.5b CEC Minutes 15.02.22.pdf (6 pages)

4.3. Corporate Risk Register

Nicola Foreman

5 minutes

4.3 Corporate Risk Register.NF.pdf (3 pages)
4.3a Corporate Risk Register Mar 2022 (QSE Committee Entries).pdf (3 pages)

4.4. Infected Blood Inquiry Update

Nicola Foreman

5 minutes

4.4 - Infected Blood Inquiry Update.NF.pdf (3 pages)

4.5. Patient Safety WalkRounds

Ruth Walker

5 minutes

4.5 WalkRound Summary - March 2022 - FINAL.pdf (5 pages)

4.6. Implementation of Datix OfWCMS

Ruth Walker

5 minutes

4.6 Datix OfWCMS - March 2022 - FINAL.pdf (6 pages)

4.7. Duty of Candour

Ruth Walker

5 minutes

4.7 Duty of Candour - FINAL.pdf (4 pages)

11:20 - 11:20

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

Susan Elsmore

11:20 - 11:20

6. Agenda for Private Board Meeting:

i) *Minutes of the Private Committee Meeting – 22.02.22*

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

iii) *DNAR Orders at St. Davids Hospital – Update*

11:20 - 11:20

7. Any Other Business

Susan Elsmore

11:20 - 11:20

8. Review of the Meeting

Susan Elsmore

11:20 - 11:20

9. Date & Time of Next Meeting:

Wednesday 15th June 2022 at 9am via MS Teams

11:20 - 11:20

10. Declaration

Susan Elsmore

“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 22 February 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
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Stephen Allen	SA	Chief Officer Community Health Council
Mike Bond	MD	Director of Operations - Surgery
David Scott-Coombes	DSC	Surgical Clinical Board Director
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Charles Janczewski	CJ	Chair of the UHB
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Ruth Walker	RW	Executive Nurse Director
Clare Wade	CW	Director of Nursing - Surgical
Observing		
Caitlin Thomas	CT	Graduate Trainee Manager
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
David Edwards	DE	Independent Member - ICT
Ceri Phillips	CP	Vice Chair of the UHB
John Union	JU	Independent Member - Finance

QSE 22/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/02/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/02/003	**Declarations of Interest** No Declarations of Interest were noted.	
QSE 22/02/004	**Minutes of the Special Committee meeting (October) and Minutes of the Committee meeting held on 14 December 2022** The minutes of the Special meeting held on 26 October 2021 and the minutes of the meeting held on 14 December 2022 were received and confirmed as true and accurate records of those meetings.	

	The Committee resolved that: a) The minutes of the Special meeting held on 26 October 2021 and the minutes of the meeting held on 14 December 2022 were approved as true and accurate records of those meetings.	
QSE 22/02/005	**Action Log following the Meeting held on 14 December 2022** The Action Log was received and all ongoing actions discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 14 December 2022 was noted.	
QSE 22/02/006	**Chair's Action taken since last meeting** The CC advised the Committee that the approval of Gene Therapy Medicinal Products & Gene Therapy Investigational Medicines Products Policy, Procedure and EHIA had been approved offline in December 2021.	
QSE 22/02/007	**Surgical Clinical Board Assurance Report** The Director of Operations – Surgery (DOS) advised the Committee that the report provided details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2021 and noted that it would also highlight the actions and progress of the Surgery Clinical Board during the COVID pandemic. The Surgical Clinical Board Director (SCBD) presented the Designing Emergency Surgery Care for the Future to the Committee. The Committee were advised that:- - the current service consisted of Emergency patients coming into the system through various streams and particularly through Primary Care into the Surgical Assessment Unit (SAU) and through the Emergency Department. - The current SAU was not fit for purpose and was too small and situated in a poor environment. • The proposal to address issue with the SAU included (i) creation of a Surgical Emergency Care Unit that provided same day care to patients and (ii) referral of Patients to Same Day Emergency Care (SDEC). • The new SDEC would extend to ENT, Ophthalmology and Maxillofacial patients and would include physical space as well as a virtual ward. - Phase one of the new SDEC was open and that it was hoped the whole unit would be open in June/July 2022.	

- Digital technology would be required for the SDEC and a number of tools had already been identified and some were already in place.

- Since April 2014 there had been a gradual increase in Emergency Trauma seen across the Health Board as well as the rest of the UK and that alternative ways of working had been introduced during the Covid-19 pandemic, such as hot clinics, and the use of digital technology which had resulted in decreased admissions.

- The future patient journey would now place more patients to a Surgical Triage Coordinator which would result in less patients being in the ED assessment area and that the rest of the patients would go through to the SDEC or directly to an acute surgical unit.

- Regarding Phase 2 – Acute Surgical Ward, (i) the short stay acute surgical ward would be moved from B2 North ward (University Hospital Wales) into the current SAU footprint, (ii) there would be further development of patient pathways to support early discharge for hospital inpatients and (iii) timely access to diagnostics and treatment.

- The model of care fitted with the direction that was dictated by national policy and that the Clinical Board had developed a MDT/professional workforce fully engaged in change with views to upskill staff.

- A new footprint which was “environment compliant” had been created to ensure delivery of safe care and to provide the best experience possible for staff and patients.

The CC noted that the emphasis on the safety and centrality given to patient care.

The Independent Member – Trade Union (IMTU) asked if there was enough staff given the current pressures and if there was confidence that more staff could be provided should they be required.

The Director of Nursing Surgical (DNS) responded that the Clinical Board had proactively recruited throughout the Covid-19 pandemic and that a lot of the recruitment had come from overseas which had supported some of the recovery plans as well as the SDEC.

The Independent Member – University (IMU) asked if there were any examples of other SDEC models that had worked and also how and when outcomes could be measured.

The DOS responded that throughout the process of creating the SDEC they had engaged with NHS England who had a number of SDECS up and running. He added that the Clinical Board had also signed up to NHS

	Improvements and noted that the SDEC worked very well in other areas of the UK. In response to the second question from the IMU, the DOS noted that attendances were being measured as well as occupied beds to see if admissions had reduced. He added that a dashboard would be created with a number of key measures that would be reported. The Executive Nurse Director (END) advised the Committee that the work being carried out by the Surgical Clinical Board had significantly reflected a Health Inspectorate Wales (HIW) report regarding the Emergency Unit and noted that the SDEC should provide an improved position. The Independent Member – Community (IMC) asked if there was any new area within digital technology that had been identified that would help move at the speed the Clinical Board were aspiring to achieve. The DOS responded that the digital tools mentioned earlier would help move the model forward and noted that help had been received from the Welsh Government (WG) as well as the Health Board with Consultant Connect. He added that bespoke reports had also been developed “in house” with the Health Board’s IT team and noted that other Clinical Boards had done the same. The Chief Officer of the Community Health Council (COCHC) advised the Committee that the new NHS 111 Wales telephone system was coming in which would replace CAV24/7 and noted that he was concerned about the Emergency Unit because patients were sitting on chairs for a long time. He noted that it would be helpful to know what the maximum length of stay would be on the recliner chairs identified within the SDEC and what mechanisms were in place to ensure patients were not there for too long. The SCBD responded that the floorplan presented to the Committee was the assessment and immediate treatment phase and that there was also a ward area which served a different purpose. He added that the purpose of reclining chairs was not just to make it nicer for patients but that it could be used for patients to have intravenous medications. It was noted that the trollies would be for patients who would have an intervention to theatres and that patients staying longer would be going to the dedicated ward areas. He concluded that the Clinical Board wanted patients to be “processed” as quickly as possible but once they had gone from treated to recovery they would move to the ward area.	

	The COCHC noted that virtual wards/virtual technology had been identified and highlighted that there could be an issue with those who were digitally excluded. The DNS responded that they were already trialling a virtual ward in ENT and that there was a clear set of criteria for the patients and that only patients who fit that certain criteria would be managed by the virtual ward and noted that the patient would know who their point of contact was for 24/7 care. The COCH asked if the SDEC would change the way that patients accessed the service moving forward. The DOS responded that the SDEC was an internal model and extension of the Emergency Unit. The DNS responded that patients would not be admitted to chairs or recliners and that they would only be used for treatment and quick turnaround patients. The CC asked what the term “hot clinic” meant. The SCBD responded that it was an outpatient appointment for a clinical consultation the following day which meant that the patient’s need was tailored appropriately. The DOS reiterated that the whole point and principle around the SDEC was to ensure a patient did not require admission to a hospital bed. The Surgical Clinical Board Assurance Report was received and the Executive Medical Director (EMD) assured the Committee that the Surgical Clinical Board took Quality and Safety very seriously. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted. b) The content of the report and the assurance given by the Surgery Clinical Board was approved.	
QSE 22/02/008 	**Presentation providing an update on:** • **Healthcare Standards** • **Duty of Candour** • **National Quality Framework** • **Annual Quality Statement** The END advised the Committee that the report would provide members with an update on where matters stood after a number of policy changes. The Assistant Director of Patient Experience (ADPE) presented the Committee with information regarding the new Health and Social Care (Quality and Engagement) Wales Act 2020 and noted four principal areas which included: • Duty of Quality	

- Duty of Candour
- Establishment of a new Citizens' Voice Body
- Requirement for NHS Trusts to have Vice Chairs.

It was noted that the Act was passed in March 2020 and received Royal Assent in June 2020 and that the intention was to bring the Act into force in April 2023.

The ADPE advised the Committee of what would be required to implement the Act, which included:

- Statutory guidance.
- Regulations that would set the Duty of Candour procedure.
- Regulations to amend the Putting Things Right (PTR) to ensure they would fit with the Duty of Candour.

The ADPE advised the Committee that the implementation of the Duty of Candour required workshops, e-learning packages, a public awareness campaign and easy to read information leaflets which would be developed with a communication engagement programme taking place across Wales.

In relation to the Duty of Quality, the Committee was informed that the said Duty would seek to achieve a system wide approach to quality in the Health Service to secure improvement and shift the focus away from simply quality assurance.

Regarding the new Citizens' Voice Body, the Committee was informed that it would replace the Community Health Council with a new, independent, national body that would exercise functions across health and social services.

It was noted that the Citizens' Voice Body would have powers to make reports and recommendations to organisations, such as Health Boards, NHS Trusts and Local Authorities, and to provide complaints advice and assistance to citizens should they had a complaint about NHS services and certain social services.

The Committee was advised that most NHS Trusts had implemented the requirement to have Vice Chairs already.

The ADPE advised the Committee that the Health and Care Standards were introduced in 2015 to bring together and update the Doing Well, Doing Better: Standards for Health Services in Wales (2010) and the Fundamentals of Care Standards (2003).

It was noted that the Health and Care Standards formed the cornerstone of the overall quality assurance system within the NHS in Wales and that, alongside the Framework for Assuring Service User Experience (2013),

	the Standards had helped to ensure that people had positive first and lasting impressions, that they had received care in safe, supportive and healing environments, and that they had understood and were involved in their care. The CC advised the Committee that the information provided on the Healthcare Standards, Duty of Candour and National Quality Framework would benefit discussion at a Board Development Session. The Chair of the UHB asked what the review of the Healthcare Standards would entail and if it would be a "revamp" of the current Standards. The END responded that a revamp of the Standards was not expected and that something new was expected. The IMU asked if the new Duty of Candour had changed anything that the Health Board was not doing already. The END responded that the driver was to be open and transparent that the Health Board was already doing everything that was required. **The QSE Committee resolved that:** a) The Healthcare Standards, Duty of Candour, National Quality Framework and Annual Quality Statement was noted.	**RW/NF**
QSE 22/02/009	**Quality Indicators Report** The Quality Indicators Report was received. The END advised the Committee that there were 3 areas to note which included: • "Never Events" – It was noted that there were currently two Never Events under investigation and the development of a Human Factors Framework and Training Strategy would be an important element of the revised QSE Framework for the next five years. The END noted that feedback at a national level regarding learning was being received around Never Events. • Falls – It was noted that there had been a significant increase in falls at the Lakeside Wing (LSW). The END advised the Committee that was challenging to observe all patients at all times and noted that a more detailed look would be required at a future meeting. • PPE – It was noted that the Quality and Safety team were measuring and monitoring incidents to feed into the PPE Cell and that the team were not overly concerned. **The QSE Committee resolved that:**	**RW**

	a) The contents of the Quality Indicators report and the actions being taken forward to address areas for improvement were noted.	
QSE 22/02/010	**Exception Reports** The Exception Reports were received. The END advised the Committee of the current pressures which included:- - The -concerns around the ED and the need for patients to be seen and treated through that department more quickly. - The "front door" was challenged by the "back door" and it was recognised that patients were staying in hospital for longer which was a system wide challenge. The END advised the Committee that excellent work was being done with the Local Authority and noted that staffing within that was challenging. She concluded that overall, the aim was to try to improve the flow, increase discharges and increase staffing. The EMD added that she was working closely with doctors and the Communications team to ask the teams to work differently and move patients through the system more quickly and noted that the Chief Executive of the Health Board was leading the work with her team. The END advised the Committee that she was holding sessions called "Ask Ruth" around staffing and professional conduct which enabled direct conversations with staff. The COCHC noted the comment made by the EMD regarding moving patients through the system more quickly and highlighted that there was a risk that the "whole person" was not being seen, just the current need. The EMD responded that due to current pressures the risk to patients in the Community was so high that they had to be focused to address the current need and get the patients back home as quickly as possible. The END concluded that the level of commitment shown by staff during those exceptional pressures was fantastic and a huge credit to the Health Board. The CC agreed and asked for thanks on behalf of the Committee to all Health Board staff to be noted. The Chair of the UHB re-emphasised the comments made by the END, EMD and the CC. **The QSE Committee resolved that:** a) The verbal update regarding Exception Reports was noted.	

QSE 22/02/011	**HIW Activity Overview & Primary Care Update** The HIW Activity Overview & Primary Care Update was received. The END advised the Committee that an unannounced inspection at Hafan Y Coed, had been undertaken in the previous week to the meeting. She added that whilst the initial outcomes had been positive there were some areas that could be improved and highlighted that once the final report was received, those would be actioned. It was noted that the report had highlighted that the staff were a credit to the Health Board and that staff intentions were very good. The IMU highlighted the National Review of Patient Flow (Stroke Pathway) within the report and asked if a national review would delay the local review and planning being undertaken by the Health Board. The END responded that the answer was unknown, but noted that the Health Board had its own plan and lots of discussions were being had regionally to flush out some of the issues. The EMD responded that Stroke remained very high on the agenda and noted that a sustainable solution would be required given that the Health Board was currently helping out a neighbouring Health Board due to pressures being seen there. The IMTU noted that it was wonderful to hear compliments to staff across all the areas and asked if the feedback was being fed back to those staff and teams which would boost morale. The END responded that the Communications team was feeding back a lot of positive comments and noted that once the formal HIW report had been received, the positive feedback would be provided to the staff at Hafan Y Coed. **The QSE Committee resolved that:** a) The level of HIW activity across a broad range of services was noted. b) The appropriate processes in place to address and monitor the recommendations were agreed.	
QSE 22/02/012	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The Committee noted that Patient Safety was one of the top three risks, alongside Capital and Workforce. The CC noted that the risks were high level and asked if the Committee felt assured that the controls were in place and working.	

	The IMU responded that he was assured and asked the Director of Corporate Governance (DCG) to confirm that since the last review were there any further additional risks or mitigations that had been put in place. The DCG responded that she met with the Executive Leads prior to every Board meeting and noted that main Corporate Risks, including the Patient Safety Risk, had not changed since the last Board meeting. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety was reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 22/02/013	**Patient Experience Overview** The Patient Experience Overview was received. The ADPE advised the Committee that the report provided an overview of the Patient Experience Team's roles and regulatory function and added that more detailed reports regarding Complaints, Claims and redress themes and trends would be provided to the Committee at later dates in line with the QSE Work Plan. **The QSE Committee resolved that:** a) The increase in concerns numbers and the increased workload from the Welsh Risk Pool were noted.	
QSE 22/02/014	**QSE Committee Annual Work Plan** The QSE Committee Annual Work Plan was received. The DCG advised the Committee that the Work Plan was reviewed annually by the Committee prior to presentation to the Board to ensure that all areas within its Terms of Reference were covered within the Work Plan. It was noted that input from the END, Executive Medical Director (EMD) and other members of the Quality and Safety team had been provided. It was noted that the Q&S Framework was still being established and noted that there were some items on the Work Plan that highlighted future establishment. The CC asked if there were any timescales for the Committees that were currently unestablished. The END responded that the business case had quite a significant financial bill attached and that it had been take to the Executives where some support had been provided. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Committee Work Plan 2022/23 was reviewed.	

	b) The Committee Work Plan for 2022/23 was ratified c) The Committee Work Plan was recommended for approval to the Board on 31st March 2022.	
QSE 22/02/015	**QSE Committee Terms of Reference** The QSE Committee Terms of Reference were received. The DCG advised the Committee that the Terms of Reference were reviewed annually by the Committee prior to presentation to the Board for approval. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Terms of Reference 2022/23 were reviewed. b) The Committee Terms of Reference for 2022/23 were ratified c) The Committee Terms of Reference were recommended for approval to the Board on 31st March 2022.	
QSE 22/02/016	**QSE Committee Annual Report** The QSE Committee Annual Report was received. The DCG advised the Committee that the Committee Annual Report was reviewed annually by the Committee prior to presentation to the Board for approval. **The QSE Committee resolved that:** a) The draft Annual Report 2021/22 of the Quality, Safety & Experience Committee was reviewed. b) The Committee Annual Report was recommended for approval to the Board on 31st March 2022.	
QSE 22/02/017	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from the Clinical Board QSE Sub-Committees were received: a) Children & Women's Clinical Board Minutes b) Specialist Clinical Board Minutes c) CD&T Clinical Board Minutes d) Mental Health Clinical Board Minutes e) Medicine Clinical Board Minutes f) PCIC Minutes g) Surgical Clinical Board Minutes h) Clinical Effectiveness Committee **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees be noted.	
QSE 22/02/018	**Corporate Risk Register**	

	The DCG advised the Committee that there was nothing further to add to the report received by the Committee. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted.	
QSE 22/02/019	**Items to bring to the attention of the Board / Committee** The END advised the Committee that the Board should be made aware of the updates received regarding the Healthcare Standards, Duty of Candour and the National Quality Framework, and a discussion around current pressures and the quality of care.	**RW**
QSE 22/02/020	**Agenda for Private QSE Meeting** *i) Minutes of the Private Committee Meeting held on – 14th December 2021* *ii) Action Log – Following the Meeting held on 14th December 2021* *iii) Pandemic Update & Any Urgent / Emerging Themes – Verbal* *iv) Cardiac Surgery Report – Verbal Update* *v) DNAR Orders at St David's Hospital*	
QSE 22/02/021	**Any Other Business** The CC advised the Committee that there had been a high number of Do Not Attempt Resuscitation (DNAR) forms at St. David's Hospital and asked if it could be looked into. The END responded that an update would be provided in the Private session of the QSE meeting and that any relevant discussion would be brought to the Public session at a future date, if appropriate.	
QSE 22/02/022	**Review of the Meeting** The CC advised the Committee that a lot of time had been spent on the Clinical Board Assurance report but noted that it had been required.	
QSE 22/02/023	**Date & Time of Next Meeting:** Tuesday 22 February 2022 at 9am	

Action Log

Quality, Safety & Experience Committee

Update for meeting 12 April 2022
(Following the meeting held on 22 February 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 21/12/016	Maternity Lifts	END would seek clarity around lifts being fixed.	22.02.22	Ruth Walker	**COMPLETE** Update provided in February
QSE 21/12/011	HIW Activity Overview & Primary Care report of discrimination	Concerns were highlighted in relation to several instances of staff feeling discriminated against in the workplace. An improvement plan has been submitted and accepted by HIW which includes actions to ensure measures are in place to eliminate potential areas of discrimination	22.02.22	Ruth Walker	**COMPLETE** Update provided in February
QSE 21/12/007	Mass Vaccination Letter issues - Penarth	The Deputy Chief Officer for the Community Health Council advised the Committee that there had been delayed letters due to postal service END requested an email to sort this out via operational means.	22.02.22	Ruth Walker	**COMPLETE** Update provided in February
QSE 22/02/009	Quality Indicators Report – Falls Update	Due to a significant increase in falls at the Lakeside Wing an update may need to be brought back to the Committee at a later date	12.04.22	Ruth Walker	**COMPLETE** **On April agenda item 2.4**
Actions in Progress					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
UHB 22/01/007	**Dental Directorate Update**	ICOO advised the Board that a more detailed report on the Dental Directorate would be provided to the QSE Committee.	**14.06.2022**	Caroline Bird	**In Progress FROM BOARD** Date of QSE Committee to which this item will be brought is **to be confirmed.**
QSE 21/12/008	Pressure Damage Update	A further updated pressure damage report to be brought back to the QSE Committee in 6 months' time.	14.06.22	Ruth Walker	**IN PROGRESS** To go to the June QSE Committee
Actions referred to Board / Committees					
QSE 22/02/008	Items to bring to the attention of the **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	TBC	Ruth Walker/ Nicola Foreman	**IN PROGRESS** A date for future Board Development Session to be confirmed, once the Board has approved the annual work plan for Board Development Sessions from April 2022 to March 2023.
QSE 22/02/014	QSE Committee Annual Work Plan	To go to Board for approval on 31 March 2022.	31.03.22	Nicola Foreman	**COMPLETE** Went to Board and was given formal approval on 31 March 2022
QSE 22/02/015	QSE Committee Terms of Reference	To go to Board for approval on 31 March 2022.	31.03.22	Nicola Foreman	**COMPLETE** Went to Board meeting and was given formal approval on 31 March 2022
QSE 22/02/016	QSE Committee Annual Report	To go to Board for approval on 31 March 2022.	31.03.22	Nicola Foreman	**COMPLETE** Went to Board and was given formal approval on 31 March 2022

Report Title:	Mental Health Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Executive Board QSE Assurance Meeting	Public	X	Meeting Date:	12 April 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Ruth Walker Exectutive Nurse Director, Neil Jones Clinical Board Director, Mark Doherty, Interim Director of Nursing, and Dan Crossland Director of Operations for Mental Health Clinical Board				
Report Author (Title):	Mark Doherty, Interim Director of Nursing, Mental Health Clinical Board				

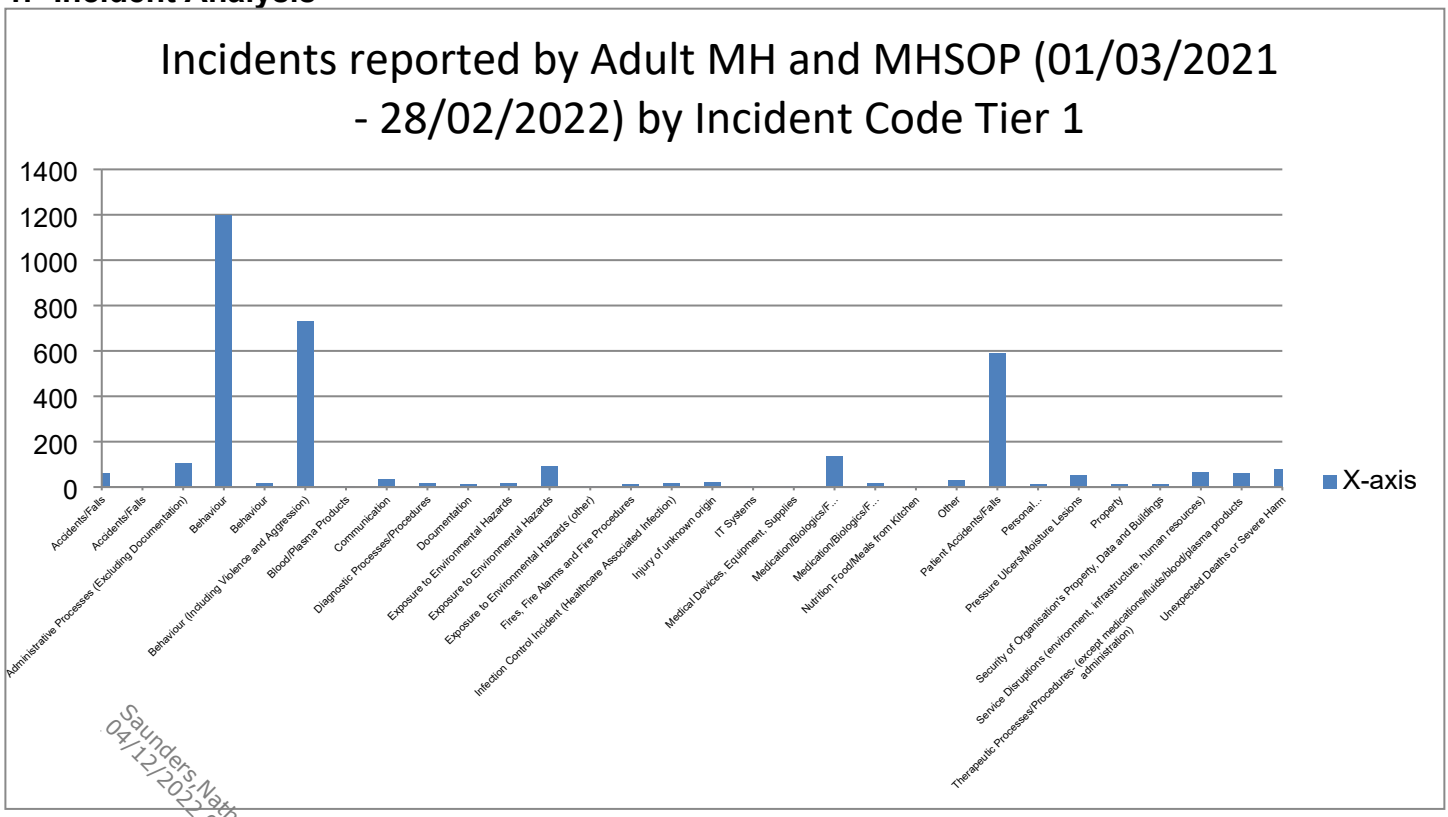
Main Report
Background and current situation:

This report has been prepared to provide assurance to the Quality, Safety and Patient Experience Committee. It aims to demonstrate that quality, safety and patient experience is at the heart of the delivery of services to the mental health service users within Cardiff and Vale University Health Board

The Mental Health Clinical Board is continuously trying to improve quality within a positive risk management culture to promote recovery. The Clinical Board will seek to ensure that risks, untoward incidents and mistakes are identified quickly and acted upon in a positive and constructive manner so that any lessons learnt can be shared, appropriate action taken and resources prioritized.

MHCB has recently experienced a higher number of serious adverse clinical events that would normally be expected. This is therefore the highest priority on our agenda in terms of learning from this experience and making changes that ensure our services, our clinical processes and our environments are as safe as they possibly can be.

1. Incident Analysis



Saunders,Nathan
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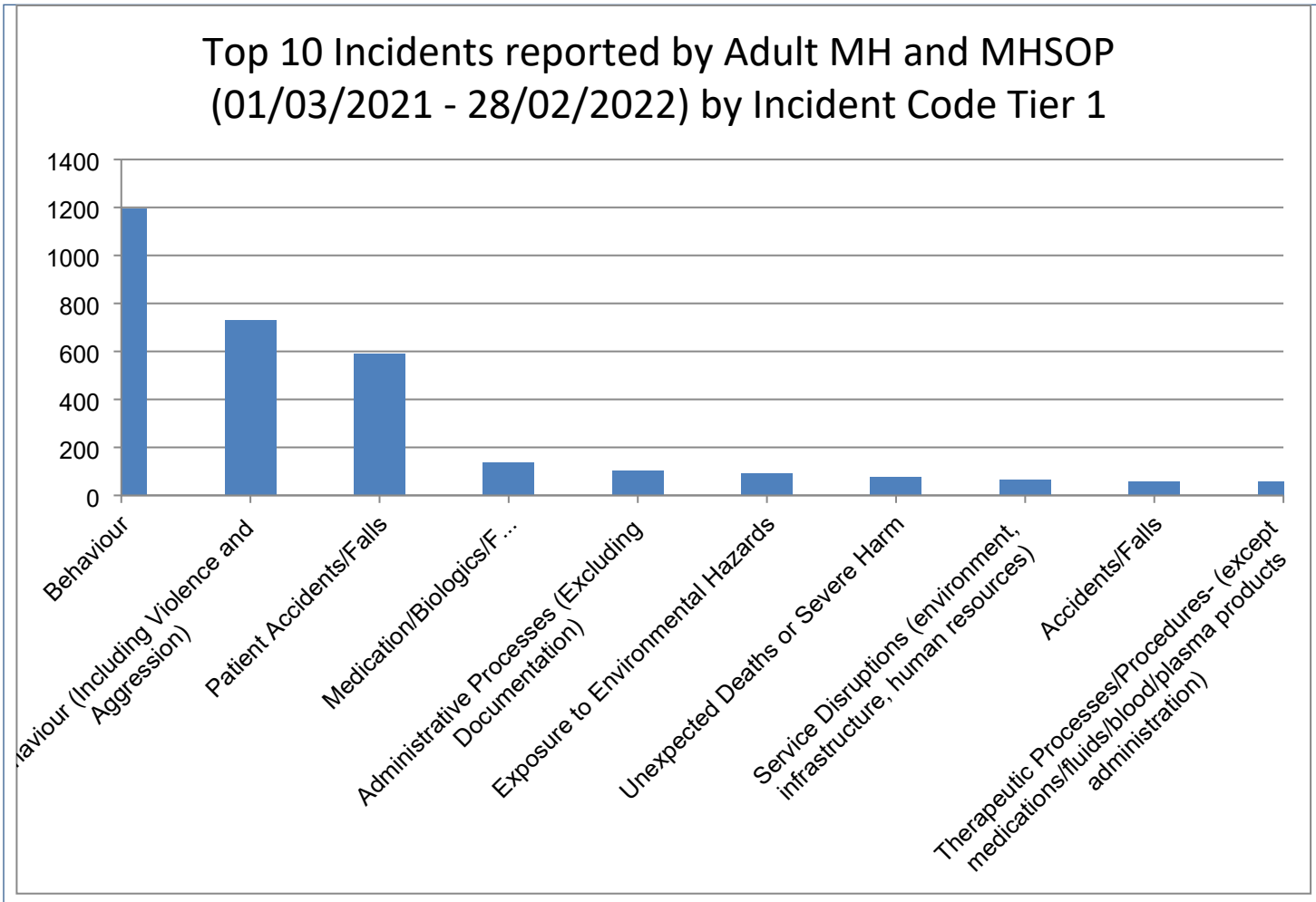


Our top ten incident categories are heavily weighted towards behavioral incidents, followed by patient falls---the great majority of which have taken place amongst our older, frailer patients within the Mental Health Services for Older People Directorate.

Behavioural incidents are carefully monitored, and we believe that one of the things we can do to substantially reduce the likelihood of challenging behavior (although the possibility can never be completely eradicated) is to work with clinical teams to return the use of our in-patient services at Hafan Y Coed to what they were originally designed to do. The pressures of COVID over the last two years have made it necessary to redistribute in-patients and disrupt clinical teams in order to create COVID-safe environments.

Mental Health Services for Older People had developed a bespoke falls training package which was seen to significantly reduce the number of injurious falls. As COVID pressures hopefully reduce we will roll the training out again, and MHSOP is working with colleagues in patient safety to improve the way falls data is analyzed and translated into lessons learned.

Response to clinical risk and National Reportable Incidents in the Acute Mental Health Inpatient setting

The Mental Health Clinical Board has encountered over a relatively short period of time, a number of suicides in the acute in-patient environment that is significantly higher than the national average. This constitutes a “cluster” according to nationally agreed criteria and the MHCB considers the need to provide a comprehensive, evidence-based series of actions to understand and reduce this phenomenon to be of the highest priority. There were six suicides over a period of eleven months:

The MHCB has provided information in support of a Rapid Review into unexpected deaths in acute in-patient settings conducted by the Delivery unit, and awaits any information this may yield.

Our Consultant Nurse for Complex Clinical Risk, Jayne Bell has conducted a Thematic Review of the untoward deaths at the request of the Clinical Board (Appendix 1) and identified a number of recommendations:

- Suicide Cluster Response Plan (regional lead)
- IRG process to be agreed with Safeguarding and South Wales Police
- Environmental differences of wards to be understood (e.g. 99/135 ROS)
- Environmental considerations (e.g. door top alarms, bedroom windows)
- Environmental milieu to be improved (garden bids)
- Ward remits / policy reviews to fully understand purposes of wards and risks / benefits of dual functions
- Re-launch of Complex Care Forum
- Re-launch of Sentinels and Lessons Learned ToRs
- Questionnaires to staff
- Professional judgement audits for Nurse Staffing Act
- SafeWards re-launch
- AIMS accreditation for working age inpatients, CRHTT and PICU
- Availability of Suicide Awareness and Mitigation Training, Cynnwys Inpatient Training and suicide
- Protected time for inpatient training and supervision
- Skill mix review – psychological input to wards & appointment of shift co-ordinators to get Ward Managers back on their wards
- Revival of the ADP for nurses
- Away Days
- Ensure ward rounds / MDTs are person centred over a focus based on tasks
- Care Aims in the inpatient setting
- Adoption of WARRN as the recommended tool in preference to form 4
- Consideration for use of seclusion (not for suicide risk but to contain other relational risks that could impact on the ward community
- Workstream on locked / open doors (National piece of work)

It is the intention of the Mental Health Clinical Board (MHCB) to implement these recommendations in full.

Further to this MHCB has identified a series of actions which should tangibly return the acute in-patient environments at Hafan Y Coed, University Hospital Llandough to a level of safety and stability that was disrupted by the need to react to the demands of the COVID pandemic over the past two years. These are:

Returning Hafan Y Coed to its original footprint

The dramatic pressures created by the need to manage COVID in accordance with Welsh Government, Public Health and local UHB guidelines has been extremely disruptive to the normal functioning of mental health in-patient services. These challenges are not unlike those experienced by staff and patients in other areas of health care. The requirement to create COVID “red” environments and to safely manage other in-patients safely through the COVID pathway has meant that most acute and rehabilitation wards have needed to change their clinical function, and the virus has also resulted in staff teams needing to be disrupted. The overall effect has been to significantly alter lines of communication and clinical team cohesion. All of the actions were necessary and were in keeping with the kinds of responses taken in other clinical areas.

It is now time to return the in-patient environments to their original functions, although this will be a complex process as it will take place in the face of a high demand for beds and the need to repatriate patients who were placed in commissioned “surge” beds in other facilities. The Adult Mental Health directorate will also be supported in considering whether this is an opportunity to review the ways in which wards need to operate.

Review of National Reportable Incident / Sentinels / Lessons Learned systems and processes

The Mental Health Clinical Board has a well-established, long-standing process for gathering information about serious, nationally reportable events including suicides, near-misses and other events. This has

evolved over a period of years into a sophisticated mechanism that is aligned to national reporting requirements and elicits themes and factors from which lessons can be learned and improvements made. We believe however that more can be done to ensure that our processes are timely, comprehensive and are as compassionate as they are objective. We know that we can do more to make our processes helpful to service users and families and also to the coroner, whilst also ensuring that the lessons learned are translated into tangible improvement plans.

Suicide Prevention Training
Whilst the understanding of and management of clinical risk---including the risk of suicide and self-harm---is central to the work of a mental health service, we recognize that those skills can always be enhanced. To that end we have worked with Welsh Government to roll out a comprehensive package of suicide prevention training that is tailored to all levels of experience and responsibility across the multi-disciplinary spectrum. This exercise was temporarily slowed by COVID pressures but is now back in train.

Multi-Disciplinary Team Reviews
We recognize from our thematic analysis that the way in which our multi-disciplinary teams communicate, the shared discourse they employ and the way in which actions are generated by MDT discussions is of the utmost importance. MDT reviews must also be timely and frequent. We have therefore asked a group of clinicians to conduct a further analysis into the quality and logistics of MDT reviews with recommendations for improvement.

Cluster Response Plan
We are working with the Welsh Government Regional Coordinator for Suicide and Self-Harm Prevention in deploying the Cluster Response Methodology, over a period of at least a year. As part of this we will also agree the terms for our participation in the Immediate Response Group, which will be a swift convening of all interested statutory bodies following any further serious events in order to agree actions on a multi-agency basis.

Implementation of the Wales Applied Risk Research Network (WARRN) risk assessment
Whilst the WARRN tool has been in use in mental health services for many years, we intend to establish it as the baseline of our risk assessments in the in-patient setting.

Royal College of Psychiatrists Review of Adult In-patient Services at Hafan Y Coed
The Executive Board have supported and commissioned this authoritative and comprehensive review, the Terms of Reference for which have recently been agreed.

Review of the Observation Policy
This policy, which governs the way in which we maintain the safety, dignity and security of our patients whilst they are in hospital, is of crucial importance. The review of the policy (which will make it clear and more informative) is nearly complete.

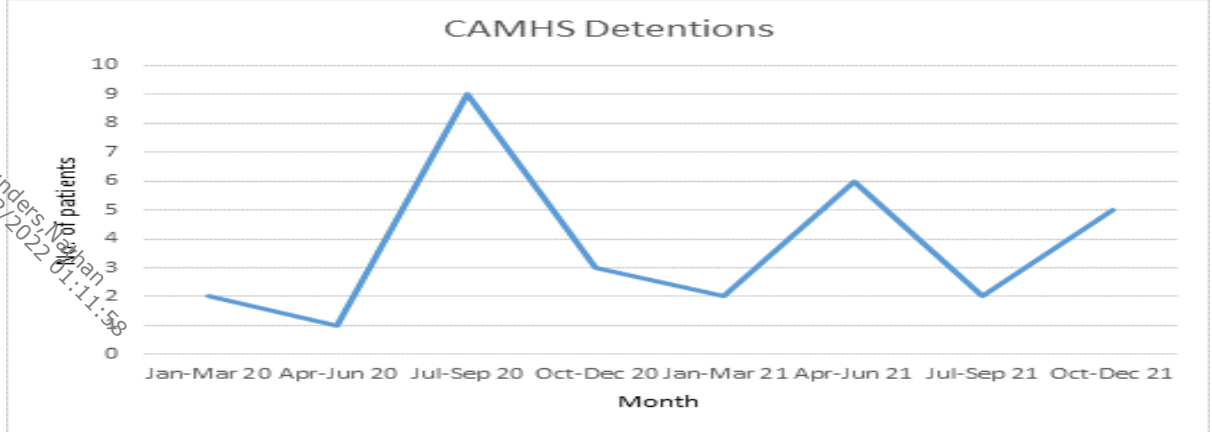
2. Risk Register
The top 4 items on the MHCB Risk Register are as follows. The Risk Ratings given are following the proposed mitigation.

Risk	Mitigation
MHSOP Nursing Staff Recruitment There are significant challenges to the recruitment of registered nurses in MHSOP. This results in nursing staff levels below the 60:40 registered to unregistered ratios for in-patient areas and creates a necessary diversion of ward managers role in order to cover ward shift work. This creates a risk of inadequate registered nursing supervision of care. There are potential adverse impacts on	Rolling recruitment of registered and unregistered staff. ADP for registered staff. All Wales pilot of nursing workload and professional judgement tool. MHSOP bed reductions in progress in line with RCP National benchmarking. Staff cover continuously risk assessed to minimise impact on patient safety. Nursing observation prescription in MHSOP under review. Recruitment effort to Northern Ireland

patient safety and quality of care, and regulatory non-compliance (EWT Directive). (Risk Rating 12)	
Poor Clinical Environment Accommodation for community services bases at Park Road, Pendine CMHT, Gabalfa CMHT, and CAU on the CRI site are in a deteriorating and potentially unsafe condition. This could adversely impact on safety of staff, service users, contractors and members of the public. (Risk Rating 12)	Maintenance efforts to slow the deterioration of the premises. Routine Health and Safety inspections and escalation of risks via corporate Heath and Safety Meetings. Case accepted for inclusion in Health and Well Being Hubs for the CMHT bases with uncertain timescales. Alternatives sought by the clinical board for Park Road Housing which is limited by its 'ward in the community' status and no means of collaborating with a housing provider due to income.
Violence and Aggression Staff are exposed to persistently high levels of violence and aggression, particularly in in-patient care. This risks physical and emotional injury withpotential impact on staff safety, compliance with statutory duty and compensation. (Risk Rating 12)	All staff trained in accordance with the All Wales Passport scheme. Incident reporting encouraged where staff are exposed to V&A. Improved working with the Case Manager to secure prosecution where appropriate. V&A training team now increased to 10 trainers to ensure adherence to training standards. Pinpoint electronic response system in place to ensure prompt support from mental health teams. Information given to service users on admission with standards of behaviour explained. Service to explore the principle of 'seclusion' in 2020. Post incident support offered to staff.
Young Person in Adult Mental Health Placement Young person with complex needs required admission to adult mental health services as no suitable alternative available. There is a risk that the patient will be in a sub-optimal clinical environment which will adversely impact on the patient's 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. (Risk Rating 20)	Additional staff allocated to the care of the patient.

3. Young People / CAMHS interface

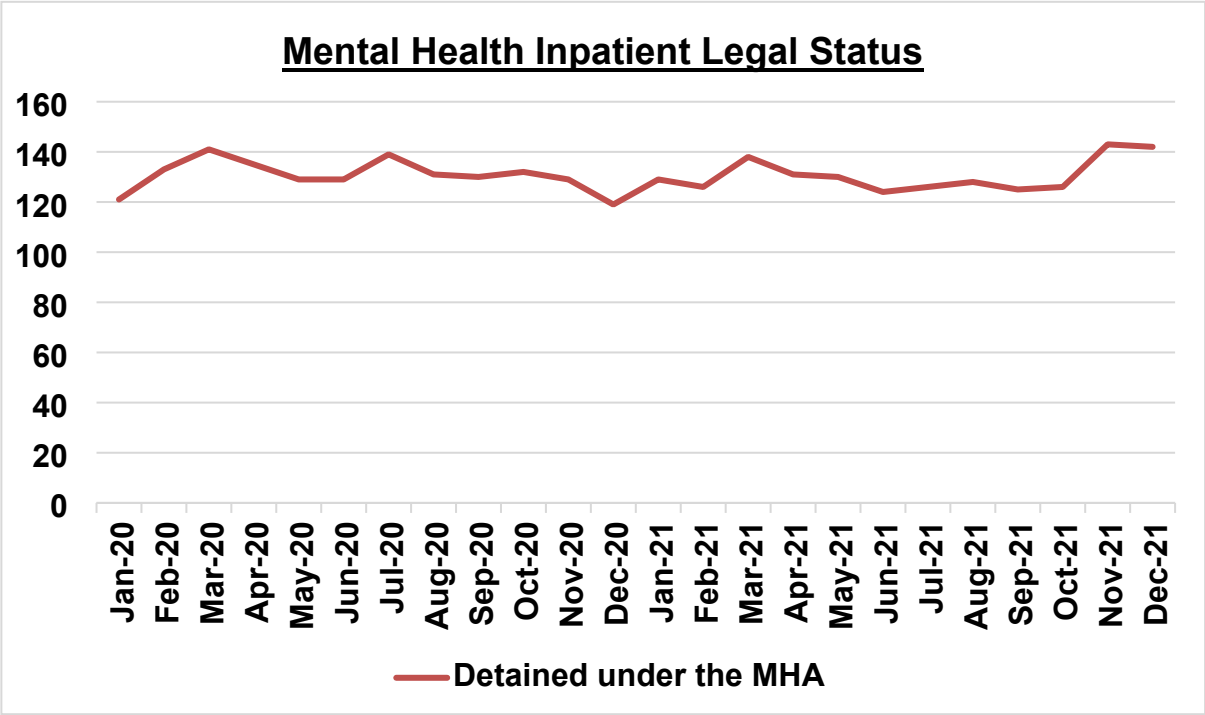
The Mental Health Clinical Board continues to provide in-patient beds for young people under Child and Adolescent Mental Health who require a swift response because of immediate clinical risk. It is recognized that, although necessary, the placing of young people in an adult mental health environment is sub-optimal in terms of patient experience and the particular needs of young people in acute distress. Although MHCB maintains a policy of always providing a bed when required to do so, the lack of appropriate placements for young people does present an added pressure on bed capacity for MHCB. Admissions of young people to Hafan Y Coed over the last calendar year were as follows:

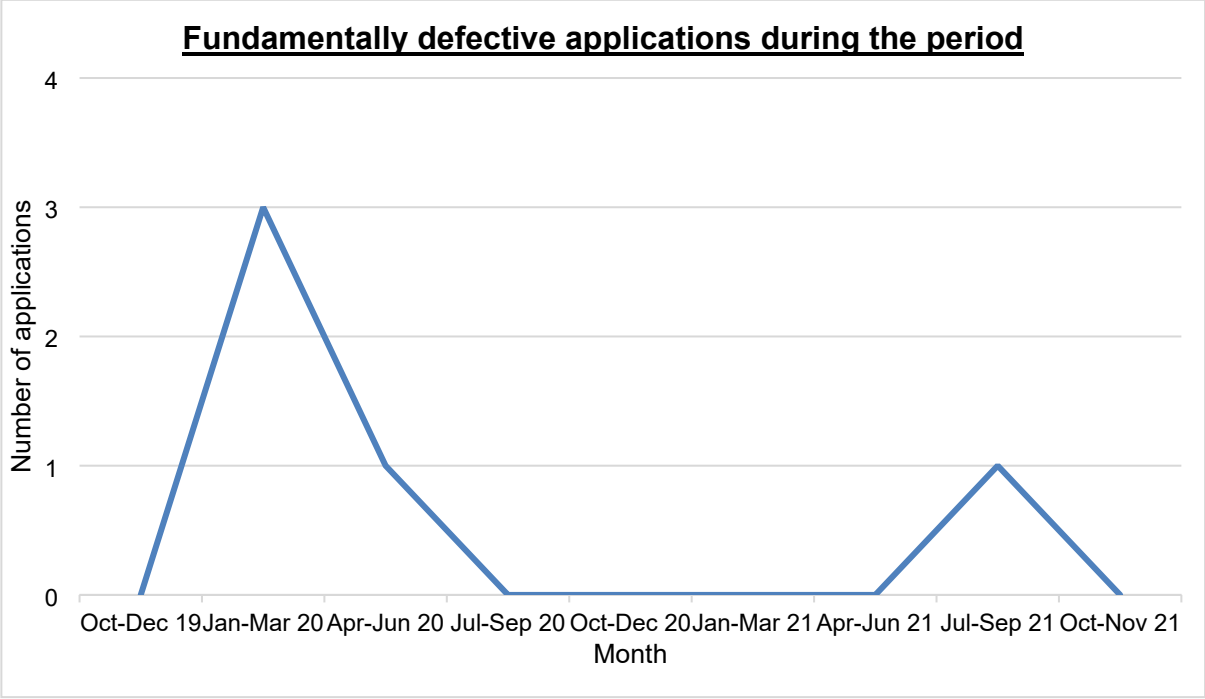


4. Mental Health Act

The MHCB Mental Health Act Office continues to provide scrutiny and oversight of MHA activity in Cardiff and Vale UHB. MHA activity is as follows:

Detained patients





January 2020

During the period there were three fundamentally defective applications made by an AMHP whose period of approval had lapsed. These incidents occurred further to an oversight which took place within the Local Authority (LA) after an AMHP returned to the rota after a period of time.

The LA have reported that the incident occurred during an unexpected period of long-term sick by the Consultant Social Worker DoLs / AMHP, Cardiff LA and coincided with the location of the electronic AMHP records migrating to a new data platform (Share Point). The Consultant Social Worker DoLs / AMHP, Cardiff LA has confirmed that provisions have since been put in place to ensure that records are also

accessible to the Operational Manager, Cardiff LA to ensure continuity of accurate record keeping and monitoring going forward.

In addition to these, one detention was identified as invalid because the detention papers were not received on behalf of the Hospital Managers. There is a process in place to prevent these incidents occurring which has been successful up until now. However unfortunately on this occasion there is no evidence that the AMHP left instruction for nursing staff on the general site at UHW resulting in the legal documents being filed in the patients records rather than furnished to the Hospital Managers for formal receipt.

September 2021
During September 2021 there was 1 fundamentally defective application for detention. This wasn't reported until October 2021 as we weren't made aware of the detention until then.

P was detained on a Section 2 in UHL general. The AMHP gave the detention papers to a ward nurse but there is no evidence that the AMHP left instruction for nursing staff which resulted in the detention papers not being given to a person authorised to receive them on behalf of the Hospital Managers, nor were the Mental Health Act office informed of the detention by the ward or the AMHP.

After a period of time, the patient moved to an MHSOP ward with the detention papers but the Mental Health Act office were not informed of this either. We were informed of the detention on the last (28th) day when another AMHP queried why the detention papers were not uploaded to PARIS.

After seeking legal advice from Richard Jones, he confirmed that although P was 'liable to be detained' on the basis of an AMHP application being completed, it does not alter the fact that the detention papers were not formally received by someone authorised on behalf of the Hospital Managers, therefore, the application was fundamentally defective and the patient was detained without authority.

This incident has been discussed with the Local Authority and all AMHP's have been advised that a receipt must be completed every time they detain someone and they must e-mail or call the Mental Health Act office to inform us of the detention so we can chase the paperwork if necessary.

Lapsed Detention October 2021
During this period 1 detention lapsed. P was detained on a Section 4 in the community due to lack of availability of another S12 doctor and risk of harm to self. P wouldn't travel to Hafan Y Coed with the social worker or CPN and instead left his flat. The AMHP applied to the courts that same day for a Section 135(2) warrant which was granted. Police were contacted to attend the flat the next day with the social worker and CPN in order to execute the warrant and convey P to Hafan Y Coed. Upon execution of the warrant the police found P was not located in his flat and as the Section 4 was nearing expiry the Responsible Clinician made a recommendation for Section 2. The AMHP went before the courts again to secure a Section 135(1) warrant in order to bring P to Hafan Y Coed for a Mental Health Act assessment.

5. Mental Health Audit
The MHCB pursues a wide range of clinical audits, the audit programme being led by Dr Bala Oruganti and audit progress overseen at MHCB Quality, Safety and Experience meetings. It is worth noting that MHCB does not at this time "shut down" clinical activity on selected days in order to discuss audit, in the way that some other Clinical Boards do, although there is a current discussion as to whether this would be a better approach for Mental Health.

Visualisation of MH community pathways
What are the opinions of stakeholders about integrating pharmacists in Community Mental Health Teams (CMHTs)
The efficacy of Voices and Visions Groups for Older adults
Service Evaluation for the on-line delivery of an attachment focused intervention "The Perinatal Play and Development group'' delivered by the Perinatal Community Mental Health Service (PCMHS).
Clinical utility of DSM 5 check list and ITQ for veterans CVUHB

Antipsychotics/BPSD
A service evaluation of the use of a stabilisation workbook focusing on emotional dysregulation, with women within the perinatal period.
Psychiatry – Understanding Medication safety Problems (PUMP)
"Improving the timeliness of discharge summaries from a crisis assessment ward".
To evaluate and inform the practice approach and generic assessment guidelines within Cardiff and Vales UHB Community Mental Health Teams
Evaluation of the teleconsultation system in Older Adults Psychiatry Community Teams during the Covid-19 pandemic.
Provision of online EMDR for PTSD
rends and predictors of Buvidal treatment success for service users in the community accessing treatment for opioid dependency: A service evaluation
Buvidal Service Evaluation – Exploring the Experiences of Clients Commencing on Buvidal
Service evaluation of physical health monitoring in patients who are prescribed antipsychotic medications.
A study exploring the impact of the COVID-19 pandemic on substance misuse
Thematic review of behaviour incidents reported by Mental Health Clinical Board
A service evaluation of the assessment of parent-infant interaction with service users in the perinatal period.
Review of Mental Health Outpatients Services : Lived Experience Views
Increasing Access to Early Intervention in Psychosis Services: An Audit of current provision
The multifaceted role of Neuropsychiatry service
Understanding service-users non-attendance of a CMHT DBT group
The online post-diagnostic group for autistic adults: a service evaluation
Documentation Pattern Following Reviews of Anti-Psychotics

Prescribing Observatory for Mental Health - POMH-UK
The Prescribing Observatory for Mental Health (POMH-UK) is a subscription based project that helps specialist mental health services across the UK improve their prescribing practice.

To achieve this, we develop audit-based Quality Improvement Programmes (QIPs) that focus on specific topics within mental health prescribing. Our lead investigators Katie Evans and Dr Stuart Fish concluded as follows:

"Overall as a health board we performed well across the practice standards. The sample generated from the acute adult side was very small (n=2) and hence definitive comparisons cannot me made. Following the audit the SHO handbook has been updated on:

- *Specific criteria regarding neurological assessment documentation*
- *Specific bloods required in alcohol dependence*
- *Utilisation of breath alcohol measurement to inform medically assisted withdrawals.*

Repeating the audit when implications of COVID-19 have settled across both inpatient acute and specialist detox wards is recommended. Along with consideration for intention to treat in standards 5 and 7, as patient refusal of parental thiamine and prevention medication was not considered."

6. Research and Development
The MHCB is pleased to advise the Board of a successful and highly informative Mental Health R&D Conference that took place in 2021:

7. External Scrutiny

Two unannounced Health Inspectorate Wales reviews were undertaken in MHCB over the last year. The first, conducted online because of the pandemic, took place on Ward E12 University Hospital Llandough, a dementia ward in the Mental Health Services for Older People Directorate on 10th March 2021. The report was highly positive (appendix 2) with very few requirements in the Improvement Plan.

The second HIW review, the first face-to-face review conducted since the onset of COVID, was at various wards in Hafan Y Coed and commenced on 14 February 2022. We have not received the formal report but were pleased to note the very reassuring positive verbal feedback from the reviewing team, which described a clinical workforce that remained motivated and enthusiastic despite the worst effects of COVID, and also very encouraging comments from service users.

MHCB has received Health inspectorate Wales's *National Review of Mental Health Crisis Prevention in the Community* and will give consideration as to how to take it's 19 recommendations forward.

8. Staffing Levels

The provision of safe, skilled staff, both in in-patient services and the community, continues to be a challenge. This has been exacerbated by the pandemic but additionally we know that there are nationwide recruiting difficulties with mental health professionals. MHCB is currently looking at alternative staffing models, including the potential uses of Physician Associates.

MHCB participates in the extensive All Wales work undertaken in support of the implementation of the Nurse Staffing Levels (Wales) Act in Mental Health. It is expected that this piece of work will conclude in approximately eighteen months, and inform future workforce planning for mental health nurses in a way that is evidence-based and rooted in accurate data and sound professional judgement.

9. Workforce and Development

Streamlined WOD report this month due to COVID absence, annual leave and changes in WOD structures. Outlined below are the key issues:

WOD KPI activity

Sickness Rate (Year-to-Date Cumulative)

WTE	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
1278.90	5.35%	7.00%	7.01%	6.98%	7.33%	7.74%	7.65%	7.79%	7.90%	8.09%	8.31%	8.35%	8.37%	8.44%

Voluntary Resignation Turnover Rate (12-Month WTE, excluding junior medical staff)

Average WTE	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
1279.74	7.21%	7.45%	7.41%	7.48%	6.52%	6.86%	6.86%	6.93%	7.45%	7.63%	7.44%	7.48%	7.92%	8.58%

Statutory and Mandatory Training Rate (12- Month Cumulative)

Headcount	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
1503	74.90%	75.15%	74.88%	72.99%	72.23%	72.88%	72.92%	73.74%	74.60%	74.92%	75.05%	75.10%	75.56%

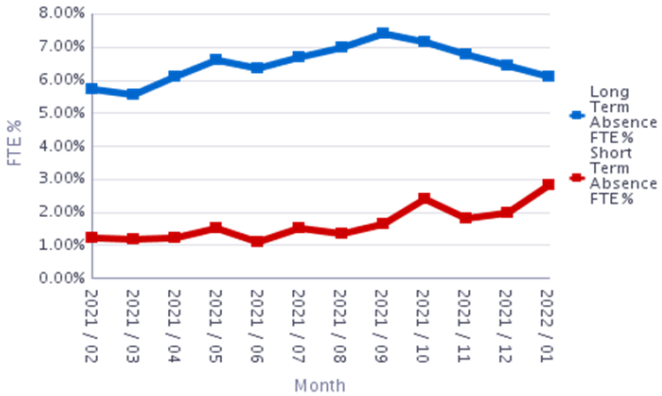
Medical Appraisal Rate

Headcount	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
62	52.73%	40.00%	43.33%	40.68%	49.15%	54.10%	59.02%	62.30%	63.93%	67.21%	65.63%	74.60%	77.42%

Non-Medical PADR Rate

Headcount	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
1406	34.74%	33.71%	35.12%	35.14%	34.40%	36.64%	35.21%	34.89%	33.43%	33.36%	32.75%	31.66%	30.73%

Sickness Absence



Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
LT FTE %	5.72%	5.54%	6.09%	6.60%	6.36%	6.68%	6.98%	7.42%	7.14%	6.78%	6.45%	6.10%
ST FTE %	1.25%	1.17%	1.23%	1.54%	1.10%	1.53%	1.36%	1.64%	2.42%	1.84%	1.99%	2.84%

COVID-19 Clinical Staff Absence Summary as at 8 Feb 2022 as reported by the CB Directorates

Clinical Board	**Headcount**	**COVID-19 Sickness**	**Self-Isolation & Shielding**	**Total COVID-19 Absence**
Mental Health	1,469	22	9	**31**

Employee Relations activity
There are currently 9 live ER cases. There are no fast track cases but one employment tribunal, linked to a grievance. No Respect and Resolution cases

Current position

Concluded	Arranging Hearing	Hearing Arranged	Fast Track	Investigation	On Hold
0	3	1	0	4	1

How long they have been running

0 – 3 Months	3 -6 Months	6 – 9 Months	9 Months +
0	3	2	4

Key updates
111 press 2 due to go live 1 April 2022 – presentation to consider options and seek approval on recommendations

People and Culture Plan shared with the papers and the themes mirror Healthier Wales. Seamless Workforce Models (theme 1) brings together the ambition for 2030. The HWOD for MH will provide an overview and what this means to the Board. Key new roles for the Board connected to the plan will be the peer worker, Physician Associate, Band 3-4 nursing roles, Kickstart, Apprenticeships alongside more integrated roles and teams with local authority and other stakeholders.

Mental Health Workforce Plan: Consultation: your chance to shape the mental health workforce plan for health and social care in Wales launched by HEIW Mental Health on 1 February 2022. The consultation is running from 1 February 2022 until 28 March 2022. Comments are being collected on the Consultation document by Nicola Evans, Head of Workforce and OD by 1 March 2022. The link is attached. https://heiw.nhs.wales/programmes/consultation-on-the-mental-health-workforce-plan-for-health-and-social-care/

Equality Strategy & Welsh Language Standards Group – our Action Plan is in development as we have listened to some of our staff sharing their lived experiences working within the Board. A draft plan is being prepared and will be shared for comment at the next CB meeting. It will be shared with the next Local Partnership Forum for comments 15 March 2022. A Welsh Language Audit has been undertaken by NHS Wales Shared Services with 5 UHB recommendations which will require CB action. Further information to follow.

Local Partnership Forum – Latest update from the Meeting is attached.
Just Culture and Learning Culture – Final Draft circulated for approval in papers
Mental Health Guidelines for the Management of Secondments – Final Draft for approval in papers

Physician Associates
Discussions are underway to review the PA role and where we could utilise their skills to support multi-disciplinary teams and medical workforce. A review of numbers and roles to be considered and a recruitment plan is in development aiming to confirm requirements for student streamlining recruitment by end March 2022 and for experienced PAs so that TRAC can be updated accordingly. Outcome measures will also be considered and agreed.

Peer Workers
Mental health services benefit from the inclusion of peer workers at all levels of our organization. Cardiff and Vale University Health Board leads Wales in having the most developed peer work structure in the country, with peer workers role at Band 6, 7 and 8 now well established.

Financial Impact	An increase in engagement levels has potential to reduce sickness and turnover costs.
Quality, Safety and Experience	Previous research demonstrates direct link between engagement levels and good HR management practices and patient satisfaction, patient mortality and infection rates.
Standards for Health Services	Standard 26 - Workforce Training and Organisational Development. Improved HRM practices will improve patient care
Risks and Assurance	Workforce risks are identified around ageing workforce, shortages, education, skills and development challenges as well as capacity. Workforce planning will underpin our current and future workforce sustainability as well as OD, and staff engagement and attendance would support overall improvement across a range of health and workforce outcomes.
Equality and diversity	Improved working relationships and engagement will improve staff experience and communications between managers and staff which supports the equality and dignity and respect agenda.

Concerns
Concerns between 1st September 2020 to 30th September 2021, Mental Health Clinical Board received 284 concerns during this time period.

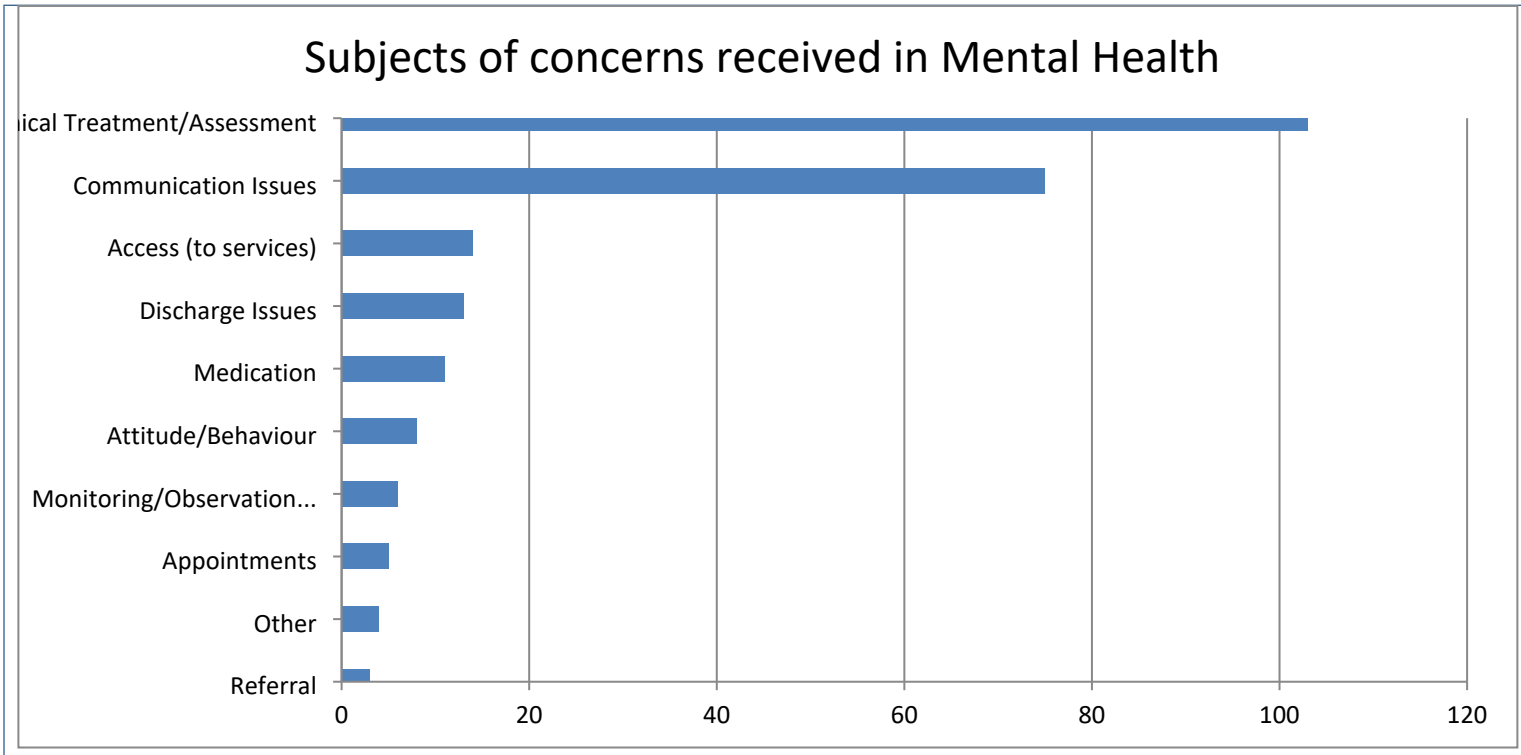
The Clinical Board responded to 249 concerns, 10 of these were resolved within 2 working days (including day of receipt). Unfortunately, due to the complex nature of Mental Health Concerns, it is very difficult to manage concerns under Early Resolution.

45% of concerns were closed within 30 working days.

The Welsh Government Target for responding to concerns within 30 working days is 75%, the Clinical Board have acknowledged that during the pandemic, there has been a failure to respond to concerns in as timely manner as they would have liked. Prior to the pandemic, regular tracker meetings were held to monitor the progress of investigations, however, these had to be stood down due to the clinical pressures.

The Director of Nursing and Head of Concerns have discussed the current position and agreed that the reimplementation of tracker meetings is essential. The commitment of Investigating Officers to attend these meeting is required to ensure accountability for timely investigations across all Directorates. This allows an overview prompting timeliness of responses and actions undertaken where delays are identified.

It should also be noted that the Director of Nursing has reiterated the importance of focusing on responding to overdue concerns that have been delayed during the pandemic.



Patient Feedback:

Patient Surveys currently undertaken on six wards within Hafan Y Coed, this is a monthly survey which was reinstated November 2021.

- Alder ward
- Beech ward
- Cedar ward
- ECT
- Oak ward
- Willow ward

However, returns from these areas have been limited and the feedback can only be viewed by site. e.g. in March, of the 55 surveys issued to wards at Hafan Y Coed, we didn't receive any returns. A breakdown of returns for the past five months since routine surveying in MH was reintroduced is given below:

For those surveys completed between November 2021 – March 2022, when patients were asked to rate their over experience on a 0 - 10 scale, where 0 is very bad and 10 is excellent: 60% of respondents gave a rating of 7 or more.

respondents gave a rating of 7 or more.

Month	Supplied (n)	Returned (n)	Response (%)
March 2022	55	0	0
February 2022	60	13	22
January 2022	55	18	33
December 2021	55	10	18
November 2021	55	12	22
Total	***280***	***53***	***19***

Patient Stories

A plan of work for digital stories has been agreed with Daniel Crossland, Director of Operations for the Mental Health Clinical Board. Patients who are willing to share their journey and stories, will be highlighted by mental health staff and their stories collected and edited by the Patient Experience Team.

These stories will then be shown at the Mental Health Clinical Liaison Committee (MHCLC) at regular intervals throughout the year.

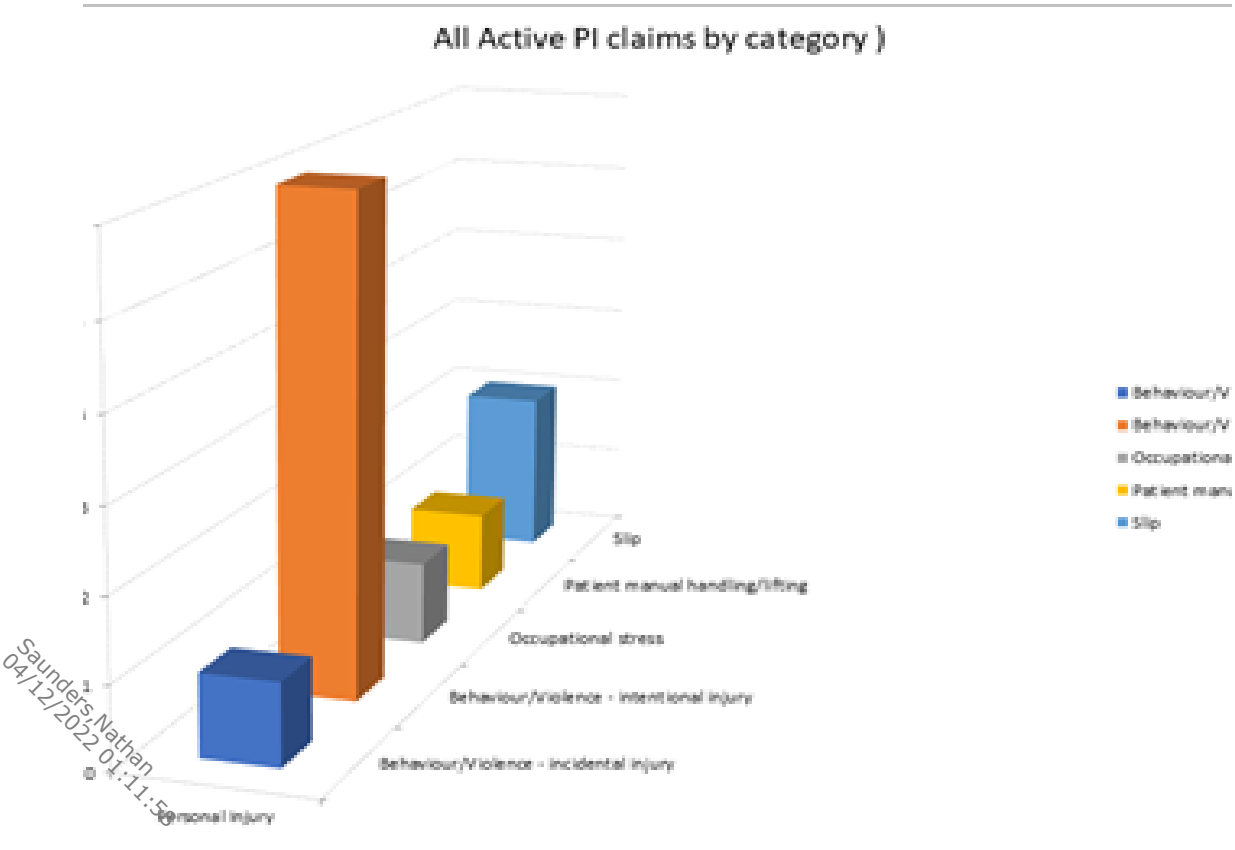
The first story, scheduled to be delivered at the April 2022 MHCLC features a young lady who had enrolled in the Recovery and Wellbeing College. She describes her experience with the Recovery and Wellbeing College as “A mutual, equal, and safe space to explore in depth the challenges of living alongside and/or recovery from mental health illness.”

Prior to this plan being developed a patient story was undertaken, in March 2021, with a patient who was in Hafan y Coed describing their experience of being detained under the Mental Health Act, and how the service could be improved to create a better experience for patients.
Title: Sectioned under the Mental Health Act ‘A Patient’s Experience’
Link: https://youtu.be/I7Y_P9ipVU0

Claims
The Claims team only opened one Mental Health Clinical Negligence claim in 2021 and prior to that the last case was opened in 2019. The MHCB does not feature heavily in clinical negligence with only three ongoing active cases.

The three active cases relate to patient suicides who were under the care of Cardiff and Vale Mental Health. Liability has been accepted in one case.

Mental Health Clinical Board do receive a higher number of Personal Injury claims and as noted in the graph below, Behaviour / Violence – incidental injury being the most common.



Recommendation:

The QSE Committee are requested to:

Note and **discuss** the content of the report

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration		Collaboration		Involvement	

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

Failure to deliver the requirements of this report would impact on the risk areas identified below. How these will present and the impact of the same will emerge based on the individual issue.

Risk: **Yes**

Safety: **Yes**

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

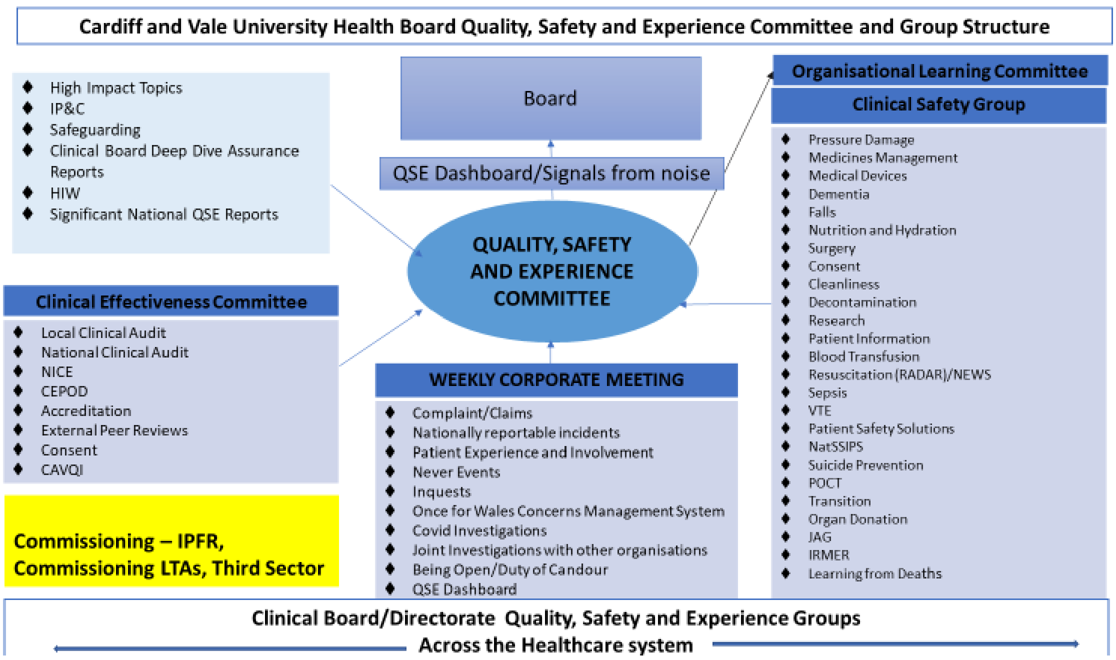
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Quality, Safety and Experience section of the IMTP			Agenda Item no.	2.2
Meeting:	QSE Committee	Public	X	Meeting Date:	
		Private			
Status *(please tick one only)*:	Assurance	X	Approval	Information	X
Lead Executive:	Ruth Walker, Executive Nurse Director				
Report Author (Title):	Angela Hughes, Assistant Director of Patient Experience				

Main Report
Background and current situation:

QUALITY, SAFETY AND PATIENT EXPERENCE section of the IMTP

We have developed our five-year QSE framework with our frontline staff, patients, carers, relatives and external regulators. Our focus on quality, safety and the patient experience extend across all settings where healthcare is provided. This includes our responsibility as a commissioner of services from a wide range of providers to have the necessary assurances in place where care is being provide by others for our population.
The chart below highlights our committee and group structures to support the delivery the framework



As an integrated healthcare organisation, our focus on quality, safety and the patient experience must extend across all settings where healthcare is provided as we look to be one of the safest organisations in the NHS. We will ensure there is no undue bias towards secondary care, recognising that the majority of care received by patients is provided in a primary or community care setting and that the primary and community care element of the patient's pathway is as key to delivering safe, high quality care as that part of the pathway which is provided in more acute settings.

We have eight key enablers in our revised QSE Framework for the next five years: These are:

- Safety Culture
- Leadership for QSE
- Patient Experience and Involvement

- Patient Safety learning and communication
- Staff engagement and Involvement
- Data and Insight
- Professionalism of QSE
- Quality Governance

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

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

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

One of the most important lessons learnt in the last few years is that organisations need to be ambitious. The experience we deliver for our service users will only ever improve when an entire organisation examines and re-creates its culture which is more than just

words, leadership, public and community engagement, staff engagement and cross-organisational measurement systems in order to improve quality and strive for excellence.

These are the key messages from our enablers

Safety Culture

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

Leadership and prioritisation

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

Patient experience and involvement

'No decision about me, without me'[1]

Staff engagement and involvement

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

Patient Safety learning and communication

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

Data and insight

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

Professionalism

.

' if we always do what we've always done, we'll always get what we've always gotten'

Quality governance

The Standard you walk past is the standard you accept'

OUR PRIORITIES for 2021 -2026

- Achieve the maximum possible reduction in avoidable harm
- Embed a systems based and human factors approach to safety investigations and solutions
- Introduce Safety Culture work programme

The summary table below provides an overview of the headline milestones which the QSE team are focusing on through 22-23 in order to make tangible progress in embedding the framework. We have been closely involved in the development of the national NHS Quality and Safety Framework which was published in September '21, and it aligns well with our own framework.

In summary: *Our Quality, Safety and Experience milestones*

QSE – *A Summary*			
TIMESCALE	**AMBITION**	**PATIENT AND SYSTEM BENEFIT**	**HOW WILL WE TRACK & MONITOR BENIEFITS**
22-23 Qtr 2	Development of the support framework for staff involved in inquests Implementation of the "What matters to me" conversations Align some aspects of the QSE Framework all Wales experience self-assessment framework with Perfect Ward and the ward accreditation process (Gold, silver, bronze)	Staff who are well prepared for inquests, feel supported and understand the process A culture of listening and hopefully understanding what matters to a patient within the larger context of their life. When patients are engaged with their health care decisions, it can greatly improve their outcomes. An ability to monitor the quality of care at ward level	Review on going feedback to monitor staff feedback including time off work and feelings of stress Through the use of PREMS, STAFF feedback and monitoring Concerns re complaints and claims where consent is a concerns and communication about treatment.

22-23 Qtr 3	Agreement of a Humans Factor Framework and Implementation plan	Agree a Human Factors Framework identifying the components or major factors that need to be addressed to gain a better understanding of the nature of preventable adverse events.	Through accreditation, feedback, complaints, claims, incidents and compliments
22-23 Qtr 4	Maximise the learning from near misses (to include the work currently being taken forward with Cardiff University to examine Covid related incidents) Establishment of the UHB stakeholder panel Development of the organisational learning committee Implement AMAT to strengthen governance in relation to National and Local audits, NICE Guidance and Patient Safety Solutions Work with Welsh Government to implement the requirements of the Health and Social Care (quality and Engagement) (Wales) Act 2020 Establish CAVQI as work stream to roll out of the current outputs from Health	Proactive management of near misses can reduce harm A crucial forum for stakeholders to inform, scrutinise and shape our work. A themed approach to UHB wide learning Able to evidence compliance with national audits and Patient safety solutions Awareness of staff of: Duty of candour Duty of quality Citizens voice body Agreed implementation plan and timeframe Able to demonstrate the roll out across the UHB All available modules in use	Identify how human factors currently impact Look for commonalities Examine outcome reliability Monitor reduction in harm Review impact upon health Inequities Reduction in same type incidents, complaints and claims Preparation of the UHB governance systems to meet the requirements of the act and further embed the culture across the UHB Evidence of data used to drive service improvement evidence of themes and you said we did from ward to UHB wide Information shared with the public, staff and stakeholder panel Undertaking PEER review with other organisations

	Foundation research project Implement the CIVICCA - Once for Wales service user experience system Complete the implementation Once for Wales Concerns Management System Development of a QSE accreditation/ syllabus	Agree Syllabus and timetable	

RESPONSE, RECOVERY AND REDESIGN

The COVID-19 pandemic has had a significant and wide-ranging impact on health services and we know that the full impact will not be known for some time. We are continuing to see rises in demand for services across primary and secondary care and as we move in to this new IMTP cycle our planning needs to be realistic, flexible and responsive to the evolving context. We are working hard to address the growing number of people who are waiting for assessment and treatment and this section of our IMTP focuses on our COVID-19 Response and Recovery plans where we will outline the operational focus of our organisation over the short to medium term with particular reference to the forthcoming year. This section is set within the context of the wider operational planning assumptions which we set out earlier in this plan.

Response: *Addressing the harms from COVID-19*

The Welsh Government "Five Harms Arising from COVID-19" continues to provide a helpful framework from which to detail some of the important elements of work which are ongoing across the UHB, our approach is provided in **Table 5.**

Mass Immunisation

It is of course well understood that one of the most remarkable and course-altering developments during the pandemic was the creation and delivery of COVID-19 vaccines. The roll out of the Mass Immunisation Programme across Cardiff and Vale was an example of what can be achieved through focused and collaborative partnership working. The success of the programme is attributed to the efforts across partners in Health, Local Authority, Academia, our amazing volunteers and many more. Following the initial phases of the vaccination programme, where over 392,000 first doses and 367,000 second doses have been administered, our teams across primary and secondary care again stepped up during December to ensure all eligible adults were offered a booster vaccine before the end of 2021. Our programme has been delivered through a multi-disciplinary approach with patients receiving vaccines in Mass Vaccination Centres, Primary Care, Community Pharmacists, from Mobile Teams and more.

As we move into the next year, we know that there will be a requirement for a continued COVID-19 vaccination programme and we will focus delivery to JCVI / WG approved cohorts ensuring there is an evergreen offer and no one is left behind. We retain our expertise to be able to implement any future emergency response, mirroring the Omicron Booster programme, should this be required moving forwards. We are using what we have learnt to develop our approach to immunisation more broadly to serve residents across Cardiff and Vale. Our vision is to effectively protect our local population against vaccine-preventable diseases through safe, innovative, timely, person-centred, and equitable immunisation delivery.

Table 5: Our approach to the five harms of covid-19

Harm 1: Direct Harm				
Covid-19 Operating Model Site Based Leadership across our two acute hospitals and our primary and community services. The introduction of our Operational Planning and Transformation (OPAT) Centre in UHW has revamped our approach by providing space and time for clinical, operational and corporate colleagues to work together on a daily basis to improve patient flow and service delivery. Modelling forms part of the daily OPAT rhythm, allowing for the escalation and de-escalation of services as necessary to meet the peaks of Covid-19 demand.	***Mass Immunisation Programme*** The roll out of the Mass Immunisation Programme from COVID-19-19 across the UHB is one of the most exceptional examples of planning, team work and mobilisation in our history. Following the success of the first and second phase, the booster programmed has now delivered over 282,000 boosters to date through a multi-disciplinary approach. As we move in to the next year we are prepared for a continued COVID-19 vaccination programme and retain our expertise to adapt the programme quickly as required.	**Test, Trace, Protect** Test, Trace and Protect (TPP) has played a key role in helping our population protect themselves and others. The cross-sector programme which includes regional oversight and close working between Local Authority and Health Board teams is being reviewed and will continue in to the coming year in a more focused capacity, addressing high risk settings and responding to emerging variants of concern.	**Treatments** Whilst vaccination remains the primary tool to combat the impact of the virus as we move into the next phase, since the start of the pandemic there have been a number of new treatments that have been trialled and are now becoming more common place. The UHB is delivering oral antiviral and monoclonal antibody treatments, especially for extremely vulnerable patients.	**Consequences of Covid** The UHB established the specialised Covid-19 rehabilitation service in December 2020 to meet the ongoing needs of our patients diagnosed with Long Covid-19. Through support from Primary Care an MDT focused Rehabilitation and Community Care pathway has been established and plans for 2022-23 will be to continue to develop the multidisciplinary model of care required to meet the needs of patients with Long Covid-19. The UHB has established Bereavement and Post-Covid-19 Support Groups to tackle the long-term impact of Covid-19 morbidity and mortality.
Harm 2: Indirect Harm				

Essential Acute Services The UHB continues to provide all essential services and has done so throughout the pandemic. Urgent and emergency care, provided through our ambulatory and emergency departments, continues to experience significant pressure due to reduced hospital flow. Cancer and other urgent surgery continue to be delivered through the implementation of our Protected Elective Surgery Units (PESU)	**Essential Primary Care Services** All nine C&V Clusters have developed and implemented plans to maintain GMS services in times of staff shortages and increased Covid-19 demand. Despite significant continued pressures, Cluster Plans outline how practices have business continuity arrangements in place to meet any future peaks in Covid-19 which place demands on primary care.	**Recovery Programme** Our recovery programme has been developed across five core service areas and is the main vehicle through which our post-Covid-19 recovery of services is monitored. The UHB is committed to returning activity levels beyond those seen pre-Covid-19 although we know that additional activity will not be enough and we must transform our pathways and services in conjunction with our patients to fully recover.	**Chronic Conditions** The impact of the pandemic on long term conditions will be significant with the full scale not yet known. The UHB has enhanced Musculoskeletal, Optometry and Diabetes services in primary and secondary care to meet the increasing needs of these patients. Further detail on our plans for caring for patients with chronic conditions can be found here
Harm 3: Arising from Population Health Measures		**Harm 4: Economic Harm**	**Harm 5: From Exacerbating Inequalities in Society**
Mental Health The impact of the pandemic has been acutely felt within our Mental Health services, as lockdowns and other restrictions including shielding and self-isolation as a case or contact have prevented normal socialising, work and education routines. Our mental health teams have worked to provide support to patients and staff despite recent increases in referrals Third sector organisations have provided much-needed support for people during this period.	**Education** Children and young people have often been reported as carrying the biggest burden through periods of enforced social isolation, particularly in relation to lost opportunities for education. Our teams are working closely with partners across education and local authority to support the recovery of services and ensure that any long-term impact on children's physical and mental health is addressed	Through coordinated partnership working, the Cardiff and Vale Public Services Boards are taking joint action to reduce the adverse economic impacts from Covid-19. This includes Cardiff's Recovery and Renewal Strategy, and City Centre Recovery Action Plan, and Wellbeing Plans which will be developed during 22-23 in both Cardiff and the Vale, to address	We know that many of the impacts of the pandemic have been felt most acutely by our communities who were already experiencing higher levels of inequalities. Further detail on the work which is ongoing to transform our population health, particularly with a focus on prevention, wellbeing improved patient outcomes, can be found in our most recent Cardiff and Vale Director of Public Health's Annual Report.

	in a holistic and joined up way. Further detail on our joint working in this area can be found here.	issues highlighted in the recent Wellbeing Assessments.	

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

This paper provides the priorities for quality, safety and patients experience for Cardiff and Vales University Health Board that aligns with our strategy and the QS&E framework which was developed with key stakeholders. This will require review on the publication of the W/G Quality Framework and Duty of Candour requirements.

Recommendation:

The QSE Committee are requested to:
Note the QSE requirements as laid out in the IMTP.

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		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

Safety: Yes

Financial: Yes

Workforce: Yes

Legal: Yes
Reputational: Yes
Socio Economic: Yes
Equality and Health: Yes
Decarbonisation: No

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

Report Title:	Clinical Effectiveness Committee Activity			Agenda Item no.	2.3
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	12 April 2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Meriel Jenney, Executive Medical Director				
Report Author (Title):	Rajesh Krishnan, Head of Quality Assurance and Clinical Effectiveness				

Main Report
Background and current situation:

There are 38 National clinical audits that Cardiff and Vale University Health Board are mandated by Welsh Government to participate in, as well as the National Clinical Outcome Review programs and NCEPOD.

The Clinical Effectiveness Committee (CEC) was established in December 2019, and is rapidly gathering momentum. To date the committee has met 11 times. In May 2021 for the first time, Clinical Boards and Directorate members were invited to attend to present their national audit findings.

The Clinical Effectiveness Committee has been established with the purpose of ensuring clinical effectiveness across the Health Board by:

1.1 Monitoring the implementation of NICE, national and local evidence, guidelines and standards to ensure best practice across the Health Board.

1.2 Providing strategic direction for the UHB's national and local clinical audit programme.

1.3 Providing assurance to the Quality and Safety Experience (QSE) committee on the above points through the production of reports.

1.4 Receiving reports from the sub groups and following analysis either escalate issues or provide assurance to the QSE committee and Board.

1.5 Contribute to the production of the Annual Quality statement to be presented to the Board of Directors

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the activity of the Clinical Effectiveness Committee since it was established in December 2019.

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

The Committee should be advised that the Internal Audit department have undertaken an audit of the Health Boards Clinical Audit Arrangements and was rated with 'limited assurance'.

The CEC is now well established. However, current resource to capture and monitor activity is limited which was reflected in the internal audit report. A business case was recently submitted to BCAG for Quality Safety and Experience was successful to procure AMaT (Tracking, Monitoring and Management system) to capture the Health Boards Clinical Audit activity centrally. Funding has also

been secured for personnel to help roll out the system across the health board. This will help to address many of the improvements identified in the internal audit report, and will considerably improve the level of assurance that will be provided.

Recommendation:

The Board / Committee are requested to:

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

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: Yes/No

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards. NHS Wales needs Health Boards to be a learning organisations which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World.

National Clinical Audit and Clinical Outcome Review Programme (NCACORP)

The UHB participates in the mandatory national clinical audits set out in the National Clinical Audit and Outcomes Review Plan, other national clinical audits of interest and local clinical audits that are designed and delivered, usually by medical students and junior doctors as part of their medical education. The table below sets out Clinical Effectiveness Committee activity/review since the last paper to QSE committee in September 2021

National clinical Audit	Report	Preliminary Overview	Further information required from clinical lead
Medical and Surgical Clinical Outcome Review Programme	Dysphagia in Parkinson's disease	√	

NDA - National Diabetes Audit	National Diabetes in Pregnancy Audit Report	√	
NABCOP - National Audit of Breast Cancer in Older Patients	National Audit of Breast Cancer in Older Patients Annual Report	√	
NCAP - Psychosis	Early Intervention in Psychosis Report (Wales only)	√	Outlier previous year – Actions undertaken and improvements made. (No longer outlier)
GI-NOGCA - Gastro-Intestinal Cancer Audit Programme - National Oesophago-Gastric Cancer Audit	NOGCA Short Report- Annual Report	√	
NMPA - National Maternity and Perinatal Audit	National Maternity and Perinatal Audit Annual Report	√	
NICOR - National Cardiac Audit Programme	National Cardiac Audit Programme Aggregate Report	√	
NCAP – National Cardiac Audit Programme	National Adult Cardiac Surgery Audit	√	Issues noted with data capture – being addressed to ascertain quality of data
NCAP - National Cardiac Audit Programme	National Congenital Heart Disease Audit	√	Further information from Clinical Leads
NCAP – National Cardiac Audit Programme	National Audit of Percutaneous Coronary Intervention	√	
PMRT - Perinatal Mortality Review Tool	Perinatal Mortality Review Tool Annual Report	√	No independent input in process: This is being taken forward by the maternity and neonatal network.
FFFAP - Falls & Fragility Fracture Audit	Falls & Fragility Fracture Audit- National Inpatient Fall Audit Report	√	Presented by Falls lead
FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Database	√	Outlier - Response returned to WG Feb 2022. Actions in progress which will be reflected in next report.
NVR - National Vascular Registry	National Vascular Registry Devices Spotlight Report	√	Data completeness issues identified – Clinical Lead invited to May CEC to discuss audit report,
MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Saving Lives, Improving Mothers Care Report	√	
NMPA - National Maternity and Perinatal Audit	National Maternity and Perinatal Audit Inequalities Sprint Report	√	

NELA - National Emergency Laparotomy Audit	National Emergency Laparotomy Audit Annual Report	√	Clinical Lead invited to Present and discuss at April CEC
NLCA –National Lung Cancer Audit	Annual Report	√	
Epilepsy – 12 (children and young people)	Annual Report	√	No data for Cardiff – CB contacted, audit lead appointed and data collection commenced.
MBRRACE – Maternity	COVID-19	√	Compliant
TARN	Major Trauma Quarterly report	√	Meetings with Clinical Board- CB taking over Audit 1st April 2022
SSNAP -	Annual Report	√	
NDA – National Diabetes Audit	Care processes and Targets	√	

<u>Main issues escalated to the Committee and under review by CEC are below:</u>

a) **National audits**

1.The National Early Laparotomy Audit (NELA)

Last year 44.2% of high risk patients were admitted to Critical Care compared to 63.2% the previous year. The national average is 82.3%. It was queried whether more patients should be transferred to Critical Care instead of being managed on the wards. The national average time for antibiotics to be administered to patients with suspected sepsis within one hour is 78.3%; CAVUHB data shows 15.1%.

Action Point
The NELA Team have been invited to March Clinical Effectiveness Committee to understand the data and to see how the committee could help the clinical team to be better compliant with the National standards.

2. The Trauma Audit and Research Network (TARN)

A reduction was seen in the case ascertainment figures for March – December 2020. Issues were because of a member of staff shielding during COVID-19, training needs and retention due to banding issues and funding which, whilst during the last three months no TARN coordinators have been in post. The shortfall has been absorbed by the Clinical Audit Team through working overtime and allocated time from other commitments, which has had an impact on other national clinical audits. There have been long standing issues and discussions have been escalated to Specialist Clinical Board regarding them having ownership of their audit the sustainability of the TARN audit and the need for additional funding to ensure future proofing from MTC as there is inadequate resource.

Action Point.
The TARN audit will from the 1st of April be returned to the clinical board. CEC will continue to monitor the TARN data.

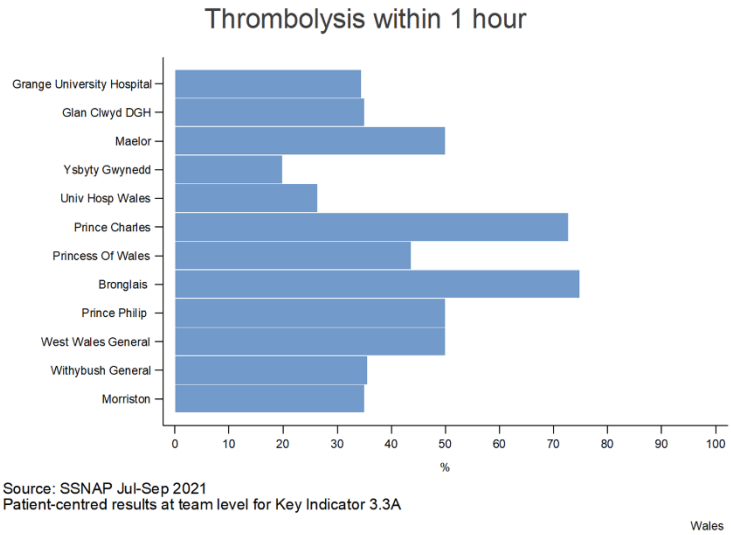
3. SSNAP
A system is in place to monitor the SSNAP data and initiatives such as 'door to ward' where the Stroke Team work closely and meet with the Emergency Department, Radiology and Patient Access. Over recent years SSNAP data has been used in several service developments and improvements, including time interval from admission to thrombolysis, HASU workforce gap analysis undertaken, thrombectomy pathway and referral procedures, and Stroke Response Nurse project.

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

- Admission to Stroke unit
- Time interval to thrombolysis

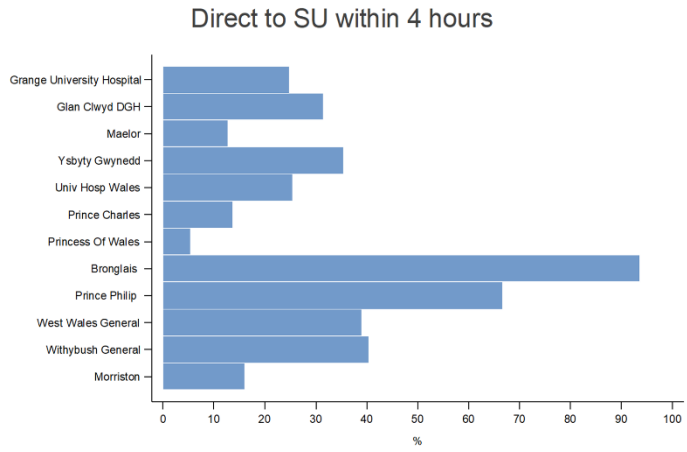
- Specialist assessments

HIW are undertaking a National Review of the Stroke Pathways and are visiting Cardiff and Vale UHB. The clinical leads will be invited to present their data and action plans in Clinical Effectiveness Committee following the report, and to update the committee on who has been appointed as the clinical audit lead for SNNAP as it is unclear if the appointment has been made



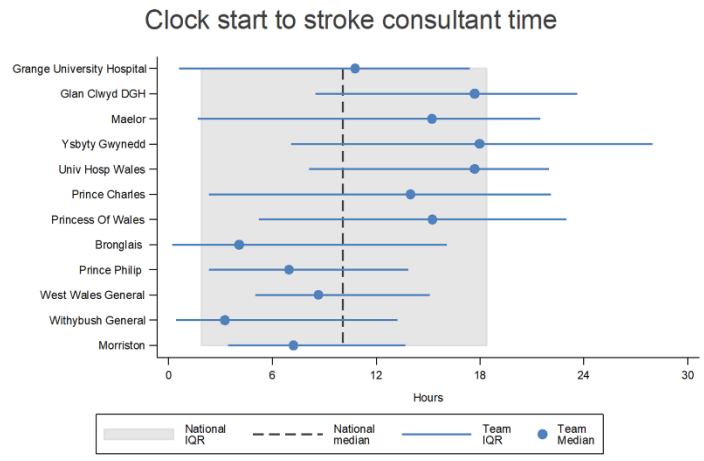
Source: SSNAP Jul-Sep 2021
Patient-centred results at team level for Key Indicator 3.3A

Wales



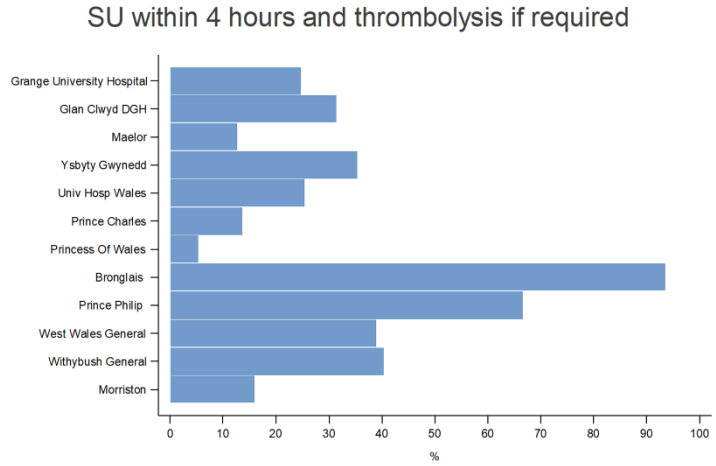
Source: SSNAP Jul-Sep 2021
Patient-centred results at team level for Key Indicator 2.1A

Wales



Source: SSNAP Jul-Sep 2021
Patient-centred results at team level for Key Indicator 4.2A

Wales



Source: SSNAP Jul-Sep 2021
Patient-centred results at team level for Key Indicator 3.4A

Wales

4. National Clinical Audit of Asthma and COPD (NCAP) Adult asthma Clinical Audit 2019/2020

Issues with data collection are ongoing due to long term sickness within the Clinical Audit Team which has significantly affected case ascertainment. Meetings have been arranged with the Clinical Audit Leads to address the issues moving forward. Due to the current situation of staffing and capacity within the Clinical Audit Team, this will take some time to address, and is likely to impact on case ascertainment. This is a long standing issue with lack or resource and the fragility of the clinical audit team.

Action Point
Investment in the clinical audit team features in the business case that is being submitted for patient Safety and Quality, which has been successful for an additional band 5 clinical effectiveness facilitator and will be put out to advert in April.

5. National Audit of Inpatient Falls, (NAIF)

The key messages were that it was necessary to assess older in-patients for factors that increase their risk of falling so that appropriate interventions and care plans are put in place. The risk factor which was most often assessed was continence with 74% of patients undergoing this component of the MFRA.

Vision and lying/standing blood pressure were the least often assessed with 44% and 35% of patients receiving this assessment respectively.

71% of patients were checked for injury before moving (compared with 69% in 2019); 26% of flat lifting equipment was used (compared with 22% in 2019) and 62% of patients were assessed by a medic within 30 minutes (compared to 69% in 2019).

Many in-patients experience delays to hip fracture care due to poor standards of immediate post-fall management. On average, it took two hours following the fall that caused the hip fracture for patients to receive the first dose of pain relief. NICE Clinical Guideline 124 recommends that analgesia should be given immediately. Less than 50% of delirium care plans and less than 75% of mobility plans were being followed at the time of the fall that cause the fracture.

Action Point
The CEC was advised that an action for the Falls Delivery Group was to recruit 1wte Falls Lead once the Patient Safety & Quality Team business case has been approved to commence post falls actions QI project and complete RCP Quality Improvement Collaborative project (orthostatic hypotension)

6. Fracture Liaison Service Database (FLS)

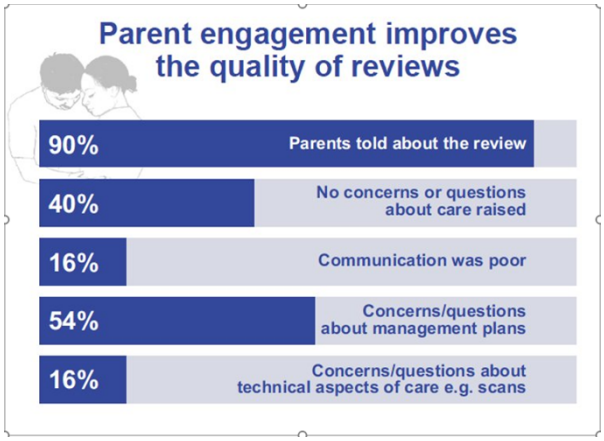
The FLS database annual report was discussed, the 2019/2020 benchmarking report showed deviation from standards at CAV. The Health Board has received a letter Welsh Government to provide a response regarding the results of the report and the actions being taken to address the issues. A part B (improvement plan) was submitted to WG in November 2021, the results of the actions taken would not be reflected until next year's report, and actions should be completed by April 2022.

Action Point
A response to WG has been prepared by the Executive Director for Therapies. An update on completion of actions to will be requested to update CEC, and a copy of the response for the records.

	Number of cases submitted		KPI 1 KPIs with >80% complete data (%)		KPI 2 Identification – all fractures (%)		KPI 3 Identification – spine fractures (%)		KPI 4 Time to FLS assessment within 90 days (%)		KPI 5 Time to DXA within 90 days (%)		KPI 6 Falls assessment done or referred (%)		KPI 7 Bone therapy recommended as appropriate (%)		KPI 8 Strength and balance commenced (%)		KPI 9 Recorded follow-up 12–16 weeks post index fracture (%)		KPI 10 Patient commenced bone therapy at 16 weeks (%)		KPI 11 Patient confirmed adherence to bone therapy at 12 months * (%)	
FLS name	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
The Ipswich Hospital NHS Trust	1946	1452	50	60	82	56	14	3	31	60	20	7	44	64	57	55	2	16	29	61	26	53	12	32
The Northern Care Alliance – Bury Community Services		394		80		11		12		48		3		66		78		0		10		4		
The Northumbria Hospital (NSECH)	1458	1339	100	90	41	34	3	2	93	91	81	44	7	22	32	38	3	28	49	47	32	14	46	45
The Rotherham NHS Foundation Trust	890	702	80	90	74	50	51	34	48	49	41	4	30	19	58	71	*	0	7	2	5	1	7	0
University Hospital Lewisham	308	339	80	90	39	43	8	11	73	84	79	38	20	38	28	17	*	3	68	31	53	24	37	42
University Hospital Llandough	782	525	60	60	29	19	5	0	100	100	*	2	46	31	69	79	2	1	25	12	16	7	81	68

8. National Audit of the Perinatal Mortality Review Tool (PMRT) Learning from Standardized Reviews when Babies Die

This is a national clinical outcomes review programme. The report reflected national themes and recommendations. Obstetric and Neonatal leads provided information on their position against the published report and demonstrated that the health board has made significant advances in recent years to establish a multidisciplinary approach to reviewing all perinatal morality cases. The collaborative monthly meetings include a wide variety of health professionals, the electronic tool is completed during the multi-professional forum. As in the previous report an area identified for improvement is in relation to having an external member present for review of the cases, due to the nature of Maternity/Obstetric care being very specialised, obtaining an external view can be challenging. Progress has been delayed the perinatal mortality review forum and the Maternity and Neonatal Network in advancing this work, However, work is expected to be revisited, and consideration of an reciprocal All Wales arrangement is being evaluated. The issues highlighted in the national report is summarized below, please note, Cardiff and Vale Specific data is not available for this report.



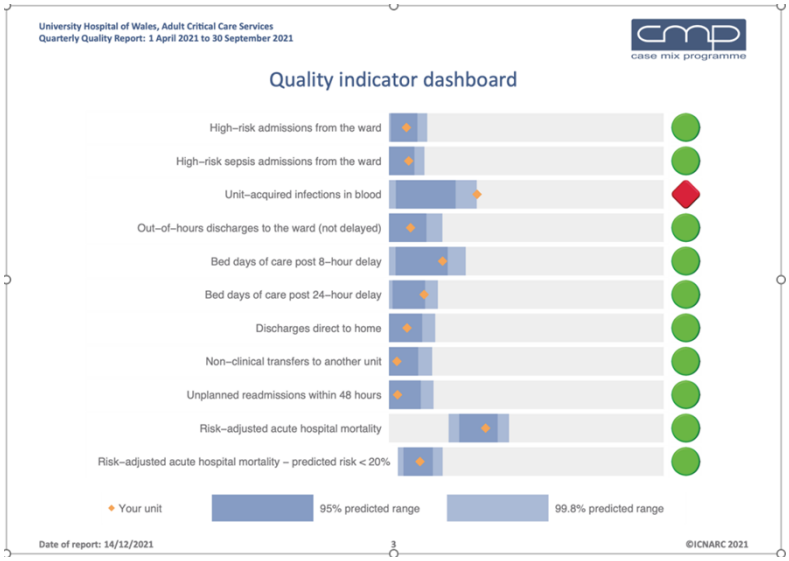
Action Point
To update CEC in 6 months with progress of work with the maternity and neonatal network in achieving external oversight.

9. National Vascular Registry : Developing and implementing implantable medical device capture for aortic aneurysm repair

It was identified that there are significant data collection and quality issues in this report.

Action Point
The clinical team has been contacted to discuss the audit and a Clinical Lead has bene invited to attend the May Clinical Effectiveness Committee meeting.

10. Intensive Care National Audit and Research Centre (ICNARC)
01.04.21–30.09.21 data has been collated, the data identified Cardiff and Vale as an outlier in comparing with comparable units for unit-acquired infections in blood. Data was also high for length of stay for Adult Critical Care. Cardiff and Vale length of stays are longer than national data; this partly reflects the problem discharging patients when medically ready. Sicker patients who survive will have longer stays. Our unplanned re-admission rates, however, are low.



b. Clinical /Audit Leads Presentations

1. National Diabetes Quality Programmer Peer Review

The NDQP Programme is an integrated programme which is built on other initiatives in paediatric diabetes and helps various other teams in paediatric diabetes across England and Wales to transform the way organisations work together, share good practice and improve outcomes for children and young people. The Programme is centrally managed by the Royal College of Paediatrics and Child Health and has the support of the eleven regional paediatric networks, of which Wales is part of.

Assessment was carried out around MDT, hospital and core measures. Two serious concerns were identified; dietetic resource and timely provision of pump therapy, which was a resource issue rather than a finance issue. Several achievements were noted; The MDT worked well together to achieve their mission statement 'working together; supporting expertise and a life without barriers'. Also the Peer Review Team interviewed patients and parents and it was noted that there was dedication to children, young people and their families which was appreciated by the patient and parent representatives and was further supported by the PREM 2019 results; patients and parents rated high overall satisfaction. A noticeable theme that arose was of collective and proactive working within the MDT to overcome challenges and provide a consistent approach. Through the pandemic no clinics were cancelled.

Serious concerns were raised around: Inadequate specialist dietetic time; 1wte for 22 patients, and the availability to deliver the requirements of a paediatric diabetes services and to meet the NDQP measurements; Patients waiting for up to twelve months – for pump therapy to be initiated as a result of the staffing pressures across the MDT which meant the pump service could not be safely delivered; Transition services – may reach the threshold of serious concern.

There was a steady improvement in HbA1c and highest completion of all care processes both regionally and nationally. A business plan has been submitted but, was unsuccessful,

Action point
An actions plan is in progress and the issue has been added to the Clinical Board risk register and will return to update the CEC in August 2022

2. **Diabetes Surgical Data**

Diabetes UK – making hospitals safer for people with diabetes 2017 report. One in six hospital beds are occupied by someone with diabetes. Problems that arise are: higher infection rates; increased length of stay by 1-3 days; increased mortality – 6.4% higher. The National Diabetes Inpatient Audit shows that 18% of in-patients have diabetes.

CPOC Surgical Peri-op Diabetic Surgical guidelines for elective and emergency surgery March 2021 in collaboration with Diabetes UK have been looking at the peri-operative pathway. This includes referral, before surgery, individualized plans, admission, theatres, and return to ward and discharge.
A review of several reports, national and local audits were measured against standards, where Cardiff and Vale UHB require improvement. Miss-management or lack of optimal care in diabetes patients increases the risks of requiring hypoglycaemia rescue, DKA, HHS, and DFU as well as increase risk of infection and longer inpatient stays.

The review took a whole systems approach of national and local reports, data and local audit, highlighting multifaceted issues, which included lack of staff knowledge and training of management of diabetic patients with hypoglycaemia in perioperative care, lack of Diabetic Specialist nurses and inadequate systems and process to identify and ensure appropriate care for diabetic patients undergoing surgery.

Action Point
Actions are in progress including work on 'theatreman' and revising the WHO checklist, updating the diabetes information on clinical portal and connecting with Primary care CD regarding healthcare pathways. To return to CEC in 6-12 months with progress. If issues not resolved to contact CEC Chair in the meantime.

3. **Orthopaedic Peer Review for Knee Replacements – Surgery Clinical Board**

The BOA carried out a Peer review of knee Replacements in Cardiff and Vale UHB They interviewed all of the surgeons, some trainees, management, theatre staff and nursing staff over four days. The committee was advised that currently every surgeon who carries out joint replacements has to register the procedure on the national database, including grade. Every year a comprehensive report is produced for individuals, units and regions etc. which includes graphical representation of performance for partial knee replacements and total knee replacements. Any members of staff e.g. fellows, registrars within the Consultant's team will have their details recorded under the Consultant's data.

One of the criticisms of the NJR is that the only measurement they have is the end point. There may be a need to re-operate on a knee replacement. It is called a revision knee replacement, which may occur for lots of different reasons e.g. could be infected or fractured.

The NJR have reported that Cardiff, as a unit, has become an outlier. The chance of needing a revision or being revised in Cardiff is higher than the average, which was felt to be for a variety of reasons

Action Point.
An action plan has been submitted and was discussed in the meeting. The Clinical Board directors and Clinical leads will be invited back to update the CEC with the progress of the action plan in 6 months.

4. **Dermatology Peer Review Action Plan Update.**

The Improvement plan has been progressing well and a significant amount of work had already been accomplished by the team.
Further support required on two points:
1. Primary Care engagement to support minor skin surgery in GP's. Some GP's keen to get on board with this. SLA to be finalised.
2. Teledermascopy project. Scheduled to commence later this year. Pilot undertaken last year. Low risk patients who we could potentially diagnose via Teledermascopy; 60-70% discharge rate.

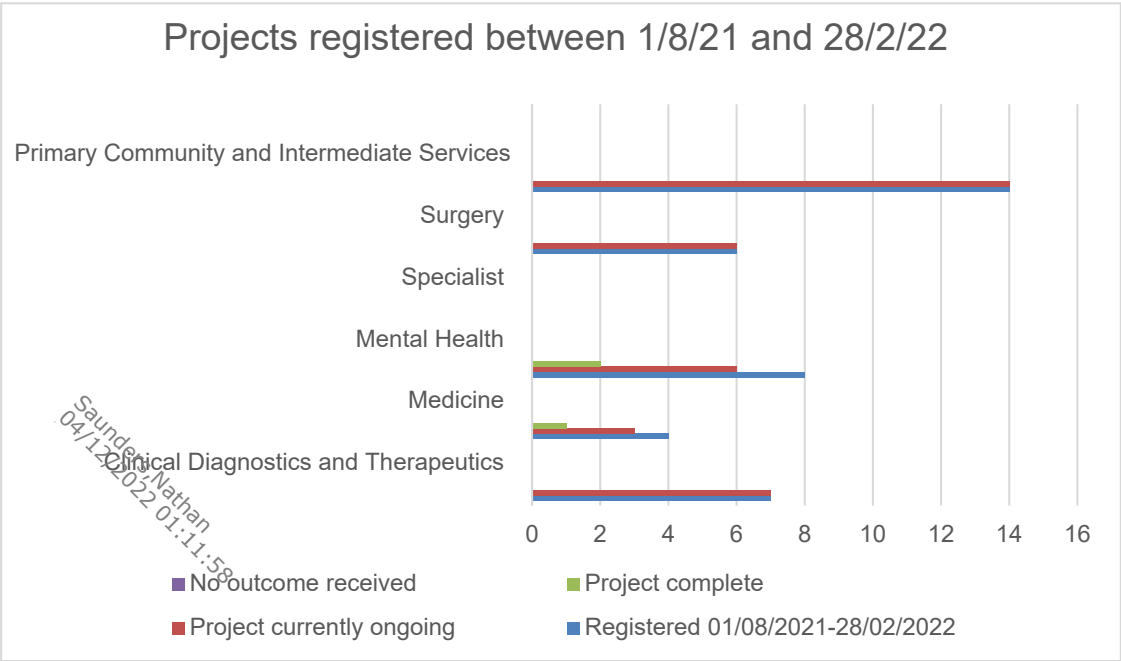
Action Point
Further discussions will be head with the Directorate Finance group moving forward.

c. Tier 2 patient safety Priority Audits

Currently the clinical audit team are unable to support any local clinical audits due to capacity, the clinical audit team register the audits that are submitted by clinicians, the IT system is very old and is wholly dependent on clinicians notifying the clinical audit of continuation, completion or disbandment of the audits to update the database, audits are often left open with closure as the information cannot be captured, as there is no capacity to follow up with the audit leads. The limited information available suggests that the findings may not presented or the quality of the data reviewed, no assurance can be provided that improvement plans are developed from the audit recommendations and taken forward.

There is a significant risk that data protection polices and guidance are not adhered to as appropriate authorisation for the audits are often either not sought for or not evidenced when registering the audit. In addition, many of the clinical audits that are undertaken within directorates are not registered raising further, quantifying this is challenging as the unregistered audits are identified by chance.

The chart below reflects the issues with the number of Clinical Audits being registered with the Clinical Audit Department – The implementation of AMaT is expected to transform this process as well as other aspects of Quality Assurance and Clinical Effectiveness and will address many aspects of the Internal Audit on the health boards Clinical Audit arrangements which gave limited assurance.



Action Point
A business case was submitted to BCAG and funding for the AMaT audit and improvement management system has been improved, and an additional Clinical effectiveness facilitator to support the project role out. A phased approach will be taken over a 12-month period to roll out the system across the organization. Clinical Boards have been asked to develop an Annual Clinical Audit Forward Plan for 2022/23

d. NICE & Health Technology Wales
Published Nice guidance and HTW have been shared with the clinical boards and directorates for action or information. There has been delay on sharing some guidance as a result of tea, capacity and sickness and recruiting process to fill the Quality Assurance Assistant post, the back log is currently being addressed. The level of responses remains poor and varies between clinical boards Implementation across the Heath Board is 26% of those that had responded only. Where a response had been received, no evidence of implementation is provided which is a flaw in the current process. There are significant challenges associated with the current system and process in place for providing assurance against NICE and HTW implementation.

A bid for investment in the AMaT audit management system has been successful. A more robust process can be implemented to ensure that evidence is provided of implementation of NICE and appropriate actions taken where NICE has not been implemented to mitigate against any potential risk.

The HTW Adoption Group has commenced and preliminary meetings have taken place with the Cardiff and Vale Associate Medical Director and Head of Patient Safety and Quality Assurance in attendance. Peter Groves was invited to present on implementation of NICE and HTW on the Grand Round to medical staff, but unfortunately this had to be canceled due to Organisational pressures and severe weather warnings.

Action Point
A business case was submitted to HTW for funding for project support for the implementation of AMaT which was successful and will allow for a years fixed term role for a band 5 clinical effectiveness facilitator which is being processed through TRAC.

e. Patient Safety Notices – Discussed in CEC

- Patient Safety Notice – MRI scan room oxygen cylinders, discussed further with CD&T Clinical Board e-learning module in place.
- Patient Safety Solution PSA008 – NG tube training for medical staff. A letter has been sent to Welsh Government and HEIW – The Delivery Unit is now taking the lead on an All Wales approach. – Action is with NHS Wales to progress.
- Patient Safety Solutions PSN040 – Compliance with adding flushing of lines following anaesthesia to the WHO checklist. Recent SI with investigation in progress, investigating officer and clinical board to present findings at September CEC meeting – Line flushing added to WHO checklist.
- Neuraxial Connector Roll-Out across Wales – PSA003 and PSA007

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:

Clinical Effectiveness Committee

Raj Krishnan, AMD Safety and Governance

Angharad Oyler, Head of Quality Assurance

GIG CYMRU NHS WALES

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

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

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

Board

QSE Dashboard/Signals from noise

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Organisational Learning Committee

Clinical Safety Group

- Pressure Damage
- Medicines Management
- Medical Devices
- Dementia
- Falls
- Nutrition and Hydration
- Surgery
- 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

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

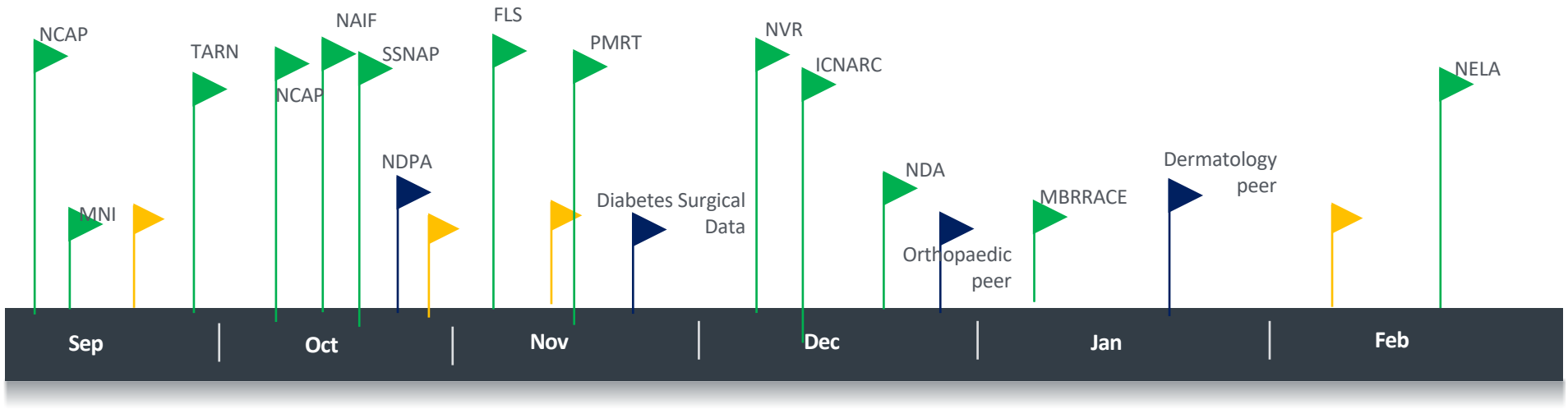
Commissioning – IPFR, Commissioning LTAs, Third Sector

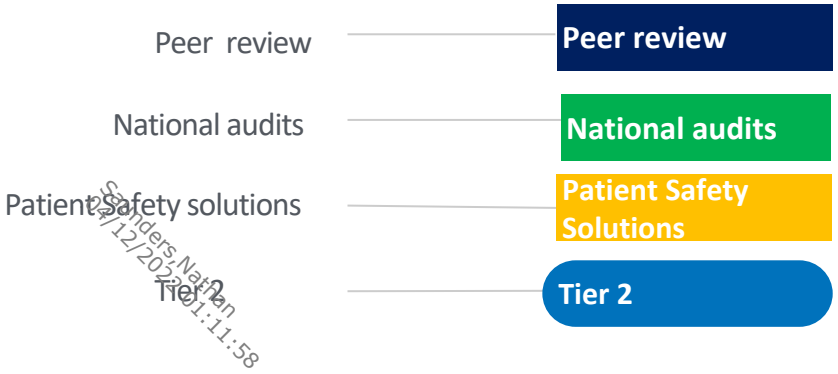
SI/Concerns

- 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 Quality, Safety and Experience Groups

Across the Healthcare system





Summary

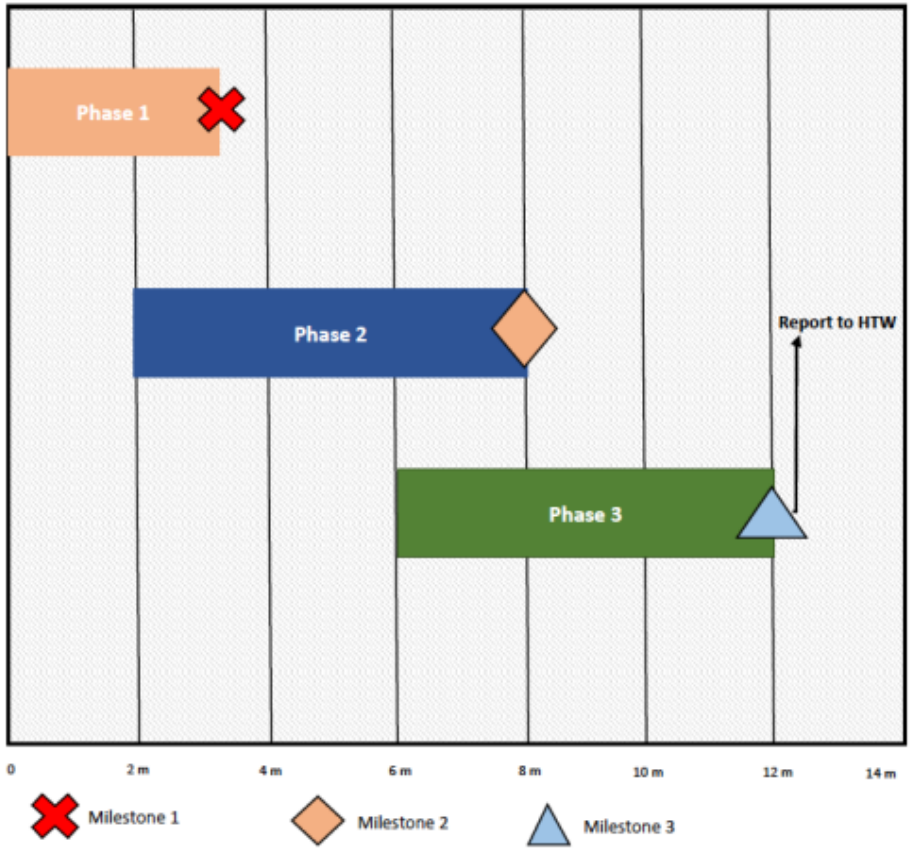
Clinical Effectiveness Committee	
◆ Local Clinical Audit	✓
◆ National Clinical Audit	✓
◆ NICE	✓
◆ CEPOD	✓
◆ Accreditation	✓
◆ External Peer Reviews	

AMaT

Audit Management and Tracking

External funding obtained

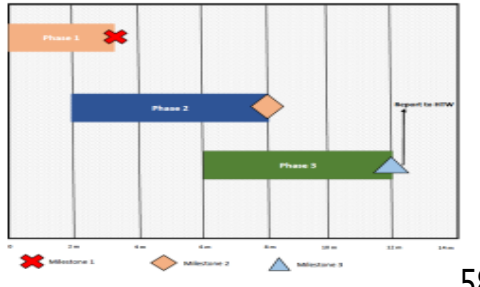
Technoleg Iechyd Cymru
Health Technology Wales



Phase 1 (0 – 3 months)

- Induction session for the Corporate Patient Safety and Experience team (the CEC is part of the Safety team).
- Introduce the Performance indicators to all the Clinical Boards.
- AMaT is introduced to two clinical boards a) Women and Children's and b) Specialist Clinical Board.
- The CEC team to work closely with the above two boards.

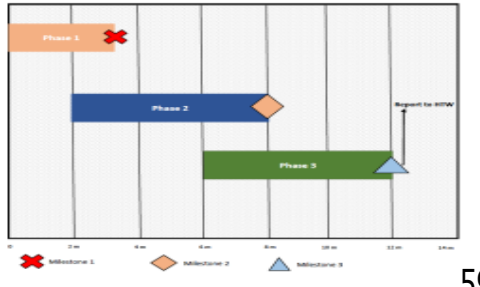
Key Milestone 1: Compliance seen from the two Clinical Boards with regards to the performance indicators.



Phase 2 (2 – 8 months)

- AMaT is introduced to further three clinical boards a) Surgical Clinical Board, b) Mental Health and c) Primary, Community, and Intermediate care.
- The CEC to work closely with the three boards.
- Monitor progress achieved in boards enrolled in Phase 1.
- Identify early adopters and enablers so their help could be sought to assist areas struggling with adoption.

◆ **Key Milestone 2: AMaT is used to monitor compliance with all the assurance activities in the monthly CEC meeting.**



Phase 3 (6 – 12 months)

- AMaT is introduced to further two clinical boards a) Medicine Clinical Board, and b) Clinical Diagnostics and Therapies.
- The CEC to work closely with all the Clinical Boards.
- Monitor progress achieved in boards enrolled in Phase 1 and 2.

△ **Key Milestone 3: AMaT is part of the Corporate Quality, Safety and Experience meeting. All assurance activity across the Health Board to be monitored by AMaT. Project report to be submitted to HTW**

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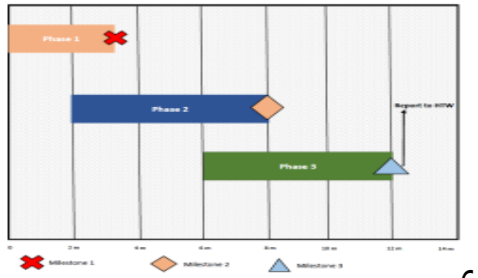


Key Performance Indicators

Ref	Key Performance Indicators	Rational/comment	Data source	Measure	Target
1	All national guidance (NICE/HTW) are forwarded to the relevant Clinical team for implementation	To identify the number of guidance send to clinical teams	NICE and HTW alerts	Percentage of guidance send to clinical teams within 4 weeks of publication	100%
2	Number of guidance (NICE/HTW) implemented in clinical areas	To identify the number of guidance implemented (compliance)	NICE and HTW alerts	Percentage of guidance implemented in Clinical areas within 3 months of publication	60-80% (1st year) 80-100% (from 2nd year)
3	Identify the mandated National audits that are reported	To identify the number of National Clinical audits	Healthcare Quality Improvement Partnership (HQIP)	Percentage of reports discussed in the CEC within two months of publication	100%

Key Performance Indicators

4	**Identify the organisational outlier status in the national audits**	**To identify the themes and trends for the outlier status in national audits**	**HQIP**	**Number of metrics falling out of the defined standards in national audits**	**Number of teams invited to discuss their outlier status within 3 months after the report has been published**
5	Monitor compliance of all the Patient safety alerts and notices	Identify clinical areas compliance with patient safety solutions	Welsh Government and NHS Wales Delivery unit	Achieve compliance within the stipulated period mentioned in the alert or notice	100% within the stipulated time
6	Discuss peer review report and have action trackers developed to monitor compliance	Identify compliance status	Report from the peer review body	Peer review reports to be discussed and action trackers developed	Number of peer review reports discussed and to develop action tracker within 3 months of publication

Report Title:	Update on Falls in Lakeside Wing			Agenda Item no.	2.4
Meeting:	QSE	Public	X	Meeting Date:	12/04/2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information ✓
Lead Executive:	Ruth Walker, Executive Nurse Director				
Report Author (Title):	Tara Cardew, Interim Head of Patient Safety / Patient Safety and Organisational Learning Manager (Falls Lead)				

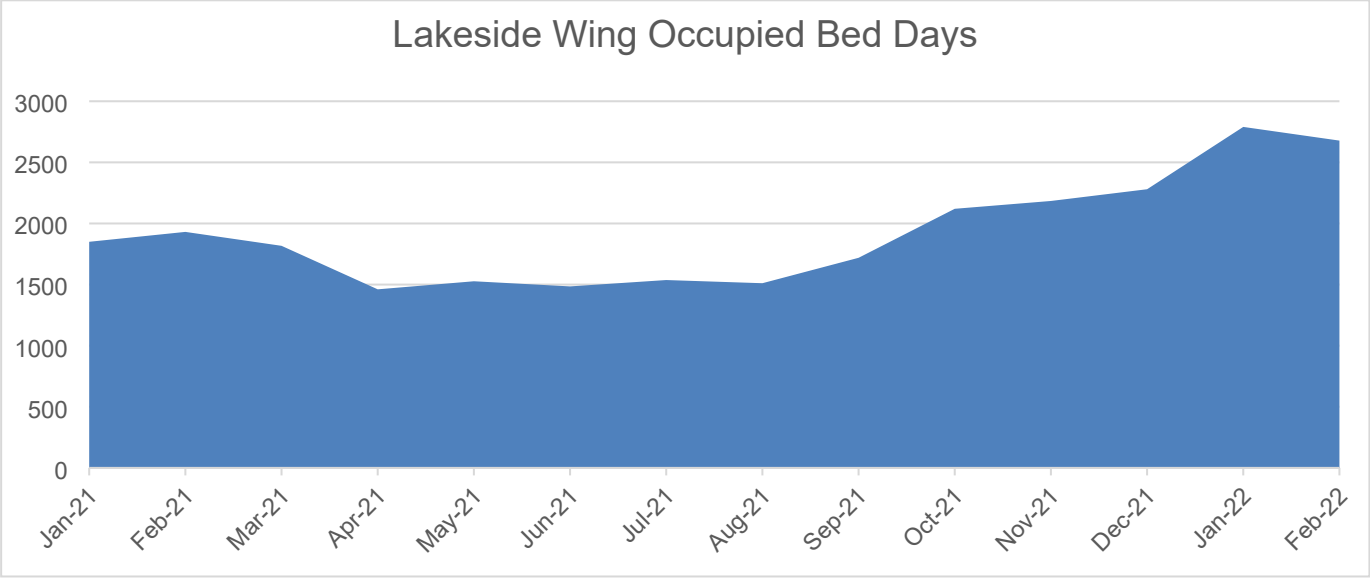
Main Report
Background and current situation:

Lakeside Wing was erected in the grounds of the University Hospital of Wales, opening in January 2021 as a result of operational pressures experienced during the Covid-19 pandemic. Lakeside initially accommodated a Trauma and Orthopaedic ward as well as wards for older patients awaiting discharge. It was agreed that the patient profile for Lakeside would be ambulatory patients awaiting discharge.

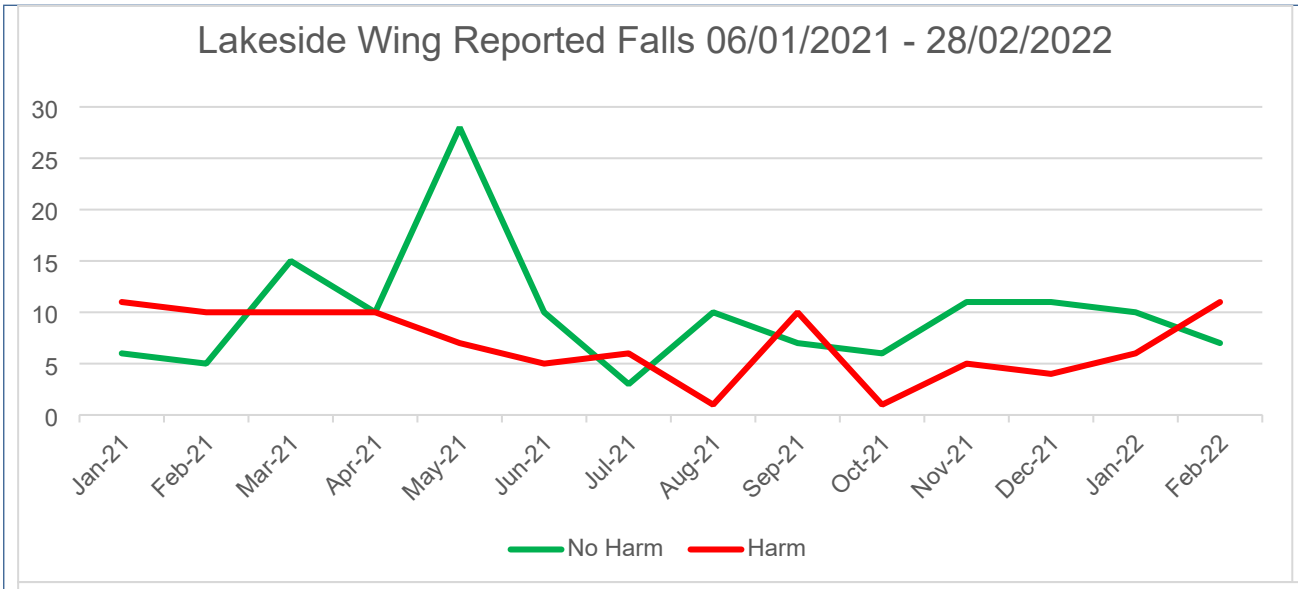
Shortly after opening, an excess of reported incidents were reported which led the Executive Nurse Director to visit the unit and request additional review to understand if further action was required to support staff in providing safe care. This took the form of an internal inspection which reviewed factors such as patient experience and provision of care, staff well-being, IP&C, environment and documentation. A number of recommendations were made following this inspection.

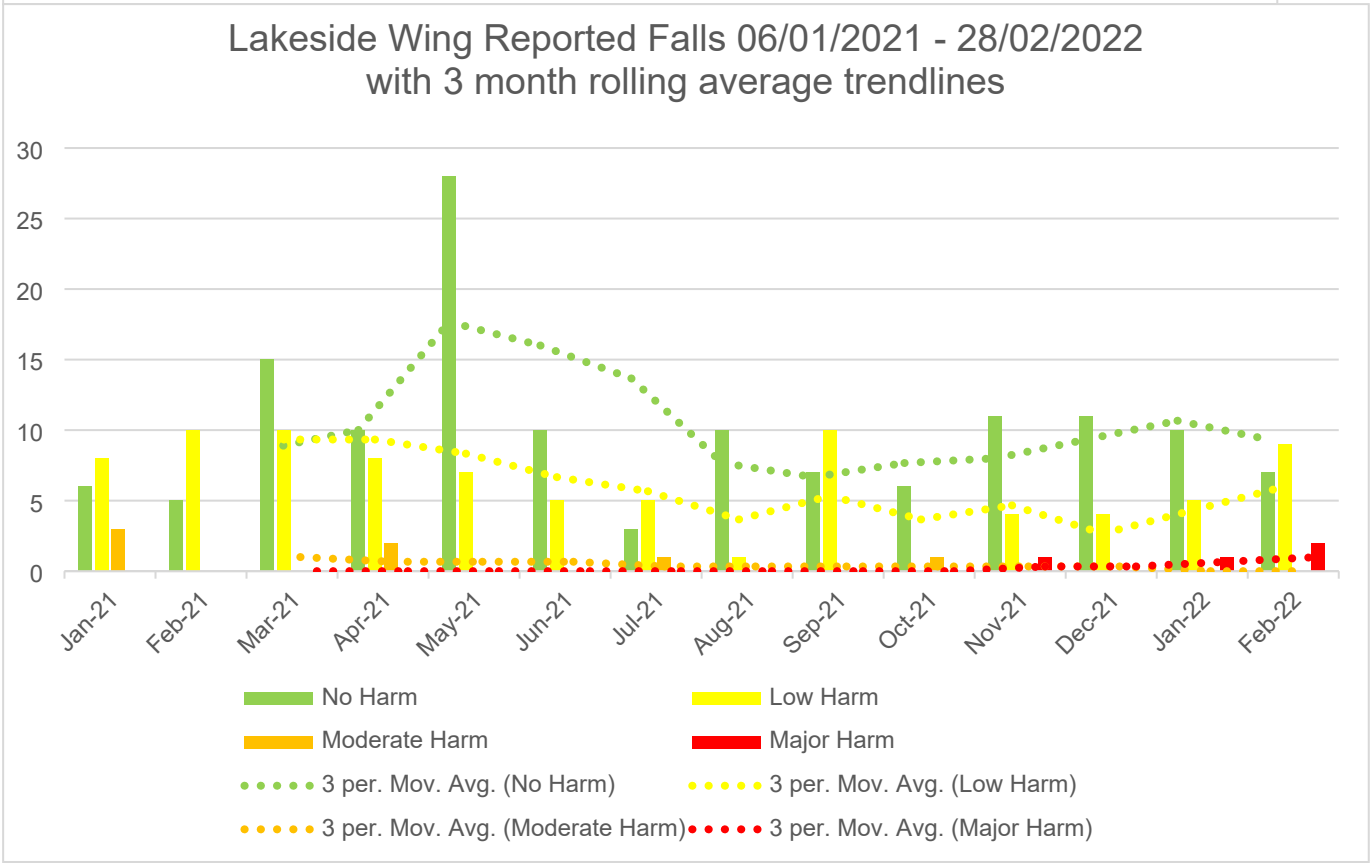
In early 2022, a further increase in falls related clinical incidents prompted a request for a thematic review to identify any learning or actions which could be implemented.

The number of occupied bed days at Lakeside has increased since the facility opened:



Clinical Incident information has been gathered from the Datix reporting system between January 2021 and the end of February 2022. The numbers of falls incidents is as follows:





The above two charts show that the 'no harm' falls are reducing, whilst those with attributed harm are rising. This data must be viewed with caution as the numbers in isolation do not give a true picture. The national mechanism for reporting falls is per 1,000 occupied bed days. The chart below shows this information for Lakeside Wing since opening:

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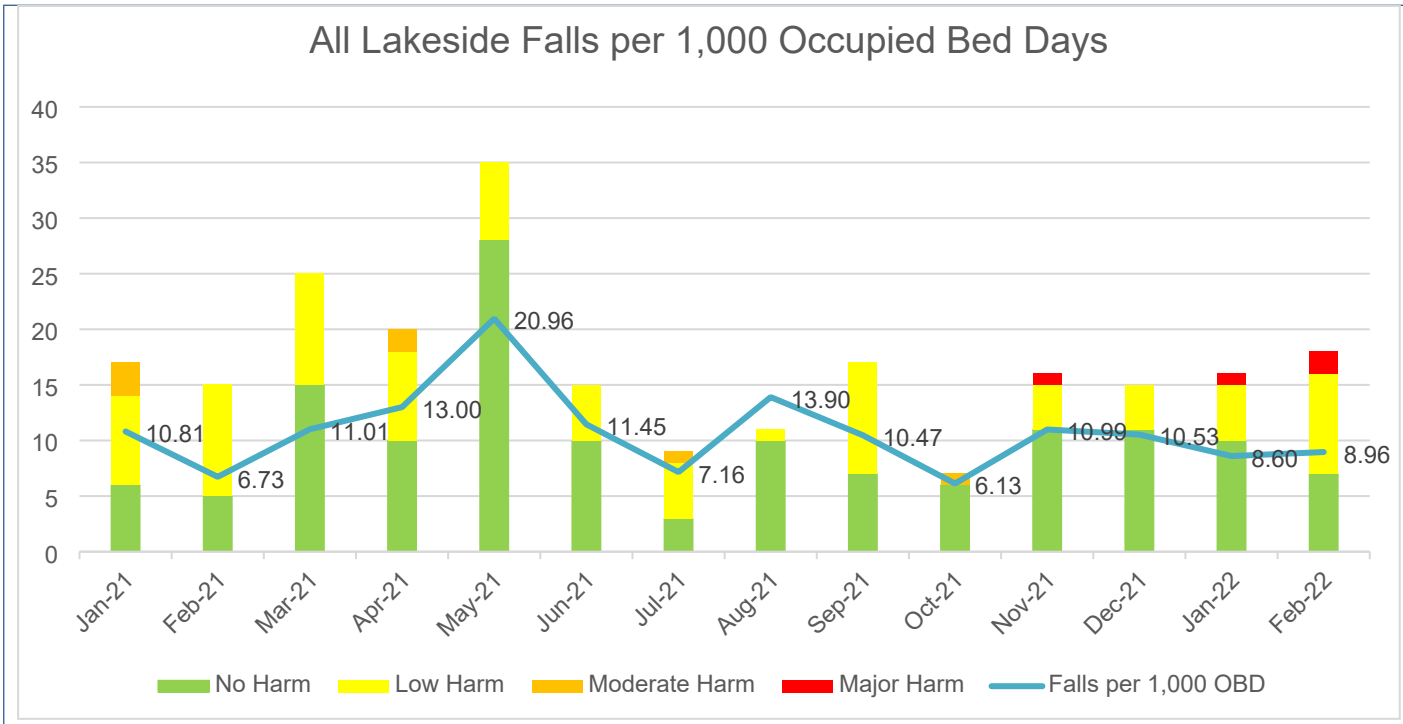
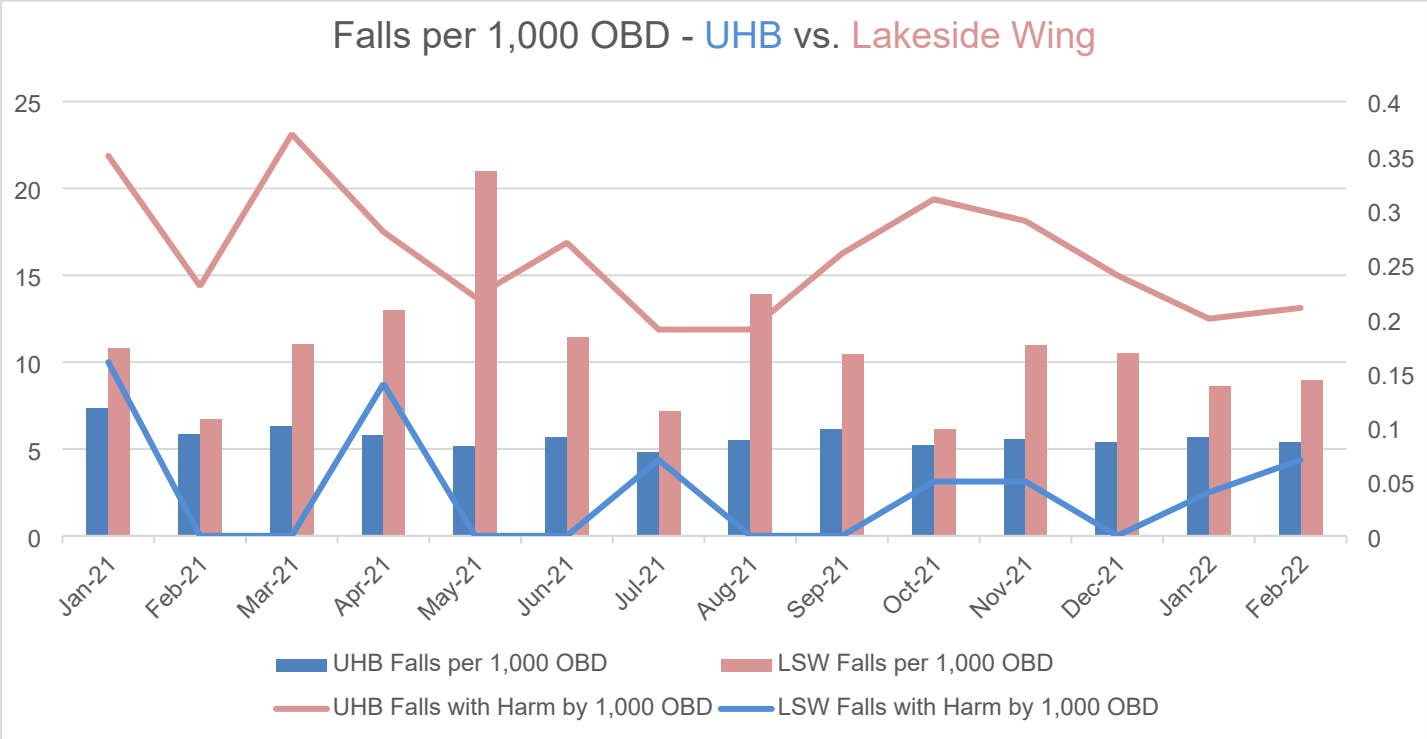
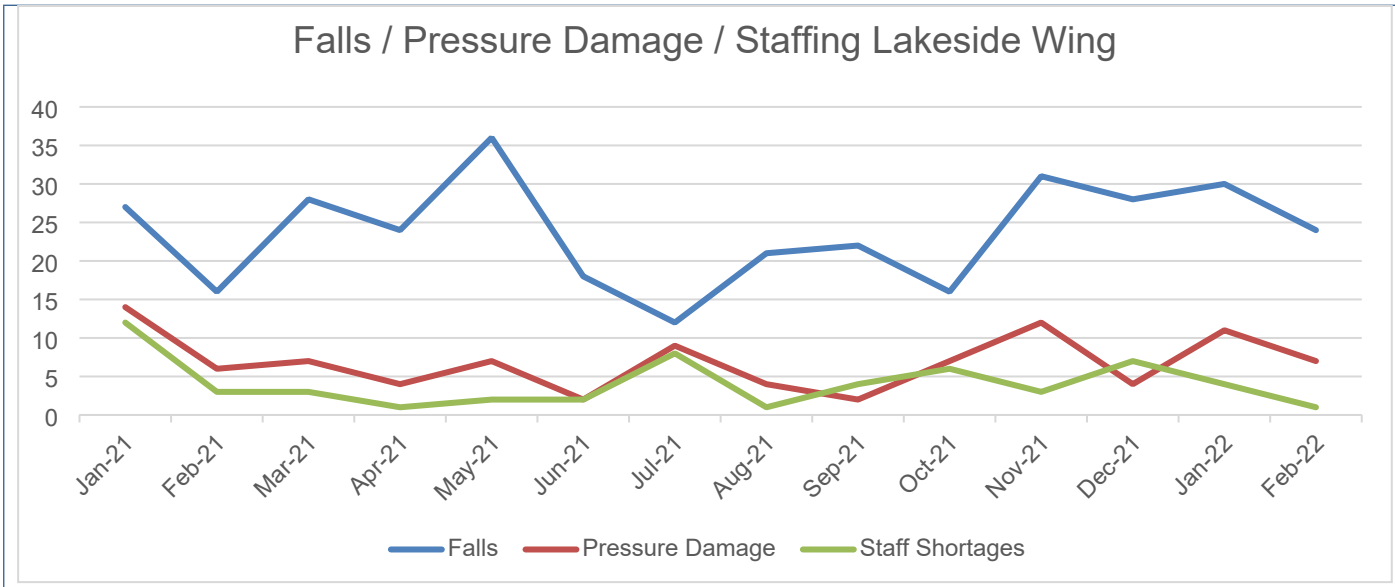


Compared to the UHB-wide dashboard and the data for Medicine Clinical Board showing falls per 1,000 OBD, the rates of all falls on Lakeside Wing are higher although the falls with harm are lower. Although it appears that there has been a cluster of injurious falls in the last few months, these have occurred at the same time there was an increase in the bed occupancy. Acuity measurement would have been helpful, however this information has not been recorded by Medicine Clinical Board due to operational pressures.



It has not been possible to accurately collate trends relating to staffing or acuity levels, however a reported incident comparison is detailed below. There is a concern that not all staffing issues are reported via Datix, as anecdotal information does not correlate with the low reported numbers in this graph.



Since Lakeside Wing opened, there have been some falls incidents with issues relating to the design of the building;

- The beds used in Lakeside were originally purchased at the height of the pandemic to use in Dragon's Heart Hospital and were of a different design to the UHB bed contract with different bedrails and operating heights
- Staff reported difficulties with visualising patients with enhanced observation requirements due to the layout of the wards
- Staff relocated to work on Lakeside Wing were often not experienced in the care of older, frail patients.

A thematic review of injurious falls on Lakeside Wing reveals:

- Insufficient staffing
- Staff not trained in the use of flat lifting equipment (Hoverjack), or did not request Hoverjack to be brought from UHW site.

Actions taken to address;

- There has been a significant focus on manual handling training since November 2021– all new starters will receive this as part of their induction. All current staff have now attended or are booked on to attend manual handling training.
- Focus on dementia training for LSW staff to improvement awareness and management of this group of patients.
- There has been a reliance on temporary staffing to manage the staffing shortfalls on LSW which has the added challenge of staff not being trained in manual handling for the hoists used within Cardiff and Vale. Since the closure of one of the wards, the staffing situation has improved increasing the number of substantive staff per ward.
- There has been a recruitment drive to improve the HCSW position, now all band 2 vacancies have been filled.

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

There is a proportionally higher rate of falls in Lakeside Wing compared to the rest of the UHB. This report provides clarity on why this picture is emerging and the action being taken.

Recommendation:

The Committee is requested to:

Note the position and discuss the actions being taken to improve the current status.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	Y	6. Have a planned care system where demand and capacity are in balance	Y
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		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	Y
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
An increase in injurious falls can have a significant impact on patient's length of stay. The nature of the patients in LSW increases their risk of falls however we know anecdotally that staffing levels there are lower than on acute wards. This increases the risk of patient falls.
Safety: **Yes**/No
Increasing falls rates increases the risk of injurious falls.
Financial: **Yes**/No
Increased injurious falls has an impact on length of stay, additional surgery required and potential claims.
Workforce: Yes/No
n/a
Legal: **Yes**/No
Increased claims ad litigation can result from injurious falls.
Reputational: **Yes**/No
Increased risk to our frail patients can have an impact on our organizational reputation
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:

Report Title:	Healthcare Inspectorate Wales Activity			Agenda Item no.	2.5
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	12 April 2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval		Information
Lead Executive:	Ruth Walker, 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/inspections carried out by Healthcare Inspectorate Wales (HIW) since the last over-arching report to the Committee in December 2020. The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

HIW is the independent inspectorate and regulator for health care in Wales. The core role of HIW is to review and inspect the NHS and Independent Healthcare organisations in Wales so that assurance can be given to patients, public, Welsh Government (WG) and healthcare providers that services are safe and of good quality.

Inspections are a means of providing assurance that services are meeting the Health and Care Standards (2015) and are meeting any other relevant professional standards and guidance. Inspections are a structured process and are underpinned by the view of Francis (2013), who emphasised the importance of undertaking direct observations of a service and care provided. Unannounced inspections undertaken by HIW allow them to see services in the way they usually operate and focus on the following themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership
- Delivery of a safe and effective service

Unannounced Inspections

Two unannounced inspections have taken place in March

- Cardiothoracic services - UHL
- Mental Health services - UHL

Provisional feedback from both inspections were overall very positive. More detail will be shared with the QSE committee when the reports have been finalised.

Quality Checks

No Quality Checks have taken place since the last HIW activity paper to QSE committee

Update on Thematic Reviews

Mental Health Crisis Prevention in the Community

The Mental Health Crisis Prevention in the Community report has recently been published. The review found challenges across Wales inhibiting the ability of people to access timely mental health support. The absence of timely care or support when a person encounters a crisis in their

mental health may lead to an increase in risk to their safety (or to others), which may result in a hospital admission or at worst; self-harm, suicide attempts or loss of life.

HIW found that those working within healthcare, emergency and third sector services and across Wales are committed and dedicated to providing support and care to people with mental health needs. It is clear that the various professionals working in primary care, community and emergency services, and also the third sector take great pride in what they do to support people with their mental health needs.

A key issue highlighted by the review is the difficulty surrounding direct referral into services. This can result in an individual being caught in a cycle, having to access their GP repeatedly in order to re-commence the referral process.

The review recognised that the referral processes can be complex, leading to potentially lengthy waiting times, during which, individuals lack sufficient support. The review noted several positive initiatives across Wales, including the implementation of a single point of access. Where this was in place, it ensured that specialist mental health professionals were available to provide clinical triage, onward referral and effective signposting to individuals in crisis.

The report makes 19 recommendations for improvement. Health Boards will be expected to consider these and begin formulating an action plan in response to these recommendations.
HIW will contact the Health board in the coming weeks regarding the actions developed in the improvement plans to address the issues identified in the report.

National Review of Patient Flow (Stroke pathway)

HIW have commenced a National Review of Patient Flow (Stroke Pathway). The review we will explore:

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

It will also explore:

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

HIW will visit Cardiff and Vale UHB on the 14 -16th of March and staff interviews will take place 17th to the 25th of March.

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

Review of Maternity Services in Wales – Remains on hold.

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

HIW have resumed routine NHS onsite inspection work. Following the move to alert level 0 across Wales on 28 January 2022, and the general decreasing trend in rates of COVID-19, all routine NHS onsite inspections have resumed as normal. HIW will continue to risk assess every piece of work that is planned and will continue to provide around 24 hours' notice for 'green', and elective, scheduled pathway inspections.

This allows opportunity for HIW to communicate with NHS staff and for arrangements to be put in place so that the inspection can be undertaken safely. The expectation is that this will be the approach for all inspections that fall into this category, however, HIW still reserve the right to operate in a fully unannounced way where it is determined there to be an extremely high risk to patient safety as a result of the way a service is operating. The position will be continually reviewed

The HIW work programme for independent healthcare settings and dental practices remains unchanged and they will continue to review their work programme and ensure it is proportionate given the ongoing pandemic situation.

Recommendation:

The Committee is requested to:

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

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
04/12/2022 01:11:58

Report Title:	**Board Assurance Framework – Patient Safety**			Agenda Item no.	2.6
Meeting:	Quality, Safety and Experience	Public	x	Meeting Date:	12th April 2022
		Private			
Status *(please tick one only)*:	Assurance	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 Patient Safety risk on the Board Assurance Framework which links specifically to this Committee.

There are currently ten key risks on the BAF, agreed by the Board in May 2021, which are impacting upon the Strategic Objectives of Cardiff and Vale Health Board. Patient Safety is one of those key risks and specifically identifies:

'There is a risk to patient safety due to COVID 19 Recovery, increased demand of unscheduled care patients, sub optimal workforce skill mix, current EU pressures and inability to segregate patient'.

It is good practice for Committees of the Board to also review risks on the BAF which relate to them. The role of the Committee in relation to the risk is to review it, check that the controls are in place and working and agree any further actions required in order to mitigate the risk. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time. The Executive Director Leads for this risk are the Executive Medical Director, the Executive Nurse Director and the Executive Director of Therapies and Health Sciences.

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 risk (last considered by the Board in March 2022) is considered to be a key risk to the achievement of the organisation's Strategic Objectives. This risk has been adjusted to take into account recovery and the impact on patient safety this will bring.

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

Recommendation:

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

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:

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

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

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within A&E. Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to post Covid 19 recovery. Due to the ability to balance risk in the community in transferring patients to EU Due to the current pressure in EU and inability to segregate patients due to the volume in the department		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care during COVID 19 creating both longer and ageing waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, higher death rate. The Omicron variant is having a significant impact on staff availability (see separate risk on workforce)		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Spire Hospital • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Implementation of Organisation and Transformation centres to focus upon patient flow within hospital sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21		

Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (2) • CAHMS position reviewed at Strategy and Delivery Committee (2) • Mental Health Committee aware of more people requiring support(2) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments		
Gap in Assurances	Discharging patients is out of the Health Boards control		

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

Report Title:	**The Nuffield Report on Cancer Services in South East Wales - Update**				Agenda Item no.	2.7	
Meeting:	**Quality and Safety Committee**	Public	x		Meeting Date:	12.04.2022	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		x
Lead Executive:	**Executive Medical Director**						
Report Author (Title):	**Head of Strategic Planning** **Assistant Medical Director (Cancer Services)**						

Main Report
Background and current situation:

Velindre University NHS Trust (VNHST) is a specialist provider of cancer services in South East Wales and runs the Velindre Cancer Centre. In 2020 it commissioned a report as the Nuffield Trust to provide independent advice on the integrated regionally networked model including analysis and assessment of the benefits and risks of the proposed model of networked cancer care in South East Wales.

In December 2020 they published its findings *'Advice on the proposed model for non-surgical tertiary oncology services in South East Wales'.* A copy of the report is publicly available and can be found here.

The report's findings were subsequently accepted by the Velindre Board and partner organisations, including Cardiff and Vale UHB (CAVUHB).

The report made 11 recommendations which are summarised **annex 1**.

The recommendations broadly fall into three categories-

I. Recommendations for VNST to progress
II. Recommendations for VNST to progress in collaboration with regional Health Board Partners collectively.
III. Recommendations which require a joint response between VNST and a specific Health Board partner.

The focus of this report is on category two and category three (the actions which require progression between VNST and CAVUHB).

Recommendation 3: Activity Benchmarking, Oncology Advice for Unscheduled Care and AOS

Recommendation 4: Revise Velindre Cancer Centre Admission Criteria

Recommendation 5: Research Hub at University Hospital Wales

Recommendation 6: Expansion of Haemato-oncology Clinics and provision of wider Diagnostic services

Recommendation 7: Velindre @ Operating Model

Recommendation 10: Future proofing' and University Hospital Wales 2

A Collaborative Cancer Leadership Group (CCLG) shared by the CEO of CAVUHB meets quarterly and consists of Executive level Officers across South East Wales to provide oversight and leadership in regards to the Cancer services in South East Wales and implementation of the Nuffield report.

A CAVUHB / VNHST Executive partnership forum is established to drive forward the specific collaboration agenda between the two organisations.

Under the Executive Partnership forum exists a Velindre@UHW Programme Delivery Board and respective programme workstreams.

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

Annex 2 provides an overview assessment as to (i) Progress which has been made to date (ii) key next steps for the 2022.

There is continued recognition and acceptance that the Nuffield report is recommending the right things for the Health Board and the Health system across South East Wales to focus on. However, there is also the recognition that the Nuffield report was published at a particularly challenging time- mid pandemic meaning that the degree of focus which the organisation would wished to have placed on the agenda, whilst good, could have been even better.

As we begin to emerge for the pandemic both the Head of Strategic Planning and the Assistant Medical Director (Cancer Services) have undertaken an exercise both internally and with VNST colleagues to understand how, as a Health Board, we refocus on the next steps which are required.

Some of the key messages which have been heard from clinicians across this agenda include recognition that now is the perinent time to;

- Revist some of the key programme objectives and approach to ensure both organisations remain aligned and engaged.
- Review our clinical leaders across the various workstreams and ensure we have the right people involved at the right time to maximise our opportunity for sucecss.
- Review both our internal and external governance arrangements and ensure they are as simple (yet robust) as possible so that they support the rogramme of work and never hinder it.

In response to what has been heard some immediate actions are already being progressed;

- Review of terms of reference for the UHBs Executive Cancer Board – a key internal forum to ensure the correct balance between operational and strategic agendas.
- Plans to refresh the CAV UHBs own internal cancer strategy to ensure ongoing alignment to the regional agenda.
- A 'time out' type session across both CAVUHB and VNHST clinicians to undertake a stock take of where we have got to, celebrate success and recalibrate for the next phase of work.

Capacity (clinical and managerial) to progress such a huge and complex agenda continues to be a challenge and this is recognised by both CAVUHB and VNHST. It is testament to both organisations commitment to this work agenda that a joint 'senior strategic planning manager' post has been developed and jointly funded. Subject to successful recruitment it is hoped this post will be filled by summer 2022. This will create some much-required capacity to support clinicians leading the various workstreams with key planning and project management support.

Recommendation:

The Quality and Safety Committee is requested to:

Note the progress being made in regards to the implementation of the Nuffield Report recommendations which are pertinent to Cardiff & Vale UHB.

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	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration	x	Collaboration	x	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:
Management Executives	18 March 2022

Saunders,Nathan
04/12/2022 01:11:58

Annex 1: *Nuffield Trust Recommendations*

1. The planning process for all South East Wales cancer services needs to be reviewed and its coordination improved, with the development of a common dataset and planning approach put in place. Steps have been taken to support this and it is going to be very important that the CCLG is effective – this will help to fill the strategic gap in the planning of cancer services that has existed across South East Wales. There are some lessons from the development of the more successful cancer alliance models in England that could be followed. These take responsibility not only for the planning of cancer services but also for leadership and performance management.

2. Full co-location would have advantages but is not practical for a significant period of time. However, action is required soon to deal with the issues with the estate and linear accelerators at the VCC.

3. In the near future, each LHB needs to:

   • Develop and implement a coordinated plan for:
      - analysing and benchmarking cancer activity against other areas
      - advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E
      - acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haematooncology and solid tumour work together

   • Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods for improving access to specialist opinion.

4. The new model should not admit who are at risk of major escalation to inpatient beds on the VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the VCC therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.

5. To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of the VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.

6. The ambulatory care offer at the VCC should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic resource for South East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics

7. The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.

8. The development of a refreshed research strategy is a priority and further work is required to fully take advantage of the networked model.

9. Organisational development and other work to create a successful cancer network is going to be required but has not featured much in our conversations for this report.

10. Flexibility in design is going to be important both for the new VCC and for whatever is developed at the new UHW due to the rapid change in the nature of treatment and research.

11. There are future strategic development opportunities provided by the development of a new VCC and a proposed UHW2. Working together over the 15- to 20-year window, the health system should look to exploit these development opportunities in light of future service needs.

	Recommendation from Nuffield Trust report	Key Progress to date during 2021	Key Next Steps for 2022
3	***Recommendation 3:*** ***Activity Benchmarking, Oncology Advice for Unscheduled Care and AOS*** *'Develop and implement a coordinated plan for:* o *analysing and benchmarking cancer activity against their areas,* o *advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E* o *acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haemato-oncology and solid tumour work together* • *Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods for improving access to specialist opinion'.*	The Velindre@UHW programme includes a Acute & Unscheduled Care workstream. Good progress has been made with pathway redesign and admission criteria review undertaken. A workshop has been held where VCC presented the results of a one-month audit of admissions against their criteria. A regional Acute Oncology Service (AOS) project board lead by VNHST **has overseen the** development of a regional AOS business case that has subsequently been developed and signed off by all partners (excluding CTMUHB). *N.B. business case was taken to the CAVUHB Board in autumn 2021*	Further discussion on admission criteria now required along with the need to redesign pathways and a plan to change/agree/implement. Development of the Acute Deteriorating Patient Pathway between Velindre Cancer Services and University Hospital Wales. Following the pathway agreement, associated infrastructure and workforce business case requirements will be progressed. To include designated admission/ inpatient area at University Hospital Wales. Further evolution of the Service model and implementation work now needs to take place through 2022 under the wider auspious of the regional AOS implementation Board which is chaired by the Director of Planning ABHB.

4	***Revise Velindre Cancer Centre Admission Criteria*** *'The new model should not admit those who are at risk of major escalation to inpatient beds on the Velindre cancer centre. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the Velindre cancer therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.'*	Criteria for all admissions to Velindre Cancer Centre, both scheduled and unscheduled patients revised and implemented. Agreement to develop an Acute Deteriorating Patient pathway between Velindre Cancer Centre and University Hospital Wales. Pathway redesign undertaken and improvement activities commenced. The establishment of a regional Acute Oncology Service also provides alternatives to admission in the first instance.	Recogniton this was an "in house" by VCC which now requires review and further testing with CAVUHB. Subsequently agree an on-going mechanism to review appropriateness of admissions and rolling clinical audit against revised Admissions Criteria. A need for ongoing development of the Acute Deteriorating Patient Pathway between Velindre Cancer Services and University Hospital Wales exploring options, such as on-site support from Velindre Cancer Centre consultants at University Hospital Wales.
5	***Research Hub at University Hospital Wales*** *'To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at University Hospital Wales. There would be advantages to this being under the management of the Velindre Cancer Centre, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity'.*	The Velindre@UHW programme includes a reasearch and development hub workstream. A draft service specification for the V@UHW Research hub has been developed by Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University. A copy of which can be found below. Joint Proposal_Cardiff Ca	VNHST and Cardiff University have approved service specification. Final scrutiny of the specification is taking place within CAVUHB with the ambition to approve the specification within Qtr1 before moving into phase 1 implementation.

6	***Expansion of Haemato-oncology Clinics and provision of wider Diagnostic services*** *'The ambulatory care offer at the Velindre Cancer Centre should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic resource for South East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics.'*	The Velindre@UHW programme includes a Haemato-oncology workstream. There is recognition that this project has failed to gain the traction that the UHB would have liked.	Within Q1 immediate plans to; ○ Review scope and purpose of this workstream with VNHST colleagues ○ Identify clear UHB clinical lead
7	***Velindre @ Operating Model*** *'The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.'*	• Velindre @ University Hospital Wales Programme (see above) partly addresses this.	There is recognition within CAVUHB that there are further opportunities to exploit in terms of how both organisations operate jointly from a clinical perspective. This will need exploring, scoping sand progressing though 2022
10	***'Future proofing' and "University Hospital Wales 2"*** *'Flexibility in design is going to be important both for the new Velindre Cancer Centre and for whatever is*	VNHST report that flexibility is built into new Velindre Cancer Centre specification.	Ongoing alignment and engagement with the UHBs *Shaping our Future Hospitals* programme as the development of a Strategic Outline case (SOC) is developed during 2022.

	developed at the new University Hospital Wales due to the rapid change in the nature of treatment and research'.		

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 25th January 2022, 8.30am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJONES), Director of Nursing Louise Waughington (LW), Associate CNS Infection Prevention & Control Ashleigh Trowill (AT), Service Manager, CYPFHS Directorate Paula Davies (PD), Lead Nurse CYPFHS Directorate Clare Rowntree (CR), Clinical Board Director Matt McCarthy (MM), Patient Safety Facilitator Martin Edwards (ME), Assistant Clinical Director, CHFW Directorate Emma Davies (ED), Risk Manager, Obstetrics & Gynaecology Angela Jones (AJ), Senior Nurse Resuscitation Service Debbie Jones (DJ), Patient Safety Facilitator Jonathan Davies (JD), Health & Safety Advisor (on behalf of Rachael Sykes) Abigail Holmes (AH), Deputy Head of Midwifery, Obstetrics & Gynaecology Anthony Lewis (AL), Clinical Board Pharmacist Karenza Moulton (KM), Lead Nurse, CHFW Directorate Becci Ingram (BI), General Manager, CHFW Directorate Catherine Wood (CW), Director of Operations **In Attendance** Kirsty Hook (KH), Risk Governance & Patient Experience Facilitator	
1.2	**Apologies for absence** Janice Aspinall, Rachael Sykes	
1.3	**To note the Minutes of the previous Q&S meeting held on 21st December 2021** The minutes of the meeting held on 21st December 2022 were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 21st December 2021** The actions were noted and closed as appropriate. An update was provided on the open actions as follows: **Access to PARIS – Cardiff Parenting Request** This action is ongoing at present. An SBAR will be shared with the Clinical Board once this is finalised. It was agreed that this could be closed by exception whilst awaiting decision. **Estates Update – Rainbow Ward** Update report on the findings, to be shared for information. JD agreed to follow up with Estates. **SBAR – DC** RCA finalised. Further discussions have been held with Safeguarding who are picking up some issues directly with the Local Authority with regards to the escalation process with regards to the case. It was noted that the CAMHS referral process was followed throughout. Outcome from	**JD**

	the discussions with safeguarding would be shared with Patient Safety for inclusion within the closure form.	**PD**
HEALTH & SAFETY		
2.1	**To note the latest Health & Safety Report** The report was noted for information. No RIDDOR reported incidents in November and a decrease of reported incidents throughout the same period. Classroom training specifically for Manual Handling and Violence and Aggression is being progressed and further information will be shared when available. It was noted that the release of staff also remains an issue across all areas with current challenges and this will continue to be monitored. **H&S Dashboard – November 2021** Noted for information.	
2.2	**Feedback from UHB Operational H&S Meeting** Agreed that the minutes from the last operational meeting will be shared for information following the meeting. **Staff COVID-19 Reporting to the Health & Safety Executive** Guidance was shared for information and onward dissemination to ensure that the correct process is being followed for reporting of these incidents and appropriate actions being undertaken.	**AJONES**
2.3	**To note the latest COSSH Report** Latest COSSH report was noted for information. A reminder was noted to ensure that the reports are updated appropriately. All were asked to ensure that inspections are being undertaken and are up to date.	**ALL**
2.4	**Fire Safety Report** Noted for information. There were no specific exceptions to report.	
2.5	**Feedback from H&S Staff Side** It was noted that from 1st February 2022, Janice Aspinall will take over as the Lead H&S Representative for staff side following the retirement of Stuart Egan. As there was no representation at the meeting, it was agreed that a deputy representative would be sought to ensure appropriate representation at future H&S meetings.	**KH**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues, Long waiting patients update)** **CYPFHS Directorate** The report was noted for information. Key items were noted as; • Risk assessments for face to face activity is being undertaken with regards to space and accommodation. Within St David's Hospital there are some issues with ventilation which has been raised with Health & Safety team and further update is awaited. • Complex Needs Care Group x2 Paediatricians working to identify clinically vulnerable children (between the ages of 5-11yrs) who are receiving the monoclonal antibody treatment. • Health Visiting home visiting continues however there remain some gaps in service, staff moving frequently and further advert is progressing. • Primary Immunisation Uptake pathway is being developed.	

- Meetings taking place with Cardiff Health inclusion service (Previously called CHAP Services) with regards to In Reach health visiting is being reviewed as part of the CHAP Post and how this service can be supported, including provision of specialist nurse input. Increase of circa 250 families arriving in Cardiff in the near future, and reviewing how support can be provided. New model for the future being explored.
- Fluenz mop up sessions are being undertaken. Sessions at the MVC have worked well. HPV delivery continues and work is progressing towards e consent for the 2nd dose.
- Child Measurement Programme is delayed at present. Immunisation and Safeguarding and Emotional Mental Health in schools is taking priority at present, which is supported by Welsh Government.
- Paediatric Continence vacancies within the service and are currently out to advert. Work being undertaken with the National lead for Continence, and will provide training and support with pathways into the service. Issues with regards to some drugs that have been included into the formulary – escalation will be undertaken through the cluster lead for GP service to look to resolve and agree.
- LAC service vacancies have been recruited to and staff will commence shortly. Current staff have increased hours initially to help support and cover the gap in the interim.
- Scoping exercises with Local Authority (Education) with regards to Special Schools medication provision. Project lead has been identified and will be the link to health services. Liaison service pilot is under discussion at present. Project is being developed with regards to the needs assessment as part of the Starting Well Workstream.
- Health Visiting safeguarding supervision is being provided for newly qualified staff (18month period) and further audit will be undertaken in the near future.
- Growth and LDP plan model is progressing. Further update is awaited
- Complex Health Needs and Early Years support work is progressing.
- X1 incident where young person received a duplicate fluenz vaccination. Reported via Datix. Investigation is progressing. Both parent and patient stated that they had not received, however on review it was found that the patient had been vaccinated. Parent was satisfied that there were no contraindications and harm to the child.
- BFI Accreditation received and feedback has been very positive. There are some actions that require completion. Congratulations were noted to all for the hard work in continuing to gain the accreditation.
- Visit from psychologist from Pets for Therapy service. The service is fully indemnified and have an SLA in place, work is progressing for this to be introduced. Happy to share details.
- Still a number of vacancies across services. Recruitment continues and is progressing.

Timely access

- Neurodevelopment waiting list has increased again. 1202 patients waiting at the end of December. To note, there was reduced capacity for assessment across the Christmas period and the service also received 170 new referrals. Positive news is the longest wait has decreased to 123 weeks from 137weeks.
- PMH performance for December was 92% for Part 1a target in December. There has been a dip due to referrals received across the Christmas period. This position is hoped to be recovered by February 2022.
- 455 patients waiting at end of December for CAMHS, with the longest patient waiting 34weeks. 180 patients transferred to Helios and this has had a positive impact on the waiting list.
- 814 patients waiting for a continence assessment at the end of December. Longest wait recorded at 127weeks. Impact on capacity within the team, and vacancy not yet being fulfilled.
- Referrals for Therapy service has seen a significant increase. At the end of December 756patients waiting, with longest wait for Occupational Therapy at 31weeks.

O&G Directorate

The report was shared for information. Key items noted;

- BFI assessment due in March 2022 and work is progressing
- Ongoing promotion of COVID 19 vaccination for women throughout the antenatal and post natal period. Work has been undertaken with the MVC to ensure access is available.
- Currently have 17 ongoing RCA's, 5 of which are NRI's. Ongoing issues continue with getting the obstetrics RCA's and timelines completed, which is outside of the health board timelines. Confirmed protected time will be available for Obstetricians from April this year which is anticipated will significantly improve this position. AJONES requested that the previous month's position also be included so that progress can be monitored. Noted that there are x5 maternity cases scheduled to be discussed at the next PSIG meeting, which can then be progressed through Directorate and Clinical Board Q&S processes.
- Weekly COVID-19 board meetings have recommenced.
- 32 safeguarding referrals made. 21 disclosures of domestic abuse in Gynaecology. 100% compliance with social birth plans.
- More streamlined working between Obstetrics & Neonatology is being progressed, including transitional care.
- Performance Board joint response required from Obstetrics and Neonatology. Neonatology response received and request was made for Obstetrics to send through to the Clinical Board for a response to be submitted.
- Face to Face CTG and PROMPT Training was cancelled in January due to staff shortages and clinical pressures– drive to increase numbers is being progressed through CTG Master classes. 79% of midwives are CTG trained.
- PROMPT – 61% of midwives have attended training. Training is being relocated to UHL which will increase number of midwives trained.
- SARC – 68 referrals received, which has been a spike in trend and counselling services being increased in January 2022. 24 adults and 33 children on waiting list for counselling. Agreed to include previous months position.
- X2 research nurses have been appointed and x2 research midwives appointed. A number of studies are ongoing and a number due to commence.
- Digital midwife has undertaken a significant amount of work including digital self booking referral system embedded and working very well. Sickness system developed, WISDOM progressing for guidelines. Text messaging being progressed.
- 23 concerns received for December, themes identified and are being worked through.
- Still a number of vacancies across services. Recruitment continues and is progressing.

Timely Access

- 1240 patients currently on the waiting list, with the longest patient waiting at 146weeks.
- Outpatients position has improved
- Cancer breaches, 7 reported for November, 7 reported for December and predicted 5 for January.

It was noted that a more detailed report will be shared outside of the meeting for information.

CHFW Directorate

The report was shared for information. Key items noted;

- POCT Testing machine is being purchased for COVID so that beds can be allocated more effectively and efficiently across the CHFW. SOP has been developed and shared with IP&C for approval and progression.
- Airflow meters Patient Safety notice received and all meters have been removed and blenders are now being used.

- Nurse staffing capacity in Outpatients is significantly impacting a number of services, specifically for phlebotomy services which will need to be significantly reduced. A risk assessment and SBAR is being produced for the Clinical Board
- X5 NRI's ongoing. X2 are almost complete AJJ and KL which will be available to be presented at the next Extra Ordinary Q&S Meeting for sharing of lessons learnt.
- In depth RCA AE being completed following self harm incident
- Learning from Events – x2 cases received. Case of EM was discussed and reviewed. All actions are being maintained, and further actions have been implemented.
- X2 Pressure damage events, both cases were children who had received T&O procedures on their legs and it was acknowledged that both these cases had been moved to epidurals from usual spinal blocks. Benchmarking is being undertaken to ascertain if this is a factor and ensure that appropriate management is being adhered to.
- Weekly COVID Meetings are taking place within the Directorate.
- Visiting leaflets have been shared and the recommendation is that parents visiting undertake daily lateral flow tests whilst visiting.
- Safeguarding, standardisation of risk assessment form and improvement work on MARF referrals work is being undertaken as part of the findings from action plans from the recent NRI's.
- Neonatal report received and noted that the findings will be presented in more detail at the next Clinical Board Q&S Meeting. Significantly highlights the acuity and capacity issues being experienced. Occupancy rate is also increased against BAPM standards.
- Oncology Peer review has been delayed and will now take place in April 2022.
- Patient Story re: Pressure Sore on face from C-PAP mask, agreed this will be shared at the next Clinical Board Q&S Meeting
- Still a number of vacancies across services. Recruitment continues and is progressing.
- X1 Nurse and HCSW supporting Adult services at present.

Timely Access

Paediatric Surgery continues to see high numbers of patients waiting over 36weeks (235 over 36 and 134 over 52 weeks), of this there are 185 level 3 children awaiting surgery with 45 having dates for surgery, which is a significant risk.
Outpatient position has improved as there has been the ability to backfill, however this has adversely affected the inpatient waiting list as there is approximately a 40% conversion rate to inpatient services.
Gastro position has improved, numbers of children waiting over 8 weeks has reduced, but there are still 34 patients waiting
Sleep Studies waiting list continues to grow, with the longest wait now at 90weeks
General Paediatrics outpatients waiting list is increasing with over 257 patients waiting over 36weeks.
Access to phlebotomy is a significant risk which will be added to the risk register.
Limited capacity within Outpatients which is significantly impacting the capacity and access to outpatient services for children. T&O remain within the Outpatient footprint which is impacting access.

It was noted that without additional elective capacity, the paediatric surgery position cannot be recovered at present, further discussions are required with WHSSC with regards to the possibility of outsourcing to alternative providers for the longest waiting patients due to the access to theatres and also the reduced anaesthetic position. Discussion ensued with regards to the level 3 patients' growth and backlog and it was agreed that the data will be shared for further discussion with Anaesthetics in order to articulate the change that is growing over time.

For the outpatient position, discussion ensued and it was agreed that the totality of the footprint needs to be reviewed in order to have a more robust plan going forwards.

3.2	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **CYPFHS** CCNS Independent review undertaken in Swansea Bay and has been shared as part of the All Wales service. A C&V action plan has been produced and this will be shared through Q&S, some themes are quite concerning and some concerns have been received recently. A memorandum of understanding will be shared with all parents, with a consultation and communication process to be implemented to manage any concerns/queries. AJONES noted that review can be undertaken to look at a standard response from the concerns team to help manage any concerns being received that are being linked to the recent review within Swansea Bay. **Updated Clinical Board Risk Assurance Framework** Updated framework was shared with timeframes added for submission of risk registers to ensure appropriate review of all risks across the Clinical Board. The deadline for the next submission to the Clinical Board for Directorates will be 1st March 2022.	**PD/AJONES** **ALL to note**
3.3	**Business Continuity Update** No further specific issues to note for the meeting, current risks noted as part of the Directorate report updates. Updated plans to be shared with the Clinical Boards prior to the March Q&S Meeting.	**ALL**
SAFE CARE		
4.1	**Update on Serious Incidents** X2 No surprises reported to Welsh Government this month with regards to Maternity pressures (In147964) and information requested from the BBC for freebirth case (In159103). It was noted that with regards to the freebirth case, this was in relation to refusal of services due to the request to provide an English based intrapartum continuity model service which is not currently available in Wales. It should be noted that there were midwifery services available to the patient, however the patient chose not to engage in these services. X2 NRI's reported in month; • In148808 – AA baby with a known cardiac anomaly was in poor condition and admitted to NNU • In37901 – AZ (Retrospectively reported) incident date 2016. Baby born in poor condition, RCA completed and shared with the family. Currently x10 reported NRI's with a further x2 due to be reported. **Inquest Cases** Patient MJ – Inquest is ongoing. It was noted that the family were very complimentary of the care provided by both the Paediatric Mental Health Nurse and also the play specialist. This has been fedback to the staff. It was noted that this has been a very challenging inquest, however acknowledging that there is nothing adverse for the Health Board. Debrief has been arranged for the staff involved. Patient SL - Inquest has been postponed due to the awaiting of further information from Local Authority. CAMHS opinion has been requested with regards to out of county support and PD agreed to pick this up. **Datix Cymru** The launch date for the new Once for Wales Datix System (1st March 2022) is imminent and thanks were expressed for all with regards to the work being undertaken to close incidents in readiness for the transfer.	**PD**

	Training for existing incident managers is being progressed and will be video based training hosted through LED platform, Learning@Wales. Log in details will be shared imminently. There are some differences which will be covered within the training. Less control with any changes, however the long term good with regards to benchmarking etc. Intranet site is being developed to provide help and support for all staff on the key areas. Discussion ensued with regards to non-patient facing staff who could help support with the closure of the incidents where appropriate in readiness for the changeover. The Directorates were asked to continue to review and action appropriately. KM queried if there were some non-patient facing staff, could they be tasked with review and closure? It was confirmed that this was possible, and any staff who didn't have an account could be set up with a temporary one so that incidents didn't have to be reallocated. Patient Safety team happy to support where necessary also. The incidents that are "submitted awaiting review" should be the main focus to ensure that any specific concerns/issues can addressed. **Directorate Super users for New Datix System** The Directorates were asked to nominate x2 superusers per Directorate who could help support.	**DMT's** **DMT's**
4.2	**Learning from Events (LFE) Reports for noting/discussion** **OF – CN/NOAH/4273** Noted for information. It was noted that this is being revisited through the Directorate Q&S process and feedback will be provided at the next meeting. **EM – CN/UHW/3915** Noted for information. This is an historical case, where a number of the staff involved are no longer working within the Health Board. The claim was relating to an alleged delay in arranging a renal ultrasound scan which the Claimant says would have identified a damaged left kidney and led to a nephrectomy (removal of kidney). It was noted that issues were originally reviewed as part of a Royal College of Surgeons review of Paediatric Surgery that was undertaken in 2017. This case was also submitted to the Ombudsman at the time. It was noted that the actions included within the investigation were around the need to appoint more permanent consultant paediatric surgeons as during the time of the Royal College review there were a number of locum doctors in post. Lack of MDT and Mortality and Morbidity meetings being in place. Non-availability of CAT lists (for urgent surgery) within the CHFW was also highlighted. The Directorate have completed a revisit of the action plan and it was noted that all actions are complete and embedded and further improvements made. CAT Lists are now available 7days per week within the CHFW allowing urgent surgery to be completed more quickly where required.	**KM**
4.3	**SI's/RCA's/Closure Forms for noting/final ratification** **SBAR, Timeline & Action Plan – AH (Datix 330662)** Shared for information. Discussed at Extra Ordinary Q&S Meeting. There were no specific issues or lessons learnt to note. Detail included as part of Extra Ordinary Q&S Minutes. **SBAR, Timeline & Action Plan – AG (Datix 332697)** Shared for information. Discussed at Extra Ordinary Q&S Meeting. Since the last meeting, it has been agreed that this is now being taken forward as a more detailed RCA and further information will be shared once this is completed. **Draft Minutes from Clinical Board Extra Ordinary Q&S Meeting 14.01.22**	**ED**

	Noted for information and sharing of lessons learnt recorded.	
4.4	**Infection Prevention Control Update** X4 Bacteraemia in January, x1 C Diff in December for Island Ward, patient is now stable and recovered with no ongoing concerns. X5 patients admitted from community with Covid Positive results, all contacts have come out of isolation. Walkarounds have been completed and increased use of the visor use which is noted as very good practice. RCA's from July 2021 – January 2022 – x13 outstanding RCA's that are awaited and all were asked to complete as soon as possible. If there is any support required, please contact the team. LW agreed to share the breakdown with the group to ensure that these are actioned as soon as possible. **Maternity Positive Birthing Partners Update** Accommodation of positive birth partners in the event of no other partners available or any exceptions for this birth. It was noted that risk assessments are completed when this is likely to occur. The X2 cases experienced were exceptional circumstances, due to risks associated for each birth. Communication has been circulated to all staff outlining that this is undertaken in exceptional circumstances. A SOP has been developed and some concerns are continuing to be worked through. KM noted that there have been occasions where a covid positive mum has needed to stay with their child within the CHFW. Risk assessments have been undertaken appropriately as they are essential carers. It was agreed that further discussions would be taken outside of the meeting to discuss and ensure that due process is followed across all areas. IP&C will also need to be included in discussion for advice.	
4.5	**Safeguarding** No issues to be noted for this meeting.	
4.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Welsh Blood Service - Blue Alert** Noted for information. This alert has now been closed. **Briefing Note: Avian Influenza - Human case in England** Noted for information. **Message from Welsh Government - CEM/CMO/2022/02 - Neutralising monoclonal antibody and intravenous antiviral treatments for patients in hospital with COVID-19 infection** Significant amount of work has been undertaken and process is in place for any children requiring access and the flowchart will be shared once finalised. **PPE Update: Clarification of use of FFP3** Noted for information. If FFP3 is required, this needs to be thoroughly risk assessed. Evidence is now clear with regards to transmission of COVID. If there are staff, within the community that need to wear FFP3, if required due to caring for patients with Covid, this would be supported. It was noted that within the CHFW unless aerosol generating, FFP3 is not worn, as per guidance, however if staff feel very vulnerable and feel more comfortable this can be worn. RCM advice	

	has also been received with regards to FFP3 for labour, which has been highlighted. It was acknowledged that this has been changed to a risk-based approach however noting that there have been no outbreaks and no concerns to have a big change in practice from professional bodies. **ISN 2021/Dec/030 - Checking of Nonsubstantive Staff** Noted for information. **PSN064 Handlebar injuries in paediatric abdomen** Noted for information. It was confirmed that the Clinical Board are fully compliant with guidance. All alerts have been disseminated widely across the Clinical Board for onward sharing.	
	NICE Guidance **TA729 – Sapropterin for treating hyperphenylalaninaemia in phenylketonuria - https://www.nice.org.uk/guidance/TA729 -** AL noted that this has been discussed and noted through the Clinical Board Medicines Management Group and is already part of the formulary. Work is progressing with regards to resource of provision.	
TIMELY CARE		
5.1	**Directorate concerns & assurance update** No specific issues to be noted that has not been discussed elsewhere on the agenda.	
INDIVIDUAL CARE		
6.1	**Virtual mental health support clinics** Noted for information	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
7.1	**Health and Social Care (Quality and Engagement) (Wales) Act 2020 Winter Newsletter** Noted for information.	
7.2	**Bulletin from Welsh Risk Pool Learning Advisory Panel** Noted for information.	
7.3	**Wound infection Study session** Noted for information	
7.4	**C&W Clinical Board Celebration Event** A C&W Clinical Board Celebration Event is being planned, acknowledging the challenging time experienced over recent months and there have been significant improvements, achievements and good practice that should be recognised. Further information will follow shortly.	
ANY OTHER BUSINESS		
8.1	**Maternity & Neonatal Safety Programme** Welsh Government have announced there will be a safety programme happening. Discovery phase will be completed by 31st March 2022. Paper will be brought to the next meeting for a more detailed discussion.	**SH**
DATE AND TIME OF NEXT MEETING		

The next meeting is scheduled for **Tuesday 22nd March, 8.30am, Microsoft Teams**

2022 Meeting Dates

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

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

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

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

MINUTES OF THE MEETING HELD ON 10TH JANUARY 2022

Present:

Matthew Temby (Acting Chair)	Clinical Board Director of Operations
Becca Jos	Deputy Director of Operations
Scott Gable	Laboratory Service Manager, Cellular Pathology
Adam Christian	Laboratory Director, Cellular Pathology
Sian Jones	Operational Service Manager
Rhys Morris	CD&T R&D Lead
Debbie Jones	Patient Safety Facilitator
Bolette Jones	Head of Medical Illustration
Gareth Jenkins	Deputy General Manager, RMPCE
Robert Bracchi	Medical Advisor to AWTTC
Louise Long	Public Health Wales Microbiology
Lesley Harris	Professional Head of Radiography UHL
Mathew King	Assistant Director of Therapies/Head of Service Podiatry
Kim Atkinson	Acting Head of Occupational Therapy
Jo Fleming	Quality and Safety Lead, Radiology
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Alun Roderick	Laboratory Service Manager, Haematology
Jacqueline Sharp	Acting Head of Physiotherapy
Alicia Christopher	General Manager, Radiology and Medical Physics/Clinical Engineering
Emma Cooke	Clinical Director of AHPs
Nia Came	Head of Adult Speech and Language Therapy
Judyth Jenkins	Head of Dietetics
Timothy Banner	Head of Patient Services

Apologies:

Sue Bailey	Clinical Board Director of Quality, Safety and Patient Experience
Sandeep Hemmadi	Clinical Board Director
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Jonathan Davies	Health and Safety Adviser
Paul Williams	Clinical Scientist, Medical Physics
Tracy Wooster	Sister, Outpatients
Nigel Roberts	Laboratory Service Manager, Biochemistry
Seetal Sall	Point of Care Testing Manager

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 22/001 Welcome and Introductions

Matt Temby welcomed everyone to the meeting.

CDTQSE 22/002 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 22/003 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 17th December 2021 were **APPROVED.**

CDTQSE 22/004 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 21/283 Reusable Respiratory Guidance

Jackie Sharp confirmed that the guidance has been implemented in Physiotherapy.

CDTQSE 21/358 Physiotherapy Non-Medical Prescribing Policy

Tim Banner reported that a meeting has been arranged to discuss whether the policy is needed and he will feedback at the next meeting.

Action: Tim Banner

CDTQSE 21/360 R&D Funding Issues

Matt Temby and Rhys Morris to discuss R&D funding issues.

Action: Matt Temby/Rhys Morris

CDTQSE 21/375 Leaks in Physiotherapy

The leaks in Physiotherapy have not yet been resolved. The Clinical Board is meeting with Estates on 14th January and Sian Jones will escalate the issue.

Action; Sian Jones

CDTQSE 21/392 Crisp Packet Recycling Bin for Academic Centre

Sue Bailey has submitted a request for a recycling bin and is awaiting a response.

Action: Sue Bailey

CDTQSE 21/392 Capital Bids

Sian Jones has requested an update on the capital bid for electric charging points in Clinical Engineering and is awaiting a response.

Action: Sian Jones

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 22/005 Patient Story

No Patient Story was presented at today's meeting.

CDTQSE 22/006 Feedback from UHB QSE Committee 14th December 2021

The minutes of the meeting held on 14th December are not yet available**.**

CDTQSE 22/007 Health and Care Standards

Nothing to report.

CDTQSE 22/008 Risk Register – Review and Revision

Nothing to report.

CDTQSE 22/009 Exception Reports

No exception reports were escalated.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 22/010 Initiatives to Promote Health and Wellbeing of Patients and Staff

Matt Temby asked directorates to consider any bids for initiatives to support staff health and wellbeing that could be implemented in the last quarter of the financial year.

Action: All

SAFE CARE

CDT QSE 22/011 Concerns and Compliments Report

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

No departments reported a Red status.

Radiology reported 1 breach in response times and Physiotherapy reported 2 breaches. Both departments reported an Amber status. All other departments reported a Green status.

The main theme reported this month related to patients' concerns with their medical treatment. This is a change from concerns relating to difficulties arranging appointments which has been the key theme over the last few months.

Becca Jos asked if compliments could be shared with directorates. Matt Temby will give thought with Helen Jenkins as to how best to share these i.e. through a newsletter.

Action: Matt Temby/Helen Jenkins

Emma Cooke requested the details of the 2 breaches in response times in Physiotherapy, to understand if these are actual breaches. Sue Bailey will provide the details to Emma Cooke and Jackie Sharp.

Action: Sue Bailey

She also requested if directorates could be issued with a concerns tracker. Matt Temby will discuss with Sue Bailey.

Action: Matt Temby/Sue Bailey

CDTQSE 22/012 Patient Safety Incidents

NRI Report

There are 2 open NRIs:

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

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

CDTQSE 22/013 New NRIs (National Reportable Incidents)

There are no new NRIs to report.

CDTQSE 22/014 Patient Safety Alerts

ISN 2021 030 Non-Substantive Checklist

This alert relates to checks that should be undertaken whenever a non-substantive (bank or agency) member of staff is booked or arrives in a clinical area. This is also pertinent for staff being redeployed into unfamiliar roles and ensuring they remain

within their competency levels. Helen Jenkins will recirculate the alert with the checklist.

Action: Helen Jenkins

Neutralising Monoclonal Antibody and Intravenous Antiviral Treatments for Patients in Hospital with Covid 19 Infection

This circular is pertinent to Pharmacy who are working with specialist teams. Pharmacy is also managing the process with the community.

In terms of antiviral treatments, the Medicines Information Team are reviewing patients on a daily basis, but very few are being treated.

CDTQSE 22/015 Medical Device Risks/Equipment and Diagnostic Systems

Ed Chapman was not present. No medical devices risks were raised.

CDTQSE 22/016 IPC/Decontamination Issues

Alun Roderick reported that a decision has been taken that no unvaccinated phlebotomy staff are permitted to enter C7. This has been escalated to the IPC team. Alun Roderick will feedback to Matt Temby if the issue is unresolved.

Matt Temby provided an update to the guidance in the event of a Covid positive member of staff who does not have negative lateral flow test results on day 6 and day 7. The current guidance is that they must continue to isolate whilst they have positive lateral flow test results.

CDTQSE 22/017 Point of Care Testing Issues

Seetal Sall was not present.

CDTQSE 22/018 Safeguarding Update

No update to report.

CDTQSE 22/019 Health and Safety Issues

No update to report.

CDTQSE 22/020 Regulatory Compliance and Accreditation

The Regulatory Compliance Group met last week. Overall good progress was noted across the majority of areas.

Haematology and Cellular Pathology UKAS assessment metrics will be reviewed at the end of the month to identify if there is any improvement to the metrics. The reviews will determine whether an improvement plan needs to be instigated and for the teams to be supported and monitored up to their UKAS inspection timescales of March and April.

CDTQSE 22/021 Policies and Procedures

Nothing to report.

EFFECTIVE CARE

CDTQSE 22/022 Clinical Audit

Nothing to report.

CDTQSE 22/023 Research and Development

Rhys Morris reported that the next R&D Group meeting will be held next week.

A Clinical Board R&D Governance Forum has also been arranged on 8th February to discuss actual research and grant applicants. Any individuals that are active in R&D or interested in research are welcome to attend**.**

CDTQSE 22/024 Service Improvement Initiatives

Sion O'Keefe reported that the digital agenda is progressing with the Clinical Board Digital Leads and Digital Champions.

Mathew King and Sion O'Keefe have arranged to meet to give thought to a Therapies Digital Group and discuss the structure and ensure there is no duplication.

It was noted that a Clinical Board Digital User Group has also been set up in the last few weeks by the Digital Leads and meetings are held fortnightly with the Digital Champions across services.

Health Board work relating to outpatient booking and utilisation has been delayed due to a lack of resource. External support is being secured and a programme of work will be developed for the next 3 months.

Work relating to future plans around non-physical space and input into virtual appointments is also being progressed.

CDTQSE 22/025 Information Governance/Data Quality

It was noted that services may have received reminders to submit their asset registers from Information Governance colleagues.

CDTQSE 22/026 Waste and Sustainability

As discussed at a previous meeting, from April the Clinical Board will consider the waste and sustainability agenda as part of all its decisions making.

Sian Jones and Sue Bailey will be leading on developing a Waste and Sustainability Strategy for the Clinical Board. Directorates are encouraged to

identify individuals within their services with an interest in sustainability, who can link in and put forward any opportunities and initiatives that can be implemented within their teams to reduce the carbon footprint. Any nominations to be submitted to Sian Jones.

Action: All

DIGNIFIED CARE

CDTQSE 22/027 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

Nothing to report.

CDTQSE 22/028 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 22/029 Initiatives Related to the Promotion of Dignity

Nothing to report.

CDTQSE 22/030 Equality and Diversity

The Senior Management Team have been meeting to discuss allied roles against the 9 Protected Characteristics. Details of which members of the Clinical Board are leading on which of the Protected Characteristics will be circulated prior to the next meeting.

It was noted Keithley Wilkinson's replacement as UHB Equality Manager will be commencing in post in the coming weeks.

TIMELY CARE

CDTQSE 22/031 Initiatives to Improve Access to Services

Mathew King is attending Management Executive this afternoon to promote and seek support for the Podiatry PACE (Podiatry Accessible Care for Everyone) project. This relates to Podiatry offering the type of interventions that are not offered by NHS Podiatry in collaboration with Cardiff Metropolitan University. This will provide income generation and help reduce health inequalities across Cardiff and Vale.

CDTQSE 22/032 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The figures for December are not yet available.

The forecast for diagnostics patients waiting 8 weeks or more at the end of December should be a reduction of around 100 patients from the November position.

1200 breaches are forecasted for Therapies as a whole, which is a significant increase on the November position. A meeting is being held with Physiotherapy to understand the marked change in their performance figures and look at future forecasting and remedial actions that can be put in place to mitigate the position.

INDIVIDUAL CARE

CDTQSE 22/033 National User Experience Framework

User experience feedback is not currently being collated.

STAFF AND RESOURCES

CDTQSE 22/034 Staff Awards and Recognition

The UHB Staff Recognition Awards are now open for receiving nominations with the deadline of 21st January. Matt Temby encouraged departments to submit nominations.

CDTQSE 22/035 Monitoring of Mandatory Training and PADRs

The Clinical Board PADR rate for non- medical staff is 34%. Directorates need to consider recovery plans for improving their PADR rates. These will be reviewed at Directorate Performance Reviews.

Action: All

Medical appraisal compliance rate is 77%.

Statutory and Mandatory training compliance is 80%.

Fire training compliance is 71.4%. Directorates to focus on improving their compliance rates for fire training.

Action: All

ANY OTHER BUSINESS

It was noted that Directorate Performance Reviews had been stood down over the last few months and these will be resumed again in full from February.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 15th February 2022 at 9am via Teams.

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

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

MINUTES OF THE MEETING HELD ON 15TH FEBRUARY 2022

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Lesley Harris	Professional Head of Radiography UHL
Ruth Alexander	Podiatry Operational Manager
Sian Jones	Operational Service Manager
Seetal Sall	Point of Care Testing Manager
Alicia Christopher	General Manager, Radiology and Medical Physics/ Clinical Engineering
Kim Atkinson	Acting Head of Occupational Therapy
Rhys Morris	CD&T R&D Lead
Debbie Jones	Patient Safety Facilitator
Samantha Davies	Radiographer, Radiology
Bolette Jones	Head of Medical Illustration
Jonathan Davies	Health and Safety Adviser
Jo Fleming	Quality and Safety Lead, Radiology
Gareth Jenkins	Deputy General Manager, RMPCE
Robert Bracchi	Medical Advisor to AWTTC
Aimee Williams	Safeguarding Nurse Adviser
Jordan Wilmer	Support Manager, RMPCE
Nia Came	Head of Adult Speech and Language Therapy
Claire Constantinou	Dietetics (for Judyth Jenkins)
Timothy Banner	Head of Patient Services
Jacqueline Sharp	Acting Head of Physiotherapy
Paul Williams	Clinical Scientist, Medical Physics
Tracy Wooster	Sister, Outpatients
Emma Cooke	Clinical Director of AHPs

Apologies:

Sandeep Hemmadi	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Becca Jos	Deputy Director of Operations
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Mathew King	Assistant Director of Therapies/Head of Podiatry
Alun Roderick	Laboratory Service Manager, Haematology
Nigel Roberts	Laboratory Service Manager, Biochemistry
Scott Gable	Laboratory Service Manager, Cellular Pathology
Louise Long	Public Health Wales Microbiology
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Judyth Jenkins	Head of Dietetics

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 22/036 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 22/037 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 22/038 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 10th January 2022 were **APPROVED.**

CDTQSE 22/039 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 21/358 Physiotherapy Non-Medical Prescribing Policy

Tim Banner to feedback from his meeting with George Oliver to determine whether the policy is needed.

Action: Tim Banner

CDTQSE 21/392 Crisp Packet Recycling Bin for Academic Centre UHL

The crisp packet recycling bins were part of a Cardiff University pilot scheme. Waste Management have advised that there are plans to launch this initiative within the UHB.

CDTQSE 21/392 Capital Bid for Electric Charging Points

Sian Jones to obtain an update on the bid and feedback.

Action: Sian Jones

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 22/040 Patient Story

Sue Bailey will review the schedule for directorates to present their patient stories.

Action: Sue Bailey

CDTQSE 22/041 Feedback from UHB QSE Committee 14th December 2021

The minutes of the meeting held on 14th December are not yet available**.**

CDTQSE 22/042 Health and Care Standards

Nothing to report.

CDTQSE 22/043 Risk Register – Review and Revision

There were no new risks to escalate.

CDTQSE 22/044 Exception Reports

There were no issues to escalate.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 22/045 Initiatives to Promote Health and Wellbeing of Patients and Staff

This Clinical Board is currently reporting the highest uptake of the flu vaccination by frontline staff with 64.4%. The target is 85% and there is a drive in the UHB to increase compliance. Walk in flu vaccinations are being offered at the Mass Vaccination Centre or the vaccinations can be obtained via the Flu Champions.

SAFE CARE

CDT QSE 22/046 Concerns and Compliments Report

The Clinical Board reported an Amber status in January. There was a reduction in the number of concerns received, with a total of 16 and 31% were resolved through early resolution. There were 4 breaches in response times. 6 compliments were received. The main theme of the concerns received relates to difficulties in arranging appointments.

There are no departments reporting a Red status.

Radiology reported an Amber status. It received 7 concerns with 28% resolved through early resolution. There were 2 breaches in response times and 1 compliment was received.

Physiotherapy also reported an Amber status. It received 6 concerns with 33% resolved through early resolution. There were 2 breaches in response times and 4 compliments were received.

Occupational Therapy reported a Green status with no concerns and 1 compliment.

Podiatry also reported a Green status. It received 2 concerns with 50% resolved through early resolution timeframes.

CDTQSE 22/047 Patient Safety Incidents

NRI Report

The Clinical Board has 2 open SIs; one of the incidents has been submitted to Welsh Government for closure. This incident has been some time awaiting closure and Welsh Government have been notified of his by the Patient Safety Team.

In143602 relates to the ultrasound scans incident which is still in progress. Sue Bailey needs to finalise information with the Imaging Academy.

Radiology are reporting 2 HIW reportable IRMER incidents in CT. One relates to a patient who was unaware she was pregnant at the time of her scan. All procedures were followed, however this is reportable as clinically there was significant exposure to the foetus. The second incident relates to a patient who received their scan as an inpatient but also had an outpatient scan booked.

A delay to a report is also being investigated to understand if any harm was caused.

CDTQSE 22/013 New NRIs (National Reportable Incidents)

There are no new NRIs to report.

CDTQSE 22/048 Patient Safety Alerts

SHOT Alert; Preventing Transfusion Delays in Bleeding and Critically Anaemic Patients

This alert has been circulated across the Clinical Board for awareness.

PSN062 Liquified Phenol

Podiatry Services have now confirmed compliance and this alert has been responded to.

CDTQSE 22/049 Medical Device Risks/Equipment and Diagnostic Systems

Kim Atkinson reported a shortage of steadies that is posing constraint issues around discharge.

CDTQSE 22/050 IPC/Decontamination Issues

Nothing further to report.

CDTQSE 22/051 Point of Care Testing Issues

Seetal Sall reported that Point of Care Covid testing devices are still being implemented across high throughput pathway services.

There is work being undertaken around lateral flow testing on patients in Heulwen South. There are concerns that if healthcare professional staff are undertaking the tests that this will fall under the remit of Point of Care Testing. Seetal Sall is linking in with Heulwen South on this. A National Point of Care Testing Group is also looking at helping stratifying the test and making it safer.

Welsh Government also have plans to put Point of Care Testing in discharge pathways and discharge to care homes and the implications of this on the Point of Care Testing Team could be significant.

Sue Bailey thanked the Point of Care Testing Team for their input on the IRMER pregnancy testing incident. The first of the QSE Lead Forums was held yesterday and Sue Bailey suggested sharing the learning with Quality Leads across the UHB. Seetal Sall suggested that point of care testing in Radiology be reviewed as this is a crucial area for a more robust set up to be put in place.

CDTQSE 22/052 Safeguarding Update

Aimee Williams noted changes to the Safeguarding Team.

Training has recommenced via Teams and training currently available is listed on the intranet site.

A new study day is being held in October on Level 3 Safeguarding and learning from reviews.

Ask and Act routine enquiries to patients attending A&E will continue due to an increase in disclosures in relation to domestic abuse.

There will be changes to legislation in March this year, ending physical punishment of children in Wales.

There are also changes to child protection referral forms, with Cardiff and Vale services amalgamated into one form.

There has been an increase in contextual safeguarding cases.

The UHB has launched a risk assessment for children and young people and will be in place to under 18s cared for on adult wards.

The Safeguarding team are still supporting staff working in busy areas in completing forms. Supervision for staff is continuing and provision of verbal advice is still being provided.

Any allegations should still continue to be reported to the team.

Sue Bailey noted that there has been an increase in professional concerns with anonymous referrals being made to Professional Bodies. She noted that there are routes internally within the UHB for staff to raise concerns outside of the normal management route and work is being undertaken in the Clinical Board to raise awareness of this.

CDTQSE 22/053 Health and Safety Issues

Kim Atkinson reported that the female toilets in Occupational Therapy UHW have been out of action for some time with repeated requests made to Estates. Kim Atkinson to send Jonathan Davies the MR details and he will follow this up.

Action: Kim Atkinson/Jonathan Davies

CDTQSE 22/054 Regulatory Compliance and Accreditation

Supported work is being undertaken with Haematology and Cellular Pathology around their metrics and assisting them with improving their compliance.

Air conditioning issues are ongoing and in some services this is affecting regulatory compliance. Sian Jones advised that she has met with Estates and will link in with the individual managers. Some progress has been made but there are still outstanding issues and meetings with Estates will continue.

Action: Sian Jones

The Toxicology laboratory lift in the Academic Centre UHL has been out of action. Robert Bracchi will enquire if this has been resolved.

Action: Robert Bracchi

CDTQSE 22/021 Policies and Procedures

Nothing to report.

EFFECTIVE CARE

CDTQSE 22/055 Clinical Audit

Nothing to report.

CDTQSE 22/056 Research and Development

Rhys Morris advised that the £100k R&D pump priming funding from HCRW has been withdrawn.

Corporate Bids for Improvement Cymru funding from Public Health Wales cannot be carried over into the next financial year.

The first CD&T R&D Forum was held last month. Anyone interested in R&D is welcome to attend. Anyone with a project to share to contact Rhys Morris.

CDTQSE 22/057 Service Improvement Initiatives

Nothing to report.

CDTQSE 22/058 Information Governance/Data Quality

Nothing to report.

CDTQSE 22/059 Waste and Sustainability

Sian Jones has been building on her knowledge and understanding of waste and sustainability issues and how this can be taken forward in the Clinical Board. She has been in discussions with Adam Christian on potential projects that could be taken forward within Cellpath. She will share the learning from this at a future meeting.

AWTTC has developed a dashboard to show the carbon footprint of inhalers. Robert Bracchi will share this with Sian Jones.

Action: Robert Bracchi/Sian Jones

DIGNIFIED CARE

CDTQSE 22/060 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

HIW will be resuming their routine inspection activities.

CDTQSE 22/061 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 22/062 Initiatives Related to the Promotion of Dignity

Nothing to report.

CDTQSE 22/063 Equality and Diversity

The Clinical Board Allies met last week and information will be circulated shortly on who will be leading on which Protected Characteristics. The Allies are currently developing knowledge on their specific areas.

It was noted that a new UHB Equality Manager will be commencing in post at the beginning of March.

TIMELY CARE

CDTQSE 22/064 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 22/065 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

An update on the waiting times will be provided at the next meeting.

INDIVIDUAL CARE

CDTQSE 22/066 National User Experience Framework

User experience feedback is not currently being collated.

STAFF AND RESOURCES

CDTQSE 22/067 Staff Awards and Recognition

Nothing to report.

CDTQSE 22/068 Monitoring of Mandatory Training and PADRs

Nothing to report.

ANY OTHER BUSINESS

The new Datix system will be implemented on 1st March. There will be a short transition period before the old Datix system becomes read only. Managers need to close as many incidents as possible prior to implementation of the new system. Training will be rolled out shortly. The new Datix system is a cloud-based product and will require internet access. This will be an issue for anyone with a generic pc account.

Lesley Harris enquired whether there is a Health Board login to access the EIDO leaflets that help inform consent. Sue Bailey will follow this up.

Action: Sue Bailey

Dietetics have submitted an accommodation request. There are ongoing issues with space for outpatient clinics and office space.

It was reported that a significant number of young adult patients are coming through A&E with eating disorders and work is underway across Clinical Boards to put a pathway in place for these patients.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 15th March 2022 at 2pm via Teams.

Minutes
Medicine Clinical Board (MCB)
Quality, Safety & Experience Committee
17 February 2022 14:30 – 16:00, via MS Teams

Attendees:
Aled Roberts, Clinical Board Director
Jane Murphy, Director of Nursing, (Chair)
Iain Hardcastle, Director of Operations
Kath Prosser, Quality & Governance Lead
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Dave Pitchforth, Lead Nurse, Integrated Medicine
Ceri Richards-Taylor, Lead Nurse, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Cath Morris, Senior Nurse, Acute & Emergency Medicine
Marianne Jenkins, Consultant Nurse Practitioner, Acute & Emergency Medicine
Annie Burrin, Patient Safety Org Learning, Patient Safety & Quality Team
Angela Jones, Resuscitation Senior Nurse
Ruth Cann, Senior Nurse, Integrated Medicine
Lisa Green, Senior Nurse, Acute & Emergency Medicine
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Sharon Jones, Consultant, Rheumatology Lyndsey MacDonald, Consultant, Acute & Emergency Medicine Diane Walker, Deputy Director of Nursing Jacqui Westmoreland, Covid Investigations Nurse Derek King, Clinical Nurse Specialist, Infection Prevention & Control Maitrayee Choudhury, Consultant, Integrated Medicine Sarah Follows, General Manager, Acute & Emergency Medicine Sam Barrett, Deputy General Manager, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted. **Improvement plan** - to address the common themes seen in pressure damage. KP to request an update from Sam Hughes for the next meeting.	KP/SH
1.2	**Maters arising** – none discussed.	
1.3	**Patient Story** – delivered by Cath Morris, Acute and Emergency Medicine regarding a compliment sent to the EU. A daughter/son (X) and their 92-year old father attended A&E on 9/1/22, during the Omicron phase of Covid-19. The elderly gentleman had fallen and was badly injured and in pain. They expected a lengthy wait, however, were greeted by helpful staff for the Covid checks who immediately found a wheel chair. Following check-in at Reception, he was triaged by a lovely	

	triage Nurse. The gentleman was addressed throughout by competent and caring professionals, who introduced themselves by their first name. Within a further 15 minutes a doctor had assessed the gentleman and he was transferred to the Assessment Unit South. X had to leave, due to Covid protocols, however, just a few hours later his named nurse called X to advise that investigations had revealed 5 broken ribs and a punctured lung and he was being admitted to the Poly Trauma Unit. The gentleman's recovery was complicated by a reaction to the pain medication but the anaesthetist who administered the nerve block took the trouble to phone X and discuss their father's confusion. The gentleman was cared for by a large team of professionals including the Nursing Staff, Pain Team, Geriatric team, Trauma Team and Cardiothoracic Team and is now back at home with his delighted wife of 65 years. The Covid Protocols were very hard (visiting an hour twice weekly) and the Hospital itself was cosmetically a little tired. X was so pleased and indeed proud to report that UHWs Human Resources are second to none and wished to thank all Staff profusely. EU staff were proud to report that C&VUHB gave a positive experience. The named nurses have had the feedback shared with them.	
1.4	**Feedback from UHB QSE Committee** – minutes from Dec 21 meeting not received yet.	
1.5	**Directorate QSE minutes – exception reporting** Minutes received from Emergency and Acute Medicine; Integrated Medicine. An addendum letter from Integrated Medicine was sent regarding short staffing and workforce issues. The letter was received yesterday.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**NIV SBAR** This has been brought to this meeting for comment. There have been a number of incidents where patients have gone a long time without NIV. Patient flow is struggling at present. Permission has been given to start long term NIV in EU/AU. This will reduce patients going without NIV for a length of time. **Action: Cath Morris and Dave Pitchforth to contact the home vent team to discuss further and it may be that the home vent team are invited to join daily huddles.**	CM/DP
2.2	**Influenza update** 49.8%. Discussions about the data and data cleansing are taking place.	
2.3	**Healthcare acquired Covid investigations update** KP to add this to next month's agenda as no update at this meeting.	KP
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**NRI update** – NRI's for closure **Integrated Medicine:** In152228 – Healthcare acquired Category 3 pressure damage. Documentation was not completed in line with UHB best practice. The patient was noted to be non-compliant with some aspects of care secondary	

	to confusion, and would not have been able to understand the rationale for frequent repositioning. The ward at the time were reliant on the use of a significant amount of temporary and agency staff as this was during the time of the second Covid-19 pandemic. This impacted on preventative interventions not being clear to inform safe and clinically effective care. **Learning**: Documentation audits are being undertaken to ensure best practice. A recent audit reported 95% compliance. Preventative measures and the importance of accurate and timely documentation is shared at daily safety briefings which includes any temporary/agency staff. All staff have been offered to attend pressure ulcer study days for continued professional development. Staffing shortfalls are escalated daily to the Clinical Board Hub and UHB Operations Planning and Transformation to fill vacant shifts. In150235 – Healthcare acquired Category 3 pressure damage. Documentation was not completed in line with UHB best practice. Given the patients reason for admission, combined with a poor nutritional intake and incontinence contributed towards the pressure damage. **Learning**: Drop in sessions provided by the Practice Development Nurse to support accurate and timely documentation was held in November 2021. Raised as part of the twice daily safety huddles. Documentation audits undertaken. A focused educational board was completed in December 2021. In141726 – Healthcare acquired Category 3 pressure damage. Believed to have been miscategorised as moisture lesions on admission rather than Category 3. There was no medical photography to support the correct category of pressure damage being reported. No pressure damage equipment sent with the patient on discharge. There was an assumption that as the patient was independently mobile they were aware of how often they should mobilise and the risk of pressure damage. **Learning:** A focused educational board was completed in December 2021. A pressure damage champion has been identified to support ongoing educational needs. Leaflets are available to ambulant patients for pressure damage prevention. A stock of pressure damage prevention equipment is now stored within the clinical area to support discharge. A discharge checklist has been added to the generic admission booklet. **Learning from these** - there are constraints in terms of flow, patients are downstairs for longer, damage can start early on, looking back at their journey, some patients have sat in chairs for a long time and then the damage starts. This is a whole system learning point. **Action: KP and SH to discuss further to put additional measures in place regarding pressure damage.** **Specialised Medicine** **In142691** - delays due to Gastroenterology surveillance. An 80-year old gentleman was referred to a tertiary service in C&V and reviewed by a Consultant. In December 2019 he was referred and placed on a list to have a procedure within 8 weeks. The procedure was booked for November 2020, unfortunately, the green Covid-19 self isolation was not be met, so the procedure was cancelled. General anaesthetic slots were then unable to be obtained due to Covid protocols. The gentleman had the procedure mid 2021 and it was found he had a carcinoma in his oesophagus. He went on to have radio and chemotherapy. Fortunately, the man had a good outcome. He has completed oncology treatment and remains under surveillance. **Learning** – the impact of the pandemic and lack of space on lists. No oversight of procedure because of changes within the dDirectorate. Now in the redress protocol. Incident/investigation is now concluded. There is an over-arching action plan. Table top exercises are taking place to provide assurance to ensure all aspects are being addressed.	KP/SH

	In143697 Patient was referred in 2016 for iron deficiency anaemia. The patient was intended for endoscopy surveillance. The patient 'dropped off' the list and did not receive results of his biopsy. Putting a patient on a list is not an automatic system. The GP referred the patient again at a later date, however, the patient did not go onto the appropriate list. The GP made an urgent further referral in May 2021, advising the original request was missed. When the patient had the procedure, he had cancer in the oesophagus and is awaiting further treatment. **Learning**: the patient did not receive any communication following the original biopsy taken in 2016. Following the referral 'dropping off' the electronic vetting system; the patient being placed on the wrong pathway and administrative issues IT issues, there is now an extensive action plan is in place. The current volume of patients is challenging.	
3.2	**Infection Prevention and Control update** - no update provided. KP to add to agenda for an update at the next meeting.	KP/DK
3.3	**Point of Care Testing** - any actions required	
3.4	**Medical devices/equipment issues** **Oxygen cylinder supply** - following Datix being submitted regarding lack of oxygen supplies, there is a meeting with Pharmacy about this very soon. There was an incident with portable oxygen being used and the patient died within another Clinical Board. It was realised the cylinder was empty after the patient died. There is no tracking of how much is in the oxygen cylinders, however, this is not a Medicine Clinical Board area of control. There are currently no particular requirements stating staff should check the oxygen flow. **Cardiac Arrest drug box supply** - the issues of the supply of new cardiac arrest drug boxes was discussed at a meeting this morning.	
3.5	**Patient Safety Alerts/MDA's/ISN** – note and share with teams. **SHOT_2022 001** Preventing transfusion delays in bleeding and critically anaemic patients – some responses from Paed EU. Action: Responses from all directorates are required. **Neuraxial Change** – Staff Comms. All to touch base with Annie to ensure the areas which are using these.	
3.6	**January Falls Infographic** – note and share with teams. **Line standing BP** – this is the responsibility of all multi-disciplinary team members, not just nurses.	
DIGNIFIED CARE		
4.1	**Patients Safety/Quality Care** If anyone wants anything discussed here, let KP know and it will be added to the meeting agenda. **Staff email addresses** – not all front-line clinical staff have email addresses and, therefore, do not get all messages. A lot of areas have them. A&E provide email addresses to all staff; however, it is then reliant on staff reading their emails.	

	WAST – in December 2021 there were 3 NRI's and now there are 6. Previously there were only 1 or 2 per month. Incidents are increasing. JM has met with the Patient Safety Team. A Clinical Board will need to hold the NRI's and ensure the right people are at the relevant meeting. If the NRI's are held corporately, they do not show in the KPI's. Within the last 8 weeks, a lot of 16 and 17-year olds have attended EU with eating disorders. There is an assumption that Gastro will take these patients and that the department will know what to do with these vulnerable people. Need to come together across all disciplines to come up with measures. There is a policy on how a patient should be fed on a medical ward (mental health patient). These patients sit under CAHMS (16 and 17-year olds), Ceri Lovell is the Senior Nurse on CAHMS. Physical health need will be seen as the priority for CAHMS, however, it is hard to fix the physical requirements in these instances. **Action: AR to chase on the discussions and note where conversations taking place and development of pathways.**	AR
TIMELY CARE		
5.1	**Cardiac Arrest in AU pathway** There have been a couple of incidents of confusion where treatment could take place. CPR pathways have been re-issued of correct process of dealing with a cardiac arrest and the correct procedure. Posters are displayed, information has been shared widely.	
5.2	**Once for Wales Datix update** There are currently 906 open datix. New system starts 1/3/22. Training for Dif 2's is available from tomorrow. Datix forms can still be submitted without an email address. **Action: Ceri R-T to send names to KP to be superusers**.	CR-T
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans Not received.	
6.2	**DTOCs** – not being received.	
6.3	**Safeguarding** – an update will be given at next month's meeting. KP to add to agenda.	KP
6.4	**Concerns update** Trying to work through concerns which are a year old or longer. These will be investigated and completed. **Action: concern figures will be presented at the next meeting.**	JM
6.5	**Compliments** **Integrated Medicine** 'I wish C4 to know how grateful and appreciative we are for the tolerant and kindly way you treated my husband. I was astounded by his abnormal aggressive behaviour. You provided constant reassurance in trying to calmly support him in dealing with the diagnosis of a Stroke. I wonder will I ever get my husband back to the man he was before the Stroke. You were also kind in letting me visit him frequently. May God bless you all.' **Specialised Medicine** 'I am a patient of Professor Choy's and I was so impressed with the level of patient care I received. I suffered a very painful and debilitating flare up of	

	my condition and after contacting Ann Marie Ellis she called me immediately to check I was ok, and was very kind to me and demonstrated real empathy to my pain. Professor Choy simultaneously agreed to see me acutely the very next day, and was very lovely and caring towards my plight. I was very impressed with his shared decision-making approach and gave me the risks and benefits of each treatment so we could decide together. Prof also took my ideas, concerns and expectations into account and acted on them. I feel this was an exemplary example of patient care and I was very fortunate to have had such a robust and caring response.'	
Staff and Resources		
7.0	**Staff well-being** – staff are really pressured at present. **Action: Cath Morris to prepare a proposal to have a therapy dog in EU and pass it to JM who is supportive of this.** **Staffing** – challenging at present and look forward to staffing getting sorted and issues reducing. **Nurse Practitioners Framework** – there is no advanced practitioners framework for development and governance. This was discussed at A&E's QSE. Marianne Jenkins(MJ) is currently looking into this and staff welcome MJ championing this. This is the start of tidying governance up for the future. **Action: any comments to be passed to MJ.** Work is ongoing on the framework for medical staff/physician associates.	CM MJ
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Date and time of next meeting** – 17/3/22 at 2.30pm	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 11 February 2022
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Ceri Phillips (CP), Lead Nurse Cardiac Services
Richard Parry (RP), Q&S Facilitator
Laszlo Szabo, (LSz), Consultant in Transplant Surgery
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Keith Wilson, (KW), Consultant Haematologist
Lisa Higginson, (LH), Interim Lead Nurse, Nephrology & Transplant
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Khalid Hamandi, (KH), Clinical Director, Neurology
Daniel Jones, (DJ), Assistant General Manager for Critical Care & MTC
Cath Evans (CE), Patient Safety Facilitator
Georgia Weaver (GW), PaRT Practitioner
Fiona Kear (FK), Assistant Service Manager Haematology
Jo Clements (JC), Lead Nurse, Critical Care
Emma Swales (ES), Senior Nurse, Nephrology & Transplant
Julie Teconi (JT), Senior Nurse, Critical Care
Lorraine Donovan (LD), Senior Nurse, Neurosciences

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		**Action**
1.1	Welcome & Introductions CMain welcomed all to the meeting.	
1.2	Apologies for absence Received from Guy Blackshaw, Clare Mahoney, Steve Gage, Rachel Barry.	
1.3	To review the Minutes of the previous meeting 19 November 2021 Matters Arising • 3.3 Nephrology and Transplant (from QS&E meeting 8 October2021) It was agreed that the email trail outlining the situation would be added as an attachment to the minutes of 8 October 2021. • 2.1 Feedback has been provided to the Coroner on the actions undertaken from the Heparin Protocol. • 2.4 Healthcare Associated Infections, the Team has met to discuss the incident of a patient death with C Difficile, the incident will be closed with no actions found.	

	• 3.3 <u>Critical Care</u> CPAP availability on CCU, in the process of investigating this with the Cardiac Team. With the amendments to the minutes of the 8 October meeting the minutes were accepted.	
PART 2: SAFE CARE		**Action**
2.1	<u>Open Nationally Reportable Incidents</u> INQ/In146473 patient SB. RP reported that there were no major breaches in care identified, details are awaited from JB in order to submit the final documents to the Delivery Unit IN152962 service user MC, ALAS awaiting completion of an RCA investigation. RP reported that there a couple of Cardiac waiting lists cases which need to be progressed, however, due to the pressures experienced over the past 2 months work has not progressed as hoped, both need improvement plans confirmed in order to submit final documents to the Delivery Unit. There are questions regarding contact with the families as there has been minimal contact with the families who are resident in the ABUHB area. IN153052. This case has been discussed and can be closed with no further action required. IN137783. Patient TL, there were actions for both peri-operative and Cardiothoracic, this investigation is now in the final stages, ready to be submitted. IN156432. Patient fall resulting in fractured neck of femur, this investigation has been completed and is ready for submission. There was an issue with lying and standing BP being requested on a ward round but not completed due to a communication issue. There is a robust action plan in progress. In terms of potential cases, in addition to the previously mentioned CPAP case there are a number of pressure damage cases which occurred during the pandemic which are being reported on retrospectively. There is a fact-finding process being undertaken regarding a blood loss case during apheresis, this is expected to be concluded shortly, to determine if this case is reportable. CE reminded all of the importance of getting all information in a timely manner, WG guidance states that there is 7-day period allowed for fact-finding. Understandably, in recent times due to pressures this time is slipping. RP added that the UHB will be focussing on the way H&S processes are managed and that he and CE will be working collaboratively in order to move the investigations forward in a timely manner. CB added that there were a couple of cases which sit under different CB's but were also relevant to Specialist Services. CMain said that once the investigations were completed these would be reviewed and any learning / actions relevant to Specialist Services would be shared appropriately.	

2.2	Alerts/Patient Safety Notices The following notices have been disseminated to the Group for information. • PSN021/November 2021 Reducing the risk of patient harm – standardised strength of phenobarbital oral liquid • Welsh Blood Service Blue Alert • ISN2021/Dec/030 Checklist for clinical areas employing non-substantive staff • PSN/060/September 2021 amended notification. Reducing the risk of inadvertent administration of oral medication by the wrong route • CEM-CMO-2022-06-Palivizumab-RPS-June-2021 • CEM-CMO-2022-06-COVID-19 Therapeutic Alert- Palivizumab passive immunisation against RSV in at risk pre-term infants CMain shared the Treatment Escalation form and asked KW to discuss the concerns he had regarding this form. KW reported that previously the form had been reviewed in this meeting and comments made which had been sent for further review. However, the form has now been issued for immediate use, KW asked how this could happen without the previous issues raised being addressed. An updated version has also been found in circulation within the HB along with further versions in use in neighbouring HB's. KW asked • What is the status with regards to documenting the Treatment Escalation Plan? • What is the latest version, how is it accessed? • How was it authorised? CMain thanked KW for raising these questions and invited AJ to respond. AJ replied that the document was updated and ratified by the HB RADAR Committee and distributed through the normal channels, for feedback and update and clinical use, it also went through the HB Clinical Safety Committee. There was an expectation and understanding that the old form would still be in existence and that there would not be a requirement to pull that form. The HB were also aware that it was being suggested that the AB version should be an All Wales form but on review it was found to be very specific to ABUHB and not suitable for use within C&V. AJ was unsure why not all areas have been sent the updated version. CMain thanks AJ for her reply. KW asked for an up to date version and explained that within Haematology due to the immuno-suppressed nature of the patients a separate "front door" is operated and the majority of patients will not access the service via A&E. CMain said that the up to date version should be distributed through this group as a number of Specialist areas operate their own admissions. ACTION	
2.3	Closure Forms There were no closure forms to discuss.	
2.4	Healthcare Associated Infections	

ACTION	• Specialist IP&C Report December 2021 January 2022 CM was unavailable to go through the attached report. CMain highlighted the increase in Covid outbreaks on a number of the wards. There are on-going challenges with the Cardiac community due to the nature of admission of emergency patients. CP gave an update of how patients are managed within Cardiac Services. Work has been undertaken in conjunction with Microbiology and IP&C in terms of amending current screening to ensure more robust screening process. Over the last 3 months CCU has been closed down 4 times due to Covid outbreaks and a temporary CCU has been set up on C3N. Authorisation has been given for point of care testing and are in the process of installing this. Inability to provide emergency CPAP remains an issue an urgent meeting to be set up to move this forward. In areas where there are particularly vulnerable patients, namely, B5, T5, B4 haem, TCT isolation for patient's positives and contacts is remaining at 14 days. Critical Care awaiting negative COVID screen before determined as 'blue'.	CMain / PA
2.5	<u>Health Care Standard 2.9 Medical Devices</u> Prior to the meeting CG sent the following summary I attended a meeting of the MDSOs sub-group of the <u>CVUHB MEG</u> on 10.02.22 at which it was reported that all the applications in response to the recent calls for both capital and non-capital medical equipment bids have been funded. It was also reported that it is very unlikely that there will be sufficient capital available in 2022/23 to repeat the process and possibly that will be the case in future years are also. That said, Clinical Boards are advised to have future bids ready prepared in case funding becomes available at short notice and to make sure that MDSOs have prior awareness of those bids to reduce the likelihood of them 'falling through the cracks' as some may have done in the recent exercise. Further to the recent humanitarian request made to the MHRA (ref. no. HAL/2021/084) jointly between University Hospital of Wales, and Medtronic for the special use of a Gold coated Cobalt CRT-D device (model DTPA2D1) for 1 patient, the surgery went ahead as planned (going well with the patient now making a good recovery) the Welsh Risk Pool and CVUHB governance requirements having been met as noted previously. KW asked if bids were still being accepted, CG replied that it was still unlikely that any further bids would be considered this year but it was advisable to continue submit new bids just in case further funds become available. CMain added that there may always be other potential routes that come up and advised that all requirements are shared with Sarah Lloyd as Director of Operations in case any other opportunities crop up. CG said that there are a number of fleet cars used in ALAS and gave details of a recent incident where a damaged tyre had been discovered at MOT which had not been possible to see while undertaking a routine vehicle check. He added that, as far as we're aware, the UHB doesn't have an up to date policy for the safe and effective management of its vehicles (the attached is believed to be a Trust legacy document from	TRANSPORT%20POLICY%20%20OPS%2(

	2005). Currently, some staff are being asked to undertake weekly (as opposed to pre-journey) vehicle checks for which they neither feel competent nor have they ever had any appropriate training. In particular, it was noted that the weekly checks relate to some (untrained) members of staff being asked to confirm that the vehicle is safe to be driven by other members of staff as opposed to pre-journey checks which are undertaken by the vehicle driver. A specific QMS corrective action was discussed at the ALAS QSE meeting that indicates that staff and others could be at very serious risk of imminent harm in the absence of clear and unequivocal guidance from the UHB (as well as contravening the UHB's legal obligations). That corrective action is being addressed urgently within the directorate, however, the UHB needs to act on this omission with equal urgency for that corrective action to be effective. CMain thanked CG for raising this issue. The policy in question sits with Colin McMillan and CMain has met with Paul Rogers to suggest that Paul takes this up with Colin at a Directorate level and the CB will provide support accordingly.	
2.6	<u>Vaccination Update</u> Nothing to report	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1 ACTION	<u>Feedback from UHB QSE Committee</u> Nothing to report CMain reported that the new Datix system goes live from 1 March and asked that as much as possible is closed on the old system in order to avoid having to manually transfer any outstanding cases. KW asked what happens to the information currently held on the old system, CE replied that all information will still be available but nothing can be added to it. RP attends the implementation meetings and will ask how the data will be accessed.	**RP**
3.2	<u>Mortality Review</u> CB reported that the Medical Examiner roll out has been delayed through the course of the pandemic we are now at the stage where C&V are the last HB to use the ME to their full capacity the delays are in part due to the pandemic but also logistical challenges as C&V will be the biggest referring HB across Wales. The Bereavement Team are working hard on ensuring the scanning of notes is as efficient as possible, the roll out date is due to be announced in the next few weeks. In the meantime any Covid related deaths must be reported to the Examiner. There have been some recent issues regarding the mortuary, where families have been advised that they will be able to access the mortuary in order to see their loved ones, the mortuary remains closed to both clinicians and families, could this information please be shared throughout the teams. Stage 2 reviews, there is currently a hybrid system. Stage 2's are being triggered through a combination of referrals back from the ME and also the completion of the Stage 1 form. CB asked that all ensure the	

	completed Stage 2 forms are returned appropriately. There is an expectation that notes will not be required to complete the Stage 2 as all notes will be scanned to go to the ME and can be accessed electronically via the CAV Clinical Portal, once all deaths are reported to the ME in the coming months everybody should be able to complete the Stage 2 without having to call for notes. Any clinician who will be completing Stage 2 reviews will need access to the CAV Clinical Portal. Any deaths which are associated with treatments provided in hospital require a Coroners' referral, could this information please be shared as appropriate. KW asked if these requirements are documented anywhere, CB replied that all requirements are provided on-line in a Government document around the statutory requirements ti refer to the Coroner.	
3.3 ACTION	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Haematology</u> KW reported that the ward is under tremendous strain due to the rules around patient facing for the clinically extremely vulnerable. Some transplant patients had to have their treatment postponed as there was insufficient nursing staff. It has implications for when Haematology staff are re-deployed to help in other areas as it is now having an impact on the Haematology service. The long-standing accommodation issues are still on-going. CMain will bring this to the attention of Sarah Lloyd on her return from leave <u>Nephrology & Transplant</u> Nothing to report. <u>Neurosciences</u> LD reported that there has been another MDRO on West 8 and 2 new cases of MDRO on West 10these infections are a different genome to the original MDRO. KH added that the footprint of Neurology remains a problem. CMain said that there is a meeting planned to discuss the Infrastructure for Specialist Services which will hopefully be the first step in resolving this problem. <u>Major Trauma</u> DJ reported Peer Review is taking place this month. <u>Critical Care</u> CB reported that Critical Care are currently under extreme pressure with a lot of the work being tertiary patients as opposed to local patients becoming unwell, however, surrounding HB Critical Care colleagues are not as busy, as a result there are daily reviews looking at potential for non-clinical transfers out, this is due to being chronically understaffed and the physical space. There is further leakage onto B3North, the infrastructure is not really supportive of a safe patient environment. CB asked if the Heparin Protocol has been updated could it be circulated through this group. <u>Cardiac</u>	

	Nothing further to report <u>PaRT</u> Nothing to report <u>ALAS</u> Nothing to report <u>Pharmacy</u> Nothing to report.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Safety & Quality Sessions 2022/2023 For information only.	
4.2	Public Health Briefing: First confirmed human case of Highly Pathogenic Avian Influenza A (H5N1) in UK For Information only	
4.3	Interim Clinical Commissioning Policy: Neutralising monoclonal antibodies and intravenous antivirals in the treatment of COVID-19 in hospitalised patients For Information only	
4.4	Datix Cymru For Information only	
4.5	Welsh Resuscitation Forum 17 January 2022 Update on PPE and Cardiopulmonary Resuscitation (CPR) For Information only	
4.6	• Minutes of the Mortality Review Group Meeting • Mortality Review Group Action Log For Information only	
PART 5: ANY URGENT BUSINESS		
5.1	<u>Any Urgent Business</u> CMain asked that anyone interested in taking up the role of QSE Lead for the Clinical Board please contact her to discuss further. Due to Clinical commitments Guy is unable to attend the meeting at the current time, we will look at changing the days and times to allow more to attend, further details will be sent out in due course. LA shared a Safety Notice “Preventing transfusion delays in bleeding and critically anaemic patients”, he asked if the content was for each Directorate to action. CMain said that purpose of sending out these documents is to ensure that this information is disseminated locally, also to ensure that staff are released to undertake training in accordance to the needs of the Directorate. Any updates to policy will be shared with this group.	
PART 6: DATE OF NEXT MEETING		

6.1	<u>Next Meeting</u> Thursday 17 March 2022 9:30am via Teams	

Minutes of the Clinical Effectiveness Committee held on 18th January 2022 via MS Teams

Present:

Dr Raj Krishnan	Associate Medical Director/Chair	RK
Prof. Meriel Jenney	Interim Medical Director	MJ
Angharad Oyler	Head of Patient Safety & Quality Assurance	AO
Joy Whitlock	Head of Quality & Safety Improvement	JW
Annie Burrin	Patient Safety Organisational Learning Manager	AB

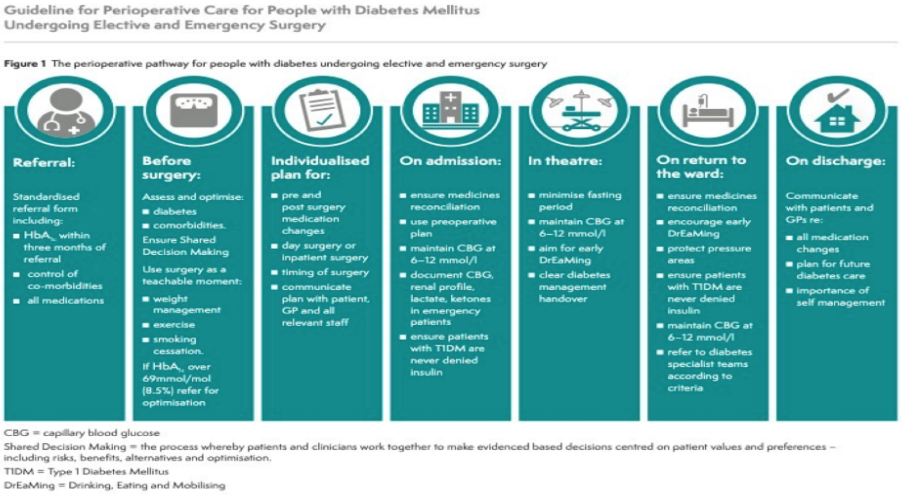
In attendance:

Catherine Doyle	Consultant Anaesthetist	CD
Tessa Bailey	Consultant Anaesthetist	TB
Juliet Evans	Minutes	JE

		Action
1.	**Welcome** RK welcomed everyone to the meeting.	
2.	**Apologies for Absence** There were no apologies for absence.	
3.	**Minutes of the meeting held on 21st December 2021** The minutes were agreed subject to the following amendments: **Present**…JW's title should read Head of Quality and Safety Improvement. **Page 5 NCHDA**…should read Paediatric Cardiologist. RK to chase. **Action Log** ***4. AMAT and Business Case Update*** To be discussed within the agenda. ***6. Orthopaedic Peer Review for Knee Replacements*** ***National and Local Audits*** *NMPA* – Clinical Board to be asked how good our data quality is, is it complete, what data is available, what was the BMI at booking, was there are previous c-section, smoking status at booking in and at the time of birth. ***Outlier Status*** To be discussed within the agenda. ***10. Patient Safety Notices*** *Patient Safety Alert – PSA063 – Deployment of Neuraxial* To be discussed within the agenda.	***AO***

4.	**AMAT and Business Case Update** The business case is due to go to BCAG in February, but further work is needed. MJ advised BCAG would require a timeline, delivery information, clarity on the reason for investment and what difference the proposed posts will make to the team. JE to check the deadline for BCAG papers to be submitted.	***JE***
5.	**Terms of Reference** It was agreed that papers needed to the QSE Committee.	
6.	**Clinical Board/Audit lead presentations** ***Diabetes Surgical Data -*** *Catherine Doyle, Consultant Anaesthetist* CD gave some background on Diabetes. Diabetes UK – making hospitals safer for people with diabetes 2017 report. One in six hospital beds are occupied by someone with diabetes. Problems that arise are: higher infection rates; increased length of stay by 1-3 days; increased mortality – 6.4% higher. The National Diabetes Inpatient Audit shows that 18% of in-patients have diabetes. For diabetes patients bespoke prescribing is required during the perioperative period. Other issues are: it is busy clinically; lack of knowledge; time and high turnover of staff. Complications can occur with multi-organ disease therefore lots of surgical problems. National Diabetes In-patient Audit (NaDIA) - the data that was collected between 2018 and 2020 (Wales opted out of this last data collection period). It was noted that on the audit day in 2019 a snapshot found that: 1.4% of in-patients with diabetes required hypoglycaemic rescue in the last seven days; 3.6% with type 1 diabetes had developed DKA during their hospital stay; 0.2% with type 2 diabetes had developed HHS during their hospital stay and 1.1% had developed a DFU during their hospital stay. The Joint British Diabetes Societies for In-patient Care March 2016, audit standard asked: Does the Trust have services of a dedicated In-patient Specialist Nurse (at staff levels recommended 1wte per 300 beds?). It was noted not for our Surgical Directorate. Also, what percentage of people with diabetes who are listed for whom a perioperative diabetes management plan is created at POAC? (The standard being 100%). CAVUHB diabetic audit in 2019 shows 72%. CD spoke about the NCEPOD Highs and Lows 2018 report, a review of the quality of care provided to patients over the age of 16 who had diabetes and underwent a surgical procedure. 19.4% of patients were not prioritised appropriately which meant prolonged fasting. There was 35.8% room for improvement in clinical care. 21.1% of patients did not have their blood glucose managed appropriately in the post-op period (opinion of case reviewers). The Centre for Perioperative Care (CPOC) is a cross-specialty collaboration dedicated to the promotion, advancement and development of perioperative care for the benefit of patients at all stages of their surgical journey. CPOC is a partnership between patients and the public, other professional stakeholders including Medical Royal Colleges, NHS England and the equivalent bodies responsible for healthcare in the other UK devolved nations. CPOC published 'Guideline for Peri-operative Care for People with Diabetes Mellitus undergoing	

Elective and Emergency Surgery' March 2021 in collaboration with Diabetes UK which looks at the whole peri-operative pathway. This includes referral, before surgery, individualised plans, on admission, in theatres, return to ward and discharge.



The second report of the Perioperative Quality Improvement Programme (PQIP) for 2018/19 showed 124 NHS hospitals were recruiting patients. The aim was to reduce complication and improving the patient experience. Once a patient is recruited, they are followed up for a year to assess general health and wellbeing.

The UHW PQIP data for March 2019 to October 2020 shows that 320 patients were recruited; 37 of those were diabetic. 10.8% of diabetic surgical patients (HbA1c less than 69) were given IV antibiotics for infection between 5-7 days post-operatively compared to 6.8% in non-diabetics. Only 13% of patients had a normal BMI. The length of stay in diabetic patients is 6.8 days compared to 5.4 days in non-diabetic patients. 43% of patients had not had a HbA1c in the last three months.

In CAVUHB there has been a type 1 diabetes external review report, recent centralisation of vascular services to UHW, including all amputations and now Covid recovery. Medicine have had unsuccessful bids for Diabetic Specialist Nurses (DSN). There are currently 2wte at UHW, with one of those self-isolating. One out-patient nurse at UHL is seconded to in-patient care for three days a week. There is a total of six out-patient DSNs.

Regarding Primary Care data collated from one GP Surgery involved in the prehab 2 rehab project, it was noted that between December 2020-February 2021, the number of HbA1c over 69mmol/mol was 89 and a HbA1c over 100 was 26. The number of HbA1c in February 2020 where HbA1c more than 69mmol/mol was 1 and HbA1c more than 100 was 0.

	HbA1c > 69	HbA1c >100
Dec 2019 to Feb 2020	1	0
Dec 2020 to Feb 2021	89	26

In Primary Care there are 2.4wte DSNs, compared with 14 in ABUHB and 12 in CTMUHB.

The Community Health Pathways states a HbA1c should be carried out by a GP

if the patient has diabetes and is being referred for surgery. We need to encourage GPs to start doing this prior to surgical referral, earlier in the pathway, so there is time for optimisation.

The 'Prehab2Rehab Cancer Project' commenced in September 2020. The vacancy for the band 7 Glycaemia/Diabetes Specialist Nurse has not yet been advertised. Currently the Lead Diabetes Nurse for CAV is away, we don't know for how long this will be. Reluctance to appoint to this funded role, when the Lead Diabetes Nurse is away.

With regards to Pre-Operative Assessment Clinic (POAC) there is no data to show how many diabetic surgical patients are seen, as paper-based system. Since 2020, orange stickers have been used at UHW (and before this time at UHL POAC) to highlight diabetic surgical patients on medication, but not diet-controlled patients.

For theatre lists at CAV the Theatreman booking system is used and diabetes has been classed as a risk since 2020, so patients should now be highlighted on the operating lists.

The updated CPOC 2021 Diabetes Surgical Guidance should now be standardised across UHW and UHL Pre Op Assessment Clinics.

A Diabetic Audit was carried out in 2019 of 25 patients at UHW. 56% had a HbA1c of less than 69mmol/mol in the last three months. 68% had HbA1c recorded. 72% were given pre-op advice on medication and diet adjustments to achieve good glycaemic control. 16% identified as diabetic on theatre list.
56% listed at the beginning of the list. 68% (17/25) perioperative CBG (capillary blood gas) between 6-12. 4/25 patients were on VRII of which 3 patients had the recommended hourly CBG monitoring.

A re-audit was carried out in 2021 (green zone) with 26 patients. 65% of patients were identified as diabetic on the theatre list. 73% were listed at the beginning of the list. 65% (17/26) perioperative CBG between 6-12mmol/mol.
The NCEPOD recommendation in theatres is to ensure that patients with diabetes undergoing surgery are closely monitored and glucose levels managed accordingly. Glucose monitoring should be included at sign-in/sign-out stages of the surgical WHO safety checklist. This had been accepted and an updated draft of the WHO checklist went to Surgical Board Quality and Safety meeting in June 2021. UHB approval was awaited.


WHO Surgical Safety Checklist

SIGN IN
BEFORE INDUCTION OF ANAESTHESIA

COVID test result?
Yes ☐ COVID positive ☐ COVID negative ☐
No ☐ Not appropriate to test / delay surgery ☐

Patient/carer verbally confirms
- Identity? Yes ☐ No ☐
- Procedure Yes ☐ No ☐
- Site? Yes ☐ No ☐
- Consent? Yes ☐ No ☐

If can't confirm:
Consent form 4 completed? Yes ☐ No ☐

Laterality?
Site marked ☐ Not marked ☐ Not applicable ☐

Anaesthetic machine and drug checks completed?
Yes ☐ No ☐

Glycaemic control? Yes ☐ No ☐
For diabetic patients on medication: Has a capillary blood glucose (CBG) been tested in the last hour? Yes ☐ No ☐

Allergy status confirmed? Yes ☐ No ☐

Difficult airway / aspiration risk?
Yes, and equipment / assistance available ☐ No ☐

Blood loss risk >500ml? (7ml/kg in children)
Yes ☐ No ☐
Electronic issue? Yes ☐ No ☐
Crossmatch? Yes ☐ No ☐

Radiology requirements? Yes ☐ No ☐

Pregnancy test result positive?
Yes ☐ No☐ Not required ☐

Thromboprophylaxis required?
Yes ☐ No ☐

Antibiotics Prescribed? Yes ☐ No ☐

TIME OUT
BEFORE SKIN INCISION

Confirm that all team members have introduced themselves by name and role if not already known: Yes ☐ No ☐

Surgeon, Anaesthetist and registered practitioner verbally confirm
- Patient name Yes ☐
- Site Yes ☐
- Procedure Yes ☐

Has essential imaging been displayed? Yes ☐ Not applicable ☐

Throat pack inserted? Yes ☐ No ☐

Anticipated critical events:

Surgeon: What are the critical or non-routine steps, anticipated blood loss, specific equipment requirements and/or any special investigations? ☐

Anaesthesia team: ASA Grade? ☐ Intubation grade? ☐
Are there any patient specific concerns, monitoring equipment and other specific levels of support required, e.g. blood or critical care? ☐

Nurse / ODP: has the sterility of the instruments been confirmed, are there any equipment issues of concerns? ☐

Perfusionist: are there any equipment issues or concerns? ☐

Surgical Site Bundle:
- Antibiotic prophylaxis given in the last 60 minutes? Yes☐ No☐
- Has hair been removed using clippers? Yes ☐ No ☐
- Is patient warming needed? Yes ☐ No ☐
- Is glycaemic control needed? Yes ☐ No ☐
- Has thromboprophylaxis been prescribed? Yes ☐ No ☐

Have all team members confirmed surgery can be commenced? Yes ☐ No ☐

SIGN OUT
BEFORE THE PATIENT LEAVES THE OPERATING ROOM

Registered practitioner verbally confirms with the team if:
- The correct name of the procedure has been recorded? Yes ☐ No ☐
- Instrument, swab and needle count is correct? Yes ☐ No ☐
- Throat pack (if used): has it been removed? Yes ☐ Not applicable ☐
- Specimen has been correctly labelled? Yes ☐ Not applicable ☐
- Glycaemic control? Yes ☐ No ☐

For diabetic patients on medication: Has a capillary blood glucose (CBG) been tested in the last hour? Yes ☐ No ☐

- Any equipment problems to be addressed? Yes ☐ No ☐

Before the surgeons / anaesthetists leave the operating theatre:

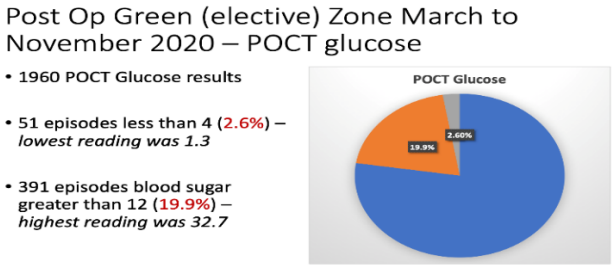
What are the key concerns for recovery and management of this patient:
- Surgical? ☐
- Anaesthetic? ☐
- Nurses / Allied Healthcare Professionals? ☐

Debrief:
Does anybody in the team consider that debriefing on this case would be beneficial?
Yes, now ☐ Yes, at the end of the list ☐ No ☐

WHO Surgical Safety Checklist, CAVUHB v 4, February 2021

The post-op green zone data from March-November 2021 for POCT glucose, based on 1,960 POCT glucose results, shows that there were 51 episodes of a

blood glucose less than 4 (2.6%) – the lowest reading was 1.3. 391 episodes of blood glucose reading greater than 12 (19.9%); highest reading was 32.7.



A 'Theatres Hypoglycaemic Audit' was carried out at UHW, in 2021 to determine the awareness amongst theatre staff of Hypo Boxes. 56 responses were received from a mixture of anaesthetists/ODPs and nursing staff. 66% did not know the whereabouts of the Hypo Box in green and amber zones; 64% were not familiar with the contents of the Hypo Box; 66% had not seen the Hospital Hypo Guidance and 84% said they would like a refresher session on Hypoglycaemia. It was noted that the guidelines on the intranet needed to be updated, as they are from 2015 and CAV Hypoglycaemia paperwork needs to be updated.

With regard to post-op care, E-consult is being used to make DSN referrals. Only one in-patient DSN is currently available. The Surgical Acute Pain Service model in Surgery is 10wte nurses providing seven days a week cover across UHW and UHL. Diabetic surgical patients are highlighted on the patient name board with blue magnets at UHW. Standard guidance is needed as well as education for ward staff, theatre staff, nurses, foundation doctors, surgeons and anaesthetists.

Key points for a Diabetes Surgical Pathways are: MDT approach, collaborative, communication, data collection, governance and continual improvement.

Surgery and Medicine need to work together to take this forward. Issues to be addressed and reviewed within the next year. MJ suggested that CD escalate the DSN cover to the Directorate and refer back to the group if not progressed.

TB shared her concerns about the length of stay in diabetic patients. It was noted that there is funding available for one band 7 and possibly more funding for another in the Pre-Assessment Clinic. TB to liaise with the Senior Nurse in Medicine to highlight the patient safety issue. ***TB***

RK suggested CD contact Helen Kemp, PCIC around healthcare pathways and patients being referred for surgery having a HbA1c check. With regards to the sign out around glycaemia and flushing line, this group signed off the changes to the WHO checklist in 2021. CD had received an email from Jon Barada advising WHO checklist had not been signed off. RK suggested that, from diabetes point of view and guidelines Lindsay George needed to be invited to discuss NDA. ***CD***

The intranet Superuser is the diabetes nurse who is currently sick. It was agreed that there should be someone else who can access the diabetes information and update the page. If this was not done by the end of January, RK to be informed. CD to be invited back in 6-12 months' time to see what progress has been made. ***AO***

NAIF

The report for in-patient falls for 2020 had been received. The audit looked at the care given to 1,357 patients who fell while they were in hospital and sustained

	a hip fracture during January–December 2020. The key messages were that it was necessary to assess older in-patients for factors that increase their risk of falling so that appropriate interventions and care plans are put in place. The risk factor which was most often assessed was continence with 74% of patients undergoing this component of the MFRA. Vision and lying/standing blood pressure were the least often assessed with 44% and 35% of patients receiving this assessment respectively. 71% of patients were checked for injury before moving (compared with 69% in 2019); 26% of flat lifting equipment was used (compared with 22% in 2019) and 62% of patients were assessed by a medic within 30 minutes (compared to 69% in 2019). Many in-patients experience delays to hip fracture care due to poor standards of immediate post-fall management. On average, it took two hours following the fall that caused the hip fracture for patients to receive the first dose of pain relief. NICE Clinical Guideline 124 recommends that analgesia should be given immediately. Less than 50% of delirium care plans and less than 75% of mobility plans were being followed at the time of the fall that cause the fracture. Eight recommendations were made: 1. Data Quality – Clinical leads should assess the extent of the gap between actual and reported falls in their Trust or Health Board if more than 10% of in-patient femoral fractures (IFFs) are recorded in NAIF as not attributable to a fall. Higher proportions of IFFs not attributed to a fall suggest under-reporting. *Compliance confirmed.* 2. Clinical – Clinical Leads should implement quality multi-factorial risk assessments (MFRAs) in all ward types, as in-patient falls can happen anywhere. *Compliance confirmed.* 3. Clinical – Senior leaders and clinical teams should run at least one quality improvement project per year aimed at improving the quality of MFRA and to ensure care plans are followed. *Compliance confirmed.* 4. Falls leads and clinical teams should use QI methods to address poor performance against NICE Quality Standard 86 statements 4, 5 and 6 (NAIF KPIs 2, 3 and 4): ♦ Checks for injury after an in-patient fall (CAVUHB = 80%; NAIF overall 76%); ♦ Safe manual handling after an in-patient fall (CAVUHB = 85%; NAIF overall 79%); ♦ Medical examination after an in-patient fall (CAVUHB = 70%; NAIF overall 69%). Timely and effective post-fall management improves outcomes for patient. *AB advised this is progressing. A registrar attended the Falls Delivery Group recently and advised that some staff are not confident in this area. AB requested more detail. We are doing well against the national target but improvement needed on prevention.* 5. Clinical teams should administer analgesia as soon as a provisional diagnosis of IFF is made, aiming for within 30 minutes of the fall. *Not fully compliant as it is dependent on what is prescribed and where they fall. NAIF audit shows it can be 1-1½ hour wait for pain relief.* 6. Senior leaders should review patients who have experienced delays in starting femoral fracture management in in-patient settings to identify where systems and processes can be improved to avoid delays. *Not fully compliant. We do not have many delays in CAVUHB, but those we do have are usually due to WAST response times.* CD advised that there was a block injection that could be used instead of an opioid, which is easy to administer. AB to discuss this further with CD.	***AB***

	7. Dissemination – Falls leads and senior leaders should review NAIF reports and online real-time data for their Trust in quarterly meetings of multi-disciplinary team (MDT) falls working groups, so that these can be drivers for local QI projects. *Compliance confirmed.* 8. Leadership/Resources – Senior leaders should include time for participation in NAIF and related QI activities in job specification and plans for falls leads/practitioners/co-ordinators. *Not compliant; AB only has capacity to work on Falls for two days per week.* AB advised that an action for the Falls Delivery Group was to recruit 1wte Falls Lead once the Patient Safety & Quality Team business case has been approved to commence post falls actions QI project and complete RCP Quality Improvement Collaborative project (orthostatic hypotension). AB to add the block injection to the Falls Delivery Group agenda. **National and Local Clinical Audits** ***NELA*** *(Emergency Laparotomy)* Last year 44.2% of high-risk patients were admitted to Critical Care compared to 63.2% the previous year. The national average is 82.3%. RK felt more patients should be transferred to Critical Care instead of being managed on the wards. The national average time for antibiotics to be administered to patients with suspected sepsis within one hour is 78.3%; CAVUHB data shows 15.1%. RK asked for the NELA Team to be invited back to the Committee to discuss where the difficulties lie. ***NHFD*** *(Hip #)* Clare Wade is leading on a pressure damage collaboration, but work currently suspended due to Omicron. CW to be invited to look at the action plan and MJ to discuss this with Ruth Walker. ***NVR*** *(Vascular)* AO to contact Kevin Conway about the data that we are reporting. AO to send RK the information about who has submitted what. It was noted that the trend is way off the national average. RK advised there was an issue with the data being reported; the national average is 2,258; CAVUHB is 15. Regarding carotid artery SBUHB are reporting 150; CAVUHB is 15-20. **Overview of Current Position** Currently up-to-date. Some national diabetes audits were received at the end of 2021 and some audits received for February and March. **Outlier Status** ***Psychosis Audit*** RK advised that a psychosis audit had been received. Mental Health are compliant with this. ***Epilepsy 12*** AO advised that she had not had a response and would follow up. ***Inflammatory Audit*** AO advised that she would follow this up.	***AO*** ***MJ*** ***AO*** ***AO*** ***AO*** ***AO***

	Local Clinical Audits ***Internal Audit report – Update*** AO is working on the Strategy and Policy. The plan is very dependent on what investment we get for the approach to clinical audits. If investment is received the plan would be to support the Clinical Boards with members of the Clinical Audit Team. If investment is not received, the support would be less. AMAT would make a huge difference. MJ advised that we needed to articulate that AMAT would be a top priority and by explaining what the outcome for each option would be.	
7.	**NICE & HTW** Currently behind but we have a good system in place on circulating information.	
8.	**Peer Review and Accreditation** ***CAMHS Report*** This has still not been received so RK to follow this up. ***Dermatology Peer Review*** The Dermatology Team will be attending the meeting in February.	***RK***
9.	**TARN Update** TARN will be slowly moving across to the MTU by 31st March 2022. They have a high-level peer review taking place in the next few weeks.	
10.	**Update Service Developments** ***Patient Safety Notices*** ♦ *Patient Safety Notices/Alerts overview* *PSN 063 – Deployment of NR FIT – Update* AB advised there were a very small number of notices outstanding: *NG Tubes (2017)* – outstanding but the Delivery Unit advised that the All Wales Medical Directors Group will progress actions for this. There will be a national solution for medical training. A request has been made that nurse training is added to this as a whole package. *PSA012 Pleural Infusions* – guidance and documentation to be ratified. *Liquefied Phenol* - to be signed off at the end of February. The only place this is used is in Podiatry. AB requested an update about changing the guidance. *Adrenal Crisis* – now compliant. *Phenobarbital* – this has now been closed. RK enquired about the chest drain. AB advised we have documentation and guideline booklet with tear off section for patient details. Recruitment and ratification had delayed this as it was due to be completed in July 2021.	

	Neuraxial – AB advised we could declare compliance against the new procedures. AB meeting with midwifery next week about training. MJ advised that this needs to be followed up with C&W and Surgery because of theatres. MJ does not want to sign off until the Director of Operations or Clinical Directors have signed off. With caveat MJ happy for AB to say yes.	***AB***
11.	**Policy and Procedures** Nothing to discuss.	
12.	**Any Other Business** ***Royal College of Physicians documentation audit*** AO advised that the Hospital Acquired Thrombosis (HAT) audit mandated by Welsh Government in 2014 is no longer mandated. Welsh Risk Pool have highlighted an increase in VTE assessments so requested we continue. Regarding the VTE assessment there is variance on who is completing; RK advised it should be the Clinical Board. Pharmacy to be invited to this meeting to discuss thrombosis, prophylaxis and prescribing.	***AO***
13.	**Date of next meeting** 14th February 2022 at 9.00am via MS Teams.	

Minutes of the Clinical Effectiveness Meeting held on 15th February 2022 via MS Team

Present:

Dr Raj Krishnan	Associate Medical Director/Chair	RK
Prof. Meriel Jenney	Interim Medical Director	MJ
Angharad Oyler	Head of Patient Safety & Quality Assurance	AO
Joy Whitlock	Head of Quality & Safety Improvement	JW
Annie Burrin	Patient Safety Organisational Learning Manager	AB

In attendance:

Barbara Davies	Lead Nurse, Specialised Medicine	BD
Vicci Page	Service Manager, Dermatology	VP
Louise Richards	Nurse Manager, Dermatology	LR
Beth Jones	Senior Nurse, Specialist Medicine	BJ
Juliet Evans	Minutes	JE

		Action
1.	**Welcome and Introductions** The Chair welcomed everyone to the meeting.	
2.	**Apologies for Absence** There were no apologies for absence.	
3.	**Minutes and Action Log of the meeting held on 18.01.22** ***Minutes*** The minutes of the meeting were accepted as an accurate record of proceedings, with the following amendments…… ***6. Diabetes Surgical Data presentation by Catherine Doyle*** Awaiting amendments to minutes from Catherine Doyle. ***National and Local Clinical Audits – NHFD (Hip#)*** The following should have been recorded under 'NVA (Vascular)': AO to contact Kevin Conway about the data that we are reporting. AO to send RK the information about who has submitted what. It was noted that the trend is way off the national average. ***Action Log*** ***3. NMPA*** AO advised there were no issues with Health Boards in Wales. ***4. AMaT and Business Case*** Funding agreed for two years. Staff to be recruited within timeframe. Process commenced with Procurement and Finance. ***6. Diabetes Surgical Data*** Diabetes information to be updated on the intranet. Catherine Doyle to be invited back in 6-12 months' time.	***AO***

	NAIF Catherine Doyle to be invited to the Falls Delivery Group to discuss the block injection. ***NELA*** NELA Team to be invited for update on antibiotic use and sepsis. ***NHFD*** Clare Wade invited to next meeting. Regarding pressure damage, no action for MJ, just to note. Clare Wade leads on pressure damage within the Executive Nurse Director's portfolio. ***Epilepsy 12*** RK to request a response. ***Inflammatory Audit*** RK to look into this as a response had not been received. ***Neuraxial*** To be discussed under the agenda. ***Royal College of Physicians documentation audit*** AO had spoken with Darrell Baker regarding VTE audit, which is required by Welsh Risk Pool. Pharmacy do not carry out regular audits on this. Meeting to be arranged with Marilyn Rees and Rachel Rayment before Marilyn retires.	***AO*** ***RK*** ***RK*** ***AO***
4.	**Terms of Reference** Item was not discussed.	
5.	**Clinical Board/Audit lead presentations** ***Dermatology action plan update by Barbara Davies, Lead Nurse, Medicine*** An update was given on the action plan and local recommendations.	

1	Implement robust IT infrastructure and electronic reporting mechanism	Ongoing
2	Review arrangements with primary care and ensure the lack of provision in primary care does not impact further on secondary care	Ongoing
3	Standardise and review the follow up procedure	Completed
4	Review existing storage arrangements and work with estates to improve the safety and reliability of storing patient notes	Completed
5	Support the appointment of a second clinical fellow post with arrangements for clinical capacity within Glamorgan House	Completed

6	Expedite the necessary requirements and amendments needed to progress the functionality of the patient administrative system to improve reporting method particularly around biologics	Ongoing
7	Review arrangements for existing Cwm Taf Morgannwg patients receiving biologic treatments in Cardiff & Vale to explore the opportunity to repatriate the service	Ongoing
8	Support the directorate to improve access to the building	Completed
9	Understand the proportion of private treatments being undertaken on NHS services	Completed
10	Review pathology support and funding for Moh's service	Ongoing

Further support required on two points:

1. Primary Care engagement to support minor skin surgery in GP's. Some GP's keen to get on board with this. SLA to be finalised.
2. Teledermascopy project. Scheduled to commence later this year. Pilot undertaken last year. Low risk patients who we could potentially diagnose via Teledermascopy; 60-70% discharge rate.

Achievements

Workforce Nursing Review:

- Nursing activity codes implemented to monitor and recognise accurate nurse activity;
- New ways of working; Band 3 Theatre Nurse Assistant recruitment successful to enable career progression. Ongoing review following benchmarking across Wales;
- Dermatology Nursing Forum;
- Nurse-led pathways being developed.

Activity Reporting

- Nursing activity codes implemented to monitor and recognise accurate nurse activity;
- Day care activity recorded on PMS;
- Biologics database implemented;
- Pilot of In-patient Booking System.

Mohs Service

- Mohs BMS appointed on a fixed term basis.

Environment/Infrastructure

- Appropriate signage in place to improve patient experience;
- Patient notes stored appropriately and in line with health and safety guidelines.

Transformation/Patient Experience

- Commenced Teledermoscopy Pilot;
- Patient Initiated Follow Up (PIFU)/See on Symptoms (SOS) implemented.

The Team meet weekly with Chris Bryant, GP. Regarding Cwm Taf, currently looking to use the SLA route, but use the GP route for the INNU. Needs to be discussed with the Directorate and Finance going forward. MJ

	is happy to support this. VP advised that the service no longer accepts benign lesions so the rejection rate has increased. **National and Local Clinical Audits** ***Sentinel Stroke National Audit Programme (SSNAP)*** Data is disappointing. Regarding the median time to thrombolysis, the graph shows our data is not good. HIW are scheduled to visit soon. Stroke Team to be invited after the HIW visit. It was believed that the Stroke Lead is yet to be appointed. RK to contact Aled Roberts as this needs to be in place before the HIW visit. ***National Oesophago-Gastric Cancer Audit (NOGCA)*** This is a statutory cancer audit with Upper GI. They are compliant and have done a good job. RK to write to the Team to congratulate them. ***Fracture Liaison Service*** The FLS database annual report was discussed, Last month the 2019/2020 benchmarking report showed poor results for Cardiff. The Health Board received a letter Welsh Government to provide a response regarding the actions being taken to address the issues. A part B was submitted to WG in 2021, the results of the actions taken would not be apparent. Actions should be completed by April 2022. A response to WG is being prepared by the Executive Director for Therapies. An update on completion of actions to be requested, and a copy of the response for the records. ***Intensive Care National Audit and Research Centre (ICNARC)*** Jack Parry-Jones and Gareth Scholey collated Adult Critical Care data for 01.04.21–30.09.21 around length of stay. Our length of stays are longer; this partly reflects the problem discharging patients when medically ready. Sicker patients who survive will have longer stays. Our unplanned re-admission rates are low. **Overview of Current Position** Currently up-to-date. Julia Platt invited to April meeting to discuss diabetes audits. Two diabetes audits have been received for March. The PICANET Team to be invited to a future meeting. Also audits for psychosis, cardiovascular prevention and SSNAP. **Outlier Status** ***FLS*** Already discussed. **Local Clinical Audits** Difficult to keep track of audits being registered as dependent on Clinical Boards letting us know what they are doing. AMaT will alleviate this and be key to providing assurance. Often, action plans are missing.	***AO*** ***RK*** ***RK*** ***AO*** ***AO***
6.	**NICE & HTW** When AMaT is implemented, data capture should be easier. Peter Groves, HTW Chair, had been invited to talk at Clinical Senate on Friday.	

7.	**Peer Review and Accreditation** ***CAHMS Report*** To remain on agenda as not yet published. If not received next month, MJ to follow up. MJ advised there are delays but a review is being carried out. GIRFT Cardiology to be discussed at a future meeting but not ready yet. MJ taking forward with the Clinical Board. GIRFT Orthopaedics was a hot topic at the moment but again not ready to be discussed at this meeting. MJ will feedback soon.	
8.	**Update Service Developments** ***Patient Safety Notices (PSNs)*** The Handlebar injuries in paediatric abdomen and liquified phenol PSNs had been closed since the last meeting. *PSN063 – Deployment of NR FIT* - AB and Cathy Morley-Jacob had discussed with C&W Clinical Board triumvirate. Concerns about the supplier due to an eight-week delay. There is a lot of fragility in the supply chain and the Pharmacy quality assurance process takes at least 84 days. It was hoped this would be finalised by June, but more likely September. A staff member from Procurement will project manage this, including financial planning. We are due declare compliance in March so will discuss at the March meeting. AB to write a position SBAR. Two other alerts received: One from SHOT around preventing transfusion delays which the Transfusion Group will lead on this and another around monoclonal antibodies. Both logged and circulated. We would not normally receive alerts via this route. RK had spoken to the Delivery Unit and WG around one channel of distribution. It was suggested that the PSA modules may be better placed on AMaT as there can be delays getting the alerts to the Clinical Boards. Regarding the NG Tubes, this was discussed at the All Wales Group yesterday. All pH strips are not marked. Education is outstanding.	***AB***
9.	**Policy and Procedures** ***Strategy/Vision for Clinical Effectiveness*** RK advised once the new Assistant Director of PS&Q was in post, the template about what should be discussed at Quality and Safety forums need to be revisited. Ownership to remain with Clinical Boards TARN to be handed over shortly. Clinical Audit Team to monitor, not deliver the audits. AMaT to have a spread and scale approach. Three months after AMaT is in place we need to review the KPIs.	

10.	**Any Other Business** The business case had been approved. AO advised we need to be mindful of capacity as we are delivery on national audits but there will addition pressures rolling out AMaT. MJ advised priorities needed to be identified as some Clinical Boards do not understand what statutory audit is. Resource will always be an issue so need to use AMaT efficiently. MJ requested clarification on the resource requirement to minimise fallout.	
11.	**Date of next meeting** 14th March 2022 at 9.00am via MS Teams	

Report Title:	**Corporate Risk Register**			Agenda Item no.	4.3
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	12/04/2022
		Private			
Status *(please tick one only):*	Assurance		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 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.

At the Health Board's March 2022 Board meeting a total of 10 (from a total of 16 scoring 20 or above) Extreme Risks reported to the Board related to Patient Safety and are linked to the Quality, Safety and Experience Committee for assurance purposes. Details of those risks are attached at Appendix A but can be summarized as follows:

Risk Score (1 to 25) - Clinical Board	20/25	25/25
CD&T		
Medicine	3	
PCIC		
Specialist Services	3	

Surgery		
Digital Health		
Estates		
Children and Women		
Mental Health		
Capital Estates and Facilities	**5**	
Total:	**11**	**-**

An updated Register will be shared with the Board at its May 2022 meeting.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that continues to be rolled out by the Risk and Regulation Team ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

Recommendation:

The Committee is 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		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:

CORPORATE RISK REGISTER MARCH 2022 - QSE Committee Entries

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital Estates and Facilities	1	Mar-21	Risk/Issue: UHW Cardiac Theatre GF AGSS Pump is faulty Impact: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	2	Mar-21	**Obsolete Medical Gas Delivery Equipment** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete in Barry. Medical Gas (Nitrous Oxide) manifolds are obsolete in UHW Maternity (manifolds 1&7), UHW A&E, UHW Dental (manifolds 4&10). In addition the UHW Medical Gas Pressure reducing set is obsolete. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety, quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	3	Mar-21	Risk/Issue: UHW Tunnels corroded Main O2 Pipeline due to building leakage Impact: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	**20**	Regular inspection and maintenance.	5	4	**20**	Repair building leak and renew section's of corroded pipework.	5	1	**5**	Feb-22	Quality, Safety & Experience Committee	Patient Safety Capital Estates

	4	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	Feb-22	Quality, Safety & Experience Committee	Planned Care Capacity Capital Estates
	5	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW CHFW 1st Floor Rainbow ward Day Case Theatre and recovery, 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	Feb-22	Quality, Safety & Experience Committee	Workforce Capital Estates Staff Wellbeing
Medicine Clinical Board	7	01/03/2019	Patients are remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	**20**	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patient's condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assessed by the Triage Nurse/Majors Assessment Nurse to ensure a patient clinical assessment is conducted.Concern by either party about the length of any delay or the volume of crews being held will be escalated by the Senior Controller/EU NIC to the Patient Access for usual UHB escalation procedures, or by WAST to their Silver Command. WAST have introduced a number of hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer. For patients arriving in UHW and UHL assessments units, the NIC will assess these patients and escalate in line with policy. Standard Operating Procedure in place within the Emergency Department to support any 'Immediate Releases' requested by WAST. Update December 21: Joint CB/ WAST partnership meetings in place to focus on improvements. The Clinical Board is engaged with the NRI process for reporting incidents where WAST delays have resulted in major patient harm. Update Transformational work being undertaken across Acute and Emergency Medicine to support flow, including RATZ, virtual ward.	5	4	**20**	Daily review and risks noted within Safety Huddles and EU Controller reports. Escalated to MCB Hub and Patient Access Services. Evaluation of Standard Operating Procedure to reflect any changes required. WAST Immediate Release Standard Operating Procedure in use to support 'Red' calls in the community. Update December 2021: OPAT accross both UHW and UHL to support WAST and patient flow.	5	2	**10**	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety
	8	01/01/2021	The ability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment is resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience.	5	5	**25**	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.	5	4	**20**	Medical staffing reviewed as part of the daily LCC meetings with ongoing planning to ensure safe staffing.	5	2	**10**	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety and Workforce
	9	01/12/2021	There is a risk of overcrowding with the Emergency and Acute Medicine footprint secondary to no flow or lack of UHB capacity. This results in the inability to provide and maintain key quality standards as patients are being nursed in inappropriate areas affecting timely access to treatment and discharge.	5	5	**25**	UHB and local escalation policy and implementation led by MCB HUB and Patient Access Services working in partnership with the EU Controller and Senior Floor Cover to improve flow. Escalation of all constraints to all Directorates. Internal escalation to key clinicians/staff to assist with flow across the department. All vulnerable patients escalated to ensure timely bed allocation. Standard Operating Procedure in place for all ambulatory areas. Implementation of Internal Professional Standards to deliver prompt specialist review within agreed timeframe	5	4	**20**	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow.	5	3	**15**	Feb-22	Quality, Safety & Experience Committee	Patient Safety

Specialist Services Clinical Board	11	Sep - 21	**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	**25**	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	**20**	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety and Planned Care Capacity
	12	Jan-16	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	5	**25**	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently. The unprecedented demand during the current Covid19 Pandemic has resulted in a temporary increase in the unit footprint and capacity which has ameliorated this issue whilst at the same time exacerbating the Crtitical Care workforce risks detailed elsewhere.	5	4	**20**	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Planned Care Capacity
	13	Jul-20	**Critical Care - Clinical Environment** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and also compromises the care of patients where temperatiure is a critical concern. The well being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dedydration. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, phamaceutical storage, device storage and management hubs areas.	5	5	**25**	**The clinical area is divided into zones to where patients are grouped according to IP&C risk to reduce the risk of cross-infection. Staff entering the clinical area are required to wear full PPE to reduce the risk of cross-infection.**	5	4	**20**	**There is an urgent need for a capital investment program and business case developed to address this need.**	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets

Report Title:	Infected Blood Inquiry			Agenda Item no.	4.4
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	12.04.2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

After a Christmas break, the Infected Blood Inquiry has recommenced hearings and hopes to be within the final 12 months of hearing evidence. The final hearing timetable has been published on the Inquiry website with deadlines for submission of final evidence (https://www.infectedbloodinquiry.org.uk/public-hearings-timetable - Please note that you will need to copy and paste the address into your browser to access the website).

Final hearings, relating to oral submissions from recognised legal representatives and unrepresented core participants about the conclusions they think the Inquiry Chair should reach are scheduled for the week commencing 12th December 2022.

The publication of the Inquiry's judgment and recommendations is not expected until at least six months following the conclusion of evidence.

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

The hearings have been, and will continue to be, aired online and the Head of Risk and Regulation has put in place arrangements to ensure that hearings are attended virtually by the Corporate Governance Legal Advisor, or himself in her absence, so that pertinent information and issues can be reported upon.

The following key headline dates have been published:

20th June 2022 - Deadline for initial written submissions in outline from recognised legal representatives and unrepresented core participants about recommendations (not related to compensation) to inform the Chair's decision about whether to call additional evidence relevant to recommendations.

24th October 2022 - Written submissions from recognised legal representatives and unrepresented core participants about the conclusions they think the Chair should reach.

An outline of the hearings timetable for 2022 is as follows:

March – Blood Transfusion Policy and Practise and Self Sufficiency and Domestic Production of Blood Products

May – June - the response of governments, transparency, Variant Creutzfeldt-Jakob disease (vCJD) and the Infected Blood Compensation Framework Study.

September – Expert Groups

October – Panels of people infected and affected

November - additional evidence relevant to recommendations, if required.

December - Indicative weeks for oral submissions from recognised legal representatives and unrepresented core participants about the conclusions they think the Chair should reach.

To date, the Health Board has engaged with and responded to the Inquiry in an open and transparent manner in response to requests made of it. The Health Board has not however, actively contributed to ongoing discussions or made representations at hearings.

Nevertheless, the Health Board does have the opportunity to present submissions to the Inquiry at this stage and consideration will be given to whether it would be appropriate to do so, and in what format, in the coming months.

Recommendation:

The Committee is requested to:

- **Note** the contents of the Infected Blood Inquiry Update

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	x
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	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No

No
Workforce: Yes/No
No
Legal: Yes/No
Yes – legal advice has been sought on pertinent issues (as detailed in the report)
Reputational: Yes/No
Yes – The outcome of the Infected Blood Inquiry and how the Health Board elects to participate will have an impact on its reputation.
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:

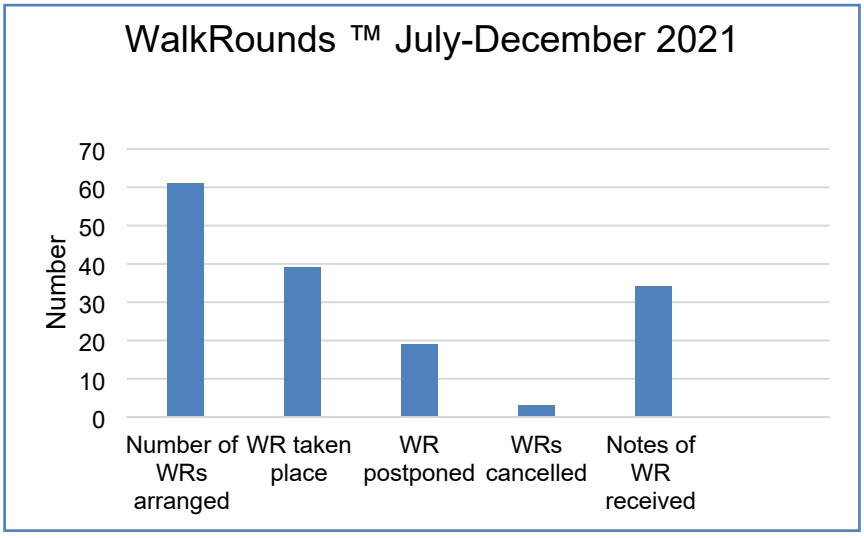
Report Title:	**Patient Safety WalkRounds™**			Agenda Item no.	4.5
Meeting:	**Quality, Safety and Experience Committee**	Public	x	Meeting Date:	12/04/2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Head of Patient Safety and Quality Improvement**				

Main Report
Background and current situation:

Patient Safety WalkRounds™ (WRs) were established in 2008 in the Health Board as part of the Safer Patient Initiative. Due to their added value to quality and safety they were mandated by Welsh Government in Achieving Excellence, The Quality Delivery Plan for NHS Wales 2012-2016. Once a month each Executive is scheduled to visit a clinical area along with an Independent Board Member. In addition to this, a few other senior leaders are also scheduled to participate in WRs. Thus, over 100 WRs can take place each year.

With the onset of the Covid-19 pandemic, WRs ceased to reduce unnecessary exposure and transmission between clinical areas with the exception of a few wards where it was felt that staff needed patient safety advice and support. They enabled visible senior leadership and provided a listening ear, particularly to staff working in new teams in unfamiliar circumstances.

WRs recommenced from July-December 2021 and stopped again due to the third wave of Covid-19.



The majority of cancelled or postponed WRs have been due to Covid-19 and staff having to isolate or ward in red status.

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

WRs are an important conduit for the Board and other senior people in the UHB to demonstrate visible leadership and provide an opportunity to promote the reputation of the Board and sense the impact of the work to translate values into action across the organisation. Senior leaders get a firsthand experience of clinical areas and engage with staff and, where appropriate, patients. Frontline staff have the opportunity to raise safety concerns and highlight things they are proud of.

The table below outlines activity from the WalkRounds™ from July-December 2021

Couplet	Number of WRs scheduled	Number taken place	Number of changes to original date	Number of Notes received
Catherine Phillips/Charles Janczewski	6	6	4	5
Rachel Gidman/Ceri Phillips	6	4	3	4
Ruth Walker/Rhian Thomas	6	6	0	4
Fiona Jenkins /Sara Moseley	6	4	2	4
Steve Curry (Caroline Bird)/Mike Jones	6	3	3	2
Len Richards (Stuart Walker)/Susan Elsmore	6	1	1	1
Fiona Kinghorn/Gary Baxter	6	4	2	2
Stuart Walker/Meriel Jenney/Akmal Hanuk	6	1	4	0
Nicola Foreman/David Edwards	6	4	2	4
Abigail Harris/Michael Imperato	6	6	0	5
Carol Evans (Joy Whitlock/Angela Hughes)/John Union	6	3	3	3

Common reasons for needing to reschedule the WRs include operational pressures and the need to isolate from both the ‘couplets’ and clinical areas being visited.

The completed notes received from the WRs have increased which helps us to understand and take appropriate action on the frontline issues as well as learn about the great work being carried out.

Some key issues were raised:

Issues Raised	Number of times raised	Actions
Estates/Environment	15	Raise with Estates. Maintenance issues addressed. Some applications to charitable funds for refurbishments and equipment.
Staffing/recruitment	15	Workforce planning. A recruitment drive is underway. Enhanced overtime in place (specifically for midwives). Wellbeing service established.
Discharge delays	1	Working with social care colleagues to minimise delay.
IT	4	Upgrades to Windows 10. Discussing mobile/remote requirements for the Community Forensics team.
Increased demand	1	Plans are being made to manage capacity and demand.
Safeguarding - Health and Safety issues around substance misuse near building.	1	Health and Safety Team engaged and risk assessments being performed.
Service	5	Various discussions regarding enhanced services, co-location of team members and the promotion of Park and Ride
Security	1	Estates involvement to secure surrounding areas.

More detailed information is available on issues and actions on request.
Things our staff said they were proud of:

Positive Comments	
Team work	15
Professionalism	6
Care Excellence	2

Despite Estates/Environment being cited most frequently, there were also lots of positive comments noted.

The visibility of the Board at the front line is important and valuable to both parties. Senior leaders of the UHB directly influence behaviours and attitudes for improving quality and safety by visiting front line teams, discussing quality and safety matters and empowering them to take appropriate action. Staff are able to share what they are proud of including their successful quality and safety improvements. This will be even more important with the introduction of the Duty of Quality and the Duty of Candour by Welsh Government.

Now that the pressures of Covid-19 are reducing again and the lessons learnt from the management of Covid-19 positive patients have been implemented it is timely now to reinstate WRs. A mixture of face-to-face and virtual WRs on Teams may be possible. However, where it is safe to do so the WRs should be carried out in the scheduled clinical area wearing the appropriate PPE and following the social distancing guidance. Additional advice will be sought from the Infection Prevention and Control Team where necessary.

At this stage it is proposed that the same couplets are maintained as per the table below.

Patient Safety Walk Round Couplets	
Board Executive	**Independent Member**
Catherine Phillips Executive Director of Finance	Charles Janczewski Chair
Rachel Gidman Executive Director People & Culture	Professor Ceri Phillips Vice-Chair
Ruth Walker Executive Nurse Director	Dr Rhian Thomas Capital and Estates
Dr Fiona Jenkins Executive Director of Therapies & Health Sciences	Sara Mosely Voluntary Sector
Caroline Bird Chief Operating Officer	Mike Jones Trade Union
Suzanne Rankin Chief Executive	Councillor Susan Elsmore Local Authority
Fiona Kinghorn Executive Director of Public Health	Gary Baxter University
Professor Meriel Jenney Executive Medical Director	Akmal Hanuk Community

Nicola Foreman Director of Corporate Governance	David Edwards Information Communication Technology
Abigail Harris Executive Director of Planning	Michael Imperato Legal
David Thomas, Director of Digital Health and Intelligence	John Union

Recommendation:

Quality, Safety and Experience Committee is asked to **note** the plan to reinstatement Patient Safety WalkRounds™ in May 2022.

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:

The greatest risk remains safety due to the possibility of Covid-19 transmission.

Safety: Yes

The IP&C Team will be consulted where necessary. Board Members will only visit clinical areas in the green zone wearing appropriate PPE and observing the infection prevention and control measures. Other WRs may be done via MS Teams.

Financial: No

Workforce: No

Legal: No

Reputational: Yes	
Positive impact on reputation where WRs take place.	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Management Executive	

Report Title:	Implementation of Datix OfWCMS				Agenda Item no.	4.6
Meeting:	Quality, Safety & Experience		Public	X	Meeting Date:	12/04/2022
			Private			
Status *(please tick one only):*	Assurance	Y	Approval		Information	
Lead Executive:	Ruth Walker, Executive Nurse Director					
Report Author (Title):	Project Lead for Datix OfWCMS Head of Patient Safety					

Main Report
Background and current situation:

The Once for Wales Concerns Management System Programme was developed from the recommendations made by Keith Evans in the Welsh Government report – "The Gift of Complaints" and is aimed at bringing consistency to the use of the electronic tools used by all NHS Wales health bodies. For a copy of the Evans Report please click here.

It was established that all organisations in Wales had varying versions and modules of the DatixWeb and Datix Rich Client systems. Following a successful competitive tender, which really tested and explored the market, RLDatix Ltd were awarded the contract for 5 years, with an opportunity to extend this period if it is successful. The solution is known as DatixCloudIQ or Datix Cymru, and has many enhanced features compared to other systems.

A **National Programme Board** was put in place and has a governance route through the NHS Wales Shared Services Partnership Committee and Welsh Risk Pool Committee. Links with key national groups were also established. Regular links with the Listening & Learning from Feedback Group (the lead body for the Evans Report recommendations) and the National Quality & Safety Forum were also established.

The **OfWCMS Programme Team** is central and hosted by NWSSP. They are responsible for the configuration, development and maintenance of all of the systems.

A number of **workstreams** have been established, to consider and implement Technical, Organisational and Functional capabilities of the new system. Each of the **Workstreams** liaise directly with the programme team, and reports are provided to the National Programme Board.

As the Putting Things Right portfolio is generally led by the Executive Nurse Directors (ENDs) in NHS Wales, the national END Forum has received, and will continue to receive, regular updates.

All organisations have **Local System Leads**, who manage and oversee the local instances of the Datix Cymru system.

The request from Welsh Government was for each organisation to implement all available modules in Phase one by 31 March 2022.

This directive has been met, with the implementation of the final module on 1st March 2022.

Cardiff and Vale Position and implementation

All modules implemented between September 2021 and October 2021 are used exclusively by the Patient Safety and Quality and Patient Experience teams. Most functions existed in Datix Web, but the Learning from Mortality and Redress Case Management modules were new.

Each module was subject to extensive review and testing, before users were set up and trained to use it. Training was delivered in small groups, in the week or two preceding the go live date.

Corporate Module Implementation Dates

Phase 1 Implementation	Actual/Effective date of implementation
Inquest Case Management	01 September 2021
Claims	01 September 2021
Complaints	01 October 2021
PALS & Compliments	01 October 2021
Learning from Mortality	01 October 2021
Redress Case Management	15 October 2021

Currently, there are many reports and dashboards still needing to be built. The previous system represented over 6 years of evolution and development, and it will take considerable time and resource to replicate or replace everything that was previously built.

This is further complicated because of differences in data structure and functionality between the old and new systems. Some of these differences have made it difficult to re-create all our data quality checking reports and procedures.

Data migration of open/active records has mostly been completed for these modules. Records are tagged as being migrated in both systems, and a final reconciliation will be carried out early in April to ensure that nothing has been overlooked.

Incident Module Implementation

Phase 1 Implementation	Actual/Effective date of implementation
Incident Module	01 March 2022

The Incident Module went live on 1st March 2022, but the implementation is still very much in progress. It is the largest and most complex of all modules, with 1,300 users (incident managers) and potentially up to 16,000 incident reporters.

Initial findings show a small reduction in incident reporting, but this is only based on one week's data and does not indicate a trend.

Communication

Delays in the initial delivery of the system had a knock-on effect on delivery of all modules. There was, however, a 5 month lead up to the Go Live date, with Clinical Boards and Directorates being kept informed of progress through a Local Implementation Group and getting regular updates on the position of incident queues in their areas.

Newsletters were sent at various times for cascade, raising the awareness of the imminent arrival of the new system. Users were also made aware of the need to close open incidents, with a Closure Guide being distributed to assist with that process and targets put in place for closures of various tranches of records based on longevity. Queue reports are also being used by Patient Safety Facilitators in their meetings with Clinical Boards.

User Validation and Training

When the Go Live date was finalised, a list of all users with active accounts in Datixweb was used as the basis of a user details validation exercise, with each Clinical Board being asked to coordinate the completion of templates for their area, and return to the Datix Administration team. This exercise is almost complete.

The logistics of training around 1,300 users in a very short time-frame, lead the Patient Safety Team to innovate its method of training to develop a more sustainable model for transition training and for the future.

An electronic training package has been developed with the assistance of LED, and this is being hosted through Learning@wales. This gives clinical staff the flexibility to complete the training at any time, and the module also tests the user's knowledge to ensure that they have grasped some of the key learning points.

Unfortunately, due to delays, the package was not available to users until Tuesday 22nd February 2022. The Datix Administration are currently activating user accounts as training is completed.

Current position:

Number of Users transition trained	250 (19%)
Number of users activated	207 (16%)
Number of users awaiting activation	1,100 (84%)

Closing Open Incidents in DatixWeb (Queue Management)

The final deadline for closure of open incidents is 12th May 2022, although we realise that complex incidents or Nationally Reportable Incidents may not be ready for closure.

The license agreement with RL Datix means that we have 3 months after the Go live date to close or migrate incidents, before the old system is locked down and becomes read only. The data and documents within it will be available indefinitely however.

The deadline gives us a further 2 weeks to oversee and guide the Clinical Boards and Directorates through a process of data migration, ensuring that no data is lost and to address potential double counting.

The current status of the incident closures is as below:

Managing Clinical Board	Incidents Reported Pre 2021 *Close by 15th Oct 2021*		Incidents Reported Jan to March 2021 *Close by 12th Nov 2021*		Incidents Reported April to June 2021 *Close by 31st Dec 2021*		Incidents Reported July to Sept 2021 *Close by 18th Feb 2022*		Incidents Reported Oct to Dec 2021 *Close by 1st April 2022*		Incidents Reported Jan to March 2022 *Close by 13th May 2022*		Total Open Incidents
	Awaiting Review	Under Review	Awaiting Review	Under Review	Awaiting Review	Under Review	Awaiting Review	Under Review	Awaiting Review	Under Review	Awaiting Review	Under Review	
Capital, Estates and Facilities	0	19	0	7	0	15	1	17	2	16	10	16	**103**
Children and Women's Services	0	6	0	10	0	24	0	85	14	183	95	158	**575**
CD&T	0	18	0	4	0	17	0	12	0	41	62	97	**251**
Executive and Corporate Services	0	15	0	4	0	4	0	3	1	12	3	36	**78**
Medicine Services	0	10	0	13	0	26	0	80	2	135	2	186	**454**
Mental Health Services	0	13	1	21	2	22	9	29	22	56	99	65	**339**
PCIC	0	3	0	0	0	1	0	3	1	8	21	62	**99**
Specialist Services	0	17	0	17	0	23	0	55	0	120	34	138	**404**
Surgical Services	0	2	0	10	0	10	3	20	8	77	68	86	**284**
Total	**0**	**103**	**1**	**86**	**2**	**142**	**13**	**304**	**50**	**648**	**394**	**844**	**2587**

Risks/Issues

Whilst we have a robust and comprehensive process for implementation, there are some inherent risks.

We previously had a mature and stable Datix system, and some of the reporting functionality will be limited in the new system until sufficient data is available to develop reports from and some functionality is enhanced.

The Datix management team of 2 people currently has carried a 1 WTE vacancy since October.	Due to the specialist requirements of the role, this has proven difficult to recruit into. This has had a considerable impact on all aspects of the implementation, including the capacity to develop of both reports and data quality assurance processes.
Decline in reporting	Other Health Boards have not reported a decline in reporting, but this is a possibility over the transition period. Early indications are that the reporting level is only slightly under average, which is reassuring, but this is only based on one week's data. and the situation is expected to improve.
Completion of Services and Locations not enforced on input	This impacts on data analysis and user permissions. This has manifested, but at only one week after Go Live it is too early to assess the full impact.
Training take-up	Users must be trained before using the system, but slow take up is affecting the number of managers available to manage incidents and giving reporters difficulty in choosing appropriate managers.
Re-development of reports and dashboards	The data analyst vacancy in Datix Management Team has had a huge impact on ability to re-build hundreds of reports. Changes in data structures from the old system further complicate this development.
Lack of system administration functionality	Many of the tools necessary to manage the system are still not available. This includes the abilities to unlink records, delete records, identify duplicate contacts and merge them.
System bugs and issues	Despite extensive testing, new issues are being identified following Go Live. These are being raised with the Central Team, and mitigation measures put in place where necessary.
IT Issues	Most of these are outside of our control, including domain issues, access for all staff, and risks related to an internet-hosted system.

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

The objective to implement all available modules in the first Phase of the Once for Wales Concerns Management System (DatixCymru) before 31st March 2022 has been met with the implementation of the Incident Module on 1st March 2022.

The implementation of a new system presents a host of challenges, as both system administrators and users have to adapt to the new software and dataset. Also, all reports, dashboard and process control mechanisms will have to be built from scratch. This will inevitably impact on the ability to provide reports for the Board and Clinical Boards in the short term.

Report and dashboard building will be done on a priority basis, as there were previously over 300 reports available in Datix Web. In addition, some data quality issues are already manifesting. These

must be remedied as a priority by building robust processes to both identify and correct data errors, or the quality of reports produced will be compromised.

In a new development, a formal request was received from the OFW team on 22nd February 2022 to also implement incident reporting for Community Pharmacists on 1st April 2022, as directed by Welsh Government.

This will require the development of processes for managing such incidents with PCIC, and an exploration of the functionality required by the Community Pharmacists, which will have to be agreed and built. We have been provided with a list of over 280 community Pharmacists who will need to be able to report into our system, and some of these may also need management accounts. At present, the CAV Server and Infrastructure Team are raising concerns at an all-Wales level around giving non UHB staff access through our network. This implementation cannot take place until these concerns have been addressed.

Recommendation:

The Committee is requested to:

To **note** the content of this report.

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	Y
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
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	X	Integration		Collaboration	Y	Involvement	

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

Risk: **Yes**/No

Risk Assessment included around the challenges of achieving a successful implementation.

Safety: **Yes**/No

Robust implementation of the system is necessary to manage the risks raised by both patient safety and health and safety issues.

Financial: **Yes**/No

Failure to manage risks can lead to financial consequences in the form of claims or redress.

Workforce: Yes/**No**

Legal: **Yes**/No
Failure to manage risks can lead to claims being brought against the organisation.
Reputational: **Yes**/No
The timely implementation of this system carried a reputational risk, and failure to properly manage concerns and incidents can be damaging to the organisation's reputation.
Socio Economic: Yes/**No**
Equality and Health: Yes/**No**
Decarbonisation: Yes/**No**

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

Saunders,Nathan
04/12/2022 01:11:58

Report Title:	Duty Of Candour (DOC)				Agenda Item no.	4.7	
Meeting:	Quality, Safety & Experience	Public	X		Meeting Date:	12/04/2022	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		X
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Asssitant Director of Patient Experience						

Main Report

Background and current situation:

The Health and Social Care (Quality & Engagement) (Wales) Act 2020[1] ("the Act") was passed by the Senedd on 17 March 2020 and received Royal Assent on 1 June 2020. It is anticipated that it will come into effect in April 2023
It has four main parts:

(i) A new duty of quality placed on Health Boards, Trusts and Special Health Authorities in Wales.
(ii) A duty of candour placed on NHS bodies and primary care providers in Wales.
(iii) The abolition of Community Health Councils and the establishment of a new Citizen Voice Body for Health and Social Care.
(iv) A power for the Welsh Ministers to appoint vice chairs to NHS Trusts.

The duty of candour builds on the "Being Open" principles embedded in the Putting Things Right (PTR) process for the handling of concerns as set out in The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the PTR Regulations"). The duty complements the existing duty of candour that applies to providers of regulated social care in Wales.

- The duty will be triggered when a service user suffers an adverse outcome where the care or treatment was (or may have been) a factor.

A service user suffers an adverse outcome where the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal harm. Through discussion with stakeholders it has been advised that the duty should be triggered at Moderate harm and above, this would be in line with England and Scotland

There will be key expectations of the organisation embedded in the regulations these will include a point of contact for the service user when the DOC trigger is met, on going contact and maintenance of records. An alignment to the Putting Things Right and Redress arrangements where appropriate.

It is expected that the DOC will be triggered through incident reporting and recorded on the Datix system across Primary and secondary care. it is intended to require the NHS Body to follow the process for investigating concerns which are set out in regulation 23 of the PTR Regulations. This means that, in effect, regulations 23 and 24 and Part 6 of the PTR Regulations (if there is or there may be a qualifying liability) will apply.

There are a number of reasons for applying the PTR process to candour investigations: it provides for a proportionate investigation; NHS bodies are used to the PTR requirements and, by investigating in this way, it is to be hoped that a subsequent complaint about the same incident can be avoided.

There will be a need for both Oral and Written communication with people and their representatives, clarity regarding time scales, the investigation and the service improvement actions will be required.

[1] Health and Social Care (Quality and Engagement) (Wales) Act 2020 https://www.legislation.gov.uk/asc/2020/1/enacted

There will need to be clarity regarding whether the redress arrangements should be triggered. If someone is unhappy with the DOC investigation they can utilize the formal complaints process to share their concerns.

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

New overarching duty will require Welsh Ministers and NHS bodies to exercise their functions with a view to securing improvements in the quality of services they provide to their service users.
This duty will apply to all of their functions, not just clinical functions.

NHS bodies will be placed under a duty to produce an annual report setting out how they have complied with the new duty. The Duty seeks to achieve a system wide approach to quality in the health service to secure improvement and shift the focus away from simply quality assurance.

Citizens' Voice Body

Will replace CHCs with a new, independent, national body that will exercise functions across health and social services. The new body will strengthen the voice of the citizen. It's overarching function will be to represent the interests of persons to whom NHS or social services are being provided in Wales. It will have powers to make reports and recommendations to organisations, such as health boards, trusts and local authorities, and to provide complaints advice and assistance to citizens when they have a complaint about NHS services and certain social services.
It will be independent with powers to employ its own staff and recruit volunteers.

There will be a significant impact upon Concerns

Duty of Candour The new law will mean that people who provide health services must tell people if they have or may have suffered harm
There will be an expected impact upon Complaints, Redress and Claims

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

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

It may be advisable to establish an internal working group to prepare for the development of the Duty of Candour

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

Preparation is required for implementation in April 2023.
The potential impact and the scale of the introduction.

Recommendation:

The Committee is requested to: **Note** the information in the report.

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	
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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-there is a risk of being non-compliant with statutory act if not implemented form April 2023
N/A
Safety: Yes/No
N/A
Financial: Yes-there will be a financial risk of litigation of DOC cases not managed in accordance with the PTR process
N/A
Workforce: Yes/No
N/A
Legal: Yes -as above
N/A
Reputational: Yes
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: