Quality, Safety & Experience Committee

Wed 15 June 2022, 09:00 - 12:00

Agenda

09:00 - 09:10
10 min

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 12 April 2022.

Susan Elsmore

1.4 Public QSE Minutes 12.04.22 MD.NF. SE.pdf (12 pages)

1.5. Action Log – Following the meeting held on 12 April 2022

Susan Elsmore

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

1.6. Chair's Action taken since last meeting

Susan Elsmore

09:10 - 10:50
100 min

2. Items for Review & Assurance

2.1. CD&T Clinical Board Assurance Presentation (including a Patient Story)

25 minutes

Presentation

2.1 CDT Assurance Report June 2022.pdf (21 pages)

2.2. Quality Indicators Report including:

10 Minutes *Jason Roberts*

Pressure Damage Update from Clare Wade

Presentation

2.2 Pressure Damage Collaborative June 2022.pdf (6 pages)

2.3. Mortality Indicators

Meriel Jenney / Rajesh Krishnan

15 minutes

2.3Learning from Deaths paper 2022.05.22_final.v1.pdf (14 pages)

2.4. Maternity Services - Verbal Update

Jason Roberts / Abigail Holmes

5 minutes

2.5. HIW Activity Overview

Jason Roberts

10 minutes

2.5 HIW Update on Activity - QSE Paper June 2022(3).pdf (4 pages)

2.6. Board Assurance Framework – Patient Safety

Nicola Foreman

5 minutes

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

2.7. Dental Services Update

Caroline Bird

10 minutes

2.7 QSE Committee Dental.pdf (6 pages)
2.7a Annex 1 GDS Contract Reform.pdf (2 pages)

2.8. Ultrasound Clinical Governance position

Fiona Jenkins

2.8 USCGG - Exec Summary for QSE-v0.4a.pdf (3 pages)
2.8a Ultrasound Governance (CDT CB) (003).pdf (16 pages)
2.8b US Clinical Governance-USCGG-ToRs - v.8.pdf (13 pages)

2.9. Concerns, Redress and Claims

Angela Hughes

10 minutes

2.9a QSE Concerns and Redress report.pdf (12 pages)
2.9b QSE Claims Report – Clincial Negligence & Personal Injury.pdf (6 pages)

10:50 - 11:00
10 min

3. Items for Approval / Ratification

No Items

11:00 - 11:30
30 min

4. Items for Noting & Information

4.1. Committee Effectiveness Survey Results 2021-2022

Nicola Foreman

5 minutes

4.1 Committee Self Effectiveness Survey QSE.pdf (3 pages)

4.1a Quality, Safety and Experience Committee Self Evaluation 2021-22.pdf (21 pages)

4.2. Exception Reports (Verbal)

Jason Roberts / Meriel Jenney

10 minutes

4.3. WHSSC Quality Committee – Chairs Report

Ceri Phillips

5 minutes

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

5 minutes

1. *Children & Women's – 22.02.22*
2. *CD&T Clinical Board – 18.03.22 & 21.04.22*
3. *Medicine – 17.03.22 & 21.04.22*
4. *Specialist – 17.03.22 & 04.04.22*
5. *Mental Health – TBA*
6. *Surgical – 15.03.22*
7. *PCIC - 17.05.22*
9. *Radiation Protection Group – Chairs Report - 26.04.22*

4.4.1 CW Minutes 22.02.22.pdf (12 pages)
4.4.2a CDT Minutes 18.3.22.pdf (10 pages)
4.4.2b CDT Minutes 21.4.22.pdf (11 pages)
4.4.3a MCB Minutes 17 Mar 22.pdf (8 pages)
4.4.3b MCB Minutes 21 April 22.pdf (7 pages)
4.4.4a Specialist Minutes 17.03.22.pdf (5 pages)
4.4.4b Specialist Minutes 04.04.22.pdf (8 pages)
4.4.6 Surgical Minutes 15.03.22.pdf (10 pages)
4.4.7 PCIC Minutes 17.05.22.pdf (7 pages)
4.4.8 Radiation Protection Group Chairs Report 26.4.22.pdf (3 pages)

4.5. Corporate Risk Register

Nicola Foreman

5 minutes

4.5 Corporate Risk Register.pdf (3 pages)
4.5a QSE Committee - Corporate Risk Register Entries May 2022.pdf (3 pages)

11:30 - 11:30
0 min

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

11:30 - 11:30
0 min

6. Agenda for Private Board Meeting:

i) Minutes of the Private Committee Meeting – 12.04.22
ii) Pandemic Update & Any Urgent / Emerging Themes – Verbal
iii) Cardiac Surgery Report Update
iv) DNAR Orders at St. Davids Hospital - Update

11:30 - 11:30
0 min

7. Any Other Business

Susan Elsmore

11:30 - 11:30
0 min

8. Review of the Meeting

Susan Elsmore

11:30 - 11:30
0 min

9. Date & Time of Next Meeting:

Tuesday 30 August 2022 at 9am

11:30 - 11:30
0 min

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 12 April 2022 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
In Attendance		
Daniel Crossland	DC	Director of Operations – Mental Health Clinical Board
Mark Doherty	MD	Interim Director of Nursing (Mental Health)
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director
Neil Jones	NJ	Clinical Board Director – Mental Health
Fiona Kinghorn	FK	Executive Director of Public Health
Rajesh Krishnan	RK	Associate Medical Director (Clinical Governance and Patient Safety)
Ruth Walker	RW	Executive Nurse Director
Observing		
Emily Howell	EH	Audit Wales
Gruffydd Pari	GP	Graduate Trainee Manager
Alexandra Scott	AS	Assistant Director Quality and Patient Safety Aneurin Bevan University Health Board
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Caroline Bird	CB	Interim Chief Operation Officer
Akmal Hanuk	AH	Independent Member – Community

QSE 22/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/04/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/04/003	**Declarations of Interest** The CC declared her interest as a Cabinet Member for Cardiff Council.	
QSE 22/04/004	**Minutes of the Committee meeting held on 22 February 2022** The minutes of the meeting held on 22 February 2022 were received. **The Committee resolved that:** a) The minutes of the meeting held on 22 February were approved as a true and accurate records of those meetings.	
QSE 22/04/005	**Action Log following the Meeting held on 22 February 2022** The Action Log was received, and all ongoing actions discussed.	

	The END advised the Committee that the action identified around the Maternity lifts was completed but noted that it was also an ongoing challenge because once one lift had been fixed, the second one would break. She added that there was no clinical concern to any of the outcomes affected by the lifts and noted that it was being monitored via the Risk Register regularly. The END advised the Committee that the action 22/02/008 which advised that the Healthcare Standards, Duty of Candour, National Quality Framework and Annual Quality Statement be received by the Board via a Board Development Session would be actioned in the future given where the process stood at the moment. **The Committee resolved that:** a) The Action Log from the meeting held on 22 February 2022 was noted.	**NS**
QSE 22/04/006	**Mental Health Clinical Board Assurance Report** The END advised the Committee that the Mental Health Clinical Board had been through a challenging year and thanked the report authors for the openness and transparency of the issues identified within the paper. The Interim Director of Nursing for the Mental Health Clinical Board (IDNMH) provided the Committee with a verbal Patient Story which highlighted the care received by a patient who had been admitted to Hafan Y Coed for 2 weeks following a suicide attempt. It was noted that the overall experience had been positive for the patient, who provided positive feedback with regards to the care received. The Mental Health Clinical Board Assurance Report was received. The IDNMH advised the Committee that the report highlighted areas that the Clinical Board had focussed upon during more recent times which included a difficult position on patient suicides. It was noted that the Mental Health Clinical Board (MHCB) had encountered, over a relatively short period of time, a number of suicides/unexplained deaths in the acute in-patient environment that was significantly higher than the national average. It was noted that the deaths constituted a “cluster” according to nationally agreed criteria and the MHCB considered the need to provide a comprehensive, evidence-based series of actions to understand and reduce. It was noted that there were six suicides over a period of eleven months, all in different locations with different scenarios underpinning the event. It was noted that the Clinical Board were doing everything possible to understand what had happened and to make changes to address the situation. The Consultant Nurse for Complex Clinical Risk (CNCCR) conducted a Thematic Review of the untoward deaths at the request of the Clinical Board and identified recommendations which included: • A Suicide Cluster Response Plan • Environmental differences of wards to be understood • Environmental considerations, for example, door top alarms, and bedroom windows alarms.	

- Environmental settings to be improved
- Ward remits / policy reviews to fully understand purposes of wards and risks / benefits of dual functions
- Re-launch of the Complex Care Forum
- Re-launch of Sentinels and Lessons Learned
- Questionnaires to staff
- Skill mix review – psychological input to wards & appointment of shift co-ordinators to get Ward Managers back on their wards
- Away Days
- Ensure ward rounds / MDTs were person centred
- Care Aims in the inpatient setting

The IDNMH advised the Committee that it was the intention of the MHCB to implement all recommendations noted within the report.

He added that further to the recommendations, the MHCB had 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.

Those included:

- Returning Hafan Y Coed to its original footprint.

It was noted that pressures created by the need to manage COVID in accordance with Welsh Government, Public Health and local UHB guidelines had been extremely disruptive to the normal functioning of Mental Health in-patient services and that it was now time to return the in-patient environments to their original functions. It was noted this would be a complex process as it would take place during a high demand for beds and the need to repatriate patients who were placed in commissioned “surge” beds in other facilities.

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

It was noted the MHCB had a well-established, long-standing process for gathering information about serious, nationally reportable events including suicides, near-misses and other events.

It was noted that it had evolved over a period of years into a sophisticated mechanism that was aligned to national reporting requirements and had elicited themes and factors from which lessons could be learnt and improvements made.

- Suicide Prevention Training

It was noted that whilst the understanding of and management of Clinical risk was central to the work of a Mental Health service, it was recognised that those skills could always be enhanced.

It was noted that the MHCB had worked with Welsh Government (WG) to roll out a comprehensive package of suicide prevention training that was tailored to all levels of experience and responsibility across the multi-disciplinary spectrum.

- Royal College of Psychiatrists Review of Adult In-patient Services at Hafan Y Coed

It was noted that the Management Executive Team had supported and commissioned an authoritative and comprehensive review and that the Terms of Reference had recently been agreed.

The Independent Member – University (IMU) noted that the CNCCR had conducted a Thematic Review of the untoward deaths at the request of the Clinical Board and asked if any further reviews were being done and how they would broaden perspectives on what the CNCCR had already achieved and was it possible to anticipate any further recommendations that could come from those reviews.

The IDNMH responded that the Royal College of Psychiatrists would hopefully support the MHCB in the locality model as it was showing good results as noted within patient feedback and added that in terms of anticipating further recommendations there could be a scope to put a role in place (Senior Nurse for Inpatient Services) and noted that the Directorate was being encouraged to think about that.

The Clinical Board Director – Mental Health (CBDMH) added that the Delivery Unit (DU) had completed their rapid review and noted that their findings were the same as those matters which the MHCB had identified.

The Director of Operations – Mental Health (DOMH) added that there could be some unknowns within the Royal College of Psychiatrists' review that had not been identified by the MHCB and noted that part of the assurance framework was to think more broadly as to what external reviews could bring to the attention of the Clinical Board.

The Chair of the Mental Health Legislation and Mental Capacity Act Committee advised the Committee that he had received oversight of the MHCB for the past 12 months and had identified that the team had at all times sought to put their patients first and that it had been to an impressive degree. He noted that the determination to learn to develop, change and move forward was amazing and thanked the staff for their continued hard work.

The Executive Director of Public Health (EDPH) asked about staff morale within the MHCB.

The IDNMH responded that staff morale had been adversely affected by various situations, including Covid-19, and noted that staff were tired.

He added that in February, Health Inspectorate Wales (HIW) had visited Mental Health services and noted that the verbal feedback provided had been very encouraging. HIW reported that staff showed high levels of enthusiasm and commitment in the face of the experiences people were having.

The IDNMH concluded that the work described within the report would be done in a way that was open, transparent, and noted that the work itself was hoped to be a morale booster.

The Assistant Director of Patient Experience (ADPE) advised the Committee that several high-profile inquests would be coming up and noted that publicity surrounding these was likely to have an impact on staff morale.

The Executive Nurse Director (END) advised the Committee that the MHCB team had recognised where they had been, recognised that it was not the place they wanted to be, and accordingly revisited that and how everything worked whilst receiving external reviews and commended them for their hard work.

The QSE Committee resolved that:

	a) The content of the report was discussed and noted.	
QSE 22/04/007	**Quality, Safety and Experience Implications arising from IMTP** The Quality, Safety and Experience Implications arising from IMTP were received. The END advised the Committee that the paper would be taken as read and noted that the key focus for the coming year was laid out within the report and aligned to the Framework for Quality, Safety and Experience. It was noted that the Framework had identified eight key areas and all the actions were aligned to those areas. It was noted that there were no key performance indicators (KPIs) identified within the paper because the Health Board was waiting for those to be received from WG. Once received, they would be brought back to the QSE Committee. The IMU advised the Committee that the emphasis on an integrated system for Quality & Safety which highlighted Primary and Community care settings was attractive and noted that if the Health Board could structure KPIs around the 8 identified key areas that would make the delivery of the important messages within the IMTP easier and would represent an effective integration of the QSE framework into the IMTP. The Director of Corporate Governance (DCG) noted that within the report there was an overview of the headline milestones which the QSE team was focusing on during 2022-23 to make tangible progress in embedding the Framework and asked if it would be worth reporting that to the QSE Committee each quarter. The END agreed and noted that a quarterly report on milestones along with key KPIs would be helpful. The Vice Chair of the Health Board reinforced the IMU's point and noted that it was interesting how the report adopted a whole system perspective and recognised the need for partnership working whilst ensuring that it was not just the focus on the hospital and acute sector. **The QSE Committee resolved that:** a) The QSE requirements as laid out in the IMTP were noted.	**END** **END**
QSE 22/04/008	**Feedback from the Clinical Effectiveness Committee** The Feedback from the Clinical Effectiveness Committee (CEC) was received. The Executive Medical Director (EMD) advised the Committee that when she took over the role, she was struck by the importance of the Clinical Effectiveness Committee and the responsibility of the Health Board to respond to a number of areas which had not been systematically approached in that way previously. It was noted that the CEC had been established with the purpose of ensuring Clinical effectiveness across the Health Board by: • Monitoring the implementation of NICE, national and local evidence, guidelines and standards to ensure best practice across the Health Board. • Providing strategic direction for the Health Board's national and local Clinical Audit Programme.	

	• Providing assurance to the Quality and Safety Experience (QSE) Committee on the above points through the production of reports. • Receiving reports from the subgroups and, following analysis, either escalate issues or provide assurance to the QSE Committee and the Board. • Contributing to the production of the Annual Quality Statement to be presented to the Board of Directors. The Associate Medical Director for Clinical Governance and Patient Safety (AMD) advised the Committee that the CEC was now well established but noted that the current resource to capture and monitor activity was limited and that was reflected in the Internal Audit report. He added that a business case was recently submitted to the Business Case Approval Group (BCAG) for Quality Safety and Experience which was successful to procure AMaT (Tracking, Monitoring and Management system) to capture the Health Board's Clinical Audit activity centrally. It was noted that a phased approach would be taken over a 12-month period to roll out the AMaT system across the organisation and that Clinical Boards had been asked to develop an Annual Clinical Audit Forward Plan for 2022/23. It was noted that funding had also been secured for personnel to help roll out the system across the Health Board which would help to address many of the improvements identified in the Internal Audit report and would improve the level of assurance that could be provided. The IMU advised the Committee that HIW was undertaking a National Review of the Stroke Pathways and noted that they would be visiting the Health Board. He asked when that would be. The END responded that HIW had already visited the Health Board and that whilst the formal report had not yet been received the informal feedback was fairly positive. The IMU noted that the report identified the appointment of a Clinical Audit lead and asked if the post had been filled. The AMD responded that there was a business case that had been approved which would provide several roles and noted that an Effectiveness Officer had also been secured by Health Technology Wales that would support the Health Board to move the programme forward. The IMU asked if there was a timeline for that and the AMD responded that job plans had been drawn up and were at the advertisement stage. The Vice Chair of the Health Board asked if there was an alignment with the Health Board's Improvement and Innovation Team. The AMD responded that there was and that from the CEC perspective, empowering teams and team engagement was key. The EDPH advised the Committee that she would need to bring the revised Interventions Not Normally Undertaken (INNU) policy and intervention list back to the QSE committee in June 2022 and that she would liaise with the AMD and EMD as to how that would align with the CEC.	
Saunders,Nathan 06/14/2022 13:03:54	The EMD concluded that the amount of work undertaken by the CEC was vast and thanked the AMD and the Head of Patient Safety and Quality Assurance (HPSQA) for all the work that they do. **The QSE Committee resolved that:**	EDPH

	a) The level of Clinical Effectiveness Committee activity across a broad range of services was noted. b) It was agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 22/04/009	**Quality Indicators Report** **Update on Falls in Lakeside Wing** The Quality Indicators Report was received. The END advised the Committee that the Lakeside Wing (LSW) remained an area of concern and noted that the report identified the level of concern, the issues and the actions taken to address those issues. The Independent Member – Trade Union (IMTU) noted that there were staffing issues being seen in LSW and across the Health Board and asked what the position was with Registered Nurse vacancies and staff morale. The END responded that progress was being made with the recruitment of Registered Nurses and noted that numbers of students who would qualify in 2022 would be known in the coming weeks. She added that it was clear that the number of absences had increased due to Covid-19 and noted that there were 165 Registered Nurses absent the week prior to the meeting and that did not include other gaps in the system. The Committee was advised that the answer to the Registered Nurse gap was to not to have as much open within the system and to look at how pressures, particularly in the Emergency Department (ED), could be balanced to better facilitate patient flow so that patients were referred to the right place at the right time. She added that the staff morale at the LSW continued to be challenging and noted that the area was opened, because of Covid-19, as an emergency overflow location and thought was required with regards to the longer-term arrangements for the LSW. The IMTU advised the Committee that his staff morale question also applied to senior nurses and managers and asked how they were coping. The END responded that the Medicine Clinical Board had found time for a 2-day “timeout session” to hear directly how senior nurses and managers were feeling. She added that the timeout day was an opportunity for discussion which was used very well and noted that one of the biggest areas identified was the lack of a perceived “end” to the pressures. It was noted that senior nurses and managers had to face day to day operational pressures, conflict and abuse and some significant safeguarding issues and front-line staff should not have to tolerate some of the standards that they were currently. It was noted that support and development would be offered to staff The END concluded that “hope” was very much a topic of conversation at the 2-day sessions and that some challenges being seen should improve. **The QSE Committee resolved that:**	

	a) The position and actions being taken to improve the status was noted and discussed.	
QSE 22/04/010	**HIW Activity Overview** The HIW Activity Overview & Primary Care Update was received. The END advised the Committee that the paper was for noting and noted that the CC and herself had met to discuss the previous report received by the Committee and the suggestion in relation to a HIW Ionising Radiation (Medical Exposure) Regulations IR(ME)R report. She added that the draft reports following the HIW visit to Cardiac Surgery at the University Hospital Llandough (UHL), and Hafan Y Coed had been received and noted that feedback had been positive but highlighted the environment concerns at Hafan Y Coed which had already been identified by the MHCB previously. It was noted that the reports would be circulated to Committee Members. The Vice Chair of the Health Board asked if all appropriate matters had been considered in relation to Maternity Services because of the issues that had arisen from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden Report). The END responded that the report had been received and a number of actions would be taken and brought back to the QSE Committee in June. She added that the HPSQA would work alongside the new Head of Maternity Services. **The QSE Committee resolved that:** a) The level of HIW activity across a broad range of services was noted. b) It was agreed that the appropriate processes were in place to address and monitor the recommendations.	**END** **END**
QSE 22/04/011	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The DCG advised the Committee that the BAF was received by every Committee and by the Board. She added that every year, the Executive team looked at the key risks that would impact upon the delivery of the Strategic Objectives of the Health Board. It was noted that Patient Safety would remain on the BAF along with Estates and Workforce. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety were reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	
QSE 22/04/012	**Recommendations from the Nuffield Trust Report** The Recommendations from the Nuffield Trust Report were received.	

	The EMD advised the Committee that they would already be aware of the new Velindre hospital and that there had been concerns from the outset to deliver safe and effective care for the sickest patients who required acute cancer care. She added that the new hospital being sited away from an acute environment had raised a number of concerns from a number of people, including herself. It was noted that a number of opportunities could have been lost by a separate siting of the hospital and so after much discussion, the Nuffield Trust Report was commissioned. The EMD advised the Committee that the Nuffield Trust Report had noted that having the new hospital site on the same site as an acute hospital environment was preferred. She added that the Nuffield Trust report provided proposals for mitigating the risk with regards to the new cancer centre being sited away from an acute facility. It was noted that there were clear recommendations within the report for the Health Board to decide upon. The IMU asked where the Nuffield Trust report sat within the Health Board as a lot of the report had alluded to strategy and delivery. The EMD responded that the question reflected the complexity as cancer was cross cutting between all clinical boards. She added that the Board should be made aware of the Nuffield Trust Report and noted that it laid with operational teams to make everything work. The DCG agreed that the report should be received by the Board. The END advised the Committee that she had been working with a carer of somebody who had used services across Velindre and the Health Board and noted that a patient story would be gathered to demonstrate how the cancer pathway had worked and how improvements could be made. The EMD advised the Committee that a Collaborative Cancer Leadership Group (CCLG) chaired by the CEO of the Health Board met quarterly and consisted of Executive level Officers across Southeast Wales to provide oversight and leadership regarding the Cancer services in Southeast Wales and implementation of the Nuffield report. **The QSE Committee resolved that:** a) The progress being made regarding the implementation of the Nuffield Report recommendations which are pertinent to Cardiff & Vale UHB were noted.	**DCG**
QSE 22/04/013 Saunders.Nathan 06/14/2022 13:03:54	**Exception Reports (Verbal)** The END advised the Committee that concerns remained around the ED and recognised that the whole system remained under pressure. She added she had met with the EMD and the Chief Executive Officer (CEO) of the Health Board to discuss improvement plans due to a large number of distressing concerns being raised and noted that staff felt under pressure. The EMD advised the Committee that the pressures seen across the system could not be overstated and noted that there were concerns about what was happening	

	to patients and staff and noted that her team and many others were putting in as many systems as they could to mitigate the pressures. The END advised the Committee that the Health Board needed to be open and transparent about the pressures being seen within ED which would help the public conversation. The EDPH advised the Committee that the Welsh Ambulance Service (WAST) had been elevated to Level 4 the previous night which meant that they may not have been able to go to people with suspected stroke or suspected myocardial infarction and wanted to note the WAST pressures. The END advised the Committee that this feedback should be received by the Board because the quality of care was not where it should be. The EMD added that one of the areas that had been striking was the quality of care that people were receiving had still resulted in positive patient feedback of the care being given by staff members and noted that although the environments were poor, the quality of care provided by staff was good. The CC advised the Committee that a further recommendation be added to ensure the Board would be sighted on the pressures being seen across the system. **The QSE Committee resolved that:** a) The Exception Reports were noted b) The pressures seen across the Health Board would be reported to the Board.	**END**
QSE 22/04/014	**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. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 22/04/015	**Corporate Risk Register** The DCG advised the Committee that there was nothing further to add to the report received by the Committee. She highlighted that there were eleven risks linked to Patient Safety across the various Directorates. The IMU asked if any of the risks could be removed because it appeared that some of the areas had an easily remediable “fix”. The DCG responded that the risk appeared on the Register because the easily remediable fix had not happened and so by adding it to the Register it would gain further scrutiny. She added that there was ongoing work to be done around how risks would be described. The DCG concluded that internal audit was currently reviewing the risk management processes which was done every year and noted that the focus for 2022/23 would be on Clinical Boards. **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 22/04/016	**Infected Blood Inquiry Update** The Infected Blood Inquiry Update was received. The DCG advised the Committee that the report highlighted a timetable and noted that the final hearings were scheduled for December with conclusions and finding to be presented approximately 6 months after. **The Committee resolved that:** a) The contents of the Infected Blood Inquiry Update were noted	
QSE 22/04/017	**Patient Safety WalkRounds** The Patient Safety WalkRounds report was received. **The Committee resolved that:** a) The plan to reinstatement Patient Safety WalkRounds in May was noted.	
QSE 22/04/018	**Implementation of Datix OfWCMS** The Implementation of Datix Once for Wales Concerns Management System (OfWCMS) report was received. The END advised the Committee that the Implementation of Datix OfWCMS was a large project that would have an impact on the QSE Committee and noted that the new system would come with challenges because the Health Board previously had a mature and stable Datix system, and some of the reporting functionality would be limited in the new system until sufficient data was available to develop reports from. **The Committee resolved that:** a) The content of the report was noted	
QSE 22/04/019	**Duty of Candour** The Duty of Candour report was received. The END advised the Committee that the report identified where the Health Board was against All Wales information and noted that it would be brought to the Board when the process developed further. **The Committee resolved that:** a) The information in the report was noted.	
QSE 22/04/020	**Items to bring to the attention of the Board / Committee** The CC advised the Committee of the areas that would be brought to the attention of the Board in May 2022 which included: • The discussions and issues raised around the Nuffield Trust Report • The issues around escalation of risk and in particular the risk around the Emergency Department.	

	• Suicide Clusters would form part of the Chair's Report as discussed at the meeting.	
QSE 22/04/021	**Agenda for Private QSE Meeting** *i) Minutes of the Private Committee Meeting held on – 22.02.22* *ii) Action Log – Following the Meeting held on 22.02.22* *iii) Pandemic Update & Any Urgent / Emerging Themes – Verbal* *iv) DNAR Orders at St David's Hospital – Update*	
QSE 22/04/022	**Any Other Business** The Senior Corporate Governance Officer advised the Chair that it was the final QSE Committee meeting that the END would be attending prior to retirement. The CC and the Independent Members present provided the END with their esteemed thanks for the hard work and support that she had shown throughout her time within the Health Board.	
QSE 22/04/023	**Date & Time of Next Meeting:** Tuesday 15 June 2022 at 9am	

Action Log

Quality, Safety & Experience Committee

Update for meeting 15 June 2022
(Following the meeting held on 12 April 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/04/010	Maternity Services Update	Meeting between the Clinical Board and the corporate Quality & Safety function to discuss the Ockenden report and provide an update to the Committee in June.	**15.06.2022**	Jason Roberts	**COMPLETED:** On June Agenda, item 2.4
QSE 22/02/030	Cardiac Surgery Report Update	**a detailed paper would be brought back to the Committee at the next meeting in June 2022.**	**15.06.2022**	Meriel Jenney	**COMPLETED:** *Moved from Private Agenda to Public* On June agenda, item 2.5
QSE 22/04/010	HIW reports	HIW reports regarding HIW visit to Cardiac Surgery at the University Hospital Llandough (UHL) and Hafan Y Coed to be circulated to Committee Members	**15.06.2022**	Jason Roberts	**COMPLETED:** On June Agenda, item 2.6
QSE 22/04/008	Interventions Not Normally Undertaken (INNU) policy and intervention list	The EDPH advised the Committee that she would need to bring the revised Interventions Not Normally Undertaken (INNU) policy and intervention list back to the QSE committee in June 2022	**15.06.2022**	Fiona Kinghorn	**COMPLETED:** On June Agenda, item 2.9
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.	**15.06.2022**	Caroline Bird	**COMPLETED:** On June Agenda, item 2.8

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
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.	**15.06.2022**	Jason Roberts	**COMPLETED:** On June Agenda, item 2.2
UHB 22/03/015	**Integrated Performance Report**	A more detailed presentation on mortality indicators to be taken to the QSE Committee in June	**15.06.2022**	Meriel Jenney	**COMPLETED:** On June Agenda, item 2.3
Actions in Progress					
QSE 22/04/007	**Quality, Safety and Experience Implications arising from IMTP**	Waiting for KPIs to be received from WG. Once received, they would be brought back to the QSE Committee along with a quarterly report on milestones.	**30.08.2022**	Jason Roberts	**In Progress** Scheduled for the QSE meeting in August 2022.
Actions referred to Board / Committees					
QSE 22/04/012	Nuffield Trust Report	The Board should be made aware of the Nuffield Trust Report	26.05.2022	Meriel Jenney	**COMPLETED** Added under Cancer Progress Update – Received by Board in May 2022.
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	Jason Roberts/ Nicola Foreman	**IN PROGRESS** *Date to be confirmed once Board has approved annual plan for Board Development Session 2022/23* National documents still awaited (Comment from Ruth Walker 03.05.22)

Report Title:	**Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Patient Experience Report**				Agenda Item no.	2.1	
Meeting:	QSE Committee		Public	X	Meeting Date:	15.06.22	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	**Interim Executive Nurse Director**						
Report Author (Title):	**CD&T Clinical Board Director for Quality, Safety and Patient Experience**						

Main Report
Background and current situation:

The work outlined within the presentation to be received by the Quality, Safety and Experience Committee on 15th June 2022 reflects the key metrics taking place to improve quality, safety and patient experience within the Clinical Diagnostics and Therapeutics Clinical Board leading to improved quality and care outcomes for patients. It also outlines the considerable development, improvement and innovation work underway within the Clinical Board.

The Clinical Diagnostics and Therapeutics Clinical Board provides a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis. Collectively these services underpin, and are core components of, almost every aspect of clinical activity undertaken within the UHB.

The Clinical Board consists of 7 directorates:

1. Laboratory Medicine
2. All Wales Therapeutics and Toxicology
3. Radiology, Medical Physics and Clinical Engineering
4. Medical Illustration
5. Outpatients/Patient administration
6. Therapies
7. Pharmacy and Medicines Management

The Clinical Board Quality, Safety and Patient Experience (QSPE) governance framework provides assurance that it is delivering its diverse portfolio of services in a safe and sustainable manner. The Clinical Board's QSPE priorities for 2022/23 include:

- A strong safety culture embedded at every level of the Clinical Board and Directorates
- Supporting the health and well-being of staff
- Regulatory compliance and accreditation
- Continued self-assessment against the Health and Care Standards with improvement planning against any indicator requiring action
- Regular review of risk management processes and action plans to provide assurance that mitigating actions and risk reduction strategies have been implemented.
- Serious and Adverse Incident Management and Concerns Management
- Embedding the Patient Experience Framework across the Clinical Board, ensuring patients are always treated with compassion, dignity and respect
- On-going support for continuing service improvement
- Ensuring safe working conditions and environments
- Timely access to services based on clinical need
- Recovery from the Covid-19 pandemic

ASSESSMENT

Governance
The Quality, Safety and Patient Experience (QSPE) agenda is a key priority for the Clinical Board. The Clinical Board Director leads the QSPE agenda and operational responsibility is devolved to the Clinical Board Director of QSPE. QSPE meetings are held monthly and the Terms of Reference are reviewed annually. The QSPE meeting agenda has been shaped to align with the Health and Care Standards for Wales and this is replicated at Directorate QSPE meetings.

The Clinical Board was clear that the QSPE priority must be maintained despite the challenges of the last two years, and the usual governance arrangements continued along with a heightened communications channel through our virtual 'Team Briefings' which were flexed up and down in response to the pandemic waves.

We have recently been undertaking an assurance mapping exercise and this has been a helpful tool in understanding the governance and assurance channels, as well as identifying any gaps, particularly for our regulated areas.

Key risks
The Clinical Board continues to work with services to review risks held on the register to ensure continued appropriate action and mitigation against all held risks.
The key risks from the risk register include:

Point of Care Testing (POCT) Risk rating 20
Developments in technology and improved manufacturing processes are producing POCT devices which are more robust and less prone to error than previous generations. However, the successful implementation of POCT is still dependent on the effective organisation and management of staff.
A Clinical Lead has been appointed to support the service but a lack of a POCT Governance committee leads to reduced corporate oversight. We are working with the Medical Devices Group to seek support in establishing a UHB wide governance process.

Backlog of diagnostics and therapies (as a consequence of Covid19) due to a reduction in capacity Risk rating 16
Weekly monitoring of waiting lists is undertaken. Significant improvement is noted.
The Directorate are currently undertaking a capacity and demand exercise to ensure the service is right-sized going forward.

IT/Digital Risk rating 16
Impact from aging hardware and software and slow delivery of key IT systems, some on-going stability issues.
The Clinical Board is fully engaged with the National Programme to work towards standardisation and interoperability, e.g. LINC and RISP.

Estates and Facilities risk rating 16
The fabric of some estate is suboptimal to delivery of modern, safe and sustainable healthcare and fails to meet regulatory requirements.
We continue to engage with schemes to update/replace our aging infrastructure, e.g. Mortuary, Radiopharmacy. Delivery of these schemes will be essential to satisfy the regulating bodies.

Health and Wellbeing
Well before the pandemic impacted upon us all, the Clinical Board recognised the significant risks from Work Related Stress, and set Wellbeing, Resilience, and Mental Health as a key priority and this is just as important than ever in the post-pandemic world.

We have seen the stresses that staff have been under manifesting in different ways and a number of workstreams have been established to support staff at this time.

In 2019, the Clinical Board won a cash prize for it successful ‘flu vaccination campaign. We worked with a group called ‘Aftathought’ who use actors to role play scenarios as a way to engage staff with the topic. Because we could not provide these sessions face-to-face a number of short videos were commissioned looking at two topics – Mental Health and Values in Action.

Linked with the ‘Civility Saves Lives’ campaign we recognised the significant impact the values and behaviours of staff have on each other, and the patients we care for. We adopted a train the trainer approach to delivering the Values in Action training and managers across the Clinical Board are delivering the training to their teams to demonstrate leadership and commitment to the messages in the videos.

The films are intended to support staff and managers to understand how the UHB's values can work in practice for the benefit of staff and patients. The values in practice might be something that the team are already doing well, and so the video can be used as a tool to remind staff of the values. However, in some Departments, the values may not be as well demonstrated, and so the film can be used to prompt discussions and demonstrate positive examples to work towards.

The feedback from this work has been very positive and we are sharing this work wider to benefit other parts of the UHB.

The Mental Health videos will be rolled out later in the year. In the meantime, we have sponsored a number of managers to attend Mental Health First Aid sessions again utilising the ‘flu prize money.

Recognising the ongoing impact upon managers the Clinical Board established its weekly Resilience session for managers. This is a safe space where managers can ‘off load’, receive support from peers and take a short time out. One manager described these sessions as the highlight of their week. The topics covered are diverse and we have used this opportunity to engage with our senior managers.

Influenza vaccination
The uptake of the Influenza vaccination is a key priority for the Clinical Board. The uptake rate for frontline staff for the season 21/22 was 63.4% which whilst was the highest in the UHB was significantly lower than the previous season of 72%.

Considerable work has been undertaken in developing the role of peer vaccinators but pressures on these vaccinators contributed to the inability for them to vaccinate as many staff as we would have wished. The mini-vaccination sessions we ran were successful and we will look to build on these in the coming season.

Regulatory Compliance and Accreditation
The governance arrangements for regulation and accreditation is through the Clinical Board Regulatory Compliance Group which uses a combination of metrics to drive the compliance dashboard, ensuring appropriate senior management oversight, escalation of issues, and monitoring of performance.

The Clinical Board services are well regulated and subject to regular inspection against legislation, regulation and standards. In 2021/22 the following inspections took place:

18th August 2021 HIW inspection IR(ME)R UHW
Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection diagnostic imaging at UHW. HIW reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017. There was very positive feedback provided from patients about their experiences when attending the department. We saw that arrangements were in place to promote privacy and dignity of patients and found that staff treated patients in a kind, respectful and professional manner. Discussions with staff throughout our inspection provided assurances that arrangements were in place to ensure that examinations were being undertaken safely.

A number of areas were highlighted in regards to ensuring the documentation required under IR(ME)R was in place, including making sure that written IR(ME)R employer's procedures accurately reflect clinical practice.

Overall, staff were happy with the level of support provided by the department leads. However, as part of their inspection, HIW also considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. Data regarding workplace culture was collected by means of an anonymous staff questionnaire.

HIW reported that that a small number of staff, who completed the survey, said that they had faced discrimination at work within the last 12 months or disagreed with the comment that staff had fair and equal access to workplace opportunities.

It is worth noting that 88 percent of staff agreed their workplace was supportive of equality and diversity. HIW received comments regarding workplace equality and diversity, which included:
"Very inclusive and diverse workplace, reflected in our department which is great to see!"
"One of radiology's strongest points, fantastic area supporting diversity"

In response, the directorate have led an action plan to address the concerns raised and to ensure that staff know the processes are in place to allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded.

In addition, the Clinical Board has been developing the Equality and Diversity Allies at Clinical Board level which supports this work across the Clinical Board.

13th October 2021 MHRA inspection SMPU
The Clinical Board had been managing the on-going response to the MHRA regarding outstanding issues in St Mary's Pharmaceutical Unit, through its enhanced governance and monitoring arrangements. This was successful in significantly improving the quality metrics provided to the

MHRA. The MHRA conducted this inspection to assure itself that the metrics were sustainable and the improvement could be demonstrated on-site.

It was an extensive and intensive inspection. The outcome of the inspection was that no Critical or Major classification deficiencies were identified and the Inspector recommended to the IAG (Inspection Action Group) committee that SMPU were removed from their oversight, to a lower level of surveillance.

We are delighted for the team, coming out of IAG status is a huge step forward for SMPU and receiving no major findings is rare in NHS Specials units and rightly the team are very proud that they have been able to achieve this.

Maintaining this level of performance is vital and the Clinical Board continue to receive assurance on compliance

9th March 2022 UKAS accreditation Cellular Pathology
Re-accreditation visits against ISO15189 in Cellular Pathology resulted in successfully maintained accreditation.

22nd March 2022 UKAS accreditation Biochemistry
Re-accreditation visits against ISO15189 in Biochemistry resulted in successfully maintained accreditation. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results and good quality management.

21st April 2022 UKAS accreditation Haematology
Re-accreditation visits against ISO15189 in Haematology resulted in successfully maintained accreditation. The UKAS Quality Manager and the peer reviewers were very complimentary and reflects again the efforts made by the team in this service.

May 2022 BSI accreditation visit Clinical Engineering
Accreditation against ISO9001:2015 in Clinical Engineering maintained. There were two minor non-conformities.

Patient Safety Incidents
In the period 1/4/21 to 31/3/22, there were two Nationally Reportable Incidents reported in the Clinical Board. These were:

In143602/5670	This incident relates to an Ultrasound trainee and concerns around competence. There has been a delay in completing the report but this is now being finalised.
In160526/5456	The delay in an interpretation of a CT scan lead to potential harm to the patient.

Since 1st April 2022, three further incidents have been under investigation

1. An incident was reported in Fetal pathology involving pregnancy remains that entered the sensitive disposal pathway before the post mortem took place. A meeting was held with the

family and they are being supported locally within their Health Board. The investigation has highlighted improvements that can be made to processes and the learning and RCA will be shared.

2. An incident has been reported that a patient was cancelled in a Urology clinic due to a consultant taking annual leave and the appointment was not re-booked. The patient has since presented with metastatic prostate cancer and the inference is that this could have been avoided if the patient had been rebooked and seen. Checks are being undertaken to determine if any other patients have not been re-booked and a factfinding meeting will be arranged next week. The clinic coordinators are currently based in the Medical Records department but at the time of the incident they were based in Urology in the Surgery Clinical Board but have since transferred across to this Clinical Board.

3. A No Surprises incident has been reported around fully covered metal stents that are inserted during an ERCP procedure. ERCP is an endoscopic procedure and some stents are designed to remain in place and others are meant to remain in place for a short period of time. A list of patients that have had stents placed since 2019 and that could be affected are being reviewed. No harm has been identified following this review

Learning from serious and adverse incidents is shared at the Clinical Board QSPE sub-committee and recorded in the risk register where appropriate. There are adequately trained staff to undertake robust investigations including RCA. Significant effort has been made to ensure closure of old incidents and submission of closure forms within WG timescales.

IR(ME)R reporting

Between 1/4/21 and 31/3/22 there were ten IR(ME)R reportable incidents (reported to HIW).

	Total incidents	Of which were reportable incidents
Referrer error: wrong patient (wrong addressograph)	0	
Referrer error: illegibility of information	0	
Referrer error: wrong examination	2	
Referrer error: incorrect referral information	3	1
Operator error: patient safety checks	11	4
Operator error: clinical history check	7	2
Operator error: Exam authorisation	1	
Patient denied pregnancy	3	3
Patient abandoned examination	1	
Equipment issue	3	

This is similar to previous years (9 reported 20/21 and 11 in 19/20).

A theme and trends review has been undertaken:

Duplicate imaging performed	Reminders sent to all staff groups. Radiographers advised to respond via email directly to acknowledge responsibilities. Discussed at radiology safety and quality meetings. PAUSED posters placed in clinical rooms. Referrer awareness poster created and distributed to all clinical boards, posters printed and placed in ward/clinic areas. Visual observations of practice/compliance with procedures to be properly documented going forward.	Admin and clerical error awareness session being developed by QSE lead and A&C line manager - to be delivered to all A&C staff early September and continue to deliver during induction of new staff.
CT incidents due to failure to complete pre-examination checks	No particular recurring pattern among CT incidents, other than failure to complete all pre-exam checks correctly e.g. ID, examination justified and checking of clinical information, exam protocol. Review of relevant CT documentation completed. Staff required to complete reflective work following incidents. Use of request proformas reinforced with radiographers and radiologists for all in-patient requests. ID procedure compliance reviewed and observations of practice completed.	Meeting to be arranged with the CT group to discuss with staff why they feel these incidents may be occurring and what we can put in place to reduce the risk. Create and display posters indicating the number of days since an IRMER incident.

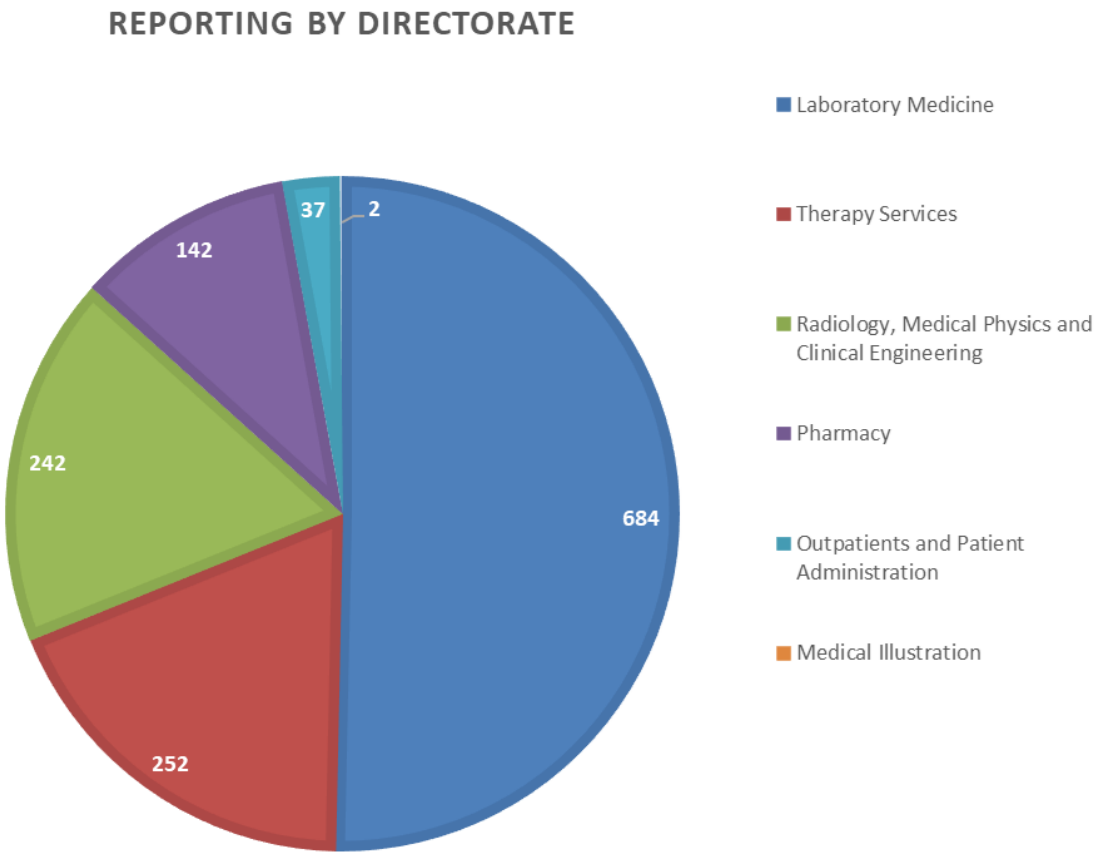
It is pleasing to note the reduction in addressograph errors which had been a trend previously.

Incident Reporting

For the period 1/4/20 to 31/3/21, 1359 incidents were reported by Clinical Board staff using e-Datix.

Datix queues are regularly reviewed and managed with emphasis placed on managers and users to action and close incidents in a timely manner.

There has been significant improvement in the number of incidents held in ‘queues’ and this work will further continue into 2022 with the move to Datix Cymru.



The top reported incident types were (taken from incidents reported on Datix Cymru only):

Diagnostic testing – Lab Medicine	34
Blood / plasma products transfusion	17
Diagnostic testing - Radiology	14
Treatment or procedure issues	8
Slip, trip or fall	6
Communication issues	5
Healthcare record	4
Medication supply errors	4
Non-medical equipment	4
Contact with needles or medical sharps	3

The Lab Medicine diagnostic testing incidents include

- Delay in testing/processing
- Demographic mismatch
- Failure to follow protocol/SOP
- Inappropriate request for test/treatment/procedure
- Incorrect result reported
- Laboratory technical error/ mishandled samples
- Missing/unavailable
- Sample mix-up (found before result entry)
- Specimen mislabelled or unlabelled
- Test results / reports - failure / delay to interpret or act on

12 of the 17 blood transfusion reported incidents on new Datix (and 63 on old Datix) involved the failure of the clinical area to return blood transfusion documentation leading to traceability issues. These have to followed up individually by the team in transfusion. Electronic tracking will help alleviate this issue (see below).

Health and safety issues

Clinical Board Health and Safety meetings are held monthly. There is a Clinical Board Health and Safety priority work plan in place which is used as a framework to drive improvement. The meeting also receives feedback from workplace inspections.

There have been 4 RIDDOR reportable incidents in the period 1/4/2 to 31/3/22:

- Slip/trip (2)
- Manual handling (2)

No common themes were noted. All cases have been managed with the support of the Health and Safety Unit.

The current training compliance for the Clinical Board is:

Training Compliance by Directorate

Org L5	Manual Handling - E Learning	Manual Handling - Objects - Classroom	Manual Handling - Patients - Classroom	Violence and Aggression Module A - E Learning	Violence and Aggression Module B - E Learning	Violence and Aggression - Module C - Classroom	Fire Safety Training - E Learning
001 Clinical Diagnostics and Therapeutics Management	100.00%			100.00%	75.00%	0.00%	77.78%
001 Laboratory Medicine	88.53%	19.86%		92.64%	83.80%	2.56%	80.74%
001 Medical Illustration Directorate	90.00%	0.00%		90.00%	72.00%	21.43%	93.33%
001 Outpatients & Patient Admin Services	87.86%		8.00%	86.89%	75.73%	48.57%	54.85%
001 Pharmacy & Medicines Management	86.50%	2.00%	0.00%	84.66%	56.60%	1.97%	59.51%
001 Radiology, Medical Physics & Clinical Engineering	90.64%	30.00%	44.74%	92.20%	86.82%	10.98%	85.38%
001 Therapeutics & Poisons	90.91%			90.91%	68.42%	0.00%	60.00%
001 Therapies	91.66%	41.67%	30.24%	91.66%	77.17%	30.79%	74.38%

Concerns and compliments

The management of concerns continues to be a key priority for QSPE and continuing efforts have been made towards timely response to patient concerns.

The number of concerns being raised in the period 1/4/21 to 31/3/22 was significantly higher at 315 (compared to 136 in the previous year last year).

Difficulties arranging and cancelling appointments continue to be the main theme of the concerns received (particularly Radiology and physiotherapy). Some actions will be taken to try to address this issue going forward; the concerns team will be issued with information to ensure that patients have the right contact numbers, Radiology are looking at a contact point email and we are aware of a number of telephone line issues that we are working through with telecoms teams.

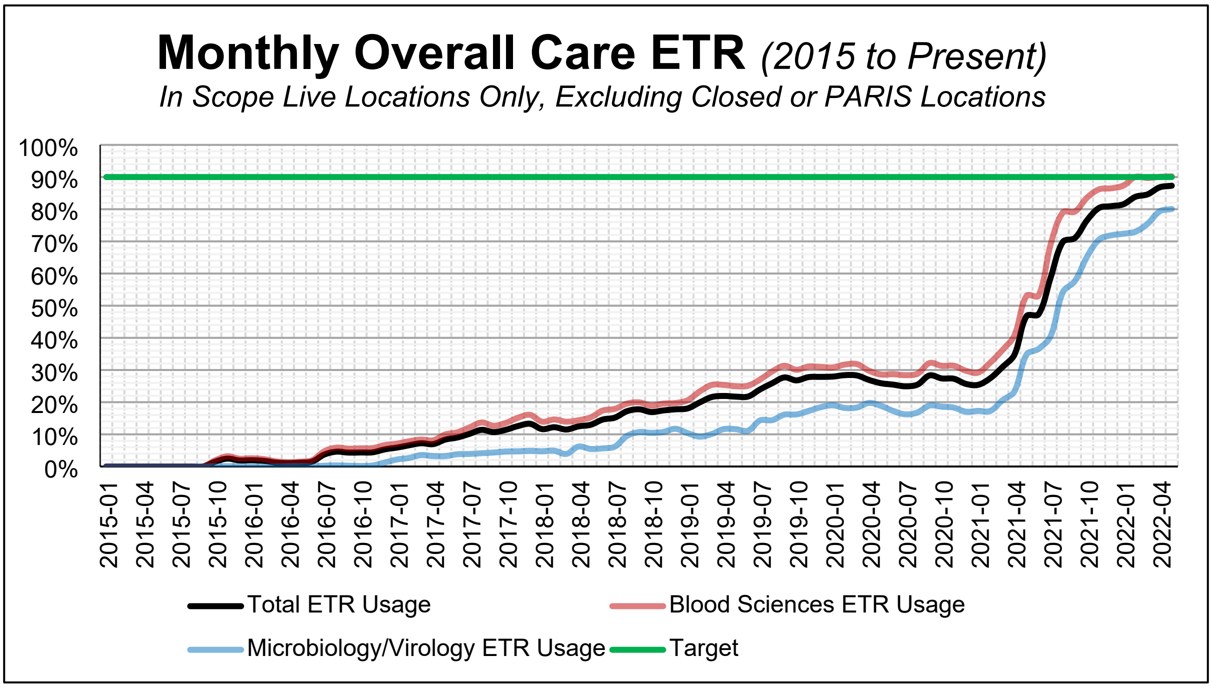
31% of concerns were resolved by early resolution. 30 (9.5%) breached response times. Tracking of concerns is undertaken and every effort is made to ensure compliance with timescales for formal responses. Delays in response times were due to complexity of some of the concerns and multi-disciplinary and multi-clinical board input requirements.

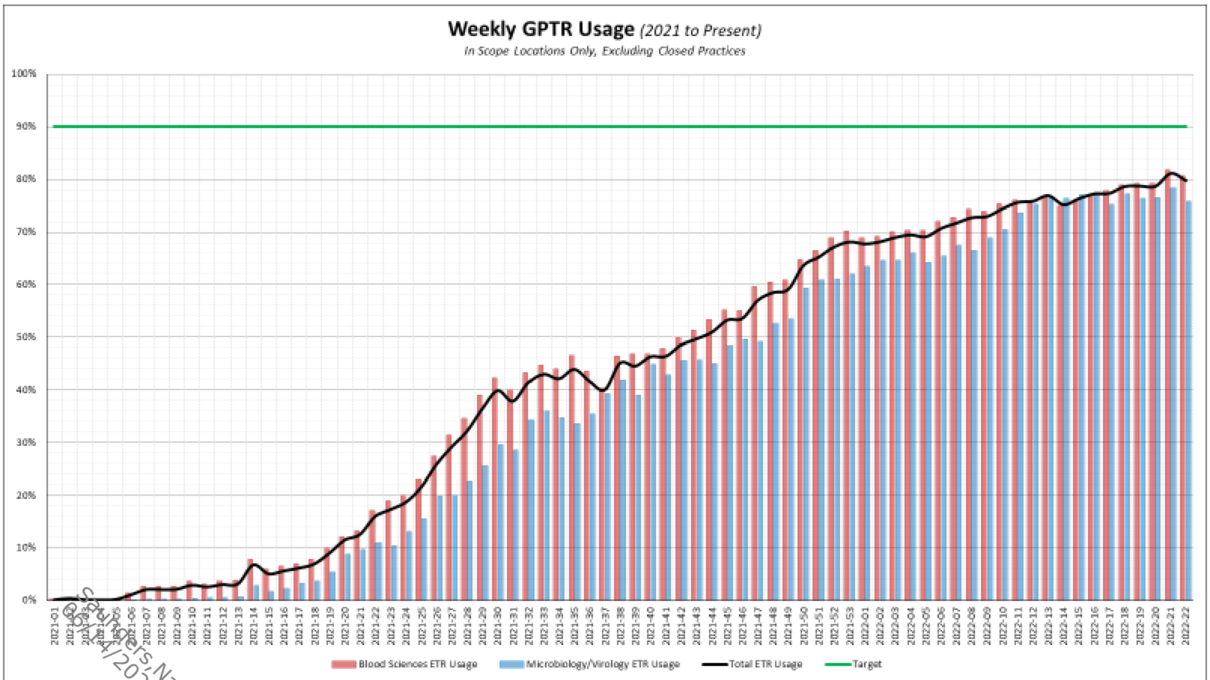
In contrast, 86 compliments were received by the Clinical Board in the same period and it is pleasing to note the positive reports received from patients.

Service Developments, improvements, and innovation
The Clinical Board would like to use this opportunity to highlight the on-going developments across the Clinical Board.

Laboratory Medicine
Electronic Test Requesting (ETR) and GP Test Requesting (GPTR) for Laboratory Medicine roll-out is well underway.

Prior to standing up an ETR Programme (Nov 2020), the UHB was at around 25% uptake in secondary care. 90% is the target ETR and GPTR for both to be achieved by the end of Dec 2022.





Blood Transfusion
Errors in the blood transfusion process (misidentification of a patient, their blood sample, or the blood component intended for them) pose significant risks to patients and in cases where blood is incompatible with a patient's blood type, can result in severe, sometimes even fatal, adverse

reactions. Patient identification, and the verification of samples and blood components from/intended for the right patient, has traditionally used manual and written checks but Electronic Blood Management Systems (EBMS) carries out some or all of these checks electronically instead, using unique identifiers (such as barcodes). We are currently in the business case phase for an EBMS which we are expected to complete this by the end of June/July so that it can be reviewed by Welsh Government. We are on track to complete this and will await their funding decision.

Blood tube shortage, business continuity
The Clinical Board would like to acknowledge the significant contribution of Lab Medicine colleagues, procurement, stores, the ADoTHS and clinical staff across the UHB in successfully managing the blood tube shortage issue.

Cellular Pathology
Recent developments include

- PDL-1 up and running for upper GI cancers
- Streamlining the biomarker testing of lung cancers

James Peaker was nominated and shortlisted for the Moondance cancer awards as a future leader, for his work in getting PDL-1 testing up and running (first in Wales), achieved as the first consultant biomedical scientist able to report GI cases independently

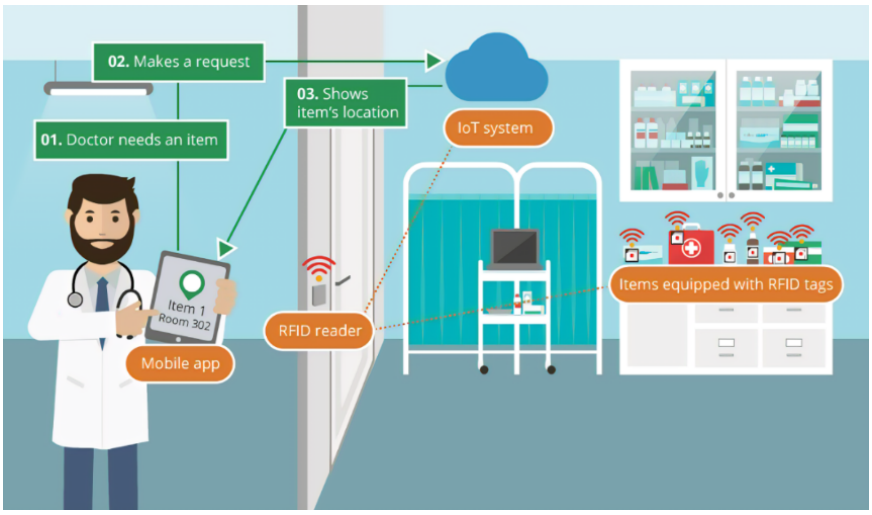
AWGOG (All Wales Genetic Oncology Group) team were also nominated who have members from Cell Path (and Genomics)

Point of Care Testing
Recent service developments include:

1. Implementation of POCT Covid devices across key acute areas. Particularly in ITUC, whereby the Unit had to be closed/ moved 6 times due to an unforeseen Covid outbreak. This is ongoing throughout the HB.
2. Service improvement for remote monitoring of specialised POCT Coagulation monitoring in Delivery suite and Cardiac Theatre settings.
3. Collaboration with Dept. of Community Emergency Medicine (DCEM) for use of mobile POCT devices in Pre-Hospitalisation patients.
4. Implementation of POCT CRP testing in Porthhceri Surgery as part of Barry Hub initiative for Antimicrobial testing strategy.
5. Implementation of POCT diagnostic testing for Diabetes Resource Centre at UHL.
6. Created income generation opportunity with diagnostic company *Invitron* for R&D evaluation of a POCT device for use in Heart Failure patients in Pre-Hospital setting. Collaboration with Consultant Cardiologist and DCEM leads to develop new pathway as part of pilot.
7. Commercial opportunity for POCT Dept. hosting an R&D project for evaluation of a mobile handheld POCT device for POCT FBC (full blood count), set-up as a collaboration with DCHEM, Velindre Oncology lead and POCT.

Clinical Engineering

There is a huge volume of medical equipment across C&V UHB that is under the control of Clinical Engineering. Keeping track of this equipment is extremely difficult as much of it is mobile and readily moved between wards. Clinical Engineering have been developing RFID tracking to address this issue.



The benefits of this project include

- Decrease in waiting times for equipment
- Reduces delays in delivery of essential vaso-active medication
- Improved governance
- Infection control
- Patient dignity
- Cost savings of 'lost' equipment.

A trial on floor 3, with Clinical Engineering, Theatres and ITU is planned. The hardware has arrived, site visits with IT and Estates have been done, we are working with SoftPro (Medusa supplier) to prototype our asset labelling process so it will conform to GS1 standards while still meeting stakeholders needs, and currently waiting on IT to provide a server for the software application (X-Track).

Clinical Engineering have been leading the way with a number of improvement projects. Two members of our team are currently on the I&I improvement course and are helping to implement some service improvement projects. For example, reorganising the workshop to improve flow of equipment; improving the spares ordering process to reduce delays and eliminate errors; and red tagging infrequently used equipment to help decide what can be disposed of.

Welsh Intensive Care Information System (WICIS); we have worked with Freeway Medical to design an enclosure for the Lantronix boxes (interfaces for connecting medical devices in ITU to the Ascom system). This will enable easy mounting of the box to the wall or pendant, and provide low cost replaceable network ports that, when the inevitable damage occurs, will prevent the HB having to purchase a whole new box.

Sustainability: Clinical Engineering have been working with a multidisciplinary team from Pharmacy, Anaesthetics, Estates, Obstetrics and Theatres to reduce or eliminate N2O and Entonox (50% N2O

and O2) use. N2O is a greenhouse gas 300 times more potent than CO2. The team has made good progress in eliminating some of the manifolds and Clinical Engineering have developed a novel plan using Entonox scavenging units (originally acquired to reduce waste exhaled Entonox in Obstetrics) to safely dispose of residual gas in these manifold cylinders before returning them to BOC (who at present can only empty to atmosphere).

Medical Physics
The improvement hub has been developed in MP/CE after the Spread & Scale training they attended which will provide access to ideas, expertise, materials and opportunity for learning throughout Medical Physics. The team have developed process maps, challenged each process to remove waste and worked with teams via Kaizen events to remove bottle necks and improve the flow of processes.

For DXA this included a patient survey which they will review before and after improvements have been made. The DXA waiting list was reduced to zero in January 2022 and has been maintained at that through the year.

There will also be encouragement to gain access to improvement training as well as building links with the improvement and innovation team. There are also plans for further improvement projects in Medical Physics as and when we notify opportunity.

We will be shortly launching the annual engagement survey in MPCE. Cedar has been doing the evaluation of the Adferiad programme for Wales (see below).

Radiology
The Radiographer Led Discharge (RLD) pathway is designed to increase patient throughput and satisfaction whilst reducing waiting times, image interpretation errors and recall rates. Under an RLD pathway, Reporting Radiographers provide a ‘Hot Reporting’ service to the EU, Monday – Friday 08:30 – 17:00, providing the required formal report for musculoskeletal plain film radiographs. The RLD pathway these staff confer imaging results to patients, imparting injury management advise and completing patient discharge procedures directly from Radiology.

This means a cohort of patients are not required to return to the EU for treatment post x-ray findings reducing the patient traffic in this area and waiting times for patients. This has been utilised beyond these hours at times of predicted high demand/ pressures.

All Wales Toxicology and Therapeutics Centre
AWTTC has developed the SPIRA dashboard to monitor the use of inhalers and their carbon impact.

AWTTC is holding a Best Practice Day in July to highlight the environmental impact of medicines and showcase projects to reduce carbon footprint of medicines used in Wales.

We are also committed to improving pharmacovigilance and will be developing a video (awaiting procurement approval) to encourage reporting of adverse drug reactions using the Yellow Card scheme.

Pharmacy
Positive feedback has been received regarding our ward-based Pharmacy technicians

‘They do make a big difference when helping qualified nurses on a busy morning. Like I have mentioned, there are number of occasions where a patient is poorly and nurses need to tend to them, having pharmacy support with medication rounds makes it a lot easier to manage other patients' medication. Their knowledge on medication is also something that is very useful specially to nurses who are not familiar with some. Also, nurses find it more convenient to order medication that are needed and TTH's are checked accordingly. It is indeed a great help not just for nurses but for patients as well’

Covid Antivirals - we have deployed 939 patient treatment course of Paxlovid and 647 treatment courses of Molnupiravir and have referred patients for 1496 doses of infusion at their local health board units since December 16th 2021.

Covid vaccine allergy service - we have advised on the safe administration of COVID-19 vaccines to individuals with allergies, 1324 times in the last 12 months, these individuals might otherwise not have been able to be vaccinated. We have set up new pages on our website to inform patients and health care professionals of antivirals and who is eligible.

Extravasation – Pharmacy have developed new materials. One is to pre-warn patients of the risk of extravasation if they are to receive vesicant drugs. This was developed in response to numerous reports of extravasation reactions in a bid to try to get patients to report early and know what to look out for. The other is kept in extravasation kits to supply to patients if they actually have an extravasation.

Pharmacy have been actively, and successfully involved in Project Search. This will be featured on an ITV news piece shortly.

YOUTH TEAM: PROJECT SEARCH

Project SEARCH is supporting young people aged 17-19 years old with additional learning needs.

The project is based at University Hospital Wales (Heath) where young people complete supported work placements whilst learning about the world of work and gaining work specific qualifications.

Jaydon started with Project SEARCH in September 2021 and began his work placement in the Pharmacy Department in January 2022.

The Pharmacy department is an integral and very busy part of the hospital supply chain, which receives, stores, and distributes all of the medicines and supplementary items used throughout the entire hospital estate.

Jaydon was a little reluctant to engage with the classroom-based activities initially but was keen to get out and do practical tasks within a workplace environment.
Jaydon immediately displayed a very enthusiastic approach to the placement; he was keen to learn every job available and to become productive as soon as possible. Jaydon's holistic development has also been clear to see. Jaydon really flourished, become more confident, and built good professional relationship with all his colleagues.

Jaydon exceeded all expectations and quickly became looked upon as an extra member of the team.
A position was advertised in the team and Jaydon has now gone through the application process and has secured a paid position.

"It has been a real pleasure to be involved with Project Search and the team. The help that the interns have given in processing the returned medication has been invaluable. I would recommend anyone to sign up for the project and become involved."

Ruth Holland, Senior Pharmacy Technician - CAVUHB

Therapies
Covid Recovery schemes in Therapies include

- To develop an enhanced therapy service to the unscheduled care pathway on A1 & A1link (OPSSU)
- To develop an enhanced therapy service to frailty trauma pathway
- To enable the reintroduction elective surgery for urgent patients in a protective environment (green)

The benefits from these schemes have been identified as:

- Reduce LOS by facilitating timely discharge
- Reduce readmissions
- Provide access to Therapies 7 days a week
- Improve Clinical Outcomes and patient experience
- Creating a robust MDT by making clear patient plans
- Reducing risk of harm/ deconditioning
- Improve compliance #NOF pathway /Hip fracture standards
-

Keeping Me Well Website

The Keeping Me Well website is a Cardiff and Vale UHB website for therapies. The website provides useful information and resources that support the therapy services available in CaV, directs people to the right services, and supports people with self-care (e.g. provides information about techniques to pace activity during recovery, techniques to improve fitness etc.)

Initially the website was designed to support service users from the 4 patient groups identified by the Welsh government who have been impacted by COVID. The Website has now expanded to incorporate many more services who have uploaded content to support their service users and help promote self-care and self-management. The site aims to provide a holistic view to condition management and signposts to relevant 3rd sector and community services.

Long COVID Rehabilitation Team

This is an interdisciplinary therapy team supporting and enabling individuals to live well and manage the long-term effects of Long COVID. The team deliver psychological informed rehabilitation and individualised recovery plans by utilising existing rehabilitation resources, and brief COVID rehab team interventions through the delivery of a set of group-based interventions.

The team provides education and supportive self-management strategies encompassing fatigue management, breathing advice, cognition and psychological support, taste and smell retraining, pain management, bladder control, vocational advice, and nutritional support. In addition, the service provides brief 1-1 support and interventions from Clinical Psychology, Occupational Therapy, Physiotherapy, Speech and Language Therapy and Dietetics as clinical indicated.

Cedar, an evaluation centre based within Cardiff and Vale University Health Board, has been carrying out an SROI (Social Return on Investment) for the Long COVID Service. We have worked with Cedar, giving access to our available data and stakeholders. Cedar's work is a component of our wider Benefit and Outcome measures assessment.

Key Outcomes	Through feedback from surveys and interviews, the key themes for the outcomes are as follows: the feeling of being listened to, understood and believed, and meeting (virtually) other people who were going through the same experiences. In addition, people mentioned the understanding that they had to pace themselves and not try to "push through", and how information such as an occupational therapist's plan for return to work could help them not only in a gradual return to work, but to feel they had something to explain to colleagues or family how gradual this had to be. In contrast changes in health was not mentioned as often in surveys or interviews, although for some individuals there were specific interventions that were very important in changing their health outcomes.
SROI (Social Return On Investment)*	The interim calculation of SROI is 1.26:1, or for every £1 invested in the service there is a social return of £1.26. It is possible that this will increase if additional information is gained from family members or secondary care teams. It is also possible that some outcomes are undervalued in terms of the importance placed on them by stakeholders, and the SROI may increase when these are verified.

Physiotherapy
Development of virtual consultations and delivery of class interventions for physiotherapy outpatients (Additional resource – IT equipment only)
This included:

- Hybrid face to face/virtual model - Stay steady virtual clinics to support potential fallers in the community delivered by shielding staff & expansion into Vale of Glamorgan
- Virtual consultations in ECAS.
- Virtual delivery of Living Well with a Neurological Condition programmes.
- ESCAPE pain for hip and knees provided online via Zoom (1hour x2 Weekly for 6/52)
- ESCAPE backs Provided Via Zoom (1hour x2 Weekly for 6/52)
- Foodwise for life with activity advice (1hour x1 a week 8/52 programme)
- Low impact chair-based exercise programme - Community Neuro (45mins x1 a week up to 12/52)
- Upper limb Activity programme - Community Neuro (1hour x1 a week 6/52)
- Tai Chi online (1hour x1 a week 6/52)
- 1:1 virtual Physio if requested in CNRS / ESD (Stroke)
- Virtual delivery of BMT Out-patient appointments and routine follow-up appointments
- Virtual delivery of all MSK outpatient services across the pathway including FCP, CMATS and core delivery one to one appointments and group intervention
- Hybrid face to face/virtual model consultations/classes within Breast Cancer service
- Hybrid face to face/virtual model Prepare Well - Pre / post admission virtual/face to face consultation/classes to enhance the orthopaedic pathway (covid recovery funded)
- Hybrid model Cystic Fibrosis virtual/face to face consultations, virtual leisure centre (on demand and live exercise sessions) & gene modifying drugs have also changed the landscape of CF care.

All services are now offering face to face interventions but are utilising the learning from the virtual consultations to further develop blended models of care.

Other Virtual Developments include

- Pelvic Health – Developed a virtual class for Pregnancy related Pelvic pain (Within existing resources)
- Development of nudging material/ resources for MSK surgical pathway (within existing resources)
- Virtual student training for neuro placements
- Virtual work experience package for observation.

- Renal Transplant- “Balance” Prehabilitation programme was redesigned and now offers a blended model of care. Patients preparing for renal transplant will be offered either face to face classes or a virtual programme to improve fitness and nutritional levels prior to surgery.

Other developments have included

- Development of MTC and NeuroRehab AHP lead role to look at rehabilitation across both services trying to breakdown silos working and roles
- Expansion of the Rheumatology service to 2.0WTE (WHSSC) roles - particularly trying to look at chronic pain services
- Development from existing resources of orthopaedic clinics within special schools to manage the coordinated care of children with complex Neuro-disability.

Dietetics

Service development/improvement/innovation projects in Dietetics include:

- Vascular service – first dietetic funding for vascular services in Wales, able to work with podiatry in limb salvage clinics as part of Prehabilitation,
- Oncology service developments – Acute Oncology Service which is a full MDT team and Cancer Prehabilitation. Prehab service analysis so far showing Clinical improvements in time to treat since service began.
- Gynae ovarian cancer research project in Prehabilitation – Multicentre trial across 3 centres in Wales has a dietitian involved
- Dietetic support workers (DSW) in Lakeside Wing funded substantively 14.5wte working 7 days a week 12 hour shifts and in the Emergency Unit 2 dietetic assistants working 7 days a week 12 hours per day funded till July. DSW well received and positively evaluated by staff and patients in EU. SBAR written as part of the Environmental Action Plan in EU for substantive funding. Dietetic support workers also implemented in Glan Ely (TCU 1 and 2) and frail trauma
- Moving towards digitisation of Outpatient clinics at UHW – ongoing.
- Renal BALANCE MDT therapy programme well established with good results. Data presented to WCN Renal network. Value based bid submitted by Welsh Renal Clinical Network for an All Wales Prehabilitation programme for patients with Chronic Kidney disease which includes dietetic support.
- WHSSC funded Ketogenic diet service to be part of the offering to manage children with Epilepsy established. Service was originally delivered by Bristol and repatriated last year to Children’s Hospital for Wales
- Mental Health Eating disorders Consultant Dietitian recruited (a first in Wales)
- Additional dietetics for EDSOTT SHED and CAHMS in eating disorders
- MHSOP transformation for a Band 7 linking with Community mental health teams
- Natural waking pilot on E12 which supports patients with dementia waking up when then are ready and being able to access food and nutrition outside the set mealtimes. This has been put forward for more transformation funding and expansion.

- Symbiotix tablet for digital ordering of patient menus has been extended to the Children's hospital and other areas in UHW as well as UHL

Following the launch of the Welsh Government Healthy Weight Healthy Wales Strategy, Dietetics has led the development of the health board weight management pathway with a focus on implementing services for children, a previous service gap.

The team recognised a gap in the provision of holistic and compassionate lifestyle programmes for the children of Cardiff and Vale. Our response to this, was to prioritise the set-up of a Children and Young people's weight management service.

NYLO (Nutrition for your Little One) is a new free 6- week programme for families with children aged 5 and under living in Cardiff and the Vale of Glamorgan. The programme has been developed by Cardiff and Vale UHB Public Health Dietitians, with the aim to support families to feel more confident to provide a healthy, balanced diet at home and help children to be a healthy weight.

AFAL is a new service, and one of only two services existing for Children and young people living with Overweight and Obesity in Wales.

At the peer review session with Welsh Government the Health Board were complimented on its progress.
Cardiff and Vale have clearly shown great progress, they have established and functioning level 3 services, growing levels of level 2 provision and a clear plan in place which will lead to positive change.
A comprehensive response from the Health Board with a, well thought out forward plan which addressed ongoing demand and capacity.
The Health Board should be proud of their progress to date, it is evident that progress in Children and Families as well as adult services has been made across the levels of the pathway

The team also implemented a dietetic service to support pregnant women above a healthy weight.

Dietetics have been very active in promoting and publishing their work:

- Poster on Developing a dietetic service for patients undergoing CAR-based cellular therapy; evaluated with patient reported experience and outcome measures. accepted at international conference

- Abstract titled 'Critical care dietetic outcomes during the first wave of COVID-19 pandemic' submitted and accepted by the British Association for Parenteral and Enteral Nutrition (BAPEN) December 2021. Subsequently, published in the Clinical Nutrition ESPEN journal March 2022.
- Abstract titled 'Critical care dietetic outcomes during the first wave of the COVID-19 pandemic' submitted and accepted by the Intensive Care Society (ICS) for ePoster display and presentation at State of the Art 2021 (December 2021). Awaiting abstract publication in the Journal of the Intensive Care Society.
- Abstract titled 'Introduction of a multidisciplinary rehabilitation assistant in to an intensive care setting' submitted and accepted by the Intensive Care Society (ICS) for face to face poster display and presentation at State of the Art 2021 June 2022.
- Abstract titled 'Critical care dietetic outcomes during the first wave of COVID-19 pandemic' submitted to the PENG awards – abstract won a PENG award April 2021 and subsequently presentation and Q&A session completed virtually.
- Following abstract submission and acceptance, due to present an MDT poster at ICS State of Art 2022 'A novel approach to an evolving cohort of critical care patients'

We are pleased to note the receipt of the Dame Barbara Clayton Award from the British Dietetic Association for work on Evaluating the Feasibility of Bioelectrical Impedance Analysis in Assessing the Nutritional Status of Patients Admitted to General Medical, Model Ward for Nutrition and Hydration Practises

David Proud presented in 45th European Cystic Fibrosis Conference, Rotterdam, the Netherlands 8 - 11 June 2022 – Poster Presentation "Seeing a trend" - increasing vitamin A levels on elexacaftor/tezacaftor/ivacaftor therapy

Occupational Therapy

The Occupational Therapy service are providing training to 19 senior staff to implement the Cognitive Disability Model (CDM) in the service. The training is taking place over 15 weeks providing 12 sessions.

The CDM is used by occupational therapists that support adult, adolescent and older adult populations where cognitive impairment has functional implications. The central construct used in the CDM considers both functional performance and global cognitive processing skills such as attention, working memory, processing, organisation, and problem solving. Levels of ability and limitations are identified while the person's capacity to perform routine tasks and adapt to novel situations are recognised.

- Reduce falls and re-hospitalisation
- Improve functional outcomes
- Decrease secondary conditions such as contractures, pressure sores, depression, and weight loss
- Prevent and manage challenging behaviors
- Prevent or delay institutionalization
- Improve safety and predict performance in a variety of activities including driving, medication management and ability to live alone and work in the community

- Reduce caregiver burden and staff turnover
- Improve engagement in daily meaningful activities and routines

In MHSOP, the occupational therapy team have redeveloped the garden to provide an occupational focus and sensory focus to aid the recovery and wellbeing of patients and staff. This has been generously supported by the Health Charity, and the Mental Health Directorate. There is an opening of the garden on 19/06/2022.

Nick Gape Band 7 Occupational Therapist and Hand therapist has just returned from the IFSSH / IFSHT congress (International Federation of Hand Surgeons and International Federation of Hand Therapists) where he presented 2 papers, one of which was put forward as one of the top papers of the congress. There were a number of positive tweets resulting from the congress.

He also has contributed a chapter to the most recent edition of a hand surgery hand book which was publicised at congress and many attendees showed interest in a splint that Nick has devised and developed

Specialist rehab therapies have been entered for CAV Staff Recognition Awards which are due to be held soon. OT we have nominated four of the therapies support staff to attend. All made a significant contribution to relocation supporting neuro and spinal teams and the wider MDT.

An Occupational Therapist is a finalist in the CAV Staff Recognition Awards for championing the Welsh Language.

Overall, it has been an exciting and busy year for CD&T – it is fantastic to be moving on from the Covid response and looking to the future delivery of all our services.

Recommendation:

The Board / Committee are requested to:

- NOTE the progress made by the Clinical Board to date and its planned actions
- APPROVE the approach taken by the Clinical Board

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	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

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

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

Saunders,Nathan
06/14/2022 13:03:54

Report Title:	**Presssure Damage Collaborative update**			Agenda Item no.	2.2
Meeting:	Quality and Safety Committee	Public	X	Meeting Date:	15 June 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Jason Roberts, Interim Executive Nurse Director				
Report Author (Title):	Clare Wade, Director of Nursing, Surgery Clinical Board				

Main Report
Background and current situation:

The purpose of this report is to provide an updated assurance report to Quality, Safety and Patient Experience Committee on the goal of reducing heath care acquired pressure damage within the Health Board

The Director of Nursing for Surgery Clinical Board is the Professional lead on this piece of work for the UHB that looks at reducing the occurrence of healthcare acquired pressure damage within Cardiff and Vale UHB.

To ensure that there is a Multidisciplinary approach to this scheme of work a Collaborative was formed in May 2021. The goal of the Collaborative is:

- reduce the incidence of healthcare acquired pressure damage with the Health Board by 25% by July 2022
- speed up adoption of innovation into practice to improve clinical outcomes and patient experience

The Collaborative has secured input from the Patient Safety Team, Improvement and Organisational Learning Team, Learning Education and Development, Nursing Informatics and various experts within the Health Board to help progress existing work and help identification and to support learning and improvement. The Collaborative will help focus and drive forward improvements in care. Every team member of the collaborative is invested in solving the problems face and developing innovative solutions. We have created a collaborative to structure a system to support our leadership methodology and continually communicated our vision and our plans.

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

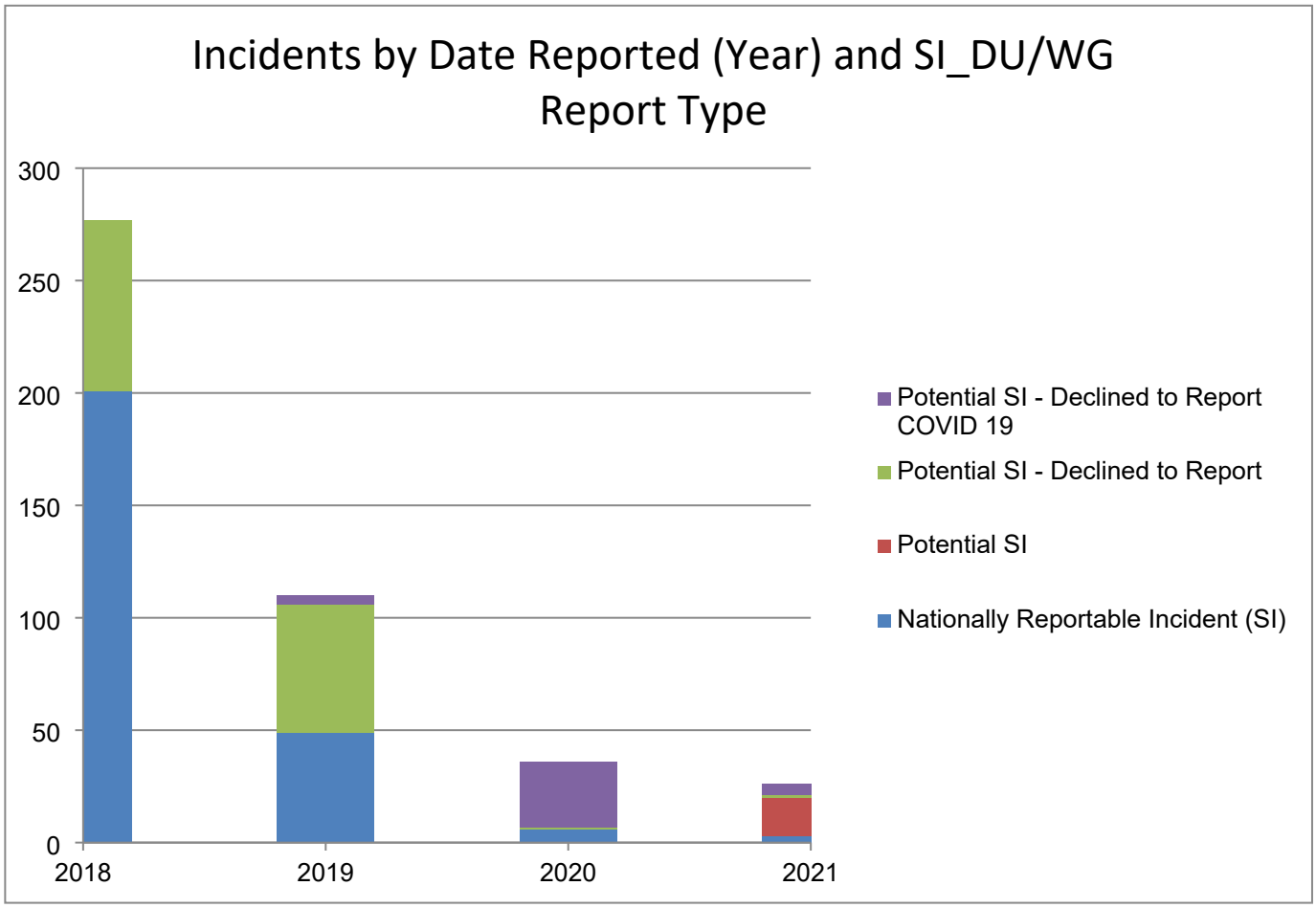
Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death (National Patient Safety Agency, (NPSA) 2010; Whitlock et al, 2011). Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers.

The costs of treating a pressure ulcer are estimated to range from £43 to £374 daily with hospital-acquired pressure ulcers increasing the length of stay by an average of five to eight days per pressure ulcer (Bennett, Dealey and Posnett, 2012). In Wales pressure ulcers affected 8.9% of all in hospital patients (Clark, Semple, Irvins et al, 2017).

Extensive work through previous All Wales initiatives such as 1000 Lives Plus and Fundamentals of Care has helped raise the profile of pressure damage and driven the development of rigorous and practical ways of recording and preventing pressure ulcer incidents. Initiatives such as SKIN bundles were introduced in Wales in 2009 through Transforming Care and aimed to improve patient care by reducing pressure ulcers. However, when pressure damage unfortunately occurs, the learning from such an incident must be effective if the risk to further patients suffering the same harm is to be reduced.

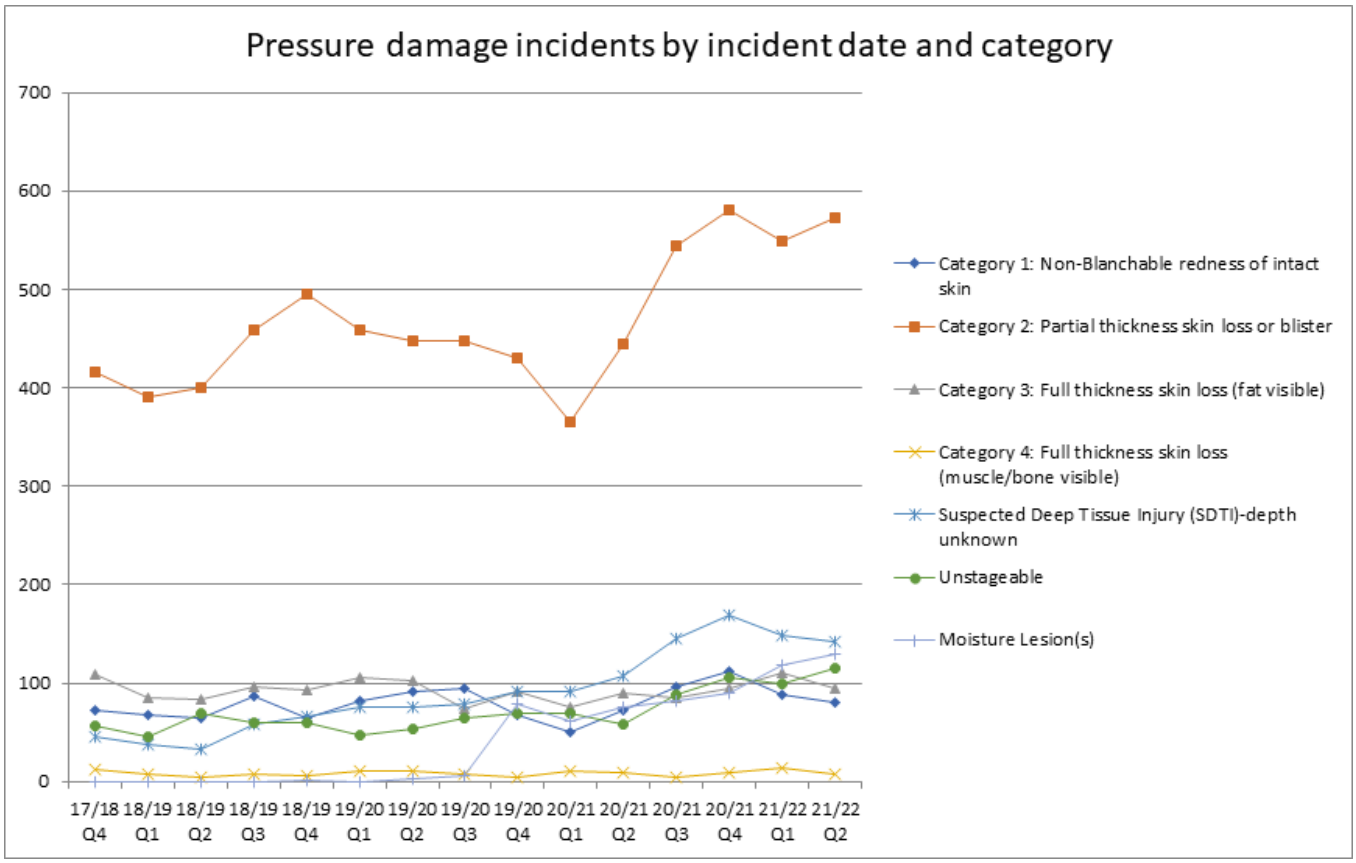
The below graph shows the decrease in the number of WG reportable pressure damage over the last 3 years.

Between April 2019 and March 2020, the UHB reported 49 Serious Incidents to Welsh Government in relation to Health Care Acquired Grade III, Grade IV or unstageable pressure damage. Between April 2020 and March 2021, the UHB reported 6 Serious Incidents to Welsh Government in relation to Health Care Acquired Grade III, Grade IV or unstageable pressure damage. However, it should be noted that the SI reporting process for Heath Acquired Pressure Damage ceased during the height of the COVID pandemic. The Health Board has still captured this data however and carried out appropriate investigations to ascertain learning and improvement during this period.



The below graph shows the number and categories of pressure damage (heath care and non-health) care acquired) reported by the Heath Board since 2018. The highest reported category of pressure damage for all years is Grade 2 which makes up 49% of the incidents reported. The Health Board has seen an increase year on year since 2018 in the number of reported pressure damage incidents so despite the wide-ranging work that had been carried out by the previous UHB Task and Finish Group this had not impacted on the number of pressure ulcer reported across the Health Board. It should be notes however that this data also includes reported moisture lesions which was only captured from 2019 onwards which affects the overall numbers. The Collaborative has commitment to reduce health acquired pressure ulcers for our patients both in hospital and in the community however there are currently some challenges in pulling out the data separating heath care acquired and non-healthcare acquired damage.

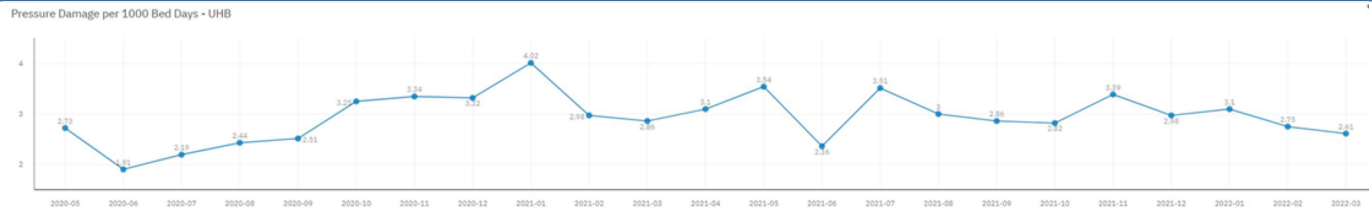
	Incident Date								
Pressure damage classification	2018		2019		2020		2021		Total
Category 1: Non-Blanchable redness of intact skin	289	10.46%	332	10.62%	287	8.29%	302	7.93%	1210
Category 2: Partial thickness skin loss or blister	1665	60.24%	1850	59.18%	1784	51.53%	1884	49.49%	7183
Category 3: Full thickness skin loss (fat visible)	374	13.53%	375	12.00%	342	9.88%	330	8.67%	1421
Category 4: Full thickness skin loss (muscle/bone visible)	32	1.16%	36	1.15%	29	0.84%	39	1.02%	136
Suspected Deep Tissue Injury (SDTI)-depth unknown	173	6.26%	296	9.47%	436	12.59%	515	13.53%	1420
Unstageable	231	8.36%	227	7.26%	286	8.26%	363	9.54%	1107
Moisture Lesion(s) [Category only available on Datix from 2020]	0	0.00%	10	0.32%	298	8.61%	374	9.82%	682
Total	**2764**		**3126**		**3462**		**3807**		**13159**

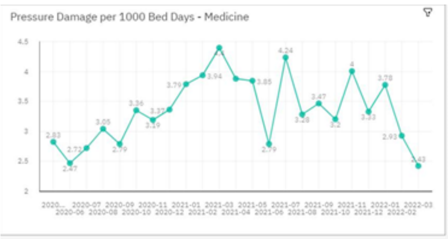


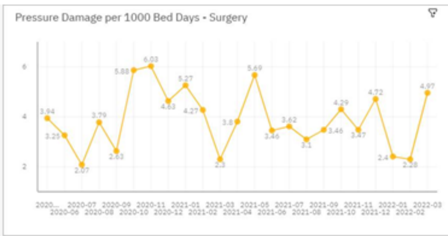
It is also challenging, based on the e-Datix reporting system used within the Health Board, to stop duplication of pressure damage being reported as patients travel across or access our health care system at different points. As Cardiff and Vale proactively encourages the reporting of incidents and pressure damage it is likely that there is much duplication of pressure incidents in the current e-datix system

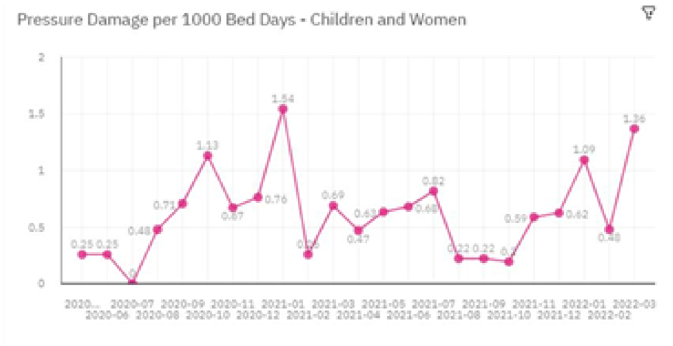
Data per 1000 Bed days as per May 27th 2022

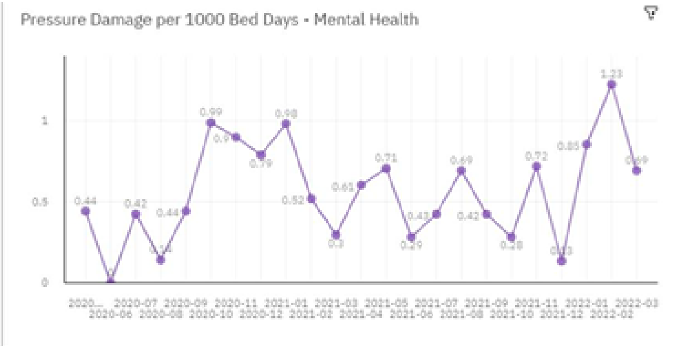
As previously discussed the goal of the pressure damage collaborative was to **reduce** the incidence of healthcare acquired pressure damage with the Health Board by **25% by July 2022**.The current data available to the pressure damage collaborative which can now for the first time can be presented per 1000 beds days shows that the pressure damage per 1000 bed days has reduced from 3.51 in May 2021 to 2.61 in March 2022 for inpatient areas which is a reduction of 24%, which at a very high simplistic level would indicate that the reduction goal has already been met.











However, it must be noted that although there is an overall reduction in reported hospital acquired pressure damage from inpatient areas until March 2022 the initial data which has not yet been verified for April 2022 does show an increase back to 3.95. This data has yet to be cleaned and many have not yet been through the Health Board pressure damage investigation process so is not yet reliable or ready to be shared.

There is a thought amongst the pressure damage collaborative that this potential increase in pressure damage in April 2022 which is not included in the above graphs may be a result of long waits for ambulance reviews in the community and the long waits in EU for patients with "decision to admit" for an inpatient bed. It is hoped that in the future the data could be triangulated with the amount of time that a patient has waited in EU or for an ambulance.

The collaborative are in the process of developing a QI dashboard for pressure damage which will triangulate data from both e-Datix and our business intelligence system (BIS) to provide a more robust streamlined reliable data set and measurement. The 8 metrics will be

- Total number or pts with pressure damage
- Breakdown of stage (moisture lesion, 1,2,3,4 etc)
- Pressure damage that occurred in our care – Acute
- Pressure damage that occurred in our care - Community
- Percentage of patients whose pressure damage deteriorates
- What pressure damage is reported comes in on admission to organisation vs what develops in a clinical area
- Length of time taken for pressure damage to develop
- Number of days pressure damage free per clinical area

Recommendation:

The Board / Committee are requested to:

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

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	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	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Prevention		Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/No

The Pressure Damage Collaborative since its formation in May 21 has progressed with a robust work plan. This work has led to the development of 7 subgroups lead by experienced clinical leads from the Health Board under the following headings

- Information and Data
- Education and training
- Incident Management and SI process
- Heel offloading.
- Pressure redistribution work stream
- Documentation
- Tendable roll out

The key actions taken by the colloborative so far since July 2021 are listed below:

- Bariatric cushion procurement completed
- Duo 2 replacments have been evaluted (Aria Pro) and are currently progressing though a Procurent process
- Scrutiny Panel commenced in Medicine Clinical Board
- Pathway to redress and litigation already in place. Flow chart for pressure damage redress to be agreed between Clinical Boards and Concerns Team
- A snapshot audit tool has been devised to examine trends and themes of reported incidence of heel pressure ulcers within the UHB in 2021. This tool is currently being piloted in Podiatry prior to review and commencement of the audit.
- Agreed use UHB wide of AsskinG – updated standardised skin bundle

- Tendable is now rolled out to all ward across Health Board
- Draft QI dashboard created and shared with collaborative, detailing a range of possible metrics available
- Launch of pressure damage Collaborative Twitter page @CV_UHBPressure
- Development of Skin Safety Card and Pressure Ulcer Quick Reference guide
- Restart of Pressure Ulcer and Prevention Virtual Study Sessions
- Updated Stop the Pressure film for both Staff and Patients - https://youtu.be/Bv7wRrG0M5I

Risks to the Collaboratives Goal

- We cannot deliver this goal in isolation of other important work that is already being undertaken across the organisation. The current overwhemling and unprecidented pressures on inpatient occupance and our workforce requirement in the Health Board may impact on the ability to consistantly deliver the reduction goal of 25% by July 2022
- As our goal is ambitious and needs to be achieved while recognising the work that is required to deliver the reduction of 'four harms approach' to our Covid-19 recovery plans
- There has been some short-term limitation with the delay in the roll out of the new "Once for Wales" reporting system
- The slow roll out of the All Wales E-documentation programme may cause duplication of work and effort

Please Note - This paper focuses on pressure damage data for inpatient areas only, additional work is required on how data is presented on healthcare acquired pressure damage in community settings.

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:

Report Title:	Learning from Mortality Reviews				Agenda Item no.	2.3	
Meeting:	Quality, Safety and Experience Committee		Public	x	Meeting Date:	15 June 2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Medical Director						
Report Author (Title):	Head of Quality and Safety Improvement/Associate Medical Director						

Main Report
Background and current situation:

Executive Summary

The reported increase in Risk Adjusted Mortality Index (RAMI) is a concern and whilst there are recognised limitations in the recording, coding and interpretation of this measure the increasing trend requires urgent review.

This paper aims to provide evidence of the past and current position on learning from deaths.

Background

The Harold Shipman and the Francis report were the initial levers for the urgent need to learn from deaths. This was followed by several other key reports which uncovered an unprecedented number of untimely deaths from systemic failures.

A Wales-wide approach to undertaking mortality reviews has been developing for some years and is overseen by a Wales-wide mortality group. This group subsequently took on the development and implementation of the Medical Examiner Service (MES).

A mortality review framework has been developed with support from the Delivery Unit to enable health care organisations to learn from mortality reviews and share this learning locally and across Wales in order to improve quality and safety of care and treatment of patients. It is also aligned to the principles of Putting Things Right (PTR) which is an integrated process for the raising, investigation and learning from concerns.

Prior to the Medical Examiner Service most patients who died in hospital had a 'Stage 1' mortality review at the time of death certification. 30-40% of these triggered a more in-depth stage 2 review. The sensitivity and specificity of the triggers were poor as was the governance around this process.

With the establishment of the UHB Mortality Review Group (MRG) in May 2020 and the steady implementation of the Medical Examiner Service the mortality review process is evolving in line with the framework and becoming more robust.

The MRG is chaired by the Associate Medical Director for Patient Safety and Governance and reports to the Executive Medical Director and the Clinical Safety Group (being established). The group has representatives from all Clinical Boards and is attended by the Chief Medical Examiner for Wales.

Structures and processes are in place to receive and review letters from the ME and agree subsequent proportionate actions. The ME sends a letter to the UHB on 20-25% of referrals they receive which highlight possible concerns. These are scrutinized and about half of these are sent to the designated clinical board lead (usually the Q&S lead) who oversees an in-depth stage 2 review.

Once the stage 2 review is undertaken, it is then to be presented in the departmental Mortality and Morbidity meeting. Themes and trends emerging from the stage 2 process are to be analysed by the respective CB and presented to, firstly at the QSE meeting and shared with the Patient Safety Team who collate the learning across the UHB and present it at the MRG.

Mortality Data

There are several sources of mortality data which should be analysed together to provide an accurate perspective on the quality of care. Crude mortality (the number of people who die), condition specific mortality (stroke, heart attacks, fractured neck of femur), risk adjusted mortality index (RAMI) and case note reviews all contribute to the assurance.

In 2014 the Welsh Government asked Professor Stephen Palmer to review the mortality ratios and associated processes. He concluded that mortality ratios including RAMI should not be seen as indicators of care. He concluded that case note reviews were the best way to identify avoidable deaths. Expansion of the Medical Examiner Service will fulfil this for all people who die in Wales.

Darzi et al also concluded that mortality ratios are not a validated tool to measure the quality of care and that healthcare organisations should be concentrating on condition specific mortality ratios as the outcomes are well defined.

Chart 1 below shows the number of people who died each month in our hospitals from January 2017 – January 2022 which clearly indicates the impact of COVID-19 from March 2020 and peaking in January 2021.

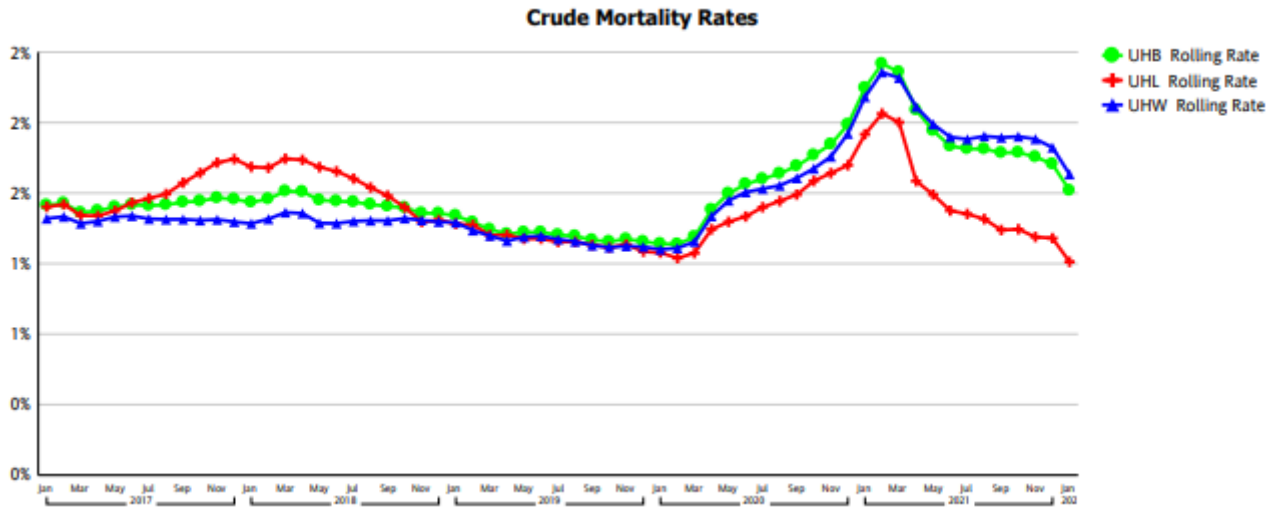
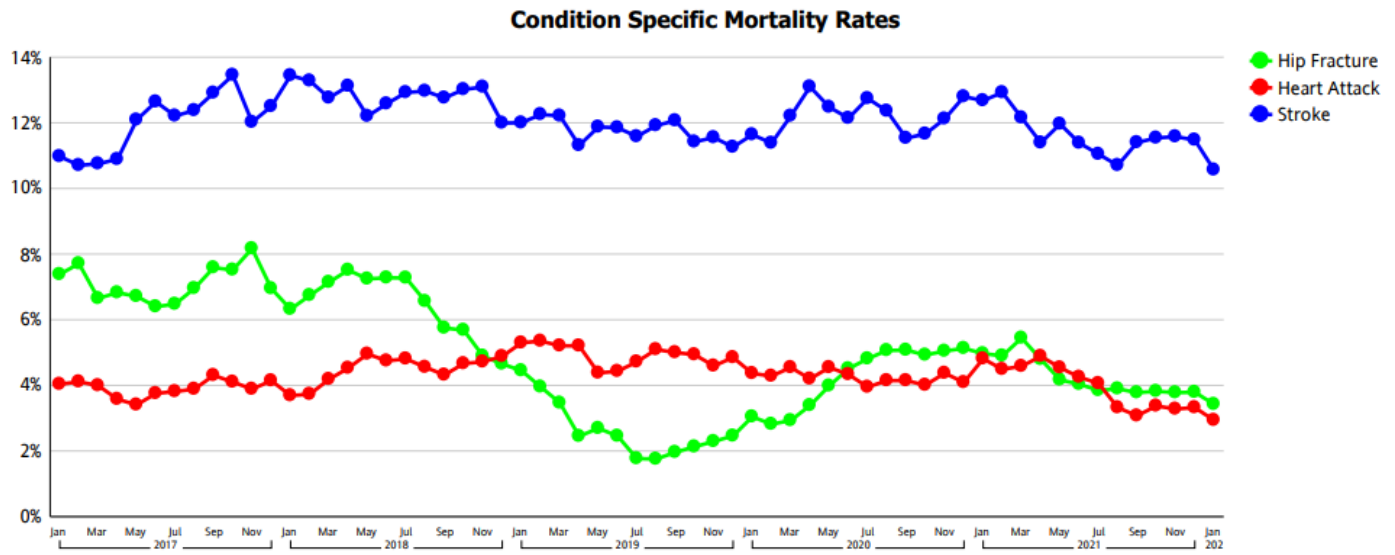


Chart 1 – Crude Hospital Mortality (% of people who die each month)

Condition Specific Mortality

The chart below shows the % of people who died in hospital following a stroke, heart attack and hip fracture. Stroke and heart attack are stable. % of hip fracture deaths steadily decreased to July 2019 and rose again to July2020 from where is has plateaued at about 4% compared to 7-8% in 2017.



Covid-19

The definition of a Healthcare Associated COVID-19 infection has been agreed by the 4-Nations HCAI Surveillance group. Welsh Government issued guidance on the 6th of November stating that all Patients who meet the criteria for the 'Probable' and 'Definite' category are deemed to be a nosocomial infection which require a review into their care.

Patients who meet the 'Probable' and 'Definite' criteria have been further broken down into 'tiers' for investigation:

Tier One

- Any patient who has died with COVID-19 on Part 1 of their Death Certificate and Outbreak has been identified
- Any patient who has died with COVID-19 on Part 1 of their Death Certificate
- Any patient who has been referred to the Coroner
- Any patient where a Concern has been raised

Tier Two

- Any patient who has died with COVID-19 on Part 2 of their Death Certificate
- Any patient who required escalation of treatment to Critical Care (to include those patients who required Non-invasive ventilation - NIV in a High Care Respiratory setting)

Tier Three

- Any patient who is in the 'Probable' and 'Definite' category but not covered by definitions in Tier One or Two

Due to the number of Patients who fit within these categories a systemic tiered approach has been adopted by the COVID-19 Investigation Team / Patient Safety Team. Since September 2021, all COVID deaths, irrespective of whether it was community acquired, have also been reviewed by the Medical Examiner to provide independent scrutiny

Some themes have emerged from the COVID-19 death reviews:

- Patients transferred from other health boards did not either have an admission swab or appropriate testing in the first admitting unit.
- Patients testing positive after being readmitted within 10 days of their discharge from outbreak areas.
- Patients moved into suspected or closed areas (mainly out of hours)
- Patients having multiple moves and subsequently testing positive.
- Missed opportunities to test symptomatic patients.

- Inappropriate use of PPE
- Concerns about documentation
- Swab results are not checked or documented in case notes.

These areas for learning are being considered by the daily IP&C operational group as part of the on-going management of COVID -19 outbreaks.

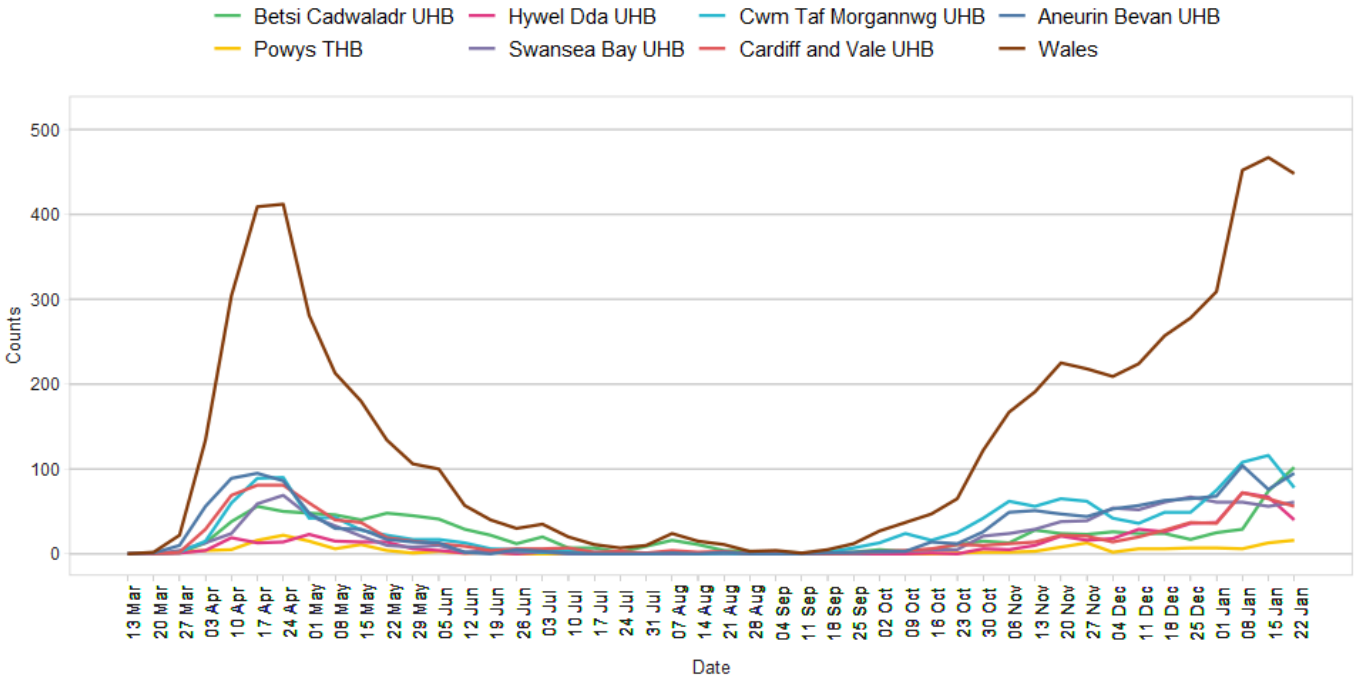
All Wales Covid-19 mortality surveillance data

Total number of deaths registered with COVID-19 mentioned on the death certificate, Local Health Board of residence and Wales, week ending 3 January 2020 (Week 1) to week ending 22 January 2021 (Week 3)

Health board	Cumulative deaths
Aneurin Bevan UHB	1,335
Betsi Cadwaladr UHB	1,024
Cardiff and Vale UHB	925
Cwm Taf Morgannwg UHB	1,388
Hywel Dda UHB	519
Powys THB	189
Swansea Bay UHB	945
Wales	6,325

Provisional figures to Week 3 2021 for Welsh residents have been produced using data provided by ONS to Public Health Wales. This analysis is based on date the death was registered, not when it occurred. There is usually a delay of at least five days between occurrence and registration. The analysis requires the joining of weekly and daily data using NHS numbers. Figures may differ slightly between those published by ONS due to the use of different extracts of the data at different time periods. Data is therefore subject to change as more information is received. COVID-19 was identified using ICD-10 codes U07.1 and U07.2 and includes deaths that had COVID-19 mentioned anywhere on the death certificate, whether as underlying cause or not.

Weekly number of registered COVID-19 deaths (any mention), Wales by health board, week ending 13 March 2020 (Week 11) to week ending 22 January 2021 (Week 3)



Provisional figures for Welsh residents have been produced using data provided by ONS to Public Health Wales. The analysis is based on date the death was registered.

Table 1 below shows hospital acquired COVID-19 and the clinical reviews subsequently being undertaken.

	Wave 1 (27th Feb '20- 26th July '20)	Wave 2 (27th July '20- 16th May '21)	Wave 3 (17th May '21- 19th Dec '21)	Wave 4 (20th Dec '21- 30th April 22)
Outbreaks	7	86	30	25
Number of Pts associated	574	1340	328	1007

Clinical Review	*387*	*966*	*286*	942
Clinical review completed	*0*	341	27	18
Req a full tool (death <28 days)	*187*	*374*	*42*	65
Underway / Completed	5	61	12	20
Sent to Clinical Board	1	47	9	0
Sent to Scrutiny	0	10	3	0
Subtotal of Full tools	*6*	*118*	*24*	20
% & Full tools completed.	***1.05%***	***34.25%***	***15.55%***	**4%**

Table 1 – COVID Outbreaks

Stage 1 – Independent Scrutiny by the Medical Examiner Service

There is a steady scaling up of the independent Medical Examiner Service, aiming for case notes of all hospital deaths to be scrutinised by September 2022. This is a far more in-depth assessment than the previous stage 1 reviews which were predominantly undertaken by junior doctors at the time of death certification. It is an independent scrutiny by a highly trained Medical Examiner supported by skilled Medical Examiner Officers. Bereaved families are contacted to enable them to share their concerns. Most are complimentary about the care provided. This is perhaps the most important element of the overall assurance.

Currently, all patients who die in UHL (average 2 per day) and 5 who die in UHW are referred to the MES for independent scrutiny of the clinical case notes. All patients with hospital acquired COVID-19 are prioritized. There is agreement that all A&E and critical care deaths will also be prioritized with the gradual scaling up to all hospital deaths in September and then on to community deaths.

Resource has been secured in medical records to sort and scan the last episode of care case notes to the MEO and are thus simultaneously available for clinical teams to review should a stage 2 review be required.

One of the outputs from the MES is to improve the quality of death certification. The certifying practitioner discusses the cause of death with the ME and only then should the MCCD be issued.

Scrutiny by the ME has increased referrals to HM Coroner as there is now a better understanding of the law. Education sessions have been delivered to disseminate this information.

Information is entered into the new Datix Mortality Module which is still under development so an Excel spreadsheet is also used to capture information and track progress.

Appendix 1 shows the reasons for referral from the ME
Appendix 2 shows the outcomes of the referrals
Appendix 3 highlight some of the learning and actions

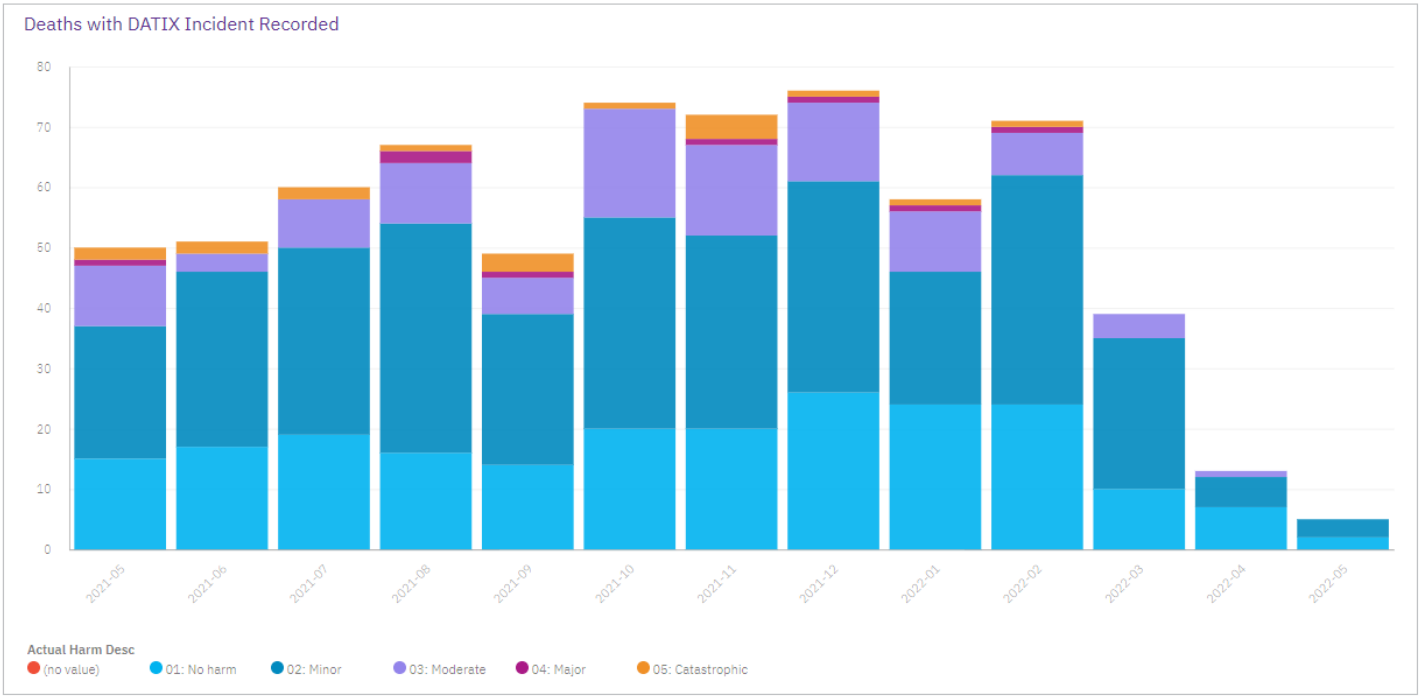
Stage 2 – All-Wales Review Tool

Where concerns are raised by the ME and/or the family of the deceased the UHB receives a letter outlining those concerns and advising further proportionate enquiry. Consistently we have 20-25% cases referred back to the UHB which is less than most other health boards in Wales.

A stage 2 Mortality Review tool has been developed to support a consistent approach across NHS Wales. This has been adapted in Cardiff and Vale to produce a hybrid of the Royal College of Physicians Structured Judgement tool and the Harm 2 tool developed for a Wales-wide research project. This enables a judgement about the quality of care the patient received and whether it was in accordance with current good practice from 1 = very poor care to 5 = excellent care.

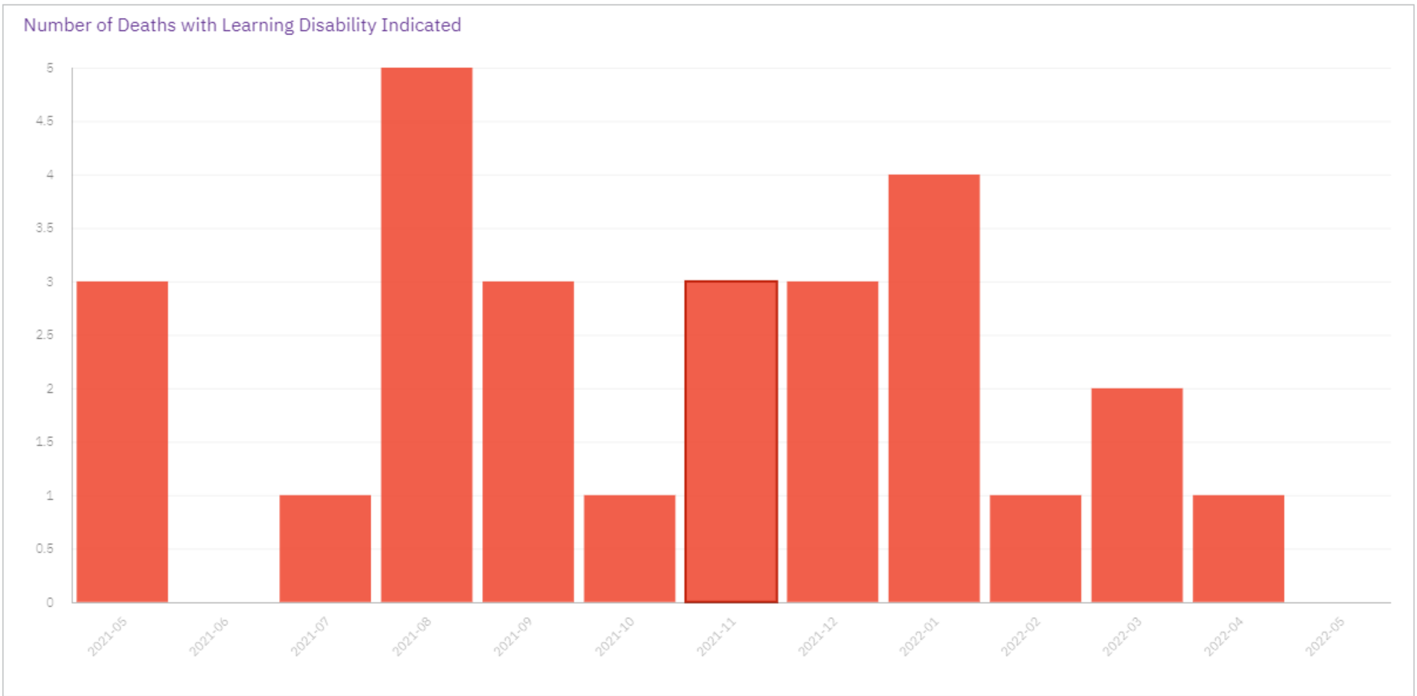
Learning from Deaths

We triangulate data with Serious Incidents involving death to ensure appropriate action is taken and to limit duplication of effort.



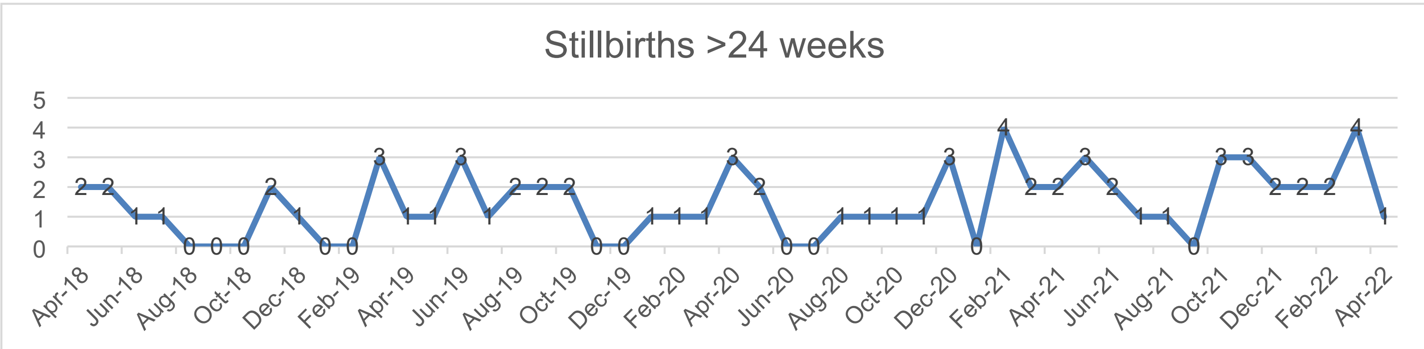
A catastrophic incident is an incident leading to the death or severe permanent harm (e.g. permanent paralysis) of an individual(s) that the organisation was in some way responsible for or failed to prevent. These all investigated under current governance arrangements.

Particular attention is paid to people who die with learning disabilities as they typically have a much shorter life span and die often from treatable illnesses. The chart below shows the number of people know to have learning disabilities who died in our hospitals.



Perinatal Deaths and Stillbirths

The graph below shows a stable number of stillbirths under 24 weeks gestation over the past 4 years.



According to ONS data, in 2021 the stillbirth rate in UK was to 4.2 stillbirths per 1,000 births. At Cardiff and Vale the stillbirth rate was 2.4 (13 stillbirths for 5468 live births) for 2021.

Paediatric and Neonatal Mortality

Data have been requested and this will be included in the next paper.

Mortality Ratios

Since the Francis Report in 2013 mortality numbers and ratios have been used as an indirect marker of quality of care and performance of hospitals. There are 2 main providers of risk adjusted/standardized mortality ratios. We use CHKS' Risk Adjusted Mortality Index (RAMI). It can be useful to bench mark against peers but is generally not considered to be a good indicator of quality of care. By definition 50% of hospitals will have a RAMI above 100.

Standardised Mortality Ratio (SMR) is the ratio of the number of deaths in hospital within a given time period (numerator), to the number that might be expected if the hospital has the same death rates as some reference population (denominator). SMR in the standard population is 100 so there is an exact match between the actual and expected deaths. A lower RAMI proportionately suggests less deaths than expected and vice versa. A higher RAMI suggests proportionately more deaths than expected.

Many things affect the RAMI. 'It has become clear that it is unduly sensitive to some aspects of coding which depend more on local administrative or coding practice than on the patient's underlying clinical condition.

Despite its complexity, neither RAMI nor its competitors takes account of the impact of length of stay on risk of death. Yet for the many patients with long term conditions, there is clear evidence that the risk of death is directly proportional to the length of the hospital spell. Welsh boards and English integrate trusts for example cover a wider range of services than their English acute trust counterparts causing patients to stay 'on the record' for longer. For this reason, Welsh mortality rates have never been able to be legitimately compared with those in England' (CHKS 2020. Risk Adjusted Mortality Index (RAMI 2019 p5). The new RAMI (2019) has built in time dependent elements which have not been used before in hospital mortality measurement, thus a conservative approach has been adopted. The new model takes account of the additional risks of a patient dying in hospital on a per day basis.

There is substantial evidence that secondary diagnosis contains large amounts of undesired administrative variation which can cause significant coding 'noise'. Of particular note is the palliative care code Z515 which is very problematic. Use of this code has increased over the last few years but with wide variation in use. Some Trusts code nearly half of all deaths as palliative care whilst others code as little as 10% this way. Deaths with the palliative care code were excluded from the RAMI. This is no longer the case. There are other inconsistent coding anomalies that also affect RAMI.

In 2018-19 there were 16 sets of case notes from deceased patients that remained un-coded. 2019-20 there were 30 sets, 2020-2021 = 241 and April – May 2022 there were 125 un-coded notes.
2 years worth of data were resubmitted to CHKS on 12th May 2022 to understand the impact of coding locally. There were improvements in RAMI for the most recent months due to an increase in the number of case notes coded.

All patients with a COVID positive result recorded, regardless of symptoms, are currently removed from the RAMI calculations. This is a significant number. For instance, in January 2021 where the RAMI was excessively high 334 patients died in our hospitals but only 117 were included in the RAMI calculation. We have asked CHKS to investigate the impact on RAMI.

CHKS recommends that the new RAMI is considered in context and triangulated against other indicators to give appropriate assurance of the incidence of delayed discharges themselves.

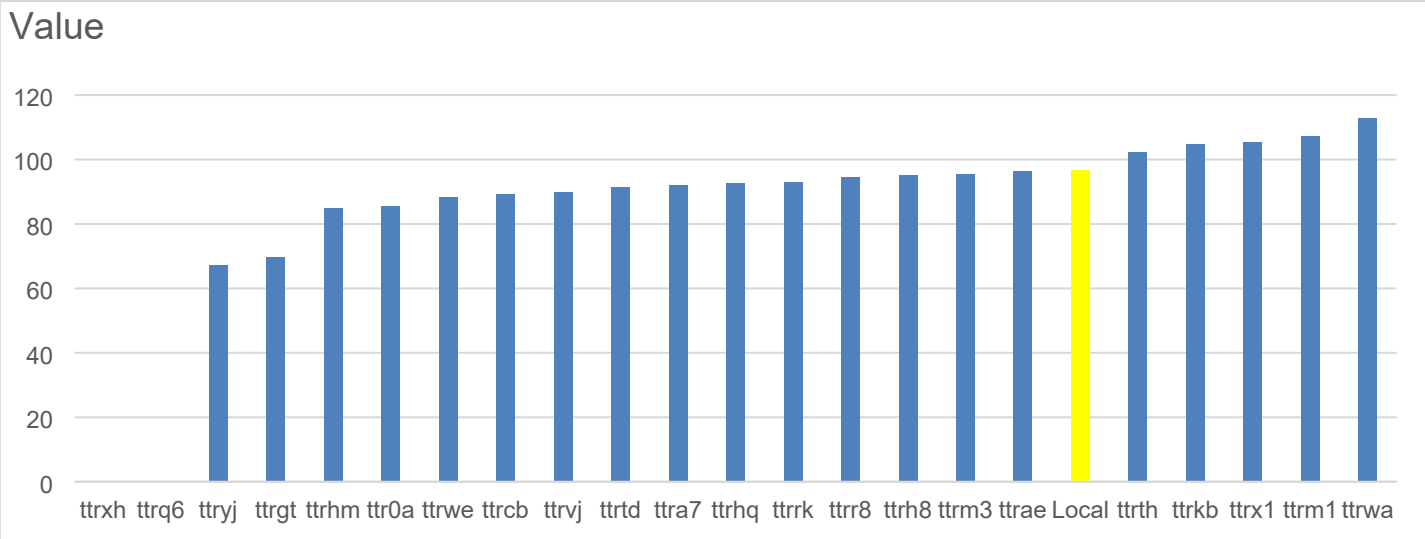
When the all-Wales mortality review work commenced, Cardiff and Vale UHB adopted the approach of reviewing 20 sets of case notes per week of people who had a low RAMI and died. This means they were predicted to have a low risk of dying but did. The hypothesis was that these could be 'rich pickings' to find harm. This was not the case, any more than those patients with higher RAMI.

Two years' worth of data were re-submitted to CHKS on 11th May 2022. The more historic data resulted in little change in RAMI. However, the table below shows a big impact as more coding had been achieved.

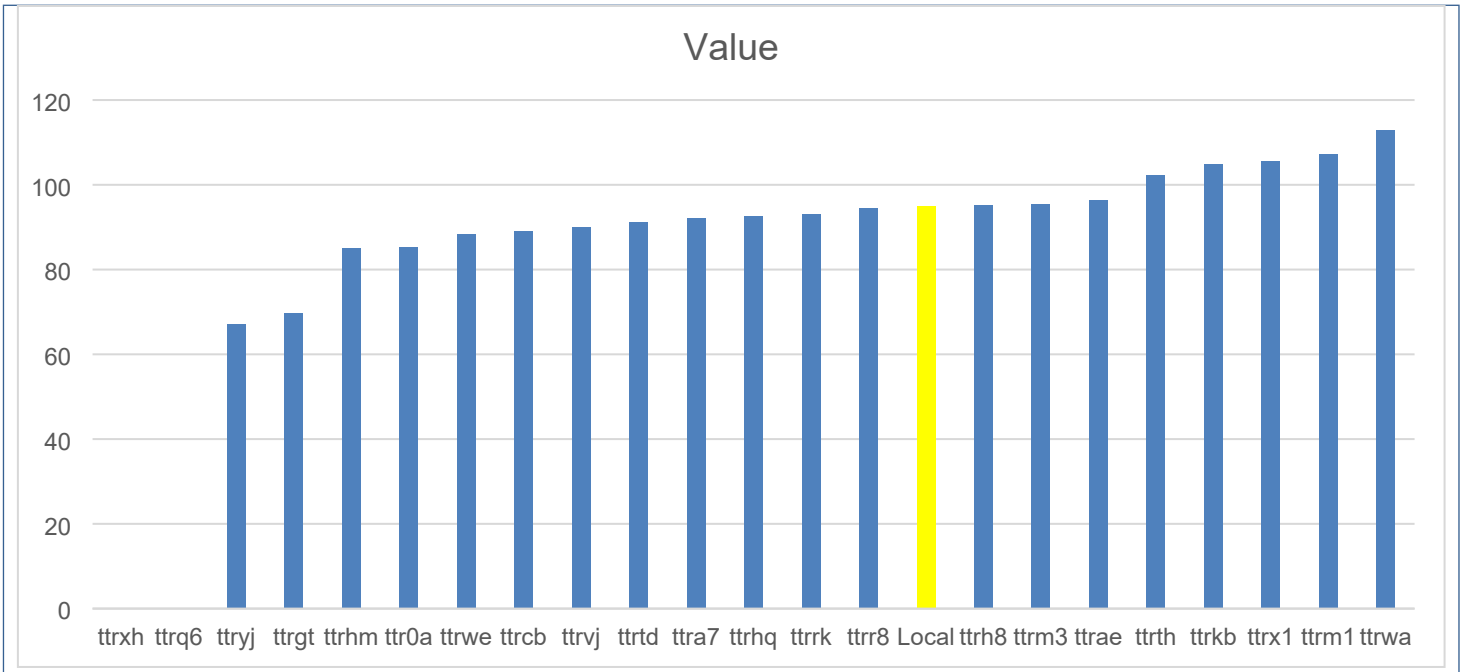
	RAMI	RAMI	
Month	Before resubmission	After resubmission	Difference
January 2021	158.0	158.1	-0.2
February 2021	129.9	129.6	0.2
March 2021	110.4	110.4	0.0
April 2021	100.5	100.5	0.0

May 2021	102.2	102.1	0.1
June 2021	78.5	78.5	0.0
July 2021	86.6	86.6	0.0
August 2021	108.7	108.6	0.1
September 2021	85.9	86.5	-0.6
October 2021	123.6	123.3	0.3
November 2021	106.7	105.8	0.9
December 2021	133.8	127.5	6.3
January 2022	131.5	121.6	9.9
February 2022	174.3	139.4	34.8

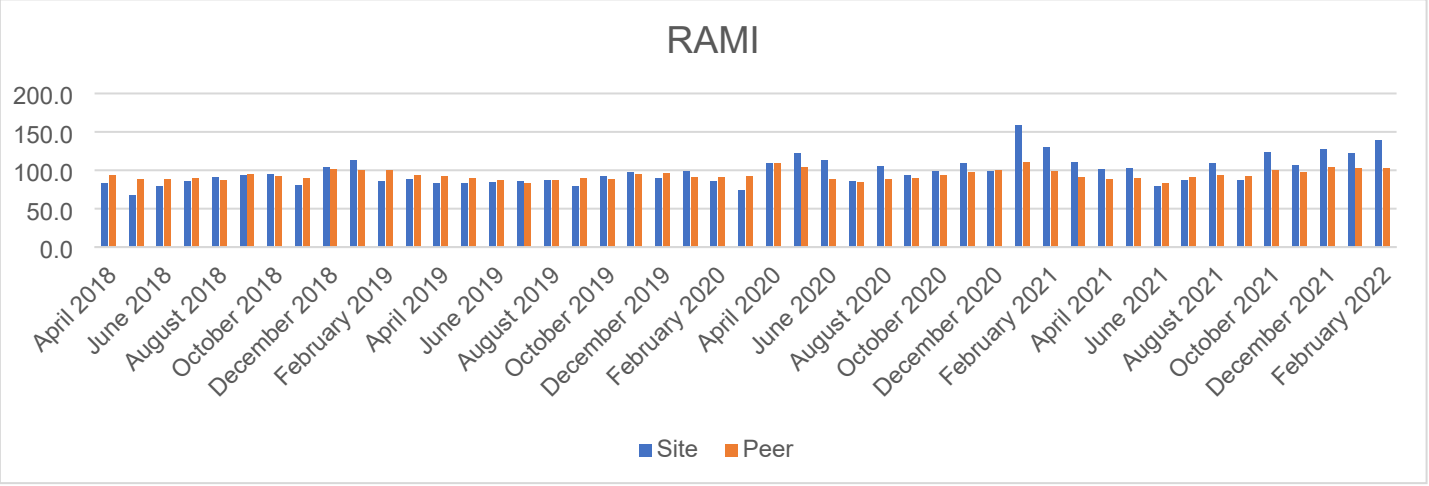
This in turn ranked us better against peers following resubmission for 2021. The chart below shows our rank before resubmission. However the data for 2022 will be published early next year.



The chart below shows improvement in ranking following resubmission of data to CHKS



The spike in RAMI in January 2021 in the chart below is unexplained. We have asked CHKS to review this. We do know that there were 334 hospital deaths and only 117 were included in the RAMI due to a positive COVID test being recorded thus eliminating them from the calculation.



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

Different sources of mortality data are required to provide assurance on the quality of care we provide. Risk Adjusted Mortality Index is a complex algorithm which is affected by several things including coding. It is an important signal but is not an indicator of quality. It should be used in conjunction with crude mortality, condition specific mortality and case note reviews in order to provide assurance.

Independent scrutiny of case notes by the Medical Examiner as well as discussions with bereaved families is perhaps the greatest source of quality assurance and for organizational learning. This is supported by increasingly robust governance structures which are now established in the UHB.

Scaling up the ME Service is currently being undertaken. It has been hindered by operational pressures on by both parties.

Challenges

- Undertaking an in-depth coding and data capture for mortality

- Further development and access to the Datix Mortality Module as currently parts of the team are working on Excel sheets which does not allow alignment of data with the existing IT systems within the UHB.
- Insufficient investment in the system
- All the data to be presented on SPC charts.
- CBs and staff need to have access to this data so they could review the care imparted to help them learn and improve.
- The mortality review process should be undertaken by all clinicians irrespective of their professional backgrounds. Both nurses and doctors should be part of the stage 2 review process.
- Time for clinicians to complete stage 2 reviews

Current actions

1. Independent scrutiny of case notes by the Medical Examiner as well as discussions with bereaved families is perhaps the greatest source of quality assurance and for organizational learning. This is supported by increasingly robust governance structures which are now established in the UHB.

   Scaling up the ME Service is currently being undertaken. It has been hindered by operational pressures on by both parties. Currently all COVID deaths are send to the Medical Examiner. This will be scaled up to include all deaths from ITU and Emergency Department from the 9th of June 2022. By the Sep 2022 all deaths across CAV will be processed by the Medical Examiner.

2. Once the Medical Examiner service is embedded into practice all themes and trends will be identified and learning will be undertaken from the process and this will be part of reporting by the Mortality review group to the Clinical Safety group.

Recommendation:

The Committee is requested to:

a) note the contents of the paper and that henceforth, the mortality paper will be submitted in the above format with detailed narrative around the different ratios.

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	√	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

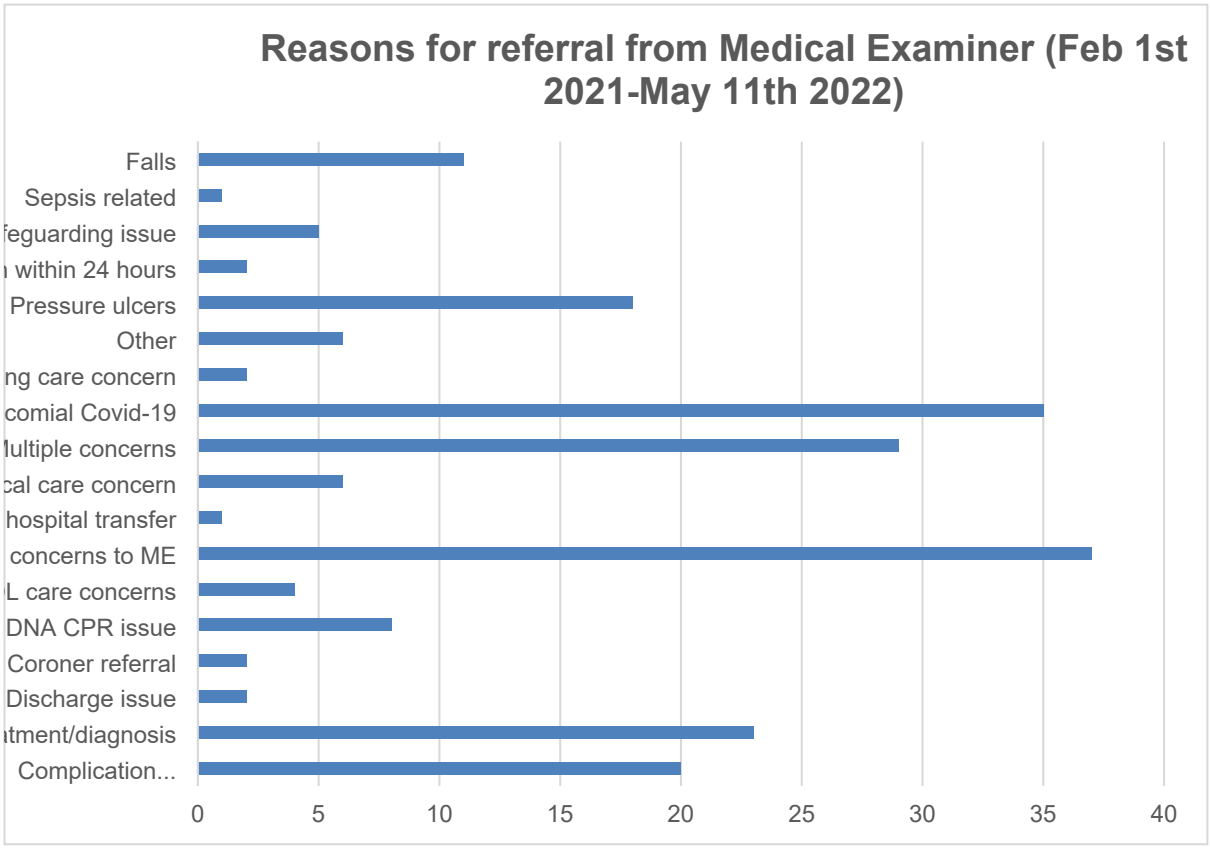
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. 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	x	Collaboration	x	Involvement	x

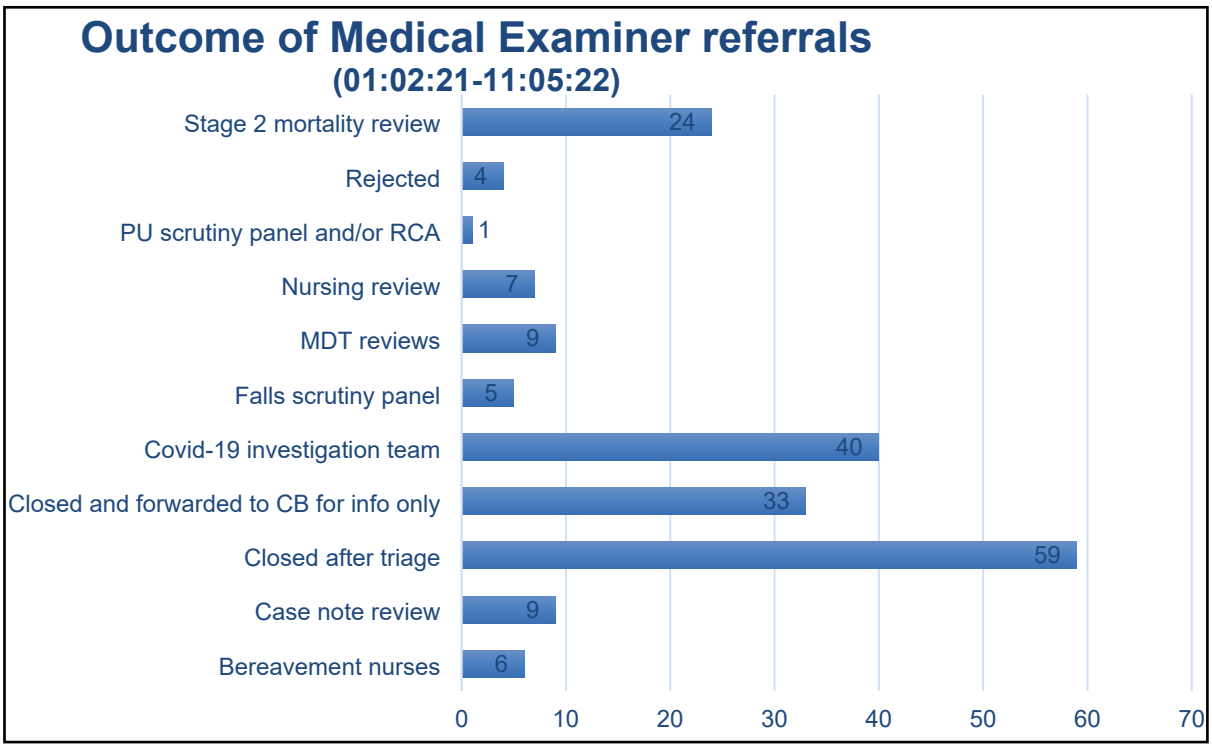
Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: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

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

Appendix 1 – chart with the common reasons for referral from the Medical Examiner



Appendix 2 – chart showing outcomes from the ME referrals



Appendix 3 – learning and actions.

The biggest concern raised by bereaved families was poor or lack of communication, particularly during COVID restrictions. To address this, Medicine Clinical Board has recruited some young people through the Kickstart Scheme specifically to coordinate communication and update families where appropriate.

If the only concern raised is a low-grade pressure damage or a non-injurious fall that is already recorded on Datix no further action is taken in line with a proportionate enquiry as there is already

organisation-wide improvement work in progress. Injurious falls go to our falls scrutiny panel for expert review.

References

1. The Mid Staffordshire NHS Foundation Trust Inquiry. Report of the Mid Staffordshire NHS Foundation Trust public inquiry (Chair: Robert Francis). www.midstaffspublicinquiry.com/report.

2. Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. www.nhs.uk/nhsengland/bruce-keoghreview/documents/outcomes/keogh-review-final-report.pdf.

3. Medical Examiner service. https://nwssp.nhs.wales/ourservices/medical-examiner-service/

4. Stillbirth ratio – ONS data https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/articles/provisionalbirthsinenglandandwales/2021#:~:text=In%202021%2C%20the%20stillbirth%20rate,the%20rate%20observed%20in%202018.

5. Written Statement - Publication of Professor Stephen Palmer's review of the use of risk adjusted mortality data in NHS Wales Welsh Government. (https://gov.wales/written-statement publication-professor-stephen-palmers-review-use-risk adjusted-mortality-data-nhs).

6. Hogan, Helen, Rebecca Zipfel, Jenny Neuburger, Andrew Hutchings, Ara Darzi, and Nick Black. "Avoidability of hospital deaths and association with hospital-wide mortality ratios:
retrospective case record review and regression analysis." BMJ 351 (2015).

6. CHKS 2020. Risk Adjusted Mortality Index (RAMI) 2019. A new approach to risk standardized mortality. Version 1.0 November 2020

Report Title:	Healthcare Inspectorate Wales Activity Overview			Agenda Item no.	2.5
Meeting:	Quality, Safety & Experience Committee	Public		Meeting Date:	15 June 2022
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Jason Roberts, Executive Nurse Director				
Report Author (Title):	Angharad Oyler, Head of Quality Assurance and Clinical Effectiveness				

Main Report
Background and current situation:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews/inspections carried out by Healthcare Inspectorate Wales (HIW). The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

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

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

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

<u>Unannounced Inspections</u>

Two unannounced inspections have taken place in March

Cardiothoracic services – UHL – Unannounced Visit

An unannounced inspection was carried out by HIW in Cardiothoracic services in Llandough hospital in February 2022. Provisional feedback from the inspection was overall very positive. More detail will be shared with the QSE committee when the reports has been Published

Mental Health Services – Unannounced Visit

A HIW unannounced Inspection took place at Hafan y Coed, Llandough Hospital in February 2022. The following areas were inspected:

- Cedar Ward – Adult Crisis Admission
- Oak Ward – Adult Locality treatment ward
- Willow Ward – Adult Locality treatment ward

The inspection was based around how services met the Health and Care Standards (2015). HIW also considered how services complied with the Mental Capacity Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and |Deprivation of Liberty Safeguards.

Overall HIW found that the service provides safe and effective care to patients, they found a dedicated staff team that were committed to providing a high standard of respectful care to patients, with individualised care plans that considered the patients views reflecting the Welsh Measures domains. However, Staff did raised concerns in relation to being overstretched due to the pressures of the COVID 19 pandemic. HIW identified this as an area in need of improvement, to ensure that the appropriate staff numbers and skill mix were available to prevent staff fatigue and allow management to have sufficient supernumerary time to undertake their operational duties.

Whilst HIW found that a range of patient information was evident, improvement on consistency of the information on display and availability of bilingual information was required, HIW also advised that the health board should give consideration to 'Getting to Know You' boards

HIW recognised that whilst every effort was made to ensure that patients were cared for in the correct locality ward, during COVID-19 pandemic and associated pressures on capacity and staffing this was not always possible. This was identified as an area that required attention.
HIW identified that improvement was also required in ensuring that copies of consent to treatments certificates are maintained with corresponding MAR charts, and that registered nurses refer to consent treatment certificates when administrating medication.

During environmental inspection, HIW found that the furniture and fittings found in the areas were suitable for the patient group. However, structurally, significant ongoing damage was found to some walls and flooring which needed attention.
HIW were satisfied that there were established risk assessment, health and safety and IP&C processes in place to enabled staff to continue to provide safe and effective care.

An Improvement Plan has been submitted to HIW

Quality Checks

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

Update on Thematic Reviews

National Review of Patient Flow (Stroke pathway)

HIW visited Cardiff and Vale UHB on the 14 -16th of March and staff interviews took place on the17th to the 25th of March as part of the National Review of Patient Flow (Stroke Pathway)
HIW aim to share findings of the review as part of their series of Quality Insight Bulletins before concluding with a national report published late autumn 2022.

Review of Maternity Services in Wales – Awaiting update from HIW

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

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 will continue to review their work programme and ensure it is proportionate to the given situation.

HIW Strategic Plan 2022-2025

HIW have published their Strategic plan for 2022-2025. The strategy focuses on the learning that has taken place over the past 3 years, and in particular during the pandemic. Full publication available on the HIW website – www.HIW.org.uk

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
06/14/2022 13:03:54

Report Title:	**Board Assurance Framework – Patient Safety**				Agenda Item no.	2.6	
Meeting:	Quality, Safety and Experience		Public	x	Meeting Date:	15th June 2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
Background and current situation:

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

There are currently nine key risks on the BAF, agreed by the Board in May 2022, 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 post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list.
- Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU).
- Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care in a larger clinical footprint in relation to post Covid 19 recovery.
- Due to the ability to balance within the health community and the challenge in transferring patients to EU.
- Due to the current pressure in EU and inability to segregate patients due to the volume in the department’.

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 May 2022) is considered to be a key risk to the achievement of the organisation’s Strategic Objectives. This risk has been adjusted to consider 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:
Board	26th May 2022

Patient Safety – Interim Medical Director /Interim Executive Nurse Director- (Meriel Jenney/ Jason Roberts)

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

Risk	There is a risk to patient safety: • Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. • Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU). • Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care in a larger clinical footprint in relation to post Covid 19 recovery. • Due to the ability to balance within the health community and the challenge in transferring patients to EU. • Due to the current pressure in EU and inability to segregate patients due to the volume in the department.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care 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. Post Covid recovery sickness is having a significant impact on staff availability (see separate risk on workforce).		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Private Partner facilities. • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Implementation of Organisation and Transformation Centres (OPAT) to focus upon operational deliver across acute sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21 • Wales wide Risk Summit in March 2022 with a refresh of health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented		

	• Resilience report being reviewed at ME on a weekly basis and reported to WG		
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) • Update of situation in EU shared in private session of QSE Committee in Feb 22. (1) (2) • Recent Executive review with Clinical Teams for understanding and review of front door pressures. (1)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes and domiciliary care settings. Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments. Difference in interpretation of IPC guidance reduces timeliness of discharge to care settings.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since March 2022
1. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Jason Roberts	30.09.22	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
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Jason Roberts/ Caroline Bird	30.09.22	Choice framework continues to be utilised
3. Work Plan currently been developed via Clinical Board for dealing with pressures in EU with oversight from OPAT	Jason Roberts	30.06.22	
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

Report Title:	**Dental Services**			Agenda Item no.	**2.7**
Meeting:	**QSE Committee**	Public	X	Meeting Date:	**15 June 2022**
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	
Lead Executive:	**Interim Chief Operating Officer**				
Report Author (Title):	**Director of Operations PCIC Clinical Board** **Director of Operations Surgery Clinical Board**				

Main Report
Background and current situation:

Background

Dental Services across Cardiff and Vale (CAV) are delivered via a number of routes:

- **General Dental Services (GDS) and General Orthodontic Service (GOS)** are commissioned by CAV via a Welsh Government national contract and delivered by independent contractors (High Street Dentists) and provide NHS general dental care and treatment. We have 63 GDS contracts in place across CAV.
- **Community Dental Services (CDS)** are delivered by CAV and provide more specialist dental care for vulnerable people and improvement of oral health of priority groups in accordance with guidance provided by the Welsh Government WHC (2019) 021. Within its portfolio the service also delivers the Designed to Smile (D2S) and Gwyn Am Beth (GAB) national public health programmes improving oral health support to young pre-school children and care home residents.
- **The Dental Hospital (UDH) and School** provides dental assessment and care to patients who have been referred by general dental practices, especially where these patients are suitable for undergraduate treatment, or are of a complexity level which requires specialist care. The role of the UDH is to contribute to the teaching of dental students and the training of junior NHS staff and provides dental care for patients who are screened as suitable for treatment by undergraduate dental students.
- **Emergency Dental Services** provide urgent dental care to patients who do not have access to an NHS dentist. Services are provided through a number of routes depending on the type and complexity of the patient and issue. Services are provided via a UHB managed service (out of hours and on weekend), GDS, CDS, and UDH

At the start of the COVID-19 pandemic, all dental services were directed by Welsh Government to work to a 'red' and then an 'amber' pathway due to the cross-infection risks associated with dental treatments many of which are aerosol generating procures (AGPs). As a result, services have been operating at much lower levels compared original capacity; approximately 40% capacity compared with pre-pandemic levels.

The impact of the COVID Pandemic has resulted in a significant backlog and reduced access to all types of dental services where all areas have been prioritising patients with the highest need resulting in increased pressure on access to urgent care. As part of Recovery, investment has provided additional capacity for both routine and urgent dental care across all providers of services.

Current Situation

There are significant backlogs and constraints in accessing dental services. Throughout the pandemic the UK Infection Prevention and Control Guidance has been the main source of COVID-19 related IPC Guidance. As of 1 April 2022 health and social care organisations have been advised to return to using the National Infection Prevention and Control Manual (NIPCM) as the primary source of general IPC guidance and principles. The UK IPC Guidance (COVID-19) will be archived by the end of May 2022.

In addition to the NIPCM Wales, Public Health Wales also publishes other IPC Guidance on its HARP website and will publish ***SARS CoV-2 specific IPC guidance*** including a revised AGP list (as published by NHS England on the 14th April 2022) in the IPC Guidance section of the website once the UK IPC Guidance is archived.

All dental services are currently undertaking IPC risk assessments in line with the latest guidance to allow them to increase throughput and capacity.

In addition to IPC constraints, dental procedures require dental nurses to work alongside other dental professionals. There is currently a severe shortage of registered dental nurses. This is understood to be due to people leaving dentistry to work in other sectors because of the pandemic and pre-dates the current cost of living problem.

A summary of current capacity, issues and risks by service are outlined below.

General Dental Services

Within **General Dental Services** there are currently **11,500 patients on the centralised waiting list** who do not have access to an NHS Dentist. In addition to this **GDS** contractors are managing the backlog of patients usually seen and treated under their care who have not been seen throughout the pandemic as a priority.

The Welsh Government's Programme for Government, sets out priorities up to 2026 and makes a commitment to reform primary care dentistry and also increase access to dentists. On 3rd March 2022 Welsh Government issued direction to all Health Boards in Wales to restart Dental Contract Reform from 1st April 2022 through to 2023 using an action learning approach. A full briefing of the contractual requirements and predicted impact can be found at **annex 1.**

All GDS practice were to be given a choice, to either be part of the reform programme with a suite of delivery measures, or to return to contractual arrangements based wholly on Units of Dental Activity (UDA's). The position in CAV is:

- 73% (46) will be operating under Dental Contract Reform
- 17% (17) will be operating under UDA's

The contract aims to move to delivering services at 90-95% capacity by year end 2022/23 compared to approximately 40% seen during the height of the pandemic. The following trajectory is predicted as Covid infection rates continue to fall and practices undertake appropriate IPC risk assessments increasing throughput: Quarter 1 - 60%, Quarter 2 - 65%, Quarter 3 -70%, Quarter 4 70%+.

In addition, one of the targets associated with operating under contract reform, is the target to see 25% (of the 75% reform value) of new patients. This means that 25% of the contract value is paid to see a set number of new patients. Considering the contract values it is estimated that 29,442 'new patient'* contacts will be achieved within 2022-23 based on Welsh Government metrics.

To support this target, the Primary Care Team are working closely with practices and supporting the transfer of new patients from the centralised waiting list and will monitor both the achievement of this target and facilitate access for new patients through this metric.

There are two further actions taken to support GDS access. Firstly, as part of Recovery, additional capacity was commissioned in 2021-22 providing access for 1,700 GDS and Orthodontic episodes to reduce the backlog as a result of the pandemic. Secondly, for 2022-23 on a recurring basis, Welsh Government an additional allocation of £320k to provide additional capacity in GDS. This is currently being tendered via Procurement.

To note we have highlighted to Welsh Government the shortfall in funding for the growing population in Cardiff and Vale and the need for further future investment to meet population demand.

Community Dental Services

Community Dental Services face the same issues in relation to backlog and access to services for our most vulnerable groups with in excess of **800 patients awaiting an assessment** as well as the backlog of patients usually seen and treated under their care who have not been seen throughout the pandemic.

Despite planning to resume services to pre Covid levels, capacity is significantly reduced due to workforce challenges with inability to recruit to key dental clinical posts as well as lack of, or poor estate. Services are currently working to approximately 50-60% capacity prioritizing patients with highest need supported by some additional capacity through Recovery funding.

Both the 'Designed to Smile' and 'Gwyn am Beth' are now reinstated following redeployment of staff to support the COVID response and delivering in line with the programme direction.

Loss of estate (Splott Clinic/Park View) or **poor estate** that does not comply with IPC requirements or, are not fit for purpose to deliver modern day dentistry is the biggest challenge to delivering access to these services. Of particular concern is Roath Clinic which is now unable to utilised. Due to asbestos risks, replacement or remedial estates works cannot be undertaken, there is no mechanical ventilation to allow AGP procedures to be performed and the dental equipment is end of life and unable to be replaced. Recruitment is negatively impacted by lack of reasonable estate.

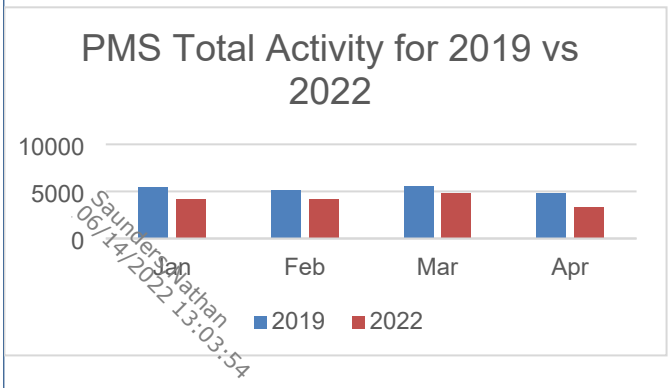
Considering all three sites, there has been a significant reduction in capacity with the loss of over 30 sessions per week. While both areas of Cardiff are within plans for SoFWB Hub Developments (CRI/Park View), timescales are unknown and will continue to compound access to services for vulnerable groups in areas of highest need and deprivation with many patients unable to travel to other sites across the city. The Community Dental Service will, therefore, require support to develop temporary fit for purpose estates capacity in high need areas of deprivation for our vulnerable population while SoFWB Hubs are operational.

University Dental Hospital (UDH)

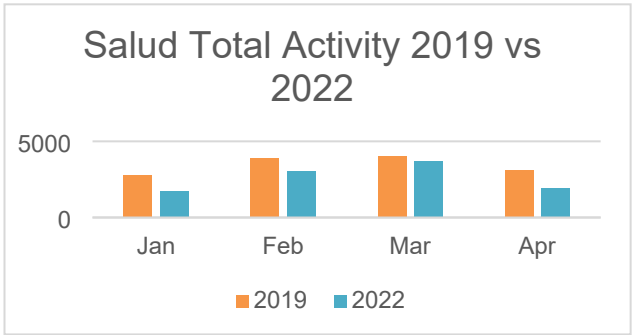
The UDH also continues to recover from the pandemic impact and has re-established all clinical services. UDH successfully graduated the 20/21 cohort and expect the 21/22 students to successfully graduate in the coming weeks.

The additional precautions needed in relation to the conduct of aerosol generating procedures continue to impact on capacity as has the need to maintain spacing which has a disproportionate effect on a largely out-patient service. This will be reviewed in line with the new IPC guidance. At present we are currently operating about 70% pre Covid capacity This however varies by specialty and operating setting.

Outpatient activity



Student Activity



Children's General Anaesthetic Services
Prior to the pandemic the great majority of general anaesthetic (GA) provision for the extraction of teeth in young children occurred in UDH. At the beginning of the pandemic this was transferred to Children's Hospital for Wales (CHfW). A combination of reduced pre-op assessment and recovery facilities in CHfW for these outpatient GA procedures has significantly reduced capacity. As a result young children are having to wait longer for access to GA than was the case pre-covid. This situation is further compounded in that the staff previously employed in UDH theatres now have to cover both UDH and CHfW theatres.

Oral Medicine
The Professor of oral medicine retired in August 2021. The Dental School has been unable to appoint a successor. This is significantly impacting on the Oral Medicine waiting list which now stands at 894 new patients with a waiting time for routine of 69 weeks. UDH are managing this having reengaged the retired Professor to undertake clinics on a locum basis. The team are working collaboratively with the Dental School who are about to re-advertise this post, however there has been no interest to the previously advertised post.

Oral Surgery
Whilst there is a lengthy wait time for oral surgery with in excess of 1400 new patients with a waiting time for routine again of 69 weeks, the establishment and anticipated continuation of a Consultant led Intermediate Oral Surgery Service in the community (Barry, Llandough and St David's hospitals) will enable us to deal with this issue. This will require continued investment in to the intermediate minor oral surgery service.

Infrastructure/Estate
The University Dental Hospital requires a full pipework replacement programme which will require significant investment, in addition the rolling refurbishment of clinics programme ceased leaving the aging orthodontic clinic with unusable chairs and outdated equipment. Our dental technical team are finding it near on impossible to find parts for the obsolete kit.

<u>Emergency Dental Services</u>

The Emergency Dental Services has seen an 28% increase in demand through its service throughout the pandemic and this increase demand continues as dental services start to reset and reform.

As part of Recovery, additional capacity has been commissioned to provide 880 urgent treatment episodes in 2021-22 and 500 urgent treatment episodes through 2022-23 over weekends and bank holidays for patients who do not have access to an NHS dentist and require urgent care, doubling capacity.

As part of General Dental Contract Reform discussions, the Primary Care Team used the opportunity to engage with the Local Dental Committee (LDC) and individual practices to secure access to daily emergency slots within weekday hours.

Prior to 1st April 2022, 66 urgent slots were available per week and through negotiation this has increased to 110 weekly slots providing an additional 44 slots per week. Once seen, these patients are offered to become a new patient of the general dental practice for ongoing NHS care. It is anticipated that this will reduce demand on emergency dental services as patients will move to be treated proactively.

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

- Dental Services have been significantly impacted by the pandemic, with reduced access and activity resulting in an increase in the backlog of patients waiting to be seen.
- All Dental services are undertaking IPC risk assessments in line with the most recent IPC guidance to allow them to increase throughput and capacity

- Workforce and estates constraints are impacting the speed of recovery for Community Dental Services
- Welsh Government issued direction to all Health Boards in Wales to restart Dental Contract reform from 1st April 2022 using an action learning approach. The contract aims to delivering GDS at 90-95% capacity by March 2022/23
- The Health Board's IMTP trajectory for GDS is a phased increased from 60% of pre-covid levels in quarter 1 to greater than 70% by quarter 4
- All clinical services have now been reestablished in the University Dental Hospital – with the service currently operating at 70% of pre-covid activity. Workforce and estates are also a constraint for some services.
- The establishment and continuation of a new model of care – a Consultant led Intermediate Oral Surgery Service in the community – will support the recovery of Oral Surgery.
- Emergency Dental Services have seen an increase in demand. Additional capacity has been secured address the acute issues while access to ongoing NHS dental care is secured.

Recommendation:

Recommendation:

The Quality & Safety Executive Committee is asked to **NOTE** the current position in regard to all Dental Services

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	
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	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Prevention		Long term		Integration		Collaboration		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:

Saunders,Nathan
06/14/2022 13:03:54

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

NHS DENTISTRY

RESTART OF CONTRACT REFORM FROM APRIL 2022

On 3rd March 2022 Welsh Government issued direction to all Health Boards in Wales to restart Dental Contract Reform from 1st April 2022 through to 2023 using an action learning approach previously adopted for the reform programme.

All practice were to be given a choice, to either be part of the reform programme with a suite of delivery measures, or to return to contractual arrangements based wholly on Units of Dental Activity (UDA's).

The Welsh Government's Programme for Government, sets out priorities up to 2026 and makes a commitment to reform primary care dentistry and also increase access to dentists. For 2022-23 the aim of the Welsh Government direction is to continue with these alternative measures and take the time to assess the impact - a 'test and modify' approach to ensure change is taking NHS dentistry in the direction needed.

UDA Contractual Requirements 2022-23

For practices opting for UDA contractual route the following targets will apply:

- The contract value will revert to pre Covid/pre-reform.
- Practices will be expected to achieve 95% of this contract value (For 100% payment)

Contract Reform Requirements 2022-23

For practices opting for contract reform route the following targets/principles will apply:

- 25% of the contract value will remain as UDA's
- 75% of the contract vale will move to reform targets:
    - 5% associated with fluoride varnish application target
    - 25% new patients to the contract (EG: *contract value of £170k =260 pts)*
    - 40% existing patients *(Continued care for a minimum number of existing patients that have previously been seen within the previous 4 contractual years)*
    - 5% recall patients *(Recall intervals linked to risk and need assessment of the patient)*

Position in Cardiff and Vale from 1 April 2022

All GDS contractors were contacted and given a choice on the route they wish to adopt for 2022-23.

Of our 63 GDS contractors, the position is summarised below:

- 73% (46) will be operating under Dental Reform
- 17% (17) will be operating under UDA's

As part of the discussion on preferred contractual delivery route, the Primary Care Team used the opportunity to engage with the Local Dental Committee (LDC) and individual practices to secure access to daily emergency slots and directing new patients requiring NHS dental services.

What does this mean for patient access?

Whilst we are yet to receive direction from Welsh Government on revised IPC arrangements, practices will undertake IPC risk assessments to allow them to increase throughput to achieve their contract values. It is predicted that practices will move to delivering services at 90-95% capacity compared to approximately 40% seen during the height of the pandemic.

In addition, one of the targets associated with operating under contract reform is the target to see 25% (of the 75% reform value) of new patients. This means that 25% of the contract value is paid to see a set number of new patients (260 patients per £170k contract value prorata).

Considering the contract values and thresholds of those 46 practices who have chosen to operate under contract reform, this would make up 86.96% of the contract value of all GDS dental contracts and equates to approximately 29,442 'new patient'* contacts within 2022-23 based on Welsh Government metrics.

To support this target, the Primary Care Team are working closely with practices and supporting the transfer of new patients from the 'Cardiff and Vale Centralised Dental Waiting List' to practices who do not hold a waiting list of new patient requests or in addition to their own lists. We will monitor both the achievement of this target and facilitate access for new patients through this metric.

In addition to new patients, the Primary Care Team through negotiation with practices has secured ongoing access to 'urgent' dental care for patients who do not have an NHS dentist. This is not a contractual obligation. Prior to 1st April 2022, 66 urgent slots were available per week. We have increased this to 110 providing an additional 44 slots per week. Once seen, these patients are offered to become a new patient of the practice for ongoing care.

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** 'new patients' are considered as someone to whom the contractor has not submitted an FP17W in the four calendar years prior to the current year of treatment preceding the appointment.*

Report Title:	C&V UHB Ultrasound Clinical Governance Group (USCGG)			Agenda Item no.	2.8
Meeting:	Quality, Safety and Experience	Public	x	Meeting Date:	15 June 2022
		Private			
Status (please tick one only):	Assurance ☑ x	Approval		Information	
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Health Science				
Report Author (Title):	Interim Assistant Director of Therapies and Health Science				

Main Report

Background and current situation:

SITUATION

Following an internal audit of Ultrasound governance across the UHB, several shortcomings were identified. These centered around a lack of assurance of appropriate governance in the correct and safe use of ultrasound across the UHB and insufficient communication and escalation pathways.

BACKGROUND

The Ultrasound (US) audit report, published August 2021 (please see attached), found limited assurance for Ultrasound governance arrangements within C&V UHB. The two high priority recommendations were:

1. The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.

2. Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

Be assured that the following actions have been taken to address the short fallings found in the August 2021 Ultrasound audit.

- Review of the Ultrasound Clinical Governance Group (USCGG) and new ToRs written and ratified by the EDoTH to cover Diagnostic and Therapeutic Ultrasound**. – Complete: Please see attached "USCGG ToRs v0.8".**
- Membership of the USCGG to be extended to include all areas of Diagnostic and Therapeutic US across the UHB. **– Complete: Please see attached "USCGG ToRs v0.8" for membership details**
- Suitable chair of the USCGG **- Complete: The Interim Assistant DoTH nominated. who will formally report into the Medical Equipment Group, chaired by the EDoTH.**
- Clear reporting pathway for USCGG ToRs **- Complete: Reporting into the Medical Equipment Group, chaired by the EDoTH, with reportable instances be directed to QSE, as per attached "USCGG ToRs v0.8".**
- Change of name for the Medical Ultrasound Risk Management Procedure and Policy to Ultrasound Clinical Governance Procedure and Policy. **– Complete: Request formally sent to rename and appropriately index both Policy and Procedure.**
- Arrange USCGG regular meetings **- Complete: The inaugural USCGG meeting took place on 23rd Feb 2022, with further meetings taking place at a minimum frequency of 3 months.**
- Requirements to appoint US roles of Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor within relevant Clinical Boards will be actioned as part of the formation of the new USCGG. **– Partially complete: information requested from all departments (https://forms.office.com/Pages/ResponsePage.aspx?id=uChWuyjjgkCoVkM8ntyPrrIXT-fm7LhNmeHyPODDv-ZUNUhINlNWUzFJSEUzUjdPSU1aTkpXQ1IwRi4u). Complete in Medical Physics, Critical Care and Physiotherapy. Pending in other areas.**

- Creation and implementation of the US Safety Training will be actioned and implemented as part of the formation of the new USCGG. **– In progress: Progress with LED. Courses to be up loaded initially to Learning@Wales (due live by 1st Sept) then subsequently to ESR (6-12month go live time scale). The work will involve creation of on-line mandatory Ultrasound safety training for all users with the responsibility of compliance lying with the relevant Clinical Boards who will report compliance into the USCGG.**
- An annual audit template will be developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework. – **In progress – The USCGG has reviewed similar audit tools used by other services, including POCT. The draft audit tool will be shared and agreed at the next USCGG meeting (29/06/2022).**

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

The following lists the short fallings found in C&V UHB Ultrasound Governance:

From the Aug 2021 Ultrasound audit report:
Objective 1: Design and implementation of ultrasound governance arrangements.

i. Lack of awareness of revised C&V UHB Medical Ultrasound Risk Management Policy (https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-policy-pdf/) and Medical Ultrasound Risk Management Procedure (https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-procedure-pdf/)
ii. Consideration of how Clinical Boards will provide US Governance assurance to EDoTH.
iii. Creation of an abridged US procedure and renaming of both policy and procedure to align with US structure and governance.
iv. Out of date Ultrasound Clinical Governance Groups ToRs.
v. Unclear routine and embedded reporting arrangements in ToRs
vi. Charing of the USCGG fell short of the level of authority required.
vii. Poor attendance of USCGG

Objective 2: Roles and responsibilities.

i. No formal documentation of roles and responsibilities assigned to staff in certain US areas and appropriately documented within certain Clinical Boards.

Reasonable assurance was found in training, noting an ambition of the USCGG to create a mandatory e-learning module for Ultrasound Safety training for all relevant staff.

Recommendation:

The Committee is requested to:

a) Note the actions being taken (as set out in this report) to address the recommendations made by Internal Audit in the Ultrasound Governance audit report dated August 2021.

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~~
The actions taken will greatly reduce the risk of staff not being adequately trained in Ultrasound use and the associated risk to patients from improper and unsafe use.
Safety: Yes/~~No~~
Improved patient safety by improving and controlling training compliance for staff.
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
Improving governance will also ensure appropriate alignment with Medical Device Regulations.
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

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

Saunders,Nathan
06/14/2022 13:03:54

Ultrasound Governance

(Clinical Diagnostics and Therapeutics Clinical Board)

Final Internal Audit Report

August 2021

Cardiff and Vale University Health Board

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Auditors:	Stuart Bodman, Principal Auditor Wendy Wright, Deputy Head of Internal Audit
Executive sign-off:	Dr Fiona Jenkins, Executive Director of Therapies and Health Science Steve Curry, Chief Operating Officer
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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to ultrasound governance, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

Overview

This report provides limited assurance for Ultrasound Governance arrangements, which stems from issues relating to the design and implementation of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2).

Governance arrangements were found to be lacking and require review to effectively direct and oversee the implementation of the requirements prescribed by the revised policy and procedure.

Two high priority recommendations are proposed, which fall under the scope of objectives one and two.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	-

Assurance summary[1]

Assurance objectives		Assurance
1	Design and implementation of ultrasound governance arrangements	Limited
2	Roles and responsibilities	Limited
3	Servicing, maintenance, repair and quality assurance	Substantial
4	Procurement of diagnostic and therapeutic ultrasound equipment	Substantial
5	Ultrasound training	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2)	Operation	High
2	Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science	Operation	Medium
3	Design and feedback of the Medical Ultrasound Risk Management Procedure	Design	Medium
4	Ultrasound governance arrangements require review	Operation	High
5	Roles and responsibilities outlined by procedure require formalisation	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

1. Introduction

The review of Ultrasound Governance was deferred in 2020/21 and carried forward to the 2021/22 Internal Audit Plan. The Clinical Diagnostics and Therapeutics Clinical Board proposed the review for inclusion in the plan.

The Health Board's Medical Ultrasound Risk Management Policy (UHB 322 v.2) was updated in 2020 and approved by the Quality, Safety and Experience Committee. The policy notes, "Cardiff and Vale UHB is committed to providing uniform, high quality diagnostic and therapeutic ultrasound services which consistently meet as a minimum all national evidence-based standards".

The lead executives for the review are Steve Curry, Chief Operating Officer and Dr Fiona Jenkins, Executive Director of Therapies and Health Science.

Audit Risks

The potential risks considered in this review are as follows:

- There is no effective clinical governance framework;
- Equipment is poorly specified or maintained;
- Examinations are undertaken or interpreted by untrained or poorly trained individuals;
- Inadequate monitoring of performance and scrutiny of outcomes.

The following policy commitment will be outside of the scope of this audit, *"Provide a robust framework for the documentation of ultrasound referrals, examinations and procedures, and the secure storage of images, to ensure data is recorded accurately and consistently, and stored safely across the UHB".* (To be considered as a discrete audit for future audit plans).

2. Detailed Audit Findings

Objective 1: The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.

Medical Ultrasound Risk Management Policy & Procedure (UHB 322 v2)

- The Quality, Safety and Experience Committee approved the revised Policy and Procedure on 20 July 2020. The accountable executive is the Executive Director of Therapies and Health Science.
- Both documents are available on the UHB's intranet site.

The following matters arising were noted:

- Audit testing identified that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure, which was published in February 2021. *(Matters Arising 1 – High Priority)*
- Further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure. *(Matters Arising 2 – Medium Priority)*

- Feedback during the audit highlighted the comprehensive nature of the procedure but an abridged version would be welcomed. Also, the naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance. *(Matters Arising 3 – Medium Priority)*

Medical Ultrasound Governance Arrangements

- There is an Ultrasound Clinical Governance Group (UCGG) in place.
- The acting Chair of the UCGG has had opportunity to raise concerns through the Medical Equipment Group and Quality Safety and Experience sub-committee in 2019.

The following matters arising were noted:

- The Ultrasound Clinical Governance Group Terms of Reference is out of date (2015) and has not been reviewed in tandem with the revised Medical Ultrasound Risk Management Policy and Procedure.
- Whilst the outdated terms of reference suggests a formal means of escalation beyond the group, we were unable to evidence routine or embedded reporting arrangements.
- The current chairing arrangements of the UCGG meetings falls short of the terms of reference, with reduced authority in the UHB, which has impacted the ability of the group to guide and direct matters of ultrasound governance.
- Poor attendance of the UCGG has been an issue, which was highlighted by the sampled audit areas and the acting chair of the UCGG.

  (Matters Arising 4 – High Priority)

Conclusion: To support the implementation of the updated Medical Ultrasound Risk Management Policy and Procedure the governance arrangements require review to provide sound oversight and direction. (Limited Assurance)

Objective 2: Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

- The revised policy and procedure requires three key ultrasound governance roles to be allocated within Clinical Boards; Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor.
- Whilst these roles may have been nominally allocated, we were unable to formally evidence the allocation of these roles within Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service. *(Matters Arising 5 – Medium Priority)*

Conclusion: The three key roles in the management of diagnostic and therapeutic ultrasound services require formal adoption by Clinical Boards. (Limited Assurance)

Objective 3: Servicing, maintenance, repair and quality assurance of diagnostic and therapeutic ultrasound equipment, in addition to decommissioning.

- For the sampled audit areas, all ultrasound equipment in use within the Obstetrics & Gynaecology, Cardiology Directorates, and Medical Physics Doppler Ultrasound Service are covered by formal UHB-wide contractual managed service agreements.
- Regular meetings are held between managed service agreement providers and key ultrasound user representatives within the UHB. Reports are provided that cover asset support given, a report of current equipment in place, issues/faults/repairs reported, and action and training provided to users in the period.
- All three areas held records of regular servicing and maintenance of their ultrasound equipment and that of call-outs for issues/faults/repairs.
- Daily quality assurance safety checks are performed by the clinical and medical users on ultrasound equipment within the Directorates as a matter of course before the equipment is put into use.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 4: Procurement of diagnostic and therapeutic ultrasound equipment.

- Purchases of new ultrasound equipment made by the Cardiology Directorate were done so in compliance with the requirements of the Medical Equipment Management Procedure prior to the publication of the revised Medical Ultrasound Risk Management Procedure.
- There are no items of ultrasound equipment on loan, trial or hire within any of the three areas at the time of the audit as confirmed by the respective Directorate Managers and the Lead Clinical Scientist of the Non-Ionising Radiation Team.

NB: We were advised that there have been no purchases of ultrasound equipment in any of the tested areas since the publication of the Ultrasound Risk Management Procedure in February 2021.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 5: Training and competence for the use of diagnostic and therapeutic ultrasound.

In accordance with Section 4 of the Medical Ultrasound Risk Management Procedure, all clinical and medical staff working with ultrasound equipment within the Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service held evidence of:

- Up to date records of statutory registration status in respect of their professional bodies/institutions.
- Up to date records of all ultrasound users' relevant qualifications and the awarding institution.

Beyond the above training requirements of the Procedure which were satisfied, section 4.1, Ultrasound Equipment Training, is nuanced to the training requirements of specific equipment, and section 4.2, Ultrasound Safety Training, to general requirements of safe management of medical ultrasound equipment. Our testing did not extend to requirements 4.1 and 4.2 given

the lack of awareness of the procedure. In accordance with 'Matters Arising 2' of this report, further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure.

The Non-Ionising Radiation Team have acknowledged that for greater oversight of ultrasound safety training an e-learning module is currently in development, with the intention of linking to ESR, which will provide a means of monitoring compliance and fulfilment of section 4.2 of the procedure.

Conclusion: Whilst no recommendations are made under this objective, the fulfilment of recommendation two of this report will provide greater assurance to the Executive Director of Therapies and Health Science on the requirements of 4.1 and 4.2 of the procedure. In addition to the introduction of an e-learning tool to provide greater oversight of general ultrasound safety training across the UHB. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) (Control Operation)	**Impact**
It was evident through audit testing that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2), although both were available on the UHB intranet site. For the sampled areas, none of the directorate management, clinical or medical ultrasound users in Obstetrics & Gynaecology and Cardiology Directorates were aware of the existence of the finalised policy and procedure. The Ultrasound Clinical Governance Group in July 2020 reviewed draft iterations of the policy and procedure, and both directorates had representatives who attended. Once the policy and procedure had been formally ratified by the UHB Quality, Safety and Experience Committee in July 2020, there was no evidence of communication to all UHB Directorate Managers or the membership body of the Ultrasound Clinical Governance Group.	Potential risk of there being no effective clinical ultrasound governance framework in place.
Recommendation 1	**Priority**
The Executive Director of Therapies and Health Science should be provided with assurance that the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) has been adequately communicated within the Health Board.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**
The Policy and Procedure will be promoted through the Medical Equipment Group, Medical Device Safety Officer's group, Clinical Board operational teams as well as through the Clinical Executive's Office of Professional Leadership.	October 2021	Assistant Director of Therapies and Health Science

Matter Arising 2: Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science (Control Operation)		**Impact**
The Medical Ultrasound Risk Management Procedure provides direction to Clinical Boards regards required assurance to the Executive Director of Therapies and Health Science, which notes, *"The Clinical Board Heads of Operations and Delivery are responsible for:* *Providing assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policies and procedures."* Given the further findings within this report relating to ultrasound governance (finding 4), it is unclear how the required assurance is determined and how it is communicated.		Potential risk of there being no effective clinical ultrasound governance framework in place.
Recommendation 2		**Priority**
Consideration should be given to the mechanisms for Clinical Boards to provide assurance to the Executive Director of Therapies and Health Science, to satisfy the assurance responsibilities set out within the Medical Ultrasound Risk Management Procedure (UHB 322).		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
An annual audit template will be developed by the membership of the UCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework.	March 2022	Assistant Director of Therapies and Health Science
Opportunities to develop a digital audit tool will be explored with corporate IM&T teams.	March 2022	Assistant Director of Therapies and Health Science

Matter Arising 3: Design and feedback of the Ultrasound Risk Management Procedure (Control Design)	**Impact**
The audit provided opportunity to disseminate the procedure and obtain feedback from those that engaged with the audit. The following observations were noted: • Whilst the procedure is comprehensive, it is a lengthy document (23 pages of text) which covers an extensive depth of content to read and retain. • An abridged version of the procedure would be welcomed, capturing key themes and requirements, summarised into two or three pages, underpinned by the full procedure for clarification when required. • The naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance.	Potential risk of the design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.
Recommendation 3	**Priority**
Following feedback through the course of the review, consideration should be given to: • Producing an abridged version of the Medical Ultrasound Risk Management Procedure, summarising key themes, to underpin the full procedure; and • The renaming of the procedure to reflect the actual content of Ultrasound Governance and to align with the role of the Ultrasound Clinical Governance Group.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
Provide an abridged version of the procedure, about 2 or 3 pages. Rename the policy and procedures to reflect more closely what they contain. Saunders.Nathan 06/14/2022 13:03:54	26th August 2021	Paul Williams, Principal Clinical Scientist

Matter Arising 4: Ultrasound governance arrangements require review (Control Operation)	**Impact**
The following observations were noted regarding the ultrasound governance arrangements and were prevalent pre-COVID: • There is an Ultrasound Clinical Governance Group (UCGG) in place, with a formal terms of reference, dated April 2015. • The UCGG terms of reference has not been reviewed in tandem with the revised policy and procedure (published 17 February 2021). • The terms of reference for the UCGG notes the following roles: Chair, Deputy Chief Operating Officer, and Vice Chair, Assistant Director of Therapies and Health Science. The auditor was advised that neither positions have chaired the group since 2018. Acting chairpersons have been assigned but hold reduced authority in the UHB. • The auditor was advised by the sampled areas that attendance at the UCGG has been poor. There were no records of attendance held, and thus quorate arrangements were uncertain. Due to the lack of documentation, we were unable to validate the strength of the UCGG. • The terms of reference for the UCGG refers to 'relationships and accountabilities with the Board and its committees/groups', specifically referencing the Medical Equipment Group (MEG) and the Decontamination Group. Minutes of the MEG and Quality Safety and Experience sub-committee (Clinical Diagnostics and Therapeutics Clinical Board) did evidence the raising of ultrasound clinical governance concerns in 2019 by the acting Chair. • There is no evidence of routine reporting to and from the UCGG. • The auditor was advised that the acting Chair and Vice Chair of the UCGG do attend the Quality, Safety and Experience Committee, with opportunity to raise concerns, as outlined within the UCGG terms of reference, but it was unclear if there are any embedded reporting arrangements of a more formal nature.	Potential risk of no effective clinical ultrasound governance framework.

Recommendation 4		Priority
Ultrasound governance arrangements should be reviewed as follows: • The placing of the Ultrasound Clinical Governance Group (UCGG) within the Health Board's governance structures. • The appointment of appropriate person(s) to Chair the UCGG meetings with sufficient seniority to escalate issues as they arise. • The reporting mechanisms to facilitate the escalation and cascade of ultrasound governance. • Membership of the UCGG should be sourced from all ultrasound using Directorates. • Actions and attendance (including quorum) are recorded for the meetings. On completion of review, the governance arrangements should be revised and formalised through an updated Terms of Reference.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
The UCGG ToR will be formally reviewed to ensure that it has appropriate governance arrangements. The UCGG will formally report through the Medical Equipment Group (MEG) which is chaired by the Executive Director of Therapies and Health Science. The MEG will receive minutes and a written report. The TORs for UCGG and MEG will be amended accordingly.	October 2021	UCGG / Assistant Director of Therapies and Health Science
The membership of the UCGG will be signed off by the Executive Director of Therapies and Health Science. Communication on expected attendance from clinical areas at the UCGG will be disseminated through the operational Clinical Board structures and the Office of Professional Leadership.	November 2021	Assistant Director of Therapies and Health Science

Matter Arising 5: Roles and responsibilities outlined by procedure require formalisation (Control Operation)		**Impact**
So as to appropriately focus, organise and stratify areas of ultrasound governance at Directorate / Departmental level, the UHB Ultrasound Risk Management Procedure has adopted three key roles based upon areas of expertise that allow this to be undertaken effectively; these are, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor. Since the publication of the revised procedure, we were unable to evidence the formal adoption of the roles outlined within the procedure, for the three sampled areas. It is noted that within the Obstetrics & Gynaecology Directorate, and the Medical Physics Doppler Ultrasound Service that these roles had been identified, but not formalised.		Potential risk of poor training and competence for the use of diagnostic and therapeutic ultrasound.
Recommendation 5		**Priority**
In accordance with Sections 2 and 3 of the UHB Ultrasound Risk Management Procedure, the three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor should be formalised within the sampled audit areas.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics.	Complete	
The O&G Directorate is setting up a quarterly formal ultrasound governance meeting, the first of which is starting in September. Within this we will be formalising roles and working through each aspect of the policy inc: roles and responsibilities and communication plan around this.	30th September 2021	Mark Denbow, Directorate Ultrasound Governance Lead

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Cardiff and Vale UHB

Ultrasound Clinical Governance Group

Terms of Reference and Operating Arrangements

CARDIFF AND VALE UHB ULTRASOUND CLINICAL GOVERNANCE GROUP
TERMS OF REFERENCE

INTRODUCTION

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

The Ultrasound Clinical Governance Group (USCGG) will be responsible for defining the scope of Diagnostic and Therapeutic Ultrasound (US), taking into consideration the clinical need for Diagnostic and Therapeutic US, its financial implications, technical feasibility, and in ensuring that appropriate measures are in place to monitor the accuracy and quality of Diagnostic and Therapeutic US and reporting. This will ensure optimal health and experience outcomes and improve patient safety across all of the UHB's US activities. The USCGG will also provide system level and strategic oversight to image storage arrangements. The USCGG report to Cardiff and Vale UHB's Medical Equipment Group which is chaired by the Executive Director of Therapies and Health Science who holds Executive responsibility for clinical ultrasound governance. See Appendix 1 – Governance and Reporting Framework.

Within Cardiff and Vale University Health Board, the USCGG advises on procurement decisions as well as seeking assurance on equipment life cycle management including monitoring, maintenance, replacement and disposal of equipment. The establishment and maintenance of service standards including training, competence assessment, supervision, operational delivery and audit are also within the Group's remit.

Key guidance.

1. Ultrasound Clinical Governance
National Diagnostic Imaging Board, Department of Health, LONDON (2008)
http://www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Diagnostics/Imaging.

2. 'Ultrasound Training Recommendations for Medical and Surgical Specialties'
RCR REF BFCR(05)2 The Royal College of Radiologists LONDON (2005)

PURPOSE

The purpose of the **Ultrasound Clinical Governance Group** is to;

- receive assurance that all US services have adopted and are adhering to the general requirements for good US governance,
- receive assurance on the achievement and maintenance of appropriate levels of competence, performance and patient safety related to the use of US equipment,
- provide regular written highlight reports and meeting minutes to the Medical Equipment Group (MEG),
- to provide assurance to the EDoTHS on all aspects of US clinical aspects, and escalating issues where assurance cannot be provided,
- through regular programmed review to maintain and develop the Medical Ultrasound Risk Management Policy and Procedure to ensure that it incorporates all contemporaneous clinical, professional and safety guidance,
- To seek assurance from each Directorate involved in US that suitable and sufficient Clinical Lead Users, Speciality Lead Users and Educational Supervisors / Training Supervisors are available within the UHB to assure continuing safe delivery of US clinical services, and escalate as necessary.
- recommend systems to ensure data is recorded accurately and consistently and stored safely across the UHB,
- advise procurement on criteria for evaluation of bids for US equipment, inform and facilitate better decision making and good governance in the purchase and use of US equipment within Cardiff

and Vale UHB,

- To maintain a robust system level governance framework and supporting infrastructure which ensures that US practitioners are trained, competent and work within the limits of their competence, and ensure all US practitioners are exposed to sufficient volume and complexity of procedures to maintain their skills and knowledge base. This will be assessed by a digital audit programme to include the development of a dashboard of balanced US service quality performance metrics where applicable,

- To develop and maintain an e-learning module to support the consistent adoption of best practice linked to the US Governance Policy and Procedure,

- Direct programmes of work where necessary to establish baseline US activity, review scope of existing practice and make recommendations on service improvement.

- develop an annual work programme to support the continuous improvement of US services at both a clinical service level and a UHB system level.

DELEGATED POWERS AND AUTHORITY

The Group will, in respect of its assurance role, seek confirmation that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality and safe US services across Cardiff and Vale University Health Board.

To achieve this, the Group's work programme will be designed to ensure that, in relation to all aspects of US service delivery:

- There is clear, consistent strategic direction, strong leadership, good governance and transparent lines of accountability with Executive oversight in the delivery of US services.

- The USCGG has a citizen centred approach, putting patients and patient safety above all other considerations.

- The US services planned or provided across the UHB are consistently delivered, strategically aligned, based on sound evidence, compliant with relevant law, clinically effective and meet standards set by relevant professional, regulatory, external quality assurance and accreditation bodies.

- The UHB has the right systems and processes in place to deliver, from a patient's perspective, effective, efficient, timely and safe US services.

- The US workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained.

- There is an ethos of continual quality improvement and regular methods of updating the US workforce in the skills needed to demonstrate quality improvement throughout the UHB.

- There is good team working across US services, with effective collaboration and partnership assured to provide the best possible outcomes for all service users.

- US risks are effectively and robustly managed and appropriately escalated within Clinical Boards and the wider UHB in a timely manner.

- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies US services, and in particular that:

    - recommendations made by internal and external reviewers are considered and acted upon in a timely basis; and
    - lessons are learned and fully evidenced from patient safety incidents, complaints and claims and disseminated as appropriate across the Clinical Directorates and Clinical Boards.

- Advise the MEG and relevant Quality, Safety and Experience Sub-Committee on the adoption of a set of US service quality performance indicators which will be regularly monitored, assessed and reported on.

These will include the following:

Clinical Governance

- To support the implementation of the Clinical Governance Programme for Cardiff and Vale UHB.

- Monitor the co-ordination and implementation of Welsh Government's Health and Care Standards and other standards relevant to the delivery of US services.

- Contribute to the Annual Healthcare Standards Improvement Plan and monitor progress within the Clinical Boards who deliver US services.

- Receive and consider reports as appropriate from US clinical services, the MEG, the Decontamination Group, the Infection Prevention and Control Group, relevant Clinical Board Quality, Safety and Experience sub committees and Operational Health and Safety sub groups within the Clinical Boards. See Appendix 1 – Governance and Reporting Framework.

- Share and communicate US best practice and continuous quality improvement.

- To advise the Point of Care Testing (POCT) Group on the suitability of US POCT Devices.

- To receive exception reports from Clinical Boards, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor which relate to the delivery of US services.

Patient Experience

- Review reporting trends in US service delivery relating to patient safety incidents with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further incidents have been identified and consistently and uniformly taken across the UHB.

- Receive and review progress reports relating to the requirements identified for patient safety and clinical governance activity relating to the provision of US services.

- Review reporting trends relating to clinical negligence claims involving US services with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further claims have been identified and taken.

Policies and Procedures

- Authorise that US Clinical Procedures are appropriate on behalf of the UHB, and provide a summary of these to the Executive Quality, Safety and Experience Committee.

Concerns/ NHS Redress, Compliments and Claims

- Receive reports from Clinical Boards on complaints, compliments and claims relating to US services and the reporting trends relating to the progress and outcome of the related processes, with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of a repeat have been identified and taken.

Clinical Audit & Effectiveness

- Receive reports on the progress and lessons learnt from clinical audit and effectiveness relating to US service delivery which will include updates on national standards implementation e.g. Royal College Guidance, Medicines and Healthcare products Regulatory Agency (MHRA), National Science Foundations (NSF)s, National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD) evidence-based practices.

- Undertake annual digital audits for each US service, to inform development of an Annual Audit Plan for the UHB, ensuring arrangements are in place to monitor and review related outcomes.

- To receive summaries of US clinical audits from Clinical Boards and / or individual US service providers. This will include audits

carried out by individual services for external regulatory authorities.

Clinical Risk Management

- Monitor the arrangements in place to assess, control and reduce clinical risk associated with use of US within the Clinical Boards.

Audit Requirements

- Demonstrate co operation with Auditors in reviewing US systems and processes, including timely response.

- Monitor, review and evaluate the timescales for implementation of Audit recommendations, and ensure that they are in line with the Audit Committee requirements.

Personal Development, Review, Training and Education

- Receive progress reports from US service departments.

- Where appropriate direct Clinical Board / Directorate / Locality priorities.

Authority

The Group is authorised to investigate or have investigated any activity within its terms of reference.

In doing so, the Group shall have the right to inspect any books, records or documents of the UHB relevant to the Group's remit in keeping with data protection and other relevant legal regulations. Patient/client and staff confidentiality will be respected at all times as appropriate. The Group may seek any relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Group); and

- Other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

Access

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

Sub Groups

The Group may establish sub groups and task and finish groups to carry out specific aspects of business and feed their activity into the Group.

MEMBERSHIP

Members

The group will comprise of:

- Chair: Assistant Director Therapies and Health Science
- Vice Chair: Clinical Specialist – to be appointed at first meeting.
- Senior Nurse representation as nominated by the Executive Nurse Director
- Senior Medical representation as nominated by the Executive Medical Director
- Lead Sonographer representation as nominated by the Clinical Director of RMPCE
- Lead US Radiologist representation as nominated by the Clinical Director of RMPCE
- Non-Ionising Safety Lead, Principal Clinical Scientist (Medical Physics).
- Physiotherapy representation as nominated by the head of Physiotherapy.
- Clinical Engineering representation – to be nominated by the Head of Clinical Engineering.
- C&V UHB Directorates* (involved in US) to provide representation. Where they have been appointed, the representative should be one of the following:
    - Clinical Lead User
    - Speciality Lead User

- Educational Supervisor / Training Supervisor

*Which must include representation from the following directorates and any others where diagnostic US is used:

- Obstetrics and gynaecology
- Radiology
- Sonography
- Cardiology
- Emergency Department

Where members are unable to attend then alternates should be identified to ensure constant representation and attendance.

Attendees

Clinical Directors or their representatives may be requested to attend from time to time as required by the Group Chair.

By Invitation

The Group Chair may extend invitations to attend Group meetings as required to the following:

- Directorate clinical leads
- Infection, Prevention and Control
- Those with specialist knowledge as required.

ULTRASOUND GOVERNANCE GROUP MEETINGS

Quorum

At least 5 members of the Group must be present to ensure the quorum of the Group, one of whom should be the Group Chair or Vice Chair.

Frequency of Meetings

Meetings shall be held quarterly with a minimum of 4 meetings per year with the Chair will make every effort to be present at all meetings, and otherwise as the Chair of the Group deems necessary, consistent with the UHB's annual plan of Board Business.

Withdrawal of individuals in attendance

The Group may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.

Probity

All interest must be declared so that the Group can inform and facilitate better decision and making and good governance in the purchase of US equipment.

RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

The Group, through its Chair and members, shall work closely with the other sub groups as appropriate, including joint (sub) committees, the Medical Equipment Group and the Decontamination Group to provide advice and assurance to the Quality, Safety and Experience Committee through the:

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

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

The Group shall embed the UHB's corporate standards, priorities and requirements through the conduct of its business.

REPORTING AND ASSURANCE ARRANGEMENTS

The Group Chair shall:

- Bring to the attention of the Executive Director of Therapies and Health Science directly or via the Medical Equipment Group any significant matters under consideration by the Group;

- Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may

compromise patient care and affect the operation and/or reputation of the UHB,

- Escalate particular issues to the Quality Safety and Patient Experience sub committees where deemed appropriate.

- Access senior advice on procurement, finance, decontamination and IP&C where necessary and as required.

- Review the Terms of Reference annually to ensure collective responsibilities can be assured/ discharged.

- Routinely provide minutes of the USCGG to the MEG.

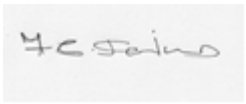
APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

Not applicable.

REVIEW

These terms of reference and operating arrangements shall be reviewed annually, or as required, by the Group.

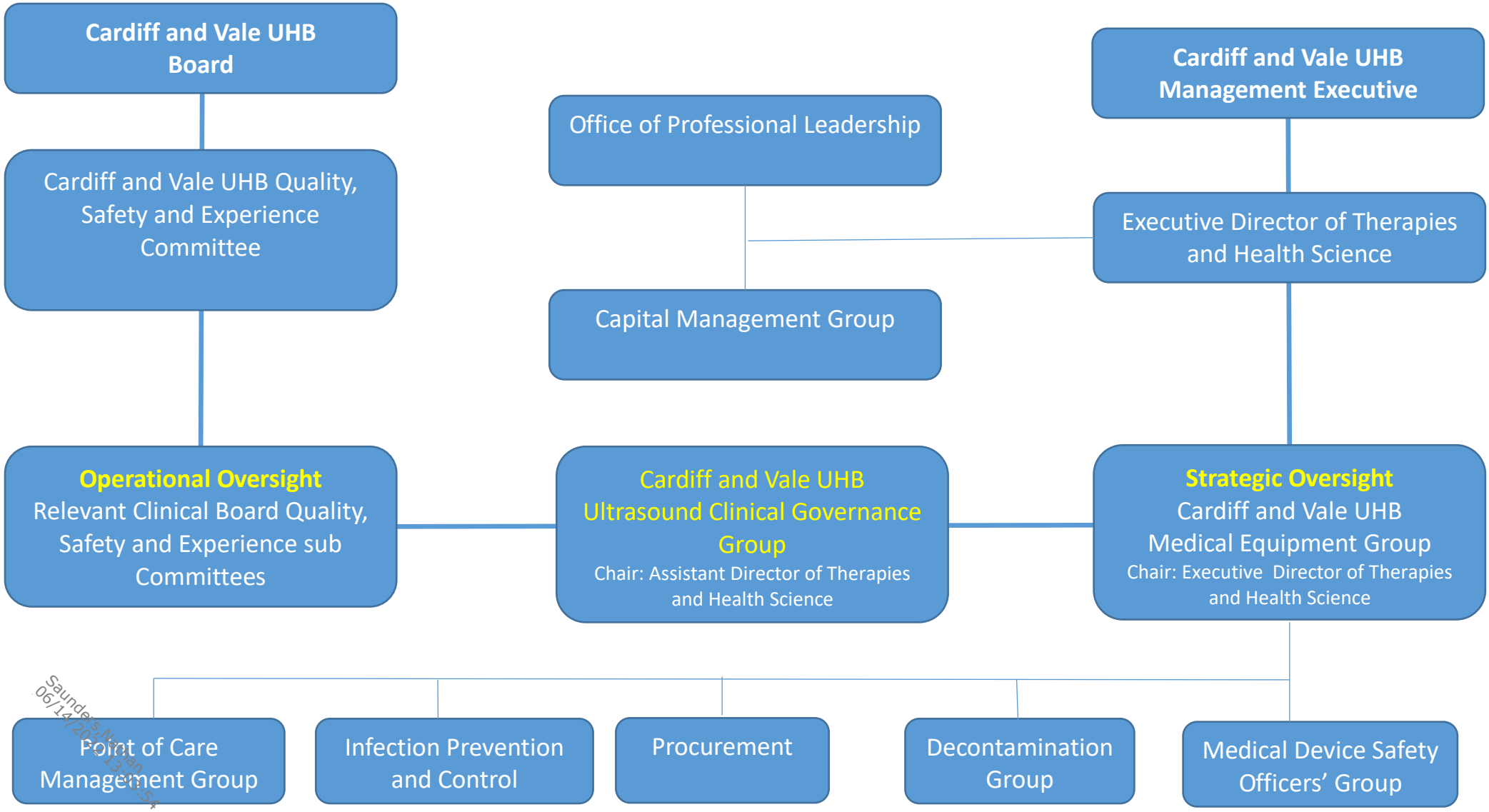
Agreed:



Singed:
Name: Fiona Jenkins
Position: Executive Director of Therapies and Health Science
Date: 25/01/2021

Proposed date for review: **Dec 2022**

1 Appendix 1: Governance and Reporting Framework



Report Title:	Concerns and Redress report				Agenda Item no.	2.9	
Meeting:	QSE		Public	x	Meeting Date:	15 June 2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Interim Executive Nurse Director						
Report Author (Title):	Vicky Stuart, Head of Concerns and Redress						

Main Report
Background and current situation:

Concerns report 01/04/2021 to 31/03/2022

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (hereafter, the 'Regulations') apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care and were introduced in April 2011. The Regulations set out the process for the management of concerns and is known as Putting Things Right (PTR). The Regulations are supported by detailed guidance on raising a concern.

The process:

• Aims to make it easier for people to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve.

• Introduced a single more integrated approach, bringing together the management of complaints, incidents and claims, based on the principle of 'investigate once, investigate well'.

• The process is underpinned by a comprehensive set of regulations and supporting guidance.

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

Arrangements in place for Managing Concerns

All concerns are reviewed by the Assistant Director of Patient Experience and graded dependent on the seriousness of the complaint. Any safeguarding or professional concerns are share. As appropriate, with the safeguarding team and the Medical Director. This indicates the level of investigation required, e.g. a full Root Cause Analysis Investigation, Informal Investigation, which we aim to resolve within 2 to 5 working days, or a Formal 30-day Investigation.

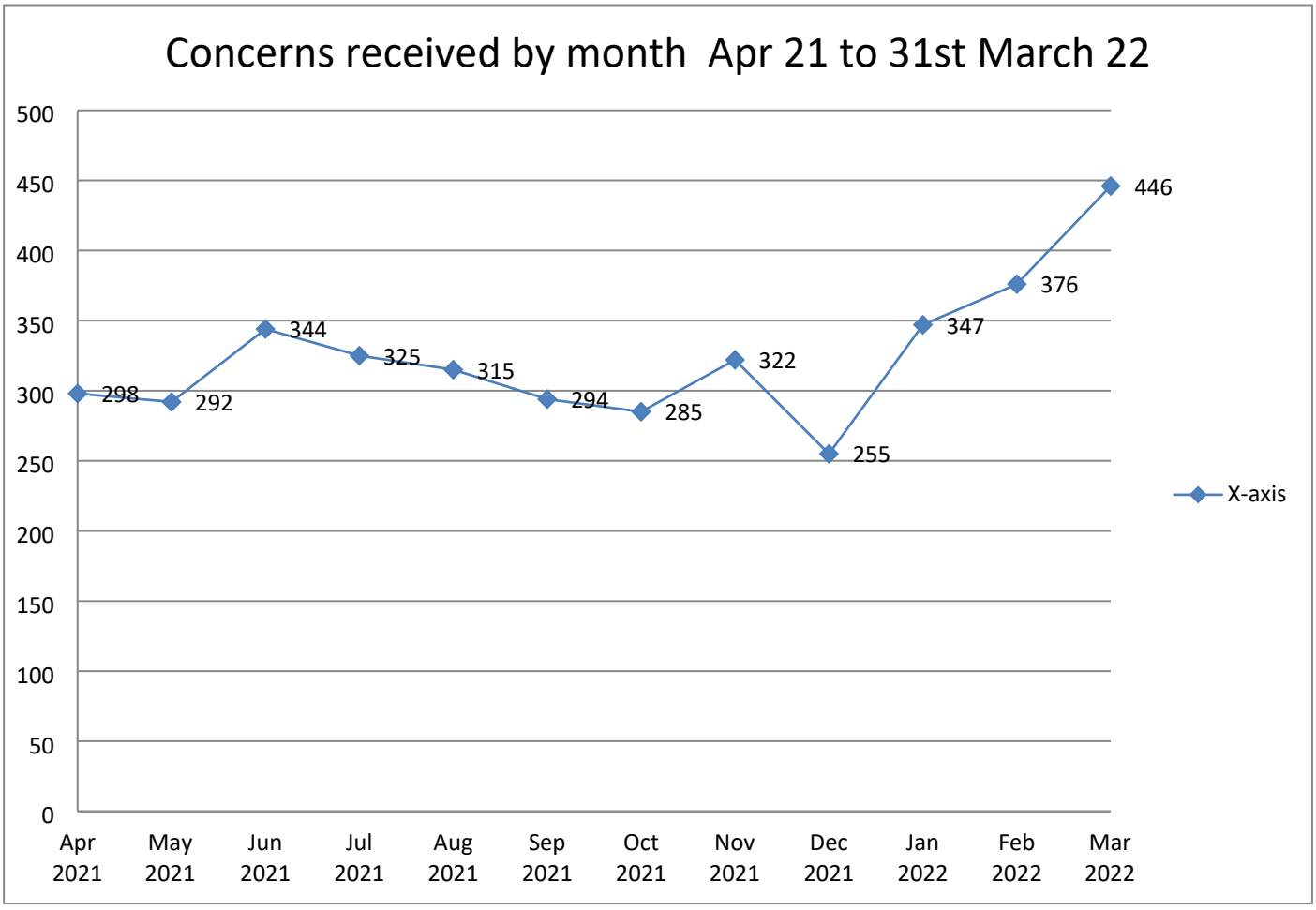
Concerns are shared with the Directors of Nursing within the relevant Clinical Board, following which an Investigating Officer is appointed. It is good practice for the Investigating Officer to contact the Complainant.

Under the Putting Things Right Regulations, all Formal Concerns have to be acknowledged within 2 working days. The Concerns Team agree the Terms of Reference with the Complainant and provide the Investigating Officer with the specific questions to be investigated as agreed with the person raising the concern. This helps to ensure a comprehensive response is provided. In our ongoing evaluation of the concerns service this initial contact and listening to people has been appreciated. We encourage

personal contact with each Complainant to ensure that we acknowledge their correspondence in a more empathetic and personal manner than just formally writing to them.
For those investigations that require further time, the Concerns Team contacts the Complainant, prior to the 30-day target, to explain the reason for the delay and advise that further time is needed. Early Resolution, where appropriate is encouraged. Early Resolution cases are considered to be complaints which are resolved no later than 2 working days (which includes the day of receipt of the complaint) to the satisfaction of the person raising the complaint.

Within the response, Complainants are offered the opportunity to meet with the Health Board Staff. As part of the regulations, there is an obligation on a Welsh NHS body to consider when it is notified of a concern that alleges harm or may have been caused, whether or not there is a qualifying liability. This is included in the response, along with the advice on how concerns can be forwarded to the Ombudsman.

During 1st April 21 to 31st March 2022, we have received in excess of 4,000 concerns. As anticipated this is a significant increase in comparison to last year, when we received 2,974 concerns (April 2020 to 31st March 2021).

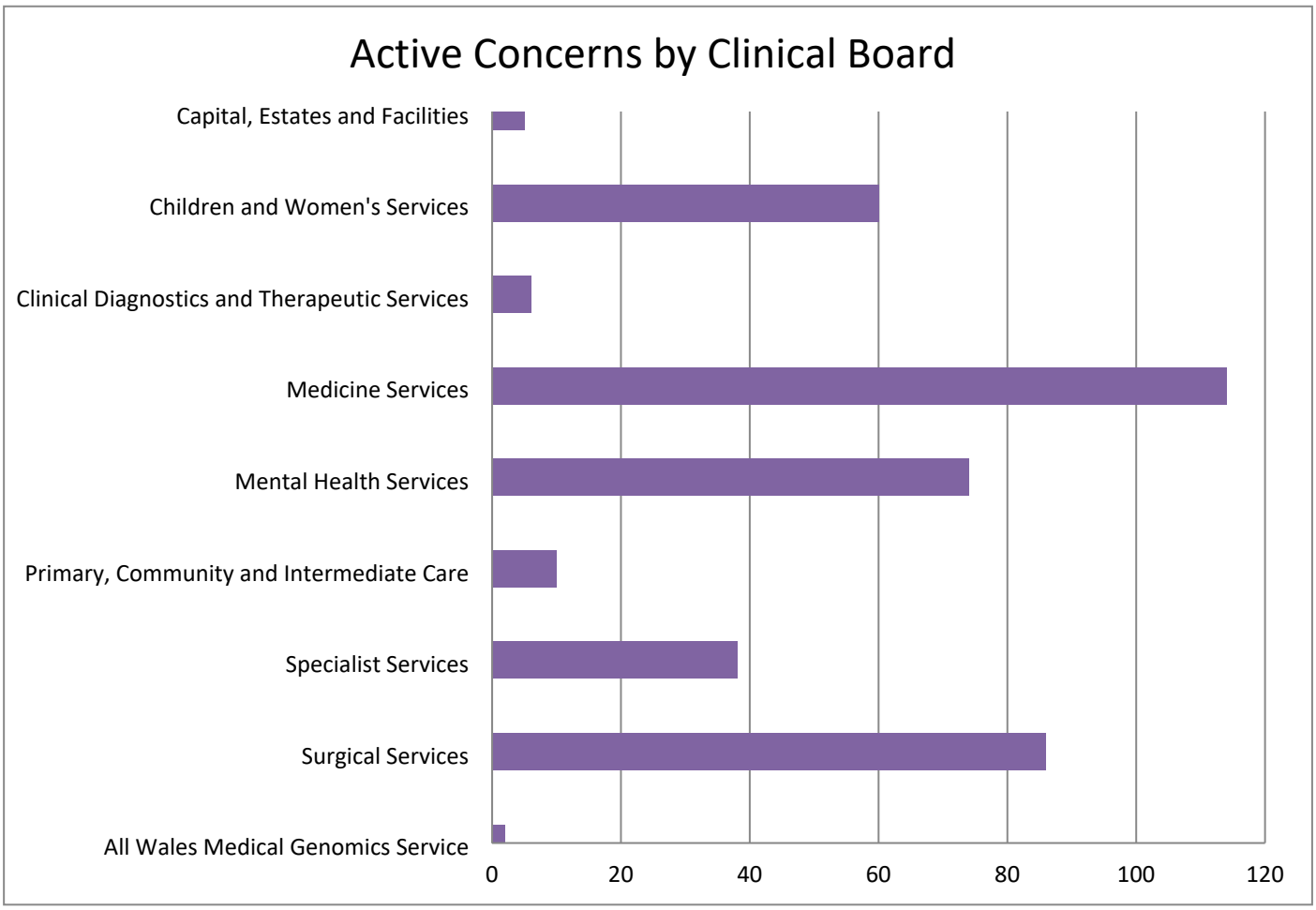


The graph above demonstrates the consistent and significant increase in the number of concerns received during the year.

In March 2020. the Concerns Team introduced 7 day working and hosted both the vaccination and visiting enquiry line.

The team received between 400 -700 calls a week.

You will note from the graph below that Medicine Clinical Board have the most active concerns, followed by Surgical Clinical Board. This has been consistent throughout the year.



Some of the themes identified in concerns relate to poor communication, waiting times, discharge arrangements, and environment (social distancing).
During the Pandemic, it was recognised that poor communication was a recurring theme across all areas including:

- Poor communication between staff and relatives

With families, not being able to visit loved ones in hospital, communication between staff and relatives was important, therefore, to facilitate better communication, the Concerns Team provided a 7-day service.

- Patients did not know what was happening with their treatment/waiting times

Clinical Boards wrote to patients with updates regarding their services.

- Poor communication regarding visiting and guidance on vaccinations

We introduced 7-day telephone helplines for patient visiting and mass vaccination information and introduced virtual visiting.

- Patients did not feel involved in their care/discharge

A number of initiatives have been taken to improve communication between patients and staff. The Safer Bundle being piloted on one ward is an example of ward staff actively involving patients in their care.

Patients are encouraged to ask:

What is the matter with me?
What is going to happen today?
What is needed to get me home?
When am I going home?

This fits in really well with the QSE framework by starting the “what matters to you” conversation with patients.

The impact of Covid on our hospital environment cannot be underestimated. The requirements of social distancing have put a huge pressure on our departments and has led to a number of concerns relating to lack of social distancing and unhygienic conditions being raised.
Whilst it is very difficult to decrease capacity in our busier departments such as the Emergency Unit, we have taken a number of actions to raise awareness of the issues raised and to improve hygiene.

Reminders are sent out via CEO connects and staff emails to remind staff of the importance of maintaining social distancing where possible.

- Designed Materials to help with social distancing

- Enhanced Cleaning procedures and rotas

- Brightened up areas with redecoration

As anticipated, we have seen an increase in concerns this year relating to waiting times and a number of initiatives and different ways of working are being implemented to recover from the backlog caused by Covid.

- Encouraged Clinical Boards to reengage with their patient to provide waiting list updates via letter.

- Clinical Boards have redesigned pathways to fast track patents that have been reluctant to access services/care during the pandemic.
- Introduced weekend clinics

- Utilising Primary Care services so patients are seen sooner in Primary Care rather than Secondary Care.

It is acknowledged that during the pandemic, there has been a failure to respond to concerns in as timely manner as they would have liked.
A number of actions have been taken to provide assurance to complainants that we are taking their concerns seriously, including letters being sent, signed by the Directors of Nursing, to all complainants with an active concern acknowledging that their response is taking longer than we would like, apologising for the delay and assuring that we are committed to providing a response.

However, we have focused our Concerns Team resource into managing as many concerns, where appropriate, as possible under Early resolution. This ensures a speedy resolution for complainants.

During this period, we closed 3641 concerns and 1406 of these were closed within 2 working days. The total number of complainants receiving a timely response within 30 workings days was 2,935.

It is pleasing to note that despite the ongoing challenges with resource and demands on the service during this period, the 30-working day performance has ranged between 77 to 88 % which exceeds the Welsh Government target of 75%.

One area of focus for concerns is to work with Clinical Board to provide responses to concerns that are overdue.

You said we did

You Said	We did
1. in the report that was subsequently sent to me by post, there are two comments made which I believe demonstrate a lack of understanding of LGBT healthcare, and one I believe to be defamatory. I would like this rectified by immediately correcting my notes to remove the reference to chem sex, and to add a clarification that I do not use any illegal drugs under any circumstances.	Diversity issues broadly are discussed under the themes of dignified and individualised care within our Quality & Safety meeting which all teams hold regularly. The Investigating officer has spoken with the Interim Team Leader for Primary Mental Health Support Service (PMHSS) and while that service is engaged in Equality and Diversity training, there has been no specific LGBTQ+ training in recent years. Following this concern, PMHSS have identified training providers who can specifically help them think about LGBTQ+ training in their area of practice and are exploring Stonewall & Umbrella Cymru, with a view to this being expanded to the wider staff group of Psychological Therapists. Updates on this training would then be taken in the Psychology & Psychological Therapies Directorates Quality & Safety meeting which meets every other month.
Concerns raised regarding lack of refreshments in the EU Department	As a result of ongoing transformation and innovation work within the Emergency and Acute Medicine Directorate, there are now regular hot drinks provided by the British Red Cross Service and the Dietetic service.
Concerns raised regarding the lack of digital referral process in Ophthamology	The Department is working towards digitalisation for all referrals which we hope will significantly improve the process and eliminate these types of errors.
Concerns raised regarding Lack of Palliative Care at Home/nursing support at home and Monitoring Saunders,Nathan 06/14/2022 13:03:54	1. Ensuring that a Lung Cancer Nurse (Key Worker) is present at all relevant consultations with the Medical team to ensure and facilitate a holistic assessment of a patient and their main carer. 2. To ensure that there are sufficient nurses available to support patient consultations, there has been an increase of nursing resource in the team from 3 full time to 4 full time nurses. 3. A new process has been implemented called a ‘health needs assessment’ championed by the Macmillan charity, to assist the nursing / medical team understand the needs of a

	patient and carer. This assessment will inform the actions the nurses take to ensure that a person is appropriately supported. This can include referral to palliative care in the community, social services as examples. 4. Ensure that this 'health needs assessment' is revisited and updated to reflect any change in a person's needs.
Concerns raised regarding lack of severity of condition	The Lung Cancer Nursing Team have implemented the following changes to practice, to ensure that your experiences do not repeat themselves; • That all patients at their first appointment are introduced to their Key Worker, clearly outlying their role in their care and the support they can offer. • The patient and family are provided with relevant contact details for the Key Worker. • To ensure that patients and relatives are told the necessary avenues to seek help if there are any urgent concerns. • A 'new calls database' has been implemented to track and ensure that all messages are answered in a timely manner with a clear outcome. • The Voice Message has been changed to prompt patients and relatives that Urgent messages should not be left and that calls may not be answered the same day, to further avoid any confusion to patients or relatives. • The Nursing Team have professionally reflected on the experiences that you and your husband had and how this was not in line with their commitment to supporting their patients.

Ombudsman:

During 2021/22 the Health Board closed 3641 Concerns, of which 89 (2.4%) were referred to the Public service Ombudsman for Wales (PSOW) and he chose to investigate 10 concerns, less than 1% of the Concerns responded to during the year. In that time period 6 concerns were upheld in whole or in part 2 concerns were not upheld. . We had 1 public interest report issued We agreed voluntary

settlement on 11, which includes agreeing an appropriate, timely resolution with PSOW and the complainant such as a meeting or a further response.

Within the PTR regulations, Breach of Duty and Redress (Duty of Candour) needs to be considered in all cases, including Incidents and complaints.

Redress:

A case moves into redress if we identify that there is or maybe a qualifying liability i.e. we have identified a breach in our duty of care and we know the patient suffered harm because of the breach or we need to investigate further to establish if harm was caused
Where the investigation of a concern concludes there has been a breach of duty the case is presented to the Putting Things Right Redress Panel.
The Panel are required to consider whether redress applies in situations where a patient may have been harmed and the harm was caused during care provided by the health board.
Redress can be the giving of an explanation, a written apology, the offer of financial compensation and / or remedial treatment, on the understanding that the person will not pursue the same through civil proceedings.

The redress panel consists of:

- Assistant Director of Patient Experience (Chair)
- Associate Medical Director
- Head of Concerns and Redress (co chair)
- Redress Manager
- Redress Leads

The Panel holds a weekly drop in Clinic, this is open to all staff across the Health Board. Members of the Patient Safety Team, Investigating Officers and Clinical Board Staff are given the opportunity to discuss cases and obtain advice on Breach of Duty and discuss possible forms of Redress. Staff also attend for Learning and development.

We are working with Patient Safety Team and Clinical Boards to bring relevant National Reportable Incidents (NRI) to our attention where there is an identifiable breach and harm caused, so that we can offer redress at the initial stage where possible. We do this in an attempt to avoid the need for a patient receiving the Root Cause Analysis (RCA) and undertaking a claim against the Health Board. It provides the opportunity for an early apology, admission of liability and support for remedial treatment if required. This has seen the workload for the Redress Team increase, however it is vitally important that where possible, we achieve early settlement under the redress scheme in order to identify early learning, support patients and staff and make savings of costs.

We are committed to using the redress process when appropriate this enables a timely resolution for those people seeking an apology, remedial treatment and/or financial compensation to the value of £25,00.

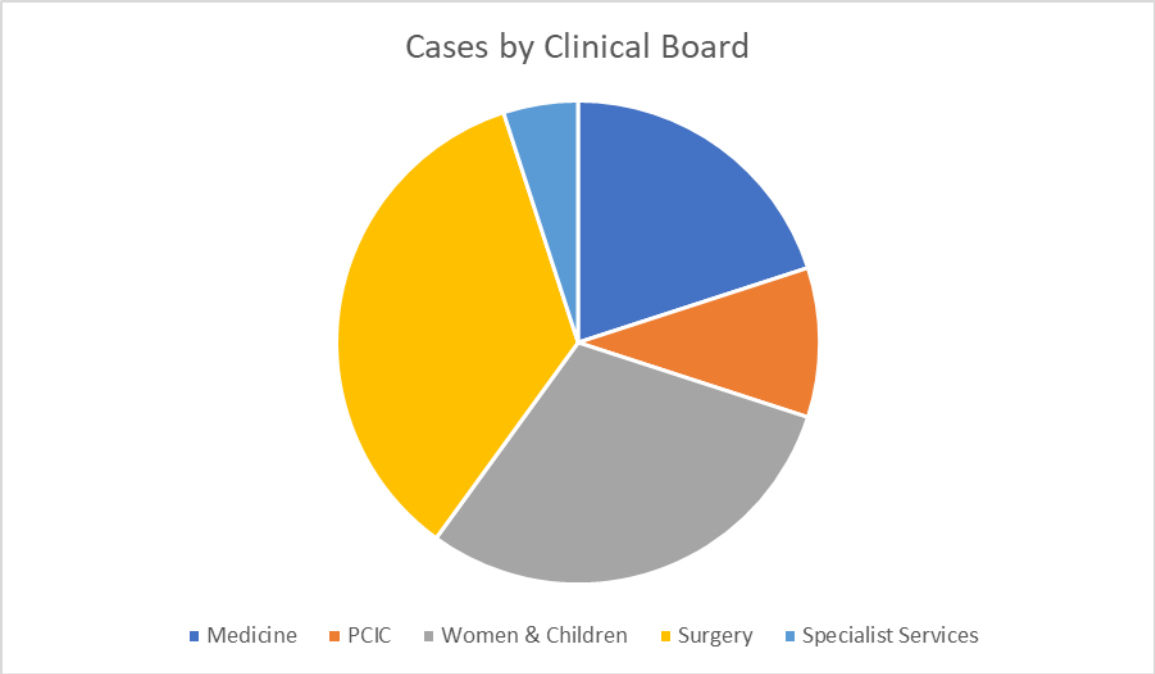
Redress legal costs significantly save the Health Board. When a matter settles under the Putting Things Right scheme, costs are mostly settled for £1920. These costs can increase slightly where a matter needs approval in Court where there is a child or a person who lacks capacity being paid compensation. This could increase costs by an additional £1,752. However, this is still a significant reduction than if the case was settled as a Clinical Negligence claim, potentially savings tens of thousands in costs alone.

Current position

There are currently 31 open Redress cases.

The pie chart below illustrates the various areas of responsibility for the live and ongoing cases, and demonstrates the apportionment of those cases (based on the Redress Forecast submitted during March 2022):

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



11 Redress cases were closed/settled during the financial year 2021/2022.There were 13 cancelled or withdrawn cases during the same period.

Redress Payments

In total, the HB paid out £121,486.75 under the Redress Regulations during the Financial Year 2021/2022. Of this, £84,218.00 was paid to patients directly and £37,268.75 was paid in respect of legal or other fees.

Themes and trends

Some recurring themes seen in the Redress cases over the financial year 2021/2022 are as follows:

- non-compliance with World Health Organisation (WHO) Surgical Safety Checklist;
- inappropriate discharge from Emergency Department (ED); and
- lack of cannula site care.

These instances have been identified, investigated and acted upon by the Clinical Boards. The standard of care provided has been investigated by reference to medical records, input from clinicians and by reference to patients' own comments where concerns have been raised. Where it is identified that learning is required, this learning is actioned and these actions are subsequently monitored for assurance of learning. Below are some examples of issues in care and the action that has been taken to promote development and learning.

Non-compliance with WHO Surgical Safety Checklist

Case	Action/Learning
A male patient underwent a wrong tooth extraction.	The Standard Operating Procedure (SOP) for tooth extraction was not

	followed and the WHO checklist was not completed prior to the extraction. Education and training has been improved, and compliance with the WHO checklist will be audited to provide learning assurance.
A female patient suffered visible scarring as a result of an incorrect incision for surgery on open reduction and internal fixation of a right distal fracture.	The 'sign-out' section of the WHO checklist was not completed. Compliance with the WHO checklist will be audited to ensure that there will not be a re-occurrence of wrong-site incision.
A female patient who underwent an episiotomy which required extensive suturing. She returned to EU sometime later when it was discovered there was a retained swab.	WHO checklist not complied with as the swab checklist had not been completed. Compliance with the "sign out" provision of the WHO checklist will be audited to prevent re-occurrence.

Inappropriate Discharge from ED

A female patient attended ED, and was reviewed by a Junior Doctor. All tests appeared normal except for a raised creatinine level of 170, which should have been further explored before discharge.	Patient was discharged by Registrar who did not review the care and test results, with the safety net of providing what advice to follow if there was a deterioration. There had been no review/investigation into the raised creatinine level. Additional training will be provided for A&E staff and an AKI audit will be implemented. Consultant grade staff will review results prior to discharge.
A male patient attended ED complaining of back spasm. He was X-rayed and discharged with a diagnosis of musculoskeletal pain. He reattended at ED 6 days later complaining of back pain once again. Blood tests were undertaken but the results were not acted upon. The patient attended for a third time 19 days later (by ambulance) and was unable to walk. He was prescribed painkillers and discharged to await MRI scan. MRI completed 6 weeks later and diagnosed with several spinal fractures and myeloma.	Failure to escalate (for Consultant review) a re-attending patient with same medical complaint resulted in misdiagnosis and delay in treatment. Amendments were made to the back-pain proforma and additional training has been developed and provided for A&E staff.

Lack of Cannula-Site Care

A female patient had numerous cannulas inserted during hospital stay. Despite the patient complaining of pain at one cannula site, it became infected and required antibiotic treatment and draining under local anaesthetic.	The patient's records did not have the required information regarding The Visual Infusion Phlebitis Score (VIPS) for monitoring infusion sites.
A female patient had a cannula inserted and was complaining of pain at the cannula site. Staff did not remove the cannula and an infection developed, which required treatment with intravenous antibiotics.	Staff did not remove the cannula in a timely manner which allowed an infection to develop. Staff are reminded during daily safety briefings of the need to check the cannula site.

Audit and Assurance

The Health Board was recently reviewed by NWSSP Audit and Assurance Services. The objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Welsh Risk Pool claims. The Health Board has been pleased to receive Substantial Assurance.

Compliments

The Concerns Team also log all Compliments received in the Health Board. During this period the Health Board received 198 compliments. it is always pleasing to receive positive feedback although it is acknowledged that a lot of compliments are sent directly to areas and are not formally logged. Staff are encouraged to share all feedback with the Concerns Team so that this can be recorded. The Executive Nurse Director sends a letter of thanks to all staff or departments when compliments are received and a letter of acknowledgement to the person sharing their feedback.

- ***I attended the A&E Department and I was treated with care and compassion***

- ***I witnessed staff being abused by patients but I was amazed by the care, dignity and respect shown to each and every patient despite their behavior.***

- ***A hospital stay was the last thing I wanted but the kindness shown by every member of staff made it easier. The care was fantastic!***

- ***I wanted to thank the Paediatric A&E department – yesterday when I visited with my daughter, the service was fantastic from the moment we arrived at the doors to leaving. We are very lucky to have you!***

- ***I was kept in the Heath for 4-5 days and after some excellent care I am finally on the mend.***

Training within the UHB

The Concerns/Redress Team has undertaken various training sessions covering PTR and Breach of Duty throughout the year. We also provide bespoke training to Senior Nurses, Directorate Managers and Investigating Officers. The Redress team is developing a training package for delivery to commence from July 2022. The aim of the training is that it will be recorded so that staff can access

this when they are able, rather than gathering a large amount of people in a room when ultimately time is limited and staff are busy. We however also, will be able and willing to provide the training to large groups of people in a seminar forum. The training that can be provided/accessed will cover topics such as breach of duty and causation, consent, material contribution, the redress process and the information we need in order to consider qualifying liability.
A newsletter is being developed for sharing with staff across the UHB. This newsletter will be circulated quarterly, the first to be made available on 30 June 2022. Thereafter the newsletter will be circulated on the last day of the month of the quarter. The newsletter will aim to cover any relevant information and updates from the Redress/Concerns Team, for example; any cases to note or noticeable themes and trends or information about any upcoming training.

Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the contents of the assurance report and AGREE the mitigation being taken to ensure a person-centered approach.to improve quality, safety and experience and reduce harm. Shaping our Future Wellbeing Strategic Objective

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

The increased activity in concerns presents a risk of inability to meet the 30 working day response times which is a performance indicator from Welsh Government

Safety: Yes

Delays in investigations presents a delay in identified learning and mitigation being put in place at the earliest opportunity

Financial: Yes

Failure to meet the Welsh Risk Pool (WRP) deadlines with a comprehensive investigation, identified learning and evidence of compliance will present a financial risk to the organization as WRP may choose to not reimburse the Health Board

Workforce: No

Legal: No
Reputational: Yes
As above
Socio Economic: Yes
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the complaints and claims data to the level of low super output areas of social deprivation in comparison to areas of affluence
Equality and Health: Yes/No
EHIA will be reviewed in October with the revised concerns policy
Decarbonisation: No

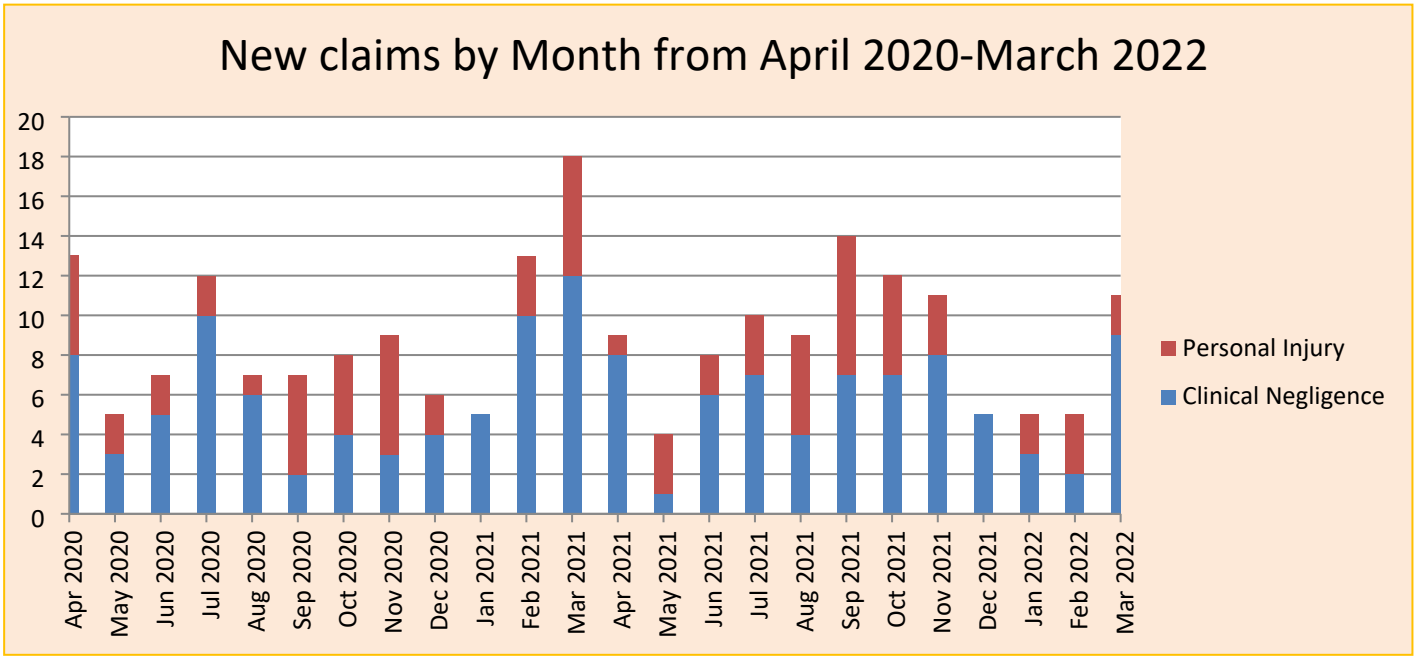
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/14/2022 13:03:54

Report Title:	Claims Report – Clincial Negligence & Personal Injury				Agenda Item no.	2.9b
Meeting:	QSE Committee		Public	x	Meeting Date:	15 June 2022
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Interim Executive Nurse Director					
Report Author (Title):	Head of Clinical Negilgence Claims and Head of Personal Injury Claims					

Main Report
Background and current situation:

Clinical Negligence (CN) and Personal Injury Claims (PI)



The CN & PI claims received during the last two years appears fairly consistent with previous years, there are no significant increases in specific categories or specialities to report. At present there has not been an influx of Covid related claims. This is being carefully monitored and there is a dedicated resource set up to respond any investigations that need to be conducted in these matters.

Welsh Risk Pool

In all Claims where the decision to concede the claim has been made, an LFE (Learning from Events Form) (See Appendix 1) is completed for approval by the Welsh Risk pool. The national Learning Advisory Panel (LAP), reviews the learning implemented by health bodies in NHS Wales following a redress, personal injury or clinical negligence claim. The completion of the LFE at the earliest possible stage ensures the opportunity for timely learning and action which mitigates risk is recognized

During the last two year the following number of LFEs have been submitted to the WRP.

2021/2022
CN – 76
PI – 18

2021/2022
CN – 69

On conclusion of the claim, a Claims Management Form (CMR) is submitted to the Welsh Risk Pool for any cases that exceed the £25,000 threshold. The CMR is submitted with the approved LFE form. During the last two years the following reclaim of expenditure has been received.

2020/2021 £10,850,906

2021/2022 £17,777,661

Failure to adhere to the strict process of LFE and CMR submission supported by robust evidence of learning could result in a decision by the risk pool not to reimburse the Health Board for any legal fees including damages and costs.

Clinical Negligence

Graph showing number of active CN claim by specialty to follow*

Clinical Negligence schedule in 2021-2022

Defence	Settlement	Claimants	Total
563,873	11,961,510	3,556,762	16,082,176

Clinical Negligence Schedule in 2021-2022

Defence	Settlement	Claimants	Total
709,536	9,965,533	2,788,00	13,463,077

Breakdown of Schedule of Claims 2020-2022

	Certain/Probable	Possible/Remote	Closed
2020-2021	89	125	**79**
2021-2022	86	117	**90**

Themes

One of the identified themes is consent and in particular when measured against Montgomery

The Montgomery case in 2015 was a landmark for informed consent in the UK**.**
The Montgomery decision redefined the standard for informed consent and disclosure. Previously, the Bolam was used to determine what should be disclosed. These tests ask whether a doctor's conduct would be supported by a responsible body of clinicians. The test of materiality defined in the Montgomery ruling was whether "a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it

The advice issued by the WRP to health bodies in July 2020, in relation to consent, is unchanged.

Therefore, the WRP standard requires that an EIDO leaflet or leaflet produced by a national professional body should be used where available. Claims relating to consent are unlikely to be

reimbursed by the WRP where it is shown that EIDO leaflets were available but not used. Where there is no EIDO leaflet available for a specific procedure, it is accepted that a compliant nationally recognized alternative may be used.

The Welsh Risk Pool requires all Welsh health bodies to use EIDO leaflets, where available, as part of the consent to treatment process. In order to ensure that the most up to date version is being used leaflets should be downloaded as required directly from the library. Any local information leaflet should be produced separately and comply with local governance frameworks for the development of patient information leaflets.

The Clinical Boards have embraced the new focus to produce learning that comply and give evidence of assurance of actions taken in response to Claims. This includes all learning being discussed and recorded as part of the wider learning requirements of the WRP. The WRP mandate that evidence is presented and recorded of all meeting, events and training where this evidence has been shared and actions agreed by the Clinical Board at meeting such as QSE. The Head of Claims has been invited to Clinical Board QSE meetings to present cases and host training that has been received well by the clinical teams who have requested this support.

Delay to Diagnosis

A settled claim whereby failure to act upon the radiological finding of an incidental tumour within a reasonable timeframe caused the patient to suffer symptoms of cough and chest pain due to the delay

A new process has been introduced since this incident. Including

- When an unexpected or significant finding is detected the Radiologist will add a ‘pathcode’ phrase to the last line of the report, e.g. **cancer
- Action is also taken to alert the clinician, MDT, or cancer co-ordinator.
- If a secretary has been asked to notify the referrer by the reporting radiologist then this is recorded in the ‘notes’ field in RadIS.

Twice weekly a list is produced from RadIS for all reports containing the pathcode **cancer and the record of their findings is then emailed to the PACS team and the Cancer Services and Acute Oncology Teams for information.

An audit of the ‘red flag’ process in Radiology was conducted in June 2021.

Training Compliance

The focus of the Women & Children clinical board Obstetric & Gynae department to actively engage in learning is notable to the claims team especially as their claims in the main attract significant awards in excess of 1 million and also involve scrutiny from Welsh government for reassurance of learning and improvements To support the identified training weaknesses with low compliance to the WRP standard of 95% PROMPT training in 2020. One improvement is an updated database has been developed. The database recognises how many midwives are “active” and therefore requires training. This figure is reviewed monthly as staff leave and return.

Personal Injury

Personal injury schedule in 2021-2022

Defence	Settlement	Claimants	Total
563,873	11,961,510	3,556,762	16,082,176

Personal Injury Schedule in 2021-2022

Defence	Settlement	Claimants	Total
709,536	9,965,533	2,788,00	13,463,077

Breakdown of Schedule of Claims 2020-2022

	Certain/Probable	Possible/Remote	Closed
2020-2021	14	75	**37**
2021-2022	44	60	**46**

Themes

Exposure to communicable disease (non-covid)

In June of 2020 the Health Board received a number of personal claims in relation to the potential exposure to respiratory communicable disease. There were a number of themes associated with the claim due to their nature and exposure. The Claimants were not employed by the Health Board. The claims centered around occupational exposure and how the health board and the claimant's employer manage the risk of exposure when dealing with high risk clients. The subsequent investigation by PHW and the Health Board's Infection Control Team found the Health Board had in place established and robust policies. Liability was shared in the settlement of these cases. The post-investigation review found that communication and the early identification though cross agency collaboration, risk assessment, early alerting systems and ongoing surveillance would and has proved beneficial in reducing the further risk of infection. It has also developed improved bilateral inter-agency understanding of infections and of our responsibilities when dealing with potential infections.

Trips and Falls from Potholes

The health board received a number of claims directly related 'potholes'. Whilst it is challenging to manage potholes with the estate, there was a theme of a number of claims submitted which lead to review which found that the reporting of potholes is often sporadic and there is also an assumption that they have been reported. This is often not the case and many do go unreported only to be identified in the case of a claim.

The Estates Department reviewed the surveillance of its estate and as result have established procedures to ensure Preventative Planned Maintenance (PPM) is undertaken. An electronic system to ensure surveillance is recorded. In addition to this a visual 'walkabout' is undertaken by the Estate Department to visibly review areas of high traffic and particular hotspots to pick up an risks or defects.

Sharps Injury

The Health Board received a small number of sharp injury claims. All claims are fully investigated and reported back to the area concerned. The WRP have sought evidence of compliance to training by the Waste Handler but also from the area that the incident arose which greater emphasis on learning in any known area that the wrongly disposed of sharp arose. To ensure awareness of polices and processes. Additionally, the introduction of a new waste audit has been established which will further improve the surveillance of waste disposal and ultimately the reduction in risk and further incidents.

Internal Audit

The Health Board received an internal audit review insert date of Welsh Risk Pool concerns and compensation claims completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board'). The Area for Assessment 3 of the standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement, made on Welsh Risk Pool Services. The relevant lead for this review is the Executive Nurse Director.

Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments. Welsh Risk Pool Services (WRPS) require claims for reimbursement and repayment to be made within specific timescales. Reimbursement of settled PI/Clin Neg claims in excess of £25k are NHS indemnity.

Under the new standard, claims management teams must complete an LFE (Learning from Events) Report within 60 days of the decision to settle date Claims Management are also expected to complete and submit a CMR (claims management report) and financial schedule to WRPS signed by the Chief Executive and Executive Nurse Director within 4 months of the final payment date.

The Health Board had achieved this target and the team received substantial assurance.

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

There has been a notable increase in the costs associated with litigation, this has been increasing as a result of legal fees associated with claims.

The number of claims received is fairly consistent with previous years, with a slight increase in personal injury claims. There is a notably increase in the complexity of claims received that do require timely responses and investigation of information to defend claims.

The Welsh Risk Pool requirement for reimbursement has led to greater emphasis on learning and increased communication between the Claims Teams and the Clinical Boards to obtain this evidence of assurance to be provided to the WRP within the specified time for this provision.

Recommendation:

The Board / Committee are requested to **note** the content so the report and the process in place to manage claims and identify learning.

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: No
Safety: Yes/
Delays in investigations presents a delay in identified learning and mitigation being put in place at the earliest opportunity
Financial: Yes/
Failure to meet the Welsh Risk Pool (WRP) deadlines with a comprehensive investigation, identified learning and evidence of compliance will present a financial risk to the organization as WRP may choose to not reimburse the Health Board
Workforce: Yes/No
Legal: Yes
We need to adhere to the relevant legislation in management of claims
Reputational: Yes
There is always a media interest in litigation management
Socio Economic: Yes
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the complaints and claims data to the level of low super output areas of social deprivation in comparison to areas of affluence
Equality and Health: Yes
EHIA will be reviewed in October with the revised concerns policy
Decarbonisation: No

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

Saunders,Nathan
06/14/2022 13:03:54

Report Title:	Committee Self Effectiveness Survey Results 2021- 2022			Agenda Item no.	4.1
Meeting:	Quality, Safety and Experience Committee	Public	x	Meeting Date:	15 June 2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

Routine monitoring of the effectiveness of the Board and its Committees is a vital part of ensuring strong and effective governance within the Health's Board's governance structure. Under its Standing Orders (SO 10.2.1), the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Further, and where appropriate, the Board may determine that such evaluation may be independently facilitated.

The Health Board undertook an annual review of the effectiveness of its Board and its Committees in April 2022 using survey questions derived from best practice guides, including the NHS Handbook, and using the following principles:

- the need for Committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives;
- the requirement for a Committee structure that strengthens the role of the Board in strategic decision making and supports the role of non-executive directors in challenging Executive management actions;
- maximising the value of the input from non-executive directors, given their limited time commitment; and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

For the 2021-2022 self-assessment, a survey was disseminated via Survey Monkey to all Board and Committee Members and Board and Committee attendees, enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2021-2022, which relate to the Quality, Safety and Experience Committee (attached as **Appendix 1**). There were no areas identified for improvement.

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

- The survey questionnaires for the annual Board/Committee Effectiveness Surveys 2021-2022 were issued in early April 2021 and attained a positive response rate overall.

- The overall findings are positive which provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committees are effectively supporting the Board in fulfilling its role.

To ensure effective governance the Board Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in March/April 2023 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2022-2023.

Recommendation:

The Committee is requested to:

a) **NOTE** the results of the Annual Board Effectiveness Survey 2021-2022, relating to the Quality, Safety and Experience Committee.

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

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

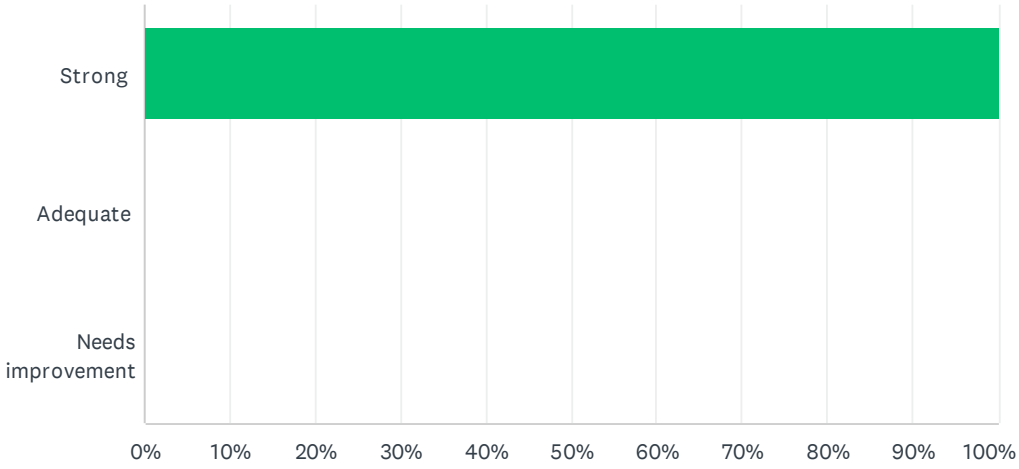
Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Audit Committee	12th May 2022

Q1 The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full Board. NHS Handbook status: 1 - must do

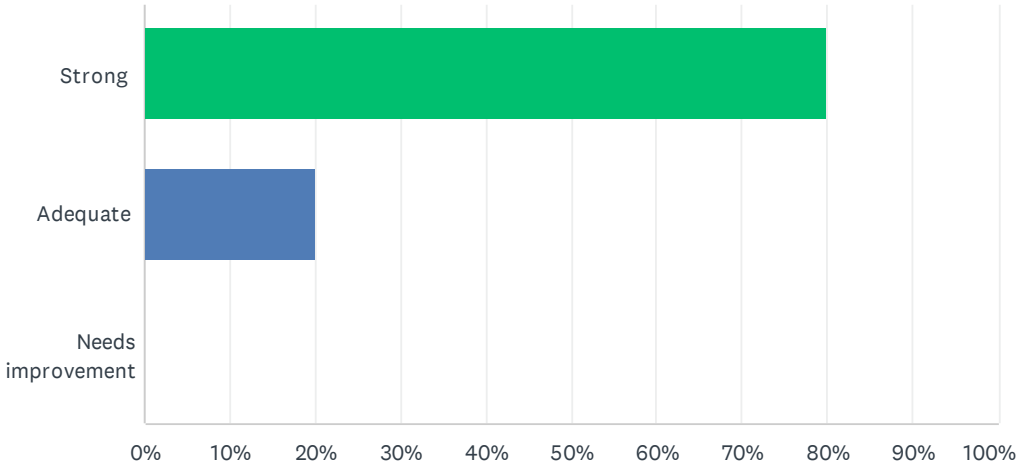
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	100.00%	10
Adequate	0.00%	0
Needs improvement	0.00%	0
TOTAL		10

Q2 The Board was active in its consideration of Committee composition.NHS Handbook status: 2 - should do

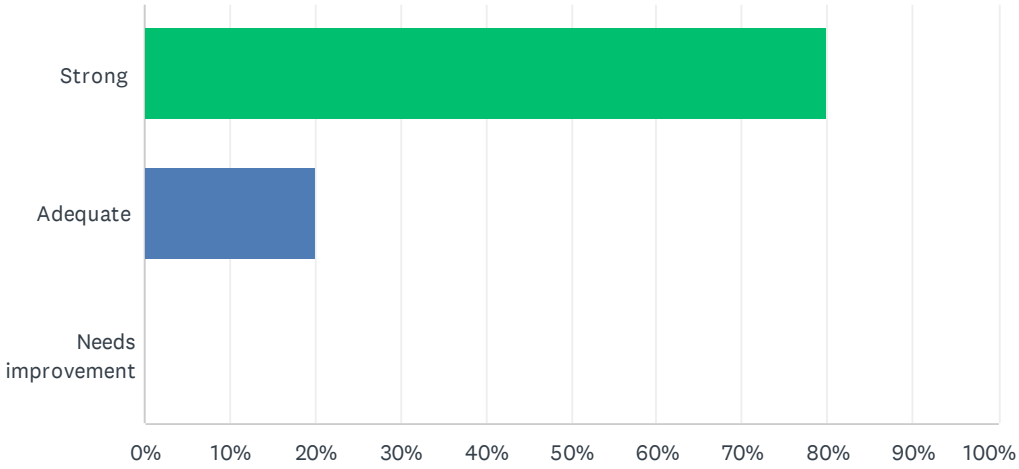
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	80.00%	8
Adequate	20.00%	2
Needs improvement	0.00%	0
TOTAL		10

Q3 The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

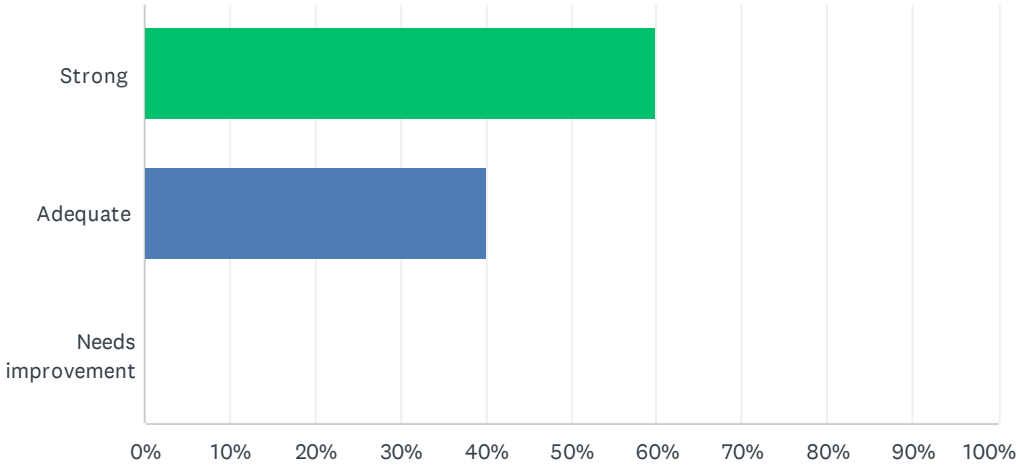
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	80.00%	8
Adequate	20.00%	2
Needs improvement	0.00%	0
TOTAL		10

Q4 The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.NHS Handbook status: 2 - should do

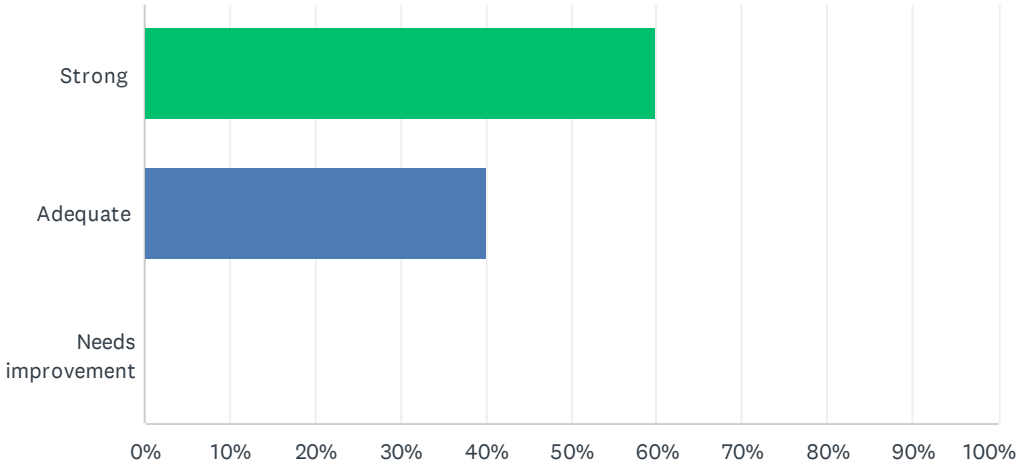
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	60.00%	6
Adequate	40.00%	4
Needs improvement	0.00%	0
TOTAL		10

Q5 Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.NHS Handbook status: 2 - should do

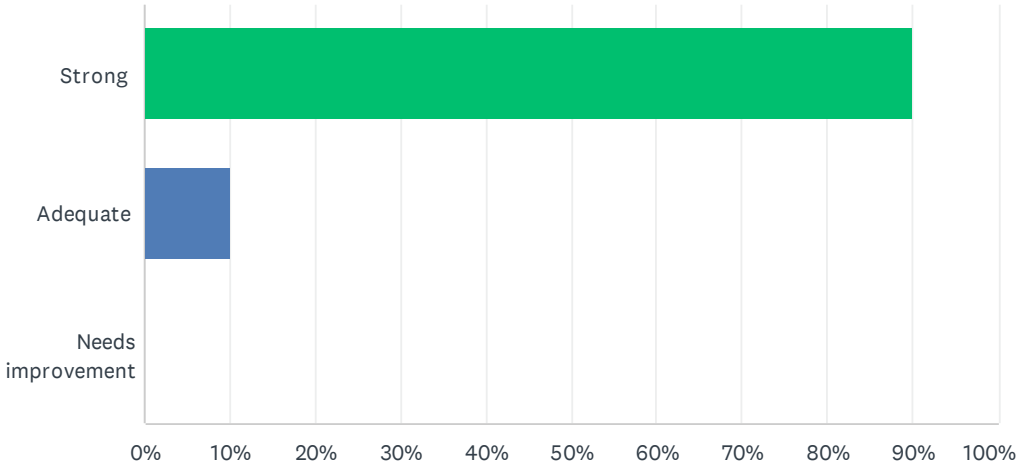
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	60.00%	6
Adequate	40.00%	4
Needs improvement	0.00%	0
TOTAL		10

Q6 Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.NHS Handbook status: 1 - must do

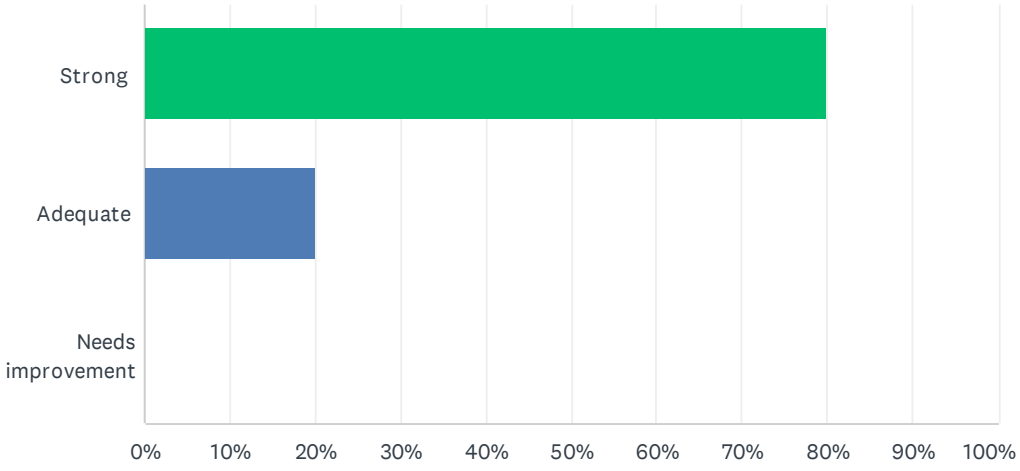
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	90.00%	9
Adequate	10.00%	1
Needs improvement	0.00%	0
TOTAL		10

Q7 The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.NHS Handbook status: 2 - should do

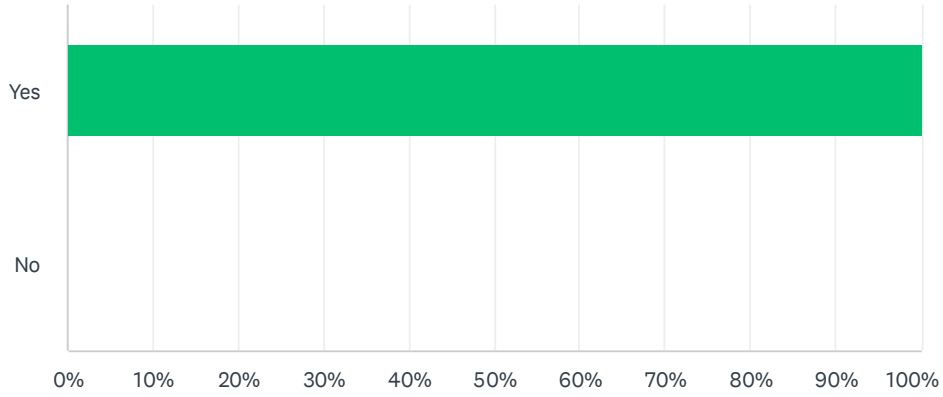
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	80.00%	8
Adequate	20.00%	2
Needs improvement	0.00%	0
TOTAL		10

Q8 Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?NHS Handbook status: 2 - should do

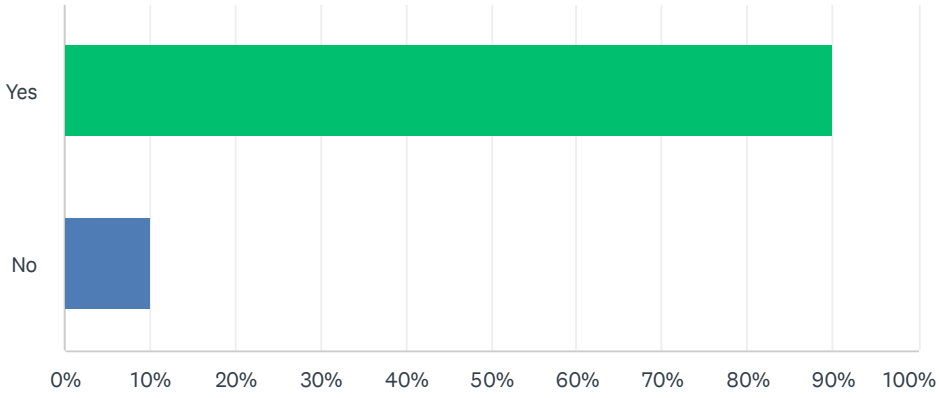
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	10
No	0.00%	0
TOTAL		10

Q9 Are changes to the committee's current and future workload discussed and approved at Board level?NHS Handbook status: 2 - should do

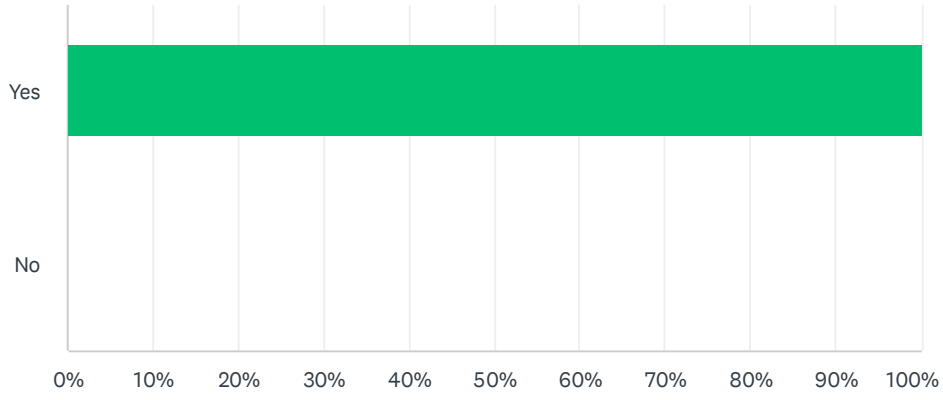
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	90.00%	9
No	10.00%	1
TOTAL		10

Q10 Are committee members independent of the management team?NHS Handbook status: 1 - must do

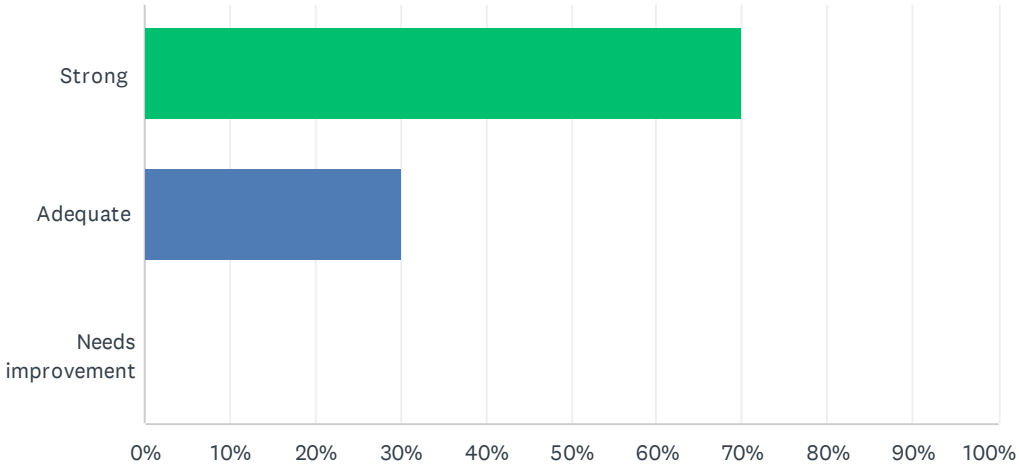
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	10
No	0.00%	0
TOTAL		10

Q11 The Committee agenda-setting process is thorough and led by the Committee Chair.NHS Handbook status: 2 - should do

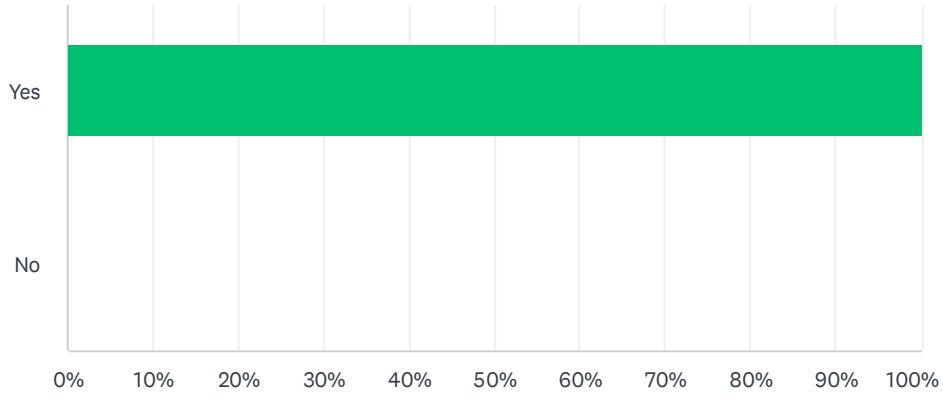
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strong	70.00%	7
Adequate	30.00%	3
Needs improvement	0.00%	0
TOTAL		10

Q12 Has the Committee established a plan for the conduct of its work across the year?NHS Handbook status: 2 - should do

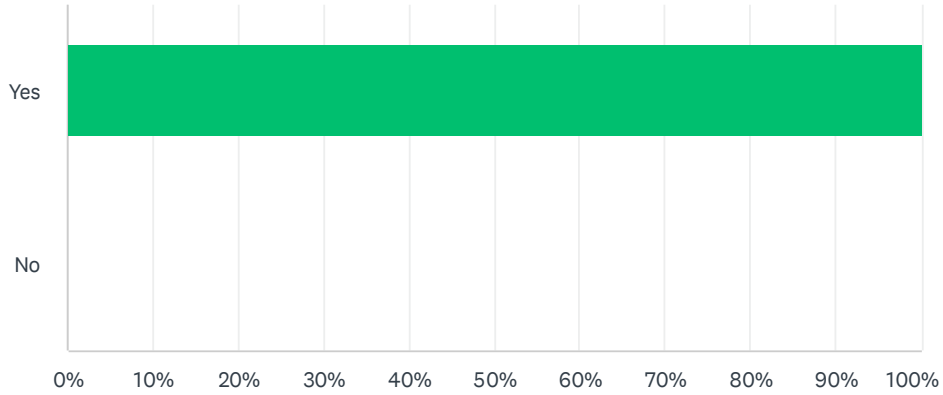
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Q13 Has the committee formally considered how its work integrates with wider performance management and standards compliance?NHS Handbook status: 2 - should do

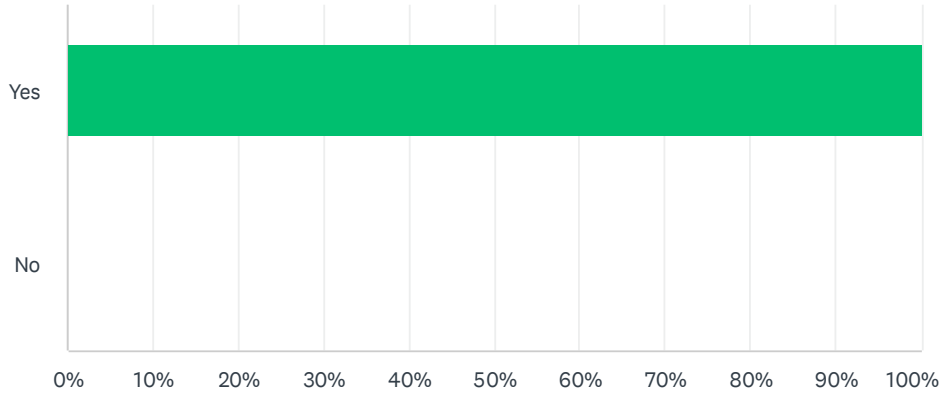
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Q14 Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?NHS Handbook status: 2 - should do

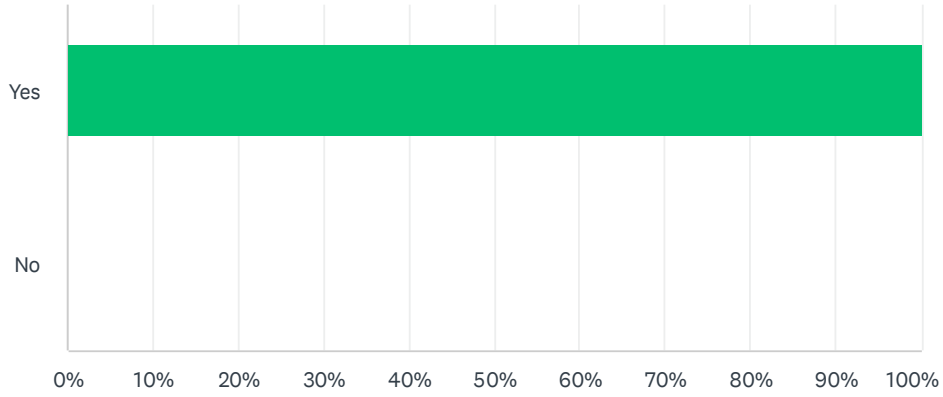
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Q15 Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?NHS Handbook status: 2 - should do

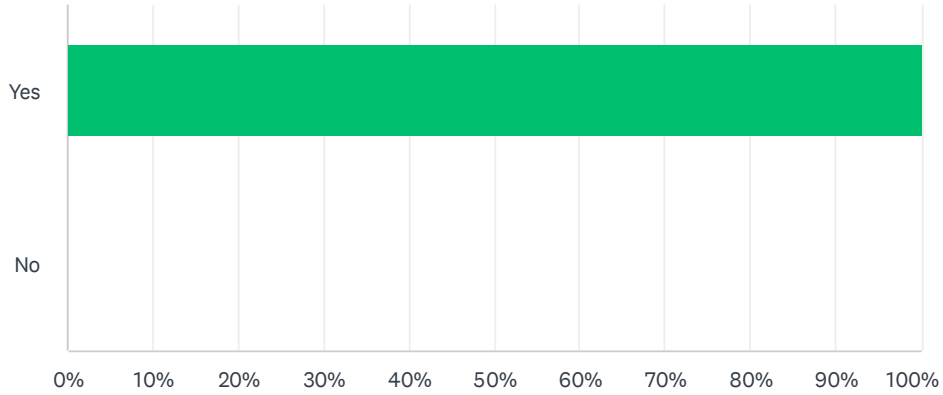
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Q16 Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?NHS Handbook status: 2 - should do

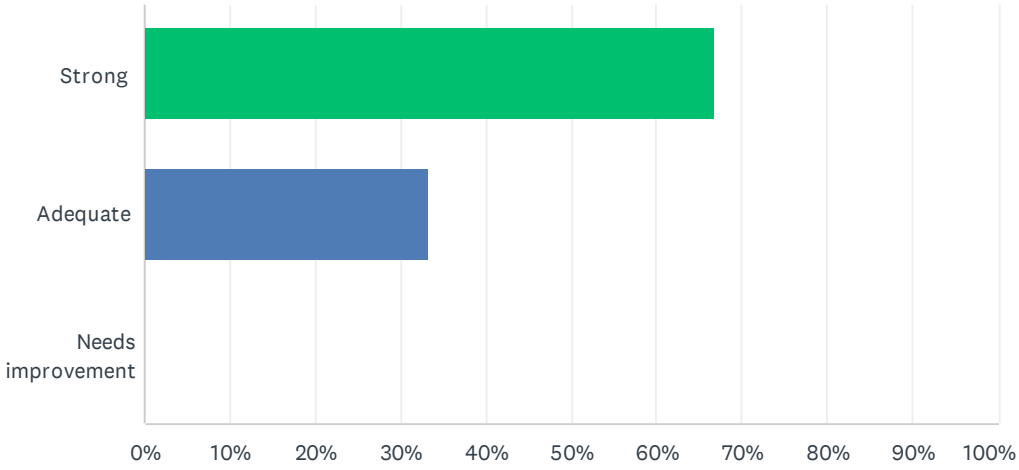
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Q17 The committee's self-evaluation process is in place and effective. NHS Handbook status: 2 - should do

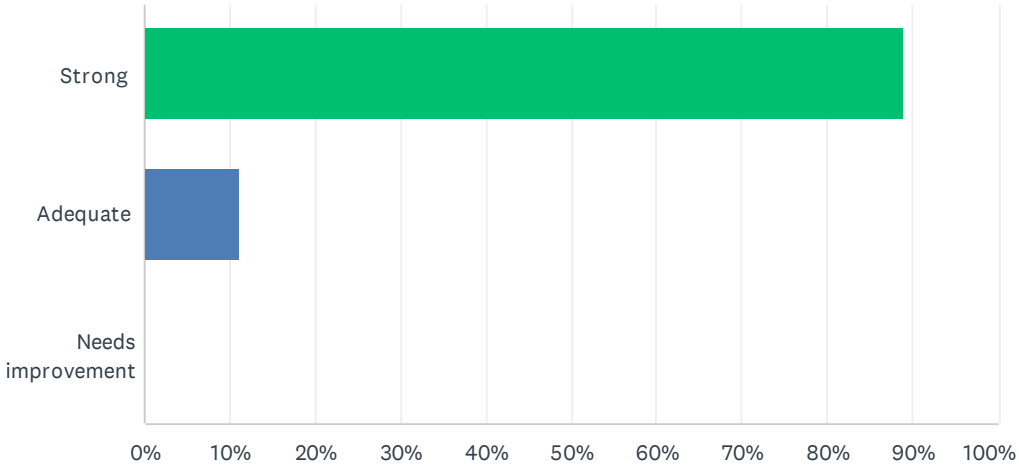
Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strong	66.67%	6
Adequate	33.33%	3
Needs improvement	0.00%	0
TOTAL		9

Q18 What is your overall assessment of the performance of the Committee?

Answered: 9 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strong	88.89%	8
Adequate	11.11%	1
Needs improvement	0.00%	0
TOTAL		9

Q19 Additional Comments

Answered: 0 Skipped: 10

Q20 Name

Answered: 6 Skipped: 4

Q21 Position

Answered: 6 Skipped: 4

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 22nd February 2022, 8.30am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJONES), Director of Nursing Ashleigh Trowill (AT), Service Manager CYPFHS Directorate Abigail Holmes (AH), Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Clare Rowntree (CR), Clinical Board Director Natalie Vanderlinden (NV), Designated Education Clinical Lead Officer (DECLO) Louise Waughington (LW), Associate CNS Infection Prevention Control Janice Aspinall (JA), Staff Side H&S Representative Emma Davies (ED), Interim Risk Midwife Paula Davies (PD), Lead Nurse CYPFHS Directorate **In Attendance** Annie Burrin (AB), Patient Safety and Organisational Learning Manager Nitin Goel (NG), Consultant Neonatologist Elisa Smit (ES), Clinical Lead Neonatology	
1.2	**Apologies for absence** Kirsty Hook, Angela Jones, Martin Edwards, Cath Wood, Anthony Lewis, Karenza Moulton, Kylie Hart, Rhodri John, Suzanne Hardacre	
1.3	**To approve the Minutes of the previous Q&S meeting held on 25th January 2022** The minutes of the meeting were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 25th January 2022** The action log was updated and actions closed accordingly. Updates were provided on the remaining open actions as follows: **Estates Update – Rainbow Ward** Update report still awaited. **Business Continuity Update** Plans awaited in readiness for the next Q&S Meeting scheduled for 22nd March 2022	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Update on Neuraxial Project** Cathy Morley Jacobs has provided an update at the O&G Directorate Q&S Meeting and discussion has been held with the Clinical Board. There was discussion with regards to ordering some consumables prior to the end of the financial year, however it was noted that there are difficulties with collating required information for ordering and supply chains are very fragile. Delivery suite is in very advanced planning with regards to the epidural pumps and QA process in pharmacy is affecting Paediatric Oncology which is currently at 84day process and difficulties in accessing the consumables. It is anticipated that the go live date for Neuraxial will be	

	September 2022. Contact made with all ward managers within CHFW to create their lists and the quantities required for changeover days so that when access is available progress can commence. Discussions have taken place with regards to storage of stock and work is continuing to confirm this. Off licence use of spinal needles is also being reviewed, however noting that this doesn't affect C&W Clinical Board as much as other areas. It was noted that once accurate lists are received, the team will be able to confirm the cost increases expected.	
2.2	**Presentation - UHW - NICU annual report 2020** The annual report was shared for information. Outline was provided with regards to the information within the report. It was noted that 2020 was a challenging year specifically with regards to staffing, resources and space rearrangements however the unit maintained its capacity for 32 funded cots, however noting that cot capacity continued to exceed recommended capacity. The cot capacity occupancy threshold figures of funded cots (70% BAPM recommended, 80% WHSSC) was shared where it was noted that occupancy threshold has been exceeded year on year for the last 5 years. The neonatal patient flow within UHW was shared, and there is significant movement between special care cots and transitional care. It was noted that if there were neonatal nurses within transitional care, there is the scope of early discharges allowing the babies to remain in transitional care, rather than needing to be transferred to the neonatal special care cots. Babies being transferred from transitional care impacted on the number of infants who were refused care due to unavailability of cots. Preliminary 2021 data was shared, noting that whilst there was reduced cot capacity from June 2021 from 32 – 25 cots due to staffing shortages, occupancy remained quite high. There are a number of governance and research activities undertaken within the Unit, and education and training are well established. The ongoing, high cot occupancy, specifically critical care remains a challenge for accommodating local population, surgical cots and the wider Network highlighting the need for further medical/nursing workforce planning and funding. Discussion ensued with regards to patients in critical care and whether they are staying longer than required if they could be moved into a transitional care/special care setting if there was adequate nursing support available. It was clarified that the data presented was the babies that required critical care and noting that due to continued high demand, there is also a need to increase the critical care capacity further. Every baby recorded is based on the care required, not the bed that they are occupying. There was discussion with regards to the infection rates, and it was noted that this is an ongoing issue which is linked to capacity and staffing. The transitional care model within Cardiff is wholly midwifery led, which is not BAPM compliant as this should be a nurse led service, which can add to delay of discharge. The model should consist of a lead Band 6 neonatal nurse, and x2-4 neonatal nurses supporting the midwifery and nursery nursing staff. It was noted that a pilot was undertaken previously with x2 neonatal nurses supporting the unit and this was a positive impact. Further discussions will take place outside of the meeting with the unit and the Clinical Board with regards to operational pressures and funding.	**AJONES/CR**
2.3	**Patient Story – Ollie's Story - https://youtu.be/O5RqJ0_xM0w**	

	The YouTube link to the story was noted, it was agreed that this would be deferred to the next meeting for further discussion and sharing of any lessons learnt.	**KH**
2.3	**Health and Care Standards – Exception reporting of key areas from Directorate QSE Reports (including any required escalation of key QSE issues)** **CYPFHS Directorate** The report was noted for information. The key exceptions were noted as: • Timeout for the Care Groups has been organised to review the communication between the management teams and the care group leadership teams going forwards • Healthy Child Wales programme compliance is low in some areas and weekend clinics are being arranged in order to increase this compliance and catch up on core contacts, which will be monitored closely • Fluenz programme has been completed with 60% overall uptake achieved, which is slightly below the national average. HPV programme has commenced. Debriefs have been arranged with staff and feedback will be shared. A small task and finish group is being developed to update the model in readiness for next year. • School nursing updates being provided on emotional mental health training and this is supported by CAMHS and Primary Mental Health team and young persons health hubs are continuing. • Recruitment to the Looked After Children's Team recently which is hoped will help the pressures currently being experienced due to vacancies within the team. Clinics are being provided at present to help support, however acknowledging that individual face to face appointments are offered where required. • Emotional Mental Health Care Group are reviewing internal risk processes including risk assessments and concerns • Development of SBAR for Transcribing Issues within Special Schools has been undertaken and it was agreed this would be shared at the next meeting. • Development of emotional mental health pathway and joint safety plan which is being piloted across the acute interface (including Emergency Dept). This is a positive piece of multidisciplinary work with local authority. • Increased volume of concerns being received. A cluster of concerns being received with regards to CCNS and a memorandum of understanding is scheduled to be shared outlining what can be provided in order to help manage expectations. • Vacancies across a number of services and further recruitment event is being considered within the next few months **Timely Access Update – CYPFHS** • Significant challenges in ND Waiting List – at the end of January 2022 there were 1186 patients waiting for assessment with the longest wait reported at 127 weeks. Reviews of SOP's for DNA's and a second waiting list validation exercise is being undertaken. Additional ND assessment clinics being implemented. • Primary Mental Health Waiting List – at end of January there were 106 patients and Part 1 compliance dropped to 51% which has been recovered to over 80%, however there has been a further increase in referrals received. Longest wait was at 8weeks which was an exception and average wait is usually around 29 days. • CAMHS – significant reduction in the waiting list due to the expansion of Helios from circa 500 patients waiting to 360 patients at the end of January. At present, there are 320 patients with a further circa 106 patients to come off the list. Longest wait for assessment was 46weeks which again was an exception, with the average wait being around 5months. • Continence service – at the end of January there were 809 patients waiting for assessment. Longest wait continues to rise and was recorded at 131weeks at the end of January. Successful appointment to the Clinical Nurse Specialist Team lead and work has been	

	undertaken with Bladder and Bowel UK Service who will provide training and review the roles within the team to build the Tier 2 service which is hoped will further reduce the waiting lists • Referrals for therapy services remain high and at the end of January there were 788 patients waiting for therapy services with the longest wait being 52 weeks for OT. 246 patients waiting for the service at 14 weeks and over. NV noted there has been a lot of activity with regards to impact of COVID, specifically within children and this is likely to impact services with regards to children presenting in schools with significant additional learning needs. Discussion ensued and there was acknowledgement of this and the unmet needs of these children which is extremely challenging and is being raised at the All Wales Professional Meetings. NV agreed to also raise through the DECLO route in order to further raise awareness with regards to the lack of opportunity that COVID has created. **Obstetrics & Gynaecology Directorate** • BFI assessment is due in March 2022 and work is progressing • Fetal Surveillance Midwife and Patient Safety Lead prepared an action plan and submitted to Welsh Risk Pool • Number of RCA's ongoing, 21 for Obstetrics (4 of which are NRI's) and 4 for Gynaecology, 13 timelines and 6 Birth Injury Tools. Ongoing issue with regards to Obstetric time allocation for RCA's and confirmed protected time has been identified from April 2022 which is hoped will further improve the position. • X1 unstageable pressure sore in Gynaecology which was deemed unavoidable. Learning has been identified with regards to risk assessments and documentation. Work is ongoing with the patient safety team and a study day has been arranged on 4th March 2022. • X1 fall reported in January 2022. All observations were normal, no harm caused and the patient was discharged home. • Hyponatremia Guideline is under construction and information has been shared within the clinical areas. The GAIN guidance is being used whilst this guideline is being developed. Internal audit presentations have been provided and discussion undertaken regularly through clinical supervision. • X1 Medicines Management incident reported with regards to diazepam instead of omeprazole. There was no adverse incident as the mistake was picked up by the patient prior to taking the medication. On investigation it was noted that the boxes are very similar and work is being undertaken by Pharmacy with regards to this and also how the medication is stored. All staff have been reminded of the requirement to check all medication before being given and all medication has been checked. • Neonatal drug error gentamycin given 12 hours following previous dose instead of 36 hours. Drug chart not checked thoroughly prior to giving medication. Escalated appropriately when error identified. Review undertaken and no adverse outcome noted. • Ongoing issue with return of blood traceability labels. • Ongoing issue with the maternity lifts, with retrospective Datix incidents being reported to outline the amount of times the lifts are out of action. A walkabout has also been undertaken with Estates to discuss some further issues including leaks, TDSI issues etc. AJONES noted that the issue with regards to the Maternity Lifts has been re-escalated to the Executive Team. AH noted that the service is permanently running at x2 lifts as the new lift hasn't been repaired for a number of months. • Ongoing effort to increase Mandatory training compliance. CTG stats are also improving and is currently at 79%. PROMPT training reported at 61%. • Research projects are ongoing. Gynae Research Nurse commenced in January and x2 full research midwifery posts commencing this month	**NV**

	• Digital referrals to midwife sonographers in place and working well. GTT requests will be digital soon and training databases in place for midwives and obstetricians. **Timely Access Update – O&G** • Electronic rota system being purchased • Move to T2 for Gynae Outpatients minor surgery has gone well • New Gynae suite plan is scheduled for 18th March • Benign Inpatient Waiting list – longest wait reported at 136weeks • 1267 patients on Gynae inpatient waiting list. • Oncology capacity v pre covid is currently at 87% • Benign gynaecology capacity pre covid is currently at 64% • In January there were 6 confirmed breach patients reported, with 8-10 breaches expected for February 2022. A paper has been submitted for investment in the Oncology service to include additional consultant and theatre capacity. • Cancer clinical psychology service has been reinstated • Concerns themes with regards to waiting times for endometriosis care, miscommunication and poor attitude, continuity of care identified and work is ongoing to address these concerns. **Children's Hospital for Wales Directorate** No update available.	
2.4	**Waiting Times Update (including Long Waiting Patients)** Covered as part of the Directorate report updates in 2.3.	
2.6	**New Risks to be considered for the Clinical Board Risk Register** No specific items to note.	
2.7	**HIW Unannounced Visits** It was noted that HIW unannounced visits have recommenced and all were asked to share for information.	
SAFE CARE		
3.1	**Update on Serious Incidents** No update available for the meeting	
3.2	**DATIX Open Incidents** **Latest Reported position** The latest queues report was noted for information. Reminders were provided to all with regards to the requirements of reviewing and closing as many incidents as possible in readiness for the implementation of the new system. **Incident Closure Guide** The incident closure guide was shared for information.	
3.3	**SI's/RCA's/Closure Forms for discussion** **In131700 Closure form – EC** Deferred	
3.4	**SI's/RCA's/Closure Forms for noting** It was noted that all the cases noted as part of the agenda have been discussed through the governance routes within the Directorate and also have been discussed in detail at the Extra Ordinary Q&S Meetings with regards to sharing of lessons learnt, and had been brought to this meeting for noting and any exception reporting as part of final ratification processes.	

	In148808 – AA The background to the case was noted and involved Baby AA being born by spontaneous vaginal delivery in poor condition at 35+5 weeks on 27/8/21, was transferred to the NNU and unfortunately passed away 4 days later. Antenatal care was between obstetrics and the fetal medicine unit due to a fetal cardiac condition. It was also noted that mum was covid positive on admission, and baby was also found to be weakly positive following birth. The root cause was identified as several missed opportunities to diagnose severe intrauterine growth restriction prior to labour. This resulted in a lack of appropriate monitoring and management of the pregnancy in the antenatal period. Had this happened baby A may have been born in a better condition with a better outcome. Recommendations from the case (taken from summary SBAR) identified; • The directorate must improve its system for the induction, supervision and mentorship of all junior doctors including MTI doctors that work in the department. The directorate should consider having educational supervisors that specialise in looking after one type of trainee for several years. MTI doctors have different needs compared to specialty trainees. By providing continuity to the supervision of MTI doctors the quality will be better. MTI doctors often start their employment in the health board at different times of the year to most junior doctors. The directorate must ensure the induction for MTI doctors mirrors induction in August when most junior doctors change jobs. • The directorate should review the RCOG/RCM self-assessment tool. Particularly 7.2 and 7.6, this will improve induction and provide assurance that appropriate induction for junior doctors is in place. The directorate must put in place a system to audit this. • The general antenatal clinic in UHW must work with the fetal medicine unit to ensure there is a robust and timely communication system in place. The department could explore the option of fetal medicine letters being sent to the antenatal clinic for review each week by clinicians rather than letters being sent to the named consultant via the secretaries. • Individuals involved in the care of AA should reflect on the importance of ensuring there is appropriate follow up in place for any patient they see. • FMU to consider having a standardised format to their letters and standardised approach to documentation with regards follow up arrangements. • The department must improve its system to ensure robust and timely follow up arrangements are in place for patients such as AA. Discussion ensued with regards to the training actions and it was noted that an action plan will be developed with the senior risk team and senior management in relation to taking the actions forward and embedding into practice. It was agreed that there needs to be a robust mechanism in place for regularly monitoring the training actions and appropriate feedback/evidence. Review of induction/GAP and Grow process is also being undertaken, as well as robust training records to ensure that this can be monitored. It was agreed that the action plan would be shared at the next meeting for completeness final and the case was approved for sign off. **In148159 – KS** The case involved a term baby born in poor condition following a forceps delivery. Mum was admitted with pre-eclampsia, and CTG performed which was suggestive of chronic fetal hypoxia. Baby required resuscitation following birth and responded well. Baby stayed with her mum in recovery and was noted to have persistent hypothermia despite adequate measures to warm her up. Her blood glucose levels were not checked until 4 hours of age despite persistent hypothermia. Baby was admitted to NNU at four hours of age due to severe hypoglycaemia. Unfortunately, baby passed away day 6 of life.	**ED**

	The root cause for the neonatal death was severe HIE secondary to a late antenatal / intrapartum event associated with severe pre-eclampsia. Baby responded unusually well to standard resuscitation. This contributed to a delay in recognition of the encephalopathy and initiation of treatment. Recommendations (taken from the summary SBAR) were noted as: • All aspirin assessments should be carried out with the woman to support patient centred care, shared decision making and reduce error. • All consultant appts should be by 16 weeks to allow time of addition of aspirin therapy if it has been missed, 'a safety net'. • All midwifery and medical staff are to familiarise themselves with the hypertension guideline and MEWS chart plotting AND management. • A robust, validated system of triage, such as BSOTS (The Birmingham Symptom Specific Obstetric Triage System should be implemented as soon as possible into the department). • Consideration to be given for all placentas to be kept for a minimum of 12/ 24 hours in a dedicated fridge on delivery suite, to ensure that they can be available for histopathology in the event of a neonatal admission in the first day of life. This will require purchase of a dedicated fridge and a change in practice. • WHO checklist – the neonatal team should be present for the WHO checklist and should receive communication from midwife and / obstetrician about the mother and the fetal monitoring. • All efforts must be made to ensure that babies remain normothermic following delivery • NICU team should document all steps taken during Resuscitation separately in the designated proforma. • The entirety of the cord blood gas result should be taken into consideration by the neonatal team, including lactate, haemoglobin and if available the sodium result. • Blood glucose should always be checked promptly if axillary temperature <36.0 degrees centigrade is identified. • Communication within the medical team needs to be clear at all times with clear designation of responsibilities and proper documentation about plans made Discussion ensued with regards to the practicality of storage of placentas for 12/24 hrs will be a challenge and will need to be thought through properly prior to implementation. There is also a need to ensure that consent is ascertained prior to sending for histopathology. Queries were raised with regards to practice elsewhere and whether our service is outwith current practices. A suggestion was made whether an expansion of current criteria is required (this baby suffered fetal distress so this could be included in the criteria) rather than a blanket storage of all due to potential impracticalities. AB noted in other areas the commencement of the hypoglycaemia protocol would prompt the need to keep the placenta, this could be something to be considered. AH/ED agreed to review all considerations. It was agreed that the action plan would be shared at the next meeting for completeness and the case was approved for sign off. **In148337 – LK** This case is not yet finalised and it was agreed that it would be deferred for discussion at the next Extra Ordinary Q&S Meeting. **In145992 – SP** This case involved an early neonatal death of a term baby following a placental abruption on the MLU. There were no concerns with regards to care provided from admission, throughout labour and following the birth. The root cause was noted as Severe Hypoxic Ischaemic	**AH/ED** **ED** **AH**

	Encephalopathy because of placental abruption in labour. It was noted that all learning was incidental and had no effect on the outcome. Recommendations (taken from the summary SBAR) were incidental as part of lessons learnt and would not have changed the outcome of this case: **Obstetrics** • Midwife A to reflect on her assessment of SP on the 17.7.21 • An audit to check compliance for obtaining umbilical cord gases as per local/national guideline and documentation when not obtained. • The incorporation of an Actim Prom test within the local UHB SROM guidelines to increase the sensitivity of detected SROM • Importance of clear and accurate documentation to be shared with Maternity and Obstetric staff • Clarification in Health Board guideline on place of birth for women who report one episode of reduced fetal movements, and subsequently report normal fetal movements when in active labour. • New midwives joining the Health Board to undergo Health Board intermittent auscultation within 1 month. **Neonatal** • Process to contact a neonatal consultant in an emergency via the 2222 call to be communicated to all staff in the obstetric and neonatal departments. • The Grab bag is to be recommissioned; it will have clearly labelled compartments to allow for easy location of equipment. This should include neonatal delivery resuscitation forms • The MLU should have a sealed resuscitation trolley kept in the same room as the resuscitaire. It should be identical and stocked to the same levels as the trolley that is taken to the CLU. This should include neonatal delivery resuscitation forms. The neonatal staff will check this trolley. • The neonatal resuscitation trolley should have both old and newer types of devices for inserting an intraosseous needle available and teaching needs to be arranged for neonatal staff on a regular basis. With regards to the SROM guidelines being updated, it was noted that this has been completed now and will be launched imminently. AH agreed to bring this back to the next meeting for noting and the case was approved for sign off. **In148517 – BO** This case resulted in early neonatal death of a term baby. Emergency admission to delivery suite via ambulance, Mum suffered an antepartum haemorrhage in a full-term pregnancy. There was an early decision for category 1 section under spinal anaesthesia due to low fetal heart rate (bradycardia). Unfortunately, despite full cardiopulmonary resuscitation and activation of the emergency blood protocol in delivery suite, the infant showed no signs of life for 23 minutes and passed away at 2.5 hours of age. The root cause - neonatal death resulted from a severe antepartum haemorrhage, which most likely occurred due to a placental abruption in an abnormally formed placenta and cord. The significant maternal bleeding resulted in fetal/neonatal anaemia and severe neonatal hypoxic-ischaemic encephalopathy. Despite prompt, adequate, and extensive resuscitation the infant did not respond for 23 minutes, and had signs of very severe encephalopathy and ongoing need for resuscitation at 30 min. Recommendations were incidental and would not have affected the outcome (taken from summary SBAR); **Maternal**	**AH/ED**

	• Positive emails to all clinicians/support workers involved in case regarding timely and appropriate delivery • Midwives on labour ward to be reminded to activate neonatal crash call if category 1 LSCS underway. • Use CTG in CTG teaching to discuss situations where the neonatal crash team should be called. **Neonatal** • Install Porter-Trac software on computer in labour ward theatre: issue to be raised with perinatal patient safety team. • SBAR style handovers and guidance on when to place emergency bleep to neonatal team already in place – reminders to be sent (Actioned 03/12/2021) • Drugs and fluids used (with correct intervals) in advanced neonatal resuscitation to be regularly revisited in neonatal simulation training. All neonatal staff attending deliveries is NLS trained. (Action: ongoing teaching / simulation program) • Location of scalpel in neonatal resuscitation trolley to be regularly revisited during neonatal simulation training (Action: ongoing teaching / simulation program) • Reminder to neonatal nursing and medical team to use the neonatal resuscitation proforma for all neonatal emergency situations where resuscitation is (expected to be) required There were no exceptions noted and it was agreed that this case was approved for sign off. **In116608 – FMB** This case involved a patient who experienced a bowel perforation 11 days after her elective caesarean section of her 2nd child. She required emergency surgery and a stoma formation. The patient had 2 readmissions with severe constipation following her elective caesarean section. On her 1st admission she was managed by junior obstetric staff for 3 days. There was a missed opportunity for a surgical review during this admission. While it is impossible to say with complete certainty this may have prevented the perforation. On her 2nd admission paralytic ileus was incorrectly diagnosed. There was a missed opportunity for a surgical review earlier in this admission. However, it is likely that on this admission it would not have altered the outcome. Recommendations (taken from the summary SBAR) from the investigation noted; • Reinforce the importance of Consultant Obstetric review and multidisciplinary involvement in all re-admissions and unusual clinical cases. • Consultant surgeon to provide educational session to discuss post-operative bowel function and management (to include monitoring of bowel movements). Discussion ensued with regards to whether a guideline is a required for management of constipation in this setting for readmission. It was agreed that that this should be considered for implementation into practice and this would be added to the final action plan. It was agreed that this case was then approved for sign off.	**ED** **ED**
3.5	**Learning from Events (LFE) for noting/discussion** **OF – CN/NOAH/4273** Deferred	
3.6	**Update Position on Lower GI Paediatric Surgery Cases** Concerns raised regarding quality & safety issues with lower GI surgery. The team have undertaken reviews and initially there were 13 cases identified, with x4 of these requiring external opinion to review whether the care received was appropriate and reasonable. These	

	reviews are progressing and it is anticipated that the reports will be received within the next 8 weeks and a further update will be provided following this. It was also noted that there were a cohort of patients who were claimed to be potentially lost to follow up. Work is progressing to identify if there is any significant harm that may have been caused. It was agreed that a summary position would be provided at the April 2022 meeting.	**AJONES**
3.7	**Infection Prevention Control Update Report** Report was noted for information. LW advised that there have been a number of months since the last case of MRSA which was in July 2021, last MSSA case was in November, last Pseudomonas case was September 2021, Klebsiella in September 2021, and last C Diff in December 2021. There are no outbreaks or increased incidents currently, with no specific concerns to report. Walkabouts continue within Maternity and Paeds. Visor use is increasing. X4 Audits have been completed within Child Health. Some small issues raised with the ward managers which have now been resolved. It was reiterated that if there is a positive LFT on an a-symptomatic staff member isolate for circa 5 days, they don't require a PCR follow up, just negative LFT on day 5 and 6 and can return to work. PCR is only required following isolation if staff member is symptomatic. RCA investigations are progressing. Work is ongoing to finalise the outstanding reports to completion. IP&C attended the recent walkabout within Maternity last week and the lifts were highlighted, including damage to one which required rapid escalation. Discussion ensued with regards to a non-hospital acquired C Diff case of member of staff and how this needed to be managed for return to work. LW agreed to link in with Midwifery led Unit.	**LW**
3.8	**Safeguarding** **PRUDIC Cases** X1 recent case within the community where the PRUDIC process is progressing. Support is being provided to the school and also the school of the sibling. Date awaited for an inquest on a further case and request has been made for attendance to discuss the RCA investigation. Queries were raised with regards to involvement in cases and it was noted that it is usually if the young person is known to the services. **Information Booklets** Shared for information and onward sharing. **Network Communication – Review of Child Suicides in Wales & Support Information available** Shared for information and onward sharing and raising of awareness. **Ending Child Physical Punishment** Shared for information and onward sharing. Further launch information is awaited.	
3.9	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** **CEM/CMO/2022/06 - COVID-19 Therapeutic Alert - Palivizumab passive immunisation against respiratory syncytial virus (RSV) in at risk pre-term infants** Noted for information and has been shared widely across the Clinical Board.	

	CEM/CMO/2022/03 - Seasonal influenza - Actions for Wales Noted for information and has been shared widely across the Clinical Board. Walk in flu vaccination clinics are still available to all staff. All were asked to encourage staff to attend. **SHOT/2022/001 Preventing Transfusion Delays** Noted for information and has been shared widely across the Clinical Board. **Use of EIDO Leaflets and WRP Claims** Welsh Risk Pool are insisting the use of the EIDO leaflets, however it was noted that concerns have been raised as to the accuracy of some of the information included which has been shared.	
3.10	**Learning from January 2022 Falls Review Panel** Noted for information	
INDIVIDUAL CARE		
4.1	No items to note	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**Risk Assessment and Flowchart for staff identified as a contact of a positive COVID-19 case** Noted for information and onward sharing.	
5.2	**WAST patient care record becoming an electronic version - Significant changes from 24th January 2022** Noted for information and onward sharing.	
5.3	**Welsh Government Learning Disability Action Plan 2021-2026 - Consultation and Engagement** Noted for information and onward sharing.	
5.4	**Welsh Sexual Assault Service Programme National Learning Event March 2022** Noted for information and onward sharing.	
5.5	**MH Support to Young People** https://gov.wales/new-look-online-support-launched-providing-mental-health-support-young-people Noted for information and onward sharing.	
5.6	**WG Tobacco Control Strategy and Delivery Plan Consultation - C&V UHB response** Noted for information and onward sharing.	
ANY OTHER BUSINESS		
	C1 Gynaecology Situation becoming increasingly difficult to manage. Support is being provided where possible from maternity with regards to HCSW and occasional nursing support, however it was acknowledged that this remains challenging. AJONES noted that a meeting is scheduled to take place outside of the meeting to review this and look to implement some interim measures to support this.	
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 18TH MARCH 2022

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Suzanne Rees	Clinical Board Lead Nurse
Bolette Jones	Head of Medical Illustration
Gareth Jenkins	Deputy General Manager, RMPCE
Jonathan Davies	Health and Safety Adviser
Robert Bracchi	Medical Advisor to AWTTC
Sian Jones	Operational Service Manager
Nadia Hodge	Physiotherapy (attending for Jackie Sharp)
Nia Came	Head of Adult Speech and Language Therapy
Joanne Jefford	Dietetics (attending for Judyth Jenkins)
Claire Fudge	Occupational Therapy (attending for Kim Atkinson)
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Timothy Banner	Head of Patient Services
Seetal Sall	Point of Care Testing Manager
Jo Fleming	Quality and Safety Lead, Radiology
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Alicia Christopher	General Manager, Radiology and Medical Physics/ Clinical Engineering
Mathew King	Assistant Director of Therapies/Head of Podiatry
Tracy Wooster	Sister, Outpatients

Apologies:

Sandeep Hemmadi	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Lesley Harris	Professional Head of Radiography UHL
Becca Jos	Deputy Director of Operations
Kim Atkinson	Acting Head of Occupational Therapy
Rhys Morris	CD&T R&D Lead
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
Jacqueline Sharp	Acting Head of Physiotherapy
Judyth Jenkins	Head of Dietetics
Paul Williams	Clinical Scientist, Medical Physics
Emma Cooke	Clinical Director of AHPs

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 22/069 Welcome and Introductions

Sue Bailey welcomed Suzanne Rees, Clinical Board Lead Nurse, to the meeting and introductions were made.

CDTQSE 22/070 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 22/071 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 15th February 2022 were **APPROVED.**

CDTQSE 22/072 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

Discussions have been held between Pharmacy and Physiotherapy. It was agreed that a policy was not required and Pharmacy agreed to provide Band 7 Pharmacist sessions to Physiotherapy for operational support to implement non-medical prescribing.

CDTQSE 22/040 Schedule for Patient Stories

Sue Bailey to produce a schedule for directorates to present patient stories to this group.

Action: Sue Bailey

CDTQSE 22/054 Air Handling Unit Issues

Progress is being made to address the air handling unit issues with Estates and currently awaiting delivery of parts for a number of services.

CDTQSE 22/054 Toxicology Laboratory Lift

The disabled lift requires urgent repair and is awaiting a callout of an engineer. The main lift has been repaired and is safe to use, however it is now reaching end of life and will be condemned in the next 6-12 months. The toxicology laboratory based on the 4th floor requires this lift to be continually operational to assist in the movement of heavy canisters. A risk assessment has been undertaken and the risk has been added to the directorate risk register. Jonathan Davies agreed to escalate the issue.

Action: Jonathan Davies

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 22/073 Patient Story

There was no patient story presented at today's meeting.

CDTQSE 22/074 Feedback from UHB QSE Committee 14th December 2021

The UHB QSE Committee noted that the Health Board is reporting a significant increase in the number of concerns received.

Feedback from HIW inspections was noted and it was reported that there have been incidences of staff reporting discrimination in the workplace. The Clinical Board is investigating concerns raised within this Clinical Board. The concerns are anonymous therefore work will be undertaken in terms of a listening exercise.

CDTQSE 22/075 Health and Care Standards

Nothing to report.

CDTQSE 22/076 Risk Register – Review and Revision

AWTTC have updated their risk register in line with the Clinical Board risk assessment procedure.

CDTQSE 22/077 Exception Reports

Gareth Jenkins reported an incident in the Dexa service relating to a user error that resulted in the loss of patient images. The clinical information can be regenerated so patients will not need to be re-scanned. A Datix incident has been submitted and an investigation has commenced, but it is unclear if this incident is reportable. The department will escalate the issue to the Information Governance department.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 22/078 Initiatives to Promote Health and Wellbeing of Patients and Staff

A lot of wellbeing information is available in the Team Brief slides. If anyone would like to receive this information to contact Sian Jones.

Sue Bailey noted that March is Sleep Month on the wellbeing calendar.

SAFE CARE

CDT QSE 22/079 Concerns and Compliments Report

In February 2022, the Clinical Board reported an Amber/Green status.

It received 22 concerns and resolved 50% through early resolution. There were no breaches in response times and 4 compliments were received. No departments reported a Red or Amber status with the majority of departments reporting an Amber/Green status.

Areas to highlight reporting a green status were Physiotherapy. The department received 7 concerns and resolved 57% through early resolution and received 3 compliments.

Occupational Therapy received no concerns and received 1 compliment.

Podiatry received 1 concern which it resolved through early resolution.

Difficulties arranging/cancelling appointments is the key theme of formal concerns however there has been an increase in concerns relating to poor staff attitude.

Sue Bailey encouraged directorates to share their compliments.

CDTQSE 22/080 Patient Safety Incidents

The Clinical Board has 1 open NRI involving a trainee in Radiology.

Welsh Risk Pool's Learning Advisory Panel

The Welsh Risk Pool newsletter was circulated. Incidents that have occurred across Wales that are of particular interest to this Clinical Board relate to inappropriate access of relatives' electronic records by a staff member, a wrong address on a patient letter being sent out and vaccination consent.

Falls Review Panel Infographic

There is a link in the document relating to information on older adults de-conditioning and incidents in the outpatient setting relating to brakes being applied on wheelchairs.

CDTQSE 22/081 New NRIs (National Reportable Incidents)

Jo Fleming reported on a new NRI relating to a delay in a CT report that resulted in a patient suffering significantly with disease progression due to the delay. An initial meeting has been held to discuss the incident. Sue Bailey asked for departments to consider a suitable volunteer to take on the role of Investigating Officer for this incident, who is external to Radiology.

Action: All

CDTQSE 22/082 Patient Safety Alerts

ISN 2022 Feb 001 Medicines Management and Student Nurses

The alert has been circulated for information. Radiology has student nurses and confirmed compliance with the notice.

ISN 2022 Mar 002 Risk of Burns when Warming Skin

Compliance was received from departments.

CDTQSE 22/083 Medical Device Risks/Equipment and Diagnostic Systems

Edward Chapman advised that Clinical Engineering are working closely with Estates, Endoscopy and IPC Team with support for ultraviolet filtration units. There are 2 types in use, UVC and HEPA filter units. There was a problem with the UVC units linked to the wiring and they had to be taken out of use which caused issues for Endoscopy as they run lists on weekend. The HEPA filter units are now being utilised and the issue has been raised to the IP&C Team.

He also reported that a new Estates Ventilation Group has been set up in the UHB.

CDTQSE 22/084 IPC/Decontamination Issues

Sue Bailey noted that the next IP&C Group meeting will be held next week.

Radiology reported that there has been an increasing number of incidences where relatives of patients in maternity are refusing to wear face coverings. A Datix incident has been submitted where a relative became aggressive when asked to wear a mask. The UHB is clear on instructions that relatives are required to wear masks and Sue Bailey will escalate the issue to the IP&C group and try to identify if this is also occurring in other areas in the Health Board.

Action: Sue Bailey

Tracy Wooster noted that in Outpatients any incidents where individuals become challenging when asked to wear a mask are recorded on the Datix system.

CDTQSE 22/085 Point of Care Testing Issues

Seetal Sal reported on the roll out of a new procedure for decontamination for point of care testing equipment for Covid. This relates to a technique involving a deep clean and environmental swabbing on equipment to ensure devices are thoroughly decontaminated and there is no risk of contamination carry over. Sue Bailey would be keen to understand the outcome this new procedure and she will feedback to the IP&C Group.

Action: Sue Bailey

Seetal Sall reported on lateral flow testing in Integrated Medicine at the last meeting and concerns that the tests being used for staff was also being used on patients. Following an investigation it emerged that care homes, local authorities and infectious diseases consultants had taken an internal decision for this practice to be implemented as guidance was unclear at that stage. This practice is now not being undertaken.

CDTQSE 22/086 Safeguarding Update

Sue Bailey reported that a peer review around consent is being undertaken within the Health Board and Interventional Radiology has been selected as an area that will be involved.

CDTQSE 22/087 Health and Safety Issues

Edward Chapman reported on the ongoing safety issues at Field Way and that quotes are needed from Estates for CCTV and exterior lighting to be put in place. Jonathan Davies will request an update.

Action: Jonathan Davies

Sue Bailey suggested a risk assessment is undertaken to support this issue.

Action: Edward Chapman

Sue Bailey reported on a RIDDOR in Public Health Wales relating to a member of staff that slipped on the wet ramp by Jubilee Gardens on their way to the Staff Haven. It was noted that there were a number of other incidents of slips in this same area and prompt action was taken.

A RIDDOR was also reported in Clinical Engineering relating to a member of staff trying to restrain equipment from falling. . Procedures in the department have been updated to address this issue.

CDTQSE 22/088 Regulatory Compliance and Accreditation

Sue Bailey reported that there is good compliance against the regulatory metrics.

UKAS will undertaking inspections in Haematology and Cellular Pathology in the next few weeks.

The annual external BSI surveillance visit will be undertaken in Clinical Engineering in May.

It was agreed that the Clinical Engineering QMS minutes will be received at this group going forward.

CDTQSE 22/089 Policies and Procedures

There are no relevant UHB policies and procedures out for consultation.

CD&T Clinical Board Risk Management Procedure

The Clinical Board risk management procedure has been updated to reflect the review period of the risk register. The procedure was **APPROVED.**

EFFECTIVE CARE

CDTQSE 22/090 NICE Guidance

HST16 – Givosiran for treating acute hepatic porphyria

TA739 – Atezolizumab for untreated PD-L1-positive advanced urothelial cancer when cisplatin is unsuitable (commissioned by Velindre)

Both guidance documents are related to Pharmacy. HST16 was approved by the Corporate Medicine Management Group. It will not be used within Cardiff and Vale but is part of the Health Board's tertiary services for treating English patients and this is fully implemented.

Tim Banner advised that Atezolizumab is a drug that will come into the Health Board's formulary as part of arrangements with Velindre and Velindre will be commissioning this. This will not be implemented in Cardiff and Vale.

CDTQSE 22/091 Research and Development

The next Clinical Board R&D meeting will be held next week.

CDTQSE 22/092 Service Improvement Initiatives

Sion O'Keefe reported that the Outpatient Transformation Programme presented its plan for 2023 to the Operational Performance Group. There are 5 key workstreams:

- Advice and Guidance linked to referrals
- Patient initiated follow ups
- Validation
- Virtual consultations
- Outpatient clinical management and organisation.

To date focus has been placed on planned are and this will be broadened wider and to provide as much care out of secondary care as much as possible without impacting on Primary Care. This work incorporates the Phlebotomy service model looking at changing service delivery.

The Clinical Board Digital work is progressing. A review of work undertaken over the last 6 months has been undertaken. Good progress has been made on how digital initiatives aid care. Awaiting a decision on whether funding can be secured for further resource to continue and further support the digital work.

CDTQSE 22/093 Information Governance/Data Quality

The offsite records storage facility in Crickhowell was subjected to severe damage from flooding a few weeks ago. Pharmacy records from 17 years ago were affected and information of what was stored is being provided to the Information Governance Team. The plan is to move to an alternative facility and the Information Governance Team are coordinating this.

Letters are being sent out from the Medical Director to any staff who have accessed records relating to relatives. Letters have been sent to staff in Medical Records and managers are trying to establish whether this was for business purposes or if this is a HR matter. Sion O'Keefe asked if the Information Governance Officer could attend the next meeting to provide guidance around this issue. This was **AGREED**.

Seetal Sall reported that she received a query from Blood Transfusion relating to changing the configuration of their patient wrist band and moving to a new system. She is working with the team to link in with the system they are looking at moving to in terms of compatibility and engagement will also be made with the Patient Safety Team.

Sue Bailey reported that a change in EU was implemented where random fake names were generated for unknown patients rather than using the ID of patient unknown. There was an issue in Blood Transfusion where there were difficulties in ensuring the right patient was identified to receive blood. This implementation has since been placed on hold whilst there is consultation with stakeholders.

CDTQSE 22/094 Waste and Sustainability

A Green Group is being set up in the Clinical Board.

Sian Jones is working with the Cellular Pathology department on a green scheme looking at using vacuum packing, with the intention of reducing single use plastics.

DIGNIFIED CARE

CDTQSE 22/095 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

Nothing to report.

CDTQSE 22/096 Initiatives Related to the Promotion of Dignity

Nothing to report.

CDTQSE 22/097 Equality and Diversity

The Clinical Board Senior Managers are taking on Ally roles relating to the nine protected characteristics and Welsh Language and details have been circulated across the Clinical Board. Background work was undertaken with the former Equality Manager and this will be taken forward with the new Equality Manager. Sue Bailey clarified that the senior team do not have lived experience and the managers are not experts in the characteristics they will be aligned to but the aim is to support staff who make contact in relation to any issues.

The Clinical Board commissioned Values into Action videos and a pilot train the trainer session has been held. Directorates will be asked to nominate individuals in their teams who will be willing to receive and lead on the training.

The Clinical Board will also be promoting the Freedom to Speak Up route for staff to escalate issues within the Health Board but outside of their departments and the Clinical Board.

TIMELY CARE

CDTQSE 22/098 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 22/099 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Sion O'Keefe reported on waiting times performance for February. The number of patients waiting for diagnostics 8 weeks or over was 1883 which is a reduction of 595 from the previous month.

Patients waiting 14 weeks or more for Therapies was 2324 which was an increase of 66 from the previous month. It is anticipated that a downward trajectory will start to be reported over the new few months.

INDIVIDUAL CARE

CDTQSE 22/100 National User Experience Framework

Suzanne Rees will be taking forward patient experience work in the next year as part of her role.

Happy or Not reports are being undertaken in Outpatients at UHW and UHL.

STAFF AND RESOURCES

CDTQSE 22/101 Staff Awards and Recognition

The UHB Staff Recognition Awards are being held in April. Sue Bailey wished all the individuals nominated in the Clinical Board the best of luck.

CDTQSE 22/102 Monitoring of Mandatory Training and PADRs

Mandatory training compliance is 79.83%

The non-medical VBA rate is 33%. This needs significant improvement and VBA sessions need to be scheduled between managers and staff within directorates.

RECEIVED AND NOTED ITEMS

Biochemistry Quality Minutes February 2022.

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 14th April 2022 at 2pm 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 21ST APRIL 2022

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Becca Jos	Deputy Director of Operations
Bolette Jones	Head of Medical Illustration
Jamie Williams	Senior Nurse, Radiology
Lesley Harris	Professional Head of Radiography UHL
Robert Bracchi	Medical Advisor to AWTTC
Sian Jones	Operational Service Manager
Cath Marshall	Physiotherapy (attending for Jacqueline Sharp)
Nia Came	Head of Adult Speech and Language Therapy
Judyth Jenkins	Head of Dietetics
Chris Cheetham	Occupational Therapy (attending for Kim Atkinson)
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Alicia Christopher	General Manager, Radiology and Medical Physics/ Clinical Engineering
Ruth Alexander	Podiatry (attending for Mathew King)
Tracy Wooster	Sister, Outpatients
Rhys Morris	CD&T R&D Lead

Apologies:

Sandeep Hemmadi	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Suzanne Rees	Clinical Board Lead Nurse
Jonathan Davies	Health and Safety Adviser
Timothy Banner	Head of Patient Services
Kim Atkinson	Acting Head of Occupational Therapy
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
Jacqueline Sharp	Acting Head of Physiotherapy
Paul Williams	Clinical Scientist, Medical Physics
Emma Cooke	Clinical Director of AHPs
Seetal Sall	Point of Care Testing Manager
Mathew King	Assistant Director of Therapies/Head of Podiatry

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 22/103 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 22/104 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 22/105 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 18th March 2022 were **APPROVED.**

CDTQSE 22/106 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 22/040 Schedule for Patient Stories

The schedule will commence in August with a presentation from the Occupational Therapy Homelessness Service.

Action: Sue Bailey

It was noted that a presentation will be delivered on Sustainability in June.

CDTQSE 22/054 Toxicology Lift

Jonathan Davies has escalated the issue that the lift is reaching end of life to Estates. The issue has also been raised at the Clinical Board Health and Safety Group. This issue will remain open until actioned.

Action: Sue Bailey/Robert Bracchi

CDTQSE 22/084 Issues Around Relatives Refusing to Wear Masks

Sue Bailey has escalated this and noted that the Communications Team will be communicating a message to visitors and relatives on the UHB's public facing social media sites advising of the requirement to wear face masks when attending UHB sites.

CDTQSE 22/085 Decontamination Procedure for Point of Care Testing Equipment for Covid

Sue Bailey is awaiting information from Seetal Sall to feedback to the IP&C Committee.

Action: Seetal Sall/Sue Bailey

CDTQSE 22/087 Security Issues at Field Way

Ed Chapman has received another report from a member of staff working late in the building that youths had climbed onto the roof. As no quotes for a solution have been received yet from Estates he will request quotes from some companies.

Action: Ed Chapman

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 22/107 Patient Story

James Webb, UHB Information Governance Lead was welcomed to the meeting to discuss two issues pertinent to Information Governance.

UHBs across Wales are using a tool, National Intelligent Integrated Audit Solution (NIAS). This tool is integrated with all national systems and identifies any suspicious activity in terms of staff accessing records. Management Executive have agreed to focus on issues of staff accessing their own records, members of their family records or persons in the media's records. Any member of staff that have accessed these records will receive a warning letter from the Medical Director. The Medical Director will shortly be circulating a communication to staff. The aim is to bring the numbers of instances of this occurring down to a manageable level.

The question was asked whether the letters could be copied to the relevant Clinical Boards so that action can be taken at directorate level. It was noted that on receipt of a first letter, the Health Board at this stage does not wish for further action to be taken against an individual or for the letters to be placed on their personal files. It has also been recognised that the Information Governance and HR departments do not have the resources to support investigations for the number of cases that receive first letters.

Judyth Jenkins reported for information that Break Glass reports are sent to managers for staff who access test results and these are investigated to determine whether the result was appropriately accessed for work purposes.

The question was also asked if there have been any discussions with Trade Unions in terms of prevention. James Webb noted that discussions are taking place but he is unclear how far this work has developed.

It was noted that despite receiving letters there are repeat offenders. Line managers for these staff are being contacted for them to take forward action via the formal route.

The issue was raised around anonymous individuals inappropriately accessing records and whether there are plans to shut down generic accounts. It was noted that a risk-based decision has been made that there are limited situations where generic accounts are required due to implications for clinical care. Currently no users of generic accounts have been inappropriately accessing records.

A concern was raised around whether all line managers are taking a consistent approach in dealing with offending staff, as all staff should be treated fairly. HR have raised similar concerns however, complaints raised by family members or other members of staff via the Concerns Team route will lead to formal investigations. There are also cases that are more serious than others and it is reliant on an investigation to clarify this, and this is the area that the UHB is struggling to support. Whilst the UHB needs to move to a position where it can support investigations and deal with all staff equitably, at present this is not possible.

In terms of duty of care to the patient, the issue was raised whether patients are informed that their records have been accessed. James Webb responded that legally the UHB has to inform a patient if a data breach has occurred if this is a high risk to their right of freedom. However, the threshold is high and must outweigh the level of distress that this would bring to the patient. This is a case by case decision, looking at what information has been obtained and how that data may potentially be used.

Sion O'Keefe commented that in terms of consistency in approach for investigations, it would be helpful if Workforce could produce a checklist in terms of questions for managers to consider as part of their investigations. It would also be helpful if general communications could be produced for staff that highlights examples of where individuals have been prosecuted. This would help staff to understand the gravity of data breaches. James Webb agreed to feedback these suggestions.

As a preventative measure, Sue Bailey requested that managers ensure their staff are aware that there is active monitoring around access to records and they will receive a warning letter if they inappropriately access records; and that repeat offenders will go through a formal process. Staff also need to be reminded to ensure they have completed the Information Governance mandatory training module.

Action: All

The second issue James Webb raised related to a major flood that occurred in Crickhowell in February and affected a records storage facility in that area that was utilised by the UHB and resulted in the loss and damage of a number of different records.

During the UHB's investigation that was undertaken, it emerged that the supplier was storing notes in a poorly constructed build. Action was taken to enlist an alternative supplier and a list of the companies and contacts affected was produced. They will be contacted to inform them of the next steps and advise them of where their notes will be stored going forward. It was noted that there were a large number of procurement documents and validation forms that could have been destroyed anyway as they were beyond their retention scheduled and had very limited value.

Sion O'Keefe reinforced the point that with health records there are existing arrangements with other suppliers and he raised the importance of due diligence

that needs to be undertaken around the use of offsite storage facilities. He noted that a tender exercise for records storage is due to start in a number of weeks with Procurement and raised the importance of the considerations that need to be given when transferring from one location to another.

He advised that the Health Records Team undertake annual site inspections to the facilities that they utilise and can provide advice to other departments that store records offsite. Retention schedules are available but there is currently an embargo on the destruction of health records linked to the Infected Blood Enquiry.

Sue Bailey stated that the Clinical Board needs to seek assurance on what information directorates have stored offsite to ensure there is compliance and there is an inventory. James Webb suggested as a starting point that directorates review their information asset registers.

Action: All

CDTQSE 22/108 Feedback from UHB QSE Committee 22nd February 2022

The minutes of the UHB QSE Committee held in February 2022 were circulated.

There were updates regarding the health care standards, the duty of candour and national quality framework. No documentation has been formally circulated yet.

CDTQSE 22/109 Health and Care Standards

Nothing further to report.

CDTQSE 22/110 Risk Register – Review and Revision

Nothing to report.

CDTQSE 22/111 Exception Reports

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 22/112 Initiatives to Promote Health and Wellbeing of Patients and Staff

Sian Jones reported that the AftaThought train the trainer sessions which also includes Civility Saves Lives, have been set up. She has contacted directorates to nominate an individual to attend the sessions and roll out the training in their areas.

April is Stress Awareness Month and there are resources available for staff. The Employee Wellbeing marquee at UHL has been dismantled. Sian Jones has escalated this to the Employee Wellbeing Service and the Cardiff and Vale Charity as sessions had been planned in this area for April.

SAFE CARE

CDT QSE 22/113 Concerns and Compliments Report

In March 2022, the Clinical Board reported an Amber status. It received 33 concerns and resolved 30% through early resolution. There were 3 breaches in response times. 6 compliments were received.

Physiotherapy received 10 concerns and resolved 20% through early resolution It reported 3 breaches in response times. 2 compliments were received.

Radiology received 14 concerns and resolved 43% through early resolution.

Podiatry reported a green status. It received 1 concern and 4 compliments.

Difficulties arranging/cancelling appointments remains the key theme of formal concerns. A large number of these concerns relate to patients who have been unable to get through to a department to rearrange their appointment dates and therefore contact the concerns team. These cases are then being logged as concerns.

Alicia Christopher reported that DNAs are increasing in Radiology. This is possibly due to patients who have tried to contact the department and their call was not answered and they subsequently did not turn up for their appointments. To address this issue, Radiology has created a generic inbox for patients to contact if they are unable to contact the department by phone. This may also result in a reduction in the number of concerns received.

CDTQSE 22/114 Patient Safety Incidents

It was noted that the incidents listed on this month's report include incidents reportable to IRMER and blood related reporting but there are no NRIs.

CDTQSE 22/115 New NRIs (National Reportable Incidents)

There are no new NRIs to report.

CDTQSE 22/116 Patient Safety Alerts

MHRA Medicines Recall Olopatadine USV

This alert was circulated and noted for information.

Medicines Shortage Advisory Group: Medicine Shortage Clomifene 50mg tablets

WAPSU in AWTTC are part of the Medicines Shortage Advisory group and monitor the shortage of medicines in Wales. This alert was circulated and noted for information.

Medicines Shortage Advisory Group: Intermittent Supply Fesoterodine 4mg and 8mg until End of April 2022

This alert was circulated and noted for information.

CDTQSE 22/117 Medical Device Risks/Equipment and Diagnostic Systems

Physiotherapy are looking at an amnesty for walking aids and are looking for space in various areas around the Health Board where patients can drop off the equipment and where they can be refurbished and cleaned.

Podiatry have recently started using crutches that have not been used for a long time and there is ongoing communication regarding the cleaning of the items. It was requested that Podiatry are included in any correspondence.

Judyth Jenkins has been informed of a changeover in supplier of PH strips paper for testing placement of nasogastric tubes. A plan for managing the changeover and ensuring wards are aware is being produced. She raised concerns that this information was not received through an official escalation route.

It was noted Joint Equipment Store are currently low on staffing resources and are prioritising deliveries.

Ed Chapman raised concerns with space and capacity for storage in the Clinical Engineering department.

CDTQSE 22/118 IPC/Decontamination Issues

Judyth Jenkins has circulated a dietary advice letter from the UK Health Security Agency advising that vulnerable and pregnant patients should only consume smoked fish that is thoroughly cooked as there are links with uncooked smoked fish and listeria. The alert has been forwarded to the patient safety team, Children and Women Clinical Board and the IPC Team.

It was noted that UHB menus have been checked to ensure these foods are not served in the UHB. However, there are concerns that visitors may bring in smoked fish for relatives who are patients, so it is therefore important that the alert is cascaded.

Communication was circulated yesterday across the UHB advising that contacts of patients on the wards that are asymptomatic no longer need to be isolated but will need to be monitored to ensure they do not become symptomatic.

CDTQSE 22/119 Point of Care Testing Issues

Nothing to report.

CDTQSE 22/120 Safeguarding Update

No update to report.

CDTQSE 22/121 Health and Safety Issues

The minutes of the Clinical Board Health and Safety Group for April 2022 have been circulated. There were no issues to escalate.

CDTQSE 22/122 Regulatory Compliance and Accreditation

Positive feedback was noted from the UKAS inspections in Haematology Blood Bank and Cellular Pathology.

CDTQSE 22/123 Policies and Procedures

Nothing to report.

EFFECTIVE CARE

CDTQSE 22/124 NICE Guidance

NICE guidance relevant to this Clinical Board has been circulated to the applicable departments to respond.

CDTQSE 22/125 Research and Development

Rhys Morris reported that it was noted at the UHB R&D Group that a lot of the records damaged were historical research records.

There is a lack of capacity in Pharmacy and Radiology to undertake commercial clinical trials despite R&D direct funding.

The Clinical Board will hold another Research Forum when staffing pressures in departments improve.

Lesley Harris presented paper relating to a clinical trial in Neurosciences and Radiology. This is a new procedure relating to Huntingdon's disease that is new to Radiology. All checks have been undertaken with involvement from the IPC team for assurance purposes. All equipment has been purchased specifically for this procedure as it needs to be MRI compatible and the air exchange in the environment is compliant.

Lesley Harris is awaiting confirmation on whether the equipment for burr holes is single use as concerns have been raised around decontamination of the equipment. If single use there will be no issues, however if the items are reusable Mark Campbell, Decontamination Advisor will need to be contacted to ensure that the process in place for sterilisation of the kit meets the required standard.

It was noted that the Clinical Board is supportive of the clinical trial, with the caveat that the decontamination element is signed off.

CDTQSE 22/126 Service Improvement Initiatives

Sion O'Keefe reported that the UHB is taking forward Phlebotomy Services transformation under the guise of the Outpatients Transformation Programme. The plan is to extend services beyond this Clinical Board and into PCIC and GPs with a 3-year programme to deliver this. Recruitment and retention of Phlebotomists is an issue that needs to be addressed as the aim is for patients to have their bloods taken at a convenient location. As part of this consideration needs to be given in terms of the laboratories and how the work will be processed.

Funding has been secured for another six months to continue the work of the Digital Leads in the Clinical Board. Therapies are currently being supported with their digital strategy. Within the funding there is the option in principle to provide funding for subject matter experts with Office 365.

CDTQSE 22/127 Information Governance/Data Quality

Nothing further to report.

CDTQSE 22/128 Waste and Sustainability

Sian Jones reported that the Clinical Board Waste and Sustainability Group will be set up shortly to follow on from the UHB Green Group meeting.

A presentation will be provided from Pharmacy to the next Clinical Board QSE Sub-Committee meeting in June.

Sian Jones is currently working on a case study with Medicines Information on electric vehicles. The plan is that as more projects and case studies are worked up for the learning to be shared.

Ed Chapman noted that there are presently delivery date delays with orders on electric vehicles.

DIGNIFIED CARE

CDTQSE 22/129 HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans

Nothing to report.

CDTQSE 22/130 Initiatives Related to the Promotion of Dignity

Information has been circulated around Dementia Care with regards to the Read About Me work.

CDTQSE 22/131 Equality and Diversity

The Clinical Board SMT have allies aligned to the 9 protected Characteristics and Welsh Language and information pertaining to this has been circulated. It was

emphasised that the team are not experts in their field but will be seeking to promote their specific protected characteristic and offer support and signposting.

The Chair attended the last Clinical Board Allies meeting and was supportive of the Clinical Board's plans. Sion O'Keefe has met with Medicine and Children and Women's Clinical Boards to ensure the work in this Clinical Board is emulated across other Clinical Boards. There will also be networking arrangements put in place through the new UHB Equality Advisor. Further information will be forthcoming on the role of the Ally that will outline what is needed, what support is available and mentorship opportunities.

TIMELY CARE

CDTQSE 22/132 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 22/133 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

For March 2022 the number of patients waiting 8 weeks or more for diagnostics was 1511. This a reduction by half from October last year. Alicia Christopher thanked the directorate team for all their efforts. It was noted that recovery funding has been secured for this year to help improve this position further.

For Therapies, patients waiting 14 weeks or more was 3380. This is an increase of over 1000. There are considerable plans and actions in progress to start to reduce this number.

INDIVIDUAL CARE

CDTQSE 22/134 National User Experience Framework

The UHB is not currently issuing questionnaires.

'Happy or Not' consoles are being used in Outpatients and good results have been noted.

Suzanne Rees will be taking forward patient experience work over the next year.

STAFF AND RESOURCES

CDTQSE 22/135 Staff Awards and Recognition

The UHB Awards are postponed until July.

CDTQSE 22/136 Monitoring of Mandatory Training and PADRs

Mandatory training and PADRs are managed through directorate Performance Reviews. PADR compliance is low and needs to be an area of focus. Mandatory training compliance rate is positive at 79% compliance.

Managers to encourage their staff to undertake fire training which is a statutory requirement and the Information Governance module following today's discussion.

Action: All

RECEIVED AND NOTED ITEMS

Biochemistry Quality Minutes April 2022
Regulatory Compliance Group Minutes April 2022
Clinical Board Health and Safety Group Minutes April 2022

ANY OTHER BUSINESS

Cath Marshall raised an issue that if staff have a positive contact in their household they are being sent for a PCR test. Staff on wards are querying whether this is no longer required. Sue Bailey clarified that UHB specific guidance has been stood down and Welsh Government guidance is now to be followed. The guidance states that PCR testing should be undertaken for household contacts so this should continue.

It was noted that Physiotherapy are hosting a celebration event for staff next week.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 12th May 2022 at 11am via Teams.

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

Attendees:
Aled Roberts, Clinical Board Director
Jane Murphy, Director of Nursing, (Chair)
Diane Walker, Deputy Director of Nursing
Kath Prosser, Quality & Governance Lead
Annie Burrin, Patient Safety Org Learning, Patient Safety & Quality Team
Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team
Angela Jones, Resuscitation Senior Nurse
Jacqui Westmoreland, Senior Nurse, Covid Investigations
Claire O'Keeffe, Senior Nurse, Integrated Medicine
Dave Pitchforth, Lead Nurse, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Cathy Morley-Jacob, Consultant Paediatric Oncologist
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Maitrayee Choudhury, Consultant, Integrated Medicine
Nicholas Manville, Consultant, Emergency Unit
Marianne Jenkins, Consultant Nurse Practitioner, Acute & Emergency Medicine
Rhiannon Owen, Service Manager, Acute & Emergency Medicine
Aimee Williams, Safeguarding
Ceri Richards-Taylor, Lead Nurse, Integrated Medicine
In attendance: Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Iain Hardcastle, Director of Operations Sam Hughes, Practice Development Nurse, Integrated 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.	
1.2	**Maters arising** **NIV SBAR** – DP communicated with the Home Vent Team as required. **Pressure Damage** – KP to liaise with Sam Hughes to discuss further and to put additional measures in place regarding pressure damage. **Therapy Dog (Maggie) in ED** – will be in the unit Mondays at 10am for half an hour. Good feedback from patients. The dog is not allowed into Paeds. **Action: RO will advise at the next QSE meeting, how long this pilot will run for and how it will be evaluated.**	KP RO
1.3	**Patient Story** – delivered by Dave Pitchforth, Integrated Medicine	

	DP has met separately with two families of patient's who died of Covid. At both meeting, the patient's family members were grateful to have met with staff, not just been sent a letter. MS Teams has its place, however, meeting face-to-face also has its benefits and allows for conversations and questions to be discussed. Following meeting with family members in person, this should be followed up with a brief letter and a recording of the meeting.	
1.4	**Feedback from UHB QSE Committee** – papers are available on CAV intranet page.	
1.4	**Neuraxial Connectors are Changing** - delivered by Cathy Morley-Jacob (CMJ) In 2001 a 21-year-old patient died when IV was given through the wrong route. Other patients have come to harm through the wrong route/never events. Following an enquiry in 2001 recommendations included 'connector for spinal needs should not be Luer'. Partial roll-out has been possible, however, it has taken until 2022 to have all the devices available. Implementation takes place in September 2022 with the aim to reduce the risk of wrong-route errors. An ISO-standard neuraxial connector has been developed, NRFit. There are now different connectors for different routes: Clear – Intravenous route (Luer). Purple syringes – Enteral. Yellow plunger – Neuraxial. The change-over in MCB will be straight-forward. Areas using spinal needles have been identified. Spinal needles are used more widely across the Health Board. A Procurement colleague is now included in the team. The level of risk will reduce, although will never be zero. Need to identify where products are used, what products are needed and whether there are changes required beforehand, ward level support is required for roll-out. Need to minimise the cost. Kit is not to be ordered at present. **Action: let CMJ know if lumber puncture needles are currently being used for anything else.** A schedule of information will be sent to staff with relevant dates and will link in with Communications. **Action: AB will send the schedule of information to Dr Choudhury who will forward this to Dr Underwood for the lunchtime teaching session.**	ALL AB
1.5	**Directorate QSE minutes – exception reporting** Minutes have been received from Integrated Medicine and Emergency and Acute Medicine.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**WAST EPCR Process** – update delivered by Nick Manville WAST now use an electronic version of the Patient Care Record (PCR). The crew will match the demographic of the patient they have with them with the Welsh Demographic Service. The patient will have their ambulance crew record uploaded to Welsh Clinical Portal, labelled as A&E document and type: medical assessment. If the crew cannot match the patient, the Welsh demographic will not happen and the ambulance crew must ensure they print the record within 24 hours of arrival. If not, A&E staff have to access the ambulance crew system and print the record within 24 hours. At handover every crew are asked if their patient is matched or unmatched. If they are unmatched, print off the final copy of the EPCR to go into the patient notes. Once the crews close the record down it will be available on Clinical Portal. The imaging function within the EPCR is for WAST crew use	

	only, ED staff cannot see this. Check Welsh Clinical Portal if a patient cannot be matched, if still unfound, contact A&E who will arrange a print out. This update has been shared with consultants. **Action: NM will raise with WAST if communication is being spread widely in the community about this update and for the need for patients to provide accurate information.** For WAST to identify a patient, it would be good to have the patient's NHS number, however, not everyone knows this. Ambulance crews may attend patients who are not at their home address, so address must be checked.	NM
2.2	**Influenza update** The flu campaign has ended. MCB were 48.8% compliant. The target was not met by any Clinical Board. Next year, the flu campaign will be looked at differently to maximise vaccinations.	
2.3	**Healthcare acquired Covid investigations update** There is a lot of activity at local and national levels regarding Covid investigations. At a local level there is a significant rise across site in the UHB. 40 deaths have been investigated, 20 of these are from MCB outbreak wards. All deaths go to the Medical Examiner who provides reference to the cause of death. These cases continue to be reviewed and investigated. Completed investigations are taken to the Covid Scrutiny Panel who look to see if care was reasonable in the context of a pandemic. Nationally, Welsh Government (WG) request investigations be carried out at pace, funding has been allocated for additional resources/staffing. Where patients contracted Covid and died, these will require full investigation. WG advise investigation staff must communicate with families pro-actively and contact families once investigations are completed. Covid deaths in Care Homes and NHS funded care settings will take place, which adds an additional amount of work.	
2.4	**Healthcare fact sheet – Ending Physical Punishment in Wales** There is a change in law from 21/3/22 regarding physical punishment towards children.	
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**NRI update** – NRI's for closure **25 open NRI's 10 with Patient safety team for closure.** **In139676** - 93-year old man, living at home with his son, had a fall or trip in his garden. He was conveyed to A&E, had a CT head scan, then his GCS dropped. The diagnosis at the time was that of a seizure related fall. The patient was transferred to C6 and had a full consultant assessment on arrival. On 24/4/22 the patient had an unwitnessed fall at his bedside and staff found him on the floor, initially unresponsive. The CT scan showed significant head injury. The patient was referred to neuro surgeons and deemed not a candidate for surgical intervention. Conservative management was commenced and the family were informed. He was then placed on enhanced supervision. He had a further CT scan, his condition deteriorated and he was made 'not for resuscitation', he sadly died 2 days later. From statements it was clarified that the bed rails were down on both sides, were they should have been three quarter length. It could not be established however if this would have prevented the patient's fall. It was also felt that the patients history of a Glioma may have also contributed	

	towards the collapse/seizure. The patient's death was referred to the Coroner and the inquest is scheduled for later this year. **Learning** – documentation about bedrails. Audits continue as part of the key harms, audits are very important and helpful in providing information. The completion of lying and standing blood pressure in line with NICE 2015 post falls guidance and UHB best practice was another theme. All HCSW have attended study days. This will be rolled out for all Registered Nurses. **Action: KP to send AB the bed rails audit.**	KP
	In142288 - in May a 101-year-old man was admitted to UHW, he was agitated on admission and it was discussed for him to be transferred to Sam Davies Ward for ongoing rehabilitation. Secondary to the acuity on the ward at the time, given the patients agitation this was declined. The patient was then subsequently transferred out of hours (over a weekend) despite previously being declined. On transfer the patient was agitated, and staff recognised his increased risk of falls, and increased agitation around 'sun downing' therefore 1-2-1 supervision was put in place. On one shift, enhanced supervision could not be put in place, and the patient had a fall and sustained a fractured neck of femur which required surgical intervention. The patient died several weeks later secondary to a pneumonia, with the fall noted as part 2 of the death certificate. The root cause was the inability to provide 1-2-1 supervision. It cannot be known if this would not have attributed to the fall. **Learning** – the patient should not have been transferred out of hours. Line standing blood pressure was another theme but recognised that the patient may not have been able to comply with this process secondary to agitation. Consideration should also have been given to the completion of a DoLS as the patient was being nursed in a Kirton chair with a sensor mat which could be seen as a form of constraint.	
	In131321 – Integrated Medicine This took place during the first wave of the pandemic, where NRI's were not needed to be reported to WG. In November 2020 a lady admitted to C6 with a 2-week history of anorexia and abdominal pain. During her stay on C6 she acquired Pneumonia and difficulty swallowing, she deteriorated and contracted Covid required high levels of oxygen. On 22 and 23 December 20 she deteriorated further. Overnight on 23 December 20, it cannot be established when or why, the oxygen was turned off at the port. The patient was seen to be struggling at 7.30am and the patient passed away 5 minutes later. The patient was not well enough to turn the oxygen off herself and no patient on the ward was capable of doing this. The lady was 'not for resuscitation'. The patient had last received intentional rounding as documented at approximately 05:30am, so it is likely that the oxygen was flowing at this time. The investigation identified that there was no need for the oxygen to be turned off. Observations were completed at 2.30am, saturation noted, observations should have been repeated 4 hours later but there is no documentation to reflect that this was completed. **Learning** – nurses are not required to look at the oxygen port to ensure flow. The news chart is an All Wales chart, therefore, cannot be changed. Key messaging of safety issues has been added to safety huddles on C6. This is to be rolled out throughout the rest of MCB. Staff to be educated on ensuring the oxygen flow meter is at the correct level. A point to consider is: do HCSWs know how to check the oxygen flow metre and understand how many litres they are on. The intentional rounding tool asks for an environment check to be done, it does not ask if there is oxygen on the patient. This incident was also referred to the UHB Safeguarding Team for review with Strategy meetings held, with no further action required.	SC

	In152499 - health care acquired category 3 pressure damage. Pressure damage on a ward where it had not been identified previously. Investigation highlighted a missed opportunity to review pressure areas, the patient was incontinent, risk assessments were not completed in line with best practice. **Learning** – key harms audit put in place. Ward now have a pressure damage champion. **Update on NRI's** – as with pressure damage (60 days to investigate and then report to DU if avoidable) this will be the same for injurious falls now rather than 7 days. DU advises this is taking place from now. **Action: SC will ask Tara Cardew to request formal notification regarding this and forward to JM to discuss at DoN's meeting.**	
3.2	**Infection Prevention and Control update** 500 days since last MRSA bacteraemia 23 days since last MSSA bacteraemia 28 days since last *C difficile* 9 days since E. *Coli* bacteraemia 74 days since Pseudomonas bacteraemia 9 days since last Klebsiella bacteraemia **Outbreaks/ Incidents** - 10 incidents/outbreaks affecting MCB wards affecting: 91 patients; 51 staff; 177 bed days lost. **C4C scores** – all wards in MCB are compliant except MEAU in UHL. Most scores are over 97%. Most scores in EU are 100%. **HCAI reduction goals** – MRSA is on target. Medicine position based on the same period in 2019, *C difficile* up 84% (being attributed to antibiotics) Staphaureus up 111% E. *Coli* down 13% Klebsiella Bacteraemia up 155% Pseudomonas bacteraemia up 33% **Outstanding RCA's** – 33. **Action: DK to send a summary update to JM.** Community cases for Covid are still high. 305 in Cardiff, 367 in Vale. All Wales case rate is 290. Flu rates in the community have dropped. **Area of concern** 1. Hand hygiene audit and bare below the elbow scores are deteriorating. 2. Commode audits are deteriorating. **Audits** – bare below the elbow, nurses are usually good, the issue is with the extended MDT. Commode audit deterioration to be taken back to areas. **Hand hygiene** – is across the board. **Line infections** – A7 have had particular issues and identified lapses in practice. Focus with Covid outbreak with IPC measures. **Action: JM will liaise with Rebecca Aylward to get an update on how we can get 'Perfect Ward' back** **Action: deterioration in commode audits – ward staff to take this back to their areas.**	DK JM Ward staff
3.3	**Point of Care Testing**	KP

	Use of bank/agency and moving staff around a lot – KP to add 'point of care, training and compliance' to the April agenda and request an update from Sian Brookes.	
3.4	**Medical devices/equipment issues** – no issues raised.	
3.5	**Patient Safety Alerts/MDA's/ISN** – these have been circulated. All to note and share with teams. ISN 2022 Mar 002 Risk of Burns when Skin Warming ISN 2022 Feb 001 Medicines Administration Student Nurse Administration of Medicines	ALL
3.6	**February Falls Infographic** – All to note and share with teams. **Line standing BP** – update to follow from AB.	ALL AB
DIGNIFIED CARE		
4.1	**Patients Safety/Quality Care** An injurious fall complaint was received by the Falls Review Panel, however, as the meeting was not quorate, this will be discussed at the next meeting. The complaint related to a fall in LSW, the staffing should have been 4 and 4 and it was 2 and 3. There was a comment; 'we do not think this would have made any difference'. **Action: AB and JM to discuss further outside this meeting.**	AB/JM
4.2	**Doctrina Welsh Risk Pool Learning Advisory Panel Trends** For information and learning.	
4.3	**Patient Journey – Right Bed First Time** To be discussed at next month's meeting. KP to add to agenda.	KP
TIMELY CARE		
5.1	**RTT position** **Specialised Medicine:** Specialised Medicine -QSE RTT (**ED Performance – February 2022** Total attendance 10,492 4-hour performance 63% on average 4-hour breaches 3,824 12-hour breaches increased to 1,175 Slight decrease in lost WAST hours 2,743 Decrease in WAST conveyances 1,898 Peak average for DTA was 55 Similar to January 22 figures Overall, there has been an improvement in crew handover times, however, there has been an increase in average length of stay in AU/EU. Average length of stay was 25 hours for patients being admitted and 13 hours for referred and discharge patients. C&VUHB is developing an onboarding protocol. Full capacity protocol has commenced. **Stroke Performance** 4-hour performance with admission to Stroke ward has declined.	

	Feedback is awaited from the recent HIW visit. The focus in Integrated Medicine going forward will be in line with recovery of the pandemic.	
5.2	**Once for Wales Datix Update** It will take 6 months to get the new system fully embedded. All to ensure the correct reporting directorate is added. Currently there are 50 MCB users trained on the next Datix system: 6 A&E, 23 IM, 6 SM. 2 for Welsh Gender Service, Specialised Medicine.	
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans **Action: JM to follow up on this to get feedback. Liaise with Angela Hughes regarding experience framework and 2 minutes of your time.**	JM
6.2	**DTOCs** – **no update. JM will deliver a brief at next month's meeting.**	JM
6.3	**Safeguarding** – update delivered by Aimee Williams **Training** - will move from virtual to face-to-face in April 22. New level 3 course coming in at the end of this year regarding Learning from Reviews. 2 Safeguarding Nurse Advisors go to MASH daily. National Referral Mechanism Panel meetings and high-risk panel meetings are taking place. **Professional concerns/allegations** – have been busy at present. **Single Unified Safeguarding Review** – combines Domestic Homicide Review (DHR) and the Mental Health Review (MHR), and the Serious Incident Review amalgamates into one review. **Change in law** - regarding ending physical punishment against children from 21/3/22 in Wales. May increase referrals in MASH and likely to see further police investigations. **Risk assessment** – has been launched for children and young people on adult wards and hoping to get that on the Clinical Work Station (CWS). In the mean-time complete it and keep in medical records until CWS is done.	
6.4	**Concerns update** **Active concerns** – there are 112. Integrated Medicine is highest, followed by Acute and Emergency Medicine, followed by Specialised Medicine. Concerns are rising hugely all around the Health Board. Concern tracker meetings are now diarised. Will look at having formal concerns meetings. Looking at further training for staff. Some concerns need tweaking. Vicky has been asked to support with a refresher training session regarding concerns writing. **Old concerns** – in Jan/Feb 22 there were concerns from April 20, this has now reduced to 11. The 11 are quite complex and are either with redress or awaiting further information from other Clinical Boards. An update on themes for concerns will be delivered at May's QSE meeting.	
6.5	**Compliments** A thank you has been sent to Heulwen Ward from a relative of a patient who was cared for on that ward.	
Staff and Resources		
7.0	**Staff well-being** Carry over to next month. KP to ask for an update from Integrated Medicine (DP) and Acute and Emergency Medicine (CM).	KP
PART 2: Items to be recorded as Received and Noted for Information by the Committee		

AOB	**Date and time of next meeting** – 21/4/22 at 2.30pm	

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

Attendees:
Jane Murphy, Director of Nursing, MCB (Chair)
Iain Hardcastle, Director of Operations, MCB
Diane Walker, Deputy Director of Nursing, MCB
Kath Prosser, Quality & Governance Lead, MCB
Anna Sussex, Transformation Lead, Acute & Emergency Medicine
Sam Barratt, General Manager, Integrated Medicine
Hannah Mastafa, General Manager, Specialised Medicine
Emma Keen, Deputy General Manager, Integrated Medicine
Derek King, Clinical Nurse Specialist, Infection Prevention & Control
Gemma Taylor, Practice Development Nurse, Integrated Medicine
Barbara Davies, Lead Nurse, Specialised Medicine
Lisa Green, Senior Nurse, Acute & Emergency Medicine
Ruth Cann, Senior Nurse, Integrated Medicine
Carly Simpson, Senior Nurse, Integrated Medicine
Natasha Whysall, Senior Nurse, Integrated Medicine
Sian Brookes, Senior Nurse, Integrated Medicine
Maitrayee Choudhury, ST7
Shannon Bakan, Service Manager, Welsh Gender Service
Catherine Bingham, Service Manager, Integrated Medicine
Harriet Foley, Frequent Attenders Lead, C&VUHB
Sheryl Gascoigne, MCB Secretary (Minutes)

Preliminaries		**Action**
A1	**Welcome & Introductions**	
A2	**Apologies for absence** Aled Roberts, Clinical Board Director, MCB Angela Jones, Senior Nurse Suzie Cheesman, Patient Safety Facilitator, Patient Safety & Quality Team Manju Kalavala, Consultant, Dermatology, Specialised Medicine Marianne Jenkins, Consultant Nurse, Acute & Emergency Medicine Jacqui Westmoreland, Senior Nurse, Covid Investigations Gill Spinola, Senior Nurse, Integrated Medicine Samantha Hughes, Practice Development Nurse, Integrated Medicine	
Part 1: Quality & Safety		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	**Minutes of the previous meeting** – received and accepted.	
1.2	**Maters arising** **Action:** Nick Manville (NM) will liaise with WAST to ensure the new WAST EPCR information has been fully communicated in the community. **Action update:** AS will follow this up with NM and provide an update. **Action:** DK to send JM a summary of the outstanding RCA's. **Action update:** DK will forward the summary to JM.	AS DK

	Action: audits and Perfect Ward – JM will liaise with Rebecca Aylward (RA) regarding audits. **Action update:** information sessions are being held. RA/Aron White met with ward staff and a number of wards are currently using Tendable. **Action:** SC will ask Tara Cardew to request formal notification regarding this and forward to JM to discuss at DoN's meeting. **Action update:** JM will follow up with Suzie Cheesman. **Action:** DTOC's. **Action update**: no update available. **Action:** National User Experience Framework. Feedback from 2 minutes of your time survey **Action update:** Aron White (AW) advised the audit is currently not being used. BD will discuss with AW and Rebecca Aylward regarding looking at developing appropriate elements of Tendable in the future to go into non-ward areas, such as day units.	JM BD
1.3	**Patient Story** – delivered by Harriet Foley (HF), Frequent Attenders (FA) Lead for C&VUHB and also a Sister in A&E. FA's are those who attend A&E 5 or more times a year, accounting for 8.6% of all A&E attendances. There are 1,500 FA's within the Cardiff & Vale UHB. HF identifies FA's and looks into why they attend A&E or contact other emergency services. FA's include those with medical needs/increased care needs, such as palliative care; with new or increased social care needs; unable to navigate the system; who have experienced adverse childhood experiences affecting their mental health. HF chairs a monthly panel meeting attended by partner agencies and other organisations such as WAST, Police, and secondary services such as housing. The panel work with the patients to better support them and reduce their A&E visits and increase patient wellbeing. **Case study** – H, a 40year old woman usually presents with shortness of breath. H is known to the C&V Respiratory Teams. Over the last 6 months H has had 17 attendances between A&E and MEAU in UHL, equating to 11.8 days in the department with 31 calls to WAST. Whilst in hospital H has had 38 blood tests; 11 X-rays; 6 swabs and 1 specimen sample. 99% of these investigations have been within normal parameters. HF undertook a clinical discovery with H's GP and her learning disability team. HF did an up to date learning disability assessment before meeting with H and found she did not meet the requirements for additional support. In Feb 22, the OT service/ FA service undertook a joint home visit to H who was unemployed, living at home with her elderly Father. H found it upsetting living at home as her mother died of a heart attack there. H feared dying like her mother, she then panics and contacts WAST or attends A&E/MEAU. H was assisted to access mindfulness apps and discussed local service provisions, eg, groups she could join. H was assisted to create a distraction box, including books, music, crafts to use when she felt anxious. The Respiratory Team confirmed there was no definitive asthma diagnosis. The FA team recommended counselling to manage her anxiety and H is awaiting an appointment. Since being supported by the FA Team, H has not had any A&E attendances, had one admission to MEAU and called WAST twice. The FA Team and H remain in contact to see if the interventions have worked. The FA Team continue to liaise with the GP and Respiratory Team. 80–90 FA's attend A&E/ contact WAST etc per month. Since October 21 there have been 157 patients who come in 4 or more times to A&E.	

1.4	**Feedback from UHB QSE Committee 12/4/22** – the minutes are not available yet.	
1.5	**Directorate QSE minutes – exception reporting** Next meetings will be in May and June, so no minutes to share at present.	
1.6	**Quality, Safety and Experience Terms of Reference and Work Plan** Reviewed every year regarding expectations and what should be included in QSE. It was agreed to add the Learning and Education Group in the sub-group. If anyone wants anything else added, let KP know.	
1.7	**People and Culture Plan 2022 – 2025** **Action: all to familiarise themselves with the plan, which is on the intranet and to and share with teams.**	ALL
1.8	**Risk Register** **Action: Directorate Risk Register leads to share updated risk registers with KP now and on a monthly basis going forward.**	Risk Register Leads
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Virtual Ward Standard Operating Procedure** **Action: KP to request an update to be provided at the next meeting.**	KP
2.2	**Winter viruses update: plan for 2022/23** The vaccination plan will be called the Winter Viruses campaign and will include Flu and Covid. The first strategy meeting for the year ahead has been held. Looking to provide a winter model with clinics for staff to go to for flu/Covid vaccinations with support of Flu Champios. The next meeting will be held in May 22.	
2.3	**Healthcare acquired Covid investigations update** The first scheduled panel meeting was stood down recently. A revised meeting date is being arranged.	
2.4	**Learning and Education Plan (LEP)** The LEP will focus on incidents occurring in MCB, eg NRI's, themes from concerns, however, there is currently no forum for learning. The LEP will launch on International Nurses Day on 12 May 22. The QSE agenda will dovetail into the LEP, which will dovetail into recruitment and retention.	
2.5	**Clinical Audit Plan** The annual clinical audit schedule, Tier 1 is the national audit (mandatory audits) Tier 2 is for more local audits. The plan for MCB must be ready by 29/4/22. The focus will be on clinical colleagues in MCB. **Action: KP to add to next month's agenda.**	KP
SAFE & CLINICALLY EFFECTIVE CARE		
3.1	**NRI update** There are 17 open NRI's, 2 with the Patient Safety Team for closure, 1 of which will be requested for a downgrade (reported as an NRI originally, however, the patient outcome would have been the same regardless of the delay in treatment). There are: 3 injurious injuries under review, a further 4 injurious injuries do not meet the criteria for being reported to the Delivery Unit; 5 health acquired pressure damage under investigation; 3 other incidents are ongoing with fact finding to determine if they are reportable. **NRI's for closure:** **In148767** - in August 21 this gentleman came into UHL following a collapse/ loss of consciousness. Diagnosis made and treatment commenced for	

	seizures. The patient was known to have a pacemaker and Alzheimer's Disease. He was deemed medically fit on 16/8/21, but became unwell on 25/8/21. On 27/8/22 the had an unwitnessed fall from the bed sustaining a shallow subdural haematoma and facial injuries not requiring surgical intervention. He was discharged on 18/10/21. Risk assessments were completed. There was evidence of intentional rounding with no gaps. He was to be transferred with a Steady. A 4AT delirium assessment had been completed and reviewed throughout his stay. **Learning** – the patient was hoisted back into bed instead of using the Hover Jack. The post falls assessment was not updated following the fall. Everything had been completed to mitigate the patient's falls risk. Education on the ward is ongoing. Learning is being shared across the MCB. Time has been spent with HCSWs and with qualified nurses as required. A plan will be put in place in the next few months focusing on new starters and overseas nurses regarding the use of the Hover Jack. It would be good to pull the common learning themes together with learning. IRMER In139437 shared learning **Feedback from Coroner's Inquest** Following a patients death an inquest was heard last month. There were 3 minor learning points: 1. Patient did not have an ID band on. All patients need ID bands. 2. As the patient's family were with him a lot, the nurses never asked if he needed assistance with washing or changing bed linen 3. Call bell was not close to hand when the family were not there. This message must be shared with staff that even if family are with a patient, bed sheets should be changed and the patient should be supported or discussed with them to provide basic care needs. Senior Nurses at UHL met monthly with Ward Sisters and this would be a good forum to share this information. **Action: JM to liaise further outside this meeting on the best way to get this information quickly to ward sisters/charge nurses. Need evidence to close the loop.**	JM
3.2	**Infection Prevention and Control update** 27 days since last MRSA bacteraemia 16 days since last MSSA bacteraemia 3 days since last *C difficile* 16 days since E. *Coli* bacteraemia 12 days since Pseudomonas bacteraemia 45 days since last Klebsiella bacteraemia **Outbreaks/ Incidents** - 1 incidents and 3 outbreaks affecting MCB wards affecting: 17 patients; 4 staff; 4 bed days lost. **C4C scores** – all MCB wards are compliant except MEAU in UHL. All scores are over 97%. **HCAI reduction goals** – no goals were achieved for year 2021 to 2022. MCB comparison to last year 37 cases last year *C difficile* (goal was 20) 28% increase 1 case last year MRSA (goal was 0) 24 cases last year MSSA (goal was 8) 46 cases last year E. *Coli* (goal was 40) 22% increase 18 cases last year Klebsiella Bacteremia (goal was 6) 125% increase 5 cases last year Pseudomonas bacteraemia (goal was 0) 20% increase	

	To aid improvement, consider promoting the Stop campaign and add to daily safety briefings. Isolate diarrhoea and vomiting (D&V) cases. **Outstanding RCA's** – 33. **Action: DK to send a summary update to JM.** **Community cases for Covid** - are reducing. 51.2 in Cardiff, 61 cases per 100,000 in the Vale. The All Wales case rate has reduced to 48. Guidance of management of respiratory infections has changed. **Flu rates** - are below baseline levels. **Training** – most *C difficile* cases are Gastro and very little can be done to alter that. Most E. *Coli* cases relate to catheters. To help prevent the spread of *C difficile*, isolate D&V patients. Go back to basics regarding IPC. **Cleaning** – has changed to Domestic Monitoring Tool (DMT). Standards have changed over the last two years. A lot of work is being done in Learning and Education with new starters. **Action: GT/SH to liaise with DK outside this meeting, and also to liaise with LED to see what is being done with new starters for training and report back to this meeting.**	DK GT/ SH
3.3	**Point of Care Testing** – any actions required. **Blood glucose monitoring** - Sian Brookes (SB) raised concern about issues with inability to monitor blood sugars. Issues are not just in Lakeside Wing (LSW) and are due to heavy use of bank/ agency staff. SB has had to move staff around as there has not been any trained staff in areas to monitor blood sugars levels. Aron White and the Point of Care Testing Team are looking at regular bank/agency staff having access to point of care training/testing which will be trialed in LSW. Kath Prosser and SB to lead on this. This matter was discussed at NMB earlier this year, and agreed, therefore, for governance, this has been signed off. Assessors are to be confirmed.	
3.4	**Medical devices/equipment issues** – no issues raised.	
3.5	**Patient Safety Alerts/MDA's/ISN** – these have been circulated. All to note and share with teams. • WHC Welsh Value in Health Care – data requirements. • Patient Safety Briefing: WRP learning Penrose drains. • National Patient Safety Alert: MHRA: 2022-002 – potential unexpected shutdown leading to loss of ventilation.	ALL
3.6	**March Falls Infographic** – no update.	
DIGNIFIED CARE		
4.1	**Patients Safety/Quality Care** The Patient Safety Team are investigating a datix concern raised by the ED and Assessment Unit regarding overcrowding and lengthy waits in the departments.	
4.2	**Patient journey – Right Bed First Time** **Case Study:** a patient came from home and was admitted. The patient had 11 moves in 3 months and the patient now has a higher level of care then when originally admitted. The moves including moves to the Assessment Unit North, Lansdowne Unit, Glan Ely Ward, Oak House Residential Home, then re-admitted to C6. The cost of admission so far is approximately £41,000. A QDS package of care was required. **Action: KP to liaise with Kay regarding how this story has been shared and what is being done to stop this happening again.**	KP
TIMELY CARE		

5.1	**Appendix B WAST 67927 ID2182 (equivalent to an NRI)** Regular meetings with WAST have taken place regarding WAST Appendix B's which are shared with the UHB. A 32-year-old man called 999 with chest pain, waited 2 hours for ambulance and was deceased when the ambulance arrived. Lengthy delays were noted across all UHB's in the South Wales region during this time. This is now subject to Coroner's inquest. C&V will support WAST with their investigation.	
5.2	**Datix update** Open datix have reduced from 1500 to 143. A further 119 could be closed by 13/5/22. All Dif 2 staff need to undertake the new Datix Cymru training as soon as possible. JM has a list of staff that are still to complete the training which will be circulated. CD's must take ownership of Datix as well. **Action: All to look to close open datix as appropriate.** **Action: All to advise teams if they have an email address they should go into datix via the logged in form.**	ALL ALL
INDIVIDUAL CARE		
6.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans	
6.2	**DTOCs** – no update.	
6.3	**Safeguarding** – no update.	
6.4	**Concerns update** **Open Concerns** – there were 112 open concerns in March. There are now 114 open MCB concerns, some of which may be duplicates. 57 of those have breached due to complexity and time of the Investigating Officer to complete them and for Lead Nurses to review them. Concern themes include lack of care; behaviour of staff; palliative care/end of life concerns; unsafe discharge; communication; Covid. **Action: GT/SH to prepare learning for staff regarding palliative care/end of life concerns.** **Action: DW will share the report on themes with JM.** **Action: DW will liaise with Vicky Stuart for accurate concern figures.** **Action: JM/DW to discuss themes at Lead Nurse meetings to see what can be done.** **Action: KP to add to next month's agenda and item to discuss with Lead Nurses how they are addressing the themes of concerns.**	GT/SH DW DW JM/DW KP
6.5	**Compliments** **Rheumatology Day Unit** – compliment received from a patient who arrived as an emergency patient of the Rheumatology Day Unit in March 22. The patient advised the service was excellent with brilliant staff and care from some truly lovely people. The person was a patient on C4North and wanted to say thank you to everyone who looked after them.	
Staff and Resources		
7.0	**Staff well-being** - initiatives being undertaken and feedback **Acute and Emergency Medicine Directorate** - visits to A&E staff from the therapy dog, Maggie, have been very well received. Maggie does not visit clinical areas. - a wellbeing service once a week providing support and counselling. - staff training for stress recognition - redecoration of the coffee room. - peer support. - recognition of staff, surprise goody bags. **Action: KP to request an update from Dave Pitchforth regarding an update on the Psychologist and what is provided for staff.**	KP

PART 2: Items to be recorded as Received and Noted for Information by the Committee		
AOB	**Date and time of next meeting** – 19/5/22 at 2.30pm	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 9:30am, Thursday 17 March 2022
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Richard Parry (RP), Q&S Facilitator
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Cath Evans (CE), Patient Safety Facilitator
Jo Clements (JC), Lead Nurse, Critical Care
Emma Swales (ES), Senior Nurse, Nephrology & Transplant
Annie Burrin,
Cathy Morley-Jacobs
Guy Blackshaw, (GB), Clinical Board Director, Specialist Services Board
Lisa Simm, (LS), Service Manager, Neurosciences
Steve Gage, (SG), Pharmacy Lead
Rachel Barry, (RB), Lead Nurse, Neurosciences
Jonathan Davies, (JD), Health & Safety
Emma Swales, (ES), Senior Nurse Nephrology & Transplant
Claire Mahoney, (CM), CNS Infection Prevention & Control
Bethan Ingram, (BI), Senior Nurse, TCT
Mathew Price, (MP), Directorate Manager, Neurosciences
Alannah Foote, (AF), Directorate Support Manager Nephrology & Transplant
Beverley Oughton, (BO), Senior Nurse, Cardiac Services

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting and asked for feedback and comments on the new structure and timings of the meeting.	
1.2	Apologies for absence Received from Keith Wilson, Kathryn Bordeaux, Cath David, Anne-Marie Morgan.	
1.3	To review the Minutes of the previous meeting 11 February 2022 The minutes were agreed as an accurate record. Matters Arising 2.2 Escalation Process. AJ reported that the document KW presented at the last meeting is the current, correct version and that this document was discussed in RADAR last week. Work is to be undertaken communication and around decision making communication.	

	2.4 Work is still on-going on screening and point of care testing particularly in the Cardiac footprint. A meeting is planned to discuss the provision of emergency CPAP in the CCU areas. 3.1 Datix RP reported that the new system can be found in the same place as the old system. CE added that all Incident Managers should have received an email regarding training on the new Datix system and asked that anyone who has undertaken the training check that they have completed the declaration at the end of the on-line training and received a confirmation email. CMain to send out a list of who has undergone training, attached 3.3 Accommodation in Haematology SL is working with the OPAT team regarding ongoing discussions on accommodation for a number of Specialist areas.	 Copy of Datix Training 2432022
1.4	<u>Update on Neuraxial Project</u> Cathy Morley-Jacob, Consultant Paediatric Oncologist gave a presentation on “Neuraxial Connectors are Changing”. CMain thanked Cathy for her presentation. Annie Burrin explained that on change-over day 2 months’ supply all stock will be transferred. It is hoped that extra staff will be on hand for the first week of changeover to help deal with any queries. Annie asked that in order to control the introduction of the new stock no clinical staff order any stock in advance. Annie is happy to support individual areas and implications of changeover	
1.5	<u>Standards of Practice</u> Martin Evans gave a presentation on Single Nurse Checking of Intravenous Medication. CMain thanked Martin for his work and invited anyone with any comments to contact Martin outside of the meeting. Due to time limitations Martin will be invited to a future meeting to present the SOP for HCSW cannula flushing.	
PART 2: SAFE CARE		**Action**
2.1	<u>Open Nationally Reportable Incidents</u> RP reported that regular communication is ongoing regarding the outstanding NRI’s all are close to closure. There is a new Never Event, a case of mistaken identity which led to the wrong size valve being inserted in a patient, the patient has recovered and the correct valve inserted, Nick Gidman is the IO.	
2.2	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group for information.	

ACTION	• WRP RMA 2020-01 Consent to Treatment CMain said that this topic will be brought back to be discussed in a later meeting. • ISN/Ref022/Mar/002 Skin Warning Risk of Burns caused by inappropriate warming technique • Medication Safety Executive Briefing for Healthcare Professionals Issue 59 February 2022 • Safety Briefing 1 March 2022	CMain
2.3	<u>Closure Forms</u> Attached report details the recent closures, nothing further to report.	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report March 2022 CM referred to the attached report which gives details of the current situation. The typing has come back from the cases related to the Pseudomonas cases in Critical Care, mainly on C3 link. The typing on the water cases are different to that of the patients and of those patients only two were found to be the same type. Neither of the patients remain on the unit. CM explained that the situation had occurred because water testing had stopped 18 months ago when Estates had been informed that the area no longer held patients, however, when the LTV unit moved to the area Estates had not been informed, which is why testing had not been reintroduced. This highlighted the importance of informing Estates when areas are repurposed. MDRO on West 8 and West 10. There have been 2 further screen positives since the last meeting, it has been decided to monitor the situation at present. Regular audits will continue. After 160 days without any cases of MRSA bacteraemia there have been 2 cases in the last 2 weeks both related to satellite dialysis units. The RCA's are going out to the units.	
2.5	<u>Health Care Standard 2.9 Medical Devices</u> CG thanked all those who had contacted him about the Medical bidding process. Work is being undertaken on this process and it is hoped that in the future it will be easier to submit bids. CG asked that any medical devices safety issues be reported to him.	
2.6 Saunders,Nathan 06/14/2022 13:03:54	<u>Vaccination Update</u> RB informed the group that take up of the staff flu vaccination for the Clinical Board is 55.5%. This is lower than previous years but in keeping with the rest of the HB. Flu cases in Wales are currently rising, vaccinations are still available, the vaccination centres in Barry, Splott and Bayside are offering vaccinations on a walk-in basis, Occupational Health are offering vaccinations on a Friday between 9am and 4pm and the local	

	Flu Champions also have small supplies available.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing to report CMain introduced Jonathan Davies from the H&S Team. As it has been difficult to hold separate H&S meetings it has been suggested that in the short-term that H&S agenda will be brought back to this meeting.	
3.2	Mortality Review Nothing to report	
3.3 ACTION	Exception reports and escalation of key QSE issues from Directorate QSE groups Neurosciences Nothing to report Nephrology & Transplant Nothing to report. Haematology KW was unable to attend today's meeting but had sent the following discussion points through, I would like to state my recurring concerns regarding: 1. Inadequate nursing staffing which is not compliant with JACIE Standards. We have started to see drug and other errors that affect patient safety and it is the opinion of the BMT consultant team that the level of staffing is not safe. We need to have this documented and I should be grateful to know who is accepting this ongoing risk of unsafe staffing in light of my repeatedly voicing these concerns at this quality and safety meeting. 2. Inadequate office accommodation. You would recall my previous reports of offices which have been intermittently drenched with effluent from the toilets in overlying wards. 3. Inadequate physical premises. A number of patients have indicated their intention to submit written complaints to the CEO regarding the woeful state of the BMT unit. You would recall that I have previously reported that the JACIE Inspectorate regarded our adult premises on the CVUHB site as "the worst ever seen". CMain will reply to KW directly and the points made will remain on the agenda. Critical Care Nothing to report Major Trauma Nothing to report Cardiac Services	

	BO reported that a meeting has been set up for 30 March to discuss CPAP Provision in CCU and AGP Guidance. Nothing further to report <u>PaRT</u> Nothing to report <u>ALAS</u> Nothing to report <u>Pharmacy</u> SG informed the group that Helen Thomas will be taking up the post of Clinical Board Pharmacist for Specialist Services. CMain thanked SG for his service over the years.	
3.4	<u>Annual Clinical Audit Forward Plan</u> The attached documents to be circulated widely.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Doctrina Winter 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 and Guy to discuss further.	
PART 6: DATE OF NEXT MEETING		
6.1	<u>Next Meeting</u> Monday 4 April 2022 9:30am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 9:30, Monday 4 April 2022
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Richard Parry (RP), Q&S Facilitator
Colin Gibson, (CG), Consultant Clinical Scientist, ALAS
Angela Jones, (AJ), Senior Nurse, Resuscitation
Cath Evans (CE), Patient Safety Facilitator
Jo Clements (JC), Lead Nurse, Critical Care
Emma Swales (ES), Senior Nurse, Nephrology & Transplant
Guy Blackshaw, (GB), Clinical Board Director, Specialist Services Board
Lisa Simm, (LS), Service Manager, Neurosciences
Jonathan Davies, (JD), Health & Safety
Sharon Daniels, (SD), Directorate Support Manager Nephrology & Transplant
Kevin Nicholls, (KN), Service Manager, Cardiac Services
Julia Teconi, (JT), Senior Nurse, Critical Care
Melissa Rossiter, (MR), Clinical Director, Major Trauma
Gareth Jenkins, (GJ), Service Manager, Haematology, Immunology & Metabolic Medicine
Shannon O'Callaghan, (SO'C), Service Manager, Critical Care
Clare Smerden, (CS), Senior Nurse, Neurosciences
Sarah Lloyd, (SL), Interim Director of Operations, Specialist Services
Lisa Higginson, Interim Lead Nurse, Nephrology & Transplant
Jo Bagshawe, Senior Nurse, Haematology, Immunology & Metabolic Medicine
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Daniel Jones, (DJ), Assistant General Manager for Critical Care and Major Trauma
Jane Morris, (JM), Senior Nurse, PaRT

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions C Main welcomed all to the meeting and asked for feedback and comments on the new structure and timings of the meeting.	
1.2	Apologies for absence Received from Keith Wilson, Claire Mahoney, Helen Thomas,	
1.3	To review the Minutes of the previous meeting 17 March 2022 The minutes of the meeting held 17 March 2022 were agreed as an accurate record. Matters Arising 2.2 Consent to Treatment. This topic will be added to the agenda of a future meeting to discuss what Patient Information leaflets are given out across the Clinical Board.	C Main

	3.3 Haematology. Further to the email correspondence from KW on some of the pressing issues in Haematology, a meeting has been arranged with the nursing staff for this week to discuss the staffing challenges in Haematology.	
PART 2: SAFE CARE		**Action**
2.1	Open Nationally Reportable Incidents RP provided an update to the group • IN146473 Patient SB sustained a fall while an in-patient on B4 Haem, this incident has been reported, a detailed investigation has been conducted with final documentation being submitted to the Delivery Unit this week. The findings are that there was no significant act or omission on the behalf of the UHB that contributed to the fall, the patient had received a very high standard of care. • IN152962 Patient MC sustained a fall from his wheelchair, there was a missing lap belt. The patient sustained a fracture and dislocation to the patella. Following a chain of events in Swansea Bay UHB the patient had an above the knee amputation. The investigation document was shared last week for comment and it is hoped to verify and move to closure in the near future. • IN136398 Patient ME, cardiac waiting list death, this case is almost at the stage when the investigation findings can be agreed with no significant breach found. • IN108123 Patient PJ, this is listed in the closure report, the documentation was submitted last week. • IN153052 Patient GL, detailed investigations revealed no significant breaches took place, this has been confirmed in the submission made to the Delivery Unit. • IN161318 Patient EM, a case of mistaken identity on the IT system which led to the wrong size valve being inserted in a patient, the patient has recovered and the correct valve subsequently inserted, Nick Gidman is the IO. • IN156432 Patient KP fell on Neuro, this investigation has been completed and submitted. CMain thanked RP and CE for the progress made on these cases. CE said that there are a few NRI's which are very near to being closed and asked if possible to work on completing these in April. KN added that Nick will be responding to the outstanding case for Cardiac this week. CMain thanked the Cardiac Team for all their work with these challenging cases. Open Inquests CE informed the Group that all inquests are now managed by the Claims Team, Eirlys Ferris and Tracey Skyrme, any queries should be directed to them.	

ACTION	CB wanted to make the Group aware, that as a result of a previous Coroners case, the IV Heparin Protocol has been re-written for the HB but it is uncertain how widely this has been circulated as a colleague in Critical Care had written a new protocol unaware of either the issues raised by the Coroner or the existence of the new HB protocol, discussions are now being held in the Critical Care Directorate on how this can be incorporated. CMain said that this issue has raised a number of important points that need to be worked through at both Clinical Board and Health Board level. Work is underway looking at the sharing of documentation, currently, there are various routes, version control is also a huge challenge and the classification of such documents and therefore how documents are searched for also proves to be difficult. There are two pieces of work being undertaken within the HB, looking at how documentation is ratified and trying to make a library of all the different places where documents are stored. CMain is meeting with the Innovation and Improvement Team to look at any actions than can be taken within the CB to try and pull together our own documents and how we source them. There are a number of Directorates which have very comprehensive repositories of their own processes and policies but these are not necessarily available to anyone else unless you know where they are or what you have access to, which is not ideal when dealing with an urgent situation. CMain said that a meeting will be arranged to look at the Heparin protocol to look at the individual areas and some of the modifications that may need to be made. MR thanked CB for raising this and asked for sight of the document. CMain informed the group that work will be undertaken to ensure that there is a robust system for closing Action Plans, partly to ensure that they are dealt with in a timely manner and also to allow time for change in practice to embed where necessary and to re-visit. Patient Safety are trying to identify themes and effect change in practice this way, work to be undertaken with CMain, RP, CE and the patient Safety Team. MR said that she would be happy to link with them on this, the MTC produce an Action Log which is submitted to the Network on a quarterly basis.	CMain CMain
2.2	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group for information and action as appropriate. • SHOT 2022 Jan 001 Preventing transfusion delays in bleeding and critically anaemic patients • PSN 2022 MAR Welsh Risk Pool Safety Briefing Shortening of Penrose Drains • PSN 064 Handlebar injuries in the paediatric abdomen • ISN/2022/Feb/001 Meds Management and Student Nurses • NatPSA/2022/002/MHRA Phillips Health Systems V60, V60Plus and V680 ventilators – potential unexpected shutdown leading to complete loss on ventilation	

2.3	Closure Forms Attached report details the recent closures, nothing further to report.	
2.4	Healthcare Associated Infections • Specialist IP&C Report February / March 2022 completed 30 March 2022 CMain referred to the attached report which gives details of the current situation and added that there has been an increase in the number of infections and the frequency of a number of areas is growing. Work is being undertaken looking at possible themes. There are a number of outbreaks and increased incidence of Covid in the hospital, in particular in Cardiology this is due to the high turnover of different patients and the number of out-breaks they are managing in the small defined footprint. CB reported that Critical Care has downgraded PPE, to fluid repellent surgical masks within the amber areas. Within 3 days of doing this there was a breach with a potential Critical Care acquired Covid case, which is the first such incident since the start of the pandemic. Staff can attend these areas to visit patients under their speciality without the requirement to be fit tested. • Welsh Health Circular – March 2022. As a result of this publication, asymptomatic patients within the hospital are no longer routinely tested for Covid, however there are a number of clinical areas in Specialist Services who have chosen not to move away from testing asymptomatic patients due to the nature of the patients, in particular those immuno-compromised patients. In addition to the IP&C cell which has been functional throughout most of the pandemic working through the IP&C challenges, there is a new testing cell being set up which will deal specifically with requests for testing and changes to the over-arching approach to not testing asymptomatic patients. CMain has asked to meet with the testing cell in order to discuss the specific challenges faced in Specialist areas. The aim is to try and reduce the unnecessary operational issues involved with finding an incidental Covid patient which may then stop them moving to a different part of the hospital.	
2.5	Health Care Standard 2.9 Medical Devices Prior to the meeting CG sent the following report Further to the recent Safety Alert: NatPSA-2022-002-MHRA - Philips Health SystemsV60, V60 Plus and V680 ventilators – potential unexpected shutdown leading to complete loss of ventilation, CVUHB Clinical Engineering and others across Wales have already been doing some preparatory work in anticipation of its publication. As I understand it, there are 15 V60/V60 Plus units in various locations (ITU/PICU/CCU/CITU) and Clinical Engineering will be making recommendations for the use of suitable alternative ventilators in the short term to manage the immediate risk. The next MDSOs sub-group of the CVUHB MEG will meet on 14.04.22 and I'll feedback anything further on this that arises from that meeting	

ACTION	Further to the UHB's failure to report a medical device related incident to the MHRA which was the subject of criticism by a coroner (as reported to the SpS QSE on 06.08.22), I can confirm that the UHB's Medical Equipment Management Policy and Procedures have been updated by the UHB MEG to clarify where responsibility lies. The updated wording is as follows: **Medical Equipment – Incident Reporting** It is vital that all incidents involving MEDICAL EQUIPMENT are reported appropriately via both the internal Datix reporting system and the MHRA Yellow Card reporting scheme (please see below). The UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS) should also be informed so that appropriate action can be taken which may include referring the incident to the MHRA (NB – only equipment managed by Clinical Engineering will be reported to the MHRA by Clinical Engineering, therefore, all other equipment should be reported to the MHRA directly by those raising/managing the internal Datix report). Internal Datix incident reports must always be completed to include the 'medical equipment' flag in order that Clinical Engineering are alerted to the incident. All equipment that is the subject incident reporting should be taken out of service and quarantined pending an investigation further advice on which may be obtained from the UHB's Clinical Engineering Department (or the Rehabilitation Engineering Unit in relation to ALAS). Yellow card reports for medical devices may be submitted at: Report Guide | Making medicines and medical devices safer (mhra.gov.uk) It was agreed that it would be helpful if this topic was added to the agenda of NRI meetings as a reminder to all.	
2.6	Vaccination Update Nothing to report.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	Feedback from UHB QSE Committee Nothing to report	
3.2	Mortality Review CB had sent the following update via email after the QSE meeting held 17 March 2022 Following the Mortality Review Group meeting this week I wished to disseminate some information to the wider clinical teams. **Medical Examiner Update**: - Following some recent queries about the ME service, it is probably worth outlining the role of MEs briefly: 1) Ensure medical certificate of cause of death is reliable and accurate – but the writing and content of the death certificate	

remains the legal responsibility of the qualified medical practitioner (QMP) who cared for the patient. The QMP cannot legally be forced to write anything on a death certificate

2) Ensure the need for Coroner referral identified – although it remains the obligation of the Medical team to complete the referral
3) Identify concerns around care and feedback via relevant primary/ secondary care governance structures to ensure appropriate review of case is undertaken if necessary.

- If clinical teams would like further, formal education around the ME service then Jason Shannon (Lead ME for Wales) is always happy to be contacted and facilitate this.

- Remains a requirement that all CAV Covid deaths are discussed with the ME team, aside from those referred to the Coroner

- Referrals to the ME service will be gradually increasing over the course of the next few weeks to months, until all non-Coronial deaths are referred for external review by the MEs.

- ME referrals are made to SE Wales ME Office, but cases may be distributed across Wales to ensure that the process is as efficient as possible.

- The Medicine MRG Lead, Rhian Morse, is currently in the final stages of a QIP looking into the development of a single A4 sheet of paperwork for communication amongst ward team members and the Bereavement team. Once she is happy with the document she will send it on to me for dissemination and potential use across SSCB directorates.

- This is not a mandatory document, but has been created with the aim of facilitating the bereavement paperwork process.

- CAVUHB has the lowest proportion of concerns identified of those case that the MEs have reviewed. This equates to a recommendation for stage 2 mortality review in around 18% of the deaths they reviewed.

- The feeling was that cases submitted to the Coroner's Office (I.e. not being reviewed by the ME) should still undergo a stage 2 review process where issues/ concerns are raised prior to or after death, as the outcome and actions from these reviews can be very helpful to any clinicians required to attend Coroner's Court.

Mortality Review Group:
Since I started as the SSCB representative on the Mortality Review Group there has been a lot of change in terms of Clinician and Senior Nurse roles, not just within SSCB, but across other Clinical Boards also. Our nominated Senior Nurse representative for SSCB has retired, and the MRG are keen to ensure Nursing Representation, alongside Medical Representation, from each Clinical Board. Raj Krishnan plans to contact each CB to discuss this further.

National Audit for care at End of Life: (Points to note/ consider)

	Organisational level: - No lay member in UHB with responsibility/ role for EOL care - Lack of tools prompting early recognition of likely deterioration – although this may well have changed following the initiation of P@RT, who are establishing ongoing links with the Palliative Care service - Lack of opportunity for staff to reflect on the emotional aspects of work (e.g. Schwarz rounds) – recognising some areas that do undertake these, but acknowledging this practice is not widespread - Single occupancy rooms 13% across the UHB (mean 30% nationally) - No designated quiet spaces for bereaved families – Sanctuary on B5 could perhaps be promoted better be all teams - Anecdotally, families often informally feed back regarding the noise levels whilst patients are dying – could teams consider a subtle way of highlighting to clinical staff when EOL care is in progress (e.g. Critical Care have previously used laminated pictures of roses to put at the entry points to areas of the Unit when EOL care is in place) - Bereavement will be looking into processes to support obtaining formal feedback from families Staff survey: - Majority of staff completing survey have <5 yrs clinical experience - Low compliance (25%) with EOL care training every 3 years - 50% of staff agree that the Health Board culture promotes an ethos of care, compassion, respect and a dignified death.	
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Nephrology & Transplant</u> Nothing to report. <u>Neurosciences</u> Nothing to report <u>Major Trauma</u> DJ reported that from 1 April 2022 Major Trauma have taken on the Trauma Audit Research Network audits. CMain added that the Major Trauma Centre had recently undergone their first national Peer Review audit which was overall very positive and highlighted some areas of good practice in the unit. DJ and MR gave an overview of the findings of the Peer Review and MR thanked everyone involved in the set up of the MTC for all their hard work and effort. MR informed the group that it is planned to start an MTC safeguarding meeting, also, to undertake a new piece of work around Major Trauma and Microbiology in particular with the orthopaedic / microbiology link, Dr Hughes to mirror the work already being carried around elective bone joint infection. <u>Critical Care</u> DJ reported that there is continued pressure due to large numbers of	

	patients, CB added there have been a number of patients who have remained in Recovery for the duration of their stay in Critical Care due to lack of space. An additional problem has been due the Covid case mentioned earlier which has resulted in a number of staff being told to isolate. A lot of the Critical Care pressures are related to the tertiary workload, neighbouring critical care units have capacity. GB reported that he would be bringing the issue of Critical Care capacity to the attention of the Critical Care Network meeting scheduled for later this morning. Cardiac Services KN reported that the Cardiac Services management team are going to discuss the proposed changes to the Green Zones at UHL later today. CMain said that the Clinical Board would be happy to provide any support required for this significant change. ALAS Nothing to report PaRT JM reported that there are current staff shortages due to Covid. The weekly educational provision in the Simulation Suite have just started. Health & Safety JD reported that the Critical Care acquired Covid case would be RIDDOR reportable because of the failure of PPE, he will pick this up as it comes through the Datix process. The unavailability of vacutainer needles will be potentially resolved 11 April. Haematology Nothing to report Pharmacy Nothing to report	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	UK Coronavirus Act Expiry – Information for Medical Practitioners For information only.	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business CE asked that teams are reminded that any existing incident managers should undertake their on-line training for the new Datix Cymru system. There will be a training session for any new incident managers on Friday 8 April. CMain said that it is important that there are people in each area who can review and approve incidents in order that all are acted on appropriately.	
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Thursday 28 April 2022 9:30am via Teams	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 15th March 2022, 08:00-10:00 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Andrew Cronin	Consultant – Dental
Annie Burrin	Patient Safety and Quality
Angela Jones	Senior Nurse RESUS
Arul Kandan	Deputy General Manager T&O
Barbara Jones	Educational Lead
Catherine Twamley	Interim Lead Nurse Surgery, Urol, Ophth & ENT
Carolyn Alport	SCB QSE Lead
Christopher John	Clinical Governance Lead
Denis Williams	Interim General Manager
Debbie Jones	Patient Safety
Emma Wilkins	Directorate Manager – General Surgery
Hayley Dixon	General Manager – Dental/Ent and Ophthalmology
Jon Barada	Interim Lead Nurse – Peri op
Sarah Rees	Senior Nurse – General Surgery
Rafal Baraz	Consultant Anaesthetist
Vince Saunders	IP&C

In attendance:

Zoe Sweetman	Surgery Clinical Board Secretary

PRELIMINARIES *(Chair)*		
SCB/QS: 22/01	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS: 22/02	**Apologies for Absence** Annabel Green Bryony Donegan Carly Podger Ceri Chinn James Lewis Michelle Abel Rachael Barlow Rowena Griffiths Richard Coulthard Siene Ng	

	Tracy Johnson	
SCB/QS: 22/03	**Minutes of meeting held November 2021** The Group approved the minutes of the previous meeting.	
SCB/QS: 22/04	**Action Log** Please see Action Log for update	
SCB/QS: 22/05	**Terms of Reference** The reviewed TOR were circulated to the Group. The Chair asked the members for any comments to be sent to the Board Secretary within the next three weeks, for these to be signed off at the next meeting in May.	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS: 22/06	**Patient Story – Dental** Andrew Cronin – Dental Consultant presented on a historical incident that occurred on the 30th September 2015. It was noted that following a referral on the 30th September by the General Dental Practitioner, the patient was seen at Consultant Clinic on the 10th May 2016, where it was agreed for the removal of LR8. The Group were informed that the procedure took place on the 1st June 2016 by a Dental Core Trainee (DCT), who was assisted by a second DCT due to difficulties (MB root fracture and not seen). During a follow-up on the 8th June the patient reported numbness to the tongue and OPG retained root observed; the socket was irrigated and dressed and patient informed that numbness may be permanent. AC reported that a further follow up appointment on the 4th October 2016, with the Consultant identified continued numbness to the tongue, however there had been improvement of numbness to the lip. It was noted that sensory deficit could take 12-18mths to reveal itself and as a result awaited recovery before addressing retained root; if at all. 24th January 2017 review with Consultant also reported lip normal no change in tongue, socket healed further review 6/12. It was highlighted that the patient had eight visits in total. AC reported on the observations and learning from this event and stated that he felt this was an important story to share to show actions taken since this time to improve processes and lessen these events occurring. It was noted that this was one of the most common procedures undertaken in Dental and due to these findings, there had been greater support and supervision for the Juniors. The Chair thanked AC for sharing this story.	
SCB/QS: 22/07	**BOA Elective Care Review Update** Arul Kandan – General Manager T&O gave an update on each of the 15 findings that were raised at the last meeting and highlighted actions taken. It was noted that progress had been made however Clare Wade – Director of Nursing felt that	

	a Task and Finish Group would help close many of the actions. **Action**: AK to establish a Working Group. The Chair asked that this item remains on the agenda and progress brought back to this meeting in 6 months' time.	
22/08	**WHO SOP** Christopher John - Clinical Governance Lead reported on the new procedures for the WHO checklist. It was noted that previous practice did not include the five steps and as a result, effort had been made to improve the use of the checklist to include these. CJ outlined the content of the SOP highlighting that with the assistance of IT, the checklist had been integrated into the Theaterman system; each step cannot move forward until the previous had been completed. It was noted that an escalation process was also being established to encourage its use and to identify areas and reasons for non-conformance. It was suggested that whiteboards would be available for theatres that that did not have access to IT, however it was reported that this would cause possible duplication as it would need to be added to the computer system when possible. CW- Director of Nursing suggested the use of tablets. CJ felt that these would be beneficial and could be something that is progressed at in the near future. The Group were informed that this system had been in use in some areas since February and positive feedback had been received.	
SCB/QS: 22/09	**Welsh Resuscitation** Update on PPE and CPR was circulated to the Group for information. Angela Jones – RESUS reported that there were no changes and the advice remains AGP PPE to be used on all patients in all settings.	
SCB/QS: 22/10	**Feedback from UHB QSE Committee:** Surgery Clinical Board Assurance Paper – 2021/22 was received and noted by the Group. Clare Wade – Director of Nursing reported that the paper had been submitted and presented at the Quality, Safety and Patient Experience Committee in February 2022 and was well recived.	
SCB/QS: 22/11	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** Directorates Exception reports were received and noted by the Group	

CJ - Clinical Governance Facilitator reported on the following key matters for **Peri-Operative** Directorate: -

UHW

- In155105. Arterial line retained in patient following dressing removal. Investigation completed, in draft format awaiting review.

- Amber Zone – Theatre 7 remains out of action following an IPC inspection. Awaiting full refurb, schedule of works expected from capital planning soon.

- There have been issues with non-phaco/cataract procedures being booked as list fillers in the Vanguard Theatres (temporary unit situated in car park outside concourse). The building is only commissioned for Phaco/Cataract procedures.

- CHFW - In160983. Child received medication through a cannula incorrectly inserted into an artery. Currently under investigation.

UHL

- In160082. Never event reported. Wrong side implant used for a primary knee replacement. The incident is currently under investigation. Progress meeting booked for 18-03-2022.

Ongoing work / Actions

UHW

- In144182. Child received a wrong site block. RCA complete. Awaiting de-brief for involved staff before closure.

- CHFW - In132551. Child received an Augmentin overdose. The incident was reported to Welsh Government as a serious incident. Investigation completed. Shared learning and improvement plan being implemented, awaiting completion.

UHL

- In149722. A patient sustained a burn following the use of Hydrogen Peroxide Solution. RCA complete and awaiting improvement plan completion.

Consultant Anaesthetist – RB shared the minutes of the last Anaesthetic QSE meeting of December 2021, highlighting some of the key items raised: -

- Awareness under GA -Lap adhesiolysis using TIVA. HR and BIS shot up on KTS
  Action: surgeon stopped, new cannula, pt reassured. Follow-up: pt had vague recollection but not distressed. Good practice: well managed, recognised and dealt with in timely manner. Possible improvement:

routinely site a second cannula as a back-up during laparoscopic surgery.

- Tazocin given in theatre to patient with documented penicillin allergy. Identified post-op by nurse of ward. No harm occurred.

- 14 G canula in left internal jugular vein and remained in situ on transfer to A6. Nurses removed and completed DATIX. When discussed with anaesthetist, clarified the line was in the external jugular vein. Peripheral IV access was difficult and unsuccessful despite use of US.

- 16 G canula in left internal jugular vein and remained in situ on transfer to A6 Same list as above, again external jugular vein. Very oedematous patient.

- Drug error -Upper limb block. LA drawn up and saline syringe also prepared
  Saline given instead of LA – error recognised. Outcome: proceeded with surgery, pain in recovery. Factors affecting incident: distraction in busy theatre environment, similar syringe, cross connectivity of syringes. Actions: all syringes must be labelled and confirm the name on the drug prior to injection. DO not hurry delivering anaesthesia and minimise distractions.

- Bariatric equipment problem - 187kg patient on Oxford help pillow on bariatric QA4 trolley – unable to sit the patient up using the electronic controller.
  Outcome: although weight limit for trolley is 250kg the back rest can only lift 45% of the total weight. Therefore, if the weight on the back rest >112kg then it may stall. Suggestion: use a ward bed in this situation as can manage greater weights.

- Propofol syringe found in patient's bed on return to ward - 16-year-old – returned to ward. Mother found syringe in bed. Action: ensure all syringes discarded at the end of the case.

Dental Services – AC reported that there were no significant issues to report on this occasion.

Lead Nurse Surgery, Urology, Ophth & ENT – CT raised key items from the Exception report, highlighting activity and discussions that took place at the Local QSE meetings for both General Surgery and Urology. This included: -

- A presentation at the GS QSE meeting in November 2021 from Dr. Daniel Parry in relation to an audit around process timing through SAU as well as a presentation from Mr Phillips on DVT prophylaxis.
- Patient Safety Noticed discussed – Fragments of rubber bung in intravenous solution.
- It was noted that Ms Sue Hill had been appointed as the Vascular QSE Lead.

	• A presentation was given at the Urology QSE meeting in December around new Macmillan Support Service. • Morbidity and Mortality x 3 cases were discussed (FLA289145, LW A133734 and CL A750570). • The Gentamycin prescription charts that is use via the pharmacy department has been replicated for the other intravesical treatments in clinic to ensure standardisation. **Lead Nurse T&O LH –** Report received and noted by the Group; no exceptional items to raise. **Pharmacy** – Documentation circulated for information purposes. **New DATIX System** Carolyn Alport – QSE Lead raised concerns around the constraints with the implementation of the new system. It was noted that many incidents were sitting in the system as Managers had not completed training. Equally, due to the crossover of the old and the new system, it was highlighted that generating reports would be a challenge, it was noted this had been escaladed to the Executives. The ask was that all Managers look to close incidents as soon as possible and complete training.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 22/12.1	**Initiatives to promote health and wellbeing of Patients and Staff:** **SCB H&S/IP&C Meeting** An overview report of key items raised and discussed at the Operational Health and Safety Group meeting 1/03/2022 was shared with the Group. CA – QSE Lead reported on the following concerns: - • Low Fire Training compliance (62%), it was noted that there would be a push to improve these figures. • It has been noted that caustic soda was being procured and used to unblocked pipes on wards; this practice was being discouraged, as it was causing skin burns to the plumbers who come to unblock the pipes. • Sharps have been repeatedly found in bins. Managers are asked to increase staff knowledge and awareness in line with the safe storage and disposal of sharps, and put in control measures to mitigate the risk of sharp injuries. • Swales fire have raised issues regarding sluice rooms being used for storage of items which increases the risk of fire. **Decontamination Group update -** No update **Water Safety Group Update –** No update	
22/12.2 22/12.3		
SCB/QS: 22/13	**Bring forward –progress on relevant improvement plans (previously approved/discussed):** No update	

PART 3: SAFE CARE		
SCB/QS: 22/14	**Health technology Wales Guidance** Document circulated to the Group for information and sharing.	
SCB/QS: 22/15	**Patient Safety Incidents** The following reports were received and accepted by the Group. • Overall Trends • SI's • RCA/Improvement plans • WG closure form status • WG closure forms – sign off • Regulation 28 reports (of relevance) DJ gave an overview of the data provided within the reports.	
SCB/QS: 22/16	**Patient Safety Alerts (internal/external)** The following items were discussed and assurance given that action had been taken by the Directorates. ▪ SHOT/2022/001 Preventing Transfusion Delays ▪ ISN 2021 Dec 030 - Checking of non-substantive staff ▪ Patient Safety Notice 060 Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route ▪ PSN061 Phenobarbital Oral Medication ▪ Internal Safety Notice ISN/2021/Nov/029 Rubber Fragments in IV Meds ▪ CEM-CMO-2022 Neutralising Monoclonal antibody ▪ ISN 2022/Feb/001 Medicine Administration The Chair reported on the Internal Safety Notice 2022/Mar/002 – Skin Warming. It was noted that this was not included in the agenda, however had been issued during the period. CW – Director of Nursing as that this be shared with local QSE Groups and brought back to the next meeting to confirm compliance.	
SCB/QS: 22/17	**Health Care Associated Infections** Report received and noted by the Group. January 2022 data reported: - • 0 C-Difficile (21 since April 2021) • 0 MRSA (2 since April 2021) • 3 MSSA (6 since April 2021) • 1 E. Coli (14 since April 2021) • 0 Klebsiella (11 since April 2021) • 0 Pseudomonas aeruginosa (2 since April 2021)	

	VS- IP&C highlighted that unfortunately the Health Board would not hit its yearly target for many of the HCAI, in particular C.diff; that have seen an increase in the number of cases throughout the year.	
SCB/QS: 22/18	**IP&C Report** The report was received and noted by the Group. A number of documents were embedder into this report for information. This included: - • Cleaning Guidance • C4C and HPV reports and data • HCAI • Recent audits within Surgery • Outbreak information VS- IP&C reported that problematic areas identified as part of the audits were commodes and hand hygiene, which was showing a compliance rate of around 84%. Emphasis was put on ensuring all areas make every effort to improve this. It was also noted that the Welsh Government were looking to stop testing asymptomatic patients for Covid infection; more details to be shared once this had been agreed. The Group were informed that the number of employees off work with Covid, was still significantly high.	
	Any key patient safety risks:	
SCB/QS: 22/19	**Q&S performance data** The report was received and noted by the Group CW Director of Nursing highlighted that this report had been circulated for information.	
SCB/QS: 22/20	**Falls reduction and Pressure and tissue damage reduction and prevention reports** The Falls and Pressure Damage Master Spreadsheets were disseminated to the Group for information.	
SCB/QS: 22/21	**Safeguarding** JB – Lead Nurse Perioperative Care informed the Group that the next meeting is to take place in May where a procedure for Paediatric patients being seen at Uhl is being discussed. JB agreed to bring this back to this meeting.	
SCB/QS: 22/22	**Medical devices/equipment issues** The Chair thanked the Group and the Directorates for the recent submission for bids. It was noted that all submitted bids had been successful.	

SCB/QS: 22/23 SCB/QS: 22/24	**Blood management** JB – Lead Nurse Peri-operative Care reported that the Transfusion Committee had met in the past few months, however there was nothing relevant to report back to this meeting. It was however noted that the Zero Tolerance report was attached for noting. **Q&S Workplan 2022 -2023** Report received and noted by the Group. The Group were informed that the new Workplan was available and the members were asked to review and make any comments to the Clinical Board Secretary prior to the next meeting for formal acceptance of the plan.	
SCB/QS: 22/25	**Mortality data analysis -** No Update	
PART 4: EFFECTIVE CARE		
SCB/QS: 22/26	**Research and Development Update** No Update reported	
PART 5: DIGNIFIED CARE		
SCB/QS: 22/27	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans –** CW- Director of Nursing highlighted that inspections had been re-instated; these had been stood down during the pandemic. It was reported that the Health Board had received a recent unexpected visit within Medicine Clinical Board. CW asked that members take this information back to their areas, to ensure they are fully aware and prepared.	
SCB/QS: 22/28	**Initiatives to improve services for people with:** **Dementia –** It was noted that there was no representative for this agenda item, CW -Director of nursing agreed to identify a representative. Action CW **Sensory loss** It was noted that GR – Senor Nurse could pick this up in the interim. CT- Lead Nurse to report this back. **Learning Disabilities –** No update	
PART 6: TIMELY CARE		
SCB/QS: 22/29	**Performance with national targets** It was agreed that this item would be rolled over to the next meeting and put higher up on the Agenda.	

PART 7: INDIVIDUAL CARE		
SCB/QS: 22/30	**Feedback from surveys – relevant improvement plans** No update .	
SCB/WS: 22/31	**Complaints and Compliments** CW- Director of Nursing highlighted that the Clinical Board receives a number of compliments and reported that these can be logged via the Claims Team; the Group were encouraged to log these. CW also reported on two Ombudsman reports, highlighting that these were shared for learning lessons and noting. The Group were informed that these reports were also in the public domain. The reports related to: - • T&O patient PJ (2018) • SAU Patient Mr D	
PART 8: Staff and Resources		
SCB/QS: 22/32	**Staff awards and recognition** No Update	
SCB/QS: 22/33	**Safer Staffing levels** It was noted that Safer staffing levels had been submitted, with a review likely to take place in May. CW- Director of Nursing, highlighted that this was a daily task for the Lead Nurses and Senior Nurses to mitigate risks and ensure safe staffing levels. CT- Lead Nurse reported on the challenges and raised concern of 14 qualified members of staff off due to Covid. It was reported that this was having a major impact on demands within areas, both wards and clinics.	
SCB/QS: 22/34	**Staff Surveys** No update	
SCB/QS: 22/35	**Monitoring of attendance at relevant training e.g. IP+C, Safeguarding, MCA, DoLs pressure damage, falls prevention** No update	
DATES OF NEXT MEETING 17th May 2022 – 8-10PM – Ms Teams		

MINUTES

PCIC CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Date and time: 17th May 2022

Attendees:

Anna Mogie (AM) Interim Deputy Director of Nursing (chair)
Rachel Armitage (RA) Quality and Safety Manager
Tanya Balch (TB) Lead Nurse, N&W Locality
Jane Brown (JB) Head of Dental and Optometry
Helen Donovan (HD) Interim, Deputy Director of Nursing
Helen Earland (HE) Clinical Operational Manager, GP OOH and CV24/7
Catherine Evans (CE) Patient Safety Facilitator
Sarah Griffiths (SG) Head of Primary Care Contracts
Helen Kemp (HK) Deputy Clinical Board Director
Anna Llewellin (AL) Director of Nursing
Lorna McCourt (LM) independent Member
Robert Parr (RP) Organisational Development Manager
Deborah Powell (DP) SNA safeguarding
Carol Preece (CP) Lead Nurse, S&E Locality
Laura O'Connor (LOC) Quality and Safety Officer
Andrea Rich (AR) CNS Palliative Care
Kate Roberts (KR) Senior Nurse, Vale Locality
Lynne Topham (LT) Assistant Director of Operations
Lisa Waters (LW) Senior Nurse for Quality and Education
Aimee Williams (AW) Safeguarding Nurse Advisor

Apologies:

Richard Baxter, Lisa Dunsford, Nicola Evans, Anna Kuyzanska.

ITEM NO.	TITLE	ACTION
1.	AM welcomed everyone and introduced new members Anna Llewellin, the new Director of Nursing for PCIC and Lorna McCourtwho has taken over the role of PCIC staff side representative following Stuart Egan's retirement.	
2.	Apologies for absence were noted as above	
3.	No Declarations of interest were received.	
4.	The Minutes of the meeting held on 6th April 2022 were approved.	
5	The PCIC Quality & Safety Action Log has been updated separately. Action 11/21/06 was closed.	
6.1	OOH Business Report HE highlighted that the transition to the All Wales 111 Service commenced in March 2022 and has gone smoothly with big thanks to the team who have worked to ensure that. There are two issues currently; patients who are calling at approx. 6pm are not being passed over to the CVUHB OOH service until Midnight or later leading	

	to a big backlog to manage at a difficult time. Secondly, the documentation often has spelling mistakes, wrong date of births or addresses for patients. One patient, who was known to the service for violent behaviour had their details misspelt so was offered a face to face meeting, which was inappropriate. Weekly project board meetings are in place to discuss and resolve keys issues. Also, the demand for the dental services has exceeded expectations. The service was expecting approximately 400 calls per month but is actually receiving 750 calls per month. This is also causing capacity issues for the emergency dental service due to the increase in demand. HE advised the new Dental Contract which came into force of the 1st April 2022 aims to combat access issues in the long term, however from a short term perspective, work is still needed to manage capacity and demand.	
6.2	N&W Locality Business Report TB highlighted that the reduction in the number of pharmacies supporting the supply of blister packages for patients with medication support needs is causing operational issues and impacting on delays in discharge. The hospital supply 4 weeks of blister packs but there are currently no pharmacies willing to supply more after this. TB advised talks are ongoing with Pharmacies and other stakeholders to identify the barriers and how they can be overcome. AM noted that the move to administration of medicines from boxes and bottles in social care will reduce significantly on demand for blister packs which should resolve that issue but even though a policy has been agreed the training and implementation of this is going to take some time so will not resolve the immediate problem	
6.3	Vale Locality Business Report KR shared that the Barry District Nurse team was visited last week by Paul Labourne from the CNO's office and the feedback received was very positive. The staff mentioned during the visit that they felt more supportive since the introduction of weekly reflective sessions for team members across the Locality. The sessions were set up due to the high levels of sickness and as a result sickness figures have improved and staff have voiced that their wellbeing has also improved.	
6.4	S&E Locality & HMP Business Report CP highlighted that staffing pressures are easing, in particular in Cardiff and Vale Health Inclusion Service (CAVHIS) however sickness across the Locality still remains an issue. Also, a visit to HMP Cardiff from the Nursing Office within Welsh Government is scheduled for 7th July 2022.	
6.5	Medicines Management No further comments were added in addition to the report submitted.	
6.6	Palliative Care	

	AR informed the group that the evaluation report from the palliative Care Webinar series has been completed. There were 55 webinars put together by care consultants in partnership with Cardiff University. They were aimed at primary care, looking at pain management, patient care, heart failure in CPD, end of life and care after death. Feedback was positive and the plan is to organise five more webinars; this time focusing on areas such as nursing homes, GPs, district nurses and Out of Hours. The group discussed the allocation of funds for end of life care; AM asked the group for evidence on staff's experience and the impact of COVID for the Health and Social Care Committee. AM has circulated an email and the deadline is end of May 2022.	
6.7	Primary Care SG highlighted that the South and East locality in particular is very fragile in terms of GP service and sustainability. The Primary Care team are supporting practices with a number of contractual variations that they want to implement. Following the two contract terminations, the team have held one reflective session and another is planned, with the aim of developing an action plan of learning points should the same process again have to be replicated. SG will present the findings at a later meeting. JB told the team that the new dental contract will be coming in next year (2023). JB will update the team accordingly. There are approximately 11,500 people on the centralised waiting list. 46 out of 64 dental practices have signed up to the contract variation, aiming to reduce that list by registering patients however this will not start until the next financial year (2023). It was recognised that this backlog has caused an increase in demand in emergency dental care and complaints.	
6.8	MVC report AM highlighted that the leases on two of the MVC centres are due to come to an end by August 2022. Discussions are taking place to identify a alternative site. Information is still awaited from Welsh Government on the expectations for the Health board regarding an Autumn booster campaign. Also, a few staff members of senior management are due to leave, which is a risk in terms of the running and operation of that service. Recruitment is underway.	
6.9	Workforce Business Report Nothing further to add to report submitted.	
AOB	RA noticed that across several of the business unit reports there was mention of research activity, however these were not submitted when requested for the year's audit plan. RA encouraged everyone to add any activity to the audit plan.	
7.	TB presented a patient story. The story involved a lady who died 24 hours after admission into hospital from urosepsis. She had a catheter in place upon admission. She also had multiple pressure damage wounds which triggered a safeguarding referral. She was receiving a package of care from social services and was being visited by District Nurses for the management of the catheter. Following a review, it was found that the lady only had a standard bariatric bed opposed to a higher specification mattress which may have better suited. The	

	review concluded that the District Nurses had done exactly what had been asked of them however a more holistic MDT approach may have been helpful as well as improvement in documentation and baseline observations could have been carried out more frequently. It was noted that the GP was requested to visit the patient but only telephone appointments were conducted so learning has been identified. The team discussed some of the recommendations below: • recurrent unplanned calls triggering nurses to check observations and a carry out a nursing assessment • more frequent NEWS score being carried out • Including an Age concern representative to build more of a relationship with the patient and to reinforce the messages. • More frequent record keeping for fluid intake • Developing a way to share documentation e.g. body map with secondary care. TB did highlight that some of the recommendations have required the local authority to be involved, as the actions relate to packages of care, so will take longer to implement. AM advocated for Multi-Disciplinary Team model and more holistic approach. The investigation highlighted that sometimes healthcare staff only looked at the present, the patient's presentation on that day and not a broader picture or timeframe. It was also noted that there was a lack of communication between GP, District Nurses and Care Agency. KR championed the Western Vale Care at Home programme. GPs, DNs, Social Services and VCRS attend weekly meetings to discuss patients of particular interest. KR advised this has worked well.	
8	Risk Register Update RA advised that the Senior management team are keen to use the risk register as a more dynamic document and key decision driver. RA has noticed a variable amount of robustness in our risk register management processes at the moment. RA asked that everyone review the risks on a monthly basis. **RA will send out link to the risk register on the shared drive.** • New Risk – Roath Clinic Roath Clinic sits within community dental service so is a managed service within PCIC. The service has been running since April 2019. In October 2021 a site visit was conducted but the report not issued until March 2022. Following the findings, A risk assessment has been carried out and the building is not fit for purpose. Also, this reason has been cited for dentists leaving the service. As a result, patients have been transferred to Llanishen Dental Practice. This does mean the more vulnerable patients may not be able to travel to Llanishen from Roath. CP also advised that the District Nurses working in the building have also been moved to the Department of Sexual Health site temporarily due to the roof leaking. **The group agreed that the risk should be added onto the risk register.**	RA
9	Once for Wales Implementation Group Update – Datix queue management	

	LW praised the work of the team as PCIC had 44 open DATIX at the last meeting, now there are 9 open incidents. 5 of them sit with the Delivery Unit in Welsh Government and will need to be transferred over to the new system. The remaining 4 incidents will hopefully be closed before the deadline, which has been extended to the 20th of May 2022. LW highlighted that the weekly scrutiny meeting has made a massive impact therefore it has been decided to continue these meetings once a month for the new system.	
10	PCIC Quality Report LW informed the group that there are currently; • 36 Interface Incidents. The most common theme are breaches of communication standards e.g. GPs being asked to follow up secondary care tests and referral errors and WAST delays. • The Vale have the highest number of pressure damage incidents, the majority of them are end of life and palliative patients which is recurrent theme within the Vale locality. • There are 10 safeguarding cases (down from 35 cases) and 6 of those are Pressure Damage. LW warned that the data in the report is rudimental due to not having a reporting facility on DATIX yet so the numbers are as accurate as they can be. Lastly, 2 compliments were read out to the group.	
11	National Reportable Incident (NRI) Update PCIC have 5 open NRI's. 2 incidents occurring in the prison, 1 case involving a child death, 1 Optometry case which is closed internally but still sits with the Delivery Unit for their approval and. 1 new case a historic incident which happened two years ago, but due to COVID and role changes, the NRI investigation has now begun.	
12	QSE 1-year plan The Quality and Safety team have been looking at planning and implementing the requirements for the Health and Social care, Quality and Engagement acts which will come into force in 2023. Case investigator training has been organised for July 2022 and Case Manager role training will be scheduled for later in this year. The Duty of candour legislation which will be coming out in the next 12 months and the Health Board internally has got its new board Assurance framework, which the Q&S Team are supporting with. The Mortality Review process will be a legal requirement by September 2022 so we are working on processes and actions to support that one, alongside a PCIC education and learning group which is being developed. Finally, RA advised work is ongoing with the Once for Wales Concerns Management System.	
13	Annual Clinical Audit Plan update The group noted the annual audit plan submitted on the 6th of May 2022.	

14	Immunisation internal Audit Initial feedback from the internal audit of the COVID immunisation program has been positive in terms of assurance but the formal internal audit report back is still awaited. The final report will be brought to the next meeting.	
15	PCIC Staff flu vaccine uptake profile The end of year profile on staff vaccine uptake for influenza was noted by the group. A decrease in numbers was observed.	
16	Safeguarding Update AW introduced herself to the group and gave a brief overview of her role. AW encouraged members to become, or nominate someone, to be safeguarding champions. AM recommended staff from each business unit and DOSH. DP gave an overview of the safeguarding team structure following some changes to personnel and the brief overview of the roles of the team. The recent changes in legislation. in particular the ending of physical punishment in Wales were logged. AM raised concerns regarding the delay of information transferred to the Health Board following referrals. RA highlighted that not all services use PARIS so its vital information is shared as via multiple channels and not just added to PARIS. The possibility of having a health practitioner in attendance at strategy meetings was also discussed. TB also raised the lack of feedback following a patient's discharge from hospital. This can result in weeks of no support for the patient. AM advised that clinical reports or MASH discussions are not always passed to the Lead Nurses who are identified as the HLP lead on many of the safeguarding referrals that have been raised in the Community but are being led by the Local Authority. The lead nurses who are expected to close the internal safeguarding process are often then not aware of what has been discussed and that cases have been closed without any further action. AW recognised the above and will explore options for improving communication DP advised that Level 2 safeguarding training is being delivered and Level 3 safeguarding is starting on the 19th June 2022. **HK advised she can promote greater attendance through health pathways and send comms to independent contractors. HK and AW to discuss this further.** DP reminded the group that a Safeguarding Procedure App is now live and can be downloaded.	
17	Welsh language – inclusion, diversity update RP advised that as well as the nine protected characteristics, Welsh Language is a particular focus. Each member of Senior Management Team is leading on 3 characteristics and Welsh Language. Leads have been identified across the Health Board but more advocates are needed. RP asked that staff promote a Health board app to help people converse in Welsh.	

18	AM noted the positive patient feedback within the FAMCARE document relating to experiences of individuals and their families admitted to the Marie Curie Hospice.	
19	The Group noted the Closure Form and Improvement Plan for DATIX reference In126015 LW advised that the patient was not harmed however there was ambiguity because normal process wasn't followed. It was this ambiguity that was responsible for that patient and what happened. The GP and Optometrist have both reflected on the case and the learning will be disseminated accordingly.	
20	AM noted and praised the teams who have received compliments	

Report Title:	Chair's Report - Radiation Protection Group				Agenda Item no.	4.4.9	
Meeting:	UHB QSE Committee		Public	X	Meeting Date:	15.6.22	
			Private				
Status *(please tick one only)*:	Assurance		Approval		Information		x
Lead Executive:	Fiona Jenkins – Executive Director of Therapies and Health Sciences						
Report Author (Title):	Dr John Rees						

Main Report
Background and current situation:

This report is a summary from the UHB Radiation Protection Group held on 26th April 2022.

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

MPE Support for Nuclear Medicine

Following receipt of the Guidance on Medical Physics Expert (MPE) Input and Support for Nuclear Medicine which was produced by the Institute of Physics and Engineering (IPEM), a gap analysis has been undertaken for Cardiff and Vale Health Board by Beth Jones, Matthew Talboys and Amie Roberts. Exclusions from the review includes the service lead role for the Dexa Service and specific support for Radiopharmacy. However, it is recognised that there is a requirement for a nominal wte to support these activities.

WTE support is based on a number of factors including the number of imaging cameras, and the complexity of the workload (therapeutic and diagnostic procedures). The exercise included AB Health Board, Cwm Taf Health Board and Velindre as a regional service as Medical Physics provide support to sub regional departments in addition to Cardiff and Vale.

Based on the guidance, current staffing at Cardiff and Vale should sit within the range of 2.2 to 4wte MPEs. For benchmarking purposes, ARSAC licence applications where used to inform the MPE support that is available. For Cardiff and Vale imaging services, this equates to 0.2 wte and non-imaging and therapies services 0.7 wte. This is a total of 0.9 wte MPEs for services within Cardiff and Vale which is a significant deficit to the recommended rate of 2.2 to 4 wte.

In terms of the services Medical Physics provides to the other organisations, there are currently 3.2 wtes employed by Cardiff and Vale, one of which is employed by Velindre. The guidance recommends that the total MPEs for services provided across other organisations should sit in the range of 5.2 to 10.6 wte. The gap analysis exercise, based on a mid way point, suggests that the total deficit is 4.7 MPEs.

Cardiff and Vale needs to move to a position to increase its complement of wte MPEs now this guidance is available. HIW inspections in Nuclear Medicine will take note of the guidance and collate this to the number of MPEs on site and will seek assurance that current staffing levels are sufficient to provide an MPE service. The Health Board needs to consider a workforce plan to increase its establishment of MPEs to meet the guidance.

The Director for QSE in the Clinical Diagnostics and Therapeutics Clinical Board has escalated this issue with Corporate Governance as part of an assurance mapping exercise and has advised of the gap. She will feedback the need for a workforce plan.

Recommendation:

The Committee is requested to:

a) Note the Health Board's deficit of MPE support against the recommendations outlined in the Guidance on Medical Physics Expert (MPE) Input and Support for Nuclear Medicine which was produced by the Institute of Physics and Engineering (IPEM.)

b) Agree for a workforce plan to be developed to increase the Health Board's establishment of MPEs to meet the guidance.

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	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	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	x	Integration		Collaboration	x	Involvement	

Impact Assessment:

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

Risk: Yes

N/A

Safety: Yes/

N/A

Financial: Yes

N/A

Workforce: Yes

N/A

Legal: /No

N/A

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Reputational: Yes

N/A

Socio Economic: /No

N/A

Equality and Health: Yes	
N/A	
Decarbonisation: No	
N/A	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	**Corporate Risk Register**			Agenda Item no.	4.5
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	15/06/2022
		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 May 2022 Board meeting a total of 13 (from a total of 18 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	4	

Surgery		
Digital Health		
Estates		
Children and Women		
Mental Health		
Capital Estates and Facilities	**5**	
Workforce and OD	**1**	
Total:	**13**	**-**

It should be noted that the Workforce and OD risk detailed within the register has not reduced due to controls not having had the opportunity to bed at the time the risk was recorded. It is hoped that this risk will have reduced in score prior to July's update to the Board.

An updated Register will be shared with the Board at its July 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	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	x

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 ENTRIES MAY 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital Estates and Facilities	1	Mar-21	**Risk/Issue**: UHW Cardiac Theatre GF AGSS Pump is faulty **Impact**: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Capital Assets
	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	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Capital Assets
	3	Mar-21	**Risk/Issue**: UHW Tunnels corroded Main O2 Pipeline due to building leakage **Impac**t: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	**20**	Regular inspection and maintenance.	5	4	**20**	Repair building leak and renew section's of corroded pipework.	5	1	**5**	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery 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	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety 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	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Capital Estates Staff Wellbeing

Medicine Clinical Board	6	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**	Jun-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Urgent and Emergency Care
	7	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**	Jul-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety Workforce
	8	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**	Jul-22	Quality, Safety & Experience Committee	Patient Safety Urgent and Emergency Care
	9	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**	Jul-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Urgent and Emergency Care
	10	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**	Jul-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Urgent and Emergency Care

Specialist Services Clinica	11	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**	Jul-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	12	Jan - 2010	**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	Risk specific policies, protocols, and guidelines. Cleaning schedules. Installation of air pressure gauges outside BMT cubicles to measure positive air pressures. Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green). HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved.	5	4	**20**	New dedicated Haematology facility required. Escalated to Clinical Board, estates and WHSSC. Bid for Lakeside Wing is to be submitted for consideration.	5	1	**5**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety
Workforce and Organisational Development	13	Feb-22	**Risk: Risk to planned care capacity due to loss of agility in operational decision making if e-rostering capability lost through failure to renew contract in June 22.** **Impact: Inability to roll out the e-rostering system resulting in poor rostering practices and continuing high staff costs. In addition we will not have access to live workforce data with an adverse impact on operational planning .**	5	4	**20**	**Reversion to the rostering procedures in place before the E-Rostering capability was adopted.**	5	20	**15**	**Business case submitted to BCAG in Dec 2021 but decision stalled due to prevailing financial situation.**	5	2	**10**	Jun-22	Strategy and Delivery Committee Quality and Safety Committee	Workforce Urgent and Emergency Care