Quality, Safety & Experience Committee

Tue 07 March 2023, 09:00 - 11:30

Agenda

09:00 - 09:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 10.01.23

Ceri Phillips

1.4 Minutes QSE Committee 10.01.23.pdf (12 pages)

1.5. Action Log – Following the meeting held on 10.01.23

Ceri Phillips

1.5 Public QSE Action Log.pdf (3 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

09:10 - 11:10
120 min

2. Items for Review & Assurance

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

Jason Roberts / Meriel Jenney

30 minutes

2.1 Assurance Specialist services.pdf (21 pages)

2.2. Looked After Children – Assessment Backlogs

Jason Roberts

10 minutes

Cath Wood & Clare Rowntree

2.2 Looked After Children Assessment Backlogs.pdf (4 pages)

2.3. Quality Indicators Report to include: C-Diff Update

Jason Roberts

10 minutes

2.3 Quality Indicators Report.pdf (30 pages)

2.4. HIW Activity Overview

Jason Roberts / Meriel Jenney

10 minutes

2.4 HIW Activity Overview.pdf (11 pages)

2.5. CHC Reports including: -

Jason Roberts

5 minutes

The following reports can be found in the "Supporting Documents" folder located on AdminControl & the Cardiff and Vale University Health Board website:

(i) *Alcohol Treatment Centre*

(ii) *Spinal Rehabilitation Unit UHL*

(iii) *Ward West 1 UHL*

(iv) *Transport to Health Services*

2.5 Community Health Council Activity Report.pdf (2 pages)
2.5a Appendix1- Q2 , Q3 and Q4 Scrutiny Visit Dates.pdf (2 pages)

2.6. Maternity Services Update - Verbal

Jason Roberts

15 minutes

2.7. BREAK – 10 minutes

2.8. Quality, Safety and Experience Framework - Effectiveness review - Verbal

Jason Roberts

10 minutes

2.9. Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response

James Quance

10 minutes

2.9 Review of Quality Governance Arrangements Cover Report.pdf (2 pages)
2.9a Review of Quality Governance Arrangements.pdf (2 pages)

2.10. Board Assurance Report – Patient Safety

James Quance

5 minutes

2.10 Board Assurance Framework Covering report.pdf (2 pages)
2.10a Board Assurance Framework - Patient Safety.pdf (19 pages)

2.11. Corporate Risk Register

James Quance

5 minutes

2.11 Corporate Risk Register Covering report.pdf (3 pages)

2.11a Corporate Risk Register January 2023.pdf (4 pages)

11:10 - 11:20
10 min

3. Items for Approval / Ratification

3.1. Committee Work Plan 2023/24

James Quance

5 minutes

3.1 Covering Report QSE Work Plan 2023.24.pdf (2 pages)
3.1a QSE workplan 23.24.pdf (1 pages)

3.2. Policies for ratification including:

Jason Roberts

1) Deteriorating Patient Policy

3.2 Deteriorating Patient Policy Cover Report.pdf (3 pages)
3.2a Deteriorating Patient Policy.pdf (36 pages)
3.2b Deteriorating Patient Policy EHIA.pdf (16 pages)

11:20 - 11:30
10 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

4.1.1 CDT QS Minutes 24.11.22.pdf (12 pages)

4.1.1. CD&T Clinical Board and Patient Experience Sub-Committee – 24.11.2022

4.1.2. Medicine Clinical Board – 17.11.22

4.1.2 MCB QS Minutes 17.11.22.pdf (8 pages)

4.1.3. Specialist – 24.11.2022

4.1.3 Specialist QS Minutes 24.11.22.pdf (7 pages)

4.1.4. Surgical – 15.11.2022

4.1.4 Surgical QS Minutes 15.11.22.pdf (11 pages)

4.1.5. Children and Women's Clinical Board – 22.11.22

4.1.5 C&W QS Minutes 22.11.22.pdf (10 pages)

4.1.6. PCIC – 17.01.23

4.1.6 PCIC QS Minutes 17.01.23.pdf (7 pages)

4.1.7. Mental Health Clinical Board - 20.10.22

4.1.7 MHCB QS 20.10.22.pdf (11 pages)

11:30 - 11:30
0 min

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

Ceri Phillips

11:30 - 11:30
0 min

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

i) Private Minutes

ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)

iii) Royal College of Physicians Summary Report: Inpatient Suicides – Verbal (Confidential Discussion)

11:30 - 11:30
0 min

7. Any Other Business

Ceri Phillips

11:30 - 11:30
0 min

8. Review of the Meeting

Ceri Phillips

11:30 - 11:30
0 min

9. Date & Time of Next Meeting:

Ceri Phillips

Tuesday 11th April

Time – 2pm

via MS Teams

11:30 - 11:30
0 min

10. Declaration

Ceri Phillips

"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 10.01.2023 at 09.00am
Via MS Teams

Chair:		
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
Present:		
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Paul Bostock	PB	Chief Operating Officer (in attendance until 10am)
Sandeep Berry	SB	Deputy Clinical Board Director – Surgical Clinical Board
Emma Cooke	EC	Deputy Director of Therapies & Healthcare Sciences
David Scott-Coombes	DSC	Clinical Board Director - Surgical Clinical Board
Marcia Donovan	MD	Head of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director (in attendance until 11am)
Fiona Kinghorn	FK	Executive Director of Public Health
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director
Clare Wade	CW	Director of Nursing - Surgical Clinical Board
Aaron Fowler	AF	Head of Risk and Regulation
Observing		
Tina Bayliss	TB	Interim Director of Operations – Surgical Clinical Board
Timothy Davies	TD	Head of Corporate Business
Claire Dunstan	CD	Quality & Safety Assistant Director – Surgical Clinical Board
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Nicola Foreman	NF	Director of Corporate Governance
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Stephen Allen	SA	Community Health Council

QSE 23/01/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 23/01/002	**Apologies for Absence** Apologies for absence were noted. The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting. The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group.	
QSE 23/01/003	**Declarations of Interest** No declarations were noted.	
QSE 23/01/004	**Minutes of the Committee meeting held on 29 November 2022** The minutes of the Committee meeting held on 29 November 2022 were received. The Executive Nurse Director advised the Committee that minute number QSE 22/11/007 had noted that the Deputy Medical Director (DMD) and himself had co-chaired the Cdiff group and that the root cause analysis of the increase in Cdiff cases would be undertaken and learnings shared with the relevant areas and brought back to the Committee via the Quality Indicators report.	

	He added that the root cause analysis had not been undertaken and that he would pick that up for the meeting being held in March 2023. **The Committee resolved that:** a) The minutes of the meeting held on 29 November 2022 were approved as a true and accurate record of the meetings	**JR**
QSE 23/01/005	**Action Log following the Meeting held on 29 November 2022** The Action Log following the Meeting held on 29 November 2022 was received. The Head of Corporate Governance (HCG) advised the Committee that there were a number of actions that had been completed and a number in progress which included: • QSE 22/11/007 – It was noted the action log would be updated to reflect the END's comments about the item coming to the next Committee meeting in March 2023. • QSE 22/11/009 – It was noted the item would be received at the meeting. • QSE 22/11/014 – It was noted the item would be received at the meeting. • QSE 22/08/013 – It was noted the item would be received at the March 2023 Committee meeting. The EMD advised the Committee that a conversation had been held with the Executive Director of Public Health around fatal drug poisoning and the link towards the mortality framework in relation the action QSE 22/11/014. She added that the data was held with Public Health and that a decision would be required as to how the Committee would like to receive the data. The Executive Director of Public Health (EDPH) added that the nature of mortality data differed as some data was within the Clinical Board's gift within the inpatient setting and the fatal drug poisoning data, which was reviewed, was a partnership endeavour. The CVC advised the Committee that a way in which to present the mortality data needed to be decided offline and brought back to the Committee in March 2023. **The Committee resolved that:** a) The Action Log from the meeting held on 30 August 2022 was noted.	**MJ/FK**
QSE 23/01/006	**Chair's Actions** The Chair's Action around the Approval of the Research Governance Policy (UHB 099) was received. **The Committee resolved that:** a) The Chair's Action was noted.	
QSE 23/01/007	**Surgical Clinical Board Assurance Report (including a Patient Story).** The Surgical Clinical Board Assurance Report was received. The END introduced the Director of Nursing for the Surgical Clinical Board (DNS), the Clinical Board Director for the Surgical Clinical Board (CBDS) and the Interim Director of Operations for the Surgical Clinical Board (IDOS). The DNS also introduced the Quality & Safety Assistant Director for the Surgical Clinical Board (QSADS) and the Deputy Clinical Board Director for the Surgical Clinical Board (DCBS). The DNS advised the Committee that the report was long and that the Surgical Clinical Board (SCB) had tried to outline everything that had happened over the past 12 months. She added that a lot more data regarding quality and mortality had been included within the report via the Nursing dashboard that was available and via the new Datix system.	

It was noted that last year the Committee had received detailed information regarding the opening of the Same Day Emergency Care Unit (SDEC) and hence the latest report contained early data in relation to admissions and length of stay at the SDEC.

The END thanked Surgery for the comprehensive assurance report and noted that it was good to see the move away from large narrative reports to a more refined data driven report.

He added that the SCB had been pleased to report there have been no cases of MRSA since January 2022.

The Independent Member – Community (IMC) asked how the workforce data from September 2022 compared with last year's data.

The DNS responded that with regards to recruitment and the SCB's vacancies, it had remained static for the 12-month period.

She added that a lot of overseas recruitment had been undertaken for the perioperative care and wards.

It was noted that the SCB was proactive and would look at all options on how Nurses and Operating Department Practitioners (ODPs) could be brought into the SCB. It was noted that that there was a good recruitment and retention programme in place, which included bespoke areas, such as keeping in touch days for new starters.

The DNS added that turnover was challenging and that the SCB had a high turnover rate which reflected the general tone within health care over the past 2 years.

It was noted that to try and improve the turnover rate, lots of opportunities had been provided for staff and internal promotion was instigated, if appropriate.

It was noted that sickness and absence rates were an ongoing issue for the SCB and that the sickness data had increased since September 2022.

The DNS advised the Committee that work was being undertaken to try and manage the issue.

She added that Values Based Appraisals (VBAs) uptake was 39.1% in September 2022, but noted that the SCB was on an improvement trajectory and that it was hoped that by March 2023, at least 65% of VBAs would be completed.

The EMD thanked the team for the report and noted that the data was very informative.

She added that the SCB's successes should also be drawn out from the report. For example, the Same Day Emergency Care (SDEC) unit had opened and was in operation during a period of remarkable pressures and that should be celebrated.

The EMD asked if the large piece of work undertaken around the 5-Steps to Safer Surgery was still working and if there was any follow up.

The DNS responded that the SCB was audited again 6 months ago and that the auditors had been content with the actions that the SCB had put in place.

She added that Theatreman system was near the end of its life and noted that basic changes were made so that it captured the data and noted that it would not let the "inputter" proceed with the theatre case until all of the relevant checklist was completed.

The Clinical Board Director - Surgical Clinical Board (CBDSCB) advised the Committee that the SCB was aware that they had protected beds for Protected Elective Surgery Unit (PESU).

The Assistant Director of Patient Experience (ADPE) highlighted to the Committee that 2 areas within the SCB (Duthie Ward and the Stoma Care department) had recently become accredited Autism aware areas following an Ombudsman's case (where a concern had been raised regarding communication with a patient who had autism).

She commended the SCB for their commitment and for being an exemplar in changing things for the better.

The Executive Director of Public Health (EDPH) thanked the SCB for their report and noted it was positive to see such a data driven representation.

She added that patient-reported outcome measures (PROMs) were still collected and noted that it would be good to see if there were opportunities to draw out upstream value on elective pathways and to see if all of the programmes were being connected.

The CBDSCB responded that Surgeons were all engaged with National audits.

He added that the DNS would draw up a spreadsheet to demonstrate how much national registries and audits are valued.

The Deputy Clinical Board Director – Surgical Clinical Board (DCBDS) presented the Committee with a Patient Story in relation to the Trans Oral Robotic Surgery (TORS) for head and neck cancers.

The Committee was advised of the journey undertaken around TORS so far and the development of the service from 2015 to 2023:

- A Business Case
- Simulation Training
- Observer Cases
- Online Modules
- Wet lab training
- Accreditation and Governance
- MDT TORS pathway
- Service Modelling
- Database implementation
- A dedicated TORS clinic.

The DCBDS presented the Committee with how the TORS machinery worked and provided visuals around it.

The Committee was advised of the TORS indications which included:

- Mucosectomy for Carcinoma Unknown Primary
- Primary Oropharyngeal resection for T1/2 Tumours
- Primary Surgery for radioresistant disease or when radiotherapy could not be given
- Salvage surgery for recurrent disease
- Surgery for other Head & Neck cancers and benign disease.

The DCBDS advised the Committee of the current status of TORS.

It was noted that it had led to a clear pathway which consisted of:

- Referral criteria's and patient suitability
- Preoperative work-up and planning
- Admission arrangements
- Day of Surgery and immediate postoperative period
- Length of hospital stay at UHW and the discharge home
- Postoperative follow ups.

The Committee was presented with a case, where it was noted that the patient had been referred by his GP with a lump on his neck, and the actions taken from referral through to treatment.

The DCBDS presented the Committee with a video of the patient's microdiscectomy which showed the techniques used during TORS.

He concluded by noting that the three essential elements of TORS were:

- "Coming together is the beginning"
- "Keeping together is progress"
- "Working together is success"

	The Assistant Director of Quality and Patient Safety (ADQSP) asked if any variation or improvements had been seen since the use of TORS. The DCBDS responded that there had been improvements and patients treated did not require further treatment. He added that another element was that cancers had been found in the patient that would not have been identified without TORS. The END noted that patients fears, concerns and experience would need ongoing management. The CVC concluded that the TORS journey had been very interesting to see and asked for the Clinical Board to keep the QSE Committee updated on that journey. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted b) The content of the report and the assurance given by the Surgery Clinical Board was noted	
QSE 23/01/008	**COVID Investigations** The COVID Investigations information was received. The ADQSP advised the Committee that investigations had been underway for over a year and a review of the care provided had been undertaken. She added that the reviews were held under the umbrella of the final 'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021) which supported the Communicable Disease Outbreak Plan for Wales (2020) by identifying, reviewing and reporting patient safety incidents, complaints or claims relating to nosocomial transmission of Covid-19 in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR). It was noted that the Health Board had a fully established Covid Investigation Team and was implementing all aspects of the National Framework. The Committee was advised that as of 14th December 2022, 3,229 patients would require scrutiny. The ADQSP noted that as of 19th December the Covid Investigation Team had undertaken 1,191 proportionate investigations and reviews. She added that the availability of patient records was the main risk impacting on the ability to progress the investigations and that additional medical records resource (ie staff hours) was being funded from the Covid investigation budget until the end of the financial year. The CVC asked when the additional medical records resource would end. The ADQSP responded that would be in March 2024 and that potentially the team had front loaded the work, but that it was the right thing to do. The Independent Member – Trade Unions (IMTU) noted that the report mentioned that each Clinical Board had a scrutiny panel and asked what the makeup of that was. The ADQSP responded that the purpose of the scrutiny panel was to consider all elements of the Covid investigations, to agree the level of harm and to establish if there was any breach of duty of care in the context of the pandemic at the time. She added that the makeup of the panels included: • The Clinical Board involved • An Independent Clinical Board acting as a critical friend to challenge discussion • Infection, Prevention and Control representation • Corporate representation The Executive Medical Director (EMD) asked whether the Health Board was benchmarking against other Health Boards.	

	The ADQSP responded that the Health Board had made very good progress early on in the investigations and noted that the Health Board had been key in steering some of the National direction. She added that for openness and transparency purposes, it would be important to note that the Health Board's progress had been slower over the past few months. **The QSE Committee resolved that:** a) The assurance provided by the progress against the framework was noted.	
QSE 23/01/009	**Quality Indicators Report** The Quality Indicators Report was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that she would take the report as read. She added the report had been set out in line with the Duty of Quality and the domains that the Health Board would be asked to report under. It was noted that a lot of information around Duty of Candour had been included because it would be implemented in April 2023. The ADPE advised the Committee that she would pull out key points from the report which included: • A reduction in Nationally Reported Incidents (NRIs) - It was noted that the reduction in NRIs was interesting because the reduction of overdue NRIs each month had been a trend over the last few months and reflected the focus and hard work of the Clinical Boards and Patient Safety Team. • Concerns – It was noted that the Health Board had seen a relatively quiet December period and that concerns had begun to increase in January 2023. It was noted that the Health Board had maintained an overall 30 working day response time for all concerns at 80%. However, a 8% decrease had been observed in November 2022 due to the operational pressures being experienced by the Clinical teams to undertake the investigations. • The Welsh Risk Pool, at the request of Welsh Government (WG), had undertaken a validation exercise of the 2022-23 Q2 quarterly complaints data prepared for submission by the Health Board. It was noted that it had been pleasing to receive substantial assurance regarding the Health Board's data collation and performance information. • Work continued to develop the dashboard for presentation at the Quality, Safety and Experience Committee. The END advised the Committee that, for assurance, development days had been set up in relation to the Duty of Quality and Duty of Candour and noted that the Senior Leadership Board (SLB) would receive a presentation from the centralised WG team. He added that the Board would receive a repeat session as its February Board Development session to ensure that the Independent Members also received the presentation. It was noted that with regards to Infection, Prevention and Control measures, there had been no hospital MRSA infections since January 2022. The EDPH noted that it was positive to see another data driven report to create change/improvement and asked that an "inequity lens" be used when looking at some of the data held to develop the equality and inequity framework. The ADPE responded that a lot of meetings had been held on inequity and a lot of discussions nationally and locally about what could be done. She added that she had spoken to WG colleagues and noted that one of the opportunities identified was to collect ethnicity data with the CIVICA patient system.	

	The ADQPS advised the Committee that in relation to the mortality data, at the last meeting, a paper was presented on the proposed model for reporting and considering mortality data across the Health Board in three tiers: • Tier 1 - Health Board level - Measuring the actual number of deaths over time (crude mortality) supported the monitoring of trends in mortality rates. • Tier 2 - Clinical Board level - The identification of Clinical Board mortality indicators would further support the proposed approach to mortality oversight and learning from death could be achieved by identifying trends in mortality data that supported additional actions and scrutiny. • Tier 3 - Speciality level A brief synopsis of the performance data and statistics regarding fractured neck of femur, Myocardial infraction and stroke, as referred to in the covering report, was presented to the Committee. The ADQPS advised the Committee that it was the first time that still birth data had been presented. She added that it had been an ongoing challenge to get the data and that her team would work with the Obstetrics team to break the data down further to understand variation. The EMD advised the Committee that the still birth data needed to be presented to the Committee but that it also needed to be benchmarked in terms of the population the Health Board was caring for. The CVC noted that the approach was a welcome one and that moving forward, the Committee could be selective as to what data was presented and that when the Health Board were within the benchmarking range, it did not necessarily need to be reported. The ADQPS agreed and noted that that there were a number of groups and Committees across the Health Board that were tasked with Clinical Governance and so the Committee should not take away from their responsibility and function. **The QSE Committee resolved that:** a) The content of the report and the developing process to monitor Quality Indicators was noted.	
QSE 23/01/010	**HIW Activity Overview** The HIW Activity Overview was received. The ADQPS advised the Committee that they would take the report as read and noted that there was little to report as no further unannounced inspections had occurred. She added that Health Inspectorate Wales (HIW) had attended Mental Health Services at Hafan Y Coed the night previously and that any pending reports would be received by the Committee at the point of publication. The ADQPS concluded that an update on HIW's visit to Opthalmology could be provided because all actions had been completed. She added that an audit of compliance with the GMC consent standards was planned for February 2023 and work was underway to develop a bespoke Ophthalmology patient experience survey which would be completed by February 2023. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and progress against existing improvement plans was noted.	**JR/AH**
QSE 23/01/011	**Community Health Council Reports** The END advised the Committee that there had been no inspections undertaken by the Community Health Council since the previous meeting.	
QSE	**Internal Audit Reports – Verbal**	

23/01/012	It was noted that there had not been any further internal audit reports.	
QSE 23/01/013	**Pressure Damage Verbal Update** The verbal Pressure Damage Update was received. The END advised the Committee that the Pressure Damage Collaboration was supposed to provide an annual paper but noted that due to operational pressures within the Health Board, the paper had been pushed back to March 2023. He added that he would provide the Committee with information prior to the full report in March and noted that a gradual increase in trajectory had been observed within pressure damage and that had been partly due to capacity issues. It was noted that the main focus of the Pressure Damage Collaborative was to reaffirm the actions that had already been implemented. **The QSE Committee resolved that:** a) The verbal Pressure Damage Update was noted.	**JR**
QSE 23/01/014	**Maternity Services – Verbal Update** The verbal Maternity Services Update was received. The END advised the Committee that an unannounced visit from the Health Inspectorate Wales (HIW) had been undertaken in November 2022 and that the Committee had received the information at its November 2022 meeting. He added that following the inspection, an immediate assurance report had been undertaken and noted that the final report was yet to be received by the Health Board. It was noted that the work had continued with Maternity services and that a Maternity Oversight Group had been implemented and it met every 2 weeks. The END advised the Committee that following the Ockenden Report, the Health Board undertook a gap analysis which was shared with the Committee and the Board. He added that it would be taken to the Business Case Approval Group (BCAG) for consideration to complete the gap analysis and actions. It was noted that the Maternity Neonatal group had come together and was established so that the Health Board could identify not only poor practice across Wales but also good practice that could be shared across Wales. The END concluded that a full maternity update paper would be provided to the Committee at its March 2023 meeting. **The QSE Committee resolved that:** a) The Maternity Services Update was noted.	**JR**
QSE 23/01/015	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Head of Risk and Regulation (HRR) advised the Committee that Board Assurance Framework provided Members of the Quality, Safety and Experience Committee with the opportunity to review the risks on the Board Assurance Framework (BAF) which impacted upon Patient Quality, Safety and Experience. He added that the BAF had been shared with the Board at its meeting in November 2022 and had outlined risks which included: • Patient Safety	

	• Maternity • Critical Care • Cancer • Stroke • Urgent and Emergency Care • Planned Care. It was noted that the highest scoring net risks were Patient Safety (20), Maternity (20) and Critical Care (20). The HRR advised the Committee that full details of each risk could be found within the BAF. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and noted - to enable the Committee to provide assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 23/01/016	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The HRR advised the Committee that since the July 2021 Board meeting, the Register had recorded only those risks scoring 20 and above. It was noted that at the Health Board's November 2022 Board meeting a total of 17 (from a total of 22 risks scoring 20 or above) extreme risks reported to the Board related to Patient Safety and were linked to the Quality, Safety and Experience Committee for assurance purposes. The HRR advised the Committee that he continued to meet with the Clinical Board triumvirates and their risks were reviewed. The Independent Member – Community (IMC) asked for further assurance on the risks that had remained static in score and asked if there was anything that the Committee could do to help reduce the scores. The HRR responded that the scores had remained static, but that it did not mean that actions were not being undertaken on those risks. He added that the risks were continually reviewed and noted that the scores were difficult to reduce due to operational pressures. The Chief Operating Office (COO) added that the Health Board now had a more joined up approach to risk management and that had helped when with those risks identified at the Clinical Board monthly reviews. The CVC commended the work undertaken around the risks and thanked staff for their hard work. 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, were noted.	
QSE 23/01/017	**Committee Annual Report** The Committee Annual Report was received. The Head of Corporate Governance (HCG) advised the Committee that the purpose of the Annual Report item was to provide Members with the opportunity to discuss the draft Committee Annual Report prior to its submission to the Board for approval. She added that all of the Board's Committees produced an Annual Report to demonstrate that they had undertaken the duties set out in their respective Terms of Reference and were able to provide assurance to the Board. It was noted that updates would be made to the Annual Report following the meeting to reflect key matter discussed that day. **The QSE Committee resolved that:**	

	a) The draft Annual Report 2022/23 of the Quality, Safety & Experience Committee was reviewed. b) The Annual Report was recommended to the Board for approval.	
QSE 23/01/018	**Committee Terms of Reference** The Committee Terms of Reference were received. The HCG advised the Committee that a review of the Terms of Reference was held annually and noted that the Director of Corporate Governance had reviewed them. She added that the draft terms were set out within the Terms of Reference and that they would be received by the Board in March 2023 for formal approval. It was noted that there were some comments within the Terms of Reference that were awaiting confirmation. **The QSE Committee resolved that:** a) The Terms of Reference were reviewed b) The Terms of Reference were ratified subject to confirmation c) The Terms of Reference were recommended to the Board on 30th March 2023 for approval.	
QSE 23/01/019	**Policies for ratification including:** The Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331) were received. **The QSE Committee resolved that:** a) The Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331) were approved.	
QSE 23/01/020	**Joint Research Governance Group Report** The Joint Research Governance Group Report was received. The EMD advised the Committee that she would take the report as read. She added that the report drew attention to the Joint Research Office, the Governance around it and the reporting mechanisms. It was noted that a number of policies ran alongside the JRO that that should assure the Committee that that the way in which research was delivered was fit for purpose. The EMD noted that the Quality Assurance group would develop and review Standard Operating Procedures and that the Clinical Trial Governance Group would overview the governance of higher risk studies. **The Committee resolved that:** a) The establishment of the Joint Research Governance Group, which would report to the QSE Committee as necessary was noted. b) The Group's Terms of Reference and Organogram were noted.	
QSE 23/01/021	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:**	

	a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/01/022	**Items to bring to the attention of the Board / Committee**	
QSE 23/01/023	**Agenda for Private QSE Meeting** i) Private Minutes - ii) Any Urgent / Emerging Themes – Verbal iii) Inpatient Suicides iv) Acute Pressures – UHB response	
QSE 23/01/024	**Any Other Business** The CVC advised the Committee that the response to ongoing acute pressures required discussion and invited the COO and EMD to provide further comment. The EMD responded that the pressures had been identified when discussing the risks and noted that it would be appropriate to mention the enormous pressures being seen across the Organisation, particularly in Unscheduled Care. She added that it was a UK wide challenge and the pressures were an ongoing concern for herself, the END and the COO. It was noted that there was constant ongoing work to manage the pressures, and that much of the work was being driven by the COO's team to address the issues around ambulatory waits, bed pressures as well as many others across the system. The EMD noted that the risks were being reviewed on a daily basis, and that managing the patients as quickly as possible was key, whilst ensuring patient safety. She added that getting urgent patients, who were waiting for specialist care, into the hospital was challenging as well as repatriating patients into other organisations, and so it required really close scrutiny on a multiple daily basis to achieve what was required. It was noted that the Health Board were an exemplar for other Health Boards and that other Health Boards would be visiting Cardiff and Vale that week to explore the ways in which the Health Board was approaching the ongoing pressures. The END noted that he had nothing further to add but thanked all of the staff and acknowledged the work that was being undertake. The CVC reiterated the Committee's thanks to staff and his thanks as the Vice Chair of the Board. **The Committee resolved that:** a) The ongoing pressures within the Health Board were noted.	
QSE 23/01/025	**Review of the meeting.** The EDPH noted that the meeting had been shorter than previous meetings with accurate and sharper data. She thanked everybody for their support. The CVC noted that 4 hours had been set aside for the meeting which was a long time and that it could be shortened. The EMD advised the Committee that with the frequency of the meetings being increased to monthly, the number of hours could decrease.	
	Date & Time of Next Meeting: Tuesday, 7 March 2023 via Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 07 March 2023
(Following the meeting held on 10 January 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/11/009	**HIW reports**	Once published, copies of the HIW reports relating to (i) Stroke Services, (ii) Maternity Services, and (iii) Nuclear Medicine, to be reported to the QSE Committee.	**10.01.2023**	Jason Roberts	**COMPLETED**
QSE 22/11/014	**Mortality Indicators Update**	The Executive Director of Public Health asked the Executive Medical Director if the work done around fatal drug poisoning could link the work with the mortality framework in the Health Board and that a conversation would be required offline.	**10.01.2023**	Meriel Jenney / Fiona Kinghorn	**COMPLETED**
Actions in Progress					
QSE 23/01/013	**Pressure Damage**	Committee to be provided with a copy of the Pressure Damage Collaboration's annual paper.	**11.04.23**	Jason Roberts	**Update on 11 April 2023**
QSE 23/01/014	**Maternity Services Update**	It was anticipated that the report would have been shared by March 2023 and so then a full paper will be received by the QSE Committee	**07.03.2023**	Jason Roberts	**Update on 7 March 2023** *Agenda item 2.6*

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 22/11/005	**Action Log – Mortality Indicators**	Revisit the way in which mortality data was presented and to consider that offline and bring back to the March meeting.	**07.03.2023**	Meriel Jenney	**Update on 7 March 2023** *To be discussed via the Action Log (agenda item 1.5)*
QSE 22/11/007	**Quality Indicators Report – Cdiff**	The Executive Nurse Director and the Deputy Medical Director to undertake a Cdiff root cause analysis and share their learnings with the relevant areas	**07.03.2023**	Jason Roberts/Richard Skone	**Update on 7 March 2023** **(agenda item 2.3)**
QSE 23/01/010	**HIW Activity Overview**	Once published, the Committee would receive a copy of the report relating to the Mental Health Services at Hafan y Coed visit.	**11.04.2023**	Jason Roberts	**Update on 11 April 2023**
QSE 22/08/013	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response**	Progress had been made and would be presented to the Committee.	**07.03.2023**	James Quance	**Update on 7 March 2023** *Agenda item: 2.9*
Actions referred to Board / Committees					
QSE 22/06/008 **QSE 22/02/008**	**Board Development**	The Chair asked for a future Board Development to have sight on the information discussed on: • Healthcare Standards • Duty of Candour • National Quality Framework • Annual Quality Statement	23 February 2023	Jason Roberts/ James Quance	**Completed** Went to the Board Development Session on 23 February 2022.
Actions referred FROM Board / Committees					
UHB 22/09/011	**Integrated Performance Report**	The IMU asked at the Board meeting for the management approach to mitigating the pressure damage issues be explored further,	10 January 2023	Jason Roberts	**COMPLETED**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		at the Quality, Safety and Experience Committee.			

Report Title:	Specialist Services Clinical Board Assurance Report				Agenda Item no.	2.1
Meeting:	Quality, Safety and Experience Committee		Public	x	Meeting Date:	March 7th 2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of Nursing Jason Roberts					
Report Author (Title):	Claire Main Interim Director of Nursing for Specialist Services Sarah Lloyd Interim Director of Operations for Specialist Services					

Main Report

Background and current situation:

Background:

This report provides details of the arrangements, progress and outcomes within the Specialist Services Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. It highlights the achievements, innovation and transformational work undertaken to date, and describes key residual risks and their mitigating actions that carry forward into 2023/24.

Quality and Safety and patient experience is at the core of all that we do within Specialist Services, and our operating framework is described below.

As a clinical board we have endeavoured to embed the culture we have built over the last couple of years to be more open to risk, innovation and transformation where clear links to improving patient quality safety and experience can be evidenced.

During the financial year 2022/23, the Specialist Services Clinical Board comprised seven clinical Directorates with associated clinical services and sub-specialties. The Clinical Board delivers a number of highly specialised services serving the South East region, South and mid-Wales region and wider all Wales population, as well as providing secondary care services to the local Cardiff and Vale population. The Clinical Board has a budget of £180m and an establishment of 1,820 WTE staff.

The services provided by the Clinical Board are predominantly Welsh Health Specialised Services Committee (WHSSC) commissioned and provide for the wider regional and Welsh population. Services are structured through the Directorates below:

- Cardiothoracic Services
- Critical Care
- Major Trauma
- Haematology & Clinical Immunology
- Nephrology & Transplant
- Neurosciences
- Artificial Limb & Appliance Service (ALAS)

The Clinical Board has also taken governance responsibility for development and oversight of Integrated Assessment and Care Unit (IACU), which opened in October 2022, and is currently running at 55 beds within the Lakeside Building.

The Clinical Board is also supporting the development of the Supportive Care Model within Cardiology, and expanding into Renal and Hepatology. Both of these services currently sit outside of defined directorates.

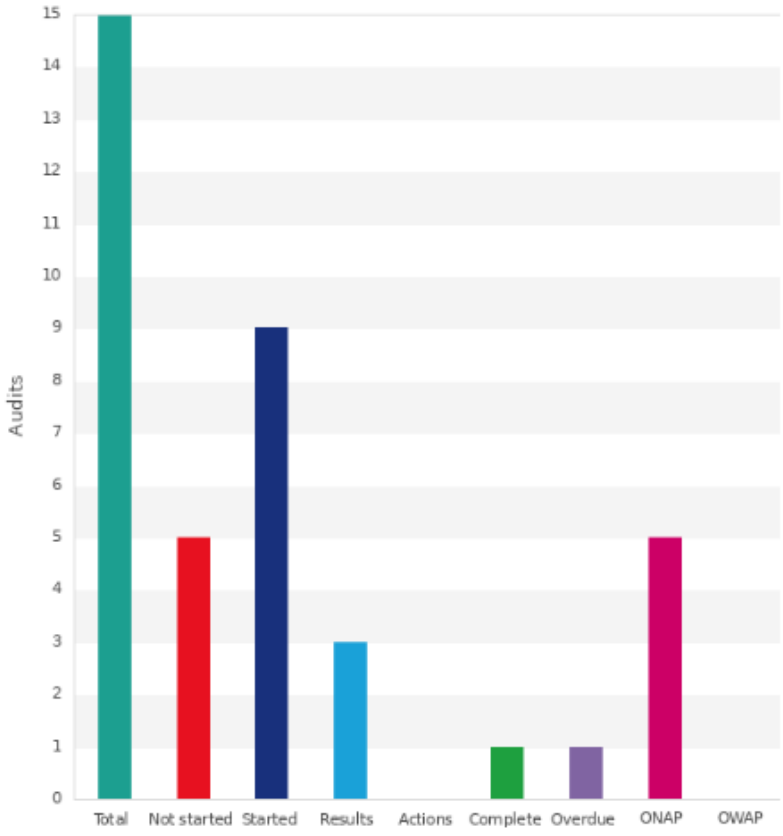
This report provides assurance of the progress being made within the Specialist Services Clinical Board with regard to:

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

Overview Quality, Safety and Patient Experience Practices and Improvements.

The Clinical Board has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e-Datix reporting system and the risk register.

Assurance is received via the robust mechanisms which are in place such as the UHB's Internal Audit processes and strong adoption of AMaT within the board and through the Clinical Board's QSPE group and formal business meetings all of which have strong multidisciplinary representation and are fully minuted. Introducing AMaT allows all of the learnings from investigations and clinical audits will be stored securely in one place and can be accessed to give assurances and demonstrate service improvement.



The Specialist Services Clinical Board has a well-established formal Quality, Safety and Patient Experience Committee (QSPE) that meets every 3 weeks which is co-chaired by the Director of Nursing for Specialist Services Clinical Board and the Medical Lead for Quality and Safety who is a Consultant Nephrologist, a new appointment last year. There is good engagement from core functions spanning the directorates such as IPC, pharmacy, resuscitation services and patient safety who are regular contributors to the agenda.

These meetings have been reviewed and a number of changes have been implemented and will continue to be developed throughout the year. The meetings are now rotated between days and times so that clinicians with fixed clinical commitments have the opportunity to attend the meetings and contribute the safety culture within the clinical board.

The agenda is being refocussed to allow each directorate to share their escalations, quality improvements and wellbeing initiatives alongside items for discussion and escalation at a UHB level. The aim of the focused agendas is to allow directorates the space to align their risk register with escalations and initiatives that bring together a rounded view of each directorate rather than just discussing the immediate priority of the day which has been the focus historically.

This structure is replicated in each of the Clinical Directorates. The QSPE group has two key sub-groups that report to it; a Health and Safety group and Infection Prevention and Control (IP+C) group. The Health and Safety group meets quarterly, and the Infection Prevention and Control group meets bi-monthly. They have formal terms of reference, are formally minuted and have a range of stakeholders who attend to ensure that there is wide engagement in the overarching quality and safety agenda.

There is a renewed focus on Health and Safety in line with the redefined agendas and structures of the UHB group. Four times a year the agenda for QSPE is given to health and safety to allow the clear links between them to be realised. This allows each directorate to be represented alongside

The Specialist Services Health and Safety group meets 4 times per year with representation from each Directorate across the Clinical Board, staff side representation, the Health and Safety team, Operational Services, Maintenance, Fire Advisors, plus other individuals or departments as required. The group reports to the Clinical Board Quality and Safety group and as such the minutes are shared for noting at this meeting. The Health and Safety group also has close links with the UHB Operational Health and Safety Group and any issues.

Through both of these agendas the aim is to draw themes and learning opportunities together so the clinical board can share actions, learning and service developments collaboratively.
As part of the review of learning from incidents that are now reported in a timely manner we focussed on one of our higher risk areas, Critical Care, that historically had a significant number of Datix reports that were left open or not reviewed for long periods of time.
To focus on this as a priority and develop a safe culture it was agreed to pilot a new role within critical care of a Quality and Safety Lead in June 2022. This role has led to the following initiatives being implemented over the last 6 months.

- Collaborative working on Quality & Safety issues between nursing and medical staff
- 1 topic each month driven by Datix incident reporting data
- 'Focus of the Month' shared at both nursing and medical Safety Briefings twice daily
- Quality & Safety meeting structure under review to achieve greater accessibility for the wide team
- 15 Audit Champions identified who attend Directorate Quality & Safety meeting
- Part time Band 6 Quality & Safety Role created to support Datix administration
- A Quality & Safety Newsletter is being launched
- Reduced incidence of avoidable pressure damage
- Patient mattress upgrades reflect high demand for pressure relieving equipment in the clinical area
- Practice Development Nurses reviewing renal filtration patients daily to identify and address training needs as they arise
- Quality & Safety Lead attends daily Huddle Meeting to ensure Quality & Safety issues are identified and actioned promptly and that awareness is immediately disseminated to the clinical area
- Medicines Management CQI Process completed
- New Medication error flowchart introduced
- A Contributory Factors Workshop took place that was attended by all senior nursing staff. This identified themes emerging from incident data and provided feedback to the DMT
- Change & Innovation Band 5 Link Roles created
- Staff Competency Framework reviewed and updated
- Team Training Days include training on Quality & Safety and incident reporting processes
- Unit Coordinator Training now includes training on Quality & Safety and incident reporting processes
- Pressure Damage and IP&C White Boards created in Operational Hub
- Manual Handling Training Days completed
- Bariatric patient manual handling equipment upgraded
- New patient bed introduced with side tilt capability to support care of bariatric patients
- Quality & Safety Lead informs Clinical Psychologist of potentially distressing incidents so that staff can receive support in a timely fashion

- Electronic Noticeboards introduced to improve information sharing with the wider team.
- The Datix management structure has been expanded to ensure full MDT participation and engagement.

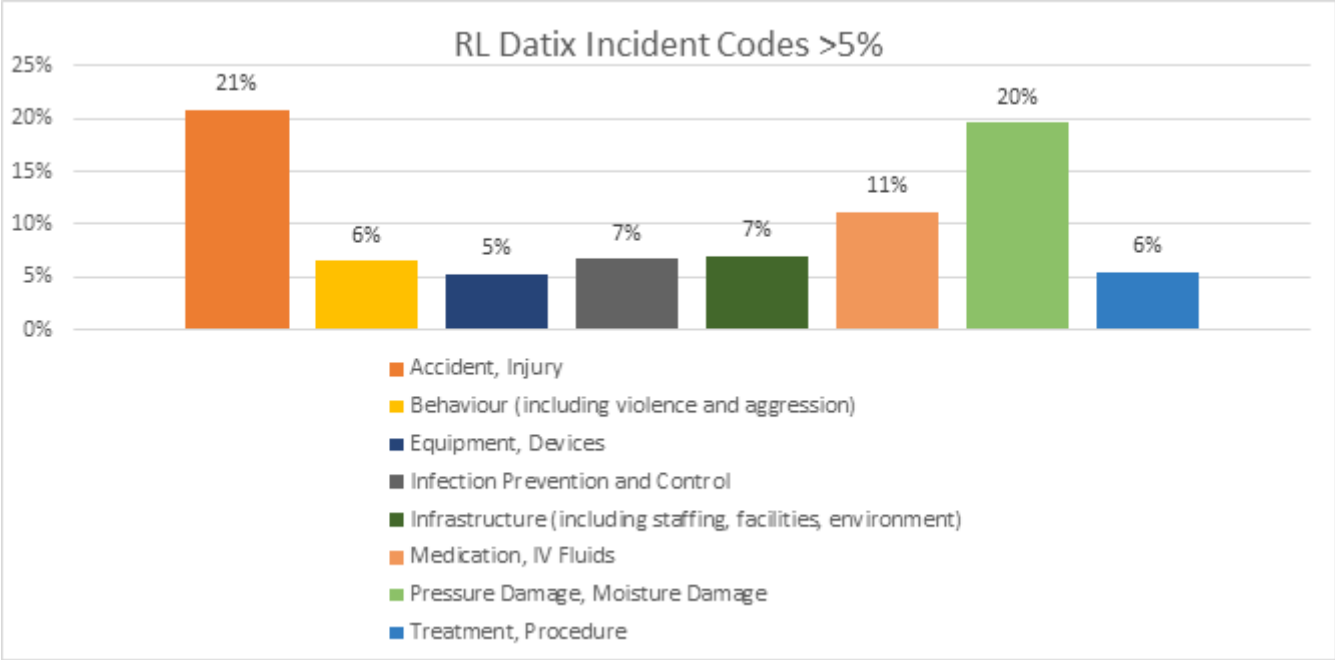
This role has also been replicated within haematology and will focus on standardising pathways and clinical practice, sharing learning from incidents; and within neurosciences to focus on concerns management initially and shared learning. Both these roles will be evaluated and practices shared to support other areas.

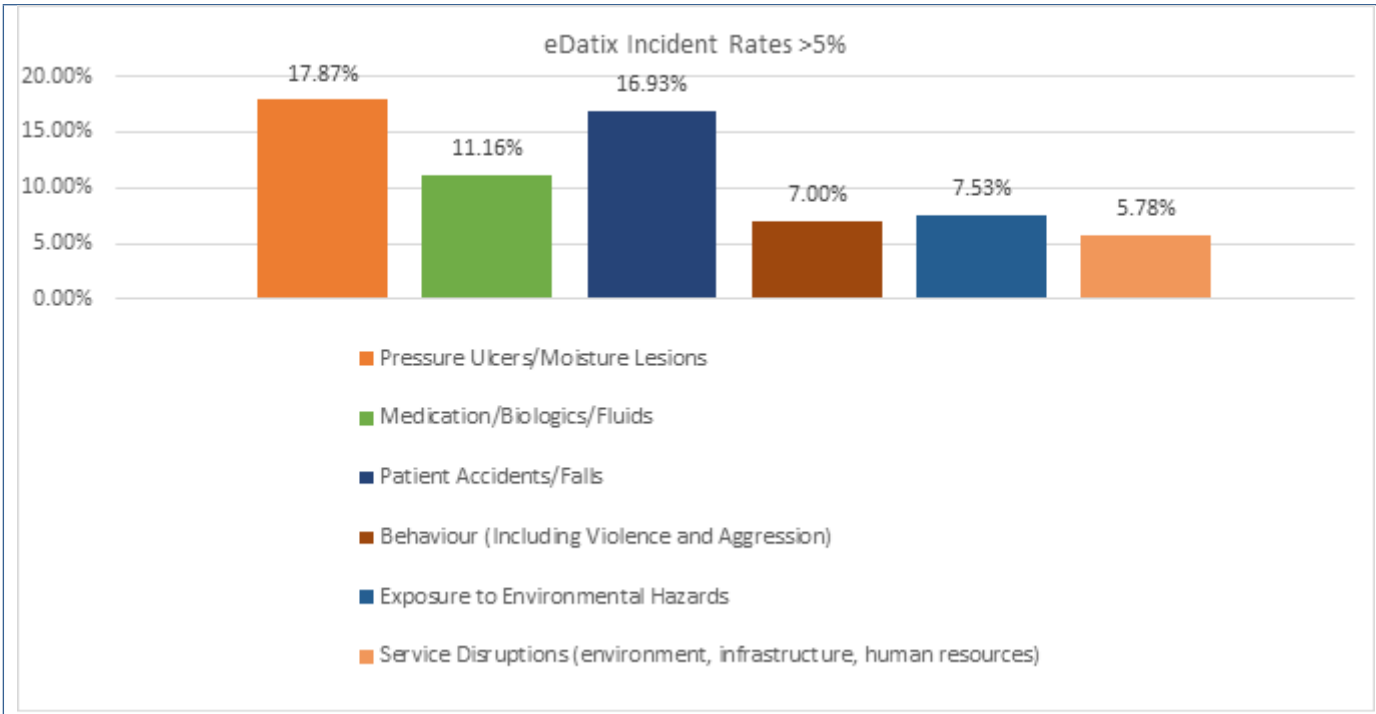
Through these initiatives the clinical board expects to see a continued increase in incidents reported as staff see that when issues are reported appropriate actions are taken in a timely manner and learning shared. The table below shows an overall increase in numbers of Datix logged without a similar rise in reportable incidents.

Annual Data	2018	2019	2020	2021	2022	Mean 18-22
Responsible Incidents	2233	2636	2559	2792	2883	2621

Through March 2022 we successfully transitioned our Datix management to the new E Datix system. This was also an opportunity to reinvigorate engagement with incident reporting and allow staff an opportunity to undertake training. A significant amount of work was undertaken to close historic datix reports down and move into E datix with minimal reports outstanding.

The graphs below show the spread of incidents reported between the two system and therefore the focus for the clinical board to address over the next 12 months. Critical care is the directorate with the highest level of reporting and is leading the way in addressing some of these issues as detailed above.



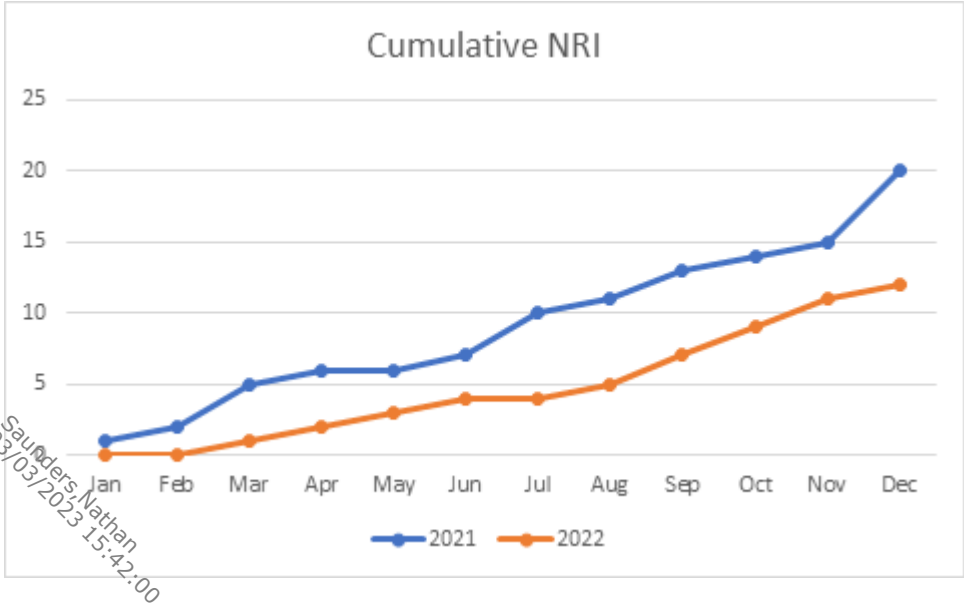


The clinical board is committed to reviewing and responding to incidents in a timely manner and the data below demonstrates this commitment since moving to the new system.

Total incidents open and those that have not been reviewed

	Total Datix Incidents	Total not reviewed for 7 days	Total Not reviewed for 30 days
Specialist	1081	22	6

Overall the Clinical Board have seen a decrease in the number of National Reported Incidents that we have seen between the twelve month periods despite seeing an increase in the number of incidents reported overall, which is a positive indicator within the safety agenda.



Of our current NRI's the breakdown is as follows:

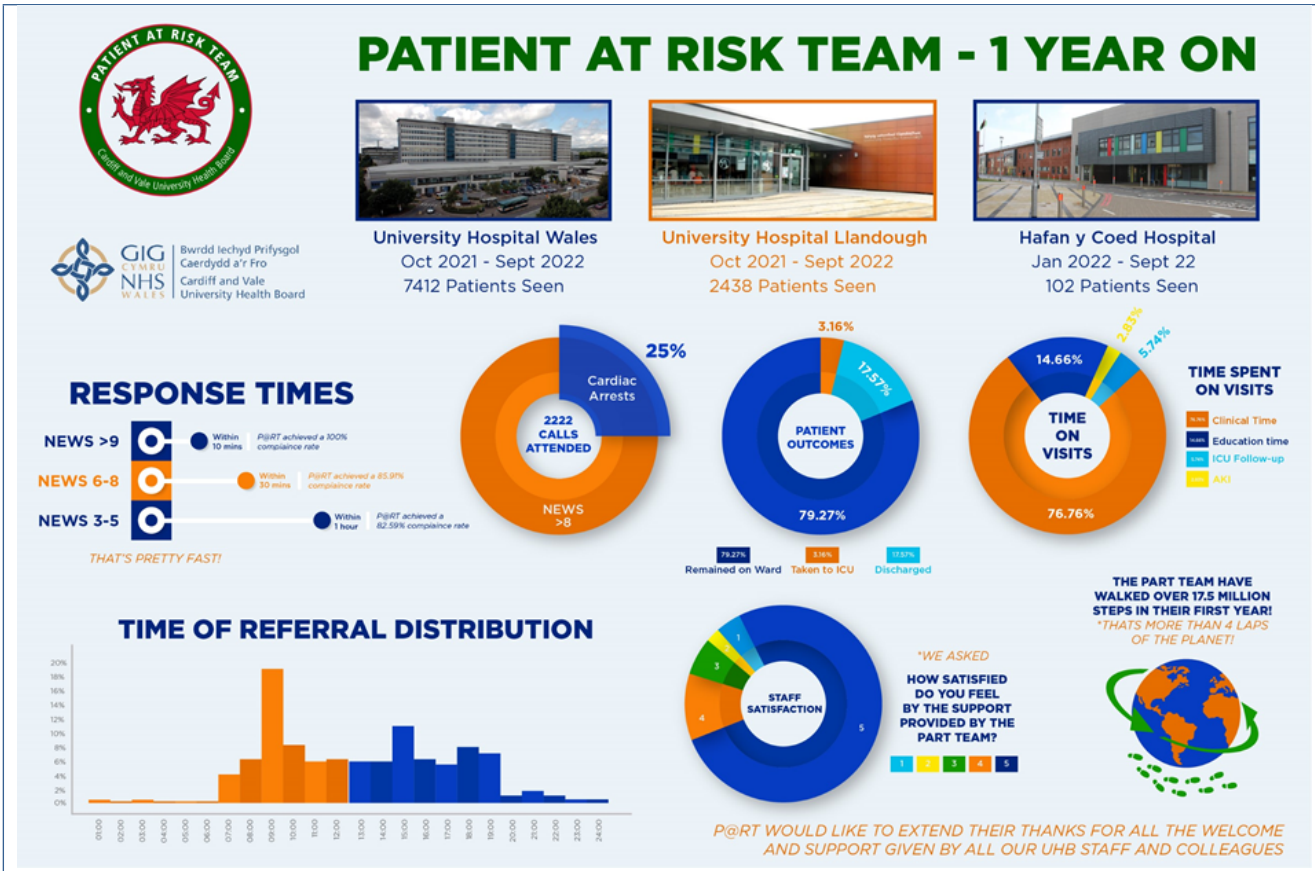
- Two that are waiting HM Coroners inquests, one relating to an injurious fall and one investigating a transfer of a patient to England as part of the Major Trauma pathway.
- Two investigation reports being finalised which have wider organisational learning regarding Welsh Clinical Portal and management system of Discharge advice letters, and one regarding an inpatient suicide.
- Two NRI's are directly linked with cardiology pertaining to timely review and treatment of a patient in the Emergency Unit
- One incident relating to management of a deteriorating patient post cardiac procedure.
- One relates to a patient that had a cardiac event whilst an inpatient that wasn't identified through cardiac monitoring
- One incident involves a patient that had a pace maker inserted but not clinically indicated at the time.
- The remaining NRI's were reported as part of a retrospective review of pressure damage care during the peak of the COVID pandemic.

The clinical board has a robust review of all NRI's through initial fact finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The clinical board has recently instigated post closure meetings at regular intervals to ensure actions are completed and also embedded in clinical practice to provide further reassurance.
Each report is also presented through Clinical Board QSPE meetings and shared more widely as appropriate.

Patient At Risk Team

October 2021 saw the launch of the Patient At Risk Team (PaRT) which was set up initially to support 7 day a week day time cover for the recognition of deteriorating patients and support of critical care stepdown patients and escalation. Two teams had previously functioned on the UHW site to address some of these issues (Critical Care Outreach and Medicine Rapid Response Team). These teams were combined with a new remit to see every patient in both UHL and UHW with a NEWS score of 3 and above, to support critical care stepdown patients for the first 24 hours and provide education and support to clinical teams in recognition of deterioration and escalation, particularly focusing on sepsis pathways. Through the first year the team also expanded into Hafan Y Coed to provide support and try and avoid unnecessary admissions into the acute medical streams.

In the first year of the service impressive results have been seen.



7412 patients have been reviewed in UHW and 2438 in UHL up to October 1st 2022. In addition, when HYC joined the service an additional 102 patients were seen from there. 79% of these patients have been supported to stay on the ward with a management plan, whilst 3.16% have been admitted to ITU, the remaining patients were discharged from the service after the first review.

Whilst the benefits of PaRT in direct patient support is clear a significant amount of time is also dedicated to delivering education and training for clinical teams. Just under 15% of the assigned time is spent in formal education delivery including simulation training, formal debriefing with ward teams and the first regional seminar with 2 more planned this year.

The case for expanding this service to 24/7 cover is being progressed.

National Organ Retrieval Service (NORS)

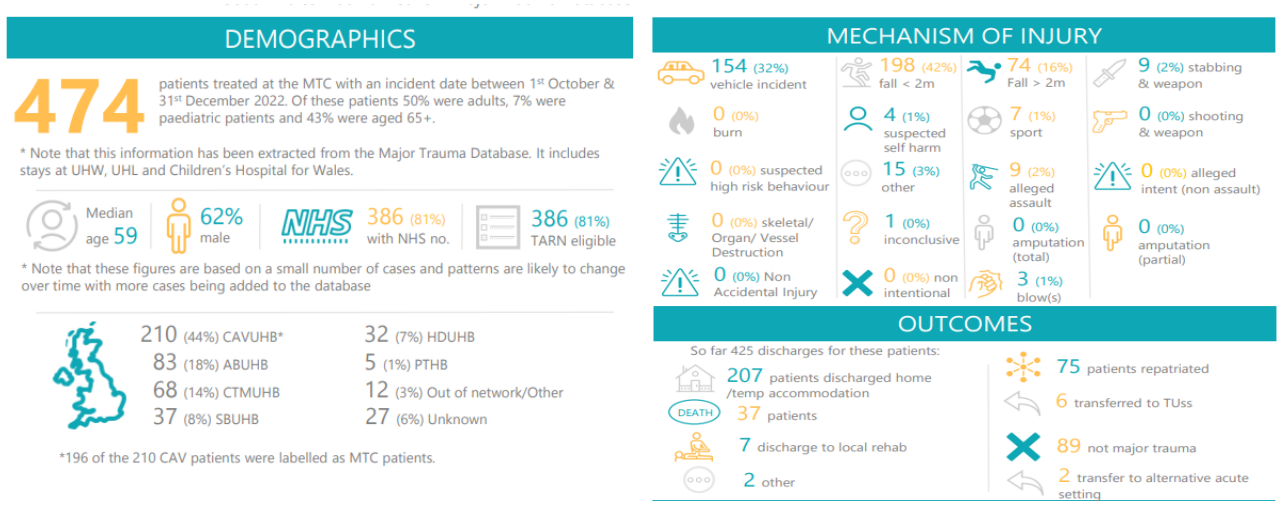
2015 saw the start of the NORS programme in Cardiff and since then the service has gone from strength to strength.
In May 2022 the Cardiff team, the only stand alone NORS team in the UK, started to use a pioneering technique, normothermic Regional Perfusion (NRP), to allow the retrieval of organs from donors after circulatory death, increasing the pool of accepted organs. This allows a pump to circulate oxygenated blood through the abdominal organs which improves transplant outcomes overall. Cardiff is one of only 3 centres in the UK able to deliver this option and the only non liver centre in the UK able to retrieve livers.

Major Trauma Centre

The Major Trauma Directorate management team (DMT) is led by the Clinical Director for Major Trauma. It sits within, and is accountable to, the Specialist Services Clinical Board. Major

Trauma care does not sit in one single directorate, but is delivered in a coordinated way involving multiple different specialities and organisations across the network.

Below is an infographic summarising the major trauma workload for Q3 of 2022. As anticipated the MTC treats a significant proportion of silver trauma (43% of all cases in Q3). The majority of patients are transferred straight to home from the MTC rather than repatriated to their home health board. This figure is higher than had been modelled, which would indicate that the intensive rehabilitation model has been a success.



In March 2022 the South Wales Trauma Network and therefore the MTC had its first peer review. The review identified 6 serious concerns. An action plan has been developed to address the issues raised. A number of the issues were within the control of the organization and have been address and closed. Others will require investment from our commissioners to resolve. The Clinical Board is working with WHSSC to seek additional investment and mitigate the risks.

Quality Audits and Performance.

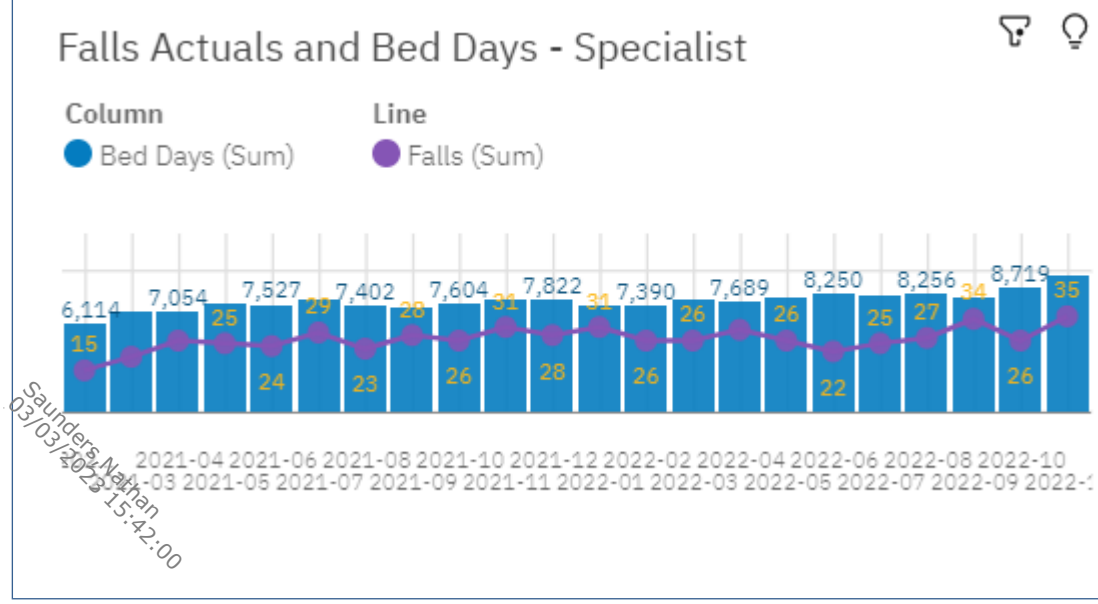
In 2022 Tendable was launched across the healthboard and has been welcomed by the clinical board as a platform to measure the quality and experience of our clinical areas and to demonstrate actions taken.
The dashboard below is an overview of the clinical areas currently as we increase the use of the app since launch. As can be seen it provides a quick snapshot of hotspots to focus on across the clinical board and then also allows detailed insight into specific clinical areas and progress with actions over time.

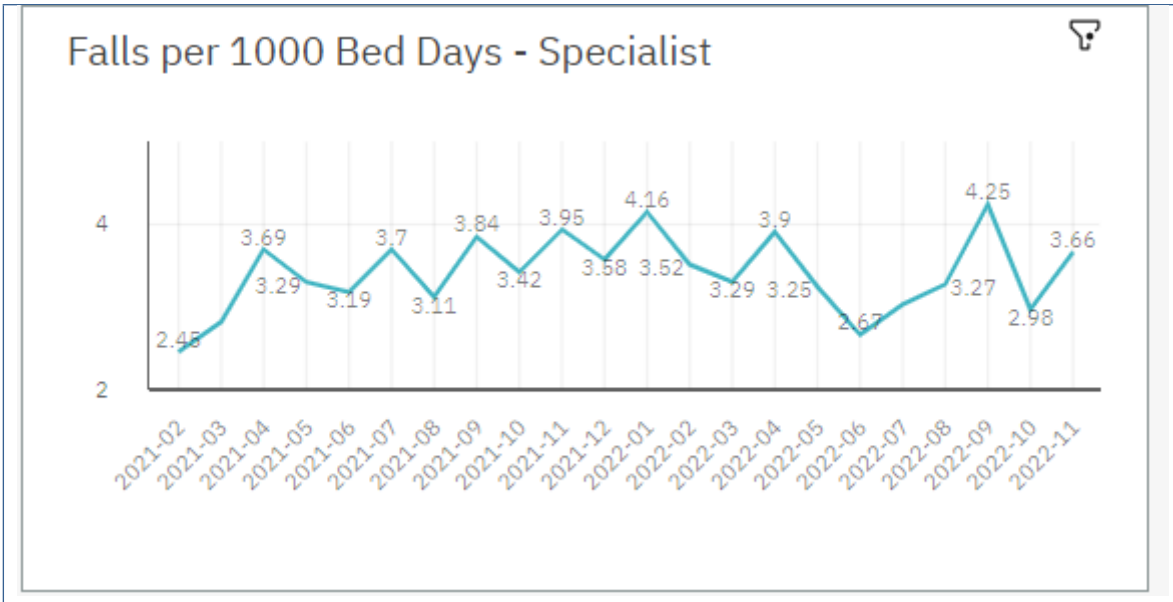
Nursing Team	Clinical Area S...	Staff Question...	Patient Checks...	Pressure Dam...	Nutrition Score...	Falls Score % -...	Bed Rails Scor...	Deteriorating P...	Core Dementia...	Patient Expe
A4 South Polyt...	93.8%	88.9%	100.0%	100.0%	62.5%	100.0%	100.0%	100.0%	50.0%	8
B1 Ward	87.1%	96.7%	100.0%	99.0%	97.9%	72.2%	100.0%	96.2%	100.0%	9
B4 Haematolo...	77.5%	83.9%	94.2%	93.3%	92.5%	80.0%	84.2%	100.0%		9
C3 Coronary C...	85.0%	100.0%	100.0%	100.0%	90.8%	100.0%	100.0%	96.1%		10
Cardiac Day Ca...										
Cardiac Intens...	92.3%	71.7%	100.0%	93.8%	94.2%	91.7%	100.0%	100.0%		10
Cardiff Transpl...	60.9%	72.2%	97.8%	93.2%	90.3%	73.6%	88.9%	85.4%	50.0%	9
Cardiothoraic ...	89.6%	98.6%	97.5%	89.6%	97.9%	84.7%	91.7%	87.5%		9
Critical Care Di...	58.3%	83.6%	100.0%	84.4%	25.0%	71.5%	91.7%	100.0%	0.0%	
Haematology -...										
Haematology ...										
Lakeside IACU ...	96.9%	76.4%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	96.9%	9
Long Term Ven...	86.0%	98.3%	99.0%	100.0%	88.5%	100.0%	91.7%	97.1%	50.0%	9
Nephrology -B5	70.8%	90.5%	90.4%	96.7%	86.8%	77.1%	95.0%	89.0%	100.0%	9
Neuro - C4N										
Neurosurgery -...	54.2%	60.6%	77.8%	84.2%	32.6%	27.8%	50.0%	90.7%	50.0%	8
Neurosurgery ...	75.0%	71.1%	100.0%	100.0%	65.0%	89.5%	100.0%	100.0%	54.2%	9
Post Anaesthe...	92.3%	100.0%	100.0%	100.0%				100.0%		10
Teenage Canc...	96.9%	100.0%	100.0%	98.4%	95.8%	82.2%	100.0%	100.0%		10

From the data it can be seen that the clinical areas for nearly all wards are falling below standard and therefore this will start a focus with our estates and housekeeping teams to work through the actions.

Falls

One of the key priorities for the clinical board is falls management, this will be measured using the data from the audits, and using the above dashboard as a basis. Whilst the falls profile has been fairly static for the year an increase has been seen over the last few months in 2022.
The initial work will entail education for ward teams in completion of multifactorial assessments and appropriate measuring of lying and standing blood pressure.
A member of the neurosciences team will also form part of the spread and scale team this year, looking at falls education.

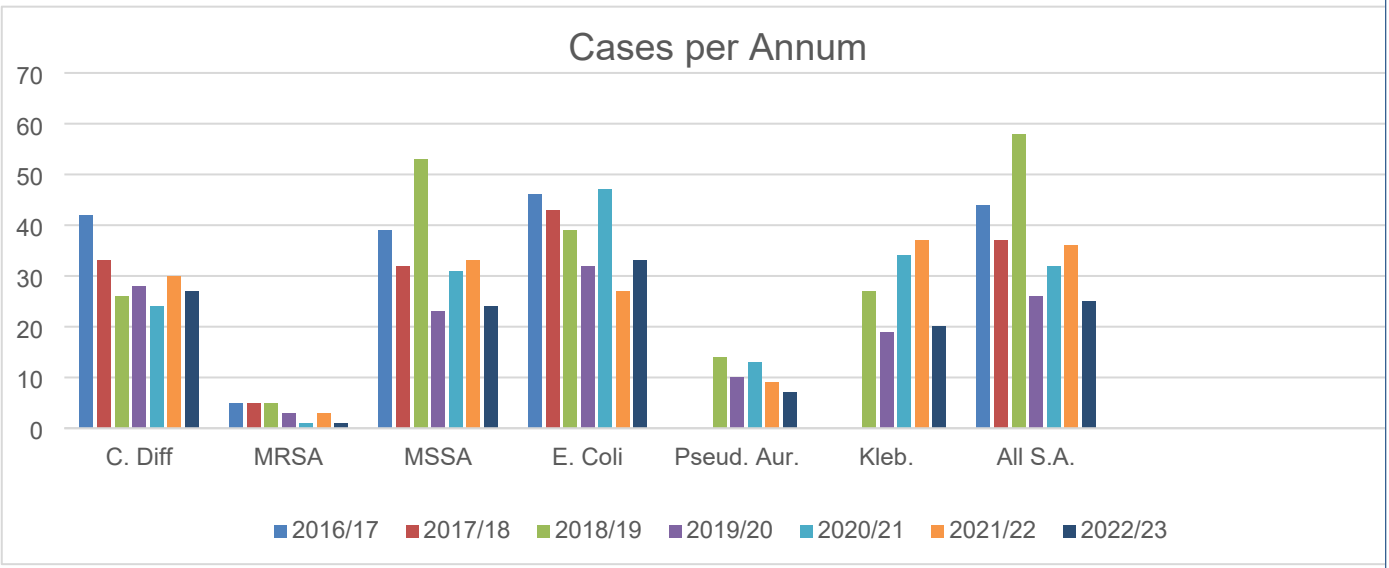




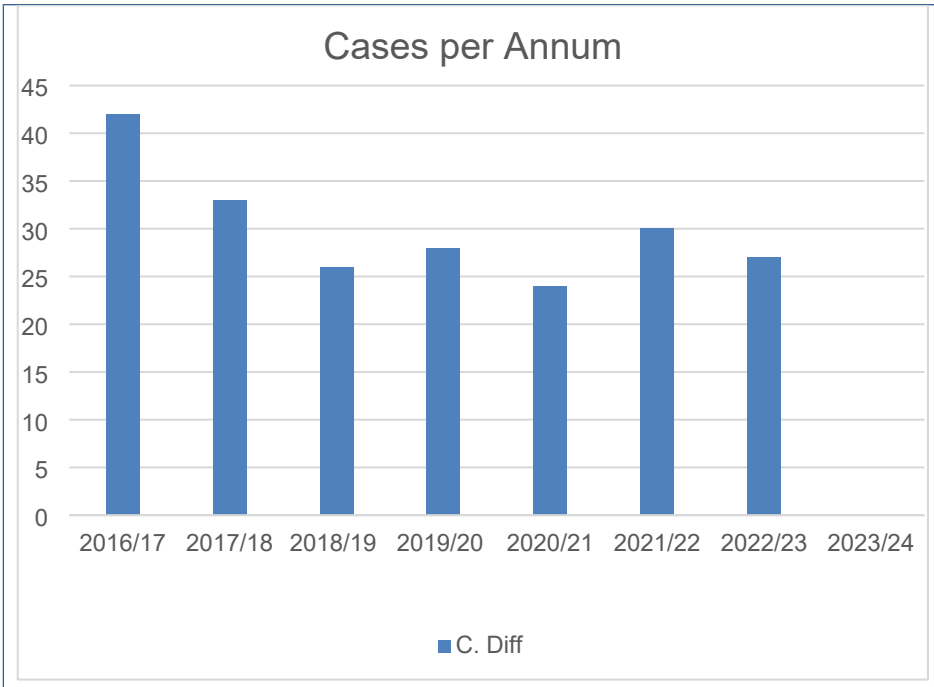
Infection Prevention and Control

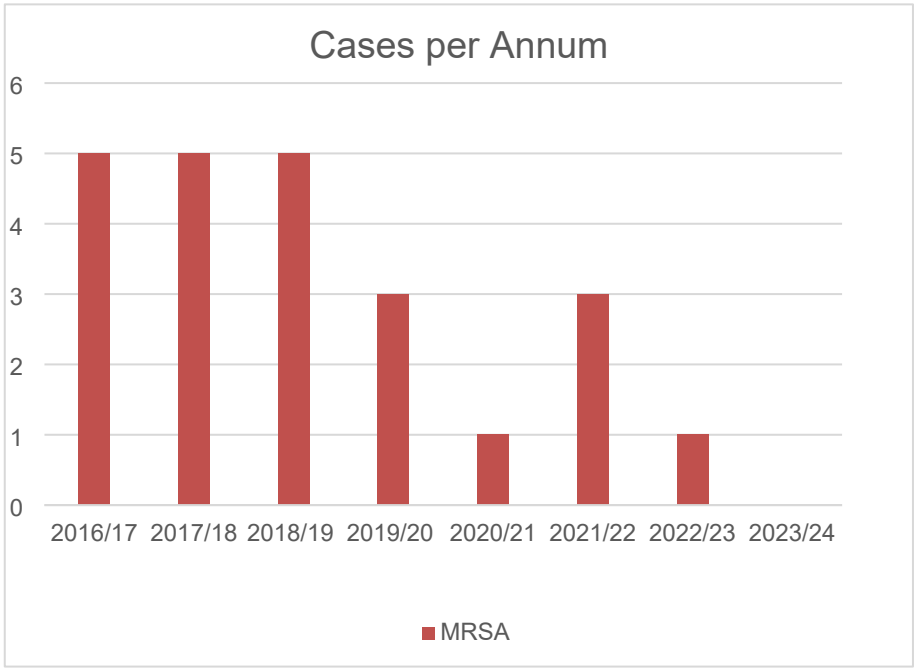
Over the last 12 months the Clinical Board has had focused reviews on the renal population, particularly MSSA, Critical Care and Neurosciences reviewing Klebsiella cases and clostridium difficile across all areas.

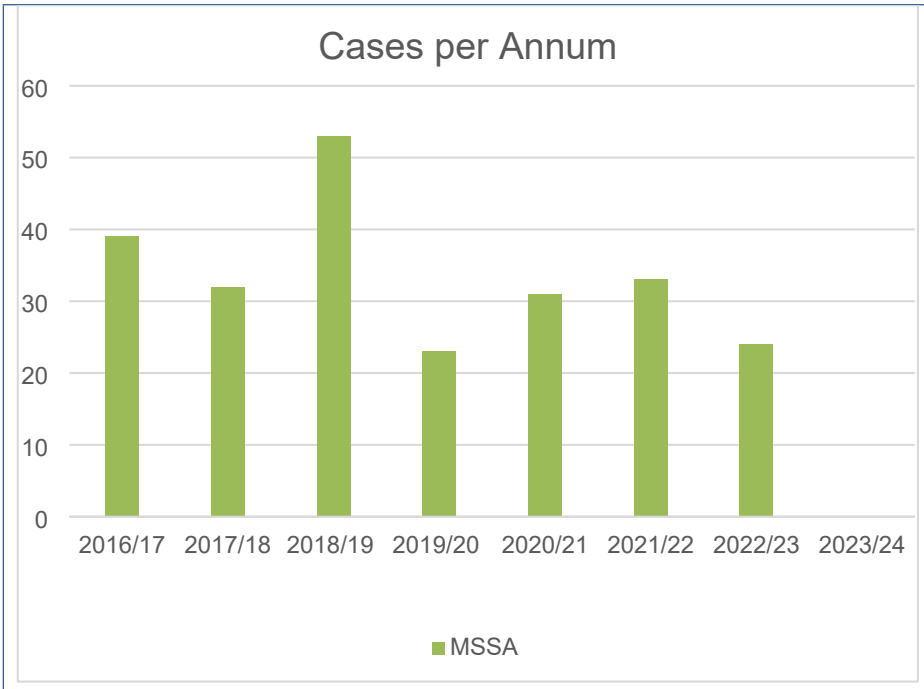
Overall we have seen a decrease in all key metrics except E Coli which will be a focus for the coming months as well as consolidating the actions already taken to achieve reductions in other areas.



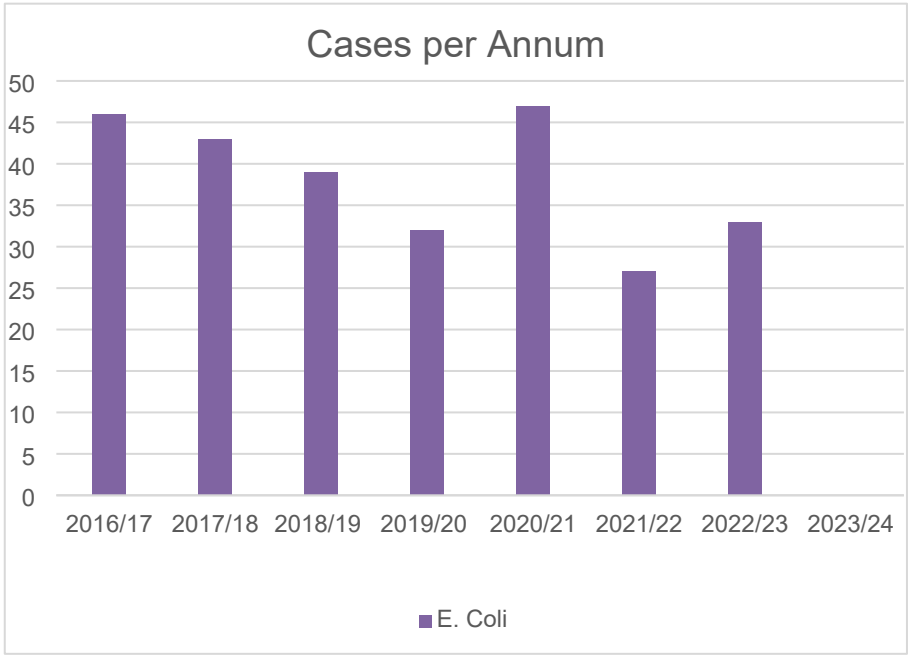
The below graphs show the data year on year per organism

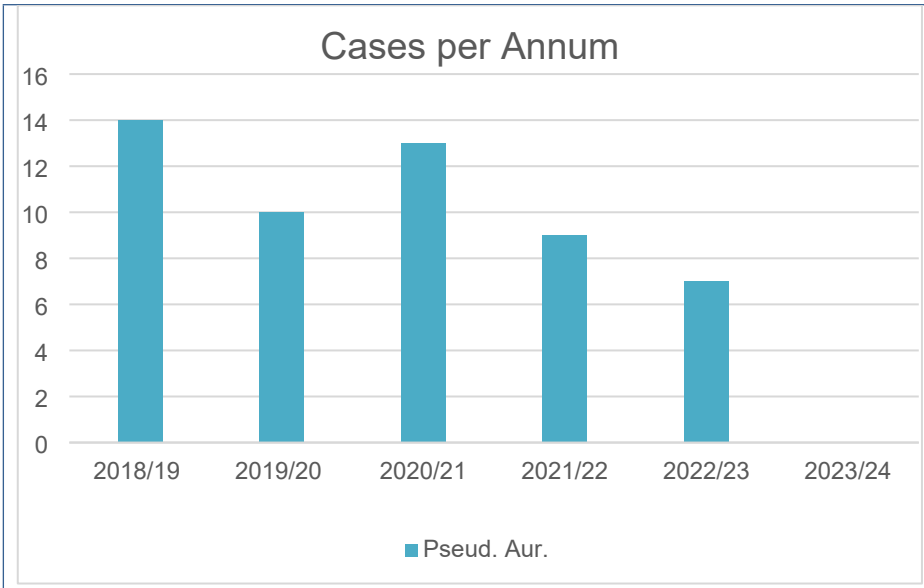


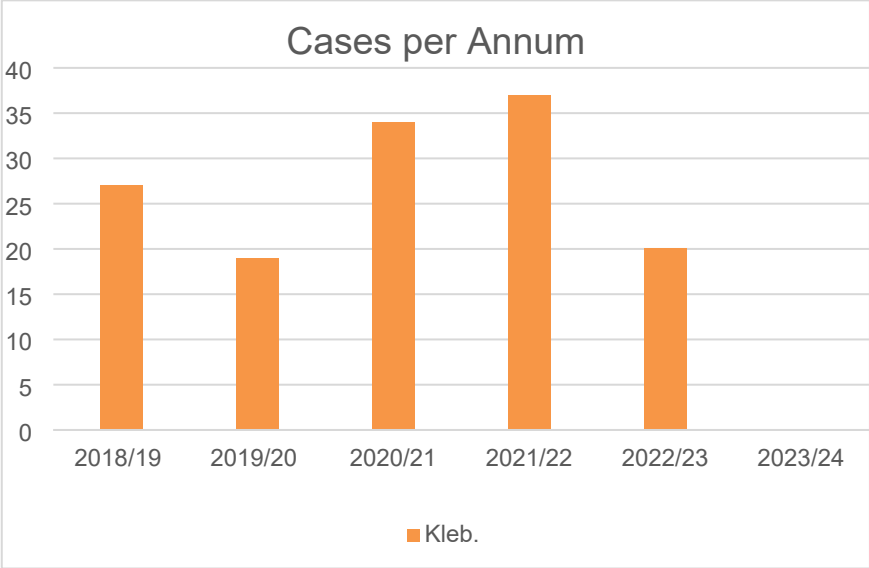




During 2021/2022 the Clinical Board saw an increase in MSSA cases particularly within the renal population. The directorate reviewed both incidences of infections between centres within South East Wales and also using the Renal Registry data across the UK. This showed that whilst our data was very similar to other populations it highlighted some variances in practice. This review resulted in a standardisation of practice for dialysis line care both prior to insertion and also through each dialysis session and an enhanced training package for staff.







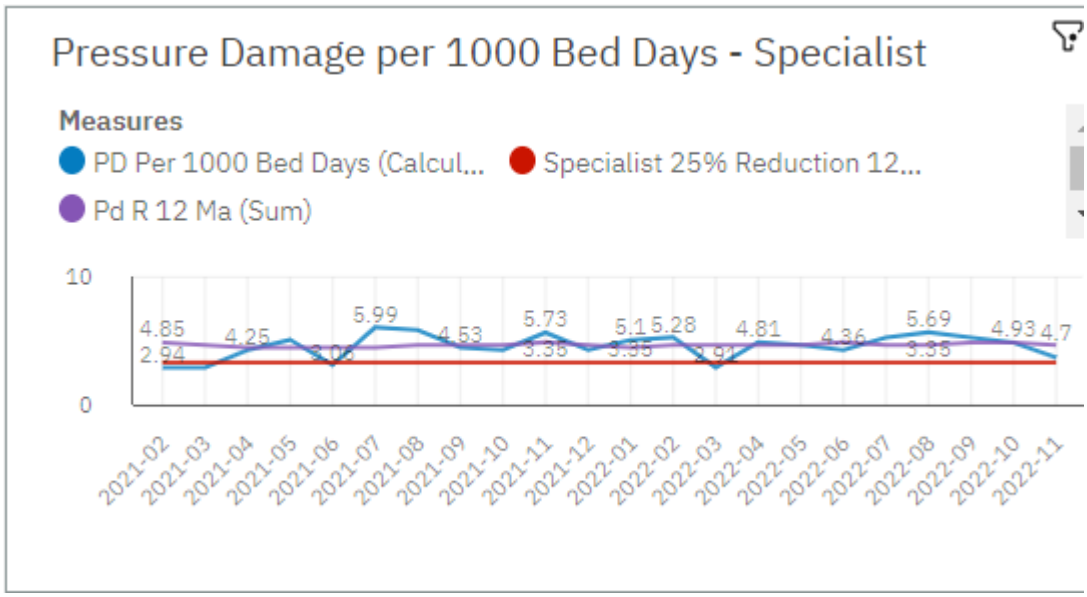
In 2020 an outbreak of Multi Drug Resistant (MDRO) Klebsiella started in the spinal rehabilitation centre originally based in Rookwood Hospital and then moved to a new facility in UHL. To date there have been 38 reported cases. 33 of those cases have been within the main outbreak strain, 5 patients in a smaller cluster and 2 additional cases that have been identified last month after a period of no cases. Patients were cohorted in the early stages of the outbreak to avoid further transmission and screening programme was started for all patients as part of the outbreak management and this is how the majority of patients have been identified.

The team have worked closely with IPC to audit all practices and also the estates team to provide assurances around availability of handwashing facilities and PPE storage within each patient area. The directorate have also worked with other similar facilities across the UK to learn from similar experiences. The directorate is working closely with Public Health Wales to review the management of the situation and are hopeful that the outbreak can be closed in March 2023.

Pressure Damage

Finally, the clinical board are in the process of developing a focused pressure damage group including a pressure damage scrutiny panel. This will allow for robust independent reviews of pressure damage with learning shared across directorates. This also allows the clinical board to provide focused training initiatives to groups of staff using our pooled resources and expertise.

The All Wales pressure damage assessments and tools are currently being reviewed in ALAS specifically due to the highly specialised care that is provided, and the unique challenge posed by supporting patients to use artificial limbs and appliances. For a number of these patients there is a need to challenge the fit of the equipment and this may cause pressure areas whilst the fit is confirmed. The team are working with centres in Bristol and Swansea to compare assessment tools and outcomes and will then discuss with the UHB pressure damage collaborative.



Due to the work undertaken within critical care as detailed earlier in the report we have seen a decrease in category 3 pressure damage and hope to continue to see a downward trend.

Reportable Grade Pressure Damage Incidents Jul - Dec	2021	2022
Device-related unstageable pressure ulcer (d)	0	1
Pressure ulcer category 3	13	9
Pressure ulcer category 4	0	0
Unstageable pressure ulcer	10	11
Total	**23**	**21**

Safeguarding

Due to the nature of some of our areas, we see many safeguarding referrals and queries, particularly within Major Trauma and Critical Care directorates. Investigations are led by Health Lead Professionals, with appropriate actions taken and shared more widely if required. The

teams have good links with the safeguarding team and psychology support for both staff and patients involved.

Workforce.

The Clinical Board remain committed to delivering the values and behaviours of the UHB to all our staff.

A significant amount of work has been prioritised on nursing workforce over the last 12 –24 months and this has resulted in both Critical Care and Nephrology and Transplant reaching their establishments with people appointed to vacancies and positive feedback from overseas nurses and students respectively. This has been possible through a number of initiatives led by a strong leadership team and developing clear objectives and learning opportunities for both environments. Learning from this is being shared with other directorates within the clinical board to implement similar initiatives.

The Clinical Board has seen an increasing sickness picture over the last 12 months with a particular rise in stress and anxiety and so work is being undertaken in a number of areas to develop wellbeing initiatives.

These include:

- Wellbeing champions
- Peer support with formal education through HEIW
- Psychology support and debriefing for staff
- Celebrating Success Awards for Specialist Services
- Newsletters developed and shared with directorates
- Partnership working with union colleagues to listen to staff and develop improvements together
- Staff rotations to develop a career pathway and also provide respite from acute areas when needed(tailored to individual plans).

However, data from January shows a drop in sickness to the lowest rate for over 12 months so this will be monitored over the next 12 months.

		2022 / 02	2022 / 03	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09	2022 / 10	2022 / 11	2022 / 12	2023 / 01	Absence FTE %
		Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	
Specialist Services Total		**7.98%**	**8.01%**	**7.46%**	**6.89%**	**7.89%**	**8.37%**	**8.37%**	**7.83%**	**8.59%**	**7.82%**	**8.87%**	**6.36%**	**7.87%**
	Add Prof Scientific and Technic	6.40%	3.86%	1.25%	2.24%	2.08%	1.41%	5.58%	5.86%	5.48%	5.45%	7.53%	5.89%	**4.57%**
	Additional Clinical Services	13.40%	14.28%	13.56%	15.30%	17.16%	15.32%	15.44%	15.25%	16.30%	12.08%	14.21%	9.55%	**14.28%**
	Administrative and Clerical	7.62%	8.45%	7.32%	6.84%	8.53%	9.85%	8.14%	6.34%	9.07%	8.43%	6.78%	5.16%	**7.71%**
	Allied Health Professionals	6.42%	6.48%	7.48%	5.72%	7.13%	3.71%	4.77%	3.05%	4.02%	4.94%	6.67%	6.82%	**5.62%**
	Healthcare Scientists	4.06%	5.66%	5.64%	4.30%	4.54%	5.64%	3.97%	5.48%	6.84%	7.18%	6.95%	5.14%	**5.48%**
	Medical and Dental	0.74%	0.67%	0.44%	0.40%	0.62%	0.33%	0.02%	0.23%	0.04%	0.25%	0.08%	0.14%	**0.34%**
	Nursing and Midwifery Registered	8.27%	7.60%	6.95%	5.59%	6.34%	7.72%	8.15%	7.57%	7.91%	7.75%	9.34%	6.70%	**7.50%**
	Students	0.00%	0.00%	1.35%	0.00%									**0.41%**

Nevertheless, there are still significant challenges with supporting staff to achieve compliance with Value Based Appraisals and this is a continued focus for the teams. There are a number of initiatives being tried to allow staff to participate in a timely VBA but still a significant way to go as detailed below, and this has been hampered by operational pressures and focus on delivering clinical care.

Specialist Services	1884	41.51%
ALAS	153	30.07%
Cardiac Services	390	42.31%
Critical Care	550	43.45%
Haematology and Clinical Immunology	233	28.33%
Nephrology and Transplant	212	59.43%
Neurosciences	288	40.97%
Specialist Services Management	58	37.93%

However Medical Appraisals are in a better position overall as detailed below.

	Staff in post		
ALAS	1		0.00%
Cardiac Services	34	26	76.47%
Critical Care	33	26	78.79%
Haematology and Clinical Immunology	27	23	85.19%
Nephrology and Transplant	26	22	84.62%
Neurosciences	44	34	77.27%
Specialist Services Total	**165**	**131**	**79.39%**

Risks for escalation

There are a number of enduring risks within the clinical board, including:

Critical Care - Bed Capacity
Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care present a risk of avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.

Critical Care - Estates
There is a risk of patient and staff harm due to aging and obsolete estate and equipment coupled with reduced capacity within the Critical Care Directorate.
Aggregated Risk following risk of harm in the following areas:
- Sub-standard Heating, Ventilation and Air Circulation
- Isolation Facilities
- Substandard Infrastructure and plumbing leading to flooding
- Obsolete Pendants System providing medical gasses.

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.

A number of actions are in progress to address the risks outlined above. As previously noted a business case to support the commissioning of 24/7 PaRT service will support the management of sick patients and will be an integral component in managing patients prior to and post ICU admission. There is a second case supporting the commissioning of three additional critical care

beds has been developed. The case is currently under review, with the aim to implement from 2023/24.

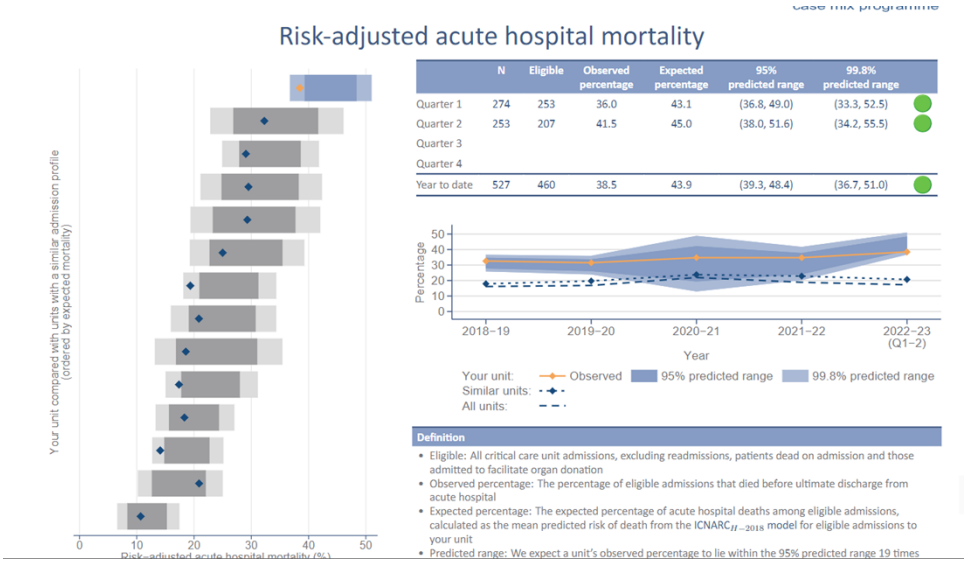
Project teams have been established to address issues pertaining to the estate and environment for both haematology and critical care services.

The haematology case is on track to be presented to the Board in Q1 of 2023/24 before being submitted to Welsh Government. The case addresses all environmental concerns as raised via JACIE in previous inspections as well as creates capacity to deliver growing CAR-T therapies as they are approved and commissioned.

The critical care development is a phased development, initially increasing cubicles within the ICU, followed by a redevelopment of the existing environment and an increase in beds available. Increases in capacity will be aligned to corresponding revenue case developments.

Mortality reviews

Mortality reviews are routinely undertaken as part of Directorate QSPE (Quality, Safety and Patient Experience) meetings. Mortality Level 2 reviews are undertaken through Mortality and Morbidity Meetings and for a number of our services, such as Major Trauma and Renal services shared with Networks and Renal registry respectively. The Clinical Board is fully engaged and working with Independent Medical Examiner reviews and form part of the UHB Mortality Group with feedback shared at Clinical Board QSPE meetings. Mortality Indicators for specialist services are currently being worked on with the Medical Examiner recognising the unique nature of a number of clinical areas.

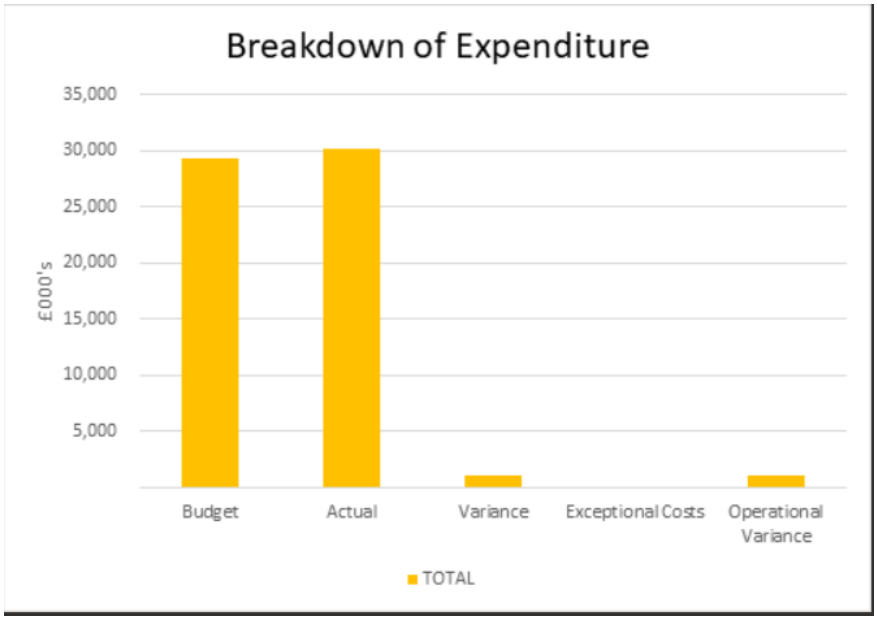


This data shows the risk adjusted mortality data for Critical Care for the last quarter of 2022 and that we are showing a higher level than other similar units referenced in the ICNARC data and supports the level of risk critical care are currently working in with complex patients.

Resources

Specialist Financial Position as at Month 10

The Board has reported an underspend of £2.625m to month 10 of 2022/23.



Month 10 Cumulative Variance (£2.625million)

- Operational (£2.639 million)
- COVID £0.015 million (inc. PPE)

Headline Year to Date Issues

- Medical £827k gaps and premium cover
- LTA Performance £478k
- PP/ NHSE Income Loss £127k – prior months
- Nursing Vacancies (Net) (£2,327k)
- Other vacancies (Net) (£1,074k)
- IACU expansion and workforce ongoing

ASSURANCE is provided by:

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

Recommendation:

The Quality Safety and Experience Committee is asked to:

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The most pressing risks have been highlighted in the Risk for Escalation section. Risks to Haematology and BMT environment, critical care environment and bed capacity continue to impact upon patient safety and experience
Safety: Yes
As above
Financial: Yes
The Clinical Board has a favourable in year financial position. This has been achieved largely on account of the vacancy rate across the clinical board and non-recurrent opportunities. As recruitment rates improve an underlying deficit will become apparent.
Workforce: Yes
As outlined in the body of the report the board has significant challenges with vacancy rates for registered nurses and skill mix.
Legal: No
Reputational: Yes
Reputational risks are outlined in the body of the report.
Socio Economic: Yes
The clinical board provides services to patients from across Wales for a variety of social economic backgrounds. Where possible we provide services closer to home to mitigate some of the costs associated with regional health models.

Equality and Health: Yes	
As above	
Decarbonisation: Yes	
ALAS and Critical Care services have established environmental impact groups to look at options to support decarbonisation. Details of these project can be found: *https://cardiffcriticalcare.co.uk/our-environment* *Towards a Circular Economy in NHS Wales: Mobility Equipment Repair and Reconditioning | WRAP (wrapcymru.org.uk)*	
Approval/Scrutiny Route:	
Committee/ Group/Exec	Date:

Report Title:	Looked After Children – Assessment Backlogs				Agenda Item no.	2.2	
Meeting:	Quality, Safety & Experience Committee		Public	X	Meeting Date:	7th March 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Executive Nurse Director						
Report Author (Title):	General Manager, Children, Young People and Family Health Services						

Main Report
Background and current situation:

The purpose of this report is to provide Committee Members will an updated position regarding assessments for Looked after Children (LAC).

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

The Children Looked After team are an integral part of the Children, Young People and Family Health Directorate and deliver an area of work where there are statutory health requirements. It is well known that children in care have adverse health outcomes so the assessments are aimed at improving health outcomes and reducing health inequalities, as well as ensuring identified health needs are actioned and monitored.

The service is provided by a small staffing team of 1.3 WTE Consultant sessions and 4.2 WTE Specialist Nurses. Statutory assessments are only a small part of the work within the looked after children team.

Performance against Statutory Regulations

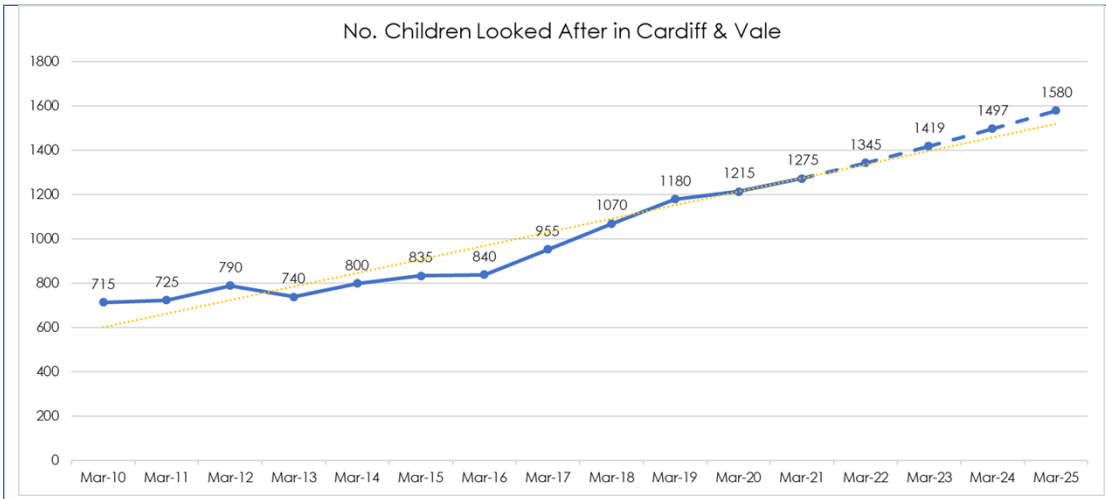
The regulations stipulate that within 28 days of a child being accommodated by the local authority they should have a holistic health assessment. For children under the age of 5 years a review health assessment should be undertaken every 6 months, for those aged 5+ years this should be completed annually.

Meeting these regulations is not currently achievable due to insufficient capacity for both medical and nursing assessments, which had deteriorated further due to the retirement of a Consultant.

The statutory requirements to see children within 28-days of entering care for an initial health assessment, is often not achievable due to delays in notification from the local authority.

Growth

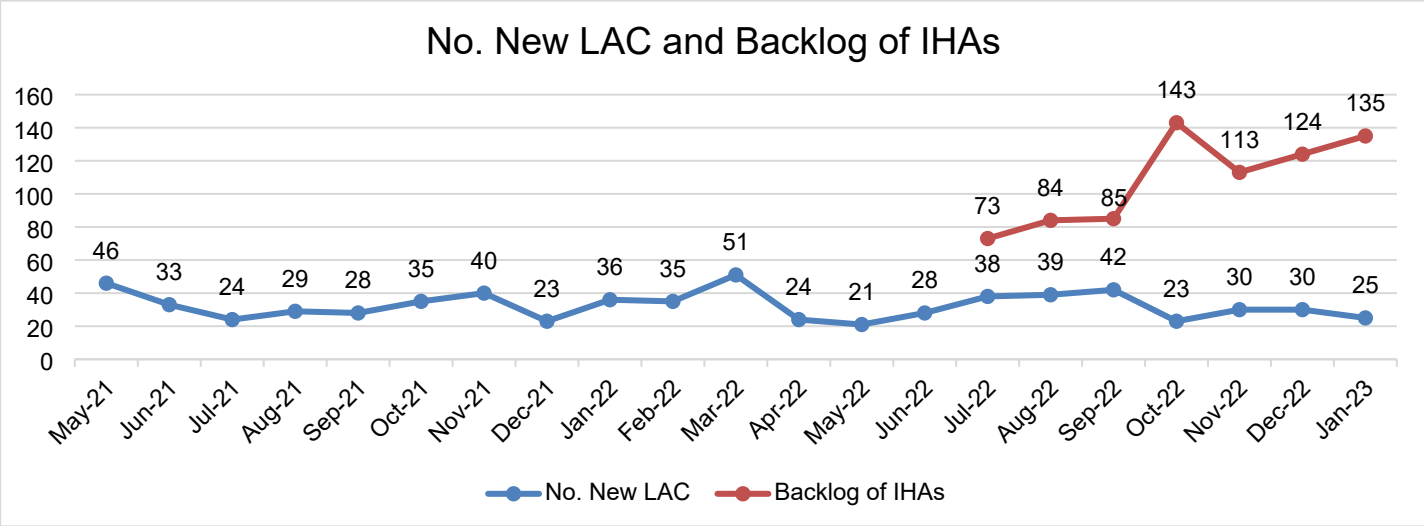
There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from 840 in 2017, to 1,275 in March 2021, as per official statistics. This growth is illustrated in the graph below, with predicted growth based on previous year's growth.



There are currently 1,638 children on the LAC database in February 2023. Included within this are 360 children from Cardiff and Vale, who are looked after out of area. Therefore 1,278 children living across Cardiff and Vale that the LAC team have statutory obligations around the new initial health assessment, and review health assessment.

The increase in numbers of Looked after have a significant impact on the number of Initial & review Health Assessments required each year. However, capacity has remained the same, resulting in a backlog of both new and review health assessments.

The graph below highlights the number of new requests for month, and the increase in backlog for new assessments.



Demand and capacity

Based on the current numbers looked after and predicted numbers entering care the estimated **demand** is summarised below.

Annual estimated demand	**How often**	**New IHA**	**Existing RHA**
Under 5	Twice a year	80*	650
5 to 10 years	Annual		250
Over 10	Annual		670
Total		**80**	**1,570**

estimate

There is current a backlog of 620 health assessments, summarised below.

	Under 10s (Medical)	**Over 10s (Nurse)**	**Total**
IHA	87	48	**135**
RHA	288	197	**485**
Total	**375**	**245**	**620**

Capacity for assessments are currently delivered by both Medical and Nursing staff. Nurse led clinics are currently undertaking assessments on over 10s. All other assessments are undertaken by Medical Staff.

The team consists of 6 sessions of a Consultant in post with 2 historical consultant sessions, and 5 specialty doctor sessions due to the retirement of a Consultant in autumn 2022, and 4.2 WTE Specialist Nurses.

The current workforce can deliver 700 assessments per annum, 530 nurse (over 10s) and 170 Medical (under 10s). Demand far exceeds capacity as summarised below, with a clear inequitable gap between under and over 10s, with a significant gap for the younger looked after children.

	Under 10s (Medical)	**Over 10s (Nurse)**	**Total**
Estimated demand			
New (assume 50/50 split)	40	40	**80**
Review	900	670	**1,570**
Total Demand	**940**	**710**	**1,650**
Current capacity	170	530	**700**
Shortfall	**770**	**180**	**950**

In addition to the increasing backlog of assessments this increase in demand has resulted in nurses carrying significant numbers of children on their caseload, in excess of the recommended 100.

Actions taken

Alternative staffing models have been explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations. These include immediate support of 2.80 wte nurse posts to increase the team to 7 WTE. This includes the team leader who has responsibility for Cardiff and Vale children placed out of area. This is will create both assessment capacity to address the backlog, and reduce the current caseloads.

With an increase in nursing this will increase capacity by 430 to 960, addressing the capacity imbalance for over 10s. These additional nurses have now been appointed and will commence employment March 2023. It is anticipated this will deliver a total of 1,130 assessments, and reduce the backlog assessments for over 10s.

However this will not address the gap in the under 10s based on the current model of care. There is a medium-term plan to recruit an additional 2.40wte Band 6 nurses to see all children over 5, and a longer-term plan to deal with expected growth and safe caseload numbers.

Other modernisation and change of delivery models will continue to be explored with the service to ensure efficiency and best use of resources, with a further expansion in nursing resource to support assessments for over 5s.

Recommendation:
The Committee is requested to:- a) note the content of the paper and the actions taken to mitigate the risks associated child health assessments.

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
This has been risk assessed and entered onto the Risk Register
Safety: Yes
In the main body of the report
Financial: Yes
Immediate financial risk has been mitigated by redirecting resource to LAC service due to risk being held.
Workforce: Yes
Detailed in body of the report
Legal: Yes
due to statutory obligations
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation:No

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

Report Title:	Quality Indicators Report			Agenda Item no.	*2.3*
Meeting:	Quality, Safety and Experience Committee	Public	✓	Meeting Date:	7/03/23
		Private			
Status *(please tick one only):*	Assurance	✓	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assistant Director of Patient Experience				

Main Report
Background and current situation:

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

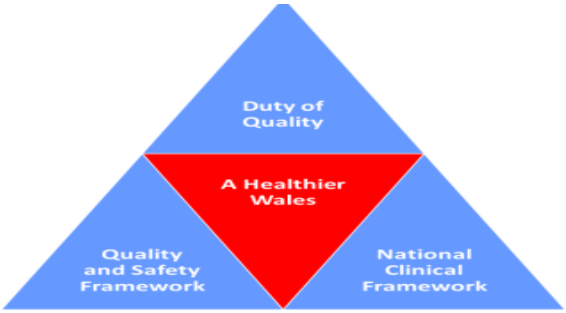
There continues to be significant operational pressures across the Organisation, made more challenging with the ongoing staffing pressures and periods of industrial action. The QSE framework continues to be embedded and the committees/groups established in 2022 will support the acceleration of the implementation of the framework, with particular emphasis in 2023 on the learning and service improvement from all of the available sources.

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

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

It is noted that following consultation, workforce will be added as an enabler

Saunders,Nathan
03/03/2023 15:42:00



Key messages

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

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

Board

QSE Dashboard/Signals from noise

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

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

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

Terms of Reference to be agreed

Clinical Safety Group (Chair: Executive Medical Director)

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

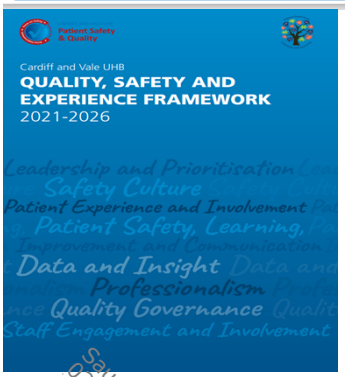
Clinical Effectiveness Committee (Chair AMD for Quality and Safety)

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

NRI/ Concerns (Chair: Executive Nurse Director)

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

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



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

These eight key areas are:
• Safety Culture
• Leadership and the Prioritization of QSE
• Patient Experience and Involvement
• Patient Safety Learning and Communication
• Staff Engagement and Involvement
• Data and Insight
• Professionalism of QSE
• Quality Governance Arrangement

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

Duty of Quality

The duty of quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will come into force in April 2023. It is a lever for improving and protecting the health, care and wellbeing of the current and future population of Wales. It aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country.

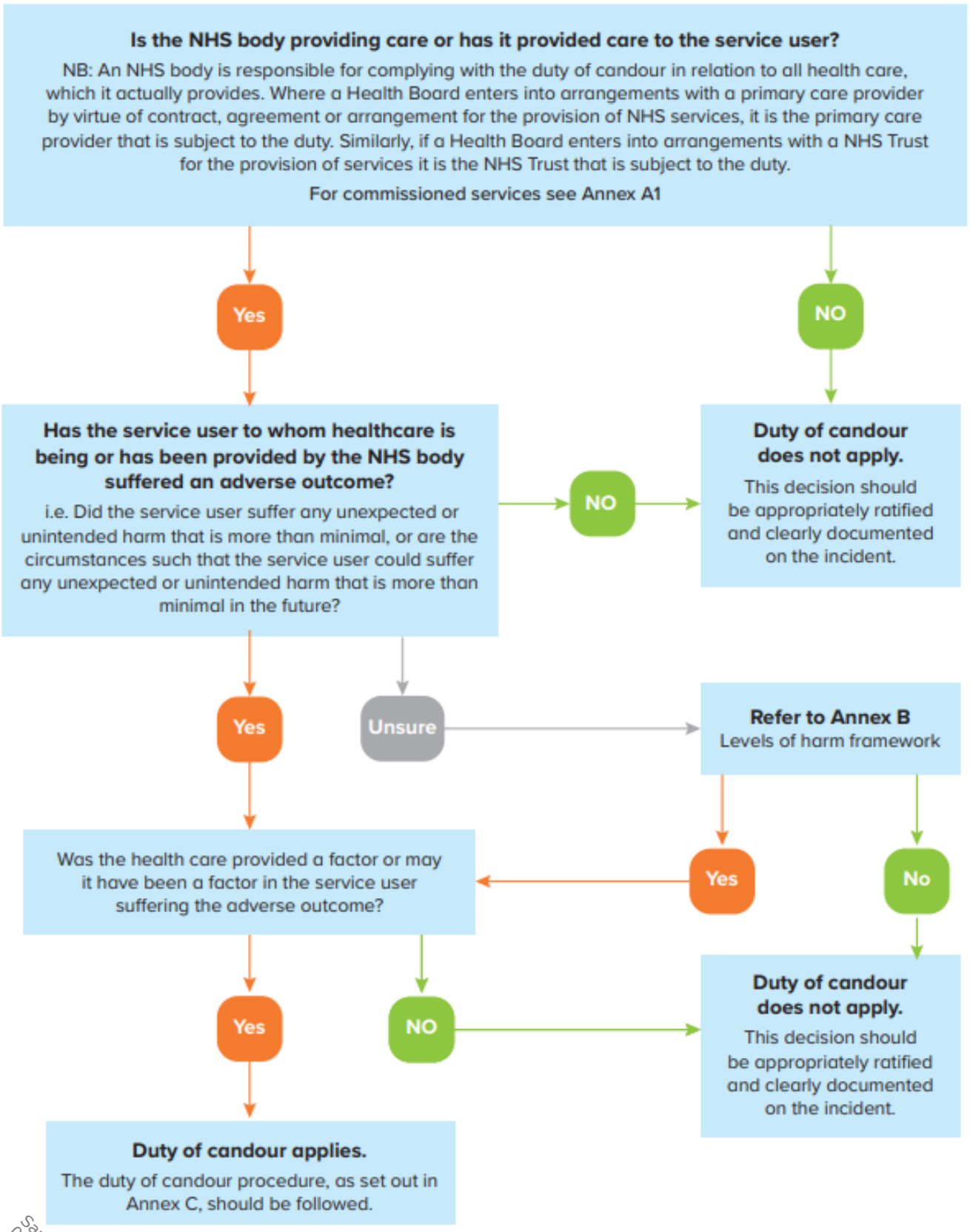
The Act is intended to have positive benefits for everyone in Wales, supporting a culture and the conditions needed to drive improvements in health care. The duty of quality requires the Welsh Ministers, with regards to their health-related functions and NHS bodies, to think and act differently by applying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

Duty of Candour

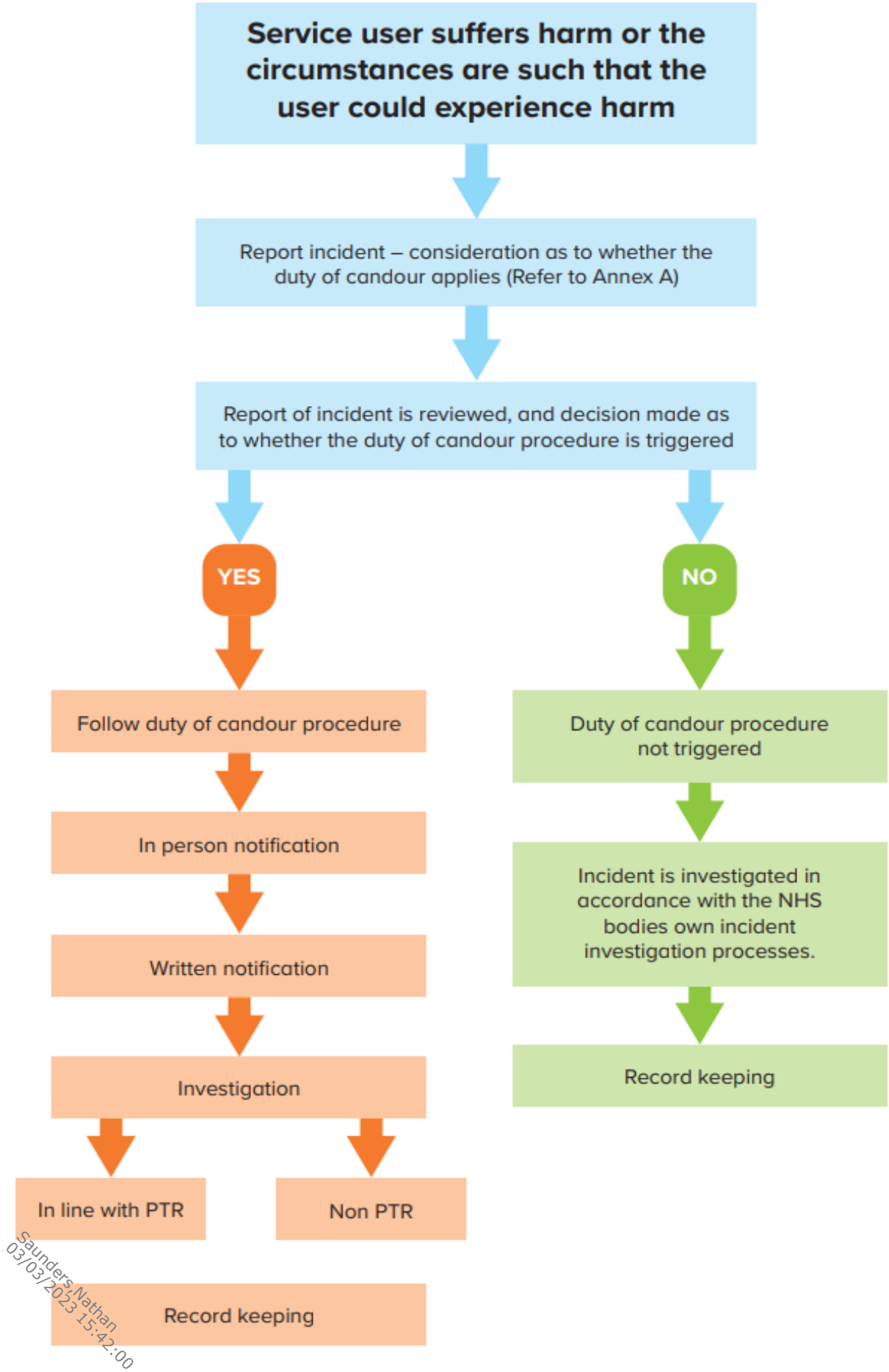
The Duty of Candour will be in force from April 2023. The duty applies to NHS bodies in Wales and requires them to be open and transparent with people when they come to harm whilst using services. The duty will be triggered when there is an incident that causes harm that is more than minimal, the harm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

Annex A - Duty of Candour

Trigger review process



Review process and record keeping



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

As part of the regulatory Impact Assessment we have considered 9 months of data in relation to Health Board recorded incidents and in excess of 3000 would need consideration as to whether the Duty of Candour applies. These figures do not include primary care incidents which will be included from 1 April 23. The initial work will be focused upon understanding the grading application at the initial recording of the incident and mandatory consideration of the grading on incident closure. Duty of Candour will be managed through the Patient Experience Team, as the process somewhat mirrors the current management of complaints and there will be an interface with Redress, which is also part of the Patient Experience Team's function.

Safe

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

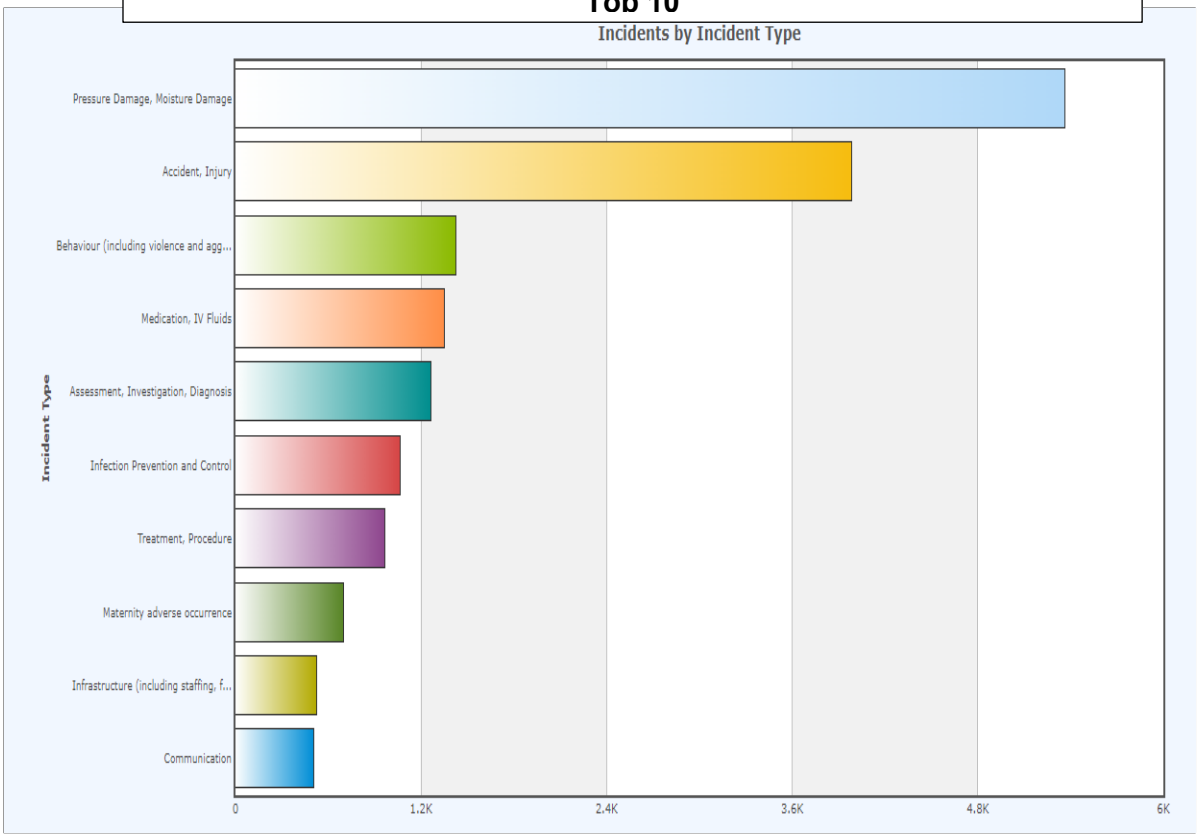
Incident reporting

The chart below illustrates patient safety incidents reported during December 2022 and January 2023 by incident type. A total of 3671 incidents were reported during this period, of these as of 1st February 2023, 831 were Covid related incidents. As we usually see, the most commonly reported incident relating to the development of pressure or moisture damage.

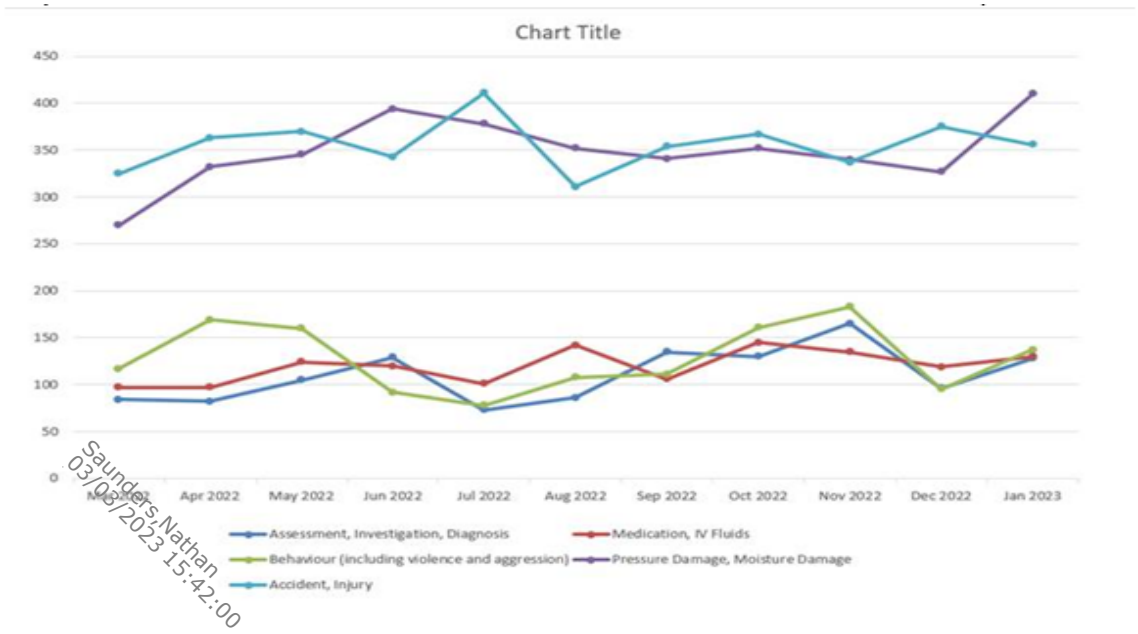
Pressure damage is subject to investigation to establish if there were any modifiable elements or omissions in healthcare. Avoidable pressure damage that is deemed to be associated with healthcare provision, are subject to national reporting requirements.

Accident/Injury (primarily falls) is the second most commonly reported incident.

Patient Safety Incidents reported December 2022 and January 2023 – Top 10



Short staffing incidents has reduced in prevalence during this two-month period in contrast with the previous 2 months (October and November 2022), it has dropped down from number 6 on the top 10 to number 9.
The above shows the trend for incident reporting by category over specific months of the year last year.



Nationally Reportable Incidents (NRIs)
The table illustrates performance of Nationally Reportable Incidents until 31st January 2023. It is an improving position and reflects the focus and hard work of the Clinical Boards and Patient Safety Team. This progress is reflected in the table below.

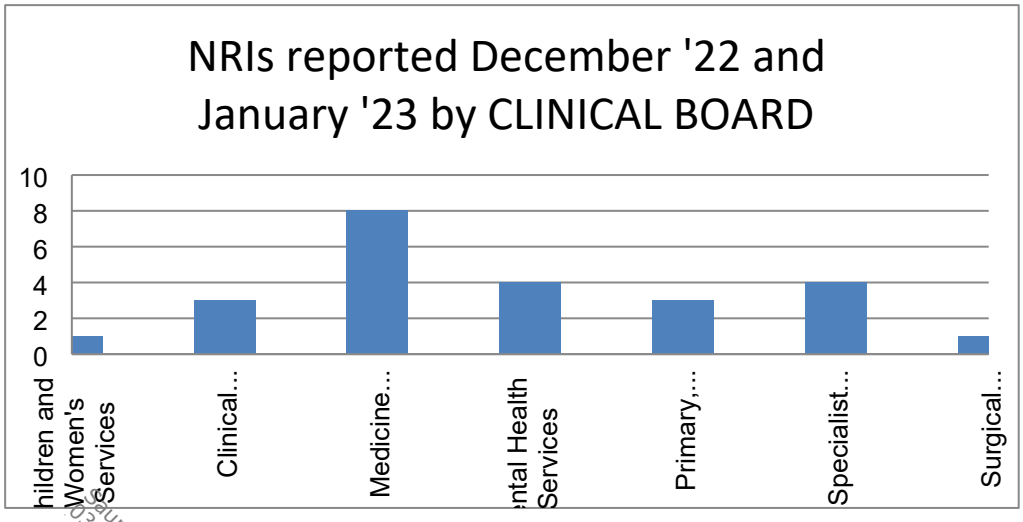
	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26
December 2022	43	19
January 2023	46	20

This demonstrates a reduction of overdue NRIs by **41%** since September 2022.

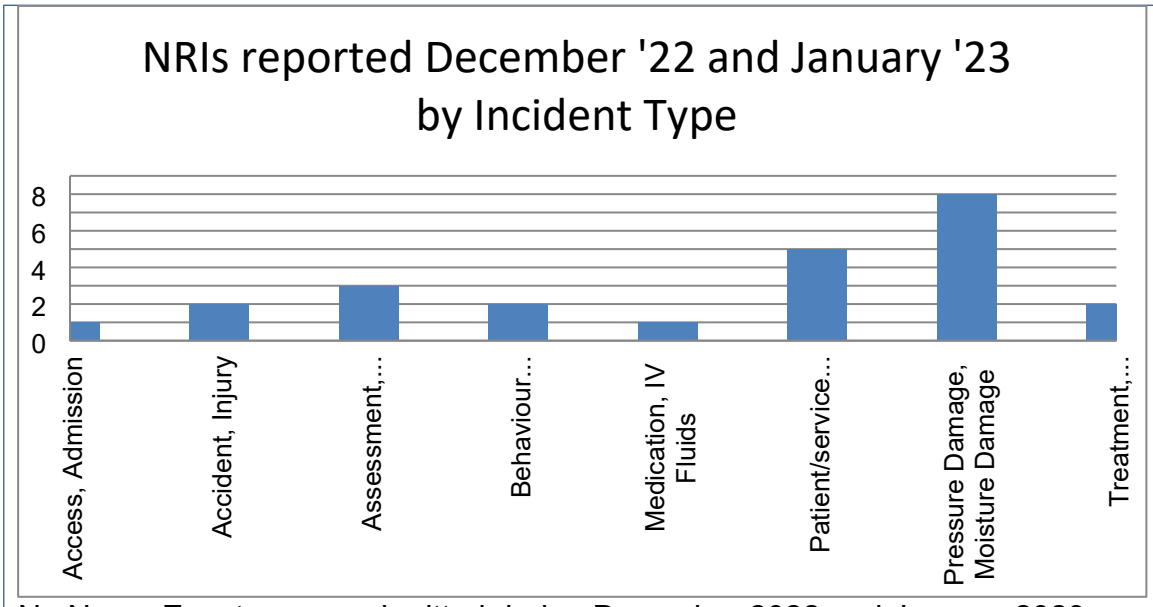
Clinical Board	**Open NRIs as of 31.01.23**	**Overdue NRIs as of 31.01.23**
Children and Women	8 ↓	6 ↑
CD&T	3 ↑	0 ↔
Executive	2 ↓	2 ↓
Medicine	5 ↓	5 ↓
Mental Health	10 ↔	4 ↓
Surgery	7 ↓	3 ↓
PCIC	3 ↑	2 ↔
Specialist	10 ↑	2 ↑
Total	**46** ↓	**20** ↓

The above shows a general reduction in the number of overdue NRIs by Clinical Board thus improving the overall UHB performance.

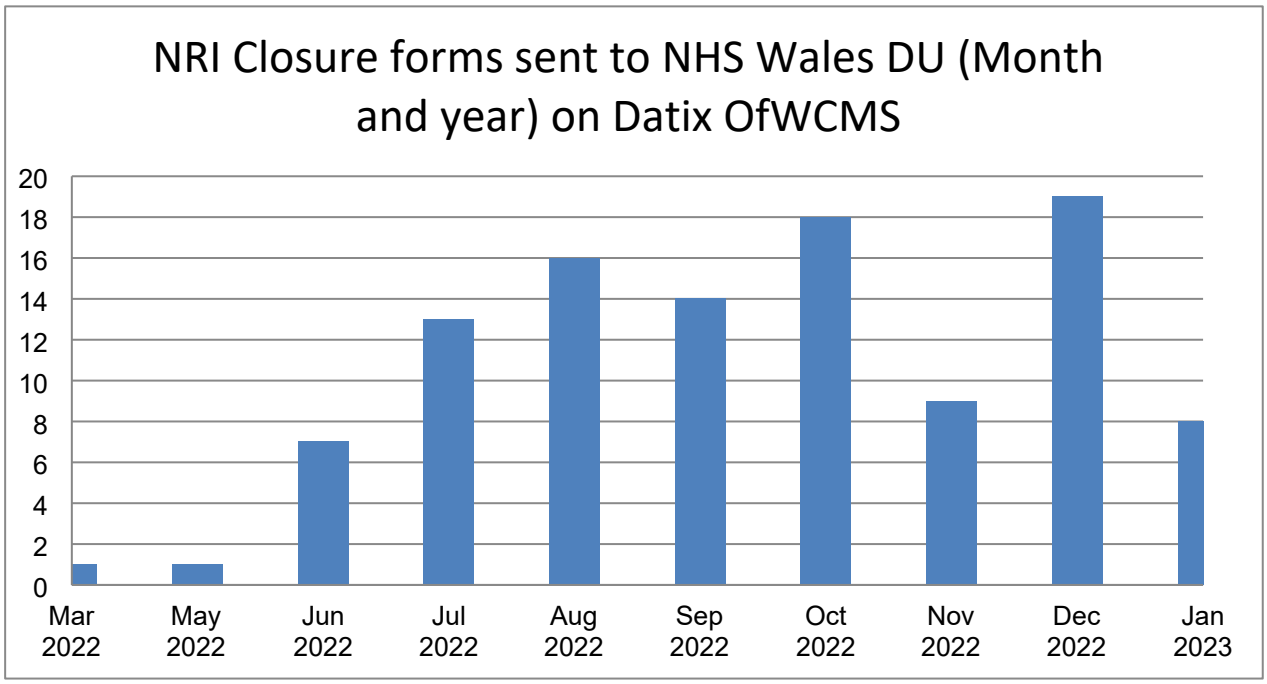
Thirteen NRIs were reported in December 2022 by C&V, eleven were reported in January 2023. Of these, the breakdown reporting Clinical Board and type of incident can be seen in the charts below.



Medicine Clinical Board reported the highest number of NRIs over this period, the majority of these were avoidable pressure damage.

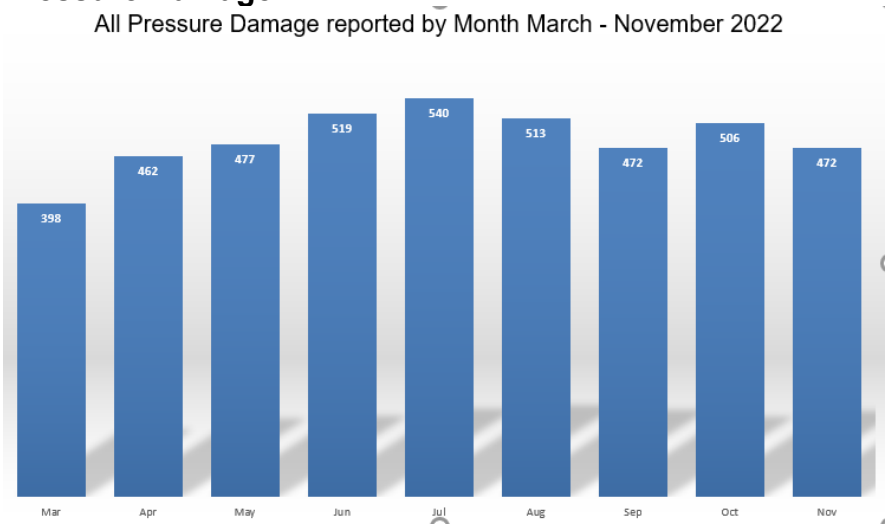


No Never Events were submitted during December 2022 and January 2023.



The lower number of closure forms from March to June 2022 can be explained by the transition to the new system, many were still being closed on the previous Datix system. The above figures represent only those closed on the new OfWCMS.

Pressure Damage



The above shows the reporting trend for ALL pressure damage entered onto Datix between 1st March 2022 and 30th November 2022. The level has remained fairly constant.

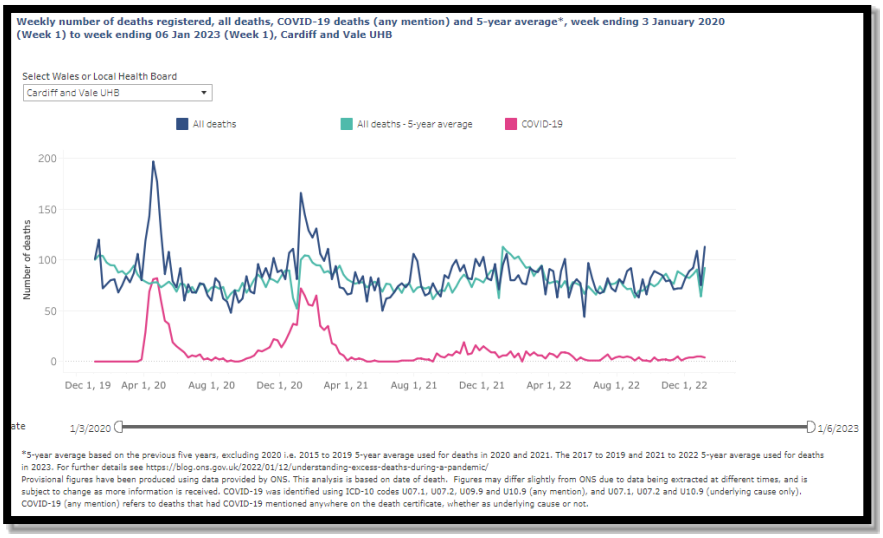
Mortality

The November 2022 Quality Safety and experience committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board.
Tier 1 Health Board wide mortality measures which will be reported including All-Cause Mortality and Crude inpatient mortality.
Tier 2 - Clinical Board level mortality indicators which includes some condition specific mortality indicators.
Tier 3 – specialty level mortality indicators to include condition and intervention specific mortality data.

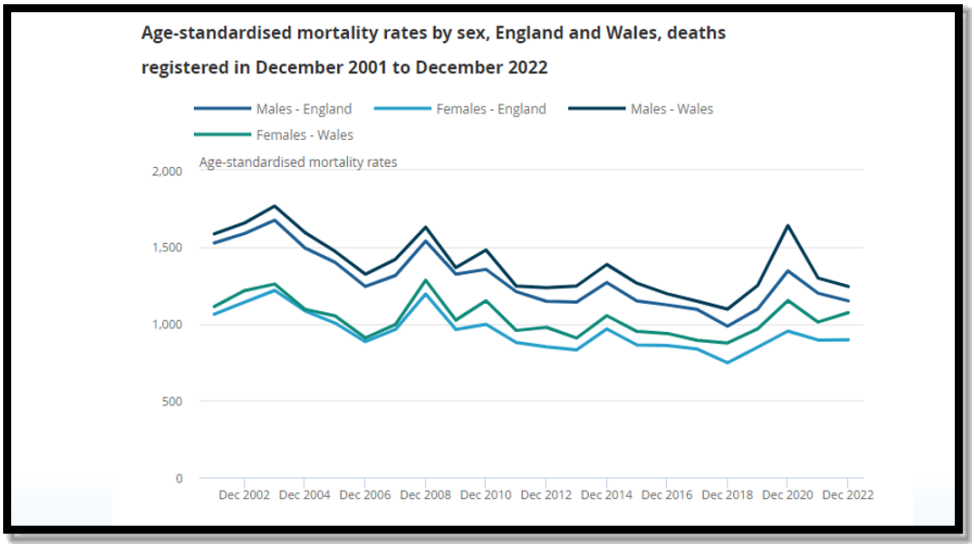
Tier 1 mortality data will be included as part of the quality indicators report on a regular basis and Tier 2 indicators will be reported to Board six-monthly.

Tier 1 Mortality

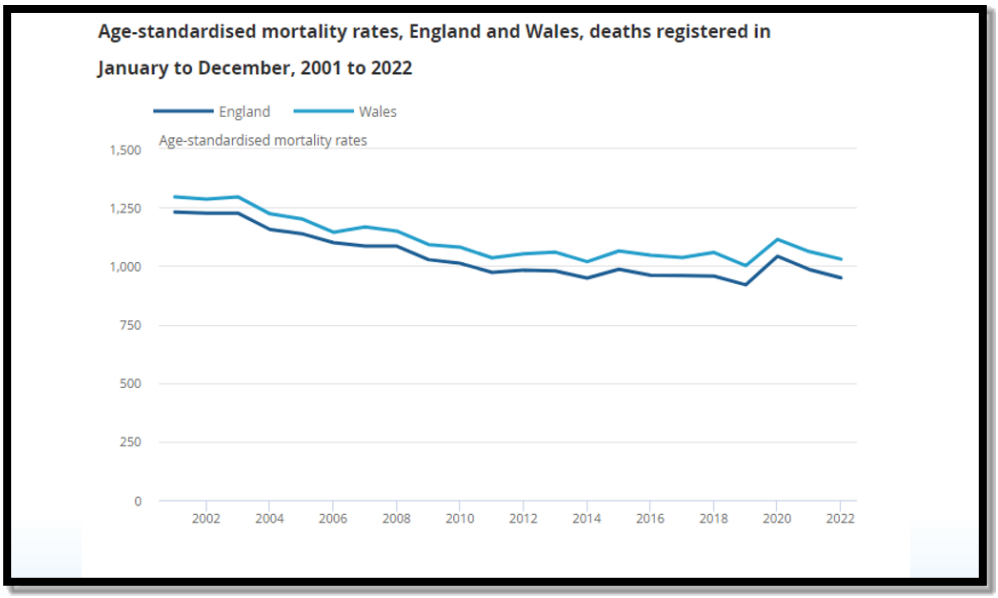
Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week with the exception of March 2020 and December 2020 to February 2021, the first and second waves of covid-19 where inpatient deaths rose above the 5-year average.
Crude all-cause mortality demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan regardless of where they occurred. COVID – 19 deaths the pink line illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic (Spring 2020 and Winter 2020/21).



Source: Public Health Wales Covid Dashboard, ONS Mortality (https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/CovidDashboard_ONSmortality/ONSdeaths) Age standardised mortality by sex is shown to be lower in December 2022 (figure 3) when compared to the same period in 2021, although this reduction is not statistically significant in Wales. The age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England, although it remains above the rate observed in 2019.

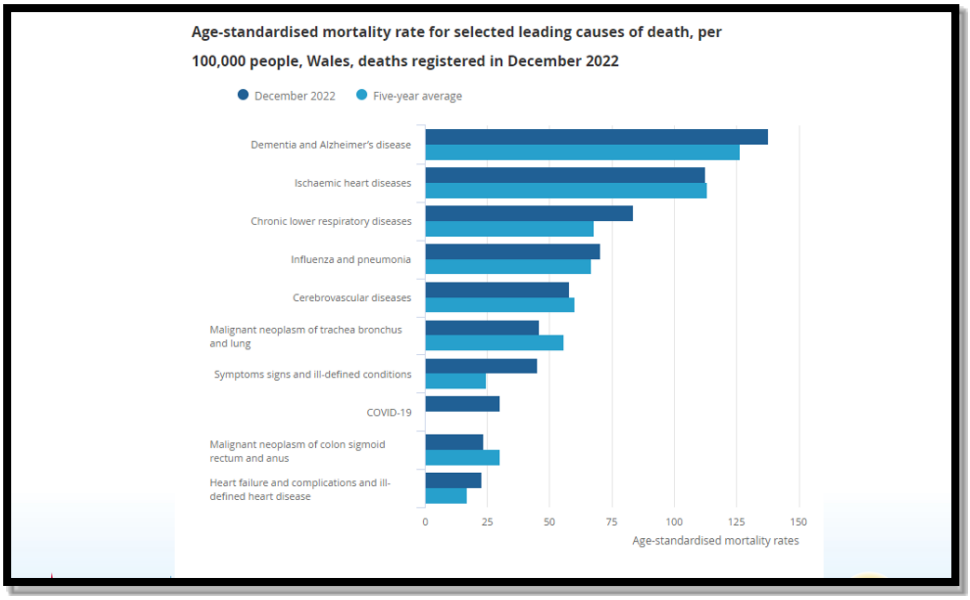


Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)



Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)

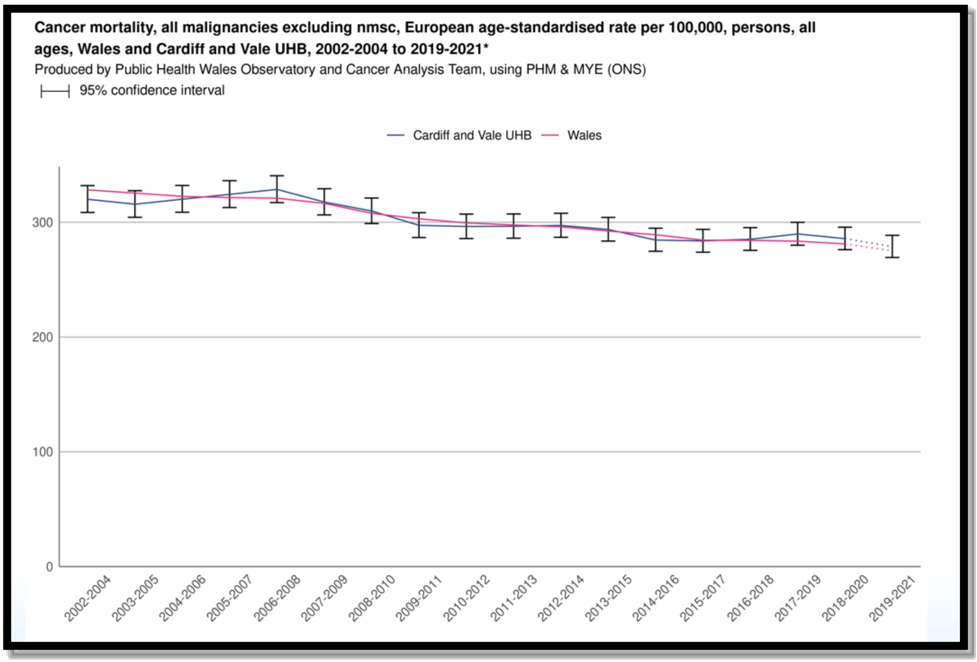
Figure below illustrates that Alzheimer's and dementia remains the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.



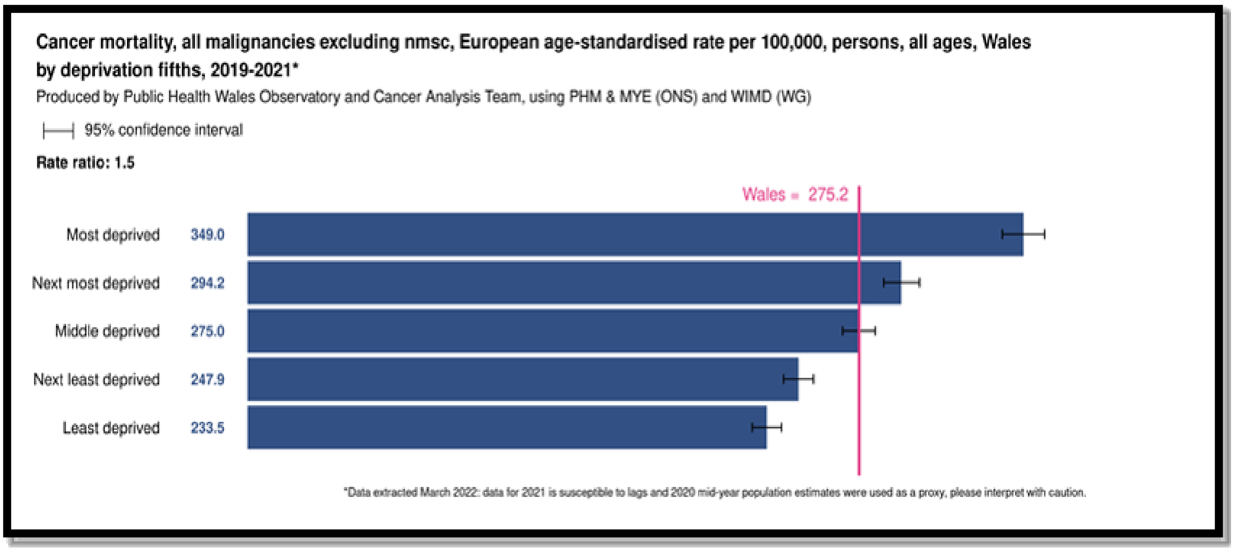
Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)

Figure below illustrates cancer mortality rates per 100,000 population (excluding non- melanoma malignant neoplasm) and demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.

Figure 6



The age standardised cancer mortality, reported as mortality per 100,000 population, demonstrates significant variation in relation to deprivation Mortality rates in those living in the most deprived fifths in Wales are around 50% higher than those living in the least deprived areas. The pandemic has impacted on this for some diagnoses, particularly marked in colorectal cancer mortality, where inequalities in cancer mortality, increased rapidly from a 30% relative difference between the most and least deprived areas of Wales in 2019 to 80% by 2021.

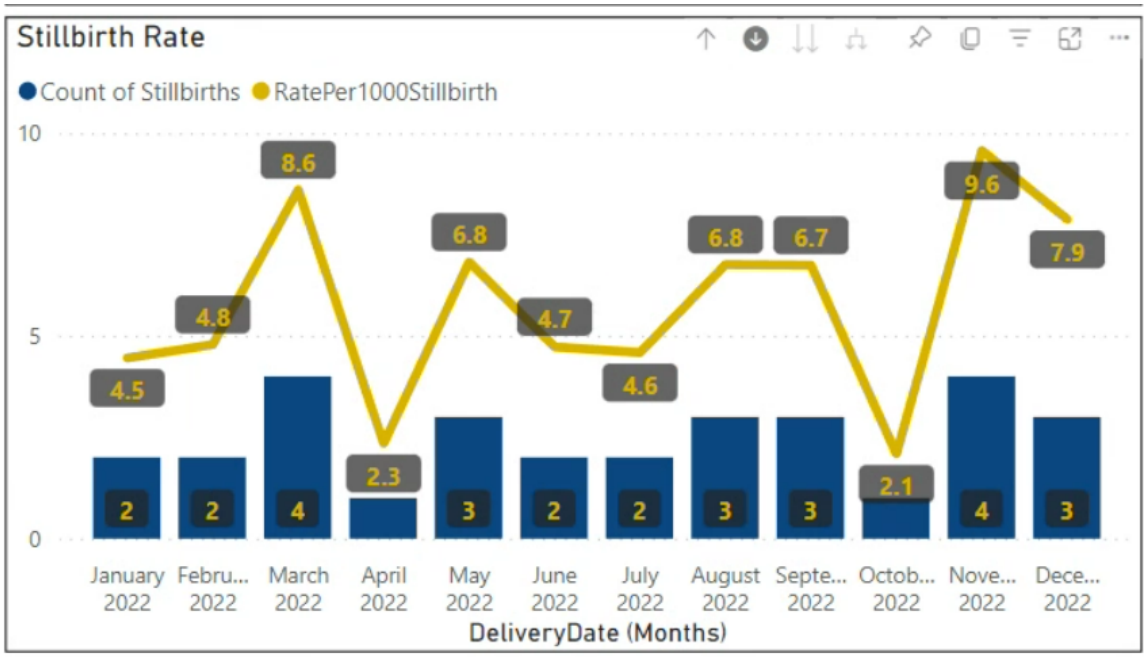


Maternity Outcome

Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the office of National Statistics suggest that still birth rates increased in 2021 to 4.2 per 1000 births with a particular increase noted in the second half of 2021, national rates for 2022 are not yet reported. Still birth rates in Cardiff and Vale UHB increased from 2.98 in 2020 to 4.39 in 2021 and to 5.74 in 2022. The presence of a Fetal Medicine unit, means that the Health Board provide specialist diagnosis and treatment of complications which might arise in unborn babies.

The graph illustrates the monthly Health Board still birth rate per thousand births in 2022.

All still births and perinatal deaths are reported through the Perinatal Mortality Review Tool (PMRT) and are reviewed at the Health Board Perinatal Mortality Review Meeting, where all aspects of maternity and neonatal care from booking to birth and beyond are discussed. Still births and perinatal deaths are also recorded by the mother's ethnic origin to support oversight and benchmarking. In 2022, 56% of still births were associated with babies that were identified as small for gestational age and 27% of mother's were from black or minority ethnic backgrounds.

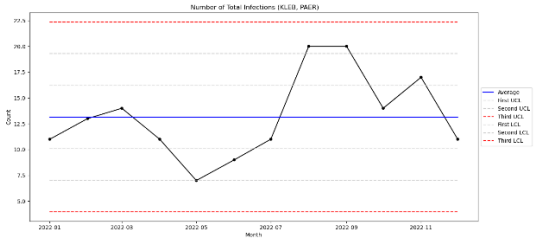


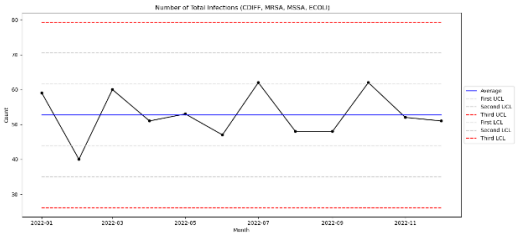
Infection Control

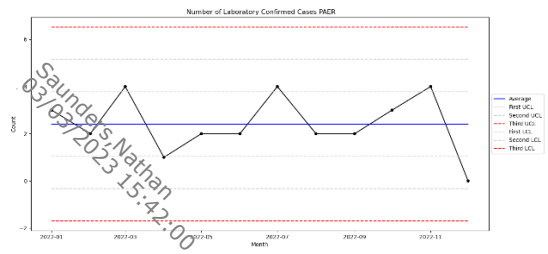
Hospital Infections – the grouped total C'diff, Ecoli, MRSA and MSSA infections, is showing no in-year improvement against the baseline. However, Ecoli, MRSA and MSSA are demonstrating an in-year improvement, whereas C'diff in-year has increased, compared to baseline of December 18.

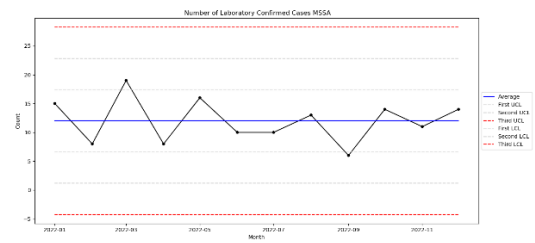
C'diff rates were observed to be high across the UK after the first and subsequent waves of Covid, all community cases are now subject to investigation to understand the cause of the infection.

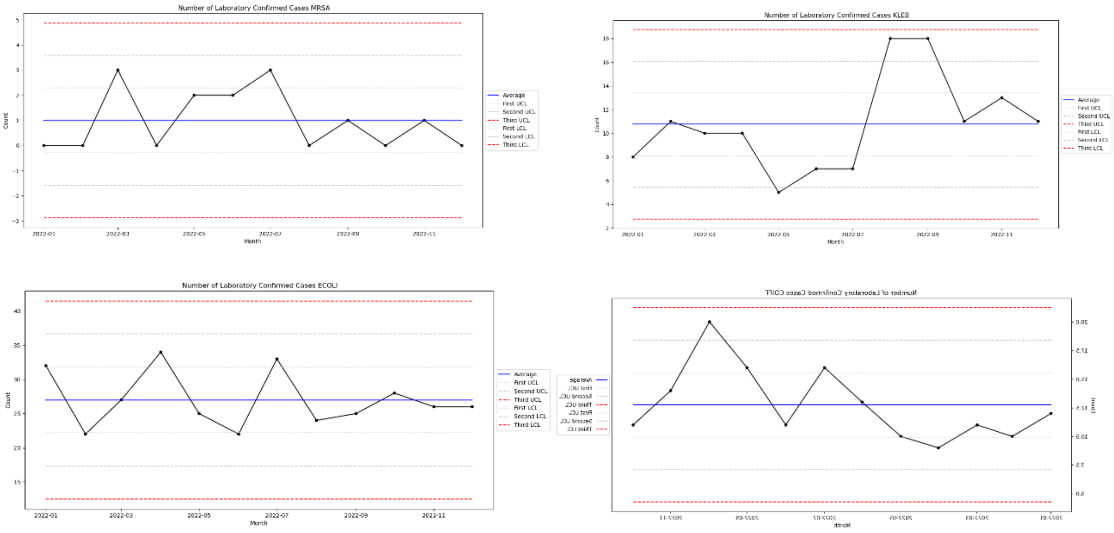
There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

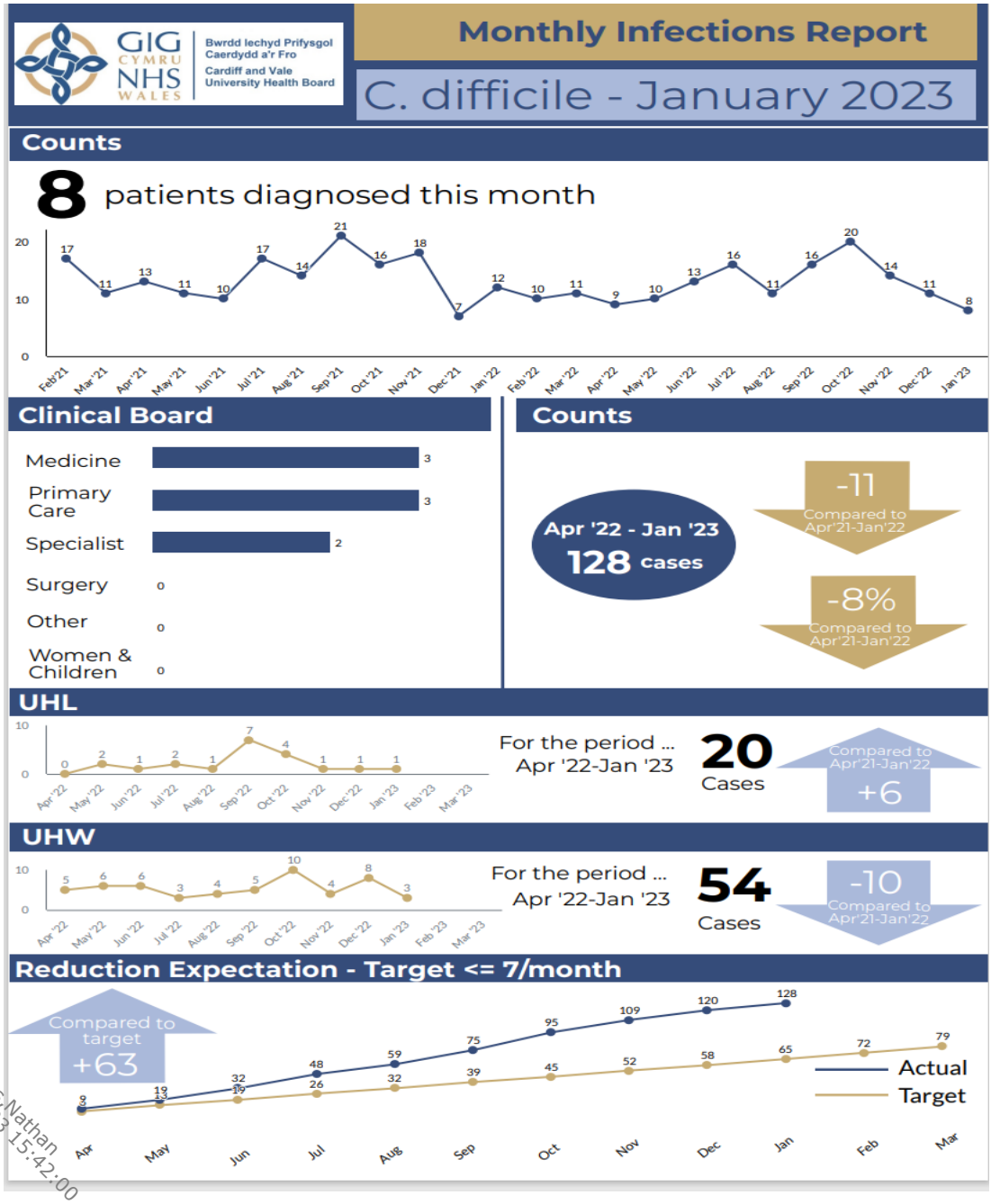












Points of note for the Committee are:

- CAV UHB cannot achieve the expected reduction for 2022/23 however we have 8% fewer cases than the equivalent period 2021/22.
- We are performing 2nd best in Wales (behind Cwm Taff HB).
- The *C'diff* oversight group meetings have commenced with the 1st meeting held in January. The meetings are led by the EDON and Deputy Medical Director supported by the IP+C Consultants and the HOV for IP&C and Clinical teams, are invited to discuss individual cases to identify learning and drive improvement.
- IP&C hold weekly *C'diff* review meetings which are attended by the IP&C nurses and Drs, Clinical Scientists in PHW, Antimicrobial Pharmacists and Microbiology registrars, in person review of new cases are also held.
- Since October 22 we have an IP&C nurse specifically to support PCIC CB. The work will include reviewing community *C'diff* cases and gathering themes from RCA's completed for each case to support learning.
- The IP&C Team are developing new education materials to support clinical teams.

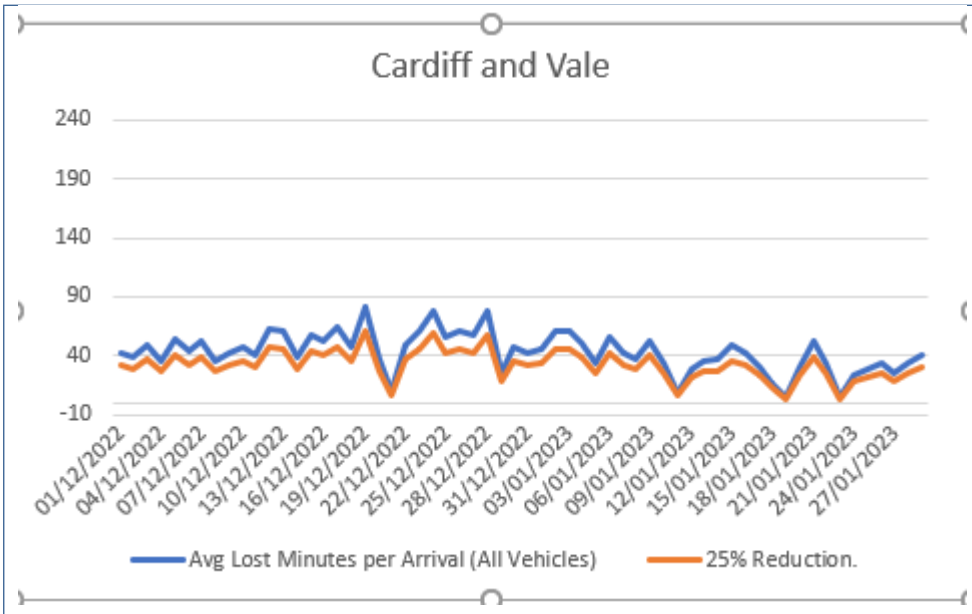
A**ctions to progress the improvement trajectory**

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

Timely

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

There has been a sustained improvement in:
Ambulance Patient Handover Improvement Trajectories



However, we continue to monitor the patient wait in the EU Department and the experience, the concerns and feedback suggests, that whilst staff continue to try and deliver high quality care, the flow throughout the Health Board remains challenging.

The Health Board is currently developing the – RELEASING TIME 2 CARE (RT2C).

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

Key principles of the framework include:

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

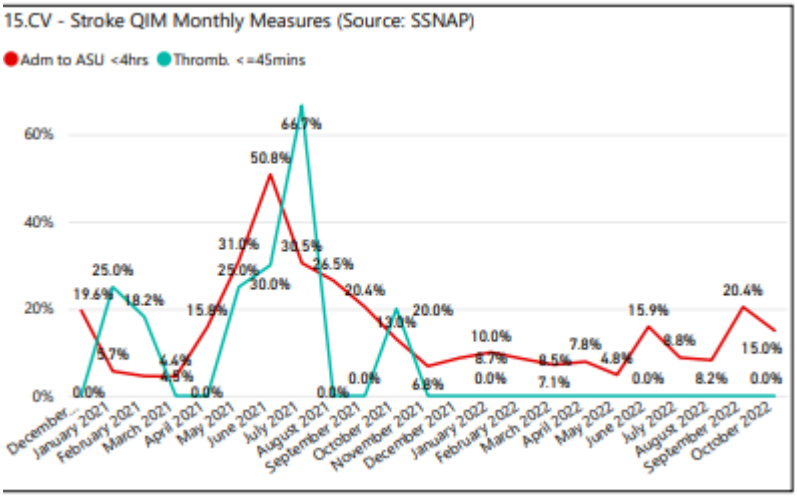
- **Expected benefits** of the approach:
  - Improve experience for staff working on wards.
  - Better organisation of ward processes.
  - Smoother discharge planning and organisation – reducing length of stay.

Following the pandemic, the long waits for treatment etc. have worsened. The Concerns data reflects the public concern regarding waiting times.

Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

The stroke pathway is one that is time critical with key decisions that improve both mortality and outcome.in relation to Quality of Life.



There has been significant public awareness raising of the symptoms of stroke and the time critical nature.

There is ongoing work to improve the service:

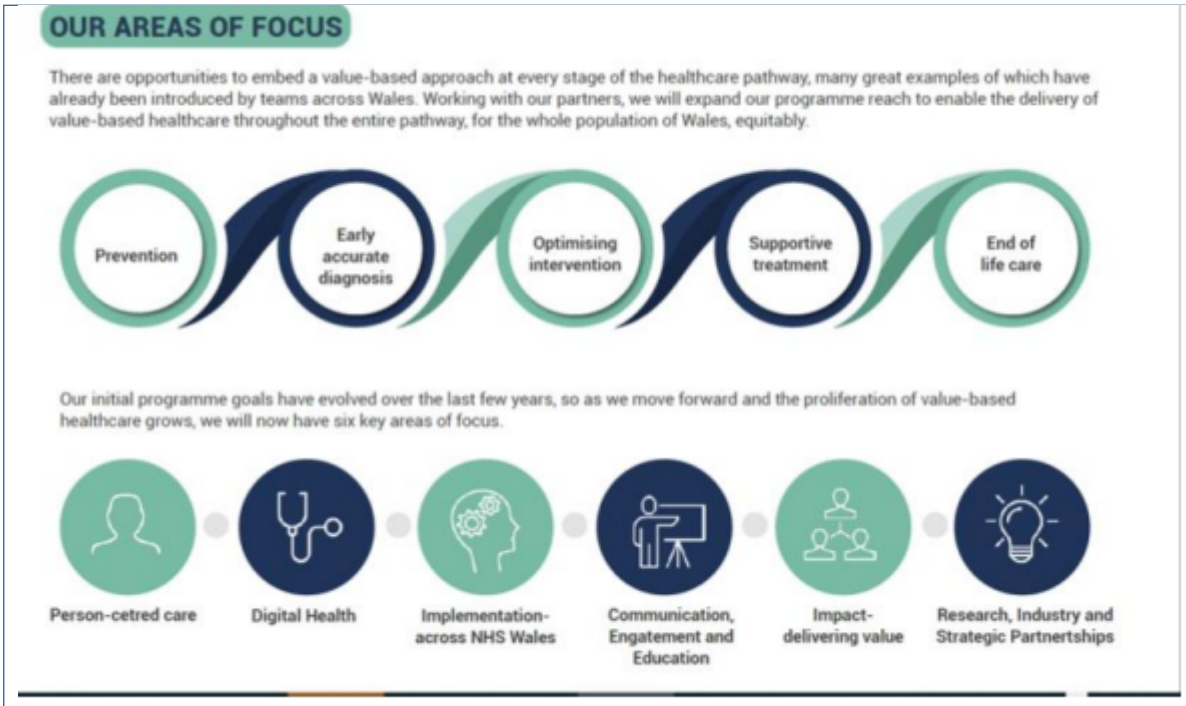
- Increased out of hours CNS support for “Code Stroke”.
- Dedicate specialist middle grade to support Emergency Unit for Stroke.
- Focused training for acute medics on stroke assessment, thrombolysis and thrombectomy.
- Ringfencing additional stroke beds and deploying pull model “Think thrombolysis, Think Thrombectomy”.
- Thrombectomy next steps – work to strengthen neuroradiologist workforce.

Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.

The more clinical staff, feel that their time is being taken up in non-clinical activity, the more likely they are to say that they would not want their relatives treated in the department.

The tools of Value Based Healthcare should be used to inform the design of all healthcare pathways and develop the outcome measures. During 2022/23 organisations were provided with funding to help accelerate their Value-Based healthcare programmes and to ensure it is embedded into the whole system to ensure a culture shift and this should be expanded during this planning cycle. The Welsh Value in Health Centre provides information and support and the Value Based Health and Care Intensive Learning Academy, provides training on what this means and how to use the right tools to do this.



Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

This is an area of focus in the Health Board.

Health Inequalities - the links between where people live, their socioeconomic status, their life expectancy and how many years they can expect to live healthily, are well-documented. Welsh Government and the NHS have been working to address health inequalities over many years. The fact that people from the most deprived areas of Wales are more likely to live shorter lives, with fewer years spent in good health, than those in the least deprived, is socially unjust and is something that must be addressed. Alongside deprivation, other factors such as ethnicity, gender, geography or intersecting risk factors have led to sustained health inequalities in society. Some health inequalities are avoidable, unfair and highlight systematic differences in health between different groups of people. Organisations will be engaging with the work of the new NHS Health Inequalities Group to strengthen the coordination of work to tackle health inequalities and to amplify its impact. Furthermore, organisations will have recently refreshed their regional population needs assessment, which will provide clarity on where the inequalities in health exist within localities in Wales. It is important to be able to demonstrate how these approaches have been adopted and embedded into the organisation. Strengthening the synergy between how these approaches operate at the local level and drive forward the ability of the workforce to be more agile, flexible and open to embracing change and new ways of working means the organisation can achieve more and fast track its delivery.

To ensure health equity, services must recognise vulnerabilities and marginalisation and act to mitigate the risks for those individuals and groups. Services should ensure that needs are identified

and that mitigations are in place, including a focus on cultural competency. These actions have the potential to make significant improvements in service quality and patient outcomes. Services for vulnerable groups should be planned and delivered in line with national guidance – such as the 2018 Welsh Government Health and Wellbeing of Asylum Seekers and Refugees: Guidance for Health Boards and Travelling to Better Health Policy Implementation Guidance for healthcare practitioners on working effectively with Gypsies and Travelers.

We have been engaging with some members of the deaf communities and they have raised concerns regarding their access to services.

BSL survey

We are keen to seek the views of people who use our services and Cardiff and Vale Health Board and WITS have undertaken a survey to ascertain the views and consider if changes to the service provision need to be made moving forward.

Following collation of the information we will arrange to feedback to the communities through a public meeting.

In the case of emergencies where WITS are not available or where interpreters cannot be agreed, we have two on-line interpreting services available, one is Sign Live.

Sign Live provides online interpreting services through its Video Relay Service (VRS) and Video Remote Interpreting (VRI). Sign Live allows BSL users to communicate with anyone, at any time, using the app to connect them to a qualified BSL Interpreter.

This is 24-hour service open 365 days of the year. All interpreters are highly qualified, have at least five years' interpreting experience, are NRCPD-registered and DBS/PVG licenced.

We have a number of devices in the Health Board that have this app it can also be used via Computer so is very accessible.

We also use language line which has the option of BSL and ASL.

It empowers you to provide outstanding service and exceptional care, on-demand, allowing limited-English speakers and Deaf and Hard-of-Hearing, to feel heard and seen by another person.

Available within seconds at the touch of a button, Language Line's award winning video interpreting is available in over 40 of the most requested languages, including American and British Sign Language.

People tend to think of interpretation as a transaction, swapping one word for another much as one would exchange currency. At Language Line, we think of interpretation as a profoundly human experience. More than transactional, it should be transformational - both for our clients and the communities they serve.

On our devices across the Health Board we have the information regarding the use of language line.

LanguageLine Solutions®

Accessing a Telephone Interpreter

When your client is with you

If you have a LanguageLine Dual Handset Phone Then please skip step 1

1. Dial your **LanguageLine access number**
2. The operator will ask you for:
   - Your Client ID (your 6 digit client number) (___________) (Please note: this code is **confidential** to your organisation or dept.)
   - The language you require (say if you need a specific interpreter*)
   - Your organisation name (and department where appropriate)
   - Your initial and surname
3. Stay on line while the operator connects you to a trained interpreter. The operator will then inform you the interpreter is "now on line".
4. Note the interpreter's ID code, introduce yourself and brief the interpreter saying what phone you are using, e.g. single/dual handset, speaker phone or mobile.
5. Ask the interpreter to introduce you and themselves to your client and give the interpreter the first question or statement. Give the interpreter time to interpret between you and your client.

   Continue the conversation.
6. Let your client and the interpreter know when you have finished.

Making outgoing client calls

The operator will connect you to an interpreter, who will conference your client into the call.

1. Have your client's name and telephone number ready.
2. Follow steps 1 to 3 for **'When your client is with you'.**
3. Stay on line while the operator connects you to a trained interpreter
4. Note the interpreter's ID code. Brief the interpreter and advise them that that you require a **'DIAL-OUT'**.
5. Give the interpreter your client's name and telephone number.
6. The interpreter will dial your client and connect them to the call.
7. Ask the interpreter to introduce you and themselves to your client and give the interpreter the first question or statement.
8. Give the interpreter time to interpret between you and your client.

   Continue the conversation.
9. Let your client and the interpreter know when you have finished.

Handling incoming client calls

If you have conferencing facilities:

1. Put your client on hold using your organisation's conference call facilities (try to obtain your client's telephone number in case they hang up while on hold).
2. Follow steps 1 to 3 for **'When your client is with you'**, but advise the interpreter that your client is **ON HOLD.**
3. Brief the interpreter, then conference your client into the call.

If you do not have conferencing facilities:

1. Note your client's telephone number, language and, ideally, name.
2. Assure your client that you will call back shortly with an interpreter.
3. Follow the procedures for **'making outgoing client calls'**.

Useful Numbers:

General enquiries, feedback and materials
Tel: 0800 169 2879
Fax: 0800 783 2443
Email: enquiries@languageline.co.uk
Website: www.languageline.co.uk
Post: 40 Bank Street, Canary Wharf, London, E14 5NR

Document Translations
Tel: 0800 917 6564
Fax: 0800 783 2443
Email: translations@languageline.co.uk

**whenever possible LanguageLine will meet specific requests, e.g. for a female interpreter*

Person-centred

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

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

During December 2022 and January 2023, it is pleasing to note that, despite the current demand on the service, we have achieved a slight improvement in our overall 30 working day response time for all concerns. We closed 80% of concerns in December within 30 working days and 77% in January.

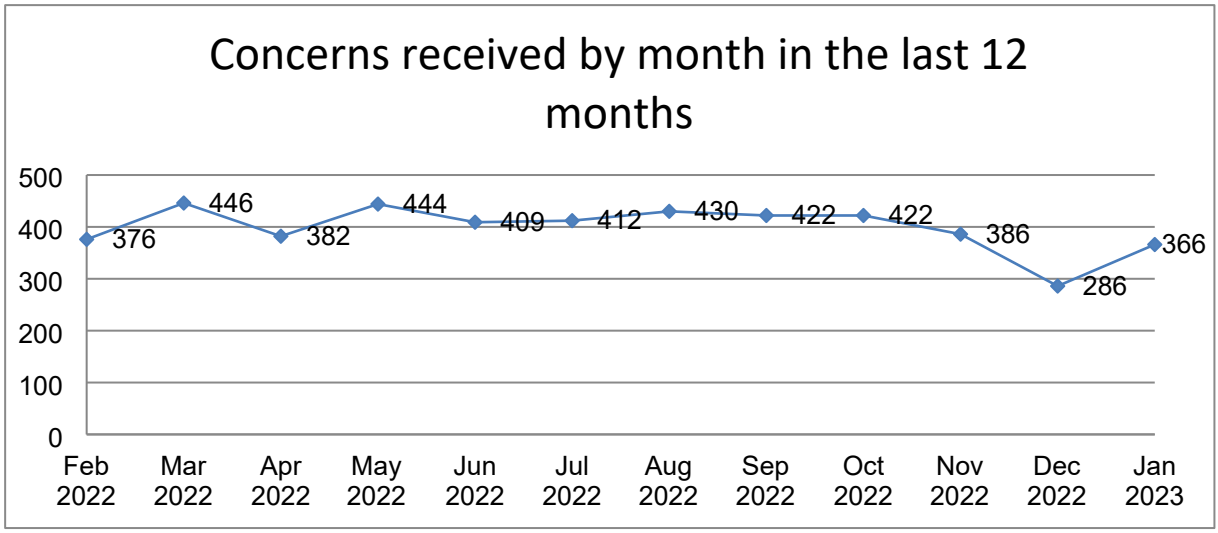
August 30 day performance 80%
September 84 %

October 85%
November 77%
December 80%
January 77%

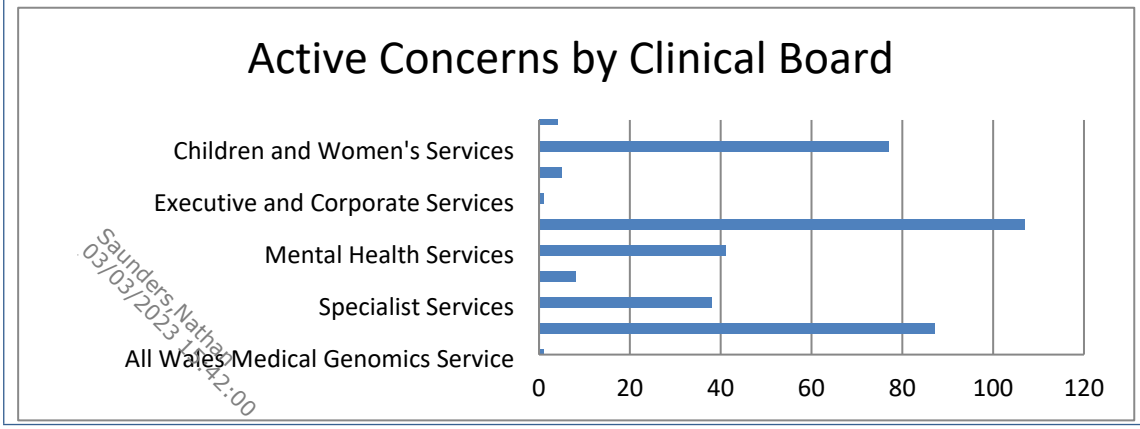
In December and January, we processed **63%** of concerns in line with Early Resolution (*this process can be utilised dependent upon the nature of the concern*) which is an increase of 3% in comparison to October and November. Early Resolution aims to ensure a response is received within 2 working days, if however, we cannot issue a satisfactory response to a concern then the formal process must be used.

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

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

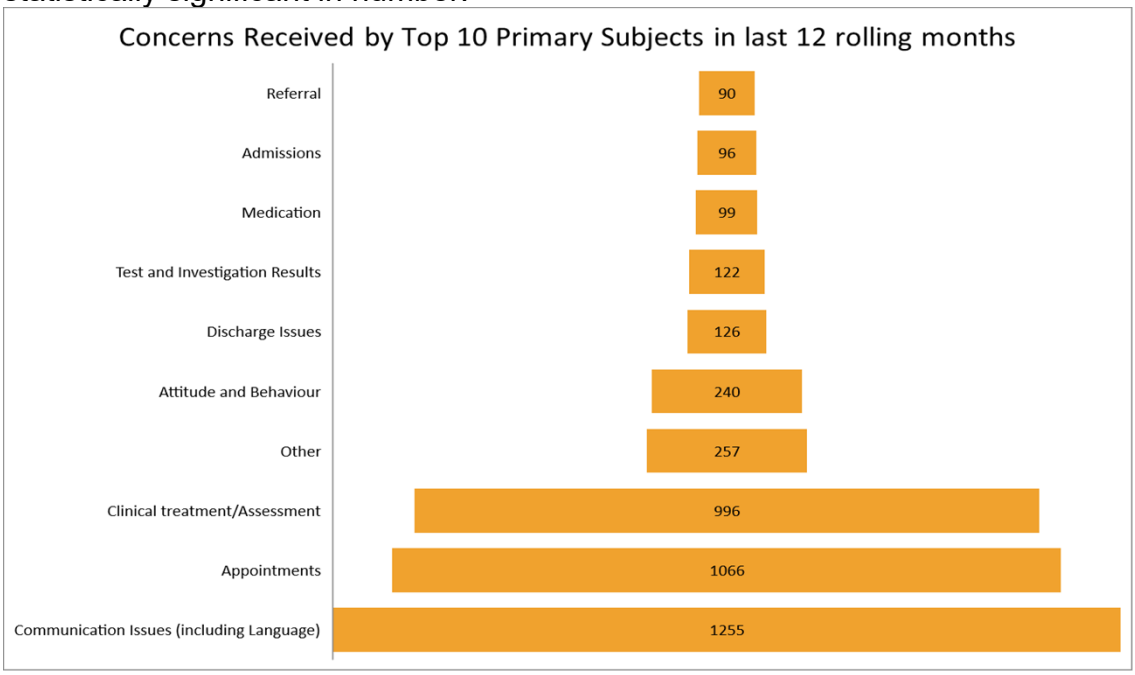


We currently have 322 active concerns. As anticipated, we noted a reduction in concerns during December which is in line with previous years due to the Christmas period, however, we had a significant increase in January also in line with previous years. Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, the high volumes of concerns received in Medicine and Surgery Clinical Board is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of necessary cancellations and delays due to Covid or Industrial action and the significant increase and demand on services like EU.



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

Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased and now follows closely behind Communication, followed by Clinical Concerns regarding environment, facilities and attitudes and behaviours are continuing to be recorded as a theme and increasingly statistically significant in number.



We have received 87 compliments in this time frame

Every Friday on Social Media we publish some feedback from our Kiosks which receive positive comments on twitter.

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

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

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

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

Validation Report – Complaints Data

V1: 31st October 2022

Health Body	Cardiff and Vale University Health Board

Assurance Report

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

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

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

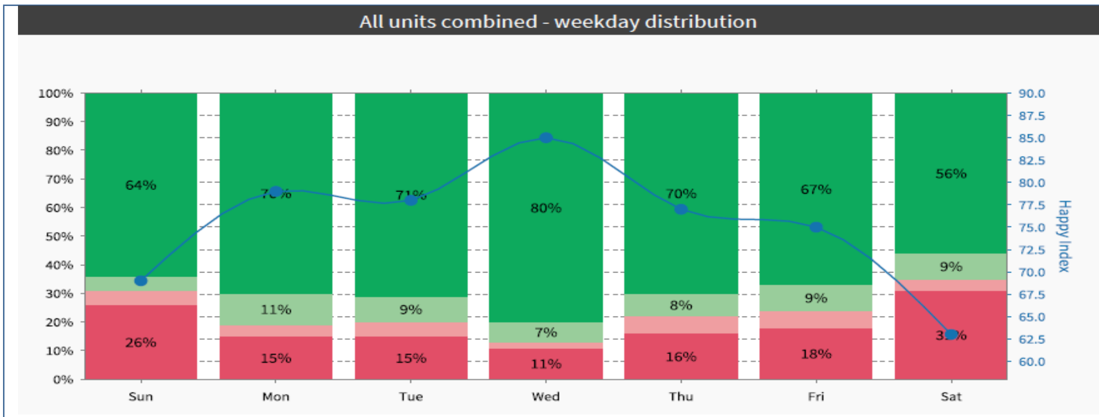
Assurance Rating	SUBSTANTIAL ASSURANCE
Proforma suitable for submission to Welsh Government?	YES – Submitted to WG by Welsh Risk Pool

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

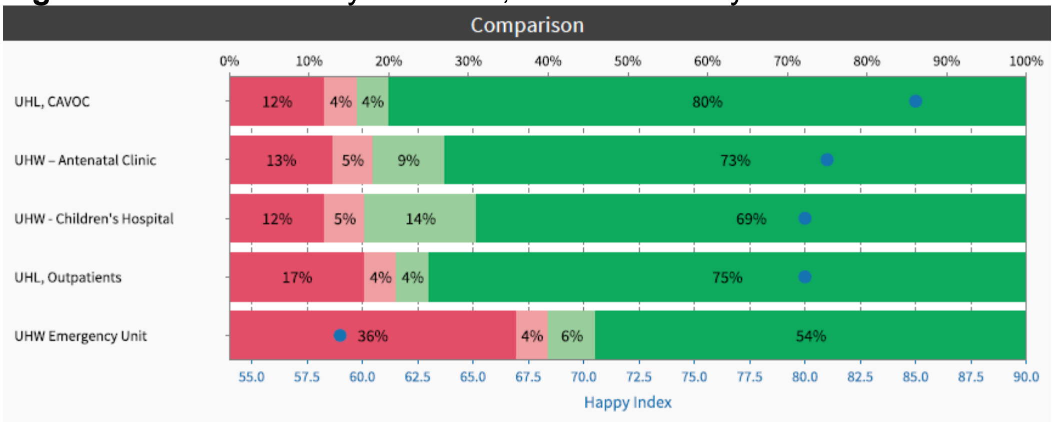
A breakdown of the feedback for December and January is:

Summary values	December	January
Surveys completed	**1669**	**1232**
Response: Very happy button (Excellent/Very positive)	65%	69%
Response: Happy button (Good/Positive)	7%	8%
Response: Unhappy button (Fair/Negative)	4%	5%
Response: Very unhappy button (Poor/Very negative)	24%	18%
Respondents satisfied	**72%**	**77%**

Below Gives the January feedback, broken down by which day of the week the feedback was received:



There is a theme of satisfaction being lowest on a weekend across the UHB
Fig 5. Gives the January feedback, broken down by kiosk location:



<u>HappyOrNot feedback</u> (EU areas only)

The table below is a basic summary of the information received from the HappyOrNot EU feedback:

Summary values	December	January
Surveys completed	803	277
Respondents satisfied	**60%**	**60%**

<u>Civica 'Once for Wales' platform</u>

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS. At the time of reporting we have contacted some 36,227 people for feedback via text messaging and we are seeing a return rate of 18%. It is our understanding this is higher than many organisations but will be a focus for improvement, with more targeted experience data collection over the next year.

The table and figures below give some of the summary information received during December and January.

Summary values	December	January
Surveys completed	1148	1599
Respondents satisfied	**88%**	**89%**

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

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

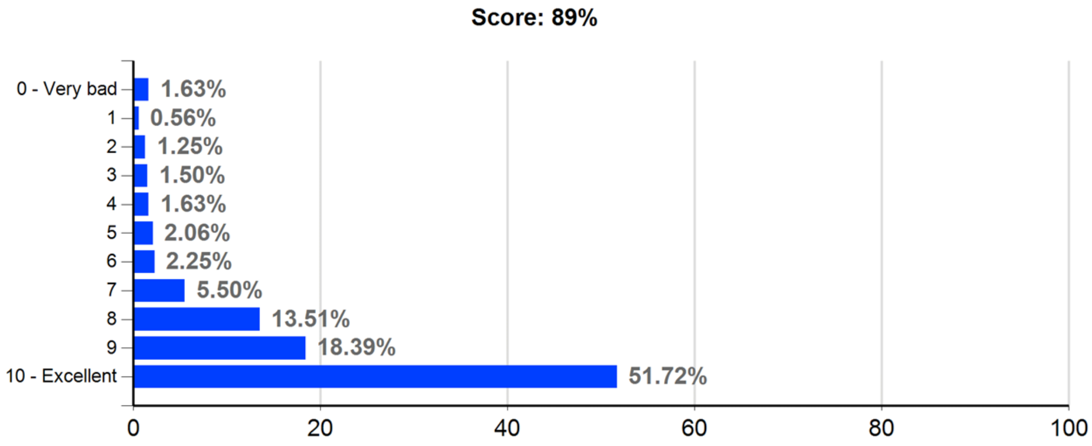
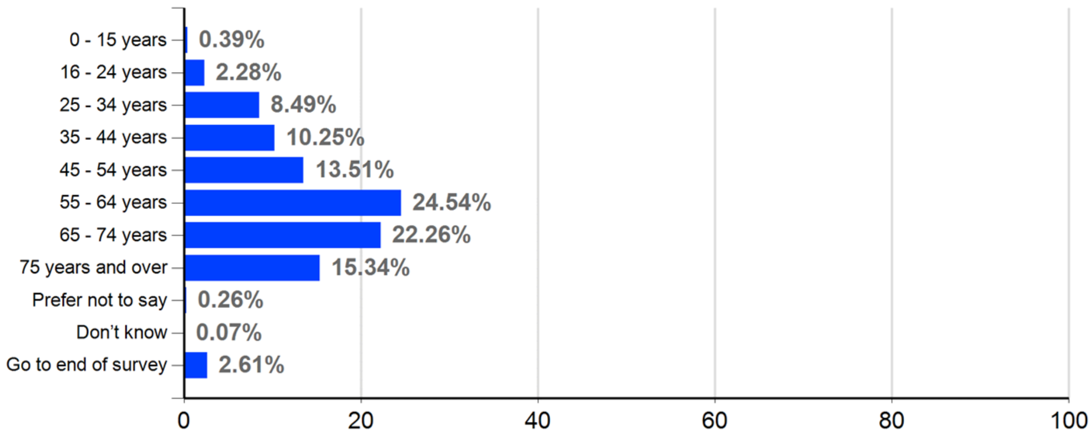


Table below. Gives January's feedback, broken down by age group of respondents.



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

- Survey summary
- Heat map
- Comment report
- Custom reports

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

<u>Bespoke project examples</u>
We are also currently involved in numerous bespoke projects, for example:

- HPN survey
- IACU survey
- Radiology / Minor Injuries questionnaire
- Staff IT skills survey

In order to improve the services, we provide, the Patient Experience Team are looking to increase the ways we receive feedback from patients relating to the care they receive. Throughout the month of February, the team including volunteers will be visiting all ward and clinic areas to install the attached stickers/posters.

The Feedback poster will be in A5 size and is a washable adhesive backed sheet which we will place on bedside cabinets, along with this, we will place the Feedback Poster at the entrances of all ward areas. Finally, the sticker will be used in communal areas.

Embedded within the poster/sticker is a QR code to the survey, along with a contact number and email address for patients who are not able to access the survey digitally. We will monitor the calls to the mobile Patient Experience number and redirect or address queries where appropriate.

The Patient Experience Team will review results from the survey which will then be shared with Clinical Boards.

We are developing the poster in other languages and will target the areas where we currently know there is a high demand for interpretation services in the specific languages - as the process develops we will also have the BSL survey established.

The roll out will be coordinated through our Patient Experience staff and volunteers.

We anticipate this will provide us with more meaningful real time data for ward and clinical areas

Key messages

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

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

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

Recommendation:

The Committee is requested to:

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

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

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

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

Prevention		Long term		Integration		Collaboration	✓	Involvement	✓

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

Risk: Yes

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

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

Report Title:	Healthcare Inspectorate Wales Activity Overview				Agenda Item no.	2.4	
Meeting:	Quality, Safety & Experience Committee		Public	X	Meeting Date:	7 March 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Head of Quality Assurance and Clinical Effectiveness						

Main Report
Background and current situation:

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

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

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

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

Activity/Published Reports Since January 2023 QSE Committee Report

Unannounced Inspections

Hafan Y Coed

HIW undertook an unannounced inspection in Hafan Y Coed from the 9th to the 11th of January. An immediate action plan has been submitted in response to the recommendations. An update will be provided following the publication of the report.

Maternity Services were subject to an unannounced Inspection by HIW on the 9th, 10th 11th November 2022. A number of immediate assurances recommendations were issued following the inspection. The report and associated improvements will be presented to the Committee on publication by HIW which is scheduled for march 2023.

IRMER Inspection

An Ionising Radiation Medical Exposure Regulations (IRMER) compliance inspection was undertaken in the Nuclear Medicine Department at UHL on the 11th and 12th of October. Overall, the

feedback was positive, and no immediate concerns were identified. An action plan has been submitted and accepted in response to the recommendations and the final report was published on 12th January 2023.

Overall summary:

Quality and Patient Experience

- Positive feedback was provided by patients about their experiences of attending the Nuclear Medicine Department at the hospital.
- Staff that were spoken with demonstrated a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department.
- A patient experience survey was undertaken, none of the 28 respondents indicated they had faced discrimination when accessing or using this health service.
- All staff who completed the staff questionnaire agreed that the organisation acts on concerns raised by patients. When asked whether the organisation takes swift action to improve, when necessary, again all staff who completed a questionnaire agreed.

Delivery of Safe and Effective Care

- HIW were satisfied with the arrangements in place for patient identification, referral guidance, duties of practitioner and operator referrer, justification of individual exposures, optimisation, diagnostic reference levels, clinical evaluation, and general duties of the employer in relation to equipment.
- HIW found that waiting areas were of a sufficient size for the numbers of patients attending the department. Responses from some patients indicate that the area could be improved upon. HIW highlighted that they saw that considerable efforts had been made to provide a pleasant environment for patients by displaying artwork and pictures throughout the department
- In relation to infection prevention and control (IPC) and decontamination, all areas of the department that were inspected by HIW were found to be visibly clean and tidy. Equipment was also observed to be clean
- HIW identified that the Medical Physics Expert support for the quality assurance of equipment had expired, the agreement was still active, but a copy of the current agreement was not available at the time of the inspection

Quality Management and Leadership

- All staff who completed a questionnaire agreed that their immediate manager could be counted on to help with a difficult task at work and gave them clear feedback. Additionally, eight of the ten staff agreed their immediate manager asked for their opinion before making decisions that affect their work and two disagreed
- Senior staff provided an example of the scope of practice for one non-medical referrer. HIW recommended the process for identifying individuals' scope of practice could be streamlined and senior staff confirmed work was being undertaken with representatives from other NHS organisations in this regard.
- Procedures and protocols: Written procedures and protocols were in place as required under IR(ME)R, however, it was not always clear when these had been reviewed or when they were due for review. It was identified that some policies had passed their scheduled review date and senior staff confirmed they were actively addressing this.
- Senior staff described a clear process for the quality assurance of written policies and protocols. This process was reflected in the employer's written procedure for the quality assurance of written procedures and protocols.
- When staff were asked by HIW about whether they felt secure raising concerns about unsafe practice, seven of the nine staff who answered the question said they would, and two did not know.
- Of the seven staff who answered the questionnaire, six agreed staff have fair and equal access to workplace opportunities and one disagreed. All staff who answered the questionnaire, agreed their workplace is supportive of equality and diversity

The complete action plan can be seen in Appendix A

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

The IRMER inspection in UHL was published in January 2023 and the improvement plan is included in Appendix A.

There have been no further HIW inspections since the January committee.

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

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

A thematic review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process has commenced.

Recommendation:

The Committee are asked to:

a) **NOTE** the assurance provided by the response to HIW inspections and progress against existing improvement plans.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment:

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

Risk: No

Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Appendix-A Improvement plan

Service: Nuclear Medicine Department, University Hospital Llandough

Date of inspection: 11 and 12 October 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to help patients identify Welsh speaking staff working in the department.	Standard 3.2 Communicating Effectively	Font size to be increase on appointment letters and appointment letters to be translated and issued in Welsh as well as English. This will be implemented on a phased approach due to the large number of examinations with differing pre-exam preparation requirements. Phase one will involve the appointment letter only being issued in Welsh. Phase two will involve the addition of the patient preparation being issued in Welsh.	Directorate Management Team	Phase one 28/02/2023 Phase two 30/6/23
Consideration needs to be given to guidance for health services,				

issued by Welsh Government, on delivering the 'Active Offer'		Appointment letters to be amended to advise patients if they would like their examination in Welsh to contact the department in advance to ensure this can be accommodated, otherwise this will be accommodated where possible on the day. Current signage within department already provides an 'Active Offer' by indicating staff with emblem on their uniform, lanyard or badge speak Welsh.	Directorate Management Team	28/02/2023
The health board is required to provide HIW with details of the action taken to actively obtain patient feedback on their experiences of visiting the Nuclear Medicine Department and to share this with relevant staff.	Standard 6.3 Listening and Learning from Feedback	Patient experience survey has been drafted with involvement of the Health Board's patient experience feedback team. Survey will initially be run as a focused pilot via QR code and in paper form to identify effectiveness before being implemented department wide. Results of all future surveys and	QSE Lead Radiographer	Pilot completion - 28/02/2023 There will be ongoing work to implement Radiology wide following pilot survey

		any subsequent actions will be shared via posters for both patient and staff information. Results will also be shared at the Radiology Safety and Quality forum. A rotational schedule will be developed following evaluation of the pilot survey to capture patient feedback The Civica system has now been implemented across the Health Board and QR codes will be displayed in every clinical area to allow patients to access the system and to provide feedback	Assistant Director of Patient Experience	01 February 2023
The employer is required to provide HIW with details of the action taken to ensure staff comply with the employer's written procedure in relation to recording enquiries of individuals of childbearing potential.	IR(ME)R Regulation 6 2	Reminder to staff of their previous acknowledgement to read and comply with Employer's Procedures. Increase frequency of regular retrospective audits and	Professional Head of Radiography / QSE lead Radiographer	Complete In place and will be monitored monthly

		observations of practice against staff where compliance levels are not met. Actions will be recorded and monitored. Monitored alongside regulatory compliance audits. Monitored through monthly clinical board regulatory compliance meetings.	Modality superintendents / Professional Head of Radiography	and adjust frequency according to level of compliance.
The employer is required to provide HIW with details of the action taken to revise written protocols so they reflect the requirement of the current regulations where practitioners who administer radioactive substances must hold a practitioner licence.	IR(ME)R Regulation 6 4	Protocols updated to include current regulation requirement where practitioners who administer radioactive substances must hold a practitioner licence. Updated documents are disseminated to staff via document management system and where applicable staff are required to acknowledge they have read it.	Nuclear Medicine Superintendent	Complete

The employer is required to provide HIW with confirmation that the third party agreement in relation to radiation protection services, including MPE support, remains current and copy is available for inspection upon request.	IR(ME)R Regulation 14 1	Update and sign agreement between Health Board and Radiation Protection Service. An agreed continuation of radiation protection services is in place and on-going. The service agreement and has been submitted to the radiation protection service for final approval	Directorate General Manager	31/01/23
The employer is required to provide HIW with confirmation that the equipment inventory has been reviewed and updated to ensure all information is included for all relevant equipment used by the department.	IR(ME)R Regulation 15 1(b), 2	Equipment inventory reviewed and updated where required. Annual review currently in place, any new equipment is added when first installed/acquired.	Site Superintendent / Nuclear Medicine superintendent	31/12/2022
The employer is required to provide HIW with details of the action taken to: • **develop written action plans following audit activity to demonstrate an analysis has**	IR(ME)R Regulation 8 3	Review currently underway of audit templates which will include the addition of an action	QSE lead Radiographer / Professional Head of Radiography	28/02/2023

been done and to capture the action taken/to be taken and follow up activity. • **Include medical physics staff within the clinical audit programme**		plan where this is not already in place. Medical physics staff invited to attend and participate in the Radiology Safety and Quality meeting. Within the specific Nuclear Medicine Clinical Audit program there will be a requirement for a minimum of 2 clinical audits annually.	Medical Physics Expert	Complete
The employer is required to provide HIW with details of the action taken to update the following employer's written procedures as follows: • **EP F (Observation and Monitoring of Diagnostic Reference Levels (DRL'S)- DRLs should include equivalent information for nuclear medicine as for general radiology**	IR(ME)R Regulation 6 1 Schedule 2 1(f), 1(l)	Employers procedure F updated to include Nuclear Medicine audit frequency. Employers procedure L updated to include the correct email address for HIW.	Professional Head of Radiography / QSE lead Radiographer	Complete

• **EP L (Clinically Significant Unintended or Accidental Exposures) must be revised to remove reference to the incorrect email address for HIW**				
The employer is required to provide HIW with details of the action taken to review those policies that have passed their scheduled review date.	IR(ME)R Regulation 6 Schedule 2	Policies have been updated and approved via appropriate Governance structures. Within Radiology, including Nuclear Medicine, a document management system is utilised and notifies of upcoming document review dates.	Professional Head of Radiography	Complete

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Alicia Christopher

Job role: Directorate General Manager

Date: 21/12/22

Report Title:	**South Glamorgan Community Health Council Activity Review**			Agenda Item no.	**2.5**
Meeting:	**Quality, Safety & Experience Committee**	Public	x	Meeting Date:	**07/03/2023**
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Executive Nurse Director**				
Report Author (Title):	**Deputy Executive Nurse Director**				

Main Report Background and current situation:

The purpose of this report is to provide a review of South Glamorgan Community Health Council (CHC) activity within Cardiff and Vale UHB. The CHC work closely with the UHB to plan and deliver services and represent the patient and public voice. The CHC engagement and feedback with the UHB consists of:

- Announced Scrutiny Visits
- Unannounced Scrutiny Visits
- Service Reviews

The CHC have the opportunity to engage directly with patients and staff or via surveys, videoconferencing and social media, throughout their reviews.

Feedback to the UHB is provided by reports which includes improvement recommendations.

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

The CHC suspended announced scrutiny visits during the pandemic and recommenced in Quarter 2.

Appendix 1 provides a list of CHC Q2, Q3 &Q4 Announced Scrutiny Visits.

To date the CHC have provided the UHB with the final reports and recommendations to the following areas:

- Alcohol Treatment Centre **Appendix 2**
- Spinal Rehabilitation Unit UHL **Appendix 3**
- Ward West 1 UHL **Appendix 4**

The Clinical Boards are progressing the required actions and all improvement plans are approved by the Executive Nurse Director and Executive Director of Planning and signed off by the Chief Executive, prior to submission to the CHC.

The following reports of services have been received during Q3 & Q4, the full reports are within Appendix **5**

- Transport to Health Services – September 2022

The Clinical Boards respond to the recommendations within each Service Report via formal letter, which is approved by the Executive Director of Planning and appropriate Executive Director, dependent on the Service Report and signed off by the Chief Executive before submission to the CHC.

Recommendation:
The Quality, Safety and Experience Committee is requested to: a) **NOTE** the contents of the report and the CHC feedback and 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	✓	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: 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:

Date	Type of Visit	Location	Site
Tuesday 28th June	Secondary Care - Announced	Ward B1 Cardiology	UHW
Wednesday 6th July	Secondary Care - Announced	Stroke Rehabilitation Unit	UHL
Friday 15th July	Secondary Care - Announced	Lakeside Unit	UHW
TBC – Awaiting UHB Dates	Secondary Care - Announced	Maternity Midwifery Led Unit/Clinician Led Unit	UHW
TBC – Awaiting UHB Dates	Secondary Care - Announced	Spinal Rehab Unit (Ward West 8 & 10)	UHL
Wednesday 3rd August	Secondary Care - Announced	St Barruc's Ward	Barry Hospital
Monday 8th August	Secondary Care - Announced	Jungle Ward / Island Ward	CHfW
Thursday 18th August	Secondary Care - Announced	Ward East 4	UHL
Tuesday 23rd August	Secondary Care - Announced	Ward West 1	UHL

Date	Type of Visit	Location	Site
WC 10/10/22	Secondary Care - Announced	SSSU / SSDEC Short	UHW
WC 24/10/22	Secondary Care - Announced	Emergency Unit	UHW
WC 31/10/22	Secondary Care - Announced	Poison Beds	UHW
WC 07/11/22	Secondary Care - Announced	Hafan Y Coed, Cedar Ward	UHL
02/12/22	Secondary Care - Announced	Alcohol Treatment Unit	Cardiff
23/01/23	Secondary Care - Announced	St Barrucs, Barry Hospital	Barry Hospital

13/02/23	Secondary Care - Announced	Midwifery led unit	UHW

Report Title:	**Review of Quality Governance Arrangements – Update on Audit Wales Report and Health Board Management Response.**			Agenda Item no.	2.9
Meeting:	Quality Safety and Experience Committee	Public	x	Meeting Date:	07/03/2022
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Executive Director of Nursing, Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report

Background and current situation:

The Audit Wales Report 'Review of Quality Governance Arrangements' was reported, together with the agreed management response to the Quality, Safety and Experience Committee in August 2022.

The Committee asked for regular updates regarding progress with the implementation of the recommendations of the report which was recorded in the Committee action log. The implementation of recommendations continues to the monitored by the Risk and Regulation Team. A number of the recommendations are recognised as longer-term and form part of the Health Board's preparations for the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

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

Six recommendations were made by Audit Wales. These are shown in the extract from the Recommendation Tracker included in Annex 1.

One recommendation (R2) related to risk management which is complete with the recommendations incorporated into the established risk management services. The recommendation is in two parts. The first part relates to the Quality, Safety and Experience Committee seeking assurance from other Health Board committees where their risks potentially impact on quality and safety. It is expected that the establishment of the new Committee structure from 1 April 2023 will result in improved flow of assurance in respect of risks which potentially impact on quality and safety. Particular attention will be placed upon the Workforce and Culture Committee given how intrinsically linked workforce risks are to quality and safety risks.

The second part of the recommendation relates to reviewing and improving the quality of risk information recorded in operational risk registers and introducing an appropriate process for the escalation and de-escalation of risk to/from the Corporate Risk Register. The improvements made to the check and challenge process by the Risk and Regulation Team are highlighted in the Corporate Risk Register report to the Committee. This is an ongoing, embedded process and therefore the Director of Corporate Governance considers this action to be complete.

One recommendation (R5) relates to Personal Appraisal Development Reviews (PADRs), known as Values Based Appraisals (VBAs) in the Health Board, noting that the Health Board's compliance rate is consistently below the national target of 85% and the need to take appropriate action to improve performance at both corporate and operational levels. This is an issue that the Health Board recognises and set a trajectory to achieve 65% compliance by the end of March 2023 and 85% by the end of quarter 1, 2023-24. Clinical Boards are being held to account on performance in Executive Performance Reviews and this will continue, with improved compliance being reported in all Clinical Boards in February. This recommendation is therefore partially complete with an agreed trajectory for completion.

The remaining recommendations form part of the wider quality improvement programme in place within the Health Board, with specific actions shown against each recommendation in Annex 1. All are

in progress and also form part of the Health Board's preparations for the implementation of the Quality and Engagement Act.

Recommendation:

The Committee is requested to:
NOTE the progress made with the implementation of the recommendations of the Audit Wales report.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	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	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	x	Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/No

Yes – The findings of the Audit Wales report relate in part specifically to risk management arrangements or arise from an assessment of risk.

Safety: Yes/No

Yes – the implementation of the recommendations should result in improvements in safety through the improvement in clinical governance within the Health Board.

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:

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022/23	Sep-22	Review of Quality Governance Arrangements	R1/7	The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.	To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP. Develop generic and specific Quality indicators aligned to the QSE Priorities in the QSE framework for Clinical Boards which are reported through QSE structure. and QSE Committee. These will be reported by exception as required and in totality at their scheduled presentation to the Committee.	Executive Nurse Director	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality	PC	The Civica Patent Experience digital platform has been implemented in Q4 of the financial year and will support reporting of patient experience indicators. The AMaT clinical Audit platform has been implemented in Q3 and Q4 and is now in use across the entire Health Board and will support oversight of quality and safety priorities. A Learning from Death Framework is under development and will standardise three tiers of mortality indicators including Tier 1 Health Board levels, Tier 2 - Clincal Board level and Tier 3 Directorate levels. Tier 1 has been agreed and Tier 2 indicators are in the process of being agreed. In Q1 of the next financial year the quality and patient safety team are appointing to a a data analyst who will sit in the information team and whose priority it will be to develop a quality dashboard to include agreed quality indicators.
2022/23	Oct-22	Review of Quality Governance Arrangements	R2/7	Risk Management There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality Safety and Experience Committee. b) The Health Board's Risk and Regulation Team operate a check and challenge system to manage the escalation and de-escalation of risks from the Corporate Risk Register. Training is also provided to risk leads to improve the detail recorded within risk registers. Both areas remain a work in progress and will continue to be implemented and improved.	Director of Corporate Governance	Head of Risk and Regulation	C	All Patient Safety risks as they are recorded will be referred to relevant Committees for review.
2022/23	Oct-22	Review of Quality Governance Arrangements	R3/7	Clinical Audit The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.	The Clinical Audit Plan is to be shared at the Audit and Assurance Committee and discussed at the October QSE Committee meeting. The plan will reference all of the actions from this report. Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee. Some investment has been provided to Clinical Audit from in year one form the internal Business case (monies to be provided over a 3 year period). Posts are being recruited into - investment was provided for a Clinical Effectiveness lead Band 8a and an Audit co-ordinator band 5. Additional resource was provided for a band 5 post to support the AMAT programme. AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation	Executive Nurse Director	Head of Quality Assurance & Clinical Effectiveness	PC	A Clincal Audit Policy and Strategy have been developed and are in the consultation phase prior to publication. AMaT clinical audit platform has now been rolled out and in use in all clinical boards and an extensive training programme is underway to support its use and wider awareness of Clinical audit. All Clinical Boards are currently working with the Patient Safety and Quality Assurance Team to develop a forward plan of clinical audits aligned to their quality and patient safety priorities.
2022/23	QSE Framework to 2026 May 2023 Project plan completion October 2022	Review of Quality Governance Arrangements	R4/7	Values and Behaviours The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel: a) that their mistakes are held against them or kept in their personal file; b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right .	A safety culture with a focus upon psychological safety is an enabler of the QSE Framework. Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues. A project plan is being developed and will be part of the QSE implementation of the framework Culture surveys and feedback will be part of the evaluation with our quality metrics and will be undertaken annually in quarter 4 to assess whether values and behaviours have improved. Work will be aligned with organisational development colleagues supported through the people and culture plan.	Executive Nurse Director	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme	PC	A patient safety communication strategy will be developed to support a programme of communication to raise awareness of safe reporting and broader psychological safety issues. A Patient Safety Framework will be published in Q1 of 2023/24 and will include use of the Just Culture Framework. Work to meet statutory requirements in line with the Duty of Quality are being explored with the People and Cuture team in relation to supporting the workforce.
2022/23	Mar-24	Review of Quality Governance Arrangements	R5/7	**Personal Appraisal Development Reviews (PADRs)** The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.	The UHB has recognised the issue regarding VBA compliance and an improvement plan has been put in place focusing on communication and engagement, training and support and the impact on staff wellbeing and performance outcomes. This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners. Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase and ever increasing service demands, the UHB target is to increase compliance to 50% in 2022/23, followed by a target of 85% in 2023/24. These KPIs are reflected in the People and Culture Plan and are reviewed monthly. A focus on promotion and engagement of the new VBA approach (launched in 2019), will develop manager capability and team buy-in through effective and accessible training and development, engagement and support, including development in delivering an effective VBA, the importance of VBAs on staff wellbeing, performance, motivation and quality.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture	PC	VBA complaince was a focus of Executive Performance Reviews in November 2022 with a Deep Dive Paper presented to Strategy and Delivery Committee 15th Dec which included current status and trajectory plans (as agreed in Exec Performance Review). The current targets are 65% by the end of March 2023, and 85% end of Quarter 1, 2023/24.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022/23	Aug-22	Review of Quality Governance Arrangements	R7/7	**Monitoring and Reporting** There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and Experience Committee and Board	The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings.	Director of Corporate Governance	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality	PC	The QSE template will be amended to reflect the six domains of quality relating to the Duty of Quality and will be used at every level of the organisation. This will be co-produced with Clincal Governance and Patient Safety and Quality.

Report Title:	**Board Assurance Report – Patient Safety & Workforce**				Agenda Item no.	2.10	
Meeting:	Quality, Safety and Experience		Public	x	Meeting Date:	7th March 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Interim Director of Corporate Governance						
Report Author (Title):	Interim Director of Corporate Governance						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the risks on the Board Assurance Framework (BAF) which impact upon Patient Quality, Safety and Experience.

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

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

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

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

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

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

The Board Assurance Framework provides the Board with information on the key risks impacting upon the delivery of the Strategic Objectives of Cardiff and Vale University Health Board.

The attached Patient Safety, Quality and Experience Risks (last considered by the Board in January 2023) are considered to be key risks to the achievement of the organisation's Strategic Objectives.

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

Recommendation:

The Quality, Safety and Experience Committee are requested to:

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

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

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

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	26th January 2023

Saunders.Nathan
03/03/2023 15:42:00

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

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

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU). Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care in a larger clinical footprint in relation to post Covid 19 recovery. Due to the ability to balance within the health community and the challenge in transferring patients to EU. Due to the current pressure in EU and inability to segregate patients due to the volume in the department.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care since the onset of the COVID 19 pandemic creating both longer waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, with an impact on patient outcomes Post Covid recovery sickness is having a significant impact on staff availability (see separate risk on workforce).		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Private Partner facilities. • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Quality and Safety and Experience Framework Implementation underway • health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented •		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position reviewed at Strategy and Delivery Committee (1)		

	• Mental Health Committee aware of more people requiring support [1] • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives [1][2] • . [1] • Recent Executive review with Clinical Teams for understanding and review of front door pressures. [1]		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes and domiciliary care settings. Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since Sept 2022
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.	Jason Roberts	30.04.23	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Paul Bostock	31.03.23	Choice framework continues to be utilised
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog	Paul Bostock	31.03.23 Review October 22	Programme currently been reviewed by COO
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 High)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**

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

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

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

Actions	Lead	By when	Update since Sept 2022
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	30.11.22	Utilisation of CAV 24/7 funding to support interim model as larger scale redesign developed for Health Board
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals Saunders.Nathan 03/03/2023 15:42:00	PB	31/10/22	Clinical Director appointed. Associated director for transformation and delivery appointed. Support for key urgent and emergency models of care developed and to be implemented in Quarter 3.

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

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

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

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

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

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

Impact Score: 4	Likelihood Score: 2	Target Risk Score:	**8 (High)**

Report Title:	**Corporate Risk Register**				Agenda Item no.	2.11
Meeting:	Quality Safety and Experience Committee	Public	x		Meeting Date:	07/03/2022
		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 Cardiff and Vale UHB (the Health Board) Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's Committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded only those risks scoring 20 and above.

Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to the Quality, Safety and Experience Committee are attached at Appendix A for further scrutiny and to provide assurance to the Committee that relevant risks are being appropriately recorded, managed and escalated.

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

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board. This includes bi-monthly meetings with Clinical Board and Corporate Directorate Risk Leads to discuss submitted risks and emerging themes, as well as the provision of support to individuals or teams. During February the Head of Risk and Regulation has also attended and advised at the Obstetrics and Gynaecology Risk Management Meeting and at the Specialist Services Quality, Safety and Experience Committee to ensure that appropriate Risk Management support is provided where required.

At the Health Board's January 2023 Board meeting a total of 18 Extreme Risks reported to the Board related to Patient Safety (from a total of 22 risks scoring 20 or above) 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	1	
Medicine	6	1
PCIC		
Specialist Services	4	
Surgery		
Digital Health		
Estates		
Children and Women	2	
Mental Health		
Capital Estates and Facilities	4	
Workforce and OD		
Total:	**17**	**1**

During discussions with the Medicine Clinical Board risk lead in February it was confirmed that Risk CRR6, which relates to Nurse Staffing Levels would reduce to a score of 20 in advance of the March 2023 Board meeting due to controls having a greater mitigating impact on this risk as the Health Board moves out of Winter.

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

ASSURANCE is provided by:

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

Recommendation:

The Committee is requested to:

a) NOTE the Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which is progressing with Clinical Boards and Corporate Directorates.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	

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

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

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	28/07/2022

CORPORATE RISK REGISTER JANUARY 2023

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital Estates and Facilities	1	Mar-21	**Obsolete Medical Gas and Air Delivery Equipment and Plant** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete at UHW Maternity (manifolds 1&7), In addition the UHW Medical Gas Pressure reducing set is obsolete. Helipad and Ambulatory Care Medical Air Plant areare non compliant to HTM02-01 MGPS Standards. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety. quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Mar-23	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	2	Mar-21	**Risk/Issue**: UHW Tunnels corroded Main O2 Pipeline due to building leakage **Impac**t: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	**20**	Regular inspection and maintenance.	5	4	**20**	Repair building leak and renew section's of corroded pipework.	5	1	**5**	Mar-23	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	3	Mar-21	**Risk/Issue**: UHL Main Boiler F&E TANKS are badly corroded and require renewing **Impact**: Corrosion causing tanks to leak and loss of Heating throughout Hospital	5	4	20	No controls in place as cleaning tanks may result in leakage	5	4	20	Renew or reline tanks to prevent leaks.	5	1	5	Mar-23	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	4	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW ITU A3N, UHW ITU B3N North, UHW Cardiac ITU C3 Link does not comply with HTM's for Ventilation. **Impact:** Adverse impact on the safety of staff working in these areas, faiulre to comply with HTM regulations.	5	4	20	System is subject to statutory testing and inspection in line with legislation and HTM regulations. Regular maintenance.	5	4	20	Preparing plans to renew the AHU. Look at improving the sytem to comply with current HTMs	5	1	5	Mar-23	Strategy and Delivery Committee Quality, Safety and Experience Committee	Workforce Patient Safety Capital Assets Staff Wellbeing
	6	08/2022	There is a risk of physical and emotional harm to patients and staff due to the number of nursing vacanies across the Clinical Board. Secondary to this is the risk of failure to comply with regulatory staffing requirements (Nurse Staffing Levels (Wales) Act 2016).	5	5	25	Posts advertised in a timely manner. Authorisation of vacancies reviewed efficiently. Maximsation of medical ward float staff. Dedicated recruitment officer in post. Bimonthly recruitment events held. Engagement with Project 95, overseas recruitment, adaptation programmes, student streamlining and staff return to practice. Risk staff framework completed daily by the Clinical Board and shared at daily OPAT UHB meetings	5	5	25	Ongoing support and escalation via OPAT. Overseas nurses coming on board October 2022 to support staffing shortfalls. Focused work on staff exit questionairres and engagement with established staff to protect establishment.	5	3	15	Mar-23	Strategy and Delivery Committee Quality, Safety and Experience Committee	Workforce Patient Safety Staff Wellbeing Urgent and Emergency Care
	7	08/2022	Patients with suspected (Basal cell carcinoma) BCC are added to a routine waiting list, due to this there is a risk that these patients may actually be unusual presentation of a higher risk Squamous cell carcinoma (SCC). Secondary to existing RTT waiting times for routine referrals (target 36 weeks) there is a risk that increased waits could impact on a patients prognosis.	5	5	25	Ongoing work within the Directorate with Clinical Board oversight to reduce waiting times	5	4	20	Waiting list initiatives ongoing as part of recovery plan to reduce overall waiting position. Triage system in place for referrals: teledermatology review of photographs to support clinical prioritisation	5	1	15	Mar-23	Quality, Safety and Experience Committee	Patient Safety Cancer Planned Care
	8	08/2022	There is a risk of patient harm due to delays in patient treatment and flow following a speciality referral from the Emergency Unit.	5	5	25	Engagement across Clinical Board specialities to review patients within 30 minutes of referral and make a plan within 60 minutes. Implementation of internal escalation cards within Emergency Medicine. Delays documented within EU Safety Huddles Report.	5	4	20	To facilatate seven day 12 hour per day presence of an Acute Medicine Consultant as per Royal College of Physician guidelines	5	3	15	Mar-23	Quality, Safety and Experience Committee	Patient Safety, Urgent and Emergency Care

Medicine Clinical Board	9	08/2022	There is a risk of Patient Harm due delays in the delivery of patient care and subsequently NRI's reported to the Delivery Unit for delayed cancer diagnosis secondary to the accumulation of therapeutic and surveillance backlog for Endoscopy and due to Covid restrictions. Change in the local lower GI pathway has shifted all USC priority CT pneumocolon requests into secondary care. Implementaton of FIT stool testing into pathway now requires result for some patient groups delaying decision making and waiting times for USC referral.	5	5	20	Clinical validation of lists. Corporate risk stratification cub available in BIS to pull through surveillance patients based upon individual risk vs chronological waiting times. NEP also provided documentation for risk stratification. High risk surveillance patients started to be listed for procedures.	5	4	20	Directorate to utilise BIS risk surveillance to prioritise patients and reduce potential harm. Administrative team to send patient risk letters for delayed surveillance cases to manage patient risk. Directorate to consider use of FIT stool test as per BSG to manage risk of overdue lower GI surveillance. Clinical validation continues risk assessing using a clinical tool recommended by steering group. Table top exercises undertaken to ensure all actions aligned and updated and will continue to be reviewed.	4	2	8	Mar-23	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Planned Care Cancer
	10	01/03/2019	There is a risk to patient safety and wellbeing due to patients remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	25	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patients condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assessed by the Triage Nurse/MAN to ensure a patient clinical assessment is conducted. Concern by either party about the length of any dealy or volume of crews being held is escalated to the Senior Controller/EU nurse in charge to Patient Access for usual UHB escalation procedures, or by WAST via Silver Command. WAST have introduced a number of hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer. Standard operating procedure in place within EU to support 'immediate release' requests by WAST. Joint CB/WAST partnership meeting in place to focus on improvement. The CB is engaged with the NRI process for reporting incidents where WAST delays have resulted in major harm. The Clinical Board work with OPAT and the completion of 'on boarding' and FCP when ambulances have been held for 3 hours. Transformational work undertaken across Acute and Emergency Medicine to support flow including RATZ, virtual ward and speciality hub. The appointment of two Band 7 registered nurses to work with Patient Access to support patient flow.	5	4	20	Daily review and risks noted within Safety Huddles and EU controller reports. Escalation via MCB HUB and Patient Access Services. Evaluation of Standard Operating Procedure to reflect changes required. WAST immediate release Standard Operating Procedure in use to support 'red' calls in the community. OPAT across both UHW and UHL sites to support WAST and patient flow.	5	2	10	Mar-23	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety Urgent and Emergency Care
	11	01/01/2021	There is a risk of patient and staff harm due to an inability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment, resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience.	5	5	25	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.	5	4	20	Medical staffing reviewed as part of the daily OPAT meeting with ongoing planning to ensure safe staffing. Work ongoing with Medi Team and Locums to support the Emergency footprint. Ongoing recruitment into F3 posts	5	2	10	Mar-23	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety Staff Wellbeing Workforce
	12	01/12/2021	There is a risk of patient harm due to overcrowding within the Emergency and Acute Medicine footprint secondary to no flow or lack of UHB capacity. This results in the inability to provide and maintain key quality standards as patients are being nursed in inappropriate areas affecting timely access to treatment and discharge.	5	5	25	UHB and local escalation policy and implementation led by MCB Hub and Patient Access Services working in partnership with the EU Controller and Senior Floor cover to improve flow. Escalation of all constraints to all Directorates. Internal escalation to key clinicians/staff to assist with flow across the department. All vulnerable patients escalated to ensure timely bed allocation. Standard Operating Procedure in place for all ambulatory areas. Clinical Board engaged and supportive of 'on boarding' to facilitate flow. Change in the Emergency Unit footprint to support flow, eg speciality hub.	5	4	20	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow. Introduction of two Band 7 nurses to support flow and patient access.	5	3	15	Mar-23	Quality, Safety & Experience Committee	Patient Safety Capital Assets
Children and Women Clinical Board	13		Due to Fetal Medicine capacity shortfall and breach of ASW 5 day referral standard, there is an increased risk of harm to compromised fetuses and reduced options for termination of pregnancy if delayed beyond 21+6 weeks	5	5	25	Fetal medicine lead is keeping accurate data regarding breach figures, along with demand and capacity data. Clinics are being overbooked to absorb urgent referrals and active triage to allow joint shared care with local delivery where possible. Twice Weekly Staffing Meetings. Monitoring of Demand and Capacity figures	5	4	20	The fetal medicine service is actively triaging on a daily basis and managing patients locally where possible and declining to accept referrals when safe to do so. A locum consultant with appropriate experience is providing 2 clinic sessions a week. Extra additional clinics are being put on where possible and will continue to be explored, however this is not always possible due to consultant availability and there still not being enough sessions available to meet the demand on the service. The fetal medicine service will continue to try manage the risk by vigilant triaging to pick off the highest risk cases and trying to manage joint care with local units when possible. Additional clincial space (current antenatal phlebotomy room) is being prepared to reduce crowding in clinics and improve efficiency.	5	1	5	Mar-23	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Maternity
	14	01.05.22	Due to staffing levels within Maternity services there is a risk that: - there will be delay and interruption to induction of labour and the potential risk of poor patient experience and poor outcomes for mothers and babies. Home Birth Services will be withdrawn resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board. - the Midwifery Led Unit will have to close resulting in the loss of choice for women. This has the potential for reputational harm to the Health Board	5	5	25	1.Undertaking an in depth review of our that there is continued assurance that sickness is being managed according to the policy. 2. Introduced a weekend planning meeting each Friday at 12pm so that we have assurance that weekends are covered 3. Introduced a postnatal / newborn spot screening clinic at UHW on the weekends. This means that women will attend ANC at UHW or UHL for their care rather than a midwife visiting. This will release a community midwife to come in to support the hospital setting but keep the home birth service going. 4. Midwives offered bank / additional hours and overtime Enhanced overtime approved	5	4	20	1. Ongoing recruitment of band 6 midwives. Band 5 vacancies have been filled and starting in October 2022. 2. Improved sickness review in place. 3. Staffing planning meetings to continue. 4. Communication to internal and external bodies including WG 5. Weekly internal escalation regarding staffing levels. 6. Ehanced overtime to continue to be offered to midwives and nurses. 7. Communication to the public regarding changes to service and MLU closures.	5	2	10	Mar-23	Quality, Safety and Experience Committee	Patient Safety Workforce Maternity

CD&T	15		**Estates and Medical Equipment** There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate. Significant aggregated risks acorss the Clinical Board Directorate risk registers including: 1. Mortuary - failure to meet HBN20 with potential for improvement notice or closure from the regulator (HTA) 2. Radiopharmacy - failure to meet the requirements of the regulator (MHRA) with potential for improvement notices or closure from the regulator - regional impact on delivery of diagnostic services 3. Stem Cell Processing Unit - inadequate accommodation, compressor failures, failure of supply of liquid nitrogen from the external tank, impact - failure to deliver liquid nitrogen to the cryogenic freezer holding patient stem cells for transplantation. 4. Health Records - inadequate storage capacity, security of the Health record, potential for data loss, health and safety risks 5. Clinical Engineering - inadequate accommodation for the equipment library, Fieldway, and mechanical engineering UHW, no space to clean returned equipment 6. Insufficient accommodation for a number of clinical board services including - Occupational Therapy, Speech and language Therapy, Pharmacy, POCT, physio, Cedar 7. Air tube for lab specimens sitting under contract for maintenance with CD&T, regular breakdowns and damage resultig in unable to use the system to deliver specimens ina timely manner 8. Air handing and chiller units - not in place, subject to regular breakdowns, impact on temperature sensitive services such as Blood Transfusion/drugs, impact on temperature sensitive equipment such as blood analysers, CT scanners leading to loss of service 9. Repeated examples of water or sewage ingressing into clinical and non-clinical areas, leading to inability to deliver services 10. UHL Main Occupational Therapy Department - Fabric of building is deteriorating , room unusable , leaks throught the area .Patient records damaged as a result . Poor condition of outpatient portacabins	5	5	**25**	Capital planning programme Discretionary capital programme Escalation routes to Estates Business Continuity Plans Managed service contracts Maintenance service agreements Medical equipment governance framework	5	4	**20**	Further work with Capital and Estates to develop prioritised timetabled plans to address known risks Continue to seek funding through WG for replacement equipment and HTF funds to substitute old technologies Engage with TRaMS project for proposed regional solution to Radiopharmacy Engage with Capital Planning with regards to Mortuary refurbishment project	5	2	**10**	Mar-23	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Capital Estates Patient Safety
Specialist Services Clinical Board	16	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**	Mar-23	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Staff Wellbeing Workforce Critical Care
	17	08/2022	**Critical Care - Bed Capacity** Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care present a risk of avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.	5	5	**25**	Currently the directorate are occupying the use of a surge ICU area (C 3 Link) to provide 10 additional physical beds. Capital Planning are in the design process for refurbishment and expansion of Critical Care.	5	4	**20**	Undertake Design work to produce an outline cost for refurbishment and expansion of Critical Care beds, overseen by Program Board.Seek funding for expansion and refurbishment. Clarify commissioning arrangements	5	2	**10**	Mar-23	Quality, Safety and Experience Committee Strategy and Delivery Committee	Patient Safety Critical Care
	18		**Critical Care - Estates** There is a risk of patient and staff harm due to aging and obsolete estates and equipment coupled with reduced capacity within the Critical Care Directorate. Aggragated Risk following risk of harm in the following areas: - HCID Level 2 and 3 (Reduced Capacity) - Sub-standard Heating, Ventilation and Air Circulation - Isolation Facilities - LTV unit - Substandard Infrastructure and plumbing leading to flooding - Obsolete Pendants System providing medical gasses.	4	5	**20**	Prioritisation of clinical need, use of neighbouring facilities and acquiing temporary mobile structures.	4	5	**20**	Business cases to be developed to secure renovation and replacement funding.	4	2	**8**	Mar-23	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Capital Assets Patient Safety Critical Care

	19	Jan - 2010	**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	Risk specific policies, protocols, and guidelines. Cleaning schedules. Installation of air pressure gauges outside BMT cubicles to measure positive air pressures. Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green). HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved. A number of options for the relocation of the service have been explored over the past 10 years but have not been successfully adopted. The directorate and Clinical Board are currently working with Estates and Operational Colleagues as part of the Health Board's Acute Sites Master Plan work to develop plans for relocation to the current Outpatient site at UHW.	5	4	**20**	New dedicated Haematology facility required. Escalated to Clinical Board, estates and WHSSC. Bid for Lakeside Wing is to be submitted for consideration.	5	1	**5**	Mar-23	Quality, Safety and Experience Committee and Strategy and Delivery Committee	Patient Safety Capital Assets

Report Title:	**Work Plan 2022/23 – Quality, Safety and Experience Committee**			Agenda Item no.	3.1
Meeting:	Quality Safety and Experience Committee	Public	X	Meeting Date:	07.03.2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Nicola Foreman (previous 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 Quality, Safety and Experience Committee Work Plan 2023/24 prior to presentation to the Board for approval.

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

The Work Plan for the Quality, Safety and Experience Committee was last reviewed in February 2022.

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

The Work Plan for the Quality, Safety and Experience Committee 2023/24 has been based on the requirements set out within Quality, Safety and Experience Committee Terms of Reference which normally meets 6 times per year. However, due to the current issues within the organisation relating to quality it has been agreed that the Quality Committee will meet monthly for the foreseeable.

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

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

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

Recommendation:

The Committee is requested to:

(a) Review the Quality, Safety and Experience Committee Work Plan 2023/24
(b) Ratify the Committee Work Plan for 2023/24 and
(c) Recommend approval to the Board on 30th March 2023.

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	

3.	All take responsibility for improving our health and wellbeing	X	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	X	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	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
03/03/2023 15:42:00

Quality Safety and Experience Committee Work Plan 2023 - 24													
App -Approval Ass- Assurance Inf - Information	**Exec Lead**	**11-Apr**	**09-May**	**06-Jun**	**12-Jul**	**08-Aug**	**13-Sep**	**10-Oct**	**15-Nov**	**12-Dec**	**09-Jan**	**08-Feb**	**05-Mar**
Agenda Item													
Standing Items													
Quality, Safety and Experience Implications arising from IMTP	MJ/JR	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Quality Indicators	MJ/JR	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Quality, Safety and Effectiveness Assurance Reports from Clinical Boards (programme to be agreed with CBs)	PB	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Sub Groups to Quality, Safety and Experience Committee : **Clinical Effectiveness Committee** (consent MCA, DoLS, National Clinical Audit, NICE, NCEPOD, Patient Information, EOL Care, Dementia and delirium, Transition, Organ Donation, Peer Reviews.)	MJ/JR												
Concerns Group (concerns and complaints, incident reporting, Duty of candour, patient/user experience and feedback in line with National Clinical Services Framework: A Learning Health and Care System, claims, datix system.)	MJ/JR												
Clinical Safety Group (Consent MCA, DoLS, Patient Information, Dementia and delirium, Transition, Organ Donation, IP&C, Pressure Damage Group, IRMER, End of Life Care, Falls Delivery Group, JAG, Medicines Management Group, Mortality Review Group, Blood Transfusion, patient Safety Solutions, Medical Devices Group. Nutrition and Hydration, RADAR)	MJ/JR												
Learning Committee	MJ/JR	Ass								Ass			
Operational Groups by Exception (IP&C, Cleanliness, Decontamination, Medicines Management, Safeguarding, Research, Patient Safety Solutions, Medical Devices, Nutrition and hydration, Falls, Health Records, Blood Transfusion, Resus, VTE, Pressure damante, Mortality, Suicide Prevention, Point of Care Testing)The operational groups will feed into the Clinical Safety Group when established with exception reporting only to QSE Committee	MJ/JR	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf
Patient Story	JR	Children and Women; Mental Health		CD&T		Medicine				PCIC		Surgery	
Quality Governance													
Quality, Safety and Experience Framework -effectiveness review	MJ/JR	Ass								Ass			
Health Care Standards Strategy and Action Plan	MJ/JR			App								App	
Policies	MJ/JR	App		App		App				App		App	
Health and Social Care (Quality and Engagement) (Wales) Act 2020- Annual Compliance	MJ/JR												
Key External Reports from CHC, Internal Audit, Audit Wales	MJ/JR	Ass		Ass		Ass				Ass		Ass	
HIW Activity Overview	JR	App		App		App				App		App	
HIW Primary Care Contractors	JR			App						App			
Health Promotion Protection and Improvement													
Public Health Promotion activities	FK	Ass											
Quality, Safety and Experience of Public Health Services	FK									Ass			
Quality, Safety and Experience Committee Governance													
Chairs Action	CP	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf
Annual Work Plan	DCG											App	
Review of Meeting	DCG	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Self assessment of effectiveness	DCG												Ass
Review Terms of Reference	DCG											App	
Produce Committee Annual Report	DCG											App	
Minutes of Quality, Safety & Experience Committee Meeting	DCG	App	App	App	App	App	App	App	App	App	App	App	App
Action log of Quality, Safety and Experience Committee Meeting	DCG	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass

Report Title:	Policy for Ratification – Deteriorating Patient Policy			Agenda Item no.	3.2
Meeting:	Quality & Safety Committee	Public	X	Meeting Date:	7th March, 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Jason Roberts, Executive Nurse Director.				
Report Author (Title):	Angela Jones, Senior Nurse, Resuscitation Service.				

Main Report
Background and current situation:

Physiological observations are fundamental to the identification of a patient's health status. They provide a baseline that facilitates the early identification of clinical deterioration through which it is possible to improve patient mortality outcomes (National Patient Safety Agency, 2007). Within all healthcare environments the monitoring, measurement, interpretation, and prompt response to physiological observations is one of the core roles undertaken by appropriately educated nurses, healthcare assistants and medical staff: this is relevant in all acute hospital settings (UHW, UHL including Mental Health Services for Older People (MHSOP), Hafan y Coed and Llanfair Unit). However, evidence suggests that the recognition of the deteriorating patient may be delayed if observations are not recorded and if abnormal observations are not acted upon and communicated effectively (National Patient Safety Agency, 2007, National Institute of Clinical Excellence, 2007, and Institute for Health Improvement, 2010).

Guideline 50: Acutely Ill Patients in Hospital (NICE, 2007), advocates the use of a "track and trigger" system. Such systems use an aggregated weighted scoring system for each of the core physiological elements of patient observation i.e. blood pressure, pulse, temperature, respiration, oxygen saturations etc. The culminating total of the sub scores provides an indication of the patients overall clinical health status at that time, and therefore acts as a trigger for taking appropriate intervention.

The National Early Warning Score (NEWS) "track and trigger" system was developed as part of the National 1000 Lives+ patient safety initiative and replaces all previous versions found in Cardiff and Vale University Health Board (UHB).

This policy was first drafted in 2018 and has been circulated numerous times within Clinical Boards and all key stakeholders pre COVID and since COVID. There has been widespread comments from members of the RADAR (Recognition of Acute Deterioration

and Resuscitation) Committee and extensive communication with the Patient at Risk Team since their inception.

Previous consultations have resulted in minor changes/amendments which were made prior to working with the Corporate Governance Department to publish the draft policy and completed the EHIA for consultation with staff. This latest consultation exercise resulted in no comments or amendments regarding the protocol.

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

The overriding ethos of NEWS is to provide a simple physiological scoring system that can easily be calculated at the patient's bedside. The system uses parameters which are measured routinely for all adult inpatients and can be used quickly to identify patients who are clinically deteriorating and require urgent intervention. The graded scoring system (Appendices1,2,3 and 4- NEWS Flowchart) informs of the actions that must be taken in accordance with the score as indicated, such as timeframes for review by the Patient at Risk Team / or doctors. However, it should be noted that due to the complexity of clinical assessment and appropriate treatment according to individual patient need, this policy and its supporting documentation is unable to provided explicit guidance in terms of the specific clinical intervention that should be taken. It does however; provide explicit guidance on accessing prompt and appropriate clinical assessment, through the implementation of a JUMP CALL pathway (Appendix 5) which empowers junior staff to escalate non-compliance when clinicians who are part of the escalation process fail to attend patient's needs.

This pivotal role of the multidisciplinary team in recording, monitoring and responding to changes in the deteriorating patient's physiological observations has been acknowledged in a number of key evidence-based publications published within the last few years. The culminating 1000 lives campaign document "Rapid Response to Illness" (IHI, 2010), combines recommendations from "NICE 50: Acutely Ill Patients in Hospital (2007)", and "Competencies for Recognising and Responding to Acutely Ill Patients in Hospital (Department of Health 2009)" thereby providing a framework for patient safety and quality that ensure patients are appropriately reviewed by appropriately trained and competent staff within a safe and appropriate time frame, which as such forms the basis of this policy.

Recommendation:

The Committee is requested to:

a) **Ratify** the attached Deteriorating Patient Policy (UHB 502).

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		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	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**
Completed and Submitted
Decarbonisation: Yes/**No**

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

Saunders,Nathan
03/03/2023 15:42:00

Reference Number: Version Number: 1	Date of Next Review: Dec 2025 Previous Trust/LHB Reference Number:

Deteriorating Patient Policy

Policy Statement

The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating patients so that immediate and appropriate review can be obtained. This policy is therefore aimed at all clinical staff employed within Cardiff and Vale UHB, who are specifically involved in the delivery of care to adult patients cared for in an emergency and ward environment within the UHW and UHL (including MHSOP, Hafan Y Coed and Llanfair Unit).

Policy Commitment

The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating Adult patients so that immediate and appropriate review can be obtained**.**

Supporting Procedures and Written Control Documents

This Policy and the Resuscitation Procedure describe the following with regard to Adult Deteriorating Patients.

Other supporting documents are:

Current NEWS charts (for Adult Patients)

Scope

This policy applies to all of our staff and students in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment has been completed.
Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed.
Policy Approved by	RADAR – Recognition of Acute Deterioration and Resuscitation Committee and Clinical Effectiveness Committee. Quality Safety and Experience Committee on ……

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/ Sub Committee	TBA *[To be inserted by the Gov. Dept]*	*New Policy - No Amendments applicable*

Contents

Executive Summary

Physiological observations are fundamental to the identification of a patient's health status. They provide a baseline that facilitates the early identification of clinical deterioration through which it is possible to improve patient mortality outcomes (National Patient Safety Agency, 2007). Within all healthcare environments the monitoring, measurement, interpretation, and prompt response to physiological observations is one of the core roles undertaken by appropriately educated nurses, healthcare assistants and medical staff: this is relevant in all acute hospital settings (UHW, UHL including Mental Health Services for Older People (MHSOP), Hafan y Coed and Llanfair Unit). However, evidence suggests that the recognition of the deteriorating patient may be delayed if observations are not recorded and if abnormal observations are not acted upon and communicated effectively (National Patient Safety Agency, 2007, National Institute of Clinical Excellence, 2007, and Institute for Health Improvement, 2010).

Guideline 50: Acutely Ill Patients in Hospital (NICE, 2007), advocates the use of a "track and trigger" system. Such systems use an aggregated weighted scoring system for each of the core physiological elements of patient observation i.e. blood pressure, pulse, temperature, respiration, oxygen saturations etc. The culminating total of the sub scores provides an indication of the patients overall clinical health status at that time, and therefore acts as a trigger for taking appropriate intervention.

The National Early Warning Score (NEWS) "track and trigger" system was developed as part of the National 1000 Lives+ patient safety initiative and replaces all previous versions found in Cardiff and Vale University Health Board (UHB)

The overriding ethos of NEWS is to provide a simple physiological scoring system that can easily be calculated at the patient's bedside. The system uses parameters which are measured routinely for all adult inpatients and can be used quickly to identify patients who are clinically deteriorating and require urgent intervention. The graded scoring system (Appendices1,2,3 and 4- NEWS Flowchart) informs of the actions that must be taken in accordance with the score as indicated, such as timeframes for review by the Patient at Risk Team / or doctors. However, it should be noted that due to the complexity of clinical assessment and appropriate treatment according to individual patient need, this policy and its supporting documentation is unable to provided explicit guidance in terms of the specific clinical intervention that should be

taken. It does however; provide explicit guidance on accessing prompt and appropriate clinical assessment, through the implementation of a JUMP CALL pathway (Appendix 5) which empowers junior staff to escalate non-compliance when clinicians who are part of the escalation process fail to attend patient's needs.

This pivotal role of the multidisciplinary team in recording, monitoring and responding to changes in the deteriorating patient's physiological observations has been acknowledged in a number of key evidence-based publications published within the last few years. The culminating 1000 lives campaign document "Rapid Response to Illness" (IHI, 2010), combines recommendations from "NICE 50: Acutely Ill Patients in Hospital (2007)", and "Competencies for Recognising and Responding to Acutely Ill Patients in Hospital (Department of Health 2009)" thereby providing a framework for patient safety and quality that ensure patients are appropriately reviewed by appropriately trained and competent staff within a safe and appropriate time frame, which as such forms the basis of this policy.

Scope of Policy

This policy does not apply to the monitoring of children or obstetric patients. However, the policy acknowledges that occasionally young adults aged between 16 – 18 are placed in acute environments, only in such cases would this policy apply. This policy also does not apply patients within General Intensive Care, Cardiac Intensive Care, Maternity Services, Coronary Care Unit and Theatres; although a NEWS score should be undertaken prior to step down to a ward level bed. Due to the diversity of disease and the complexity of clinical assessment it is beyond the scope of this policy to provide an exhaustive reference source on the clinical management of patients. The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating patients so that immediate and appropriate review can be obtained.

This policy is therefore aimed at all doctors, registered nurses, healthcare assistants and Allied Healthcare Professionals employed within Cardiff and Vale UHB, who are specifically involved in the delivery of care to adult patients cared for in an emergency and ward environment within the UHW and UHL (including MHSOP, Hafan Y Coed and Llanfair Unit).

Essential Implementation Criteria

The policy specifically provides a framework through which clinicians are informed of their responsibilities in relation to: -

- The minimum standards for monitoring patient's physiological observations.
- Recording and communicating the results of the monitoring of such physiological observations
- Recording and communicating the results of the monitoring of such physiological observations
- The minimum actions and referral route that must be taken in accordance with the NEWS scoring system
- The maximum timeframe within which escalation and review of deteriorating patients must occur

Aims

The policy aims to ensure that all patients cared for within the aforementioned environments receive the appropriate level of physiological observation and subsequent care. This should be aligned with the Treatment Escalation Plan (TEP) which MUST be completed for EVERY patient on admission. The TEP identifies, for all adult patients the level of care for the individual in the event of their deterioration. Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) decisions should also be clearly documented and communicated as per the All Wales policy.

Policy Statement

These Core Standards are applicable for all patients admitted into acute inpatient and emergency settings at UHW and UHL and Mental Health patients in MHSOP wards, Hafan y Coed and Llanfair Unit, and to all Health Board staff who are caring for them: -

If a patient refuses treatment, and / or the taking of physiological observations, then the risks of non-compliance must be explained to the patient.(See also the paragraph on Mental Capacity Act 2005 below). It is essential to be sure that the patient understands the risks and this should be documented and reported to both the nurse-in-charge and the doctor. If language poses a barrier to communication then the nurse/ doctor or allied healthcare professional (as appropriate) must ensure that interpretation/translation services are offered to the patient and/ or relative and provided as required. Reasonable adjustment will be made for disabled patients/carers to ensure equality of communication and policy implementation.

Exploration of underlying causation, and escalation, should be taken if a patient who refuses physiological and / or neurological observations has:-

- received a head injury prior to, or during their period of hospital admission, or
- previously complied with treatment and the taking of such observations
- started acting out of character

Where there is reason to doubt a patient's mental capacity to make a decision about having or not physiological/neurological observation, the Mental Capacity Act 2005 must be followed – see the UHB's Consent Policy to Examination or Treatment Policy for further details.

Minimum Standards for Monitoring Patients Physiological Observations

- A complete set of observations i.e. temperature, heart rate (pulse), blood pressure, respiration rate, pulse oximetry, and level of consciousness and pain assessment, will be undertaken within 1 hour of admission. Some patients may require lying and standing blood pressures. It is also a mandatory requirement to perform and record a one-off blood sugar at the point of admission for ALL patients. This will provide a baseline from which to prescribe nursing and medical interventions. However, it is recognised that more frequent monitoring of blood sugars will be required for those patients who are diabetic, or who are giving cause for concern.
- A complete set of observations (excluding blood sugars in non-diabetic patients) should also be recorded at the point of ward to ward transfers.
- Ward transfers should be clearly indicated on the NEWS observation charts and recorded within the documentation records.
- Glasgow Coma Score must be recorded dependent upon the individual presentation/clinical need. All patients who have sustained unwitnessed falls/ known head injuries either prior to admission, or during their period of hospital admission, must have the Glasgow Coma Score recorded in compliance with NICE 176: Head Injury: assessment and early management (2017). The Cardiff and Vale UHB Head Injury Pathway should also be followed.
- The NEWS protocol is clearly documented on the rear of the NEWS chart and must be complied with at all times.
- There is a NEWS Standard Operating Procedure (Appendix 6) that outlines the process of undertaking NEWS scores, frequency of scoring and escalation of care.
- All observations of pulse must include the palpation and recording of a radial pulse as a minimum standard in order to detect any irregularities such as fibrillation, doubling of beats etc which would not routinely be detected by mechanical devices.
- Respirations must be observed for one full minute. If the patient is in receipt of oxygen therapy the percentage of oxygen being administered must also be checked at source and documented on the observation chart.

- Monitoring equipment must be kept in good working order with regular planned servicing and calibration in accordance with manufacturer's recommendations. Equipment must be available in a variety of sizes e.g. large blood pressure cuffs, in order to support accurate monitoring of patient's physiological observations.
- That appropriate infection control measures are taken to prevent/minimise the risk of cross infection.

Recording and Communicating the Results of the Monitoring of Physiological Observations

- Only documentation that has been supported by both the Executive Medical Director and the Executive Director of Nursing, and validated by the appropriate levels of consultation and ratification can be used within the Health Board. Amendments and modifications to the documentation must only be made with prior approval of both the Executive Medical Director and the Executive Director of Nursing Director.
- All patient documentation will evidence the following standards within the patient record: -
    - the exact time and date of the observations will be recorded on the NEWS chart
    - the NEWS score must be calculated correctly
    - the frequency of the observations will be notated on the NEWS chart based upon the patient's NEWS Score and the NEWS protocol described on the rear of the NEWS chart.
    - a record of the actions taken e.g. outreach referral, commencement or discontinuation of treatment regimes will be recorded in the patient's documentation. This should be documented on the SBARD document. A copy of which should be inserted into the patient's notes, and a second copy forwarded to the Resuscitation Service for audit purposes.
    - all entries on the observation chart will be signed
    - if observations are undertaken by unregistered staff then these must be counter-signed by a member of registered staff
    - All information will be recorded on authorised Health Board documentation
    - The observational results of all patients causing concern/ triggering on NEWS will be communicated to the nurse in charge of the patient or the

Team Leader for onward escalation

- All patients causing concern / triggering on NEWS will be highlighted at the ward handover/ safety briefing.
- SBARD(Situation, Background, Assessment, Recommendation, Decisions) will be the format of choice for communicating information during the referral and escalation process.

- The Nurse in Charge must give consideration to contact the next of kin, or nominated family member/advocate if :-
  - the patient's condition gives significant cause for concern
  - the patient requires transfer to a higher level of care e.g. HDU, Theatre, ITU, specialist regional services e.g. Morriston
  - the deterioration is associated with a witnessed or unwitnessed fall.
  - The patient's death is considered imminent

- All communications with the patient's next of kin must be documented in the patients' health records noting: -
  - the date and time of the communication
  - mode of communication e.g telephone, face to face meeting
  - to whom the call was made
  - the detail of the conversation (using the SBAR format)
  - the outcome of the communication e.g. family travelling in to be with patient/ see doctors etc.
  - the name and designation of the staff member contacting the family

- On transfer to another ward or hospital, or discharge all documents pertaining to the patient i.e. medical / nursing records, prescription charts, observation/ NEWS charts, fluid and diet charts etc. must be filed securely within the patient's health records.

Minimum Actions and Referral Route that Must be Taken in Accordance with the NEWS Score

- Any patient who has either a perceived deterioration or who trigger the NEWS score will be referred for immediate review by an appropriately qualified healthcare professional as per NEWS flowchart (Appendix 1,2,3 and 4) i.e.:-
    - The NEWS score is 0 – 2 but the patient is showing cause for concern
    - The NEWS score is 3 – 6
    - The NEWS score is 6 – 8
    - The NEWS score is 9 or above
    - There is any concern about a patient who would not ordinarily trigger a response according to the NEWS protocols
- In order to document the requirement for escalation of care an SBARD form should be completed. A copy is placed in the patient notes and a copy returned to the Resuscitation Service for audit purposes.
- When a patient is causing concern, the appropriate clinician will be alerted immediately and attend the patient within the given timeframe as per NEWS flowchart. The name of the person who is being requested to attend, and the exact time that the request was made will be recorded within the patient record and dated and signed by the person making the referral
- Upon review, the clinician reviewing the patient, should sign the SBARD form to indicate that the patient has been reviewed and indicate the time of the review. The yellow copy should be sent to: The Resuscitation Service, Upper Ground Floor, Jubilee Courtyard, UHW, for audit purposes. The white copy should be filed in the patient's notes
- Any deviation/non-compliance with the time frames stipulated in the NEWS flowchart must result in a DATIX incident form being completed and the JUMP CALL (Appendix 5) pathway being immediately initiated.
- To ensure ongoing patient safety the clinician reviewing the patient will make an accurate and sufficiently detailed record within the patient notes that will include the following:-
    - Exact date and time that the patient was reviewed by the reviewing clinician.

- Signed and printed signatures including bleep numbers for all clinicians involved in the review. An accurate assessment of the patients presenting clinical condition, including differential diagnosis, and measurements as appropriate e.g.location of any lesions, dimensions etc.
- A sufficiently clear and detailed treatment/ action plan to facilitate the safe implementation of care / treatment interventions. Using upper and lower parameters of measurement, or clinical indicators for further escalation or clinical review e.g. the thresholds for systolic and diastolic blood pressure readings etc.
- The time of the next planned review (pending that there is no further deterioration or increase in the NEWS score within the interim).

- On transfer to another ward or hospital, or discharge all documents pertaining to the patient i.e. medical / nursing records, prescription charts, observation/ NEWS charts, fluid and diet charts etc must be filed securely within the patients health records.

Maximum Timeframe within which Escalation and Review of Deteriorating Patients Must Occur

Clinicians MUST respond and attend the patient within the timeframe as indicated within the NEWS flowchart.

- When a patient has been referred to a Clinician it is their responsibility to ensure that the patient is attended to within the required timeframe.
- If a Clinician is requested to attend but unable to do so they must immediately inform the referrer (usually the nurse in charge of the ward) who will then :-
  - document the reason for non-attendance within the patients case notes
  - escalate the referral to another appropriate Clinician. The handover should emphasise that the patent needs to be attended to and reviewed within the original timeframe as specified within the NEWS flowchart

Responsibilities

Individuals Undertaking, Monitoring and Recording the Observations of the Patient (including healthcare support workers and allied healthcare professionals)

It is the responsibility of the individual undertaking, monitoring and recording the observations of the patient to ensure that they make the Nurse in Charge of the shift aware of any limitations in his/her practice that would prevent them from safely discharging their duty of care to the patient e.g. unfamiliarity with equipment to be used, lack of training in taking observations, unfamiliar with documentation being used etc. Whilst of relevance to all healthcare staff in terms of accountability for commissions and omission in their practice this is of particular relevance to Registered Nurses and Doctors in terms of remaining accountable under their professional codes of conduct (NMC 2018 & GMC 2013).

ALL STAFF undertaking, monitoring and recording patient observations must ensure:-

- They have undertaken appropriate training and education to ensure that they are competent and capable of performing this role (including use of associated equipment).
- They understand the process for determining and recording the NEWS score and are compliant with the Core Standards as outlined in this policy: -
    - the exact time and date of the observations are recorded on the observation chart
    - that the NEWS score is calculated correctly
    - that a record of the actions taken is recorded.
    - that all entries on the observation chart are signed and countersigned
    - that the required frequency of observations is documented as a result of the NEWS score.
    - that the information is recorded on authorised Health Board documentation

That they immediately communicate to the Nurse in Charge (via the Team Leader if appropriate) for onward escalation any perceived deterioration in the patient, or NEWS score which indicates a deterioration, i.e:-

- The NEWS score is 0 – 2 but the patient is showing cause for concern
- The NEWS score is 3 – 6
- The NEWS score is 6 – 8
- The NEWS score is 9 or above
- There is any concern about a patient who would not ordinarily trigger a response according to the NEWS protocols

Registered Nurses / Doctors /Allied Healthcare Professional delegating the recording and monitoring of observations

Delegation of the task of taking patient observations must be according to the standards set out in the Nursing and Midwifery Council Code for Profession Practice ("The Code"), Health Care and Professions Council Standards of Conduct, Performance and Ethics (SCPE), or General Medical Council's Good Medical Practice. The Registered Nurse, Doctor or Allied Healthcare Professional delegating the recording and monitoring of observations to ensure:-

- That the person(s) to whom the task of recording and monitoring the observations has been delegated, is able to carry out the instructions to the required standards
- To ensure that junior staff/ team members are supported in performing the tasks required of them, and that they are able to do so within their individual level of competency and capability
- The confirmation and outcome
- That the observations are satisfactory and to ensure that the NEWS score is acted upon appropriately
- That subsequent actions are documented incorporating the standards of this policy.

- Where there is a delay in the attendance of the clinician, that the JUMP CALL pathway is initiated immediately and recorded appropriately within the patients nursing/medical record

Clinicians who are Instructed/Requested to Respond to a Deteriorating Patient / NEWS Score

It is the responsibility of the individual who is being requested to respond to a deteriorating patient / NEWS score to ensure that they make known to the Nurse in Charge of the shift and their line manager any limitations in his /her practice that would prevent them from safely discharging their duty of care to the patient. Whilst of relevance to all healthcare staff in terms of accountability for acts and omissions in their practice this is of particular relevance to Registered Nurses and Doctors in terms of remaining accountable under their professional codes of conduct (NMC 2018 & GMC 2013).

ALL STAFF responding to a deteriorating patient/ NEWS score must ensure:-

- They have undertaken appropriate training and education to ensure that they are competent and capable of performing this role (including use of associated equipment).
- They understand the process for by which the NEWS score has been determined and that they are compliant with the Core Standards as outlined in this policy.
- That they respond within the timeframe as indicated within the NEWS flowchart, and that timings are accurately documented in the patient's notes to reflect response times.
- When unable to attend due to competing pressures the Clinician must escalate this to another appropriate Clinician, emphasising the need to attend within the original timeframe as specified within the NEWS flowchart.
- The Clinician who is unable to attend must immediately inform the referrer (usually the nurse in charge of the ward) who will then document the reason

for non-attendance within the patient's case notes.

- When responding to instructions/ requests to attend a deteriorating patient/ NEWS score then the actions taken and the actions prescribed must be both verbally communicated to the Registered Nurse caring for the patient and clearly recorded within the patients records as per Core Standards of this policy

Consultants/ Clinical Directors with Overall Clinical Responsibility for the Patient

The Consultant/Clinical Director with the overall clinical responsibility for the patient is accountable for the acts and omissions of care afforded to the patient over the period of admission. It is therefore the Consultants / Clinical Directors responsibility to ensure:-

- That doctors in training are knowledgeable and competent in the interpretation of physiological observations.
- That doctors in training are supervised to ensure that all patients have a documented plan for physiological monitoring that include the following:-
    - Exact date and time that the patient was reviewed by the reviewing clinical professional
    - Signed and printed signatures including bleep numbers for doctors and advanced nurse practitioners/ members of the PART Team
    - An accurate assessment of the patients presenting clinical condition, including differential diagnosis, and measurements as appropriate e.g. location of any lesions, dimensions etc
    - A sufficiently clear and detailed treatment/ action plan to facilitate the safe implementation of care/treatment interventions. Using upper and lower parameters of measurement, or clinical indicators for further escalation or clinical review e.g. the thresholds for systolic and diastolic blood pressure readings etc
    - The time of the next planned review (pending that there is no further deterioration or increase in the NEWS score within the interim)
    - That all members of the Consultants / Clinical Directors team understand their individual responsibilities in terms of responding to an instruction/ request to attend to a deteriorating patient / NEWS score within the given timeframe as specified within the NEWS flowchart and JUMPCALL pathways.

- Failure to comply with the NEWS flowchart and JUMPCALL pathway must result in a DATIX and appropriate actions initiated.

Ward/Departmental Managers and Senior Nurse Responsibilities

- It is the responsibility of Ward/Departmental Managers and Senior Nurses to ensure that within their areas of managerial accountability that:-
- Appropriate and Health Board compliant documentation is available for use by staff.
- A NEWS champion be appointed for each clinical area
- The required level of daily and bi monthly audit as outlined in this policy is undertaken and reported as part of the Quality Dashboard.
- An equipment inventory is maintained which details the asset number, dates of planned maintenance etc. as detailed within the Medical Equipment Management Policy (2015, UHB 082). Staff working within their area of managerial accountability are aware that they are responsible for ensuring :-
    - the prompt removal of defective equipment from respective clinical areas and ensuring that prompt arrangements are made for its repair or condemning as appropriate.
    - DATIX incident reports are initiated where defective equipment has impacted on patient care
    - That any deviation/non-compliance with the time frames stipulated in the NEWS flowchart must result in a DATIX incident form being completed and the JUMPCALL pathway being immediately initiated.
    - All members of the nursing team understand their individual responsibilities in terms of implementing the requirements of this policy.
    - Failure to comply with the NEWS flowchart and JUMPCALL pathway must result in a DATIX and appropriate actions documented and initiated.

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Patient Safety & Quality Leads (Nursing/Medical)

It is the responsibility of the Patient Safety & Quality Leads (Nursing/Medical), to ensure that systems and processes are in place to ensure that :-

- Members of the Nursing and Medical Teams are aware of their responsibilities as outlined in this policy
- Resources and deficits in service provision are managed and escalated appropriately in order to ensure the safe and effective delivery of care within the Clinical Boards and are included within the Risk Register as appropriate
- Incidents arising from a failure to appropriately implement this policy, the NEWS flowchart and JUMPCALL pathway are escalated to the Patient Quality and Safety Team, and Executive Medical Director/ Executive Director of Nursing for information and support as appropriate.
- Incidents arising from a failure to appropriately implement this policy, the NEWS flowchart or JUMP CALL pathway are investigated appropriately so that lessons can be learnt feedback and shared across the Health Board and wider health community as appropriate.
- Professionally accountable individuals who fail to implement the requirements of this policy, the NEWS flowchart and JUMP CALL pathway are investigated under the disciplinary rules if considered appropriate by the Executive Professional Lead and/or the educational supervisor.

Executive Medical Director and Executive Director of Nursing

It is the responsibility of the Executive Medical Director and Executive Director of Nursing to ensure that: -

- Services provided within the Health Board and its composite areas are fit for purpose, providing safe and effective care which is patient centered and evidence based
- Processes and systems are in place to ensure that documentation associated with the implementation of this policy i.e. Observation charts, NEWS score charts, NEWS flowchart and JUMPCALL pathway are those approved by the Health Board.
- The Patient Safety team will oversee the investigation of Serious Incidents i.e. Red Concerns that arise from a failure to implement this policy, NEWS flowchart and JUMPCALL pathway, and to support the implementation of arising recommendations.

Training

- The induction programme for all clinical staff (nurses, doctors and health care support workers) will include awareness raising to this policy, the NEWS flowchart and JUMPCALL pathway.
- Training of staff takes account of the need to comply with all legislation regarding all minority groups.
- All staff using equipment must be trained and instructed in its use, demonstrating their competency and capability to use the equipment for its intended purpose.
- NEWS champions will receive specific training from the Resuscitation Service in order to perform audits and ensure compliance of NEWS protocols

- During the induction period of all new staff, mentors must ensure that all newly registered nurses and health care assistants are competent undertaking the basic physiological observations outlined in the Core Standards of this policy using both electronic and manual means of observation where appropriate e.g. electronic devices which read the pulse and digital palpation of the radial pulse.
- Newly registered staff must be assessed by their preceptor.
- Deficiency in competency and capability in registered staff and health care assistants must be dealt with by the ward / departmental manager.
- Student Nurse and Medical Students undertaking observations must be assessed by their mentor using the appropriate university competency document. Deficiencies must be fed back to the university link tutor and recorded in the practice book.
- A Database for all training undertaken regarding equipment for observations must be maintained by the Ward/ Departmental Manager.
- Any revisions to the policy or adaption of the NEWS flowchart, JUMPCALL pathway must be communicated to all doctors, registered nursing staff and health care assistants. Monitoring and Effectiveness

Audit

The ward /departmental manager or NEWS champion will undertake NEWS audits using the associated audit tool via Tendable at the required frequency.The results of audits will be forwarded to the Resuscitation Service for collation of data regarding NEWS compliance.

The Resuscitation Service has overall responsibility for the auditing of all 2222 calls, including those generated by deteriorating patients.

The Resuscitation Service also conduct audits of standards on NEWS charts to ensure that NEWS protocols are followed.

Results of audits will be fed back to Clinical Boards via the Patient Safety and Quality Frameworks of the Health Board. The Resuscitation Committee (RADAR) will oversee implementation of the policy and associated audits.

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Nursing and Midwifery Council. Raising concerns: Guidance for nurses and midwives 2015 Accessed via Internet 22.08.17 https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/

Appendices

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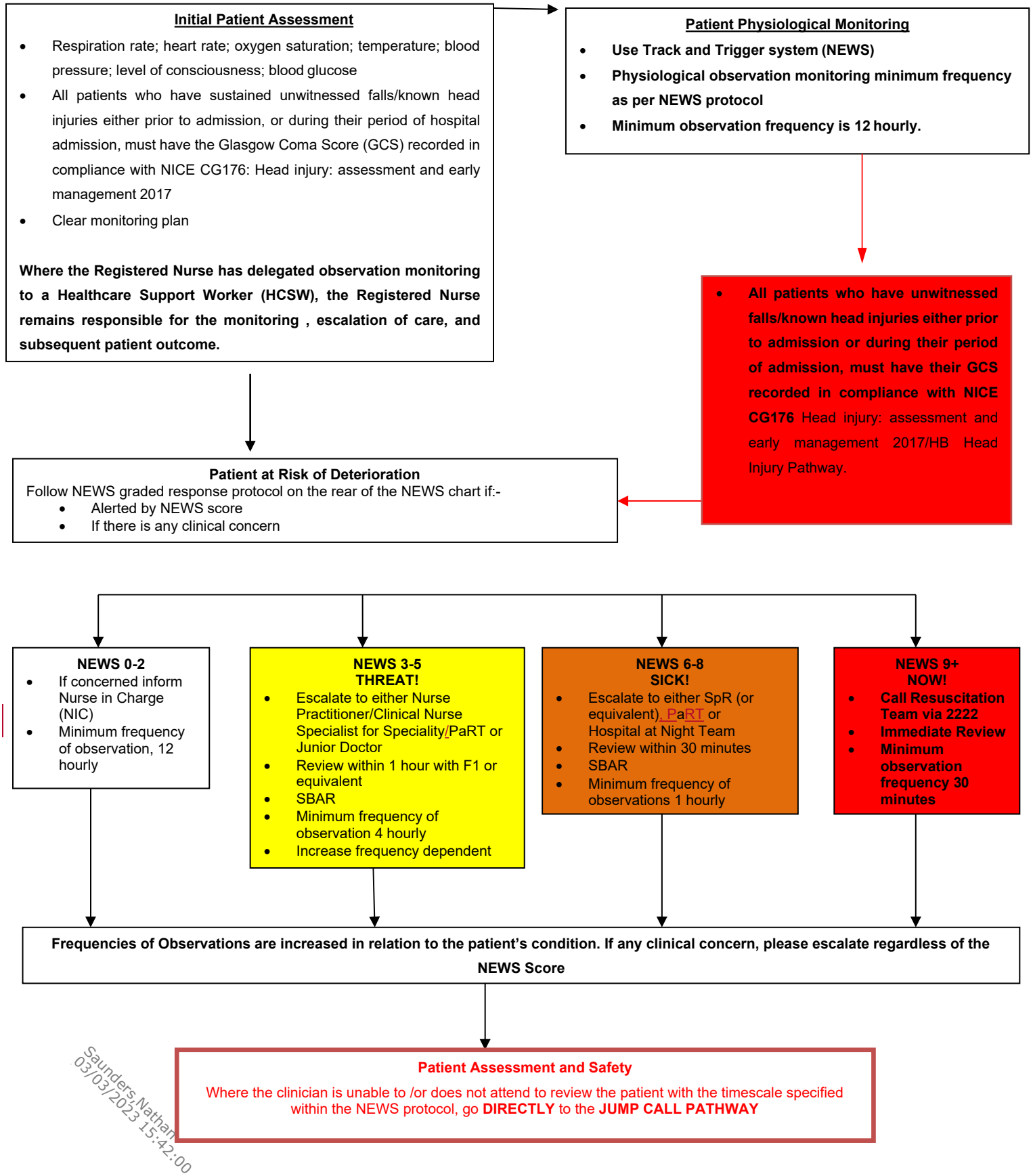
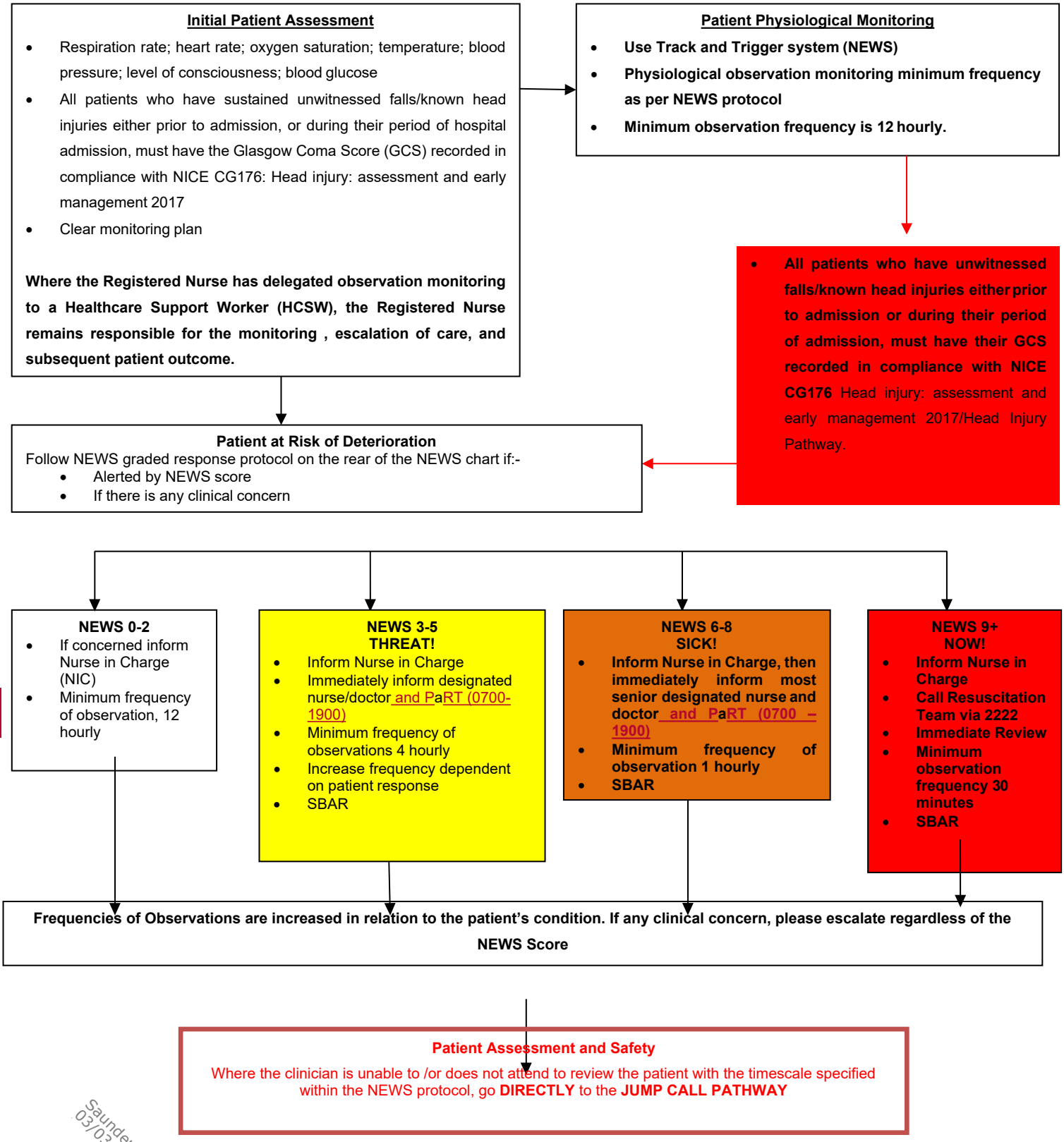
Appendix 1 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Acute Hospital (UHW/UHL)

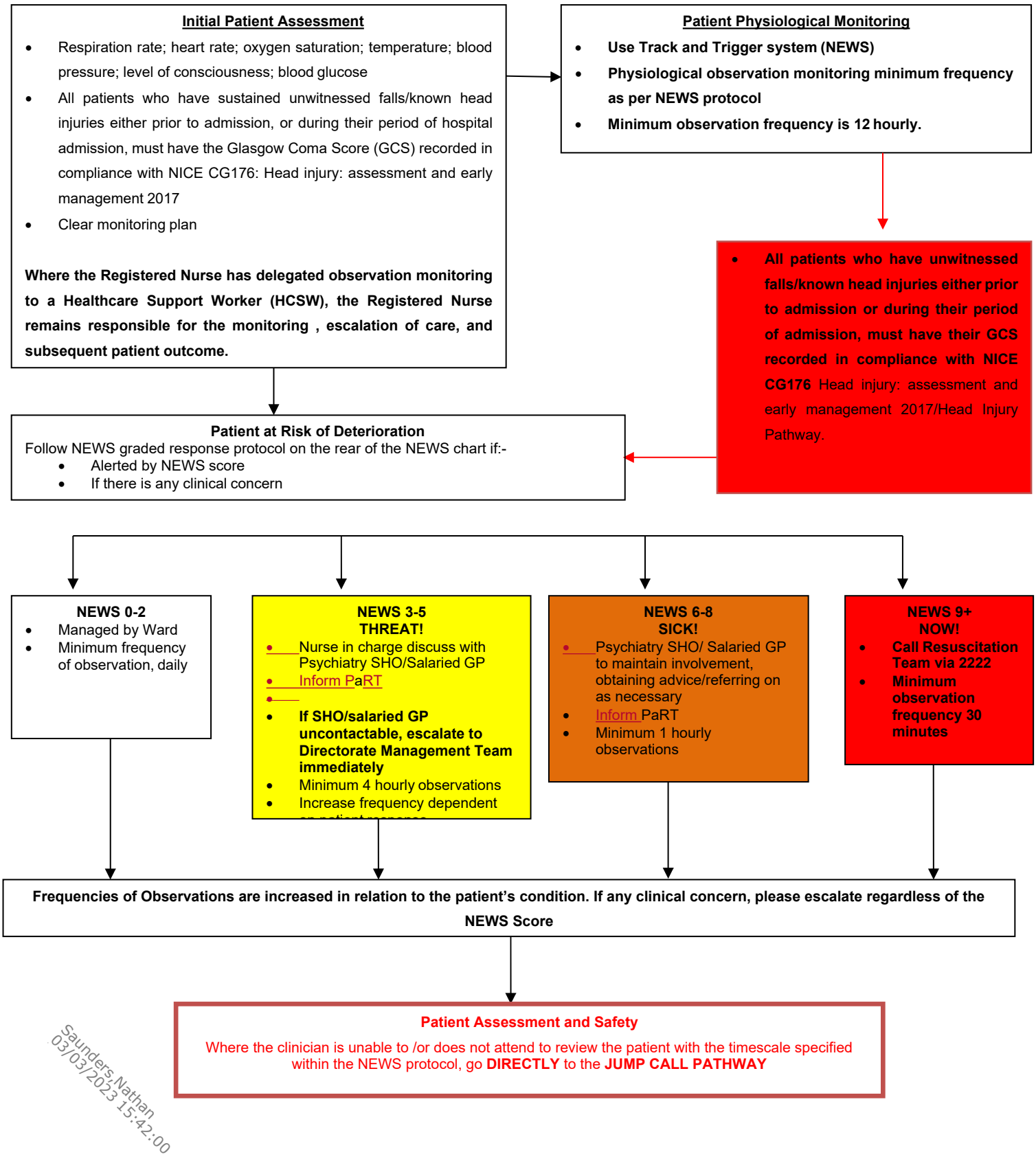


Appendix 2 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Acute Mental Health



Appendix 3 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Mental Health Services for Older People (MHSOP)

In Hours (9am-5pm Monday to Friday)



Appendix 4 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Mental Health Services for Older People (MHSOP)

Out of Hours (5pm-9am/Weekends/Bank Holidays

Initial Patient Assessment

- Respiration rate; heart rate; oxygen saturation; temperature; blood pressure; level of consciousness; blood glucose
- All patients who have sustained unwitnessed falls/known head injuries either prior to admission, or during their period of hospital admission, must have the Glasgow Coma Score (GCS) recorded in compliance with NICE CG176: Head injury: assessment and early management 2017
- Clear monitoring plan

Where the Registered Nurse has delegated observation monitoring to a Healthcare Support Worker (HCSW), the Registered Nurse remains responsible for the monitoring , escalation of care, and subsequent patient outcome.

Patient Physiological Monitoring

- **Use Track and Trigger system (NEWS)**
- **Physiological observation monitoring minimum frequency as per NEWS protocol**
- **Minimum observation frequency is 12 hourly.**

- **All patients who have unwitnessed falls/known head injuries either prior to admission or during their period of admission, must have their GCS recorded in compliance with NICE CG176** Head injury: assessment and early management 2017/HB Head Injury Pathway.

Patient at Risk of Deterioration

Follow NEWS graded response protocol on the rear of the NEWS chart if:-

- Alerted by NEWS score
- If there is any clinical concern

NEWS 0-2

- Managed by Ward
- Minimum frequency of observation, daily

NEWS 3-5
THREAT!

- Days:discuss with shift coordinator who will call Out of Hours – OOH GP
- Inform PaRT (0700 – 1900)
- Nights: Discuss with Mental Health Night site Manager who will call OOH GP
- Minimum 4 hourly observations
- Increase frequency dependent on patient response

NEWS 6-8
SICK!

- Ward to contact Med Reg for advice (make sure shift coordinator/ Mental Health Night Site Manager are aware)
- Inform PaRT (0700 – 1900)
- Minimum 1 hourly observations

NEWS 9+
NOW!

- **Call Resuscitation Team via 2222**
- **Minimum observation frequency 30 minutes**

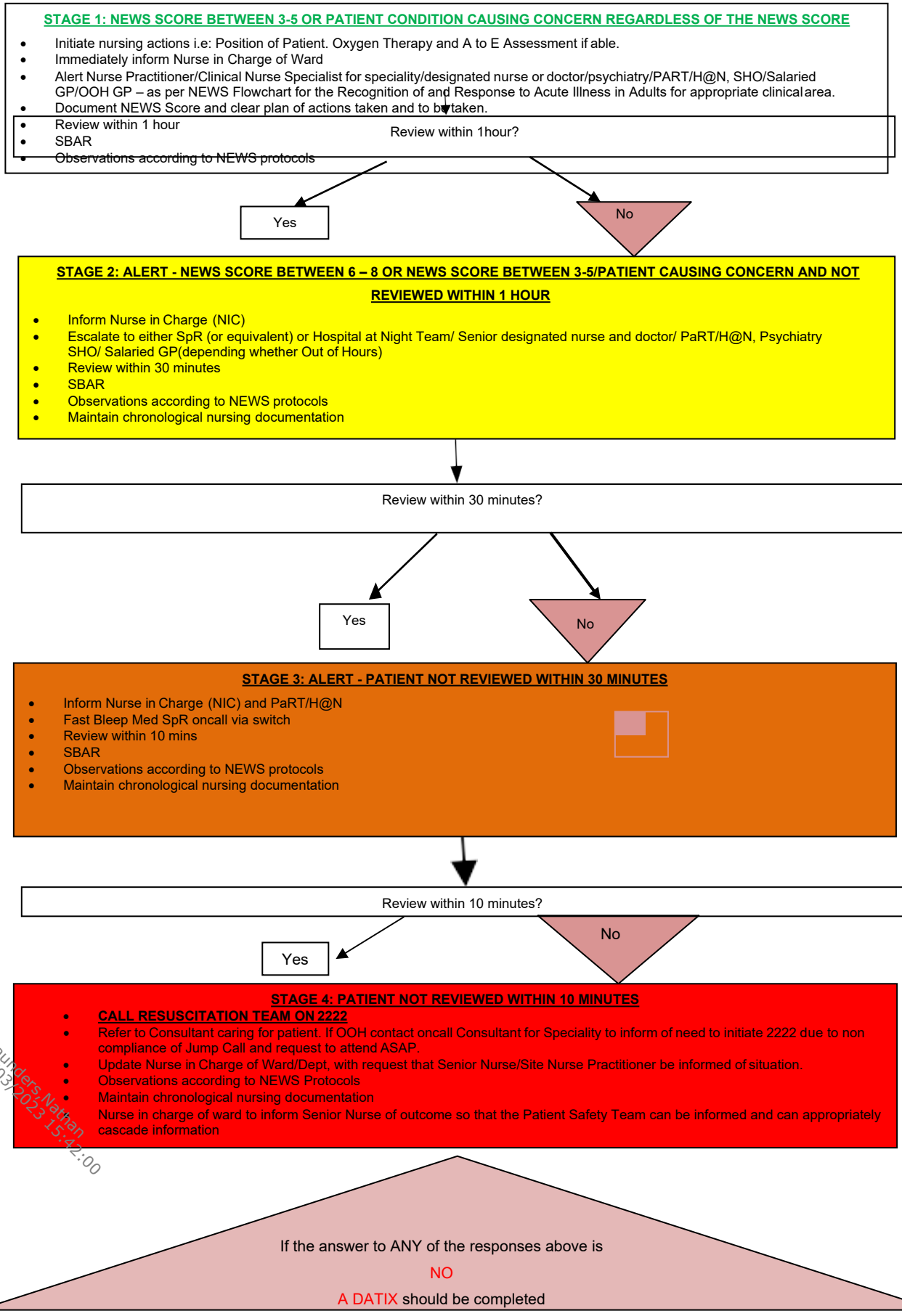
Frequencies of Observations are increased in relation to the patient's condition. If any clinical concern, please escalate regardless of the NEWS Score

Patient Assessment and Safety

Where the clinician is unable to /or does not attend to review the patient with the timescale specified within the NEWS protocol, go **DIRECTLY** to the **JUMP CALL PATHWAY**

Routine Clerking to be done by Psychiatry SHO

Appendix 5 – Jump Call Pathway for Recognition to Acute Illness in Adults in All Settings (Acute, Adult Acute Mental Health, MHSOP)



Appendix 6 – NEWS Standard Operating Procedure (SOP)

Introduction

Published literature from NICE and NPSA highlights that a significant risk to patient safety exists from the lack of recognition and treatment of acutely ill adults in Hospital resulting in a significant increase in potentially avoidable deaths.

NICE 50 guidelines cover the care of all acutely ill adult patients in hospital, including patients in emergency departments. It addresses three key areas:

1. Identification of patients who are either at risk of clinical deterioration or whose clinical condition is deteriorating. This includes assessment of: scoring tools that record physiological parameters and neurological state; the level of monitoring needed; and the recording and interpretation of the data obtained.
2. Response strategies, including the timing of response and patient management, and the communication of monitoring results to relevant healthcare professionals, including the interface between critical care and acute specialities.
3. Discharge of patients from critical care areas back to ward-based care. This includes monitoring requirements on the ward and the timing of transfers.

Organisations will only respond effectively when medical, surgical and critical care areas collaborate in improving systems of care.

An effective system must -

- Operate hospital-wide
- Work 24 hours a day
- Facilitate rapid treatment
- Facilitate escalation of care
- Feedback to referring teams on process and outcome

Roles and Responsibilities

It is recognised that NEWS observations will be undertaken by a variety of staff. However, if NEWS observations are undertaken by Health Care Support Workers (HCSW, Theatre Assistants (TA) etc. The HCSW or TA etc must sign to indicate that they have taken the patient's observations and a Registered Health Care Worker must countersign the NEWS score in order to acknowledge that a patient's NEWS score has been assessed. Delegation of the task of taking patient observations must be according to the standards set out in the Nursing and Midwifery Council Code for Profession Practice ("The Code"), Health Care and Professions Council Standards of Conduct, Performance and Ethics (SCPE), or General Medical Council's Good Medical Practice.

Documentation

NEWS charts form an essential element of a patient's care and as such all parameters on the chart should be completed. The parameters included in the NEWS chart are Respiration Rate, Oxygen Saturations (SpO2), Inspired Oxygen, Temperature, Blood Pressure, Heart Rate and Neuro (CAVPU). Each parameter on the NEWS chart is of equal importance when determining a NEWS Score. Any parameter that is omitted will result in inaccuracy in calculating a score. This may result in a lack of escalation of care resulting in patient deterioration. Each observation should be inserted into the correct box on the chart i.e White, Yellow, Amber or Red depending upon the score. A numerical value should be inserted into boxes so that observations are recorded accurately. The Date and Time of Observations should be clearly documented on every entry of the chart. The NEWS chart only forms part of the mechanism for patient monitoring and other methods can be employed e.g. hourly urine output, biochemical analysis (e.g lactate, blood glucose, base deficit, arterial pH) and pain assessment (NICE 2016).

Frequency of observations

NICE (2016) Clinical Guideline 50 states –

"Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at a minimum of every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy."

Therefore, within Cardiff and Vale UHB Acute Hospitals, (University Hospital of Wales, University Hospital Llandough) physiological observations should be undertaken at a minimum of every 12 hours. Depending upon the clinical area, the frequency of observations may be increased e.g. minimum 4 hourly, minimum 6 hourly. But the frequency of observations may not be reduced. The Frequency of Observations should be documented on the NEWS Chart.

The reverse of the NEWS chart denotes minimum monitoring frequencies and how this relates to the patient's NEWS score. An increasing NEWS score will inevitably result in increasing the frequency of the patient's observations. Again, this is a minimum requirement – the frequency may be increased to greater than the protocol but never decreased.

- The frequency of observations should be documented in the appropriate space on the NEWS chart every time the observations are undertaken.
- The NEWS Score and Frequency of Observations should be noted on the Patient Status At a Glance board (PSAG) if used on the ward, or clearly communicated with those caring for patients.

Acceptable Parameters

There are four parameters on the NEWS chart that can be adjusted by Medical Staff to allow for the patient's normal physiology. These are Respiratory Rate, O2 Saturations, Blood Pressure and Heart Rate. No other parameters may be adjusted. These parameters are only to be adjusted to reflect a patient's normal ranges when they are not acutely unwell. In the case of O2 Saturations it is recommended that 94–98% is applicable for most acutely ill patients or 88–92% for patient-specific target range for those at risk of hypercapnic respiratory failure (O'Driscoll et al, 2017). This should be documented in the O2 saturations section of NEWS chart.

Some patients may always require oxygen therapy even when they are not acutely unwell. The parameter for inspired oxygen may not be changed even in these patients, as requirement for supplementary oxygen is not considered to be physiologically normally in any patient group. In the case of Inspired Oxygen, trend of oxygen demand should be monitored closely and any increase in oxygen demand should result in an escalation of patient care.

Changes in acceptable parameters should not be made solely in order to prevent a patient from increasing their NEWS score. The changed parameters should reflect the normal physiology for the patient when they are not acutely unwell.

Changes in acceptable parameters should be signed for in the appropriate area of the NEWS chart.

Escalation of Care

Nice (2016) Clinical Guideline 50 recommends a Graded Response Strategy. This graded response is described on the rear of the NEWS chart. The response taken will depend upon the NEWS score calculated.

- A NEWS score of greater than 9 means that a patient requires a response “Now”. This requires a minimum of half hourly observations. This frequency can be increased dependent upon patient response. The Resuscitation Team must be called via telephone using 2222. If the Resuscitation Team is not called via 2222, then the rationale must be clearly documented within the patient’s medical notes. In the vast majority of cases, 2222 must be called. The patient must be reviewed immediately.

If there is any concern with a patient’s condition, then their care can be escalated regardless of the NEWS score. In theory, this could result in a patient scoring 0 on NEWS, and their condition resulting in a 2222 call.

Sepsis

On the rear of the NEWS chart there is a Red Flag Sepsis Screening/Awareness section. If patient scores 3 or above, has suspicion of infection, plus any ONE of the Red Flags, the Sepsis 6 pathway should be initiated. Further information regarding Sepsis can be obtained from the Sepsis Lead for Cardiff and Vale UHB.

Areas that do not use NEWS

Within Cardiff and Vale UHB there are several Clinical Areas that do not use NEWS due to their clinical speciality and the limitations that NEWS presents

in those clinical areas. These include (but not limited to) the Intensive Care Unit, Cardiac Intensive Care Unit and Coronary Care Unit. These units do not use NEWS routinely as part of their monitoring of patients, but should include a NEWS score when a patient is “stepped down” to ward level care, so that a NEWS baseline can be scored.

There is no NEWS scoring in the Children’s Hospital for Wales at the time of writing.

All areas not mentioned above must use NEWS and must complete NEWS on the approved documentation. No area may discontinue using NEWS without prior authorisation from the RADAR Committee.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

DNACPR orders may be present for some patients. The overriding principles of this policy are:

1. To ensure an individual’s life is respected and valued.
2. To ensure early senior clinical involvement and accountability in the decision making process.
3. To make clear that a DNACPR decision must not prejudice any other aspect of care.” (NHS Wales 2016)”

These orders only refer to cardiopulmonary resuscitation, and do not refer as to whether a patient requires NEWS scoring. As stated previously, these patients should have a minimum of 12 hourly monitoring (depending upon the NEWS score) and escalation of the care of these patients should be in accordance with the rear of the NEWS chart.

If NEWS scoring and the escalation of care is no longer appropriate for a patient (e.g those patients who are in the terminal phase of their illness), this should be clearly documented in the notes. It is not appropriate for patients to

have observations taken but NEWS scoring discontinued, as nurses responsible for the care of these patients will have no parameters in place in which to escalate their care. It is also not appropriate to continue active treatment on a patient and discontinue NEWS scoring.
If a patient is in the terminal phase of their illness they may have Care Decisions in Last Days of Life - Symptom Early Warning Scores (SEWS) (NHS 2015) implemented.

References

NHS Wales (2021) All Wales Care Decisions for the Last Days of Life

NHS Wales (2020) “Sharing and Involving” A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales

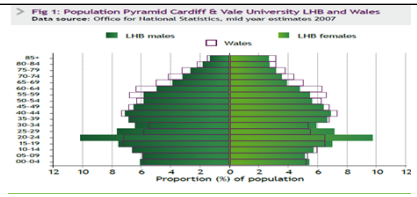
NICE (2016). Acutely ill adults in hospital: recognising and responding to deterioration | Guidance and guidelines | NICE. [online] Available at: https://www.nice.org.uk/guidance/cg50/chapter/1-Guidance#graded-response-strategy [Accessed 7 Jul. 2017].

O’Driscoll BR,Howard LS, Earis J, Mak V (2017) BTS guideline for oxygen use in adults in healthcare and emergency settings Thorax 2017;72:i1–i90.

Equality & Health Impact Assessment for

Deteriorating Patient Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Deteriorating Patient Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Surgery [Perioperative Directorate] Dr Aled Roberts, Chair, Resuscitation Committee; Angela Jones , Senior Nurse, Resuscitation Service
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating Adult patients so that immediate and appropriate review can be obtained
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively

	• participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All healthcare professionals working in Cardiff & Vale UHB are affected by this guideline. The procedure will provide a clear guide for staff and compliment national guidance published by the Resuscitation Council (UK).

EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	the Act. As such, the Policy has been made accessible to staff in both electronic and paper copy.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of gender.	N/A	Procedure put out for consultation within the organisation and ratified by the RADAR Committee

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of sexual orientation.	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	There appears not to be any impact.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of race	Whilst there doesn't appear to be any impact, if a member of staff was known to have difficulties with the written word, good management would dictate that alternative arrangements be made, such as individual meetings. Members of the public would be supported by staff or family members as appropriate	All departments to be aware of their staff profiles. Policy put out for consultation within the organisation and ratified by the RADAR Committee
6.7 People with a religion or belief or with no religion or belief.	It is unlikely to be any impact on staff regarding their religion.	Staff are able to raise any issues with their line manager/Human	Procedure put out for consultation within the organisation and ratified by the

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
The term 'religion' includes a religious or philosophical belief		Resources.	RADAR Committee
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact on staff or patients.		Procedure put out for consultation within the organisation and ratified by the RADAR Committee
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is no provision for the use of Welsh Language within the Guideline.	The policy prompts staff to ask patients which language the patient/service users would like to communicate in, either English or Welsh, in line with the 'Active Offer' requirements of the Welsh Governments' More than Just Words Strategy.	Procedure put out for consultation within the organisation and ratified by the RADAR Committee

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff, and this policy has a positive impact on people on low income as the policy is applicable to all people.	N/A	Procedure put out for consultation within the organisation and ratified by the RADAR Committee
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There appears not to be any impact	N/A	Procedure put out for consultation within the organisation and ratified by the RADAR Committee

6. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	As a procedure, there will be no impact	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking	As a procedure, there will be no impact.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working	As a procedure, there appears to be no impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	For this procedure, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	N/A	N/A	
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross	Welsh Government Policy		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales			

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	On reviewing the previous procedure and writing the latest version, improvements have been made in people who communicate using the Welsh language, people with a religion or belief or with no religion or belief. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	None	Dr Aled Roberts	N/A	Action in accordance with UHB Employment Policies and Procedures.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified is unnecessary to undertake a more detailed assessment.	N/A	N/A	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

8.4 What are the next steps?
 	
Some suggestions:-
• Decide whether the strategy, policy, plan, procedure and/or service proposal:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	It has been approved by the RADAR Committee, and will continue to be reviewed as necessary as part of the groups Terms of Reference. When this policy is reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).	RADAR Committe	3 years	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee
Held On 24th November 2022
Via MS Teams

Present:		
Helen Luton (Chair)	Chair	Director of Nursing CD&T/Multi Professional Teams
Sandeep Hemmadi	SH	Clinical Board Director
Becca Jos	BJ	Deputy Director of Operations
Jo Fleming	JF	Quality Lead, Radiology
Matthew Temby	MT	Clinical Board Director of Operations
Alun Roderick	AR	Laboratory Service Manager, Haematology
Catherine Evans	CE	Patient Safety Facilitator
Kim Atkinson	KA	Head of Occupational Therapy
Jenna Walker	JW	Pharmacist, Pharmacy
Robert Bracchi	RB	Medical Advisor to AWTTC
Edward Chapman	ECh	Head of Clinical Engineering/ Medical Devices Officer
Bolette Jones	BoJ	Head of Medical Illustration
Seetal Sall	SS	Point of Care Testing Manager
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Jonathan Davies	JD	Health and Safety Adviser
Jamie Williams	JWi	Senior Nurse, Radiology
Sian Jones	SJ	Directorate Manager, Laboratory Services
Lesley Harris	LH	Head of Radiography UHL
Secretariat:		
Helen Jenkins	HJ	Clinical Board Secretary
Apologies:		
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Louise Long	LL	Public Health Wales Microbiology
Paul Williams	PW	Clinical Scientist, Medical Physics
Rhys Morris	RM	CD&T R&D Lead
Tracy Wooster	TW	Sister, Outpatients
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Suzanne Rees	SR	Lead Nurse, CD&T
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Marie Glyn-Jones	MG-J	Deputy General Manager, Radiology & Medical Physics/ Clinical Engineering
Timothy Banner	TB	Clinical Director, Pharmacy

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 22/354	**Welcome & Introductions** HL welcomed everyone to the meeting and introductions were made.	

CDTQSE 22/355	**Apologies for Absence** **The Group resolved that:** a) The apologies for absence were noted.	
CDTQSE 22/356	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting held on 17th October 2022 were accepted as an accurate record.	
CDTQSE 22/357	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 22/158 Risk assessment for the NICE guidance relating to rehab following a traumatic injury* HL will discuss with SH. *CDTQSE 22/243 Maintenance Issues with Toxicology Lift* As discussed at previous meetings, the main lift at the Academic Centre UHL has experienced numerous breakdowns and following assessment it was deemed as end of life. It was noted that it was out of action again this week. Laboratory staff based are based on the 4th floor and require the lift to be operational. The issue has been escalated to Peter Welsh and the Capital Estates team. BJ will request an update from Paul George. RB noted that the risk assessment has been reviewed and he will submit the updated risk assessment to HL. *CDTQSE 22/247 SBAR for Therapies relating to Rehab estates issues* Sue Bailey has added the risk to the Clinical Board risk register. KA will request for the SBAR to be produced at the Therapies DMT. HL will add the Clinical Board Risk Register to the Teams Channel. *CDTQSE 22/264 Digital Therapies Presentation* MK and SO will present on Digital Therapies at the December meeting.	**HL** **BJ** **RB** **KA** **HL** **MK/SO**

	CDTQSE 22/332 Point of Care Testing contract review for pregnancy testing equipment This has now been signed off and is progressing through Procurement. **The Group resolved that:** *a)* The update on the actions from the previous meeting were noted.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CDTQSE 22/358	**Patient Story** Hannah Carroll, Occupational Therapist, MHSOP was welcomed to the meeting. She presented a patient story based on the Allen's Cognitive Disability Model. The toolkit was produced in the 1960s to better understand patterns of performance difficulties in adult patients with mental health disorders and thereby serve the needs of these patients. The model forms a key part of the Occupational Therapy toolkits which is used to record a systematic and careful collection of observations of these difficulties. The cognitive levels are broken down into 6 levels based on the level of support required. John, aged 80 is currently an inpatient referred to OT to assess his functional skills for discharge planning. He was diagnosed with vascular dementia with symptoms of self-neglect, confusion, poor short-term memory and recall. He has some word finding difficulties and has difficulty sequencing tasks. Observations over a 4-week period were based on personal care, kitchen assessment, on ward activity group and walks to the hospital shop. He was scored at a level 3.4. The outcome of the assessment was that by ensuring tactile cues were used, John could continue to engage in many of his previously valued occupations and could retain a level of independence. He requires assistant from one person for personal care. He needs prompting and support to sequence the tasks and some physical assistance is required at times when he is tired. He requires support and prompting for tasks such as making a cup of tea. He values doing this himself but can be at risk of spillage. He struggles with time telling and requires prompting to attend sessions on the ward. He engages best when there is minimal verbal instruction or when verbal instruction is mirrored in the tactile cue for the task. John has a strong sense of achievement and reward when he undertakes the tasks for himself. Staff on the ward can work with John more successfully and the personalised care booklet is a key intervention. It is used as a guide on how care is facilitated and is personalised to the individual. It helps families and care homes understand the needs and abilities of the patient and the care that is required.	

	For John it has been agreed that a care home is his best option and he is now living happily in a care home, regularly visited by his family. By providing the care home with this booklet, this will help avoid further hospital admissions for John. HL asked if the booklet is similar to the Read About Me booklets. It was noted that the personalised care book supplements Read About Me but is based on the level the patient is assessed at and interprets what the score means and interprets the tailored care that the patient requires. CE asked if the feedback is given to ward nurses. Hannah Carroll advised that this is an MDT document and input is sought from nursing staff, physiotherapists, dietitians and other professionals involved in the care of the patient. There is research that demonstrates that where there is full implementation of this model within the MDT, this has had a positive impact on falls and this was a key reason for implementing the model within the UHB. **The Group resolved that:** a) HL will email Hannah Carroll to discuss raising the profile of this work within the Health Board.	**HL**
CDTQSE 22/359	**Feedback from UHB QSE Committee** **The Group resolved that:** a) This item will be discussed at a future meeting when the UHB QSE Committee minutes become available.	
CDTQSE 22/360	**Health and Care Standards** **The Group resolved that:** a) There was no update to report.	
CDTQSE 22/361	**Risk Register – Review and Revision** A new risk has been added to the AWTTC directorate risk register on possibility of the disruption of information and services due to software failure of their health technology assessment database. The department is currently working with the UHB IT to build a new database. There is also a further risk that AWTTC is dependent on a software licence for Tableau that is dependent on being funded by Public Health Wales. Work relating to information on the carbon footprint of inhalers throughout Wales and the benefits of changing inhalers is at risk if this licence is not available. RB to email the updated risk assessments to HL.	**RB**

	JF reported that 2 of the Vascular Rooms in Radiology have experienced downtime this week which has resulted in no neuro work being able to take place. The engineer has been on site this week but there have been a number of issues with downtime this year. The risk assessment is being updated. KA reported there is a shortage of supply in nutritional products in dietetics. Funding for the Covid Rehab Service ends on 31st March 2023. Papers are being produced to be presented to the Clinical Board. She also reported that the loss of Therapy space in the Children's Hospital and issues with Therapy space in Lakeside is a key risk. It was noted that the Clinical Board are aware of the issues and have escalated this risk at various forums. The next submission of the risk register to the Corporate Governance Team is due end of December. HL will request updates from directorates in mid-December. **The Group resolved that:** a) The next submission to the corporate risk register is due end of December. HL will request updates from directorates in mid-December.	**All**
CDTQSE 22/362	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** EC submitted an SBAR advising that all paper records relating to equipment are still being stored in filing cabinets and the department is seeking support to shred the paper records. The records were all transferred to digital systems in 2017 and are no longer required. A risk assessment has been undertaken and this was scored as a low risk. Lack of space in the department is a key issue. By shredding the paper records, this would free up much needed space to provide beneficial support for the storage of equipment. Some cabinets have already been moved off site to a storage facility and these can be destroyed in 2027. The retention policy is not explicit for medical equipment and Clin Engineering have always worked to a retention period of 11 years. Clinical Board sign is required prior to escalating to the UHB SIRO. The Directorate Manager, for Outpatients and Patient Administration and the UHB Information Governance Officer are content for the SBAR to be signed off. MT queried the retention period of 11 years as the legal position is 8 years for all corporate records that are not patient records or associated with children and mental health. He requested that the Clinical Engineering Retention of Records Policy is revised to reflect this.	

	He is supportive of the archive records being destroyed but it needs to be ensured that what is being destroyed is logged. He also suggested that live records less than 8 years could be scanned. EC noted that the resources required for this is greater than the costs of offsite storage. MT suggested that EC contacts SO to consider if there is an option of using the industrial scanner within the Patient Administration department. MT requested that EC undertakes a cost benefit analysis for the offsite storage. A decision is not required by this group but should be agreed locally by the General Manager for the directorate. **The Group resolved that:** a) The request for the destruction of the archived records was approved, with the proviso that the UHB process for destruction is followed in line with policy.	**EC** **EC**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
CDTQSE 22/363	**Initiatives to promote the Health and Wellbeing of Patients and Staff** JW reported that the Wellbeing Representative within Pharmacy is implementing a process which allows Pharmacy colleagues to give positive feedback on their fellow colleagues and a newsletter will also be produced. **The Group resolved that:** a) The positive feedback initiative being implemented in Pharmacy was noted.	
SAFE CARE		
CDTQSE 22/364	**Concerns and Compliments** For October 2022, the Clinical Board reported 50 concerns with 52% resolved through early resolution. 10 compliments were received. Despite the high number of concerns received , good concerns management is in place with no areas reporting a Red status, 2 areas reporting an Amber status and all other departments reporting a Green status. The main theme of the concerns received continues to relate to patients accessing the appointment booking systems. **The group resolved that:** a) Overall, good concerns management was reported within the Clinical Board for October 2022.	
CDTQSE 22/365	**National Reportable Incidents (NRIs)** The Clinical Board is currently reporting 2 open NRIs:	

	4123 – an incident relating to the breakdown of a Radiology machine during a neuro interventional procedure. The patient experienced ill effect following the procedure. 5670 – this incident relates to a delay to the reporting of a CT scan, where the patient suffered harm as a consequence of the delay. The investigations into both incidents are nearing completion. **The Group resolved that:** a) The investigations into both incidents are nearing completion.	
CDTQSE 22/366	**New NRIs** **The Group resolved that:** a) No new NRIs have been reported.	
CDTQSE 22/367	**Patient Safety Alerts (internal/external)** **The Group resolved that** a) There were no alerts to report.	
CDTQSE 22/368	**Medical Device/Equipment Risks** EC reported that the position with Arcomed has vastly improved since the previous meeting. **The Group resolved that:** a) The update on medical devices was noted.	
CDTQSE 22/369	**IP&C/Decontamination Issues** HL requested that teams raise awareness that influenza is circulating in the community and to encourage staff to receive the flu vaccination. She reminded the group of the UHB guidance which states that staff with respiratory symptoms should not come to work. **The Group resolved that:** a) The information relating to influenza was noted.	
CDTQSE 22/370	**Point of Care Testing** SS reported that the first Point of Care Testing Governance meeting has been held and is chaired by Dr Skone and Dr Rebecca Aylward. Dr Skone will be writing to all Clinical Boards for representation on the Group.	

	The Group resolved that: a) The Point of Care Testing update was noted.	
CDTQSE 22/371	**Safeguarding Update** **The Group resolved that:** a) Training dates for 2023-24 for various levels of safeguarding training will be circulated to the group.	**HL**
CDTQSE 22/372	**Health and Safety Issues** The Clinical Board is reporting 1 RIDDOR incident this month and this will be discussed in detail at the next Clinical Board Health and Safety Group in December. The health and safety alert relating to a fire risk for computers on wheels was circulated for information. **The Group resolved that:** a) Directorates to confirm they have checked the health and safety alert and have no issues.	**All**
CDTQSE 22/373	**Regulatory Compliance and Accreditation** HL reported that SMPU and Blood Transfusion departments are reporting improvements against their regulatory compliance metrics. The Production Unit in UHL were subject to a quality assurance inspection last week. The teams are working on actioning the recommendations in advance of receiving the final report. EC noted that the findings of the Shared Services Medical Devices Report provided Reasonable Assurance on the UHB's internal policy and procedure. There are a small number of recommendations to be actioned. **The Group resolved that:** a) The minutes of the Regulatory Compliance Group held on 10th November 2022 were received and noted. b) EC will share the Shared Services Medical Devices Report with the Group.	**EC**
CDTQSE 22/374	**Policies and Procedures** **The Group resolved that:** a) There were no relevant policies and procedures to note.	

EFFECTIVE CARE		
CDTQSE 22/375	**NICE Guidance** NICE guidance has been received relating to Radiology and AWTTC which were shared with the group. **The Group resolved that:** a) Comments have been received from the relevant department leads on both sets of guidance.	
CDTQSE 22/376	**Clinical Audits** **The Group resolved that:** a) There are no relevant clinical audits to report.	
CDTQSE 22/377	**Research and Development** The Clinical Board R&D Group was held on Monday. It was highlighted that attendance was poor. A new R&D Lead is required for Laboratory Medicine and a new Pharmacy Lead will be nominated shortly. The R&D Governance Forum was cancelled last week due to the operational pressures across the sites. The session will be rescheduled in January. **The Group resolved that:** a) The update from the Clinical Board R&D Lead was noted.	
CDTQSE 22/378	**Service Improvement Initiatives** **The Group resolved that:** a) There were no service improvement initiatives to report.	
CDTQSE 22/379	**Information Governance/Data Quality** **The Group resolved that:** a) There were no information governance and data quality issues to report.	
CDTQSE 22/380	**Waste and Sustainability** The Clinical Board Green Group is being held today. Discussions will be held on sustainable travel and ideas for a greener Christmas. **The Group resolved that:** a) Representation from all directorates is requested.	

DIGNIFIED CARE		
CDTQSE 22/3811	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** The final report has not yet been received following the HIW inspection of Nuclear Medicine at UHL. Verbal feedback was very positive. Work has commenced on actioning the recommendations made. **The Group resolved that:** a) The final report will be circulated to the group when it is received.	
CDTQSE 22/382	**Any initiatives specifically related to the promotion of dignity** **The Group resolved that:** a) There were no initiatives to report.	
CDTQSE 22/383	**Equality and Diversity** **The Group resolved that:** a) Directorates will feedback any equality issues to Sion O'Keefe.	
TIMELY CARE		
CDTQSE 22/384	**Initiatives to Improve Access to Services** It was noted that good work is ongoing in Radiology and Laboratory Medicine to work towards achieving cancer targets and reducing waiting times for cancer patients. MT noted that Paediatric Podiatry has reached a 0 breach waiting time position. Significant improvement has been made in the turnaround times in Cellular Pathology. The team have been working across seven days for a number of weeks to achieve this. **The Group resolved that:** a) Feedback has been provided to the Executive Team on the positive work that is ongoing.	
CDTQSE 22/385	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Radiology reduced their waiting times by 237 this month.	

	Physiotherapy have reduced their waiting times and are reporting 0 breaches. Dietetics are reducing their waiting times and aiming to achieve a 0 breach position in February. Speech and Language Therapy reported a small increase in their breach position by 8 this month. **The Group resolved that:** a) The waiting time position for diagnostics and therapies is monitored in detail in the Directorate Performance Reviews.	
INDIVIDUAL CARE		
CDTQSE 22/386	**National User Experience Framework** Local kiosks in Outpatients are reporting a patient satisfaction score of 75%. More detail is needed to identify where improvements can be made. A new platform is being launched in the UHB to capture patient experience and HL will be attending a meeting to gain further information. CE noted that duty of candour is being implemented next April. The Patient Experience Team is attending the next meeting to provide further information. **The Group resolved that:** a) Approaches for capturing patient and service users' feedback and outcome measures are being considered within services.	
STAFF AND RESOURCES		
CDTQSE 22/387	**Staff Awards and Recognition** Therapies were successful at the AHA Awards. Judyth Jenkins was awarded AHP of the Year. Dietetics were also Award winners for their Maternal Obesity service and Rehab model. **The Group resolved that:** a) Directorates will inform HL when they are nominated for any awards.	
CDTQSE 22/388	**Monitoring of Mandatory Training and PADRs** For October, the Clinical Board is reporting 79.54% compliance against Mandatory training. PADR compliance is 60%.	

	BJ noted that positive feedback was received from the Executives at the Clinical Board Review this month regarding the approach being taken within the Clinical Board for improving its compliance. **The Group resolved that:** a) The monitoring of mandatory training and PADR trajectories are discussed in detail at the Directorate Performance Reviews and the Executive Performance Reviews.	
	ITEMS TO RECEIVE/NOTE FOR INFORMATION	
CDTQSE 22/389	Regulatory Compliance Group Minutes 10th November 2022 **The Committee resolved that:** a) The above item was received and noted.	
	ANY OTHER BUSINESS	
CDTQSE 22/390	EC noted that Emma Cooke and Sara Moseley are undertaking a patient safety walk round of the equipment library in December. It is hoped that the visit will highlight the lack of space within the library. He will provide feedback at the next meeting.	**EC**
CDTQSE 22/391	**Date & time of next Meeting** 22nd December 2022 at 11am via Teams	

Minutes of the Medicine Clinical Board

Quality, Safety & Experience Committee Meeting

Held on 17 November 2022 14:30 – 16:00, Via MS Teams

Present:	
Jane Murphy	Director of Nursing, MCB (Chair)
Aled Roberts	Clinical Board Director, MCB
Angela Hughes	Assistant Director of Patient Experience
Suzie Cheesman	Patient Safety Facilitator, Patient Safety & Quality Team
Kath Prosser	Quality & Governance Lead, Medicine
Emma Keen	Deputy General Manager, Integrated Medicine
Niki Turner	Service Manager, Stroke, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Gemma Taylor	Professional Practice Development Nurse, Integrated Medicine
Sam Hughes	Professional Practice Development Nurse, Integrated Medicine
Barbara Davies	Lead Nurse, Specialised Medicine
David Pitchforth	Lead Nurse, Integrated Medicine
Jenna McLaren	Senior Nurse, Acute & Emergency Medicine
Ruth Cann	Senior Nurse, Integrated Medicine
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Aneurin Buttress	Consultant, Respiratory Physician
Biju Mohamed	Consultant
Tom Hughes	Consultant, Neuro-rehabilitation
Sarah Arnold	Specialist Nutrition Nurse
Rachael Maiden	Senior Nurse, Integrated Medicine
Marianne Jenkins	Consultant Nurse Practitioner
Angela Jones	Senior Nurse, Resuscitation Service
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Louise Platt	Director of Operations, MCB
Diane Walker	Deputy Director of Nursing, MCB
Sam Barratt	General Manager, Integrated Medicine
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Natasha Whysall	Senior Nurse, Integrated Medicine
Sian Brookes	Senior Nurse, Integrated Medicine
Lyndsey MacDonald	Consultant, Acute & Emergency Medicine
Manju Kalavala	Consultant, Dermatology, Specialised Medicine
Sharon Jones	Consultant, Rheumatology

Item No	Agenda Item	Action
MCBQSE/2022/0092	**A1. Welcome & Introductions** – were undertaken.	
MCBQSE/2022/0093	**1.1 To receive the minutes of the previous meeting** The group resolved: that the minutes were agreed and accepted.	
MCBQSE/2022/0094	**1.2 Matters arising:**	

	4-hour and 12-hour performance update, Emergency Medicine – discuss at the next meeting. **C&V pneumothorax pathway, Pleural procedures** – Craig Dyer and AR have met to discuss and AR has signed this off. **Directorate QSE** – Maitrayee Choudhury to email AR to enquire if the morning directorate QSE meetings could be held in the afternoon. **Action update**: meetings are set a year in advance and cannot be changed as it may cause disruption or difficulties for clinic co-ordinators to amend and rebook cancelled clinics. MC has asked for medical QSE meetings from 2024 to have afternoon slots for Integrated Medicine. **Hoverjack** – SBAR was taken to DoN's on 27/9/22. Sam Skelton is progressing this and also looking to get the Hoverjack training added to ESR, which will then be a central area to confirm training. **Action: CR-T/DP to follow up with Sam Skelton.** **DNA CPR audit results St David's** – no concerns highlighted. The independent audit will be shared when completed. **Action update**: it was found that the DNA CPR was: Pre-Covid 81% of patients During-Covid 87% of patients Post-Covid 88% of patients The audit was thorough, without bias and found the relatively high number of DNA CPR's were appropriate for this target group. Lasting Power of Attorney was not the focus of the audit. In April 2020 the treatment escalation plan was introduced in the Health Board. Previously frailty nurses went out in the community to discuss DNA/CPR with families. Look at using the Sharing and Involving book/booklet which is on line and currently still in date. **Action: RC will look at using this book/booklet.** **Action: DP will liaise with Biju Mohamed to look at what can be done in Integrated Medicine; look at how UHL/UHW are performing.** **Action: patient information leaflets are still available. Angela Jones and DP will discuss audits further. Routinely audit twice a year.** An All Wales piece of work regarding having a level of nurses as decision makers for DNA CPR has been discussed at NMB.	Ceri Richards-Taylor/ Dave Pitchforth Ruth Cann Dave Pitchforth Angela Jones
MCBQSE/2022/ 0095 Saunders.Nathan 03/03/2023 15:42:00	**1.3 Patient Story, Rheumatology/ Dermatology, Specialised Medicine (SM)** delivered by BD A 53-year-old lady under the care of Rheumatology, presented with a rash in Feb 2017 and was referred to Dermatology. Within 7 days both her legs had deteriorated rapidly. The lady attended the Dermatology day unit for dressings. With significant work her right leg healed. Wounds on the lady's left leg continued to break down despite input from the team. The patient had to have a toe surgically removed. Biopsies were taken. Topical agents, steroids, biologics were used. At the start of 2022, there were still wounds on the left foot. The case was discussed at the complex patient forum. A decision was made in July to use a chemotherapy drug, although there was limited resource in SM to deliver this. The lady raised concerns regarding delays. The Rheumatology Team's competencies for chemotherapy were out of date. A member of the Rheumatology Team was then trained to deliver the drug. The patient contracted Covid, so her appointment was delayed. The patient later started the chemotherapy treatment. No new wounds have developed and long-standing wounds are improving.	

	This complex and challenging patient needed input from several speciality areas in the Health Board, further complicated by Covid. A positive outcome is being reached for this patient. Careful management will be needed for staff to maintain these skills. Two staff are trained in the department and if they do not have patients, they will use their skills in other departments. The group resolved: this had a positive impact on the team. **Action from discussion** – none.	
MCBQSE/2022/0096	**1.4 Feedback from UHB QSE Committee** The group resolved: August minutes are not yet available. **Action from discussion** – none.	
MCBQSE/2022/0097	**1.5 Directorate QSE minutes – exception reporting** **Acute & Emergency Medicine Minutes** – received The group resolved: minutes were received from the above. **Action from discussion** – none.	
2. HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
MCBQSE/2022/0098	**2.1 Respiratory Acute Oncology Service** The group resolved: this will be discussed at next month's meeting. **Action from discussion:** none.	
MCBQSE/2022/0099	**2.2 Winter Vaccination Programme** MCB is 5th at present across all the clinical boards. MCB has vaccinated 882 staff with the Covid boosters and 540 staff with the Flu vaccination. Staff are encouraged to have the Flu booster at the same time as the Covid booster. Long stay patients, over 65 years old, will be offered vaccination. The move has been made for clinicians to administer the vaccine to this group. The group resolved: the above protocol will be followed. **Action from discussion – guidance will be shared by Dave McRae for sharing the information with nurses.**	Dave McRae
3. SAFE & CLINICALLY EFFECTIVE CARE		
MCBQSE/2022/0100	**3.1 NRI's for closure:** **Acute and Emergency Medicine** **ID14931** An 82-year-old lady presented to medical admissions at UHL with confusion, agitation and was hallucinating. The working diagnosis at the time was that of alcohol withdrawal. The initial risk assessment showed the patient was independently mobile and needed close supervision with walking. The patient was moved to a two bedded area on the ward, the ward was two Registered Nurses short and were unable to give the patient enhanced supervision. Twenty minutes later the patient had an unwitnessed fall sustaining a fractured neck of femur which required surgical intervention. **Learning**: if a member of staff had been there, the risk of the patient falling would have been reduced. The patient did not have lying and standing blood pressure completed in line with guidance and she did not have a delirium assessment. Post fall, the Hover jack was not used as there was a space constraint in the two bedded area. The ward now has 100% compliance with lying and standing blood pressure following a recent	

	Tendable audit. Raised in safety briefings the need to have patients in more visible areas if at a falls risk. This case was discussed at re-dress and further information is required to be provided. The patient has since been discharged home. **Action: GT will send KP the data of compliance regarding all staff who have been trained in falls prevention.** **Integrated Medicine:** **ID4184** A lady was admitted with confusion and diagnosed with a urinary tract infection. Multi factorial risk assessment recognised the patient needed supervision of one to mobilise. The patient was noted as a falls risk. The patient had a witnessed fall sustaining a fractured neck of femur which required surgical intervention. Post falls procedures were completed in line with best practice. The patient has subsequently discharged home. **Learning** – Secondary to an unforeseen episode of sickness, the ward during the night shift were left with non substantive registered staff, despite the Senior Nurse and Site Manager attempting to swap with another clinical area. A Safety Briefing was not undertaken to highlight those patients at risk. The agency nurse believed the patient was independently mobile. Whether substantive staff are on shift or not, there should always be a safety briefing. Staffing impacted on this case. **ID1852 & ID12595** (presented together as both involve avoidable, unstageable pressure damage) The pressure damage focused reviews identified there were gaps in the patients individual care plans, which would not support effective care. The patients should have been placed on Duo 2 mattresses earlier in their inpatient stay. To support this the mattress selection algorithm is being changed. Intentional rounding guidance supported by TVN and evidenced in recent literature supports patients being repositioned every 4 hours, 2 hourly intentional rounding has no impact or found to be beneficial for patients. Education for staff for staff including 'stop the pressure' study days have taken place. Two RGNs and two HCSWs from E4 and C5 are being trained to be Pressure Ulcer Advisors (PUAs) and are having 1-2-1 study days with the Tissue Viability Team. They will still work as RGNs and HCSWs, however, will have the added knowledge base which they have to be able to educate staff. The group resolved: if this works well this can be rolled out onto other wards. **Actions from discussion – SH to share the names of the advisors when they are trained.**	Gemma Taylor Sam Hughes
MCBQSE/2022/0101	**3.2 Infection Prevention and Control up-date** 108 days since last MRSA bacteraemia (UHL E7) 25 days since last MSSA bacteraemia (UHW Heulwen) 3 days since last *C difficile (SDH Lansdowne)* 3 days since last E. *Coli* bacteraemia (UHL E8) 15 days since last Pseudomonas bacteraemia (UHW A7) 9 days since last Klebsiella bacteraemia (UHW LSGF 1) There is an ongoing outbreak on B7, UHW which has affected 2 patients 0 staff and 0 bed days were lost. • DMT scores – All wards within MCB are compliant for the last 4-week period, except UHL W1 and E7.	

	• MCB position based on the same period 2020-2021: *C. difficile* - 17% reduction, *Klebsiella* 10% increase, 8% increase with *E. coli*, 33% increase with SAUR and 100% increase with *Pseudomonas*. • 17 RCA's remain outstanding. • BBE. All UHW MCB wards audited. Only 35% of wards achieved compliance. • Ebola. Ongoing meetings to ensure SOP's, action cards updated. VHF PPE training for EU, A7, ID consultants performed. More training dates to follow • Influenza remains below the MEM threshold for baseline activity, however the rate is increasing. RSV cases have also increased in recent weeks, now at very high intensity levels. Rhinovirus, Parainfluenza and RSV are the most commonly detected cause of non-COVID-19 Acute Respiratory Infection currently. • Covid cases continue to trend downwards in the community. • On target to achieve the E.coli and C.*difficile*. • MCB catheter bundle audit ongoing. Results available soon • Monkey pox. There are now cases identified in wales. • Ebola. Patients will be in EU, then sourced to England or critical care. A7 is having training there, do not think any patients will go to A7 this is just a precaution. Ongoing meetings to ensure SOP's, action cards updated. VHF PPE training for EU, A7, ID consultants performed. More training dates to follow. The group resolved: the above was noted. **Actions from discussion** – Lead Nurses to support staff attending the Practitioner Study Day which will be held on 14/12/22.	Lead Nurses
MCBQSE/2022/0102	**3.4 PE Pathway** presented by Dr Aneurin Buttress This was presented at Integrate Medicine QSE in October regarding the PE updated guidelines. The biggest risk is around the loss of ART (Acute Response Team). Dr Katie Pink has been in discussion with Inga an SPR in ED to come up with an ambulatory pathway as 7-day monitoring and 7-day access should be available to patients. The update in the guidelines is to allow low risk patients to be seen in the Virtual Ward. Guidelines show who to image. The group resolved: plan for rollout/ training – focus on the front door, need guidance for wards **Actions from discussion** **Action 1: AB will share this presentation with A&E QSE to raise awareness. If there is agreement, this can then go onto next stage.** **Action 2: GT and SH will focus on bespoke nursing training. If further training is required, this could be arranged. Link in with LED who may be able to put a training package together.**	Aneurin Buttress Gemma Taylor/ Sam Hughes
MCBQSE/2022/0103	**3.5 Medical devices/equipment issues** **Actions from discussion: none**	
MCBQSE/2022/0104	**3.5 Patient Safety Alerts/MDA's/ISN's** Arterial Blood Gas 'Urgent Product Notice' shared and shared across all Directorates. **Actions from discussion: None**	
4. DIGNIFIED CARE		

MCBQSE/2022/0105	**Patients Safety/Quality Care** **4.1** The group resolved: to note the above for information. **Actions from discussion** – none.	
5**. TIMELY CARE**		
MCBQSE/2022/0106	**5.1 NICE guidance NG128 – Stroke and transient ischaemic attack in over 16's; diagnosis and initial management audit** presented by Niki Turner and Dr Tom Hughes In the summer of 2022, the Clinical Audit office asked C&VUHB to report on compliance against the NICE clinical guidelines for Stroke and TIA in the over 16's: diagnosis and early management. The Clinical Audit office asked if the clinical area had fully implemented this guidance and the answer was 'not completely'. The clinical Stroke area were asked to discuss this further at QSE regarding why not fully compliant. This presentation has currently been discussed at the ED and Acute Medicine QSE meeting and is being discussed at today's MCB QSE. **Areas of good practice identified**: - Use of FAST screening tool out of hospital. - Development of the FAST imaging protocol, increased use of CTA within first scanning slot, focus on potential thrombectomy cases. - Improving thrombolysis and thrombectomy rates. - High dose aspirin early after stroke and TIA. - MDE input once patient arrives at the Stroke Unit. - Oct 22, 4 patients were thrombolised. There were also thrombectomies. In November 2022, 6 patients were thrombolised and there were 3 thrombectomies. **Partially or not compliant with guidelines**: - Once at hospital, establish likely diagnosis rapidly using a validated tool such as Rosier. - TIA specialist assessment and investigation, to be seen within 24 hours of onset of symptoms. - Do not use ABCD2 Score in urgent triage of TIA patients. - After specialist assessment in TIA clinic, consider same day MRI scan to determine territory of ischaemia or to detect haemorrhage or alternative pathologies. - Urgent carotid imaging for those considered as a candidate for carotid surgery. - Acute haemorrhage and large infarct management, BP lowering and neurosurgical pathways. **Identified actions improvement opportunities** - Pre-hospital assessment pilot project opportunity with WAST. - Introduction of the Rosier tool into ED Stroke Assessment Pathway. - Revision of ED Stroke pathway, ideally remove code stroke 1 and 2. - Revision of TIA clinical referral pathway and clinic provision. - ICH management pathway. - Large infarct management pathway. - Protection of beds – flow is a big challenge. **Challenges and barriers** - Resource – small stroke team size. - Senior clinical decision maker presence. - Volume of presenting patients/increase in those self-presenting with stroke symptoms. - Capacity in stroke beds/flow.	

	Top priorities - If the protection of beds is supported, this would help to manage resources. Ringfencing beds has been discussed at MCB SMT. A new SOP is to be prepared and discussed at SMT, expressing the number of beds required. - Pre-hospital pilot with WAST, SIG funded project. WAST want to trial this with more rural areas as well. - Routine for 30-40% of people who reach the stroke unit for the diagnosis eventually to be something else. More senior decision makers at the front door and better imaging, would assist with getting more people on the correct pathway earlier. Need better imaging, more senior decision makers and it is a huge challenge. The group resolved: the action below will be done. **Action from discussion** NT to update the SOP, send to DP who will take it to MCB SMT as urgent business.	Niki Turner/ Dave Pitchforth
6. INDIVIDUAL CARE		
MCBQSE/2022/ 0107	**6.1 National User Experience Framework - Feedback from 2 minutes of your time survey – relevant improvement plans** The group resolved: no information discussed. **Actions from discussion** – none.	
MCBQSE/2022/ 0108	**6.4 Concerns update** The group resolved: to be discussed at the next meeting. **Actions from discussion** – none.	
MCBQSE/2022/ 0109	**6.5 Compliments** **LSW** – 'thank you for all your support and care of our Mum 'R'. You gave her a lot of care, dignity and respect towards the end of her days. Special thanks to Dr Butlers team for making Mum comfortable in her end of life care. My brother, family and I are extremely grateful. Mum will be sadly missed'. **Endoscopy, UHL** 'I recently attended as an outpatient and would like to compliment the staff on the excellent treatment they provided. This was not an appointment I was looking forward to so it was with some anxiety that I attended. I need not have been concerned, the staff were unbelievable, caring and completely understanding of how I felt. My treatment was undertaken by Nurse Natalia Fumis who was ably assisted by Nurse Mazella. Both were very professional which made me feel I was in capable and experienced hands. This caring approach was provided by all staff I came into contact with, Christie, Jing and Jeremy. They certainly presented a cohesive team.' The group resolved: keep collecting compliments and share with teams. **Actions from discussion** – none.	
7. STAFF AND RESOURCES		
MCBQSE/2022/ 0110	**7.1 Any updates to share** Gemma Taylor leaves today and will be moving to Pharmacy. Thanks were given to GT for her dedicated work within MCB. The group resolved: no issues were discussed. **Actions from discussion** – none.	

PART 2: Items to be recorded as Received and Noted for Information by the Committee		
MCBQSE/2022/0111	**7.2 Any other business** **RSV** – currently there are very sick babies being seen in the EU. To be noted for information. The group resolved: please note the above. **Actions from discussion** – N/A.	
MCBQSE/2022/0112	**7.3 Date & time of next Meeting –** 2.30pm to 4pm on 15/12/22	

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee

Held Thursday 24 November 2022 at 9:30am

Via MS Teams

Chair:		
Claire Main	CMain	Interim Director of Nursing, Specialist Services CB
Present:		
Alannah Foote	AF	Directorate Support Manager, Nephrology & Transplant
Anne-Marie Morgan	AMM	Lead Nurse, Haematology
Beverley Oughton	BOu	Senior Nurse, Cardiac Services
Carly Simpson	CS	Lead Nurse, Neurosciences
Caroline Murch	CMu	Health & Safety Adviser
Catherine Evans	CE	Patient Safety Facilitator
Colin Gibson	CG	Consultant Clinical Scientist, ALAS
Fiona Davies	FD	PaRT Nurse Practitioner
Gareth Jenkins	GJ	Interim Directorate Manager for Haematology, Immunology and Metabolic Medicine
Gayle Shepperd	GS	Assistant Service Manager, Cardiac Services
Guy Blackshaw	GB	Clinical Board Director, Specialist Services
Hayley Valentine	HV	Quality Lead for Critical Care
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Jane Morris	JM	Senior Nurse, PaRT
Jo Clements	JC	Lead Nurse, Critical Care
Jordan Wilmer	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Keith Wilson	KW	Consultant Haematologist
Laszlo Szabo	LSz	Consultant Transplant Surgeon
Lisa Higginson	LH	Interim Lead Nurse, Nephrology and Transplant
Lisa Simm	LS	Service Manager Neurology and Rehab
Mat Davies	MD	Consultant Nephrologist, Quality and Safety Lead SSCB
Niamh Sully	NS	Patient Safety Facilitator
Nicola Carter	NC	Service Manager for Malignant Haematology
Rachel Long	RL	Directorate Manager for Nephrology & Transplant
Richard Parry	RP	Q&S Facilitator
Sarah Doherty	SD	Interim Senior Nurse Haematology, Immunology & Metabolic Medicine
Sharon Daniels	ShD	Directorate Support Manager, Nephrology & Transplant
Sian Williams	SW	Senior Nurse, Cardiac Services
Sophie Griffiths	SG	Service Manager, Neurosurgery
Tom West	TW	Critical Care Consultant
Tracey Skyrme	TS	Head of Inquests
Secretariat		
Mandy McGee		

Apologies:		
Bethan Ingram		Interim Lead Nurse Haematology, Immunology and Metabolic Medicine
Nicola Foreman		Director of Corporate Governance
Ceri Phillips		Lead Nurse, Cardiac Services
Ravi Nannapaneni		Consultant Neurosurgeon
Jo Bagshawe		Interim Lead Nurse for Haematology, Immunology and Metabolic Medicine

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed all to the meeting.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Minutes of the Meeting Held 13 October 2022** There were no outstanding actions from the minutes of this meeting. **Minutes of meeting held 31 October 2022** **The Committee resolved that:** The minutes were recorded as a true and accurate record.	
1.4	**P@RT** CMain introduced Fiona Davies, one of the Patient at Risk Team Practitioners who presented - **Call for Concern -** giving details of a pilot scheme to be undertaken where patients leaving ITU will be informed of the service as part of their discharge visit. Copy of the presentation attached. Discussions were held around the presentation. FD informed that she would present the SOP and leaflet to this Group when available. FD asked the group contact her if they had any further questions, comments or ideas at Fiona.davies6@wales.nhs.uk CMain thanked Fiona for her presentation.	C4C presentation.pptx
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP informed the Group that there had been a number of changes made to the list initially sent out, he will send an updated list through after the meeting. IN5007 HN – awaiting completion of the report.	

IN12119 – patient fall on T4, the review process has been completed and a report is being produced.

IN13127 – incident where a Discharge Letter was amended and reverted to draft rather than being sent out. RP reported that the IO initially recruited has withdrawn from the investigation, further update to be provided at the next meeting. Discussions were held around the unreasonable length of time it takes between requesting a change on Welsh Clinical Portal and the change being implemented, KW reported that a number of “work around” solutions are being instituted as a result of the delays in processing requests on Welsh Clinical Portal. CMain reported that she would discuss this with Alex Scott later this week and feedback accordingly.

RP added that he has submitted a list of questions to Digital Healthcare Wales who have agreed to produce a report answering these questions which RP will share when available.

IN 14869 – incident where a patient left the Cardiac ward and sadly committed suicide in Heath Park. An initial meeting has been held and Mental Health have nominated an IO who will be investigating with a view to reporting by the end of January

IN15539 A meeting has been held to discuss the case of a pacemaker insertion on a patient who initially didn’t appear to require it but subsequently it has emerged that the pacemaker had been required, this case has been downgraded from a Never Event to an NRI. An IO in Cardiac Services is investigating this.

IN15553 an incident of a complex cardiac arrest in the Cath Lab, Cardiology are in the process of gathering statements and compiling a timeline.

IN18570 – patient on Critical Care with central line inserted which was removed by an Agency member of staff and resulted in an air embolus experience which required resuscitation. This is a reasonably straightforward case and it is hoped that the timeline will result in robust recommendations being made in due course.

IN18924 – patient on C3 Cardiac ward who had been stepped down from Critical Care. The patient’s telemetry was disconnected at 06:50 and the patient appeared to be sleeping when observed by different people at certain times, no staff were aware of any telemetry alarms. The patient was found in asystole at 08:40 and staff were unable to resuscitate. Investigations into this case are underway.

Children & Women Clinical Board are investigating two incidents of maternal death. The cause of death is SUDEP. RP will produce a report for these two cases to be incorporated into the C&W investigation once approved by Neurology.

	Potential NRI's RP Nothing to report **The GROUP resolved:** a) It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** TS informed that there had been some technical difficulties which have now been resolved and she had sent the Inquest Report through. CMain said this would be sent out to the Group as soon as possible. **The GROUP resolved:** a) To review inquest information as appropriate	
2.2	**Closure Forms** RP reported on findings for the investigation of the case of a patient who had a cardiac arrest 30 minutes after being put on dialysis. As a result of the findings the SOP's are being updated and a CNS service is being launched to support pleural tap procedures that are taken across the HB.	
2.3	**Alerts / Patients Safety Notices** CMain invited HT to discuss the following notices which have been disseminated to the Group, to share as appropriate: • Report on Adverse Drug Reactions HT reported that the findings of this survey highlighted the need to raise awareness of yellow cards and to provide training accordingly. HT said that the Yellow Card Centre will be producing more accessible training, details of which she will share when available. • DHSS Medicine Supply Notification Azelaic Acid (Finacea) 15% gel - for information • DHSS Medicine Supply Notification Pentoxifylline (Trental) 400mg modified release tablets – for information • Urgent Product Notice Arterial Blood Sampler – for information **The GROUP resolved:** a) All documents shared at this meeting to be shared within the Directorates	
2.4	**Healthcare Associated Infections** No report received	

2.5	**Health Care Standard 2.9 Medical Devices** CG thanked everyone who had submitted an expression of interest re the Medical Device Capital bids and informed that to avoid any bids going astray links have been added to the QSE channel to the new bid forms.	
2.6	**Health and Safety** The RIDDOR report was attached for information CMu reported that good progress was being made in terms of investigations and closing off incidents and noted that the quality of the investigations is improving.	
2.7	**Vaccination Update** KB was unable to attend today's meeting, CMain informed that the latest flu and Covid vaccination figures were sent with the agenda. Further communication will be sent out in due course regarding flu vaccination drop-in centres.	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** Nothing to report	
3.2	**Mortality Review** Nothing to report	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** <u>Haematology</u> KW reported that correspondence will be sent to the CB informing them of the need to alert the Commissioner regarding the lack of capacity, there are patients ready for transplant having finished their treatment but there are no admission beds available until February 2023. This information will be input onto eDatix shortly. This will be discussed further at the Directorate Performance review scheduled for later in the day. KW asked how within the organisation is risk managed and actually lowered as opposed to simply documenting it on the Risk Register where it stays ad infinitum. CMain informed that the Clinical Board hold an overall Risk Register and all risks of 15 and above are escalated to this. The Clinical Board then escalate these risks up to the Executive Board for executive decisions in terms of planning and bigger decisions. In terms of updating these larger issues where there is a lot of work being undertaken there isn't a mechanism for capturing this on the Risk Register and is something we are unable to mitigate further. In terms of the lower scoring issues which are causing problems these should be reported on through this forum and through the	

	Directorate Performance Reviews to enable the Clinical Board to discuss and escalate as appropriate. RP added that the risks are owned by the Directorates and are shared with the Clinical Board who in turn share with the Executive Board. The Directorates are the authors and as such able to amend them as they are resolved. RP suggested that Aaron Fowler could be invited to present an update on the current Risk Governance Strategy. MD added that part of the reason of having the Risk Register is to broadly indemnify the clinicians to conduct themselves knowing that they will be supported if the risks they face lead to sup-optimal care because the Organisation knew and accepted the risk <u>Nephrology and Transplant</u> RL reported that there is currently very limited capacity for dialysis slots and a great deal of time is being spent by lots of clinical and senior managerial staff in trying to mitigate against this. <u>Critical Care</u> TW reported that the current bed situation in Critical Care is dreadful but that there is an escalation plan in place, he then gave details of an incident whereby a level 3 patient was transferred to Recovery to be looked after by an anaesthetist rather than the escalation plan being implemented and asked why this was the case. CMain replied that this case needs to be investigated further to understand the rationale behind the decisions made not to follow the escalation plan and offered to find the relevant senior manager reports if TW required assistance in locating these. <u>MTC</u> Nothing to report <u>Neurosciences</u> Nothing to report <u>PaRT</u> Nothing to report <u>Cardiac Services</u> Nothing to report <u>ALAS</u> Nothing to report	

	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	Fire Safety – Computers on Wheels Fire Risk	
4.2	Medication Safety – Briefing for Healthcare Professionals	
4.3	Fire Safety Drop-In Session Dates	
5.1	**Any Urgent Business**	
	Nothing to report	
6.1	**Date & time of Next Meeting**	
	Thursday 16 February 2023 9:30am via Teams	

Minutes of the SCB Q&S Meeting
Held On 15TH November 2022
Via MS Teams

Present:		
Clare Wade	CW	Director of Nursing (Chair)
Claire Dunstan	CD	Consultant Anaesthetist
Adrian Turk	AT	Pharmacist
Alex Young	AY	Speciality Manager
Alexandra Scott	AS	Corporate Nursing
Angela Jones	AJ	Senior Nurse
Annabel Green	AG	Workforce Programme Manager
Antonio Riccioli	AR	Orthopaedics Recovery Manager
Ashley Moturi	AM	Finance Management Trainee
Barbara Jones	BJ	Educational Lead
Beverly Withers	BW	Interim Director Manager for Dental
Carolyn Alport	CA	SCB QSE Lead
Carly Podger	CP	Finance Business Partner CDT Surg
Catherine Twamley	CT	Interim Lead Nurse
Christopher John	CJ	Clinical Governance Lead
Debbie Jones	DJ	Patient Safety
Gemma Roberts	GR	Interim Senior Nurse
Haley Dixon	HD	Director of Operations
Laura Hodges	LH	Lead Nurse T&O
Niamh Sully	NS	Patient Safety Facilitator
Rafal Baraz	RB	Consultant Anaesthetist
Richard Hughes	RH	Consultant Anaesthetist
Susan Mogford	SM	Senior Nurse
Terry Stephens	TS	Procurement Nurse
Thomas Betts	TB	Ophthalmology
Tracy Johnson	TJ	Practice Development Nurse
Secretariat		
Genessis Viola	GV	Surgery Quality and Safety administrator
Apologies:		
Ceri Chinn	CC	Lead Nurse Peri-Operative Care
Rowen Griffiths	RG	Governance & Quality Lead Manager
Tracy Johnson	TJ	Practice Development Nurse

Item No	Agenda Item	Action
SCB/QS: 22/113	**Welcome & Introduction** The Chair welcomed everyone to the meeting.	
SCB/QS: 22/114	**Apologies for Absence** a) The apologies given were noted.	

SCB/QS: 22/115	**Amat** **DJones** gave an update on the implementation of Amat. A link was shared with the Group for information and members were encouraged to start using this system; adding any relevant documentation.	
SCB/QS: 22/116	**GOVERNANCE, LEADERSHIP AND ACCOUTABILITY** **Patient Story** **TB** sheared the following patient story with the Group: - TB highlighted that a new Macular Service had been established within Cardiff University at the beginning of the year; providing a teach and treat set up. It was noted that a male patient, who was initially seen by his optometrist, was later seen in Cardiff University on the 2nd of March 2022, where the patient was diagnosed with a macular degeneration, that required treatment. TB reported that the gold standard would be for that patient to be seen within two weeks for treatment, however this was significantly delayed, with patient not seen until six weeks later. The Group were informed that following a review, it was identified that there had been a failing in the referral pathway, due to the transfer over to the newly established service. IT issues were also highlighted as a contributing factor. TB reported that these concerns had since been addressed and patient had received his treatment with success. TB discussed the that lessons learnt, reporting on a number of shortcomings within the initial service, which had since been rectified. **The GROUP resolved:** a) Assurance had been given that issues identified had been addressed to mitigate any further delays to patient treatment.	
SCB/QS: 22/117	**Feedback from UHB QSE Committee** Apologies received from AS; no feedback was provided. • NS agreed to meet with AS later that and feedback to the Chair on any urgent updates. Action: NS	

SCB/QS: 22/118 118.1.1	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** **Peri-operative** **CJ** give a verbal update to the group, highlighting the following: - **UHW Main Theatres** ID 8548. Retained swab. Fact finding meeting 07/07/22. The swab was found to be missing on the final count, patient did not leave theatre or wake from anaesthetic. Fact finding Investigation underway. ID 3612. Anaesthetic awareness. Concerns department received complaint. Redress has forwarded cheque in order for patient to receive private phycological support following incident. Timeline and Action Plan uploaded to Datix-Cymru. Concerns department dealing with solicitor regarding incident. ID 16008 16-10-22. Rounger Pituitary Forceps snapped whilst being used for a spinal procedure. Fact finding meeting conducted 25-10-22. Patient returned to theatre for removal of fragment 24-10-22. Instrument photographed by Medical Illustration and sent to SMTL for analysis. ID 9047 Missing retractor arm from Nuvasive loan equipment. Staff have submitted statements. Staff did not miss any opportunity to check equipment. Nuvasive Rep has accepted responsibility for error. Response letter sent to patient. Concern has now been received for the incident and we are in the process of answering the patient's questions via the concerns department. In view of recent information, it has been decided that this is a reportable incident - this will be done in retrospect. Awaiting further information from patient safety team. ID 15096 – missing ketamine vial on CD Checks Staff involved have been asked for statements. Thorough search of department conducted but vial was not located. Further information being sought and investigation under way. Safety memo shared. ID 15550 – Patients earlobe cut with scissors whilst trimming sleek tape in preparation for neurosurgical procedure Statements requested, investigation for shared learning underway. Earlobe sutured with 2x Ethilon sutures by neurosurgical registrar. Documented in notes and full disclosure to both patient and family. Theatre 7 sluice floor needs repairing. Estates aware and dealing with issue. Saunders.Nathan 03/03/2023 15:42:00 118.1.2 **PESU**	

	ID16750. 21-10-22 Incorrect medication administered via catheter during a Urology case. Fact finding meeting conducted 08-11-22. Timeline information and staff statements have been compiled. Not a reportable incident – no harm to patient. Incident managed appropriately and awaiting closure. Several issues with the Vanguard Ophthalmology Theatre units. The ceiling has had several issues with leaks and water ingress causing damage to stock. A list of damaged stock being compiled. Vanguard aware of issues and are repairing leaks as and when identified.	
118.1.3	**UHL** ID 17000. Thread from Raytec swab retained during a difficult orthopaedic case. Timeline information and statements being gathered. It has been reported that the swab was NOT retained during this incident. Awaiting further information.	
118.1.4	**HSDU** Concerns raised in relation to workforce issues, due to staff shortage. Plans in place to address this shortfall, including additional support from other areas and posts out to advert.	
118.1.5	**ALL AREAS** Staff sickness increased due to COVID-19. Possible impact upon future theatre utilisation and ability to run lists effectively. Impending industrial action could impact upon ability to run elective surgery. Information being gathered and contingency plans underway. • No Actions were implemented from the group.	
118.2	**General Surgery & Urology** **CT** gave a verbally update to the group, highlighting items that were raised and discussed at the Local QSE in September and October. It was noted that the following was presented at the September 2022 meeting: - - Speciality Audit was carried out within the Colorectal Service - HEAT Clinical Trial presented - Outpatient Transformation Programme - HALT-IT Study - Medical Examiner Case **Urology** - Outpatients Transformation Programme – opportunities for Urology	

	- BAUS MITRE Audit - Morbidity & Mortality Reviews It was noted that an additional audit session was carried out in October for all clinicians who use SDEC within General Surgery, Urology, Vascular and Head & Neck SCB directorates to discuss electronic ways of working facilitated by Mr Chris Morris and SNP team. Aim to improve compliance which is currently an issue across all of the specialities, impacting on performance and patient data. The following items were raised and discussed**: -** - Speciality Audit – HPB - Research Trial Outcome – PPAC2 Study - Elective POPS service **Urology** - PROM based follow up of patients with renal stones - Electronic Operation notes - Outcomes from Regional Robotic Partial Nephrectomy Service - Morbidity & Mortality - Consultant discussion – Interface GP for Urology/ED service	
118.3	**ENT/H&N** No representative at the meeting • No actions to implement	
118.4	**T&O** **LH** reported on the following key updates: - + Incident on A6, DW. Timeline complete, meeting at end of the month to discuss. + x3 C.difficile reported on West 5 in October, RCAs completed + x1 C.difficile reported on CAVOC in October, RCA to be completed + x1 Klebsilella reported on CAVOC in October, RCA completed + x1 C.difficile reported on A6S in October, RCA to be completed + Patient safety alerts shared with teams. + IPC audit plus Tenable app launch + Pressure damage figures for September and October were discussed. + NOF pathway work commenced – difficulty ring fencing the beds/gender/IPC issue + PACU business case ongoing + Trauma SDEC -moving to A4N 4th Nov	

	• No actions were implemented	
118.5	**Anaesthetic** RB reported on a case of severe hypoglycaemia within theatre suite that was not acted upon, this has since been reported as and NRI and is progressing also as a coroner's inquest	
118.6	**Dental** **RG** sent apologies; no update given.	
118.7	**Pharmacy** AT updated the group verbally, reporting on the Corporate Medicines Management Group October 22 At highlighted that the Medical Director was looking for lead clinician sessions to support the Electronic Prescribing and Medicines Administration (EPMA) project as this will be a huge project transforming the digitalisation of these areas of health care over the coming 12-18 months. Wide ranging clinician input is vital to the success of this project. AT also updated the group regarding the position within ophthalmology regarding developments in wet AMD treatments etc and the current issues surrounding the implementation of a new Nice recommendation (Vabysmo). AT queried the availability of the Medicines Safety Executive Briefing (MSEB) for staff. This appears to be patchy, and endeavours are to be made to increase awareness of this amongst all staff. The latest issue (Sept 22, no 65) headlines the current safety issues with the 'Flozins' group of drugs since they are now used in the treatment of renal and heart disease as well as their original licensed indication for diabetes. CD mentioned the recent serious incidents that occurred, due to the lack of awareness of withholding 'Flozins' for 48 hours pre-op due to the serious risk of DKA (diabetic ketoacidosis). AT reported poor awareness amongst patients including withholding Flozins etc if unwell or NBM for theatre, which raises the importance of prescribers initiating 'Flozins' to educate patients. The existing 'Traffic light' NBM guide for peri-op medicine administration includes the correct advice, and therefore further distribution this resource is being undertaken. CD suggested further discussion with Dr Cath Doyle (anaesthetic diabetic lead) outside of this meeting. **Action:** CDoyle	

	AT advised he will send copies of the minutes for cMMG, Medicine Safety Executive and the MSEB as papers for the future meetings; highlight relevant surgical issues. **Action:** AT **The GROUP resolved:** a) Assurance had been given by each Directorate that any issues identified had been actioned or escalated as appropriate.	
SCB/QS: 22/119	**HEALTH PROMOTION PROTECTION AND IMPROVEMENT** **Initiatives to promote health and wellbeing of:** **Patients**	
119.1	**SCB H&S/IPC meeting update** **CA** shared the following report with the group • **Reflection on Performance against Reduction Expectations for *C. difficile, Staph. aureus* bacteraemia (MRSA and MSSA) and *E. coli* bacteraemia 2020/21** It was noted that Tendable had now been set up in all ward area and will enable regular IPC audits to be undertaken with immediate visual results available to share with senior teams and ward staff, identifying immediate good practice, highlighting areas for improvement, and develop action plans for improvements. Concerns were raised in relation to C-Diff rates. CA highlighted an increase in cases against this time last year. The Group where informed that outbreaks were appropriately being managed and meetings were being held with the IPC Lead Nurses. Three cases in September were confirmed as an outbreak on West 5 Other HCAI discussed: - **MRSA bacteraemia** There were no case recorded in all August & September **MSSA bacteraemia** No cases were recorded in August or September **P Aeruginosa** There have been no cases of Pseudomonas A since October 2021	

	Klebsiella There have been 3 cases in September It was noted that Pharmacy had produced a draft document outling the results of audits taken in April 2022 and June 2022; this was being finalised before sharing with the Clinical Boards. It was noted that glove usage increased during Covid, and is still expected to increase due to covid outbreaks, however it was suggested that there was an opportunity to reduce their use. It was highlighted that gloves can hinder handwashing, IPC are delivering a presentation to staff within surgery to promote the correct use of gloves and to increase handwashing. CA reported that an anonymous concern was raised to HIW outlining specific issues in theatres of which the member of staff felt were impacting on IPC compliance. These included . Condition of changing rooms, and cleaning . Toilet out of use . Theatre 2 estates issues A walk around was undertaken with Theatre Lead Nurse & IPC Lead Nurse. There were no immediate IPC concerns raised following the inspection. All issues raised were known and in the process of being addressed and maintenance requests were in progress. A meeting was held on 05/10/2022 with the DoN, Theatre & IPC Leads, estates and patient safety. An action plan was put in place to address and expedite immediate outstanding MR's. A response was prepared and submitted to HIW on 07/10/2022.	
119.2	**Decontamination group update** **BJ** explained to the group that she hasn't attend any meeting since last Q&S meeting so nothing to report. a. No actions were implemented	
119.3	**Water safety Group Update** **BJ** gave a verbally update to the group, reporting enhanced Legionella flushing to remain ongoing at UHL; flushing logs had been updated to reflect areas audited. **The GROUP resolved:** a) That appropriate feedback had been provided for each of the relevant Sub Groups.	

SCB/QS: 22/120	**SAFE CARE** **Patient Safety Incidents** **NS** gave an update to the group stating that 7 NRI's where open however it was possible to close the oldest one's. Now they have some new NRI's opened bringing them back to 7 • 2 Peri-op • 1 ENT • 1 Dental • 2 Gen Surgery • 1 Neurology	
SCB/QS: 22/121	**Patient Safety Alerts (internal/external)** **TS** updated the group about the cannulation pack stating that the issue surrounding the pack was to do with the dressing, how it'd been sterilized, also no other clinical board refuses to work with this pack in exception of UHB.	
SCB/QS: 22/122	**Health Care Associated Infections** **HCAI rate** Discussed as part of agenda item 119.1	
SCB/QS: 22/123	**Q&S performance data** **CW** gave a verbal update to the group highlighting that the name had changed and is no longer call performance data is now call Executive reviews. It was noted that the newly established Nursing Dashboard was to be release very soon. **CW** agreed to invite Ceri Dallimore for the next QSE meeting to give an overview of that dashboard. **Action:** CW	
SCB/QS: 22/124	**Falls reduction and Pressure and tissue damage reduction and prevention** **CW** shared both spreadsheets with the group, highlighted that this data would become easy to obtain, in the future using the Nursing Dashboard.	
SCB/QS: 22/125	**Medicines management issues/incidents/audit findings** AT updated the group agenda item 118.7	

SCB/QS: 22/126	**Medical Equipment Group** **RH** asked the group to complete requests forms for new equipment	
SCB/QS: 22/127	**Blood management/ Zero Tolerance Report** **CJ** explained to the group that he hasn't receive any updates since September 2022, no update to give to the group	
SCB/QS: 22/128	**Q&S Workplan 2022-2023** It was highlighted that ENT/ Ophthalmology is due to present at the next meeting.	
SCB/QS: 22/129	**Mortality data analysis** No representative currently implemented for this group **AS** updated the group re future plans of sharing mortality data via a dashaboard using a stratified approach so that everybody has access to the data they need and the level they need to be more accessible to everybody **The GROUP resolved:** a) Appropriate sharing of incident and performance data. Assurance given that this information had been cascaded at local level.	
SCB/QS: 22/130	**Effective care**	
130.1	**Monitoring of CB Clinical audit plan** **CW** highlighted the importance of AMaT and how implementing it would be very beneficial.	
130.2	**Implementation of key Nice Guidance** **NICE Spreadsheet** **CW** highlighted to the group that Nice Guidance Spreadsheet is regularly updated and saved onto SSG, a paper copy is also sent to clinicians and now it would be uploaded to AMat system too.	
130.3	**Research and development update** No representative on the meeting.	

	The GROUP resolved: a) Assurance had been given in relation to effective care and the appropriate record keeping of key NICE Guidance. **Dignified Care**	
SCB/QS: 22/131	**HIW/CHC, Deci (dignity and essential care inspections) reports and improvement plans** **CW** reported verbally to the group CHC are back visiting areas and they have scheduled a few visits to the clinical areas. Also, it was stated that the outcomes from last visit to EU was reported to the press and clinical board already implemented some actions with regards some of the findings, one of them is the concern about the long ambulance waits outside EU. **Timely Care**	
SCB/QS: 22/132	**Initiatives to improve access to services/ management of risks** Apologies received from DW. **Staff and Resources**	
SCB/QS: 22/133	**Staffing levels** **CW** Mentioned that safer staffing levels had been signed off at the beginning of October with the Executive Nurse, Director, the Finance Director and the director of People and Culture. It was reported that these had been signed off for all inpatient clinical areas for the next six months. CW highlighted that there was not much variation with regards to what had previously signed off. **The GROUP resolved:** a) Assurance given that the Safer Staffing sign off had been completed for all inpatient areas for the next six months. No further action required.	
SCB/QS: 22/131	**4. Date & time of next Meeting** Tuesday 9th January 2023 at 08:00 -10:00	

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 22nd November 2022 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board (Chair)
Abigail Holmes	AH	Head of Midwifery, Obstetrics & Gynaecology Directorate
Catherine Bickerton	CB	Operational Manager, CYPFHS Directorate
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Janice Aspinall	JA	Staff Side Representative
Louise Protheroe Davies	LPD	Interim Service Manager, Obstetrics & Gynaecology Directorate
Laura McLaughlin	LM	Risk Manager, Obstetrics & Gynaecology Directorate
Matt McCarthy	MM	Patient Safety Facilitator
Clare Rowntree	CR	Clinical Board Director, C&W Clinical Board
Becci Ingram	BI	General Manager, CHFW Directorate
Ashleigh Trowill	AT	Care Group Operational Service Manager, CYPFHS Directorate
Lois Mortimer	LM	Interim Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate
Louise Waughington	LW	Associate CNS, Infection Prevention & Control
Siwan Jones	SJ	Clinical Nurse Specialist, Infection Prevention & Control
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Catherine Wood	CW	Director of Operations, Children & Women's Clinical Board
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Rim Al-Samsam	RAS	Clinical Director, CHFW Directorate
In Attendance		
Debbie Jones	DJ	Deputy Head of Quality Assurance & Clinical Effectiveness Lead
Secretariat		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator
Apologies:		
Anthony Lewis	AL	Clinical Board Pharmacist

Item No	Agenda Item	Action
CWQSE/ 2022/095	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2022/096	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2022/097	**1.3 Minutes of the previous Q&S Meeting held on 25th October 2022** The minutes of the meeting were agreed to be an accurate record. **The CWQSE resolved:**	

	a) The minutes were noted and agreed as an accurate record.	
CWQSE/ 2022/098	**1.4 To note and update the action log of the meeting of 25th October 2022** Updates were provided on the actions from the last meeting and it was noted that a number of actions have been resolved. The outstanding actions were noted as: **Maternity Services Data** Presentation to be provided on work being taken forward within Cardiff and Vale UHB Maternity Services by DJ, Digital Midwife. Date to be arranged. **Fire Safety Update** Breakdown of data by Directorate and Clinical Board is awaited. KH agreed to follow up outside of the meeting. **SARC – Medical Expertise** Risk assessment to be completed and shared with O&G for review and comment. **Guidance for Use of Analgesia** Guidance being reviewed and further update to be provided at the next meeting. **The CWQSE resolved:** a) An update on the outstanding actions will be provided at the next meeting.	**KH** **KH** **PD** **AL**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2022/099	**2.1 HIW Inspections** Update was provided on the recent unannounced HIW Visit to Maternity Services. Post investigation inspection feedback sessions have been arranged with staff to offer feedback on the initial findings from the visit and the immediate actions that were required and continue to be progressed. A more detailed action plan has been received and work is progressing to respond and complete the actions within the timescales that have been set. A formal report is awaited and further feedback will be provided when this is received. Thanks, were expressed to all staff for the hard work that has been undertaken in response to the visit within the tight timescales set and the ongoing work that is being taken forward. **The CWQSE resolved:** a) The update was noted.	
CWQSE/ 2022/100	**2.2 Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report. **2.2.1 CHFW Directorate Report** • Increasing numbers of RSV cases across the CHFW, with highest areas of pressures within NICU and PICU, and staff movement has taken place to mitigate risks and manage acuity.	

	• Encouraging all staff to take up the flu and covid vaccinations • There has been an increase in reported adrenaline incidences recently and pharmacy are working with the teams to see what improvements can be made. In relation to the anaphylaxis incidents, a comparison has been undertaken with Paediatric ED to compare practices and look at what can be done to improve. Practice Educators have implemented a new monogram is being used for adrenaline and increased teaching within the areas is taking place. Further discussions are taking place as part of the Safer Medicines Group and update is awaited. • Increase in early resolution concerns with a general theme in relation to waiting lists times. No other themes identified. • All student streamliners will be part of the numbers from the end of this week which is hoped will help to ease some pressures within the workforce. • X2 NRI cases complete and being progressed through the governance processes. X1 NRI is almost complete and is progressing well. • Infant Feeding Lead is being progressed within NICU. • X2 neonatal consultants were appointed last week. This additional support will allow daily ward rounds to take place on the Post Natal Wards and a formal daily huddle to be undertaken with maternity services (currently undertaken however there will be a 3rd on consultant who will be the liaison point for maternity services) which is hoped will support with planning for cot capacity and flow back out. • Daily report is also submitted to OPAT and Executive Teams with regards to the pressures within NICU/Maternity Services which will be included as part of the daily SITREP report for the UHB. **Timely Access** • Paeds Surgery continues to have long waits with a high number of level 3 children awaiting surgery dates – with 236 patients who should have received surgery within 3months, with a significant number still to receive a date. Work is ongoing to ensure that all children receive the surgery within 2yrs as per Welsh Government targets and reduce the waits to 52 weeks. 127 children waiting over 52 weeks. • Cardiology waiting times pressures continue, long waiters over 36 weeks, target of which should be 12weeks. • General Paediatrics, 1400 patients waiting, of which over 200 have waited more than 36weeks. • Paediatric Endoscopy, 94 children waiting for an endoscopy, with 77 children waiting over the 8week target. Theatre capacity challenges has meant that there has been an inability to undertake the additional list. • Work is progressing with regards to reviewing of the long waiting patients and those procedures that can be undertaken at a local DGH, rather than a tertiary centre. Of the patients reviewed, 129 Patients have been identified that it is not required for them to have procedure within C&V and can be treated elsewhere. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	
CWQSE/ 2022/101	**2.2.2 CYPFHS Directorate Report** Report was noted for information. **Timely Access** • ND is biggest concern, slight reduction in the waiting list for October with	

	1666 patients waiting for an initial assessment. Backlog of triage which may see an increase again. Longest wait is currently at 147weeks. • PMH and CAMHS – 100% compliance achieved for Part 1a Target as a merged service. Internal waiting lists pressures continue, however there has been a slight decrease to 331 and work continues to try to improve this further with the help of Helios and caseloads reviews are ongoing. It was noted that there continues to be a number of DNA's within the service and this is continuing to be reviewed in order to minimise these rates further. Patient letters are also being reviewed where information will also be included regarding DNA. • Continence waiting list has increased for October with 614 patients waiting with the longest patient waiting at 108weeks. • 531 Patients waiting for children's therapies in October. OT continues to be biggest pressure with 259 patients waiting, with the longest at 55weeks. • LAC – backlog of 143 initial health assessments within the service. Medical staffing pressures is impacting this and work is ongoing to address this. Struggling to meet initial health assessment target of 28 days, work continues to improve this position. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2022/102	**2.2.3 O&G Directorate Report** The detailed report was shared for information and an update was provided on the key highlights from the report. • BFI Action plan has been submitted for review. • Staff vaccines are being offered for flu in conjunction with Covid boosters. • Baby Loss Awareness month took place in October 2022. • Increased number of open Datix incidents and there has been significant work undertaken to review and action as appropriate. A plan has been developed to undertaken twice weekly Datix meetings to review and monitor progress to work towards addressing some of the backlog. Themes identified include recognition and escalation of the deteriorating patient on the ward, documentation on shoulder dystocia proformas etc. This information has been shared within the risk newsletter and action plans are being monitored through the AMaT system. • Number of ongoing RCA's and BIT Tools in progress • No pressure areas reported for August and September, x4 falls reported for August and appropriate actions taken. • Update to be provided on the October statistics for medication errors, falls and pressure areas outside of the meeting. • Number of concerns are ongoing. • IHI Safe Collaborative space available and it was agreed that a representative would be identified. Further discussion ensued with regards to the number of outstanding incidents. Queries were raised as to the possibility of combining incidents with episodes of care and whether there is a way to link them together as there may be one episode of care linked to a number of open Datix incidents. Concerns were raised with regards to the impact of this on workload. It was felt that there should be the opportunity of inputting more than one code onto	

	the new Datix system, which was agreed to be the best way forward. It was acknowledged that there is an issue with regards to recording more than one code on the system and due to this being an All Wales system, this will take time to achieve given this is an All Wales System which has a specific governance structure for any specific changes. It was agreed that the process should be reviewed to ensure that there is removal of any unnecessary waste within the system. It was agreed that this issue should also be raised through the Mat/Neonatal Programme. Euro king has been discussed as an option. There was also acknowledgement that there is some duplication across Maternity/Neonatal services as they sit between two Directorate teams. It was agreed that there would be a more detailed discussion outside of the meeting. From a visibility perspective, this may be possible however this would likely need to be a complete view rather than part view **The CWQSE resolved:** **a)** The update was provided for information and key highlights recorded. b) IHI Collaborative - representative to be identified to attend c) Further discussion to take place with regards to recording of episodes of care rather than individual Datix incidents needing to be raised, and required actions to take forward.	
CWQSE/ 2022/103	**2.3 Waiting Times Update** The waiting times update was noted as part of the Directorate QSE Exception Reports **The CWQSE resolved:** **a)** The update was noted	
CWQSE/ 2022/104	**2.4 New Risks to be considered for the Clinical Board Risk Register** No new risks to note for this meeting. Further to the earlier discussion it was agreed that the volume of Datix incidents and duplication to be considered and added to the Directorate/Clinical Board registers as deemed appropriate. **The CWQSE resolved:** a) New risk assessment to be undertaken on the Datix incident risk and actioned as appropriate.	**AH/LM**
SAFE CARE		
CWQSE/ 2022/105	**3.1 Update on Serious Incidents** 14 open NRI's, 11 within O&G and 3 within CHFW. There were x2 cases retrospectively reported since the last meeting, reports and action plans have been developed and it is hoped that these can be progressed to closure shortly. Patient Safety Learning Review tool has been developed which will replace the current RCA template. Feedback received has been positive and final changes are being made which will be formally launched in the near future. It was agreed that a formal presentation will be provided at an upcoming meeting. **The CWQSE resolved:**	**MM**

	a) Update was noted. b) Formal presentation update to be arranged.	
CWQSE/ 2022/106	**3.2 SI's/RCA's/Closure Forms for noting/exception reporting** It was noted that all cases have been discussed in detail as part of the Clinical Board NRI/RCA Governance Sub Group and an overview was provided on the cases, with root cause, recommendations and lessons learnt shared. **SBAR, RCA & Action Plan – BR – Datix Ref 160187** Intrauterine Death at 28+3weeks. SBAR was shared providing the background to the case. Baby was delivered in Swansea Bay. Lady had a high-risk pregnancy and was shared care between Swansea and Cardiff. Full background to the case was provided and noted in the supporting SBAR shared for information. Recommendations identified as (taken directly from SBAR); • It would have been appropriate to offer computerised CTG (cCTG) during the FMU consultation to provide multi-modal assessment of the fetus when hospital admission was declined. • When the ductus venosus Doppler reading is challenging to obtain or record then cCTG may offer more comprehensive assessment of fetal wellbeing. • The Directorate and Clinical Board must explore how it develops the FMU service in Cardiff in the future. In due course, when future FMU consultants are appointed they must consider employing fetal medicine consultants who undertake their own ultrasound scans in clinic. • Update the local SGA guidance to include cCTG where ductus venosus Doppler is unavailable or challenging to obtain. **SBAR, RCA & Action Plan – ED – Datix Ref 352623/7281** Case involved a baby who was born in poor condition following an instrumental delivery using forceps. Baby was admitted to the neonatal unit and subsequently has been diagnosed with Hypoxic-Ischaemic Encephalopathy (HIE) Grade 2. Full background to the case provided and noted in the supporting SBAR shared for information. Recommendations identified as (taken directly from SBAR); • When undertaking trial of operative birth, fetal monitoring must be commenced on arrival in theatre and continued until birth. If there are concerns about fetal wellbeing then the operative vaginal birth should not be used as a training opportunity (junior doctor performed procedure under the supervision of a senior obstetrician). Directorate training sessions are in place for obstetric staff in the safe management of operative vaginal birth. • If it is unclear whether midwifery led intrapartum care is suitable then advice should be sought from the Labour Ward Co-ordinator or Midwifery Unit Manager • Where intelligent intermittent auscultation is performed, fetal movements and accelerations should be recorded to verify fetal wellbeing. This should be included on regular fetal surveillance study days. • The Directorate is moving to electronic plotting of growth ultrasound scans. This will reduce the risk of inaccurate plotting of fetal growth.	

	SBAR, RCA & Action Plan – HD – Datix Ref 333861 The case involved a baby was born in poor condition requiring resuscitation and admission to the neonatal unit. Baby required breathing support and experienced seizures on Day 1. An MRI of baby's brain revealed a right middle cerebral artery infarct. The baby required medication for seizures. Full background to the case provided and noted in the supporting SBAR shared for information. Recommendations identified as (taken directly from SBAR); • Reminder added to safety briefings about documentation of discussions during intrapartum care to include all options discussed. • A list of indications for sending placenta for histology to be laminated and placed on the wall in all obstetric theatres, along with a reminder on the safety briefings. **SBAR, RCA & Action Plan – NB – Datix Ref 337941/6533** The case involved an unexpected Neonatal Unit Admission of Baby with a diagnosis of: • Respiratory distress syndrome (RDS) • Sepsis suspected • Subarachnoid haemorrhage • Subdural haemorrhage Baby spent 20 days on NNU. Chest X-ray suggestive of infection. Full background to the case provided and noted in the supporting SBAR shared for information. Recommendations identified as (taken directly from SBAR); • Scenario based training in fetal monitoring with strict attendance register for both medical and midwifery staff. • This case to be used in this scenario-based training. • A structure which provides a high standard of frequent and regular training in fetal pathophysiology to understand complex intrapartum situations. • Human factors and Team building sessions for maternity staff to enhance MDT working under challenging circumstances and mutual respect for the knowledge and expertise of each other. • A robust structure to manage 'junior doctors' long term and short-term rota gaps such that the on-call consultant Obstetrician is not 'assumed' to step down to fill up the junior doctors' gap. • Training of Band 7s to adopt their responsibilities around escalation through the Band 7 co-ordinator development programme. • Senior obstetricians and senior midwives to reflect on the case **The CWQSE resolved:** a) The cases were noted and action plans have been developed for all which are progressing with lessons learnt being shared. There were no exceptions to note and agreed that the cases could be progressed for sharing.	
CWQSE 2022/107	**3.3 To note the draft minutes from the Clinical Board NRI/RCA Governance Sub Group Meeting held on 14.10.2022** The minutes of the meeting held on 14th October was shared for information. There were no specific exceptions to note for this meeting.	

	The CWQSE resolved: a) The minutes were noted.	
CWQSE/ 2022/108	**3.4 Infection Prevention Control Update Report** The report was shared for information. Update was provided on the number of days since the last reported bacteremia cases. At the time of reporting it was 644 days since the last reported pseudomonas case, however one has been reported in November 2022. In relation to outbreaks and periods of increased incidents, closure report is being completed on the outbreak of MRSA within NICU/Maternity. There were some outstanding actions that needed to be completed following the last meeting and the closure meeting will be arranged. Audits are ongoing within Maternity & Paediatrics. Some improvements have been identified and work is ongoing with the ward areas to complete this work. Flu & Covid uptake numbers are low and conscious effort to be made to encourage staff to take up the vaccines. Discussion ensued and it was noted that there has been a significant impact on staff and patients with the circulation of flu recently. RCA investigations are continuing and a number are now being finalised in a timely manner. Thanks, were expressed to Louise for the support provided to the Clinical Board. Welcome to Siwan and look forward to working with you. Discussion ensued and it was noted that full viral screens have been undertaken and a number of staff have been very poorly with flu recently. Further discussion ensued as to increasing awareness of the importance of uptake. It was noted that due to staffing pressures, there has been an impact on the access to flu champions. It was agreed that additional pop-up clinics would be explored to look to increase the uptake across the Clinical Board. **The CWQSE resolved:** a) The report and update were noted. b) Pop up Flu Vaccination Clinic to be explored.	
CWQSE/ 2022/109	**3.5 Safeguarding** The safeguarding annual report was shared for information. Any comments to be shared outside of the meeting to feedback to the Safeguarding Steering Group Meeting. **The CWQSE resolved:** a) The annual report was noted.	
CWQSE/ 2022/110	**3.6 Patient Safety Alerts (internal/external)/Welsh Health Circulars** **Urgent Product Notice – Arterial Blood Gas Syringes** Previously circulated for noting and onward dissemination. Recall of syringes across the Health Board, which has been completed with an appropriate alternative ordered.	

	The CWQSE resolved: a) The alert was noted.	
CWQSE/ 2022/111	**3.7 NICE Guidance – Update on Progress** DJ was welcomed to the group and provided an update on a change to the process. All amended and published guidance from November onwards will be shared through the AMaT system with a request for a statement of compliance through the system. Further training sessions will be rolled out to support this module. At present, as part of the duty of quality bill across the Health Board there is limited assurance with regards to implementation of the guidance. Where possible it was requested that evidence of assurance to be included, including inclusion as part of risk registers where appropriate to highlight what is being done to mitigate and manage the risks where non or part compliance is evident. Also, for those that are for information only or not relevant this can be included within the system. Assurance also needs to be provided to other Health Boards on their patients that we provide services for and also to highlight any risks associated and how this could/should be mitigated. There was acknowledgement that there is a lot of important work that is being taken forward and this will also provide further evidence of this. The new guidance received in month was shared and noted. • **IPG738 – Removal, preservation and subsequent reimplantation of ovarian tissue to prevent symptoms from the menopause** The guidance has been shared for review and appropriate action. • **NG225 – Self-harm: assessment, management and preventing recurrence** The guidance has been shared for review and appropriate action. • **CG189 – Obesity: identification, assessment and management** The guidance has been shared for review and appropriate action. • **TA821 – Avalglucosidase alfa for treating Pompe disease** Currently there are no patients with Pompe's (in Cardiff and Vale or the whole of South Wales). Guidance is therefore just for noting at this point. • **IPG735 – Transcutaneous electrical neuromuscular stimulation for urinary incontinence** The guidance has been shared for review and appropriate action. **The CWQSE resolved:** a) The update on the new process through AMaT was noted and the new guidance was shared for review and action. Updates to be provided as appropriate following the meeting.	
CWQSE/ 2022/112	**3.8 Reporting Adverse Drug Reactions** Guidance was noted for information. **The CWQSE resolved:**	

	a) The guidance was noted.	
TIMELY CARE		
CWQSE/ 2022/113	**4.1 Directorate concerns & assurance update** Discussed as part of the directorate reports. **O&G Update – October 2022** Shared for information. **The CWQSE resolved:** a) The update was noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2022/114	**5.1 Staff Winter Vaccine Uptake Profile** The winter vaccine uptake profile was shared for noting. **The CWQSE resolved:** a) The profile was noted.	
CWQSE/ 2022/115	**5.2 Medicines Safety Briefing – November 2022** The medicines safety briefing was shared for noting **The CWQSE resolved:** **a)** The briefing was noted.	
ANY OTHER BUSINESS		
CWQSE/ 2022/116	**6.1 Youth Board Meeting** Discussion ensued with regards to the Youth Board and queries raised with regards to engagement from CHFW into the Youth Board and how this information is communicated. Discussion ensued with regards to social prescribing and it was noted that Holly Tarren is the lead for social prescribing for young people. It was agreed that links would be made to ensure that joint working can be progressed ensuring appropriate roll out of the service. It was agreed that Lisa Cordery would communicate out the planned discussion points within this forum widely across the Directorate teams and there is an open invite to attend as it is a UHB Youth Board, where documents ideas etc. can be shared/discussed.	
CWQSE/ 2022/117	**6.1 Date and Time of Next Meeting** **Tuesday 20th December 2022 8.30am, via Microsoft Teams**	

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 17TH JANUARY, 2023, 11 AM
Venue: MS TEAMS

Attendees	
Anna Llewellin (AL)	Director of Nursing (Chair)
Rachel Armitage (RA)	Quality and Safety Manager
Clare Clement (CC)	Head of Medicines Management
Kate Morris (KM)	Locality Lead Pharmacist, Cardiff South and East
Anna Mogie (AM)	Deputy Director of Nursing
Lynne Topham (LT)	Locality Manager, South and East Locality
Helen Kemp (HK)	Deputy Clinical Board Director
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Clare Evans (CE)	Assistant Director Primary Care
Neil Morgan (NM)	Vale Locality Manager
Catherine Evans (CEv)	Patient Safety Facilitator
Alison Lewis (AL)	Patient Safety Facilitator
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Theresa Blackwell (TB)	PCIC Business Manager
Louise Thomas (LTh)	Quality & Safety Officer

Apologies	
Carol Preece (CP)	Lead Nurse, South & East Locality
Andrea Rich (AR)	Lead Nurse, Palliative Care

Lisa Waters (LW)	Senior Nurse for Quality and Education
Anna Kuczynska (AK)	Community Director
Lisa Dunsford (LD)	Director of Operations
Sarah Griffiths (SG)	Head of Primary Care
Rachel Thomas (RT)	Assistant Director of Operations
Julie Loxton (JL)	Advanced Nurse Practitioner

ITEM NO.	TITLE	ACTION
01/23/01	AL opened the meeting by welcoming Ruth Cann to the group. Ruth has recently taken up post of Consultant Nurse for Vulnerable Adults. Introductions were made.	
01/23/02	Apologies were noted as above.	
01/23/03	No declarations of interest were raised.	
01/23/04	Minutes The minutes of the meeting held on 8th November, 2022 were approved and accepted as an accurate record. There were no other matters arising.	
01/23/05	Action Log Please refer to item 5.	
01/23/06.1	OOH Business Report The Urgent Primary Care Centre went live on 12.12.2022 and is working well. Some slots were not initially utilised due to inappropriate referrals but have since been opened up to 111. The department is working towards '111 Press 2 for Mental Health'. AM queried if there have been any discussions regarding palliative care patients accessing 111. HE noted that a group has been established to look at this due to the number of Wales wide complaints received and will make enquiries regarding its progress and potential launch date. AL noted that OOH capacity was opened up during the period of industrial action but was not utilised. This will be closely monitored during future industrial action.	HE
01/23/06.2	N&W Locality Business Report Workforce remains the biggest issue with a large increase in sickness over the winter months. It was noted that there have been difficulties recruiting a speech and language specialist. Physiotherapists have also agreed to take industrial action. A low number of hospital referrals make it challenging to fill CRT capacity. AL noted that additional bed capacity has been opened in UHL and additional beds will be opened in Lakeside for such patients with the aim of supporting some of	

	these areas. A targeted piece of work is being carried out with the nursing team who are working in tandem with secondary care.	
01/23/06.3	<u>Vale Locality Business Report</u> The main issue being experienced in the Vale is in relation to VCRs due to the low referral rates coming through. A pilot is being run with nurses at the front door looking at areas that can be turned around. Recruitment is going well; the team should be fully staffed within a few months. AL suggested investigating if anything is being done differently in this cluster in comparison to others in the Clinical Board. A piece of work is being carried out within the Wellbeing service looking at integrating the Wellbeing matters service and Wellbeing aspects of the Local Authority service. Neil Morgan is creating a Falls Strategy Group and will link in with the wider Health Board's Steering Group. RC to ascertain who the Chair is and inform Neil Morgan.	RC
01/23/06.4	<u>South and East Locality & HMP Business Report</u> A small number of staff have been recruited alongside several resignations. Significant staffing pressures (nurses and GPs) are being faced in HMP. OCP work has commenced to bring all services in HMP under the same Clinical Board. Interviews for the recruitment of a Senior Nurse Operational Lead are scheduled on 20th January 2023. Many erectile dysfunction complaints have been received, primarily in relation to the blockage in access to urology care. The revised HMP food and refusal policy will be brought to this meeting when it has been approved by the PPB Partnership Board in the prison. RA noted that this documentation will need to be ratified across the Corporate Quality and Safety group. The auditing of HMP medical notes continues along with work in relation to nursing documentation of safeguarding notes. There is no risk of the MillCare system being hacked as it sits on the Health Board's server. Fire Text is running as an alternative to the texting service.	
01/23/06.5	<u>Medicines Management</u>. There is a new risk associated with the interim UPC model in CAV24/7 due to the use of Adastra. The risk around overspend in the prescribing budget has been revised with a score increasing from 9 to 20. The team structure has been reorganised focussing on workstreams and organisational medicines management responsibility rather than Locality support. Locality support will continue. The response for the recent complaint received by PCIC regarding availability of topical testosterone on the formulary associated with the menopause was answered via the Corporate Clinical Board.	

	RA noted that compliments received should be entered onto the patient quadrant spreadsheet and will send CC the link. Many meetings discussing Strep A have taken place since the group last met. The incentive scheme for GPs will be finalised by the end of March and brought to the next meeting.	RA
01/23/06.6	<u>Palliative Care</u> Item 6.6 is for noting in AR's absence. AM updated the group about the pilot being undertaken that is looking at supporting carers who are caring for end of life patients. The pilot aims to find out if further information could be provided to such carers to help support them before their family member, etc is brought home. Consideration is being given to dedicated paramedic support for palliative care patients. A dashboard has been developed entitled 'Last year of life' that looks at every person who has died in Wales within the last three years. AM will share the dashboard link with the group. Hospice beds continue to be restrictive, resulting in waiting lists. The situation is gradually improving; bed numbers have increased from 12 to 14 with a view to opening all commissioned beds.	AM
01/23/06.7	<u>Primary Care</u> Sustainability issues are being faced by both GMS and GDS. Strep A contributed to a significant increase in escalation for GMS practices. Twenty practices are scoring at level 3 or 4 due to demand and sickness. A formal offer has gone out to 10 out of 57 practices offering support of which intense support has been offered to 4. 2 practices have indicated that they plan to merge. The GMS team successfully managed to turn around a potential termination of contract in Cardiff North by offering intensive support. A large dental contract worth £315k will be returned as of 01.04.2023; the GDS team is looking to put this contract out to tender. A small dental contract will terminate. There are 16k patients on the dental centralised waiting list. 22.5k new patients were seen between April – December 2022. New metrics will be implemented next year as instructed by WAG. CDS is working at 50% capacity. Improved processes and ways of working have been implemented; the waiting list has reduced from approximately 900 to 650 over the past 8 months. The optometry contract remains under negotiation. HK thanked CE and her team for all of their hard work.	

01/23/06.8	Mass Vaccination Centre (MVC) report The team exceeded the target set out for the delivery of the autumn Covid booster. They have been involved in other programmes such as Meningitis B, Polio mop up and Flu mop up and will work towards the delivery of the spring and autumn Covid boosters. IMAP clinics were supported before being stepped down. Fixed term contracts are due to expire. Hearing loops have been installed in the modular build which continues to be noisy when busy.	
01/23/07.0	Risk Register RA referred to item 7 noting that there was nothing specific to be raised but requested the group to alert AL should anything need updating.	
01/23/07.1	Duty of Candour Angela Hughes, Patient Experience, joined the meeting to provide an update on the Duty of Candour which will come into force as of 01.04.2023. This legislation is already in place in England and Scotland. In order for the Duty of Candour to be triggered, the patient must be receiving NHS care and something will have to have happened that was not expected or meant to happen and have caused moderate harm, or could potentially cause harm in the future. Incident reporting will be utilised to trigger a Duty of Candour. Should a Duty of Candour be triggered, a series of actions will be followed, i.e. a conversation with the patient involved, acknowledgment of what happened, apology offered, provide an explanation of what was known about what happened at the time along with an explanation of the next steps in relation to the review. This must be followed up with written acknowledgement to the patient within 2 days. Nursing homes will have a duty to undertake an investigation and share their findings with us (private legislation will come into force in 2024). HK expressed her concern in relation to our independent contractors and their requirements. She believes that the Primary Care Clinical Board is the Clinical Board anticipated to be the most affected by the Duty of Candour and noted that a very clear process will be required. AH noted that national videos have been made but have not been released as yet. WAG will talk with the Senior Leadership Board and the Executive Board where questions regarding Primary Care will be raised. HK noted that GMS do not use the Datix system so there will be a training need. However, the legislation does not state that the Datix system has to be utilised for the Duty of Candour which will put further pressure on Primary Care. RA thanked AH for advocating for the Primary Care service. She noted that the enforcement of the Duty of Candour will also coincide with the enforcement of the Mortality Review. AH will share the presentation slides used at the meeting with the group along with the recording of a previous meeting explaining the Duty of Candour. AH is happy for these aids to be shared with independent contractors.	AH

01/23/07.2	Hijinx Patient Story AM explained that this is a piece of work interviewing carers of people with disabilities and their experience of accessing care services in Cardiff and Vale. She encouraged the group to listen to the recording at their own convenience and to play at their own Quality and Safety meetings.	
01/23/08.1	PCIC Quality Report AM ran through item 8.1 in LW's absence: Vacancy numbers are slowly decreasing. Sickness is still high but levels are not increasing. There are three open reportable incidents; two of which are nearing conclusion. Trends and information reported via Datix are very rudimentary due to reporting restrictions. Primary Care pharmacies and community pharmacies are using the Datix system. Complaints continue to be responded to in good time (as per the set targets). Lovely compliments have been received under considerable working pressures as detailed in item 8.1 Please note further compliments as per items 8.2a, 8.2b and 8.2c.	
01/23/09	National Reportable Incident Update One NRI came into the system as a patient concern. The concern was thoroughly investigated and deemed to be an NRI.	
01/23/10a	IPC update There is a zero MRSA tolerance across the Health Board. Although there were no cases in December, the target was missed due to three previous cases. There were 6 cases of aureus bacteria in December, bringing the total number to 27 (the target is less than 30). Recent RCAs have not identified any specific trends. An All Wales clostridium difficile study day recently took place. IPC nurses have visited medical practices to look at patient notes themselves in order to complete RCAs. ED will collate Primary Care's RCAs and update the group should there be any learning. One Health Board has noted a strong link between their Cdiff cases and antibiotic usage within their dental services. ED asked if it can be clarified if GPs are happy to be contacted by the IPC team. ED and CC will discuss outside of this meeting. Time will be put aside for regular, specific IPC meetings in order to scrutinise information and set actions. Covid cases are reducing; a 43% decrease was seen in Wales this week.	ED/CC

01/23/10.b	<u>Cervical screening uptake promotion video with Wales Online</u> A Wales Online reporter linked in with one of our practice nurses to create a video promoting the uptake of cervical screening. Please view item 10b and share as appropriate.	
01/23/10c	<u>Subcut fluids in the home</u> Item 10c is an update of current guidance and is pertinent to palliative care.	
01/23/11	<u>Outcome of an investigation</u> RA undertook to provide a summary of incident reference In153159 and will circulate to the group. *Post meeting: notes circulated, task completed.* RA referred to item 11a 'Learning from a patient safety incident – delayed CT scan' and drew attention to the 'lessons learnt' section.	
01/23/12	<u>NICE guidelines</u> The group noted item 12 (NICE guidance proforma) regarding osteoarthritis in over 16s.	
11/23/13	<u>Quality Services, Delivering what matters</u> AM advised the group to watch the link embedded under item 13 of the agenda detailing procedures for contracted care and support services for children, young people and adults.	
11/22/14 AOB	<u>Any Other Business</u> TB to be informed of any amendments to the Business Continuity tracker.	
PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 28th March, 2023 at 11.00 am.		

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

MENTAL HEALTH CLINICAL BOARD

Quality, Safety & Experience Committee

Thursday 20th October 2022 at 09.30am

MS Teams Meeting

Present:
Mark Doherty, Director of Nursing (Chair)
Bala Oruganti, Consultant Psychiatrist
Claire Humphries, Safeguarding Nurse Advisor
Clare Quinn, Consultant Clinical Psychologist MHSOP
David Seward, Acting Mental Health Act Manager
Gail Evans, Advanced Nurse Practitioner, MHSOP
Jayne Bell, Consultant Nurse for Complex Clinical Risk Management (MH)
Joanne Wilson, Directorate Manager MHSOP/Neuro
Julia Somerford, Senior Nurse Physical Health MHSOP & NeuroPsychiatry
Karen Bonham, Speech Therapist
Kelly Panniers, Senior Nurse for Physical Health Adult MH
Marianne Seabright, Lead Nurse for Mental Health Services for Older People
Neil Jones, Clinical Board Director – Consultant Psychiatrist – Addictions
Robert Kidd, Consultant Clinical & Forensic Psychologist
Suzie Cheesman, Patient Safety Facilitator
Tara Robinson, Interim Deputy Director of Nursing Mental Health
Tracey Skyrme, Head of Inquests Patient Experience
Anita Lindsay,
Victoria Gimson, MHCB Pharmacist

Apologies:
Andrea Sullivan, Senior Nurse for Nursing Education, Quality and Patient Safety
Andrew Vidgen, Consultant Psychologist, Assistant Clinical Director, Adult MH
Ann Marie Dunsby, Senior Trainee, Adult MH
Catherine Evans, Patient Safety Team
Daniel Crossland, Director of Operations Mental Health Clinical Board
Darren Shore, Lead Nurse for Adult Mental Health
Jenny Pinkerton, Occupational Therapist Clinical Lead MHSOP
Julian Willett, Transformation & Innovation Lead, Mental Health Clinical Board
Keithley Wilkinson, Corporate Management
Lisa Walters, Interim Lead Nurse for Adult Mental Health
Mark Jones, Directorate Manager AMH
Martin Ford, Directorate Manager, Psychology & Psychological Therapies Directorate
Melanie Smolinski, Consultant Clinical Psychologist & Service Lead Cynnwys
Nicola Evans, Head of People and Culture
Norman Young, Consultant Nurse, Early Intervention Psychosis Service
Paul Williams, NW Locality Service Manager AMH
Rachel Rushforth, Senior Nurse for Nursing Education, Quality and Patient Safety
Rachael Sykes, Health & Safety Adviser

Shahnila Sohail, Sho Speciality Doctor
Yvonne Hyde, CNS in Infection Prevention And Control

Part 1:	PRELIMINARIES
1.1	**Welcome & Introductions** A warm welcome was extended to all and introductions made.
1.2	**Apologies for absence** Apologies for absence were noted
1.3	**Minutes of the Meeting held on 14th July 2022** Discussed and agreed as read
1.4	**QSE bring forward/action log** **SECTION 140** Marianne Seabright advised she and Darren Shore have been tasked to write a policy on section 140. They have developed from a health perspective a clear pathway for staff, detailing how to seek a bed when one isn't available in and out of hours and what to do for patients who are out of area but need to come in. A future meeting with MH Lag; local authority leads has been requested, to review and share a joint approach to the policy. The lead nurse from AMH Lisa Walters, will also be required to attend. Date of meeting TBC **Risk Register – review and revision** Please see section 2.3 **MHSOP** Marianne advised there have been a number of low-level safeguarding incidents and wanted to affectively highlight how we can help staff to identify these are safeguarding issues and raising the profile. A survey has been conducted and responses by staff acknowledged they have little knowledge on how to raise safeguarding referrals. Marianne and MHSOP have designed a non-threatening poster to raise awareness with staff and safeguarding; quoting "think safeguarding 1st leave no stone unturned". Further discussions with staff and the safeguarding team will be on-going. Action complete **Risk Register – review and revision – 16Ft Fence** Darren Shore unavailable for comment; Heather and Ruth now leading on this item. **Controlled Documents** Mark advised they had met recently to restart MHCB policy management processes, and this will be a monthly/6 weekly meeting known as the Controlled Document Oversight Group, if anyone has any further queries to let Mark know.

Each ratification policy document in the "proposed" folder was reviewed by the QSE group. After discussion, it was agreed the following documents were to remain “open” as they require further work and review:

Physical Health Monitoring procedure version 2
ECT Procedural Guidance working 1.2
Corporate Policy CRHTT
Corporate Policy CAW

The following controlled documents were agreed and ratified by the QSE group:

Application for admission under Part II of the Mental Health Act Policy Final
Application for admission under Part II of the Mental Health Act Procedure Final
Patient Rights Information to Detained & Community Patients Policy Final
Patient Rights Information to Detained & Community Patients Procedure Final
Physical Health Monitoring procedure version 2
Review of Detention and Community Treatment Order Procedure Final
Review of Detention and Community Treatment Policy Final
RRP - Equality & Health Impact Assessment
RRP - Protocol with appendices sixth draft
Unexpected death procedure

These are now “closed” and each ratification policy document has been moved to the "approved" folder.

Patient Stories

Jayne Bell confirmed posters have been distributed to each lead nurse and their areas; further posters required, Jayne to double check and action if required. Jayne also confirmed the lead nurses of each directorate were to explain with staff the purpose of the posters and the key messages.

Jayne advised she has retweeted the poster.

Further conversations on how we gather feedback need to take place.

Digital Display Boards

Mark and Jayne have not had the opportunity to discuss; action on-going

Monitoring of CB Clinical Audit plan

Bala acknowledged the prospective list and audit plan had not yet been actioned. Mark to review with Neil.

PRESENTATION:

AMH - Injurious Falls Presentation (Jayne Jennings) presented by Kelly Panniers

Kelly Panniers shared Jayne Jennings Injurious Falls Presentation an adult mental health incident, explaining a time line of an unwitnessed fall and situation with the group. Kelly discussed the background of the patient and previous admissions to hospital. An assessment of the case and falls

review meeting held to discuss outcome of investigation, noting the findings, further training and recommendations and actions following an in-patient fall.

MHSOP - Injurious Falls Presentation (Julia Somerford)

Julia Somerford shared Mental Health Services for Older People Injurious Falls Presentation and discussed the new eDatix System being introduced to MHSOP explaining data reporting is reliant on staff entering information at the time of reporting rather than staff reviewing the form. Currently MHSOP are teaching staff/colleagues how to use the new eDatix System. Julia reported on the data review, patient findings and possible themes why these falls occurred. Next steps, MHSOP are developing a new falls policy, building on Natalie Robertson's work. Mandatory falls training for al staff and falls discussed daily at meetings.

Prevention of Venous Thromboembolisms (VTE) in MH (Julia Somerford)

Julia Somerford shared Prevention of Venous Thromboembolisms Presentation and discussed the Welsh Risk Pool review on VTE prevention in health boards across Wales. Julia reported on the findings of VTE related deaths in Wales and concluded VTE risk assessments were not usually completed on admission. The Welsh Risk Pool report recommended all Health Boards adopt the All Wales Thromboprophylaxis Policy, all clinical staff are trained in VTE and HAT and All Wales checklist for investigation of HAT is developed. Data and learning are shared and implemented into practice.

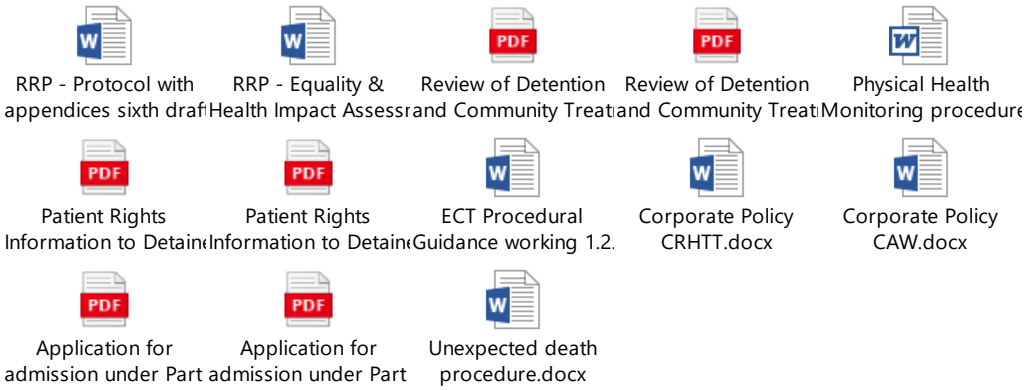
See attached presentations for more details:

Presentation - Injurious Fall - AMH - | Presentation - Injurious Fall - MHSOF | Presentation - Prevention of Venous

Part 2:	GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY
2.1	**UHB QS&E Committee** Mark advised they were asked to present mental health, which was a successful exercise of reassuring the execs and non-execs the MHCB are being open and clear. They discussed, people absconding, safety and security, CAMH's and the challenges faced in AMH and Welsh government guidelines.
2.2	**Regulatory compliance** No up-date
2.3	**Risk Register – review and revision** Mark advised the group, he now attends the engagement review meeting with the executive board on a monthly basis to discuss the live top 3 MHCB risks; these currently are: • MHCB staff recruitment and retention of registered nurses. • Violence and Aggression. • Young Person with complex needs in AMH and the impact on adult patients and staff. Proposed there should be a separate risk register forum meeting with Mark Doherty, Claire Quinn, Rob Kidd and Joanne Wilson, to collaborately discuss staff recruitment issues in other professions across Psychology and other directorates, AMH & MHSOP. This would be beneficial and should be on a 6-monthly basis. Action added to the Action Log.

2.4	**Exception reports and escalation of key QSE issues from Directorate QSE groups** **AMH Directorate Quality & Safety Meeting** - dated 20th July 2022 **Adult – Lisa Walters** Unavailable to discuss See attached document for more details: 2.4a AMH QSE Minutes July.docx **MHSOP Directorate Quality & Safety Meeting** - dated 3rd October 2022 **MHSOP – Marianne Seabright** • MHSOP are currently looking into refining the Mental Health Dementia Path 3 measure and response times to fit in with the 111 Press 2 and historical coroners ruling, liaising closely with patient safety. Developing patient information leaflets for patients who are admitted to MHSOP. Also pushing VBA's and clinical supervision. MHSOP are reviewing CCQI audit and results on wards with the ward managers; identifying key themes and improvement projects across the wards and to discuss the 'Tendable' App that replaces 'Perfect Ward' for Ward Managers and Deputy Ward Managers. Staffing numbers continue to be a challenge, recruiting and retaining staff who can care coordinate and this is specifically putting mounting pressure on staff and impacting on their wellbeing; a number of Q&S issues arising from this. See attached document for more details: 2.4b MHSOP QSE Minutes 03.10.22.docx **Psychology & Psychological Therapies Quality & Safety Meeting** - dated 5th October 2022 **Rob Kidd** • Safeguarding discussed, briefly touched upon issues of compassion fatigue for staff. Debbie Jones from patient safety presented AMaT and explained the roll-out of AMaT which is due to go live on 7th November 2022, and will be implemented across all HBs across Wales which will include NICE guidance. Noted a further publication by NHS Scotland on The Provision of Digital Therapy. Discussed dignified care, and sexuality and gender; 2 x workshops provided by Stonewall for front-line staff to increase awareness of the common mental health issues for people with an LGB orientation. Time of care, acknowledged waiting lists are lengthy and there are plans in place; waiting lists initiatives to address this. Rob acknowledged several staff accolades within Psychology & Psychological Therapies team. See attached document for more details:

	2.4c Psychology Q&S Minutes and Action Lc **PHARMACY** – dated 16th September 2022 **Victoria Gimson** • Victoria advised pharmacy currently have severe staff shortages, and non-availability of meds. See attached document for more details: 2.4d MH Medicines Management Group M **MH Act** **David Seward** • David advised they are still struggling with rights on wards, and explained they understand the acuity and availability of staff on wards; however, in the last 10 days they have had to refer 2 patients to Welsh Government to appeal their detention (11 in total so far this year) due to patients not being read their rights for 15 days since admission. David advised in some cases patients have not been read their rights for up to 40/50 days. Darren has previously suggested a MH champion on wards, however unsure of the reality of this? David is happy to discuss to try and take this forward. **MHIPC** Not discussed **SUI Steering Group** **Jayne Bell** • Jayne discussed the rapid review of inpatient suicides, and health boards who were present were asked to describe how they are reacting to the rapid review; all other health boards have developed an action plan. Jayne advised Cardiff and the Vale have a safety and stability plan and is not aware if Cardiff and the Vale have a rapid review action plan. Jayne wanted to acknowledge Andrea Sullivan's outstanding presentation on family work report. NRI process needs acknowledgment and response regarding changing guidance on retrospective reporting on unexpected deaths, should this be changed? Also looking at the current process of suspected suicides report and changing its process, due to the real-time suicide surveillance data. Jayne is currently in the process of looking at what to do at next year's collaborative event, and potential themes, all to let Jayne know.
2.5	**Controlled Documents** All "proposed" policy documents for review can be found in the below link: S:\Mental Health\MHCB QSE & Lessons Learned\Ratification Policy Documents

	Mark advised they had met recently to restart our policy management processes, and this will be a monthly/6 weekly meeting known as the Controlled Document Oversight Group, if anyone has any further queries to let Mark know. Each policy document in the proposed folder was reviewed by the QSE group and agreed these will now be approved with the exemption of: • Physical Health Monitoring procedure version 2 • ECT Procedural Guidance working 1.2 • Corporate Policy CRHTT • Corporate Policy CAW Further work and review required on these policies. See attached documents for more details: 
Part 3:	**HEALTH PROMOTION PROTECTION AND IMPROVEMENT**
3.1	**Initiatives to promote health and wellbeing of Patients and Staff** **Patient Stories:** Not discussed
Part 4:	**SAFE CARE**
4.1	**Patient Safety Incidents** Not discussed **Discussion around Critical Action Plans, roles, responsibilities and expectations** Not discussed **Overall Trends** Not discussed **New SIs** Not discussed **RCA/Improvement plans** Not discussed **WG closure form status**

	Not discussed **Regulation 28 reports (of relevance)** Not discussed **Lessons learned process** Not discussed **Thematic review** Not discussed **HYC Stabilisation Programme** Not discussed **Case note audit in inpatient services, feedback from the review conducted by Dr Neil Jones and discussion** Not discussed **VTE (Prevention of Venous Thromboembolisms) risk assessment documentation and HAT (Hospital Acquired Thrombosis) Group** Julia Somerford presented, please see "presentations" section above for further information.
4.2	**Patient Safety Alerts (internal/external)** **New alerts:** Mark acknowledged and highlighted the new patient safety alerts, please see below and attached documents for more details: • ISN 2022 Aug 003 - SGLT2 and Euglycemic Acidosis • PSN057 - Emergency Steroid Therapy Cards • Antibiotic Review Kit (ARK) chart - AWMSG Acknowledgement 4.2a ISN 2022 Aug 003 - SGLT2 and Eugl 4.2b PSN057 - Emergency Steroid Th 4.2c Antibiotic Review Kit (ARK) chart - AWM
4.3	**Key patient safety risks:** **Falls reduction** Kelly Panniers on behalf of Jayne Jennings (AMH) and Julia Somerford (MHSOP) presented their departments recent injurious falls' cases and recommendations, please see "presentations" section above for further information. **Pressure and tissue damage reduction and prevention** Not discussed **Medicines management issues/ incidents/audit findings** Not discussed **Safeguarding – any key issues; action being taken** Not discussed

	Medical devices/equipment issues Not discussed **Blood management** Not discussed
Part 5:	**EFFECTIVE CARE**
5.1	**Monitoring of CB Clinical Audit plan** Bala advised they have submitted an Audit action plan to UHB and identified the local leads for each Audit. Mark and Neil previously agreed they would email the people who have been identified as local leads about this. Bala discussed the progress of SLA (service level agreement) with Cardiology and electrophysiology about ECG's where we need their input in community mental health teams. The SLA has been agreed and Heather Hancock will oversee the implementation along with service manager in the counterpart.
5.2	**Implementation of key NICE Guidance** Not discussed
5.3	**Research and development** Not discussed
Part 6:	**DIGNIFIED CARE**
6.1	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** Not discussed
6.2	**Equality, Diversity and Access** Not discussed
6.3	**Trauma-Informed-Wales-Framework (1)** Robert Kidd discussed the Trauma-Informed-Wales-Framework document, advising the following four defined practice levels: • Trauma-aware approach • Trauma-skilled approach • Trauma-enhanced approach • Specialist interventions The levels describe the different roles that people may have within a variety of contexts and represent a spectrum rather than a hierarchy. Many people affected by traumatic events will need support from different levels at the same time and a person-centred, integrated, interacting system is vital to maximise its effectiveness Rob recognised the MHCB would need to review the framework report and discuss further their response to take forward to the Traumatic Stress Wales Implementation Group. See attached document for more details:

	 Trauma-Informed-Wales-Framework (1).pdf
Part 7:	**TIMELY CARE**
7.1	**Initiatives to improve access to services** Not discussed
7.2	**Performance with national targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** Not discussed
Part 8:	**INDIVIDUAL CARE**
8.1	**National User Experience Framework** **Feedback from surveys – relevant improvement plans** Not discussed
8.2	**Compliments** Not discussed **Complaints** Not discussed **Trends** Not discussed **RCA/ Improvement plans for serious complaints** Not discussed **Ombudsman reports/improvement plans** Not discussed
Part 9:	**STAFF AND RESOURCES**
9.1	**Disciplinary Trends** Not discussed
9.2	**Staffing levels** **Streamline nurses** Not discussed
9.3	**Staff surveys** Not discussed
Sub – group reports	
Part 10:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE:**
10.1	**PPE Audit** Not discussed

10.2	**Did Not Attend Guidance (MHSOP)** Not discussed
Part 11:	**AOB**
	No AOB discussed
Part 11:	**MEETING RECORDING & DATE & TIME OF NEXT MHCB QSE MEETING:** MHCB QSE Meeting Recording - 20th October 2022 **Thursday 15th December 2022 at 09:30am** **DATE & TIME OF NEXT MHCB LESSONS LEARNED MEETING:** **Thursday 17th November 2022 at 09:30am**