



QUALITY, SAFETY AND EXPERIENCE COMMITTEE

**Tuesday 18th April 2017
Corporate Meeting Room, UHB HQ
University Hospital of Wales**

QUALITY SAFETY AND EXPERIENCE COMMITTEE
9am on 18th April 2017
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

Part 1: Items for Action		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Committee held on 21 st February	Chair
5	Action Log	Chair
6	Chair's Action Taken since the last meeting Approval of EQIA for Patients' Property Policy	Oral - Chair
Governance, Leadership and Accountability		
7	Patient Story	MH Clinical Board
8	Mental Health Clinical Board Quality, Safety and Experience Assurance Report	Clinical Board
9	Community Health Council Report	CHC No report
10	Policies for Approval Donation of Organs and Tissues After Death Policy and Procedure	Medical Director
11	Quality Safety and Improvement Framework	Assistant Director Patient Safety and Quality
12	Patient Experience Refreshed Framework 2017-20	Executive Nurse Director
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
13	Patient Safety Solutions Alerts and Notices	Executive Nurse Director
14	Patient Falls Exception Report	Director of Therapies and Health Sciences
15	Her Majesty's Coroner Regulation 28 Prevention of Future Deaths Reports	Executive Nurse Director
16	HIW Unannounced Visits – Update	Executive Nurse Director
17	Corporate Risk and Assurance Framework Update	Director of Corporate Governance
Theme 3: Effective Care		
18	Cancer Peer Reviews	No outstanding reports

**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



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

Theme 4: Dignified Care		
Theme 5: Timely Care		
Theme 6: Individual Care		
Theme 7: Staff and Resources		
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		
19	Learning Disabilities Specialist, Secondary Care and Primary Care Services Commissioning Update	<i>Director of Therapies and Health Sciences</i>
20	Healthy Restaurant and Retail Policy	<i>Director of Therapies and Health Sciences</i>
21	WAO Review of Delayed Transfers of Care in the Cardiff and Vale Health and Social Care Community – Review of Discharges	<i>Interim Chief Operating Officer</i>
22	Welsh Risk Pool Annual Review 2015/16	<i>Executive Nurse Director</i>
23	Minutes from Clinical Board Quality Safety and Experience Sub Committees 1. Clinical Diagnostics and Therapeutics – January and February 2. Mental Health – January and February 3. Primary, Community and Intermediate Care - January 4. Specialist Services – February x 2 5. Medicine – January, February and March and A&E waits in November 6. Surgery – January 7. Children and Women – January 8. Dental – January	<i>Chief Operating Officer</i>
24	Agenda for the Private QSE	
25	Items to bring to the attention of the Board/other Committee	Oral – <i>Chair</i>
26	Review of the Meeting	Oral – <i>Chair</i>
27	Date of next meeting 9am on Tuesday 20 th June 2017	

**UNCONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND
EXPERIENCE COMMITTEE HELD AT 9am ON 21 FEBRUARY 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

Present:

Prof Elizabeth Treasure	Chair / Independent Member – University (up to item 17/016)
Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Margaret McLaughlin	Independent Member – Third Sector
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Angela Hughes	Interim Assistant Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Geoff Walsh (part)	Director of Capital and Estates
Joanne Brandon (part)	Director of Communications (Observer)
Matt Temby (part)	Director of Operations, CD&T
Ruth Walker	Executive Nurse Director
Stephen Coombs (part)	Podiatrist
Steve Curry	Interim Chief Operating Officer
Sue Bailey (part)	Quality and Safety Lead, CD&T

Apologies

Martyn Waygood	Independent Member – Legal
Abigail Harris	Director of Planning
Alice Casey	Chief Operating Officer
Fiona Kinghorn	Acting Director of Public Health
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

Secretariat

Julia Harper

Prior to commencement of the meeting, the Executive Nurse Director, Mrs Ruth Walker, presented the Chair of the Committee, Prof Elizabeth Treasure, with a bouquet and thanked her for her leadership and commitment to the quality and safety agenda. This was Prof Treasure's last meeting prior to taking up a promotion at Aberystwyth University.

QSE 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular new Independent Members, Cllr Susan Elsmore and Akmal Hanuk.

QSE 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted

QSE 17/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/004 MINUTES OF THE COMMITTEE HELD ON 13th DECEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED**. At the request of a new Independent Member, it was agreed to remove part of a sentence from minute QSE 16/219: “.... when the domiciliary care market in Cardiff Local Authority collapsed”.

QSE 17/005 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 16/204 Medicine Clinical Board QSE Report – Discussions were ongoing.

QSE 16/205 CHC Reports – A meeting had taken place and discussions were ongoing.

QSE 16/186 HIW Clinical Governance Review of WHSSC – As this related to action for the Community Health Council and not a member of the Committee, it was agreed to remove the item from the Action Log.

QSE 16/148 Trends and Themes in SIs – A business case had been agreed in principle, but there was a need to identify a source of funding for 2017/18. This was important to prioritise as serious incidents demonstrated a continuing issue with the misidentification of patients.

Action – Mrs Ruth Walker

QSE 17/006 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken between meetings.

**QSE 17/007 PATIENT STORY – CD&T CLINICAL BOARD
“WALKING TO BETTER HEALTH”**

Podiatrist, Mr Steve Coombs presented Diane's story. Diane presented when she moved from England with severe pain in her foot which prevented physical exercise. She was overweight and was in danger of developing Type 2 diabetes. The treatment prescribed was the provision of insoles. This corrected the problems with her posture and she was able to become active because the pain in her foot was eliminated. This one small change had a massive improvement on Diane's health and wellbeing.

Diane's motivation to improve her own health was inspirational and it was hoped that a video of her story would be made in order to share more widely and inspire others.

It was noted that currently only a small number of patients waited longer than the 14 week target for this treatment and overall, the podiatry service was performing well.

It was accepted that collecting patient stories could be improved with more training. This was important as the direct experience of patients needed be used to redesign and improve services.

The Chair thanked Mr Coombs for presenting. The Committee **NOTED** the patient story.

**QSE 17/008 CD&T CLINICAL BOARD
QUALITY, SAFETY AND EXPERIENCE REPORT**

The Chair invited comments and questions:

- The report demonstrated good use of “values into action” being put into practice.
- Asked about recruitment of Welsh speaking staff, it was noted that not many person specifications identified Welsh as essential because of the difficulties of recruitment in general.
- Good engagement with teams was noted, as was the challenge of engaging with medical staff. However, an engagement charter had been agreed with medical staff in radiology.
- In terms of the biggest risks in the Clinical Board, it was noted that challenges remained with IT software, hardware and capital. However, there were mitigating actions being taken to reduce the risk scores. Within a month it was hoped that Cwm Taf University Health Board would be in a position to offer a solution to Telepath. In terms of

PACS, Fuji had asked for a meeting to be postponed. Following the meeting, the next steps could be determined.

- The greater breadth and depth of the quality and safety agenda was welcomed.
- Asked about the momentum for addressing the issue with medicine cupboards, it was noted this topic remained live, but priority was being given to the replacement of the robots in pharmacy.
- Judyth Jenkins was thanked for leading work on nutrition and hydration.
- Some year-end funding had been made available to purchase medical equipment for the Clinical Board.

ASSURANCE was provided by:

- The progress the Clinical Board had made on the range of key quality, safety and patient experience performance metrics and the focus on its integrated governance arrangements. The Clinical Board recognised the key areas of improvement and actions required to further improve the patient experience received.

The Quality Safety and Experience Committee:

- **NOTED** the progress made by the Clinical Diagnostics and Therapeutics Clinical Board to date and its planned actions.
- **APPROVED** the approach taken by the Clinical Diagnostics and Therapeutics Clinical Board.

QSE 17/009 COMMUNITY HEALTH COUNCIL REPORTS

The UHB's response to the CHC's national report "Older People in Community Hospitals: Avoiding Boredom and Loneliness" was received. The Chief Officer had offered to receive any questions on the findings.

The Chair invited comments and questions:

- It was disappointing that the WRVS had ceased to provide a trolley service at UHL. It was agreed to check the long term strategic plan of the WRVS.

Action – Mrs Ruth Walker

- The boredom and loneliness themes were powerful and it was suggested that the UHB's response to the report underplayed the use made of charitable funds to improve services, such as the funding of wifi.
- It was agreed to suggest to the Charitable Funds Committee that the boredom and loneliness themes be used to help determine the allocation of charitable funds.

Action – Mr Martyn Waygood

- It was agreed to receive the UHB's formal response to this report at the next meeting, and then share the papers with the Charitable Funds

Committee. In addition, a progress report would be provided within 6 months to a year.

Action – Mrs Ruth Walker

- A pilot scheme working with volunteers was in operation on ward East 8 at UHL.
- Reducing length of stay would have a positive impact on boredom and loneliness.
- During walkarounds it was noticed that patients in Rookwood and Mental Health was most at risk from boredom.
- It was important to get a clear direction on the role of each ward as this was important for staffing levels and efforts to improve stimulating activities could be promoted on non- acute wards.

ASSURANCE was provided by:

- Current status and future plans were reported through the Quality Safety and Experience Committee.
- The Health Board had considered and formally responded to the Community Health Council.

The Quality, Safety and Experience Committee:

- **RECEIVED** the report issued by the CHC.
- **NOTED** the progress made to provide engagement and activities for patients.
- **NOTED** the challenges identified in providing engaging activities for patients.

QSE 17/010

BLOOD COMPONENT TRANSFUSION POLICY AND PROCEDURE

ASSURANCE was provided by:

- The policy and procedure were based on national guidelines, best practice and regulatory requirements and subsequent recommendations.
- Staff training records, PADR/appraisal.
- External regulatory reporting systems [haemovigilance] and Transfusion Group reports.

The Quality, Safety and Experience Committee:

- **APPROVED** the Blood Component Transfusion Policy and Blood Component Transfusion Procedure
- **APPROVED** the full publication of the Blood Component Transfusion Policy and Blood Component Transfusion Procedure in accordance with the UHB Publication Scheme

QSE 17/011 COMMITTEE WORK PLAN 2017-18

The Executive Nurse Director, Mrs Ruth Walker **AGREED** to set up an induction for the new Independent Members with Assistant Nurse Directors.

Action – Mrs Ruth Walker

ASSURANCE was provided by:

- Inclusion of items identified in the CRAF, Health and Care Standards as well as recommendations from external reports.

The Quality Safety and Experience Committee **APPROVED** the Committee Work Plan for 2017 -2018.

QSE 17/012 REVIEW OF COMMITTEE TERMS OF REFERENCE

ASSURANCE was provided by:

- Regular annual review of the Terms of Reference.

The Quality Safety and Experience Committee **APPROVED** the revised Terms of Reference for the Committee.

QSE 17/013 ANNUAL QUALITY STATEMENT

The Assistant Director, Patient Safety and Quality, Mrs Carol Evans advised of the timetable for the production of the 2016-17 AQS. The timetable for production had been brought forward this year and the AQS needed to be published by the end of June. Prior to this, it would require sign off by Internal Audit. Stakeholder engagement was via the Community Health Council and the Stakeholder Reference Group. Mrs McLaughlin offered to provide further advice on engagement opportunities.

Action – Mrs Margaret McLaughlin

ASSURANCE was provided by:

- The plan of work to support the development of the Annual Quality Statement.

The Quality, Safety and Experience Committee **AGREED** the time frame for the development of the 2016/17 Annual Quality Statement.

QSE 17/014 REVIEW OF OUTSTANDING POLICIES

The report was presented by the Assistant Director, Patient Safety and Quality, Mrs Carol Evans. It was noted that some progress had been made in addressing the number of out of date policies, but there were still 34 out of date policies assigned to the Committee. A member of staff within the team had been identified to project manage this particular staff and to adopt a risk based approach to the work and set priorities.

LIMITED ASSURANCE was provided by:

- The progress that had been made since the last report to the Committee in February 2015.
- The plan to address existing out of date policies.

The Quality, Safety and Experience Committee:

- **NOTED** the progress that had been made
 - **APPROVED** the proposal to work towards a position where all clinical policies were in date.
 - **AGREED** to receive a progress report in September.
- Action – Mrs Carol Evans**

QSE 17/015 NUTRITION AND HYDRATION REPORT

It was noted that this report pulled together the actions identified from several reports. It was agreed that a check would be made of the actions that appeared to indicate they had time-expired. It was also agreed to include an additional column for a status update.

Action – Dr Fiona Jenkins

Concerns were expressed about oral health. Whilst there were pockets of really good practice, this was not evidenced across the UHB. The measure for implementation would be via the next fundamentals of care audit.

REASONABLE ASSURANCE was provided by:

- The status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the management action plan, some of the slippage was due to shared service procurement of the all Wales menu, additional actions were required by nursing teams which they were aware of.
- **WAS ASSURED** that the nutrition and catering committee would keep a regular review of the plan to ensure progress.

At this point Mr Ivar Grey took over as the Chair of the meeting.

QSE 17/016 UPDATE ON HIW ACTIVITY

The Executive Nurse Director, Mrs Ruth Walker explained to new members that Health Inspectorate Wales undertook inspections of the UHB's services. The Committee noted that the UHB was now receiving reports of inspections at primary care and dental facilities as well. The reports following the recent inspections of wards C6 and C7 were now in the public domain.

ASSURANCE was provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the inspections and thematic reviews that had been undertaken.
- **AGREED** that the appropriate processes were in place to address the recommendations.

QSE 17/017 HIW OPHTHALMOLOGY THEMATIC REVIEW

Dr Fiona Jenkins, Director of Therapies and Health Sciences advised that the report had been received at the UHB Eye Care Board and the National Eye Group. The UHB had its own local implementation plan which was being monitored closely. There were overlaps in reports from HIW, the CHC and the National Eye Care Plan and Welsh Government was trying to co-ordinate the findings into one overarching plan.

It was noted that this service was under considerable pressure and had the largest volume of clinic patients. There had been a spate of complaints about the waiting times for appointments and the length of time patients spent waiting in the department before being called in. In addition, concerns had been raised about clinical practice and cancelled appointments. Whilst the waiting time had reduced considerably, there was need to reform the patient pathways.

Correspondence with optometrists was being improved via changes to the PMS system. In addition, the UHB was leading work on communicating with optometrists.

The Committee discussed the position of the eye care liaison officer and noted that the Surgery Clinical Board was trying to identify a recurring source of funding via workforce reconfiguration. In addition, a session was being held in February to further engage with staff and support their feedback.

ASSURANCE was provided by:

- The Inspection report.
- A detailed action plan developed around the recommendations identified in the report.

The Quality, Safety and Experience Committee:

- **APPROVED** the Improvement Plan
- **AGREED TO RECEIVE** an update on progress in September 2017, in particular, the position with complaints about waiting times and cancellations.

Action – Mrs Ruth Walker

QSE 17/018 CORPORATE RISK AND ASSURANCE FRAMEWORK

The CRAF contained the QSE Committee's key risks. The risk around the identification of clinical failures and patterns from information and data sources had been reviewed and reduced. The risk in the neonatal unit had not reduced, but this was expected on completion of the unit's refurbishment.

A number of issues had been identified with blood and Committee queried why this did not feature on the QSE CRAF. The Director of Corporate Governance would be asked to investigate this further.

Action – Mr Peter Welsh

ASSURANCE was provided by:

- Mitigation of the risk was being progressed and was being closely monitored by the Committee.

The Quality, Safety and Experience Committee **NOTED** the Quality, Safety and Experience Committee Corporate Risk and Assurance Framework Update Report and the reduction in the number of extreme risks assigned to the Committee.

QSE 17/019 IS THERE AN INCREASED TOLERANCE OF SUICIDES?

The Executive Nurse Director, Mrs Ruth Walker presented the report that had been specifically requested by the QSE as there had been much discussion about suicide over the years. The question posed was not easy to answer but assurance was provided that the Clinical Board was learning lessons and taking action following investigation of all suicides.

It was not the UHB's experience that the city was experiencing a rising number of childhood deaths due to substance misuse. In addition, the cover available in the Emergency Unit for managing patients on the verge of suicide had improved, but there continued to be delays in the CAMHS provision. Mrs Walker advised the Committee that the deaths of all patients known to the Mental Health Clinical Board were investigated and all interventions were itemised and advised to Welsh Government and the Board. Currently there were a higher than normal number of incidents still open.

With regard to zero tolerance of suicide, it was noted there were views and opinions on both sides as to whether this was a practical. The Mental Health Clinical Board was monitoring the work being undertaken in Manchester.

ASSURANCE was provided by:

- The Clinical Board undertook a full and robust review of all suicide incidents.
- Lessons learned were disseminated widely.

The Quality, Safety and Experience Committee **SUPPORTED** the position taken by the Clinical Board.

**QSE 17/020 REDUCING RISKS TO PATIENTS WITH THE
CHANGEOVER TO THE NEW NEURAXIAL
CONNECTOR**

In the absence of the Medical Director, the Committee accepted the report.

ASSURANCE was provided by:

- The setting up of a Task and Finish group to implement and monitor the introduction of the new neuraxial connector.
- The described work-plan and implementation plan consistent with an All-Wales approach.

The Quality Safety and Experience Committee:

- **AGREED** the continued work of this group and to receive a further update in September 2017, prior to the implementation of the new neuraxial connector with a completed risk assessment.

Action – Dr Graham Shortland

QSE 17/021 LEADING IMPROVEMENT IN PATIENT SAFETY (LIPS)

The Executive Nurse Director, Mrs Ruth Walker presented the report and advised the Committee that good value for money was obtained from the £60k training programme with a positive difference being made through the projects undertaken. So far more than 500 staff had undertaken the training that was based on IHI improvement methodology. Currently there was no identified source of funding for 2017-2018, but it was suggested that the UHB could not afford not to do this as the skills developed were vital for service transformation. It was agreed that this message would be shared with the Board.

ASSURANCE was provided by:

- Outcomes from the previous 3 years of LIPS.
- Individuals and teams already enquiring about future cohorts, including some aligned to BIG 3.
- Presentations at national and international events.
- Interest in the LIPS programme from another NHS Wales organisation and the Health Service of Namibia.

The Quality, Safety and Experience Committee **NOTED** the content of the report and progress made.

QSE 17/022 CLINICAL AUDIT PLAN 2016-17 PROGRESS

In the absence of the Medical Director, the report was presented by the Assistant Director, Patient Safety and Quality, Mrs Carol Evans. It was noted that Clinical Boards had been asked to make a small number of audits their priority. This cycle was being repeated this year and was linked to the UHB's greatest risks. It was important that these audits were more focused, registered and assessed in order to provide the Committee with assurance. It was noted that the Medical Director was monitoring results through the Performance Review process.

LIMITED ASSURANCE was provided by:

- compliance with the clinical audit plan for 2016 -2017

The Quality, Safety and Experience Committee:

- **AGREED** the proposal for the 2017/18 clinical audit plans.
- **AGREED** to receive a progress report in September.

Action – Dr Graham Shortland

QSE 17/023 CARE OF THE DETERIORATING PATIENT (NEWS)

In the absence of the Medical Director, the Executive Nurse Director, Mrs Ruth Walker, introduced the report. It was noted that there were different approaches to managing deteriorating patients across the UHB. There were a variety of models and no one model was in place over a 24 hour period. £70k had been secured to set up a project team to scope current arrangements and to propose the best way forward.

The Quality, Safety and Experience Committee:

- **AGREED** the way forward and to bring back an update on progress in six months (September).
- **DIRECTED** that the project team should come to an objective conclusion having considered all the differing views.

Action – Dr Graham Shortland

QSE 17/024 WARD BATHROOM REFURBISHMENT PROGRAMME

Mr Geoff Walsh, Director of Capital and Estates reported that work was underway on wards A4 and B4. However, ongoing difficulties were being experienced because of the lack of a decant facility, and workers were withdrawn during times of infection outbreak. Ward B5 would be refurbished during the current financial year if access was facilitated. This would be discussed outside the meeting.

Action – Mr Steve Curry and Mr Geoff Walsh

The need for a decant ward and single rooms was reiterated in order to control outbreaks. This would be raised for the Board and the QSE Chair would also write to the UHB Chair.

Action – Professor Elizabeth Treasure

It was **AGREED** to analyse the data to determine whether the new bathrooms had had a positive impact on the number of falls and infections.

Action – Mrs Carol Evans

Refurbishment work was also underway in the x ray reception in collaboration with the RNIB that involved colour coding. The UHB would be gaining one of the first awards for this work from the RNIB.

ASSURANCE was provided by:

- Planned programme of works for ward bathroom replacement based on condition of bathrooms was currently on programme.
- Conversion of bathrooms to wet rooms to meet Equality Act where possible.

The Quality, Safety and Experience Committee **NOTED** the report.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

The following reports were received and noted for information.

QSE 17/025 HIW INSPECTION OF NUCLEAR MEDICINE DEPARTMENT

ASSURANCE was provided by:

- Letter of assurance from Healthcare Inspectorate Wales in relation to the compliance improvement plan on 20-10-16.
- Monitoring of the action plan through the CD&T QSPE sub-committee.

The Quality, Safety and Experience Committee **NOTED** the progress made in relation to the HIW inspection action plan.

UHB 17/026 PATIENT EXPERIENCE: CARERS

ASSURANCE was provided by:

- An overview of key activity being undertaken to support carers in light of the findings from these reports.

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report.
- **AGREED** to maintain the focus on working positively with carers.

**UHB 17/027 MINUTES FROM CLINICAL BOARD QUALITY AND
SAFETY SUB COMMITTEES**

- 1. CLINICAL DIAGNOSTICS AND THERAPEUTICS – SEPTEMBER,
OCTOBER AND NOVEMBER**
- 2. MENTAL HEALTH - DECEMBER**
- 3. PRIMARY, COMMUNITY AND INTERMEDIATE CARE - NOVEMBER**
- 4. SPECIALIST SERVICES – NOVEMBER & JANUARY**
- 5. MEDICINE (AND ACUTE AND EMERGENCY WAITS) – NOVEMBER**

Page 383 – reference to the National Hip Fracture database - length of stay in England was reducing but this was not replicated in Wales. The reason for this would be investigated.

Action – Mr Steve Curry

- 6. SURGERY – SEPTEMBER AND NOVEMBER**
- 7. CHILDREN AND WOMEN – NOVEMBER X 2**
- 8. DENTAL – NOVEMBER**
- 9. WHSSC QUALITY AND PATIENT SAFETY - JANUARY**

In light of the forthcoming disbandment of the Equality, Diversity and Human Rights Sub Committee, it was hoped that the Committee would ensure that engagement and equality issues were given greater attention in the Clinical Boards. It was **AGREED** to bring together the Clinical Board quality and safety Leads to review good practice with regard to minutes.

Action – Mr Steve Curry and Mrs Carol Evans

QSE 17/028 AGENDA FOR THE PRIVATE QSE

**QSE 17/029 ITEMS TO BRING TO THE ATTENTION OF THE
BOARD/OTHER COMMITTEE**

- Urgent need to identify a decant ward to allow ward refurbishment and deep cleaning as well as single isolation rooms. This was an ongoing issue.
- LIPS – The UHB could not afford not to continue doing this training as the skills developed were vital for service transformation and were good value for money.

QSE 17/030 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/031 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 18th April 2017.

ACTION LOG FOLLOWING QSE COMMITTEE FEBRUARY 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 16/204 QSE 17/005	13.12.16 21.2.17	Medicine Clinical Board, Quality Safety & Experience Report	1	For the Medicine CB to work with the A Casey on Length of Stay project	R Evans and A Casey	This work is on-going and is being taken forward through the In-Patient sub-group of the USC Programme Board
QSE 16/192	18.10.16	Critical Care Outreach Team (Identifying and Managing the Deteriorating Patient)	3	Clinical Model for managing the deteriorating patient to be agreed. Discuss at Management Executive the options for strengthening on site clinical and managerial support. Finalise ongoing shape and purpose of services at UHL through the acute medicine review with the Planning Team.	R Walker and Dr Dr G Shortland S Curry S Curry	Dec 2016 – meeting had been held and progress being made with an outline plan. Actioned – Lead Role out to advert Planning Team continue to work on this
QSE 15/171 QSE 16/148 QSE 17/005	20.10.15 13.9.16 21.2.17	Trends and Themes in Sis	4	Revisit decision on patient wristbands.	R Walker	Feb 2017 - Solution agreed but funding yet to be identified for 2017/18.
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness	5	Check WRVS long term strategy for trolley service.	R Walker	Despite effort, clarity on the WRVS position is unclear.

5

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/011	21.2.17	Committee Work Plan	6	Set up induction for new QSE IMs with Assistant Nurse Directors	R Walker	Carol Evans preparing a draft programme
QSE 17/013	21.2.17	Annual Quality Statement	7	Provide advice on stakeholder engagement opportunities	M McLaughlin	
QSE 17/023	21.2.17	Care of Deteriorating Patient	8	Ensure all differing views are taken into account when scoping the way forward	Dr G Shortland	
QSE 17/024	21.2.17	Ward Bathroom Refurbishment	9	Write to UHB Chair about the urgent need for a decant ward and single rooms. Analysis of comparative data – new bathroom effect on falls and infection rate.	Prof E Treasure C Evans	
QSE 17/027	21.2.17	Medicine QSE Minutes	10	Investigate reason why length of stay (National Hip Fracture database) had reduced in England but was not replicated in Wales.	S Curry	
QSE 17/027	21.2.17	Sub Committee QSE Minutes	11	Bring together the Clinical Board quality and safety Leads to	C Evans	Carol Evans will be attending the Directors of Nursing weekly meeting in April to discuss.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				review good practice with regard to minutes.		
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/215	13.12.16	Mortality Data and Mortality Review	12	To include in next report the mortality/death rate differences between weekends compared to other times	Dr G Shortland	QSE June 2017
QSE 15/135 QSE 16/006	01.09.15 23.2.16	Corporate Risk and Assurance Framework Exception Report -	13	Business Case for Critical Care Outreach (CCO) and Hospital at Night to be considered at Investment Panel.	A Casey changed to S Curry	December update: Awaiting funding for Advanced Nurse Practitioners to address Hospital at Night
QSE 16/202 QSE 17/023	13.12.16 21.2.17	Care of the Deteriorating Patient : Critical Care Outreach Service		Need to resolve Critical Care Service issues at UHL.	Dr G Shortland / S Curry	February 2017 - Reported to HSMB in December that more work was required to make the plan resource neutral. Update agreed for September 2017
QSE15/016 QSE 15/04 QSE 16/006 QSE 16/049 QSE 16/059 QSE 16/129 QSE 16/186 QSE 16/200 QSE 16/209 QSE 17/014	10.2.15 21.4.15 23.2.16 19.4.16 13.9.16 18.10.16 13.12.16 21.2.17	Review of Outstanding Policies	14	Discuss reinstate and reconstitution of the Policy Task and Finish Group with Dr Turley. Out of date policies received in February 2017. Update to be provided in September 2017 with timeframe for	C Evans C Evans	QSE September 2017

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				each policy amendment		
QSE 17/017	21.2.17	HIW Ophthalmology Thematic Review	15	Progress report including complaints on waiting times and cancellations to be received in September	R Walker	QSE September 2017
QSE 17/020	21.2.17	Changeover to new neuraxial connectors	16	Update report to be received in September with risk assessment.	Dr G Shortland	QSE September 2017
QSE 17/022	21.2.17	Clinical Audit Plan	17	Update report to be received in September	Dr G Shortland	QSE September 2017
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness	18	Receive an update in 6 months to a year.	R Walker	QSE September or December 2017
COMPLETED ACTION SINCE LAST MEETING						
QSE 16/053 QSE 16/129 QSE 16/186	19.4.16 13.9.16 18.10.16	HIW Clinical Governance Review of WHSSC	19	Further discussion between WHCCS and HIW.	S Allen	This action was being removed as it was not for a Member of the Committee.
QSE 17/015	21.2.17	Nutrition and Hydration Report	20	Insert additional column for status update and check timescales	Dr F Jenkins	Additional column inserted and will be used in future reporting to Nutrition and Catering Committee. Complete
QSE 17/010	21.2.17	Blood Component Policy	21	Publish on website and highlight strengths of the EHIA.	J Harper	Complete
QSE 16/026 QSE 16/048	23.2.16 19.4.16	Care for Patients with a Learning	22	Discuss a process for the review of deaths of	C Evans	Such deaths will be identified during Mortality Reviews.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Disability		patients with learning disabilities.		Complete
QSE 17/018	21.2.17	CRAF	23	Check why Blood was not featuring on QSE CRAF.	P Welsh	Blood is contained in 6.8 and 6.9.1 (IT systems) and comes under PPP Committee. Also in 5.1 Safe and Effective Care which comes under QSE with a score of 12. Complete
QSE 16/107	28.06.16	Primary Care General Medical Services and Dental Governance	24	To look at decontamination process and queries raised	C Evans	This is being taken forward by the Deputy Director of Therapies and Health Sciences through the Decontamination Group. Complete
QSE 16/107	13.12.16	HIW Practice Inspection Update		To take forward to Decontamination Committee	F Jenkins	
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness	25	Ask Charitable Funds Committee to consider boredom and loneliness as a criterion for allocating funds.	M Waygood	Considered at the CF Committee on 21 st March 2017 and agreed in principle. Complete
QSE 16/203	13.12.16	Learning Disabilities Specialist, Secondary Care & Primary Services	26	To bring update on ABMU provision for service	Dr F Jenkins	The team stated there was lack of understanding of quality of service being delivered and due to the concerns had been escalated. On April 2017 agenda - Complete
QSE 17/024	21.2.17	Ward Bathroom Refurbishment	9	Discuss access to ward B5 in order to start work before the end of March	S Curry	Complete

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 16/205 QSE 17/005	13.12.16 21.2.17	Community Health Council Reports	2	To raise issues at next meeting with CHC on Ty Hyfryd, The Day Rooms and Maintenance Schedule	R Walker and A Harris	A meeting had taken place on 9 th March but discussions were ongoing. CLOSED

MENTAL HEALTH CLINICAL BOARD QSE ASSURANCE REPORT	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting	18 April 2017
Executive Lead :	Executive Nurse Director
Author :	Director of Nursing, Mental Health Clinical Board Tel 029 2182 4997
Caring for People, Keeping People Well :	This report underpins the Health Board's strategy of 'home first', delivers outcomes that matter, is a service priority, is sustainable and embraces the values of the organisation.
Financial impact :	Nil
Quality, Safety, Patient Experience impact:	This report provides assurance on a range of quality, safety and experience issues and is aligned with the Health and care Standards focusing on what we are doing in relation to our governance arrangements, promotion of health, delivery of safe and effective and dignified care, as well as how we are improving access to services and managing our staff and resources.
Health and Care Standard Number:	1.1, 2.1, 2.3, 2.4, 2.5, 2.6, 2.7, 3.1, 3.2, 3.3, 3.5, 4.1, 5.1, 6.1, 6.2, 6.3, 7.1
CRAF Reference Number	
Equality and Health Impact Assessment Completed:	No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The operational leadership and management tone of the Clinical Board is to have an open and transparent Multi Disciplinary Team (MDT) approach to core business and processes
- Regular performance management
- Openness to learning and development

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the actions being taken by the Mental Health Clinical Board.

SITUATION

This report has been prepared to provide assurance to the Committee that Quality, Safety and Patient Experience is at the heart of the delivery of services to the mental health services users within Cardiff and Vale UHB. This report describes the activity of the Mental Health Clinical Board over the last year. The Mental Health Clinical Board links very clearly with the 'home first' strategy of the UHB, with community facing services supporting around 5000 individuals and supports individuals to participate as fully as possible in making choices that direct their own care moving toward recovery.

BACKGROUND

The Mental Health Clinical Board works collaboratively with partners in delivering services to the most vulnerable people in our society. It is essential that alongside service strategic plans the quality, safety, patient experience and effectiveness of services is of the highest standard. The Clinical Board is continuously trying to improve quality within a positive risk management culture to promote recovery.

ASSESSMENT AND ASSURANCE

Governance, Leadership and Accountability

The Clinical Board meets on a monthly basis as part of the quality, safety and experience arrangements. There are two set agendas with each being met on a bi-monthly basis. The first is the standardised agenda that follows the Health and Care Standards with the Directorate Management Teams and heads of profession attending, and the second agenda is a 'Lessons Learnt' agenda where recommendations following Serious Incident investigations are discussed and cascaded to all bands of staff. The Lessons Learnt meeting is open to all/any staff that wish to attend and is very well attended by the MDT. Terms of Reference are in place for the Quality Safety and Experience (QSE) sub committee.

The Clinical Board has made good progress against the Health and Care Standards 2016/2017 and took the approach of identifying 2-3 key areas for each standard. An action plan was developed to support the improvement of these key areas and is monitored through the Clinical Board QSE and also via the Clinical Board committee.

The key risks identified on the risk register are:

- Patient flow – the Complex care and Commissioning Team is being enhanced to better manage Delayed Transfers of Care in the inpatient service as the Clinical Board has a higher than average length of stay (in Wales) and more timely step down in community placements. This will include a minimum of annual monitoring of commissioning arrangements with private providers, care co-ordination of patients in high and medium secure placements, monitoring of care plan delivery in line with assessed needs and a more robust plan identifying the patient pathway.
- Nursing establishments for some inpatient areas do not comply with Working Time Regulations and the UHB Meal Break policy. The Clinical Board is participating in the All Wales mental health nurse staffing project to develop a bespoke tool to marry professional judgement and indicators of quality of care to appropriate staffing levels. The next data collection exercise for 100% of inpatient wards is later this month.
- Staff are exposed to high levels of violence and aggression – staff are trained in accordance with the All Wales Violence and Aggression

Passport and all inpatient staff receive SIMA (Strategies and Interventions to Manage violence and Aggression) training on an annual basis and all community staff receive Breakaway training. The Clinical Board is the only Board in Wales to follow best practice and only use supine restraint.

- Smoking – mental health services are not subject to the same legal requirement not to smoke in public areas as the rest of NHS services. The Clinical Board has held discussions with service users and staff to work towards mental health service users being supported to stop smoking whilst in hospital. This will not be without risk, i.e. service users may well try to hide their smoking activity and staff will need to be more vigilant until the ban beds in.

Staying Healthy (Theme 1)

The Clinical Board has increased the availability of self help groups and self help literature through the Primary Mental Health Support Service (PMHSS). PMHSS is an age blind service that aims to assess individuals referred within 28 days, and to commence short term treatment, where appropriate, within a further 28 days. Information related to health promotion, protection and improvement is accessed via the Stepiau website and includes:

- Self help literature – 23 self help leaflets are available in both English and Welsh covering a range of issues such as alcohol and you, anxiety, eating disorders, self harm, hearing voices, PTSD, sleep problems, prisoner anxiety etc. Websites such as moodjuice and living life to the full, the exercise referral scheme and the book prescription scheme are also promoted.
- Local services – links to Dewis Cymru and cavamh
- NHS support – via services such as PMHSS, Primary Care Counselling services and NHS Veterans
- Drop In – Stress Control and ACT-ion for Living courses are available on a rolling programme – no referral is necessary
- Therapeutic Groups – Live Life to the Full, OCD, Anger management, Mindfulness for wellbeing and Healthy Minds specifically for refugees and asylum seekers
- Other support services contact details such as CALL, Samaritans, Mind, Silver Line, Meic Cymru or NHS Direct.

Mental Health services have an exemption to the no smoking policy for the UHB; however, the Clinical Board has commenced a piece of work using the same health principles for the whole of the UHB population. The aim is to pilot a reduction in service users smoking over a 3 month period in June/July 2017.

The Clinical Board improved upon the staff Flu vaccination rate this year, increasing the number of flu champions and through promotion at the staff health and wellbeing day held in the autumn.

Safe Care (Theme 2)

Health Inspectorate Wales (HIW) undertook an unannounced visit of three MHSOP wards based in UHL in February 2016. On receipt of the inspection report the Clinical Board and MHSOP Directorate placed itself into 'Supportive Administration' and received additional support and scrutiny from the Executive team in developing and delivering the action plan against the HIW recommendations for improvement. The actions have been / are being delivered within the timescales set.

HIW revisited MHSOP and also reviewed adult services in March 2017. The written report has not yet been received; however, the verbal feedback was that excellent progress had been made.

Mental health services work with a client group that often exhibits high risk behaviours. As a result, 62 Serious Incidents (SIs) have been reported to Welsh Government this year.

Report Run 30.03.17	Administrative Processes (excluding documentation)	Behaviour	Behaviour (including violence & aggression)	Patient Accidents/ Falls	Therapeutic Processes (except medication errors)	Unexpected Deaths or severe self harm	Total
Adult Mental Health	8	27	1	2	1	11	50
MHSOP	0	0	0	12	0	0	12
Total	8	27	1	14	1	11	62

There have been 2 major SI's in adult inpatient services; one sadly resulted in a death with the other resulting in a patient that is significantly physically compromised. The key issues around these two incidents related to resuscitation where, despite the high percentage of staff trained in Basic Life Support (over 75% of nursing staff), the lack of task familiarity played a part in rescue breaths / non re-breathe masks being utilised. The Resuscitation service has reviewed the BLS training provided by mental health trainers and is assured that the training is accurate and delivered appropriately and confirmed that they believe the issues to be one of task familiarity.

In MHSOP, the Serious Incidents relate to injurious falls. As a result of this, the Clinical Board has developed bespoke falls training which the nursing workforce of the MHSOP Directorate is currently completing. Much of the training is experiential and is evaluating well. The training has also been presented at the All Wales Community of Practice for MHSOP.

A trend identified following review of medication errors was that the majority of staff were new or relatively newly qualified nurses. A focus group was held with a newly qualified staff. There was recognition that they felt unprepared to administer medication in a busy, noisy inpatient area. To address this issue, the Clinical Board has developed a bespoke induction programme for new starters that includes specific training around pharmacology and medication administration for both adult and MHSOP service users.

Incidents of physical violence against staff per 100,000 occupied bed days is 361 – the highest reported in Wales, with the mean average being 207. The Clinical Board will compare this data with other inner city Health Boards/Trusts for greater benchmarking relevance. The Clinical Board has encouraged a culture of reporting incidents and the UHB is the only mental health service in Wales to undertake face up restraint in line with best practice guidance.

The Clinical Board has 13 patients subject to Safeguarding investigations. Three of these are currently in the Criminal Justice system and a further where a member of staff is under disciplinary investigation for conduct.

Referral rates to the adult Community Mental Health Teams (CMHT) continue to increase placing pressure on the teams in relation to duty work for emergency and urgent referrals. This impacts upon the ability of the teams to provide psychologically based interventions to patients on their case load and also in the team's ability to release staff to the Psychological Therapy Hub. A review of adult community services has commenced to look at demand and capacity in line with service delivery models.

Effective Care (Theme 3)

The Clinical Board has established a 'Psychological Therapies Hub' as a virtual hub of expert practitioners providing and supervising the provision of a suite of evidence based psychological interventions to individuals in primary and secondary mental health care. This Hub encourages any interested staff to participate and receive protected time to deliver expert practice.

Following the establishment of the MHSOP RAID Liaison multi-disciplinary team to provide mental health / dementia support to District General Hospital (DGH) wards, there has been further investment from the Welsh Government to fund a support worker team. This will provide assessment, advice and practical support to DGH wards in an effort to reduce patient flow delays and improve the quality of services to dementia patients.

The audit plan has been developed to tie in with Service and & Intermediate Term Plan (IMTP) priorities, in response to Serious Incidents and HIW investigations/reports and to assess our compliance with external guidelines e.g. Royal College directives, NICE guidelines etc. We use the findings to influence our QSE agenda and use the QSE agenda to formulate our plan. The Clinical Board will have a new audit lead later this year.

The Clinical Board has initiated an academic/clinical research and development (R&D) steering group and a neuropsychiatric/genetics MDT that both meet bi-monthly, both supporting enhanced opportunities for R&D to influence service developments, education and training. An annual R&D and Innovation day has been initiated jointly with the academics to discuss new ideas, share good practice and contribute to service transformation plans and the IMTP e.g. in developing the First Episode Psychosis and ASD services.

We have looked at other services and our own and learnt that there is a general appetite for increasing R&D in the clinical service supported by an 'opt out' approach to service users being offered R&D opportunities; we are working through this jointly with the academics at present.

Dignified Care (Theme 4)

Dignity/Essential care inspections carried out this year have not identified any significant issues specifically related to dignity. Following the HIW report for the February 2016 inspection a comprehensive action plan was developed and implemented. HIW returned in March 2017 and verbal feedback following inspection of five mental health wards was excellent. The MHSOP Directorate is aiming to have 100% of their staff trained in the Continence Bundle later this year. The MHSOP Directorate is currently working through the Kings Fund Dementia Audit for each of its wards.

The UHB values underpin and are woven through the 'in-house' training offered to mental health staff and the bespoke induction offered to Healthcare Support Workers and newly appointed registered nurses specifically considers dignified care.

Hafan y Coed opened in April 2016 with all rooms having en suite bathrooms. Each service user is provided with an electronic bracelet that opens their bedroom and room safe; this ensures only they and the nursing staff can access their bedroom. The rooms are also serviced by the Reassurance Observation System which allows staff to observe service users to ensure their safety without having to enter their room. Service users have access to a secure garden enabling access to fresh air and all wards are accessible to those with mobility problems. Each ward has at least one bedroom accessible for wheelchair users.

Timely Care (Theme 5)

The Clinical Board submitted successful costed plans against available Welsh Government recurrent funding in the areas of Peri-Natal mental health, psychological therapies, older people's liaison teams into DGHs (RAID model) and first episode psychosis (FEP) in conjunction with Child and Adolescent Mental Health) CAMH services.

A new service model has been completed for a single point of referral for all primary care mental health services with primary care agreement – for full implementation in April 17 following a reduction in waiting lists for primary care counselling services. The objective is to simplify access for GPs, helping people more quickly and reducing demand on specialist services.

The adult community services have piloted, with a positive evaluation, a Peer Support Worker project with lived experience of mental illness to support the discharge of appropriate service users back to community support services from specialist services.

The MHSOP LPOP/RAID dementia services to the DGH wards has commenced with the expectation that the new Welsh Government funded Flexible Hospital Resource Team will complement this. The aim is to prevent unnecessary admissions to DGH beds, reduce length of stay where admission is necessary and provide training and support for DGH staff.

The Clinical Board has a number of services users who are Delayed Transfers of Care. A variety of initiatives are underway to address this issue:

- Support has been attained from the Head of Integrated Care to review current processes and has successfully reduced the number of delays, particularly in MHSOP.
- Planned expansion of the Complex Care and Commissioning Team to support the DST process and step down in community placements.
- Joint funding panels with the Local Authority.

Individual Care (Theme 6)

Work is ongoing to develop 'mental health friendly' service user feedback questionnaires as the national surveys do not provide meaningful data to support our services. There will be four questionnaires aimed at adult inpatient, adult community, older person's inpatient and older person's community services. The Clinical Board will utilise the volunteer workforce to support inpatients to complete the questionnaires as the current response rate is poor.

The current inpatient responses tend to cluster into not wishing to remain in hospital (many service users are detained under the Mental Health Act 1983), having helpful staff, not seeing enough of their consultant and being bored. The last point is being addressed via the Activity Nurse Team in Hafan y Coed and the Refocussing Nurses in MHSOP.

MHSOP have developed a support group for carers, Ican, which offers a weekly social activity away from the inpatient ward for carers to meet and support each other and form new social networks, as it is recognised that caring for a loved one with dementia can be very isolating. Carer groups are also run on a monthly basis on each ward.

The inpatient services provided at Hafan y Coed and the MHSOP at UHL all provide access for disabled service users/carers. This is not the case for 3 of our Community Mental Health Teams where disabled access is challenging. The Clinical Board has concentrated its effort on sensory loss this year, specifically hearing loss, and has invested in more Loop systems and has implemented a specific email address for those individuals with hearing loss who are seeking help.

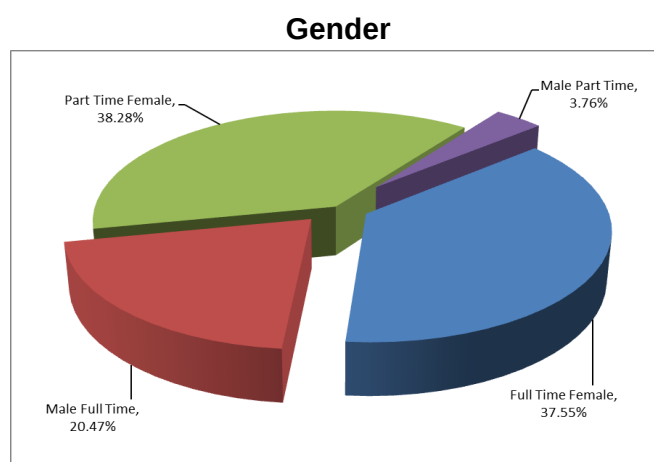
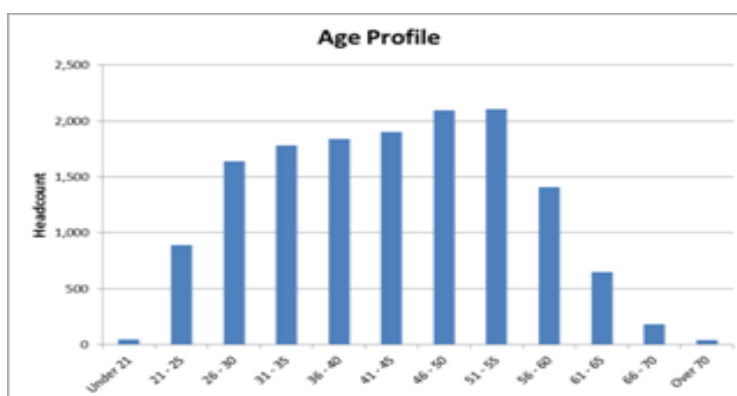
The Clinical Board has received 172 concerns during the past year. Very few are managed informally and training has been provided to managers to increase this; however, it is recognised that many of our service users are unwell at the time they raise their concern and that informal resolution is not

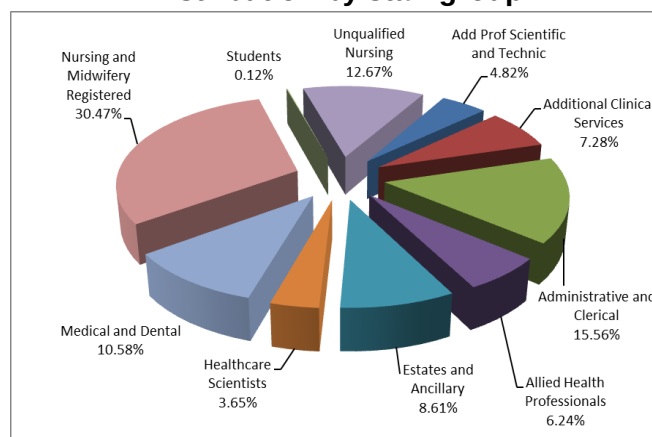
an option. The main theme for MHSOP relates to injurious falls, and as previously mentioned, bespoke falls training is being implemented across the Directorate to minimise the number of falls.

In adult services, the themes across community and inpatient services relate to two main areas - communication and concerns about medical treatment. A comment by one of our service users was that 'when I am well I can see my consultant in out-patients, whereas when I am unwell, I can't get an appointment and have to see a duty worker who can't amend my medication.' This specific point is being addressed as part of the adult community service review.

Staff and Resources (Theme 7)

The workforce profile is as shown below:



Distribution by staff group

Work is ongoing nationally to look at safe staffing for mental health inpatient areas. The Clinical Board has participated in several pilot data capture exercises looking at current staffing levels, professional judgement (what is required for that shift) and is developing a tool to triangulate this against quality indicators, such as levels of observation, escorts, untoward incidents etc. The Clinical Board will participate in the next data collection exercise for 100% of inpatient areas across Wales, with feedback from this data collection being presented at a conference in September.

Locally, the Clinical Board utilises temporary staffing to support inpatient and some community areas when required. The Clinical Board has not utilised off contract agency since October 2016. Recruitment can be a challenge due to the number of Registered Mental Health Nurses available nationally, although the Clinical Board is doing better than other areas in Wales, with 90% of band 5 positions being filled. Recruitment is undertaken on a quarterly basis and the Board also runs a successful Accelerated Development programme for newly qualified nursing staff. The Clinical Board has also led, with the support of the Executive Nurse Director, the project for Nurse Benefits to support the UHB recruitment challenge with the website now live.

To engage more fully with staff, the Clinical Board publishes a quarterly newsletter which outlines service changes, celebrates staff/team successes, promotes health and wellbeing etc. The Board also hosted a Garden Party to welcome the rest of the UHL site into Hafan y Coed and conducted its own ward Christmas decoration competition. The Clinical Board has utilised the LIPS (leading improvement in patient safety) programme every year and this year has a project looking at age based services versus needs based services.

APPROVAL OF DONATION OF ORGANS AND TISSUES AFTER DEATH POLICY**Name of Meeting** Quality, Safety and Experience Committee**Date of Meeting** 18 April 2017**Executive Lead:** Chair of the Organ Donation Committee**Author:** Clinical Lead for Organ Donation Tel 029 2074 8004

Caring for People, Keeping People Well: This report underpins the Health Board's strategy for delivering outcomes that matter to people both for patients at the end of life and their families and for those people awaiting transplantation to manage organ failure.

Financial impact: not applicable

Quality, Safety, Patient Experience impact: These documents improve the quality of treatment and care for patients at the end of life ensuring that their decision regarding deceased organ donation is supported. It also enhances the safety of decision making at the end of life and aims to support patients and their families to ensure that their experience is the best that it can be in difficult circumstances.

Health and Care Standard Number 3.1,3.2,4.1,6.2**CRAF Reference Number** 5.1**Equality and Health Impact Assessment Completed:** Yes**10.1****ASSURANCE AND RECOMMENDATION****ASSURANCE** is provided by:

- The document adheres to the Human Tissue and Transplantation Act 2013 (Wales)
- The documents comply with good practice guidance of the General Medical Council; Treatment and care towards the end of life.
- The documents support clinical practice in line with National Institute for Clinical Excellence Clinical Guideline 135
- The documents support professional practice in line with guidance from the Royal College of Emergency Medicine for end of life care and certification of death and decision making around withdrawal of treatment from the Academy of Medical Royal Colleges.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Donation of Organs and Tissues After Death Policy
- **APPROVE** the full publication of the Donation of Organs and Tissues After Death Policy in accordance with the UHB Publication Scheme

SITUATION

Following the implementation of the Human Transplantation Wales Act 2013 the UHB requires an updated Donation of Organs and Tissues After Death Policy that adequately supports healthcare workers in the application of the Act in patients at the end of life with the potential to donate organs and tissues. The previous policy has also been revised to ensure it is in keeping with the standardized format of the UHB.

The Donation of Organs and Tissues After Death Policy supports the UHB Strategy as it will deliver choices to people at the end of life regarding how their organs and tissues are used after death and ensure that patients suffering from organ failure who would benefit from organ transplantation are more likely to receive that treatment by increasing the availability of organs. This will result in delivery of outcomes that matter to people in our population.

BACKGROUND

Despite considerable progress in the processes of donor identification and retrieval of organs and tissues after death there remains a shortfall in the number of organs available for transplantation. In Wales this is being addressed by a change in legislation which seeks to change the default position of the community as a whole to one which considers organ and tissue donation after death a normal part of end of life care. This has led to a change in the law surrounding consent for organ donation.

This updated version of the Donation of Organs and Tissues After Death Policy and the supporting Procedure document sets out how this legislation can be put into practice by healthcare workers at the UHB.

ASSESSMENT

Wide consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 3/3/2017 and 03/04/2017;
- The document was shared with the UHB Ethics Committee in February 2017.
- Comments were invited via individual e-mails from Clinical Leads in Unscheduled Care, Critical Care and Theatre Services.
- No alterations to the documents were required subsequent to this consultation period on the intranet and with key stakeholders.

The primary source for dissemination of the Donation of Organs and Tissues After Death Policy and supporting Procedures within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

10.1

Reference Number: 110 Version Number: 1 <i>unless document for review</i>	Date of Next Review: <i>To be included when document approved</i> Previous Trust/LHB Reference Number: 110
Donation of Organs and Tissues after Death Policy	
Policy Statement To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that organ and tissue donation is considered a usual part of end of life care, that all patients with the potential to donate organs or tissues are supported by appropriately trained medical and nursing staff, ensuring that both the patient and their families are able to make the decision regarding donation after death that is right for them and to ensure that if they wish to become an organ donor they are supported in doing so.	
Policy Commitment The Health Board is committed to ensuring that organ and tissue donation is considered a usual part of end of life care. All patients meeting criteria set out in the NICE guidelines are referred to specialist nurses for organ donation in order to assess their potential to donate and their recorded decision on the NHS Organ Donor Register. Family members are approached in line with the good practice set out in national guidelines.	
Supporting Procedures and Written Control Documents This Policy and supporting procedures describe the following with regard to donation of organs and tissues after death: • Identification and referral of potential organ donors • Best practice in approach to families of potential organ donors • Establishing consent to proceed with donation after death Other supporting documents are: • UHB Donation of Organs and Tissues After Death Procedure • National Institute Clinical Excellence (2011) Organ Donation for transplantation: improving donor identification and consent rates for deceased organ donation. • NHSBT Best practice guidelines: Approaching the families of potential organ donors • Academy of Medical Royal Colleges (2008) Code of Practice for the diagnosis and confirmation of death. • The Human Tissue Authority The Human Transplantation (Wales) Act 2013 • The Human Transplantation (Wales) Act Code of Practice	
Scope	

10.1

Document Title: <i>Insert document title</i>	2 of 2	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

This policy applies to all of our staff in all locations including those with honorary contracts and covers deceased solid organ and tissue donation.

Equality and Health Impact Assessment	<i>An Equality and Health Impact Assessment (EHIA) has been completed. The EHIA completed for the policy found there to be negative and positive impacts. The results of this assessment can be reviewed in the EHIA for the Donation of Organs and Tissues after Death Policy and Procedure together with an action plan which addressed the issues.</i>
Policy Approved by	Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Cardiff and Vale UHB Organ Donation Committee
Accountable Executive or Clinical Board Director	Medical Director
<u>Disclaimer</u> 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 <u>Governance Directorate.</u>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA [To be inserted by the Gov. Dept]	<i>Donation of Organs and Tissues after Death Policy Reference Number 110 is superseded by this document. The main amends reflect changes in Welsh Legislation surrounding consent for deceased donation to take place. The medical treatment and care of the patient by UHB nursing and medical staff remains unchanged. Furthermore the documents are presented as separate policy and procedures documents in line with the template provided by the UHB.</i>

Reference Number: TBA Version Number: 1		Date of Next Review: April 2020 Previous Trust/LHB Reference Number:
Deceased Organ and Tissue Donation Procedure		
Introduction and Aim This document supports the UHB Policy on Organ and Tissue Donation after Death. It provides guidance for medical and nursing staff at Cardiff and Vale UHB caring for patients with potential to become organ donors at the end of life. The Human Transplantation Act (Wales) 2013¹ has led to a change in how consent for organ donation can be determined and this procedure supports medical and nursing staff in its application. The overall aim of the procedure for deceased organ and tissue donation is to ensure best practice is followed in order that at the end of life a patient's decision with respect to organ donation is appropriately explored and their decisions are supported.		
Objectives • All patients are considered for organ donation as a usual part of end of life care.² • All patients at the end of life who meet minimum notification criteria³ (NICE Guideline) are referred to the specialist nurse for organ donation. • The family of all patients with the potential to become an organ donor are approached in accordance with the best practice guidelines⁴. • The decisions of all potential patients are determined by accessing the NHS organ donor register⁴. • Consent for organ donation is explored using the criteria set out in the Code of practice⁵. • Potential organ donors who have consented to proceed are managed according to clinical guidelines.		
Scope This procedure applies to all of our staff in all locations including those with honorary contracts and relates to all patients at the end of life who have the potential to donate solid organs or tissues after death.		
Equality and Health Impact Assessment	<i>An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found there to be negative and positive impacts. The results of this assessment can be reviewed in the Equality and Health Impact Assessment for Donation of Organs and Tissues after Death Policy and Procedure.</i>	
Documents to read alongside this	<i>Donation of Organs and Tissues after Death Policy</i>	

Document Title: <i>Insert document title</i>	2 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Procedure	
Approved by	Quality Safety and Experience Committee

Accountable Executive or Clinical Board Director	<i>Organ Donation Committee</i>
Author(s)	<i>Clinical Lead for Organ Donation Specialist Nurse for Organ Donation</i>
<u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.	

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
	<i>Date of Committee or Group Approval</i>	<i>TBA</i>	<i>Donation of Organs and Tissues after Death Policy Reference Number 110 is superseded by this document. The main amends reflect changes in Welsh Legislation surrounding consent for deceased donation to take place. The medical treatment and care of the patient by UHB nursing and medical staff remains unchanged.</i>

Document Title: <i>Insert document title</i>	3 of 22	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

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1.0 Introduction

1.1 Clinical teams often experience a conflict between providing medical care and compassion to patients at the end of life and their families and society's need to procure donor organs for transplant. This document sets out the guidance for the clinical team to ensure that they work within accepted national professional best practice guidance and the law.^{1,2,3,4,5,6,7,8,9}

1.2 It is known that a significant proportion of people in the UK wish to donate their organs after death for the purpose of transplantation¹⁰. However it is a complex process not least because the majority of potential organ donors do not have the capacity to be directly involved in the decision-making².

1.3 It is recognised that the potential donor can be located in any part of the hospital although it is most likely that they are in an intensive care unit or emergency unit. This procedure is relevant to all patients at the end of life irrespective of their location in the hospital.

1.4 This guidance pertains to both donation after cardiac death and donation after brain death. Specific differences between the two processes are clearly stated when necessary.

1.5 This guidance refers to all patients irrespective of age. However there are some specific differences in paediatric practice not least with reference to the HTA Wales 2013¹ and a paediatric organ donation policy is under development.

10.1

2.0 Identification of the potential donor

2.1 Organ donation should be considered as a usual part of end of life care^{3,4,8}. It is recognised that the early identification of potential donors will ensure that the patient and their families are given the best level of support and ensure that donation takes place in a timely fashion.

2.2 NICE Clinical Guideline 135⁴ offers detailed guidance regarding the clinical situations that should lead to initial discussions with the specialist nurse for organ donation. This ensures that a systematic approach is followed for referral to the specialist team, enabling earlier referral and reducing the risk of missing a potential donor.

2.3 In line with these recommendations all patients who fulfil the following criteria, known as **minimum notification criteria** should be referred to the specialist nurse. All treatment and interventions should continue at this stage.

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- Clinical trigger factors in patients who have had a catastrophic brain injury are:
 - The absence of one or more cranial nerve reflexes
 - Glasgow Coma Score of 4 or less that is not explained by sedation
- The intention to withdraw life-sustaining treatment in patients with life-threatening or life-limiting conditions, which will or is expected to result in circulatory death.

2.4 Decision to withdraw life supporting treatment (WLST): the decision to withdraw treatment in a patient must be made by at least two consultants with knowledge and understanding of the General Medical Council guidance regarding good decision making in treatment and care towards the end of life.^{3,8}

3.0 Referral of potential donor to the specialist nurse for organ donation (SNOD)

3.1 This section describes the process for referring patients to the SNOD following identification of the potential to donate as outlined above.

3.2 The consultant in charge of the patient's care or their deputy, including junior doctor or nursing staff, refers the patient to the resident SNOD or the regional SNOD on call.

3.3 The SN-ODs are available 24/7 and are contacted on pager **07659 591889**.

3.4 It is good practice to contact the SN-OD as early as practically possible.^{4,7} This allows for early discussion regarding the potential to become a donor, the identification of relative or absolute contraindications and allows transplant surgeons to screen potential organ donors with marginal likelihood to proceed to donation. The SNODs need time to travel to the location of the patient. Furthermore it allows early clinical intervention with donor optimisation bundles enabling clinicians to increase the potential to donate.

3.5 On referral the SNOD will ask for the patient's name, NHS number, date of birth and address in order to be able to check the ODR and ascertain whether the patient had recorded a decision (as indicated in the Human Transplantation (Wales) Act 2013).

4.0 Approach to those close to the patient regarding donation

4.1 Before the approach: There must be a multidisciplinary and collaborative planning meeting between the consultant, nursing staff familiar with the patient and family members and the SN-OD prior to approaching the family.⁷

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4.2 Planning meeting: During this planning meeting clinical issues should be clarified, the patient's donation potential assessed and the implications of organ retrieval understood, review of evidence of prior consent for organ donation and a discussion about the key family members involved in the decision making including the need to involve other parties such as faith representatives. A discussion should also take place to decide who will cover each element of the process.⁷

4.2 Timing of the approach: The main emphasis regarding the timing of the approach for donation is to ensure that the relatives have demonstrated an understanding that the patient has died or that death is imminent. The time taken for the relatives to comprehend this can vary considerably but it is crucial they have this understanding before considering approaching the family for donation. If the family do not understand the diagnosis of death or the plan to withdraw treatment an approach for donation **must not** be made.⁷

4.3 Location of the approach: it is important that family members are spoken to in a private room without interruptions and not at the patient's bedside. Best practice should be observed with a planning meeting and SNOD presence irrespective of the location of the patient. The subject of donation must only be raised at a time when families have demonstrated understanding of imminent death and the irreversible nature of the condition. It is important that donation is not raised prematurely prior to the family acceptance or before the medical management has been agreed.⁷

4.3 Roles and responsibilities: Evidence indicates that a collaborative approach between senior medical teams and the SNODs is the standard of best practice. SNODs have received detailed bespoke training in communication and best understand how to support families. They are able to recognise the cues from family and best determine the correct timing with respect to raising the subject of donation.⁷

4.4 Introducing the SNOD: some consultants will have difficulty introducing the specialist nurse, recognising that the subject of organ donation has not yet been raised. Consider introducing them as "a specialist nurse who works on the unit to support families."⁷

4.5 Discussing organ donation: The SNOD will discuss the organ donation process and answer any questions. If it is agreed that the patient's last known decision was that they wanted to donate their organs, consent documentation will then be completed. A medical, behavioural, travel and social history assessment will also be obtained from the family and other relevant individuals.⁷

4.6 The SNOD will provide information for the family on organ donation and the processes involved in a language of their choice utilising translation services if required. The relatives will be encouraged to ask questions which will be addressed. Where requested the family should be left to discuss

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donation privately, ensuring appropriate support is available should they require it.⁷

4.7 When families raise organ donation: If the family raise the possibility of organ donation with local staff without being formally asked for donation, the consultant should be informed and a referral to the SNOD should be made. The SNOD will advise staff on how to proceed, if it is clinically appropriate to consider organ donation, the SNOD will facilitate the process in discussion with the family. If there are reasons why donation is not clinically appropriate, the SNOD will explain those reasons in discussion with the family.

4.8 It is possible that out of hours there might be an occasion when the SNOD is delayed in attending due to logistics such as travel delays or multiple donation activity around South Wales. Following detailed discussion and advice from the SNOD the clinical team might consider approaching the family prior to the SNOD arrival. However this should only occur if significant delays are anticipated. It is important to understand the need to decouple the breaking bad news and discussion of futility of further treatment from the approach to organ donation in this conversation. The clinical team should only approach in unusual circumstances with express advice of the SNOD and when delays are going to cause the family greater distress.

5.0 Consent for organ donation

5.1 Consent in the process of deceased organ donation has changed since the implementation of The Human Transplantation (Wales) Act 2013 on 1st December 2015.¹

5.2 The HTA Wales Code of Practice informs the multidisciplinary team how to use the new transplantation act to determine consent for deceased organ donation.⁶

5.3 It is emphasised that SNODs based in Wales have undergone training and education in the detail of the HTA (Wales) 2013 and therefore are best placed to determine whether a patient has given consent for organ donation. This is a further reason to why it is important to involve SNODs early in the process.

5.4 The HTA Wales 2013 applies to people over the age of 18 who have capacity and who voluntarily live in Wales and then die in Wales. It means that consent to donation can be deemed.^{1,6}

5.5 Deemed consent means that if an individual does not register a clear decision either to be an organ donor (opt in) or not to be a donor (opt out), they will be treated as having no objection to being a donor. This choice can be recorded on the NHS Organ Donor Register, carrying a donor card or

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through conversations with family members. It is the last known wish of the individual that is important.^{1,6}

5.6 Patients who have not registered a decision with respect to deceased donation can have their consent deemed provided they are over the age of 18 had capacity to understand the HTA Wales, they lived voluntarily in Wales for one year or longer and they died in Wales.^{1,6}

5.7 Patients who do not fit the criteria for deemed consent can become donors after death by seeking consent from families.^{1,6}

5.8 Following the introduction of the Human Transplantation (Wales) Act 2013, those patients who have not registered a decision on the Organ Donor Register, may have their consent for donation deemed. The conversation with the family will be presumptive in nature until such time the family disclose that the patient had made a verbal/written decision. This is set out in the codes of practice and NHSBT best practice guidance.^{6,7}

5.9 It remains possible for family members to override the individuals expressed or deemed consent decision. SNODs will sensitively but openly explore this decision and guide the family to support the patient's decision, however it is recognised that the impact of proceeding with donation when there is opposition from family would potentially harm the bereaved relatives and is not likely to be in the patients interests or the wider transplant world.^{6,7}

5.10 The HTA Wales also stipulates that a patient can nominate a representative to make decisions with respect to organ donation and supersede the family. The SNODs are best placed to support patient's who have nominated a representative and ensure that the legal process is followed.^{1,6}

5.11 Qualifying relationships: The code of practice sets out hierarchical qualifying relationships and consent must be sought from the person highest on this list. Refer to the glossary terms for further detail.⁶

5.12 Children Deemed consent does not apply to people under the age of 18 years. However children or their parents on their behalf can register their wishes on the organ donor register.⁶

5.13 Further detail regarding the use of the HTA Wales 2013 should be sought in the Code of Practice.⁶

6.0 Diagnosis of Death

6.1 Donation can take place after brain stem death (DBD) or after circulatory death (DCD)^{9,10}

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6.2 Brain stem death tests should be conducted on all patients suspected of being brain stem death irrespective of a plan for organ donation. Refer to the Academy of Medical Royal Colleges 2008 Code of Practice for the diagnosis and confirmation of death and UHW guidelines for further detail in how to conduct brain stem death tests.⁵

6.3 In paediatric practice for infants less than 2 months old consult the RCPCH guidelines published in April 2015.¹¹

6.4 An explanation of the tests must be offered to family members and in some circumstances family members might wish to observe the tests.

6.5 A patient with a plan to withdraw treatment has the potential to become a donor after circulatory death. The consultant in charge will determine how this withdrawal takes place acting in the best interests of the patient. The process might involve extubation and cessation of haemodynamic support. Deceased donation after cardiac death is more likely to proceed if the patient is extubated as part of their end of life care.

6.6 The patient must be observed by the clinician responsible for confirming death for a minimum of five minutes to establish that irreversible cardio respiratory arrest has occurred. This observation is carried out with the use of an arterial line and arterial pressure trace.^{5,9}

6.7 The SNOD is responsible for documenting timings and liaising with transplant surgeons in theatre.

7.0 Donation from patients in areas other than ITU

7.1 It is recognised that patients with the potential to donate organs and tissues after death might be located in areas other than ITU. The principles surrounding decision making in these patients are the same as for patients on the ITU.

7.2 The emergency unit is the most likely area where potential organ donation patients will be located however it is possible that they might be identified on a stroke unit or other wards after emergency critical care interventions.¹²

7.2 Specifically it must be robustly and firmly established that further treatment is not in the patient's best interest. Two consultant clinicians should be directly involved with this decision making. The plan to withdraw treatment must be clearly documented and communicated sensitively to the family.⁸

7.3 The approach of families of potential organ donors must be planned with the SNODs and made collaboratively.⁸

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7.4 It is recognised that in order that organ donation can proceed patients will be transferred to the ITU.

8.0 Donation Process Roles and Responsibilities

8.1 The SNOD will:-

- Attend the unit in a timely manner
- Check the Organ Donor Register
- Ascertain eligibility for consent to be deemed
- Ensure that all necessary information pertaining to the potential donor's admission has been obtained and communicated to the coroner to agree cause of death and reporting requirements. This can be done directly or via the responsible healthcare professional in the hospital. The SNOD is responsible for ensuring that the removal of organs and/or tissues for donation occurs only following coroner approval for donation when referral to the coroner is necessary. Occasionally the coroner may place some restrictions on donation dependent upon the circumstances of the patient's death. In this case, the SNOD will inform the family of the coroner's restrictions.
- Plan the approach for donation with the responsible medical practitioner and facilitate a collaborative approach
- Assess suitability for donation potential on an individual basis
- Work with ITU consultants and referring clinicians to ensure that patients not in the ITU at time of referral can be admitted to the ITU in a timely fashion to facilitate donation.
- Take Blood specimens and send for tissue typing and virology testing
- Request further testing as required and review results.
- Support staff through donation process +/- brainstem death testing
- Advise on donor management
 - DBD – NHSBT DBD optimisation extended care bundle
 - DCD – Treatment and intervention in a potential DCD donor is justified if it is thought to be in the patient's best interest and expected to result in a net benefit to the patient rather than burden or harm. The clinician in charge of the patient's care on an individual case-by-case basis must be the judge of their best interests (12).
- Ensure a full assessment of the patient is made and this information is placed onto the Electronic Offering System (EOS). Recipient transplant centres have access to this system and can make a decision on suitability of potential recipients. It remains the responsibility of the implanting surgeon (and the informed recipient) to decide whether the risks associated with organ donation outweigh the benefits of using that organ.
- Mobilise a transplant team once organs placed
- Liaise with theatre

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- Arrange anaesthetic support if required i.e. for DBD patients and for DCD patients donating lungs
- Be present throughout theatre process and be responsible for all explanted organs until they have either left the hospital or been handed over to Cardiff and Vale transplant team (if remaining in Cardiff).
- Will record a clear and precise record of all events in the hospital medical notes.
- Be responsible for (alongside theatre staff) last offices and removal of cannulas, endotracheal tube, catheter etc. before transfer to the mortuary.
- Provide on going contact with family during donation.
- Provide support for the families of eligible and proceeding donors following their death, providing family and relevant parties with outcomes of donation as appropriate.

8.2 For DCDs SNODS will also:

- Pre-arrange the time of withdrawal of treatment with intensive care medical staff.
- The retrieval team must be ready in theatre before withdrawal of treatment. Withdrawal without SNOD being aware/surgical team being ready may stop organ donation proceeding.
- If the patient suffers from a cardiac arrest at any time during donation process, resuscitation should not be attempted.

8.3 Responsible Medical Practitioner will:

- Refer all patients who are suspected brain stem dead and patients who have planned withdrawal of treatment in a timely manner
- Plan approach for donation with bedside nurse and SNOD and facilitate a collaborative approach
- Be responsible for speaking to HM Coroner to discuss the case and confirm the circumstances surrounding the admission of the patient/potential donor, and the decision surrounding the cause of death to be written on the necessary NHSBT documentation and patient's medical notes.
- Instigate donor management:
 - DBD – Optimise patients using NHSBT DBD optimisation extended care bundle and arrange tests as necessary e.g. chest x-ray, echo, ECG.
 - DCD – Plan on an individual basis introducing new therapies or increasing existing therapies in line with the code of practice.
- Liaise with SNOD about timing of withdrawal of treatment
- Retrieval team MUST be ready in theatre before withdrawal. Withdrawal without SNOD being aware and the surgical team ready may stop organ donation proceeding.

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- Be readily available (or nominate a suitable deputy) to certify death 5 minutes after asystole, immediately prior to theatre.
- Plan for treatment withdrawal and document in the medical notes along with Do Not Attempt to Resuscitation Documentation.

8.4 Nursing staff will:

- Continue to provide all care as per normal practice e.g. regular repositioning, oral care, management of ABGs and ventilation, fluid management, electrolyte replacement, temperature control et al.
- Optimise patients using NHSBT DBD optimisation extended care bundle
- Continue pastoral care of family
- Report any changes of patient's condition to SNOD and medical staff
- Report any new family concerns to SNOD and medical staff
- Assist in any further investigations e.g. Xray, ECG, Echo etc.
- Complete pre-op check list as per usual guidelines
- Assist with transfer to theatre

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8.5 Theatre staff will jointly:

- Develop with the Organ Donation Team a comprehensive Standard Operating Procedure for patients going to theatre and procedures to be followed. This will include; Support for the retrieval team
- Support for the SNOD
- The procedure will be consistent with “UHW Guidelines for Donor Care During Multi-organ Retrieval”

8.6 In all cases the organ retrieval process will be coordinated by the SNOD who will support all staff involved in the patient's care throughout. Care of the deceased patient's body is performed by the hospital staff and assisted by the SNOD in accordance with the hospital policy. Respect and dignity for the patient, family and friends is maintained at all times

8.7 As per NMC code of conduct, GMC guidance and hospital policy any party involved in the donation process has a responsibility to ensure confidentiality is maintained.

9.0 Tissue Donation

9.1 Tissue donation is often possible after death.

9.2 To determine a patient's eligibility for tissue donation after death nursing staff must contact the National Referral Centre on 0800 432 0559.

9.3 Advice will be offered as to the patient's suitability and staff supported to approach families. Where tissue donation is not contra-indicated, a healthcare professional involved in the patient's care should approach the family about tissue donation. The nearest relative should be offered information regarding tissue donation options.

9.4 Families who wish to consider tissue donation the National Referral Centre will contact the family to complete formal consent process. The National Referral Centre will co-ordinate all tissue-only retrievals.

9.5 For patients who are proceeding organ donors the SNODs will complete the process of referral to the NRC.

Please see Appendix 4 for the flow chart on tissue donation.

10.0 Communication and Education Plan for this document

10.1 Dissemination at the Organ Donation Committee

10.2 Disseminate to Cardiff and Vale University Health Board; Medical Director and all Clinical Board Directors and Directors of Nursing.

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10.3 Circulation of policy to key areas –Senior Nurse Manager & Lead Clinicians for intensive care unit, emergency department, cardiac intensive care unit and paediatric critical care unit.

10.4 To raise awareness of the policy through internal communication mechanisms.

10.5 Formal programmes of training and education, tailored to the needs of the specific clinical teams and staff, will be delivered and provided by the SNODs and the Clinical Leads for Organ Donation (CLODs). These will be updated on a yearly basis or as necessary, and a record kept of training carried out.

11.0 Monitoring Effectiveness

11.1 The SNOD will continue to audit all deaths occurring within critical care areas using the Potential Donor Audit. This audit will demonstrate rates of eligible donor identification, referral, and approach to relatives and consent to donation.

11.2 Effectiveness of the policy will be monitored using the results of the PDA and benchmarking C+V UHB against other health boards.

11.3 Detailed review of missed potentials will be undertaken and incident forms completed if appropriate. Issues around performance will be discussed at the organ donation committee meeting.

11.4 Variation from the guidelines will be investigated and action taken as necessary to feedback to members of the team.

11.5 Furthermore any concerns raised by the users of the policy or complaints from families of potential donors will also be used to assess the guidance and direct future amendments.

12.0 Review

This document will be reviewed in 2 years time or earlier if there are significant changes to the policy or the national guidance.

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<http://www.odt.nhs.uk/donation/deceased-donation/donation-from-emergency-department/> last accessed on 09/01/2017

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Glossary of Terms used in the Document

Specialist Nurse for Organ Donation

A senior nurse with specialist knowledge in the process of organ donation, who is expert in communication with families and has an important role within the hospital in supporting deceased donation at all levels.

Clinical Lead for organ donation

A consultant in hospital medicine with a special interest in deceased organ donation, who supports the process of donation in the hospital through education, development of policies and providing expert knowledge.

Eligible Donor after Brain Death (DBD)

A patient whose death has been confirmed using neurological criteria, with no absolute contraindications or relative contraindications to solid organ donation.

Eligible Donor after Circulatory Death (DCD)

A ventilated patient, whose imminent death is anticipated, when a decision has been made by a consultant that treatment is to be withdrawn based on medical futility and acting in the patient's best interests or when there is a valid and applicable advance decision to refuse treatment (ADRT).

Non Proceeding Donor

An individual that begins the process towards organ or tissue donation but does not progress through to donation.

Opted in/out

An individual has recorded a positive or negative decision on the organ donor register.

Deemed Consent

Unless a person has made a decision to opt in or opt out of donation then they will be regarded as having no objection and their consent will be deemed to have been given.

Deemed Consent Eligibility

- Over the age of 18

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- Who ordinarily live in Wales and have done so for longer than 12 months
- Who have not expressed or recorded a decision
- Who die in Wales
- Who have capacity as per Mental Capacity Act 2005

Nominated/Appointed Representative

One or more people whom the individual has nominated to make decisions solely regarding organ donation. A nominated representative will supersede any other qualifying relationship in relation to organ donation.

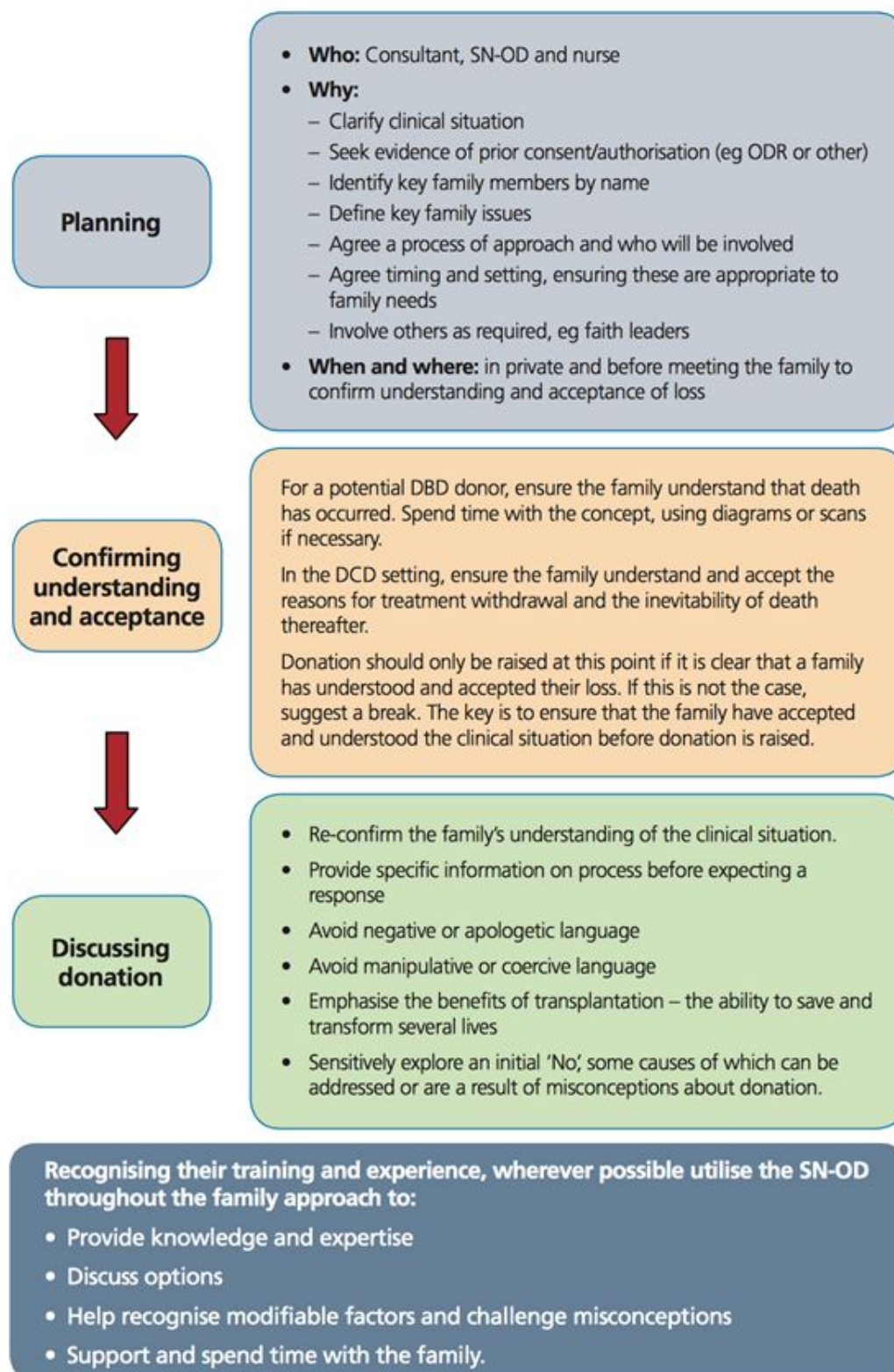
Qualifying Relationships

The human tissue act sets out a hierarchy of relationships that in the event that there is disagreement regarding consent for donation allows the opinion of certain relatives to carry greater weight.

- A. Spouse or partner
- B. Parent or child
- C. Brother or sister
- D. Grandparent or grandchild
- E. Niece or nephew
- F. Stepfather or stepmother
- G. Half-brother or half-sister
- H. Friend of longstanding

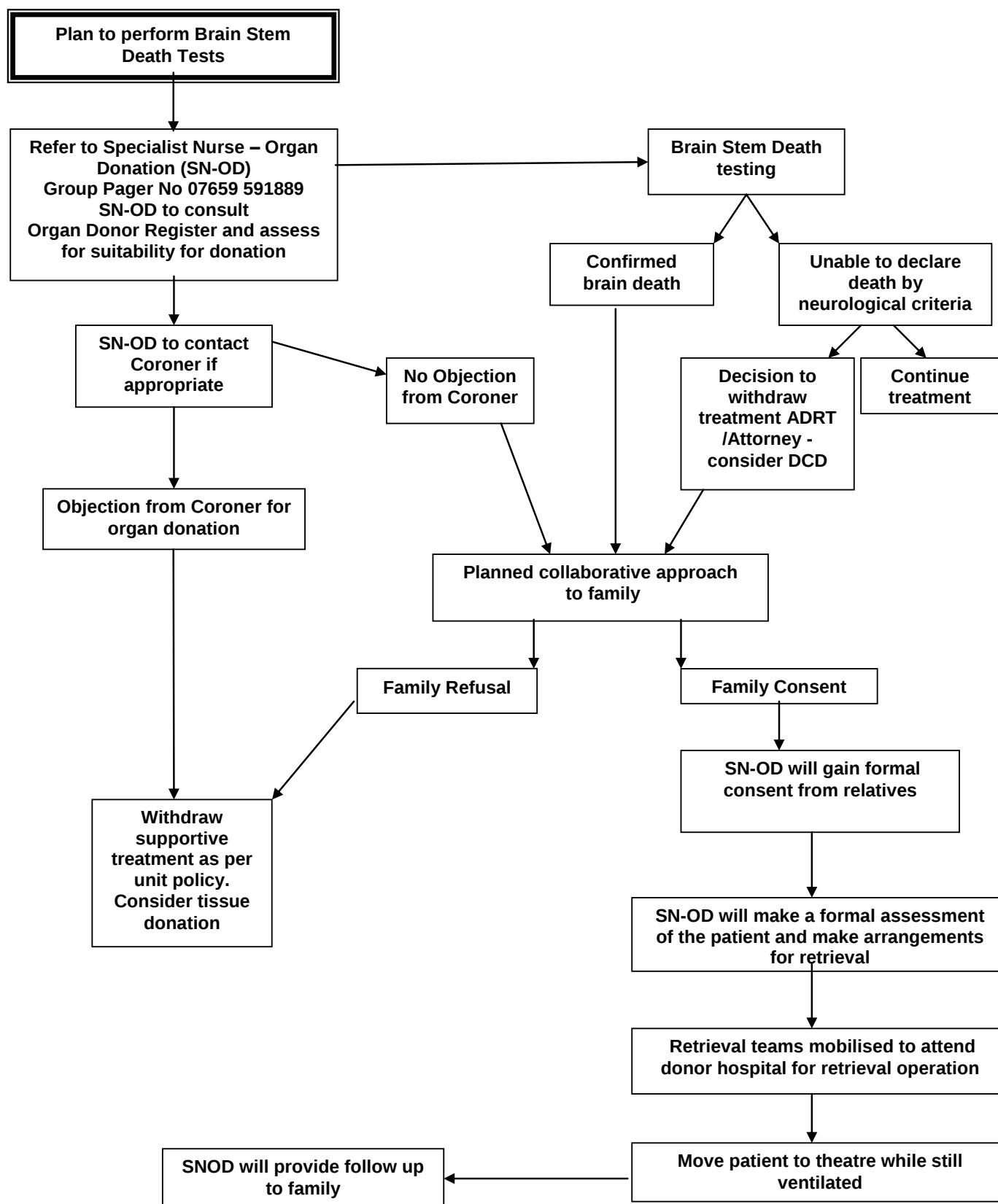
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Appendix 1: Flow Chart for the Approach of Family of Potential Donors



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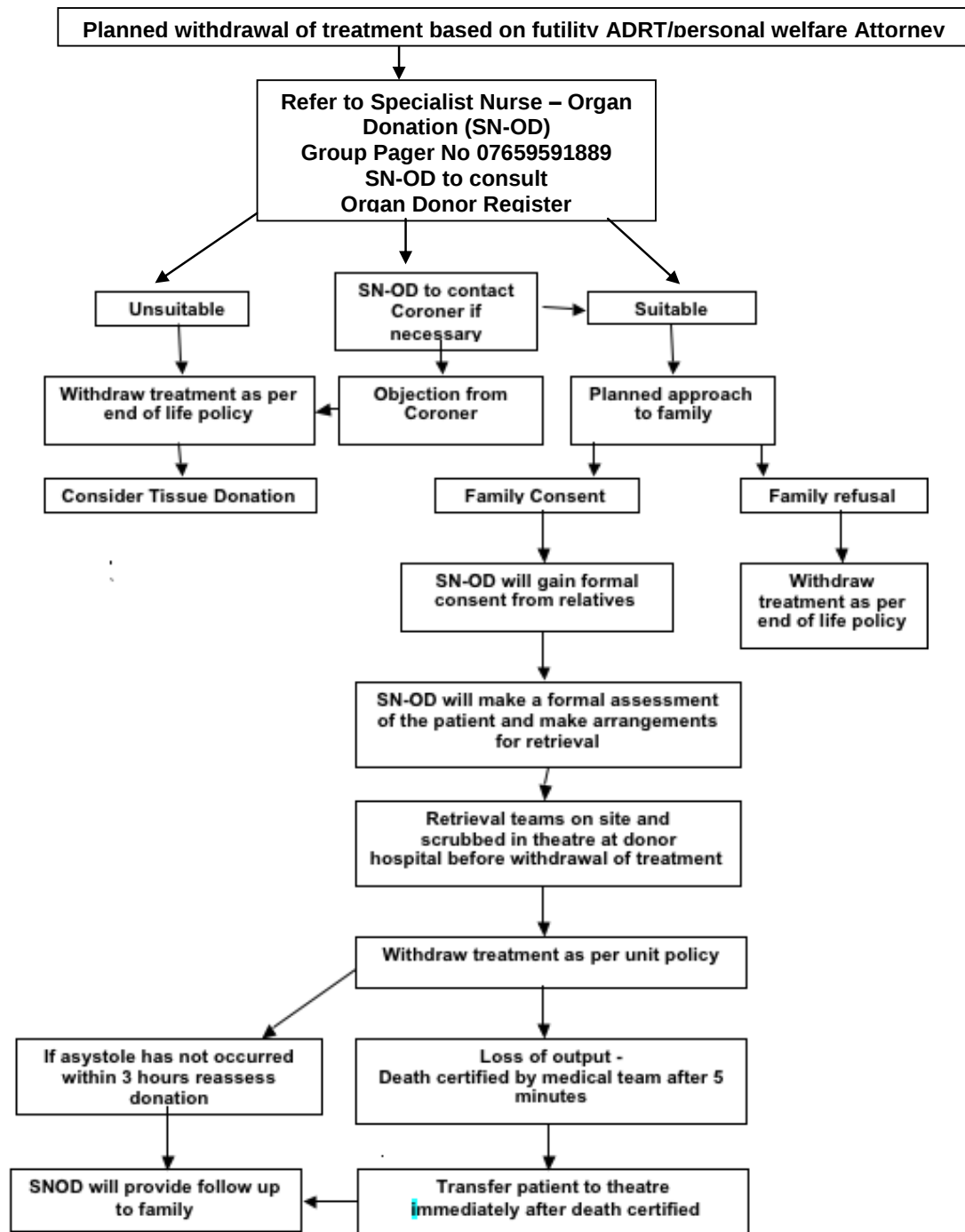
Appendix 2: Flow Chart for Donation after Brain Stem Death



10.1

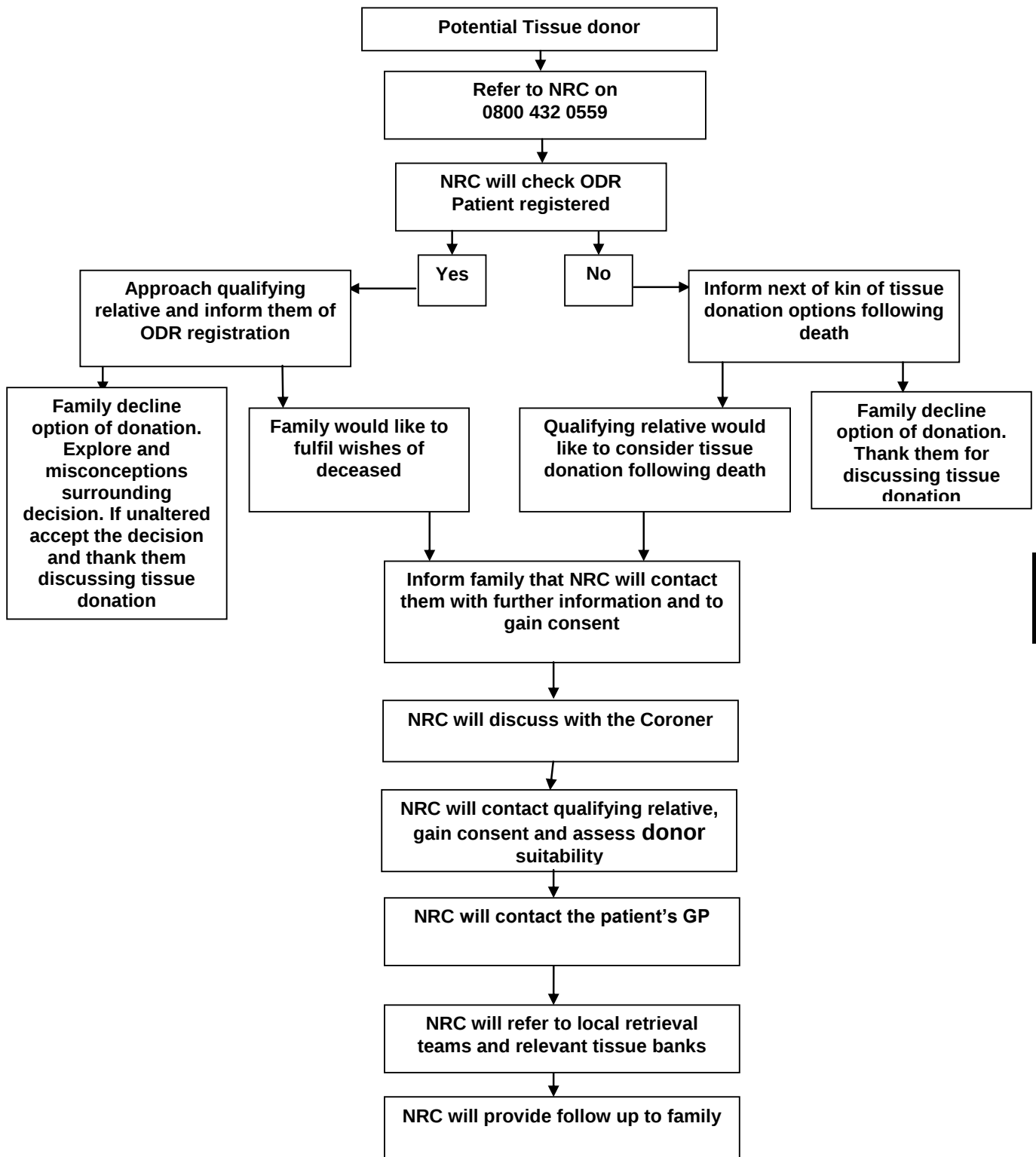
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Appendix 3: Flow chart for Donors Eligible for Donation after Cardiac Death



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Approved By:		

Appendix 4: Flow Chart for Tissue Donation after Death



Equality and Health Impact Assessment for Donation of Organs and Tissues after Death Policy and Procedure

1	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Cardiff and Vale University Health Board: Reference Number 110 Donation of Organs and Tissues after Death Policy And Donation of Organs and Tissues after Death Procedure.														
2	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Cardiff and Vale University Health Board Organ Donation Committee. Clinical Lead for Organ Donation: Katja Empson Specialist Nurse for Organ Donation: Charlotte Goodwin														
3	Objectives of strategy/ policy/ plan/ procedure/ service	• All patients are considered for organ donation as a usual part of end of life care. • All patients at the end of life who meet minimum notification criteria (NICE Guideline) are referred to the specialist nurse for organ donation. • The family of all patients with the potential to become an organ donor are approached in accordance with the best practice guidelines. • The decisions of all potential patients are determined by accessing the NHS organ donor register. • Consent for organ donation is explored using the criteria set out in the Code of practice. • Potential organ donors who have consented to proceed are managed according to clinical guidelines.														
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 • participant knowledge	<table><tr><td colspan="2">Cardiff and Vale University Health Board</td></tr><tr><td colspan="2"></td></tr><tr><td>Total population</td><td>482,000</td></tr><tr><td>Population aged 75 and over (%)</td><td>7.3</td></tr><tr><td>Life expectancy at birth - males</td><td>78.6 years</td></tr><tr><td>Life expectancy at birth - females</td><td>82.9 years</td></tr><tr><td>Adults who are overweight or obese (%)</td><td>54.0</td></tr></table>	Cardiff and Vale University Health Board				Total population	482,000	Population aged 75 and over (%)	7.3	Life expectancy at birth - males	78.6 years	Life expectancy at birth - females	82.9 years	Adults who are overweight or obese (%)	54.0
Cardiff and Vale University Health Board																
																
Total population	482,000															
Population aged 75 and over (%)	7.3															
Life expectancy at birth - males	78.6 years															
Life expectancy at birth - females	82.9 years															
Adults who are overweight or obese (%)	54.0															

- 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 Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².	Adults who smoke (%)	18.4
	Adults who drink above guidelines (%)	41.6
	MMR uptake (%)	94.2
	Live births per 1000 women aged 15-44	55.9
	Emergency hospital admissions (European age standardised rate per 1,000 population)	92.9
	'Public Health Wales Observatory'³ http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf	
	'Shaping Our Future Wellbeing'³ http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face	

1. Population size and composition

- Our population is:
 - growing rapidly in size - projected 4% increase between 2013-17; will pass 500,000 for the first time (much higher than average growth across Wales)
 - ageing - number of over 85s increasing at a much faster rate than the rest of the population (10.4% increase between 2013-17)
 - ethnically very diverse, compared with much of the rest of Wales. Arabic, Polish, Chinese and Bengali are the four most common languages spoken after English and Welsh. Cardiff is one of the few centres in the UK designated as a receiving centre for people newly arrived in the UK who are seeking asylum

2. Risk factors for disease

- Unhealthy behaviours which increase the risk of disease are endemic among adults
 - Nearly half (45-46%) drink above alcohol guidelines
 - Nearly two thirds (65-68%) don't eat sufficient fruit and vegetables
 - Over half (53-56%) are overweight or obese. This increases to two thirds (64%) among 45-64 year olds
 - Around three quarters (71-75%) don't get enough physical activity
 - Just over one in five (21%) smoke
- Many children are also developing unhealthy behaviours
 - Two thirds (66%) of under 16s don't get enough physical activity
 - Nearly a third (31%) of under 16s are overweight or obese
- Around 1 in 10 adults are recorded as having high blood pressure

3. Equity, inequalities and wider determinants of health

- There are stark inequalities in health outcomes and how, when people access healthcare
 - Life expectancy for men is nearly 12 years lower in the most-deprived areas compared with those in the least-deprived areas
 - The number of years of healthy life varies even more, with a gap of 22 years between the most- and least-deprived areas
 - Premature death rates are nearly three times higher among the most-deprived areas compared with the least deprived
- There are significant inequalities in the 'wider determinants' of health, such as housing, household income and education
 - For example, the percentage of people living without central heating varies by area from 1 in 100 (1%) to 1 in 10 (13%)
- The Annual Report of the Equality and Human Rights Commission highlights that of the 23% of people living in poverty in Wales, 46% are disabled, 43% are from minority ethnic communities, 27% are aged 16-25 years and 48% are lone parents (9/10 are women). There are clear links between socio-economic inequalities and those associated with particular protected characteristics who may have specific health needs to be met

4. Ill health in Cardiff and Vale

- The disease profile is changing
 - Chronic conditions including diabetes, respiratory and heart disease, are now common
 - Around 1 in 10 (9.4%) people consider their day-to-day activities are limited by a long-term health problem or disability
 - Many people with chronic conditions are not diagnosed and do not appear on official registers
 - Because of changes in the age profile of the population and risk factors for disease, new diagnoses for conditions such as diabetes and dementia are increasing significantly
- Heart disease, lung cancer and cerebrovascular disease are the leading causes of death in men and women
- Preventable illness and deaths
 - Many (but not all) of the most common chronic conditions and causes of death may be avoided by making changes in health-related behaviours

5 Who will be affected by the strategy/ policy/ plan/ procedure/ service	• Patients who are a potential organ and/or tissue donors and their families/carers. • Members of Organ Donation Committee. • Medical and nursing staff involved in the care and treatment of potential donors.
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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	There is a negative impact on a small minority due to the age limitations on organ and tissue donation. The upper age limit when considering organ donation is 85. Those under the age of 18 will not be eligible for deemed consent and the qualifying relationship will apply. However, they can register their wish or their parents on their behalf.	Set criteria are essential as above the age limit is not appropriate due to poor organ viability and the presence of certain conditions that may be associated with older people. Deemed consent criteria is stipulated within HTA Wales.	On referral to the SN-OD the patient's date of birth would be obtained. Referral to SNOD (3.0)
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Specific medical contraindications may exclude certain individuals with varying disabling conditions from being organ and/or tissue donors; otherwise people with disabilities are not excluded from donating organs and/or tissues. Relatives with impaired hearing or visual impairments will need the policy to be provided in accessible formats	Each individual case is discussed and weighed on its merits. BSL signers or interpreters should be present to facilitate discussions as appropriate.	Referral allows the SN-OD to ascertain potential and establish contraindications to organ donation. Referral to SNOD (3.0) Eligibility for tissue donation will be communicated via the National Referral Center. Tissue Donation Referral (9.0)

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
	and it must be ensured that they understand the consequences of implementation prior to any action being taken.		
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 is no evidence to indicate that men or women will be adversely impacted by this policy. No difference between gender is noted in the ability to become an organ and/or tissue donor. There is no reason or contraindication that would prevent a person from being an organ and/or tissue donor due to them being transgender. However, the registration on the ODR may have an impact if uncertainty surrounding what gender to document is experienced.	Expressed wish can be in varying formats and not solely ODR registration.	Reflected within consent for organ donation (5.0)
6.4 People who are married or who have a civil partner.	There is no evidence to suggest marriage or civil partnership will have any impact by this policy.	The qualifying relationship hierarchy gives greater weight to spouse or partner.	Reflected within consent for organ donation (5.0)
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 they are on maternity leave.	Any female between the ages of 13-53 years who is a potential organ donor, it must be considered that they may be pregnant. NHS Blood and Transplant have a management process description that guides the possibility of organ donation in relation to pregnancy. Pregnancy does not preclude organ and/or tissue donation	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
	but it must be considered and planned for.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	NHSBT cited in The Welsh Government's EQIA of the Human Transplantation (Wales) Bill reported the people from Black and Minority Ethnic (BAME) Communities are under represented on the ODR with only 1.4% being of Asian origin and 0.4% Black, yet they are three times more likely to need a transplant due to their likelihood of developing conditions such as diabetes and high blood pressure, which can lead to kidney failure or heart disease. Finding a match can take longer, meaning that people from these communities on average wait a third longer than others for a transplant. There is also a much better success rate when transplants are carried out within the same ethnic group. Studies show that while African-Caribbean and South Asian People are supportive of organ donation and transplantation, they are not aware of the specific needs of their community for organs. References shown in Randahawa G. (2011) Achieving equality in organ donation and transplantation in the UK: challenges and solutions. BAME groups are likely to benefit from increased numbers of donors. Race is not a criteria for deciding on whether or	Translators/interpreters should be available to assist in discussions and information sharing.	Identification of translators/interpreters should be shared at the referral process (3.0)

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
	not an individual may be a donor or recipient.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	For many BAME people, their faith will be significant in determining their decision on organ donation. No religious faiths object completely to the principle of organ donation, although there is a divergence of opinion within Islam. However, religious views are often cited as a reason by relatives not to consent to organ donation. It is unclear whether these views are an informed view of their faith's position or more personal, intuitive views based on personal interpretation. It should be recognised that both positions are legitimate. Religion or belief does not exclude an individual from being a donor/recipient.	This highlights the need to ensure that faith leaders and the public should be encouraged to discuss and debate organ donation within the context of their faith – included in publicity campaigns?	Consideration of BAME within the communication and education plan (10.0)
6.8 People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)	There is no evidence that LGB people will be adversely affected by the implementation of this policy and LGB individuals requiring donations will benefit from the implementation of the policy and are not excluded from receiving donations. Some LGB individuals will be excluded from being donors due to the presence of conditions as specified in the exclusion criteria, but the decision is on the basis of the condition being present, not on the basis of sexual orientation.	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
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	The UHB Welsh Language Policy prescribes that service users may receive their services through the medium of Welsh. People for whom Welsh is their first language find it much easier, particularly when under distress or grieving to talk about emotions and issues in Welsh. The “active offer” should be implemented when introducing the topic of organ donation and bilingual information leaflets should be made available as appropriate.	The South Wales organ donation team has two first language Welsh speakers. If this is a preferred method of communication they can be mobilised to attend at the Cardiff and Vale UHB.	Consideration of a Welsh speaking SNOD requires implementation prior to approach/consent (4.0/5.0)
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	Income has no impact on the potential of organ and/or tissue donation. Information will be collected when conducting the patient assessment as risks need to be identified such as an individual who is homeless may be exposed to further infection risks.	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	Residency will only have an impact in regards to the Welsh legislation. Deemed consent can only apply when voluntary residence is at least 12 months within Wales.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Other groups that may be relevant to this policy are students, asylum seekers or refugees with regards to Welsh residency under the legislative act of deemed consent.	N/A	N/A

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	If eligible as a potential for organ and/or tissue donation all patients should be referred if they meet the minimum notification criteria as stipulated by NICE guidelines. Referrals are monitored and audited so that if a missed case has occurred this will be addressed and escalated to the clinical leads in organ donation.	Staff and public education and engagement.	Education Plan (10.0)
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination,	N/A Previous and current lifestyle will be assessed during donor characterisation.	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
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 conditions Well-being Goal – A prosperous Wales	N/A The impact of death for family/friends may have an impact financially but this is beyond the reach of this policy.	N/A	N/A
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	N/A	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
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 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	- Impact may be evident if criteria for deemed consent is not met. Therefore the hierarchical qualifying relationships will be established to gain consent for potential organ and/or tissue donation. - The policy will be in conjunction with the End-of-life to ensure social and community needs are respected after death.	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
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	N/A	N/A	N/A

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Obstacles to success might include: • Lack of engagement from the Critical Care areas. • Misunderstanding/misuse of the policy. • Staffs' personal feelings and perception about the policy. • Local Implementation of the policy across different areas of the UHB may differ. • Lack of awareness of the policy by staff that are not permanent employees of the Health Board and may be working locum/bank nurse shifts. • Lack of public and patient awareness around issues of organ and tissue donation. Elements which may enhance the success of the policy might include: • Training and awareness raising - there will be a need to educate staff about this policy and to include in education plans. • There are no financial implications to this policy as all donor activity is reimbursed.
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10.1

Action Plan for Mitigation / Improvement and Implementation

8.2 Action Plan for Mitigation / Improvement and Implementation What are the key actions identified as a result of completing the EHIA?	A full impact assessment was undertaken and the policy was considered to have a high relevance to the Equality Duties and in relation to the organisation's activities and outcomes for service users. The intent behind this policy is to outline best practice in relation to the organ donation process. Evidence shows that there is potential for negative impact on certain groups of people such as medical contraindications precluding certain individuals from becoming organ donors at assessment. However, the need for organs is a significant issue in the UK and for this reason alone, every effort would be made to remove reasons why people can not donate. The only absolute reasons for people not being able to donate are on a risk: benefit ratio, where the potential for harm to a recipient outweighs the benefit. This is solely a clinical decision based on the risk: benefit ratio and not in any way based on any one protected characteristic.	CLOD SNOD	Completed For consultation at next policy review	No-one will be excluded from being a donor on the basis of any protected characteristic alone, nor will anyone be assumed to be consenting to be a donor on the basis of their protected characteristic. On this basis, the policy was assessed as having a neutral impact in terms of donors and a positive impact in terms of recipients across protected characteristics.
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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?	No further assessment is required at this stage as all factors have been considered at great length. The policy has been distributed for consultation to varying personal within the equality act and no further actions have been identified.	SNOD	Completed	No action required
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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	Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. - Suggest adding in a section to ensure that alternative formats for the policy and /interpretation services (BSL and other languages) must be made available as appropriate to facilitate discussion and understanding and referring to the active offer of services provided through the medium of Welsh. This will ensure that such issues are not missed during crucial discussions at a sensitive time. The policy has been examined by Organ Donation Committee members and will be forwarded for board approval following appropriate amendments. Once published this will be accessible within the UHB and wider community on the internet/intranet.	SNOD CLOD SNOD	Completed 3 Months	If a Welsh speaking SNOD is requested the Team Managers will endeavour to mobilise a SNOD to the clinical unit. Recommendations will be examined and alterations made as appropriate.
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10.1

QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK 2017 – 2020

Name of Meeting: Quality, Safety and Experience Committee

Date of Meeting: 18th April 2017

Executive Lead: Executive Nurse Director

Author: Assistant Director Patient Safety and Quality.

Caring for People, Keeping People Well: The Quality, Safety and Improvement (QSI) Framework has been specifically written to deliver the following elements of the UHB Strategy – Delivering Outcomes that matter to people; avoiding waste, variation and harm.

Financial impact: Delivery of the QSI framework has the potential to reduce costs that are incurred when patients are harmed as a consequence of their care. There are costs associated with some of the actions required to deliver the necessary improvements e.g. to achieve full compliance with Patient Safety Solutions requires an investment in the region of 100k.

Quality, Safety, Patient Experience impact: The QSI framework has been written to deliver improvements in key areas of the Quality, Safety and Experience agenda based on what we understand to be our current risk profile.

Health and Care Standard Number: This covers implementation of all Health and Care Standards.

CRAF Reference Number: 5.1

Equality and Health Impact Assessment Completed: No but it is anticipated that full implementation of the QSI Framework would lead to positive equality and health impacts.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- ◆ The triangulation work that has been undertaken to date to identify key areas that the QSI Framework will aim to improve.
- ◆ The plans in place to monitor and evaluate implementation over the next three years.
- ◆ The degree of consultation and engagement undertaken in the development and agreement of the Framework

The Quality, Safety and Experience Committee is asked to:

- ◆ **APPROVE** the Quality, Safety and Improvement framework.
- ◆ **AGREE** to monitor the implementation of the framework and to receive twice yearly progress updates.

SITUATION

The purpose of this report is to present the Quality, Safety and Improvement Framework 2017 - 2020.

This QSI Framework will support delivery of two key elements of the UHB Strategy – Delivering outcomes that matter to people; avoiding waste variation and harm.

BACKGROUND

In developing this framework, the team have looked at our local and national data and focused on themes and trends in patient safety incidents, concerns raised by patients through complaints and claims as well as evaluating feedback from local and national surveys, and triangulation of the findings from key national reports and national audit reports. Our Internal Audit programme has also provided a valuable source of assurance and helped us focus on areas for improvement.

What has come through strongly in talking to our service users and stakeholders to date is the need for good communication and information. Hygiene standards are important, as is the need to be treated with dignity and respect and for everyone to have a shared understanding of what this means to individuals. One of our stakeholders told us that accessing care in the NHS should be 'effortless' – people should not struggle to navigate a complex organisation. We have looked at what our Health and Care Standards monitoring and self assessments have told us and some of the issues that staff have raised with us on Safety Walkrounds, in surveys and through our Safety Valve and Freedom to Speak up processes.

In addition, there has been careful consideration of the very valuable feedback received from our external and internal inspection processes; in particular that from Healthcare Inspectorate Wales and the Community Health Council. Some of the key issues and emerging patient safety concerns, brought to the attention of the Quality, Safety and Experience (QSE) Committee, are also reflected. The work of the Older Peoples' Commissioner has provided a valuable insight in to the concerns of the older person and the UHB will to ensure that the views of older people inform the development of our plans now and in the future.

ASSESSMENT AND ASSURANCE

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015, recognising that our colleagues in Public Health and in

Workforce and Organisational development will be taking forward their own work to support the embedding of Standards within other domains. We are also mindful of workstreams and priorities emerging from the 1000 Lives programme. The Framework is also aligned with the UHB Patient Experience Framework for 2017 - 2020.

It is anticipated that this framework will provide a vehicle for quality assurance and improvement across all our services in primary, community, hospital and mental health services. It will support and be integral to delivery of our Integrated Medium Term Plan and embraces the philosophy of Caring for people, Keeping People Well; supporting the broad organisational objectives of our overall UHB strategy – Shaping our future Wellbeing Strategy – that is, to deliver outcomes that matter to people and avoid waste, variation and harm.

There has been a considerable amount of consultation and engagement undertaken in developing the framework and discussions have been undertaken with:

Directors of Nursing of each Clinical Board
 All Clinical Board Quality, Safety and Experience Committees
 Assistant Medical Director Patient Safety and Quality
 Patient Safety and Quality team
 Corporate Nursing team/Deputy Executive Nurse Director/ Senior Nurse professional Standards
 Director of Infection Prevention and Control
 Consultant Medical and Nursing Leads for Sepsis
 Consultant Medical Lead for Acute Kidney Injury
 Nutrition team
 Director of Pharmacy and Medicines Management/ Nurse Lead for Medicines
 Nurse Thromboprophylaxis lead
 Management/ Medication Safety Executive
 Head of Midwifery
 Assistant Director Planning –Scheduled care and unscheduled care
 Consultant in Public Health medicine (dementia)
 Health Professions Forum
 Stakeholder Reference Group
 Community Health Council
 Healthcare Quality Division – Welsh Government
 Director of Nursing Welsh Health Specialised Committee

The QSI Framework will form an integral part of the Integrated Medium Term Plan for the UHB.

Our Annual Quality Statement will now provide an open and honest account of how we are progressing with the implementation of the framework over the next three years.

QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK

PATIENT SAFETY QUALITY AND IMPROVEMENT DELIVERY PLAN

2017/18 - 2019/20

FOREWORD

I am pleased to bring you the Cardiff and Vale University Health Board (UHB) Quality, Safety and Improvement Framework 2017/2018 - 2019/2020 which sets out our priorities for the next three years. It builds on the excellent work that is already taking place. We have made great progress in reducing blood stream infections and Clostridium difficile, and improving outcomes for people with heart disease, stroke and diabetes and those who suffer hip fractures. We have made good progress in reducing waiting times, especially for diagnostic tests. Our governance arrangements in relation to Quality and Safety have been strengthened and we have developed a performance dashboard to monitor quality and safety across the University Health Board (UHB). 60% of concerns raised with us are now managed informally within 3 days and our service users, in feedback surveys continue to report an excellent experience of their care. We are proud of our openness and transparency, knowing that we are a Board who makes sure that quality and safety is central to all of our discussions and decision making. We work hard to ensure that the patient's voice is heard at every level of the service and recognise that leadership, commitment and visibility must be evident throughout the organisation. We also know there is more we need to do.

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

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

This framework will provide a vehicle for quality assurance and improvement across all our services in primary, community, hospital and mental health services. It will support and be integral to delivery of our Integrated Medium Term Plan (IMTP) and embraces the philosophy of Caring for people, Keeping People Well; supporting the broad organisational objectives of our overall UHB strategy – Shaping our future Wellbeing Strategy – that is, to deliver outcomes that matter to people and avoid waste, variation and harm.

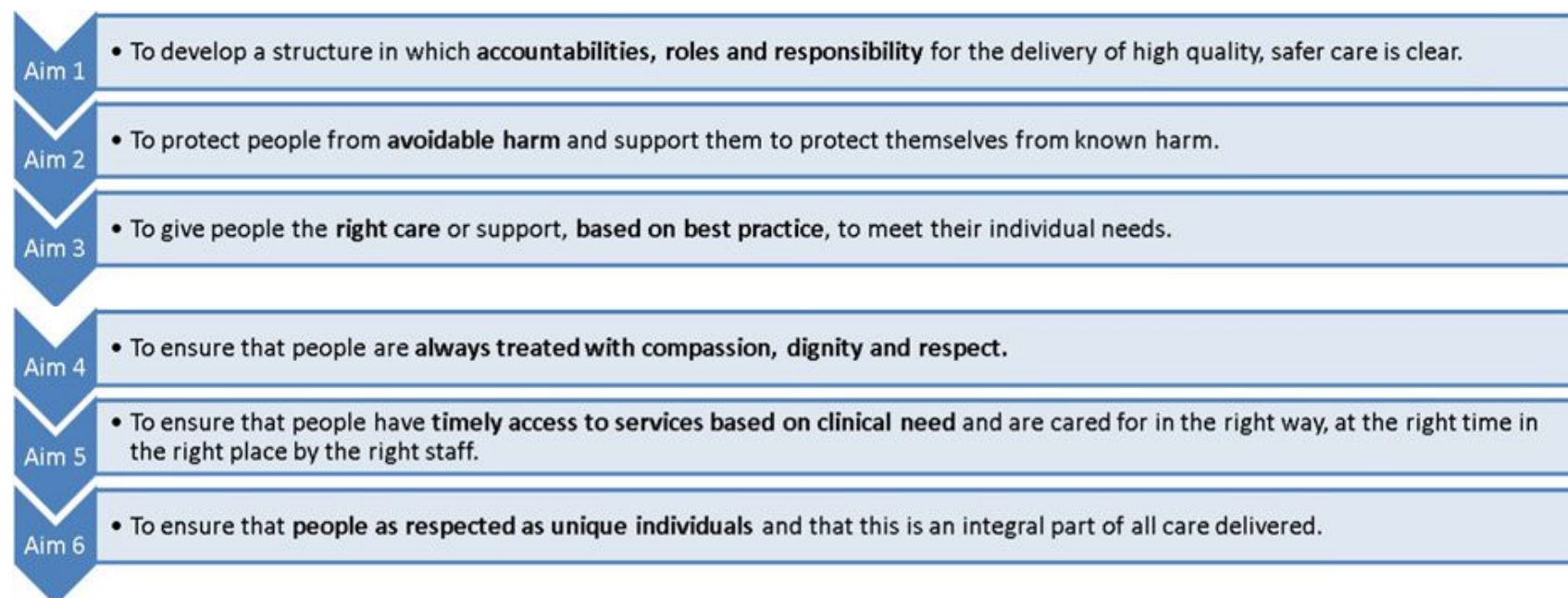
In developing this framework, we have looked at our local and national data and focused on themes and trends in patient safety incidents, concerns raised by patients through complaints and claims as well as evaluating feedback from local and national surveys, and triangulation of the findings from key national reports and national audit reports. Our Internal Audit programme has provided a useful source of assurance and helped us focus on areas for improvement. We have listened to patients, to staff and to the system and continue to act on what we hear and what we see. What has

come through strongly in talking to our service users and stakeholders to date is the need for good communication and information. Hygiene standards are important, as is the need to be treated with dignity and respect and for everyone to have a shared understanding of what this means to individuals. One of our stakeholders told us that accessing care in the NHS should be 'effortless' – people should not struggle to navigate a complex organisation. We have looked at what our Health and Care Standards monitoring and self assessments have told us and the issues that staff have raised with us on Safety Walkrounds, in surveys and through our Safety Valve and Freedom to Speak up processes. In addition, we have taken on board the very valuable feedback received from our external and internal inspection processes; in particular that from Healthcare Inspectorate Wales and the Community Health Council as well as peer review of services particularly those that focus on cancer. Some of the key issues and emerging patient safety concerns, brought to the attention of our proactive Quality, Safety and Experience (QSE) Committee, are also reflected. The work of the Older Peoples' Commissioner (OPC) has provided a valuable insight in to the concerns of the older person and we look forward to working in partnership with her and her office to ensure that the views of older people inform the development of our plans now and in the future.

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015, recognising that our colleagues in Public Health and in Workforce and Organisational development will be taking forward their own work to support the embedding of Standards within other domains. We are also mindful of workstreams and priorities emerging from the 1000 lives programme and will work closely with the 1000 lives team to ensure that the UHB is supporting with and driving the national priorities for improvement. The Framework is also aligned with the UHB Patient Experience Framework for 2017-2020. We recognise that we must consistently search for new ideas and better ways of working to improve the quality and safety of the care and services we provide and to deliver outcomes that really matter to people.

WHAT ARE WE TRYING TO ACCOMPLISH?

Our aim is to be one of the safest organisations in the NHS – delivering high quality, seamless care where people have a great experience every time they use our services. It is inevitable that there will be emerging risks to both patient safety and quality across the whole system of healthcare provision, and the UHB will need to anticipate and respond to these. This will form an important focus for quality and safety initiatives over the next three years. We have 6 broad aims:



We continue to work hard to ensure that the principles which underpin the National Quality Delivery Plan are fully embedded within the UHB, i.e:

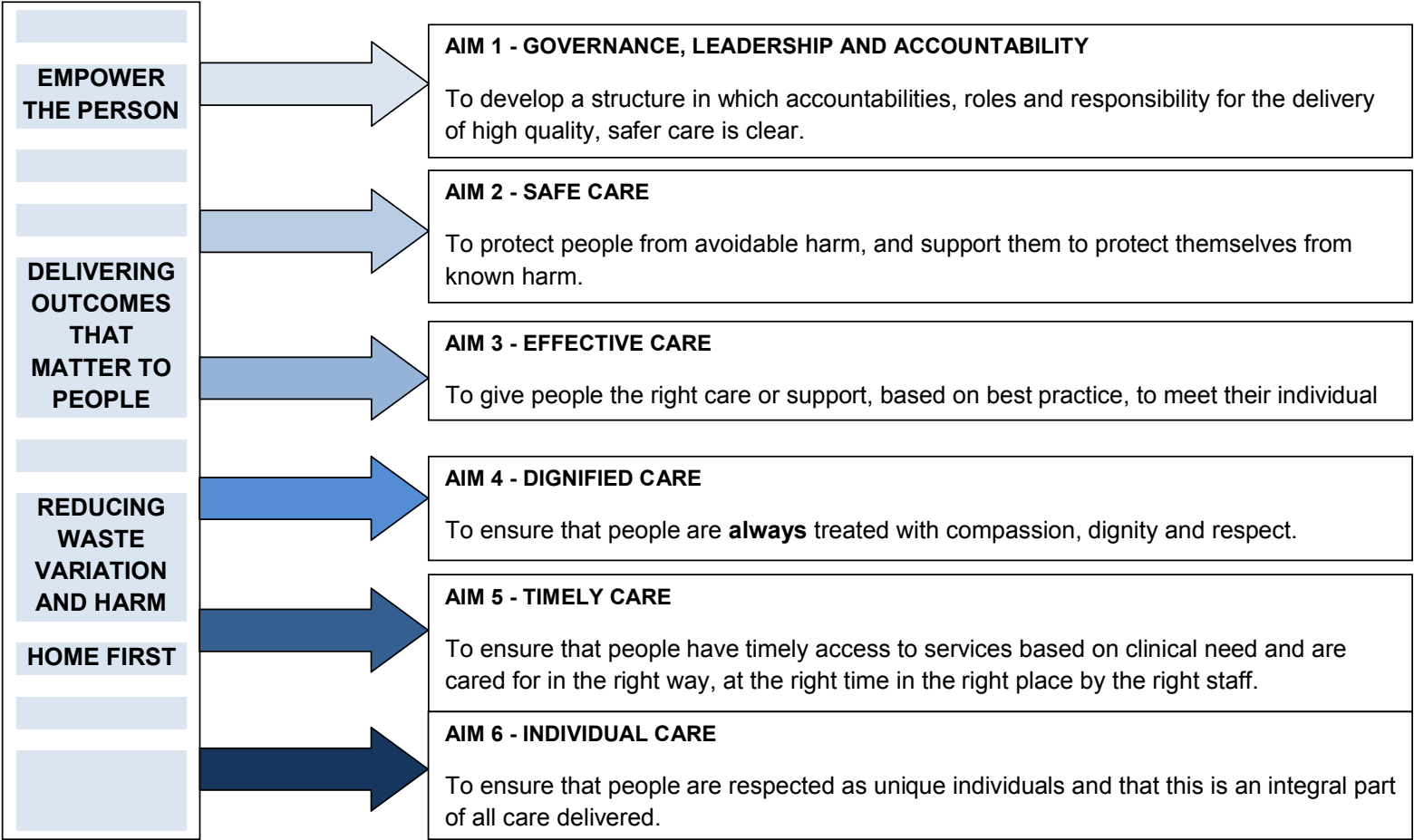
- Quality is key to the operating framework for the UHB, underpinned and aligned with financial, workforce and information plans and goals;
- Quality drives service and system improvement;
- Service delivery is focussed around the needs of the person - patient/ service user and not those within the organisation;
- Robust processes will be in place to provide assurance;
- Streamlined data collection – provided once, and put to multiple use;
- Alignment with social care and other partners to ensure that the care and treatment takes a whole person perspective; and
- Absolute transparency and information sharing with the public.

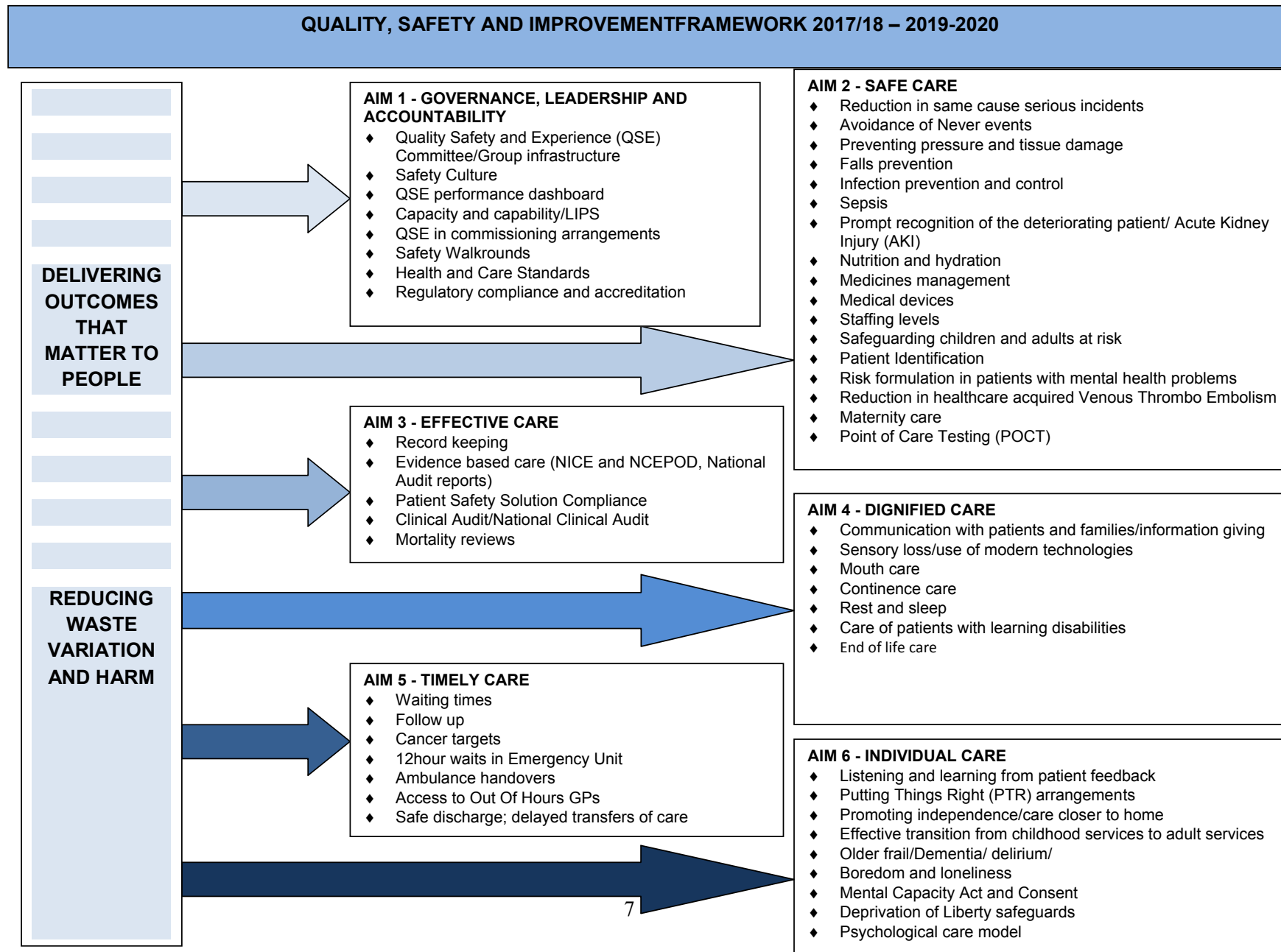
The UHB continues to support the work of the National Quality and Safety Forum and to contribute to the development of the National Quality Delivery plan for the next four years. Cardiff and Vale will also be leading a piece of work to develop a set of Quality Triggers for the NHS in Wales.

We look forward to working with our staff, patients, families and carers as well as our inspectors and other stakeholders, to implement our framework and will report progress in our Annual Quality Statements over the next three years.

Ruth Walker - Executive Nurse Director

QUALITY, SAFETY AND IMPROVEMENT FRAMEWORK 2017/18 – 2019-2020





AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
A well embedded QSE committee/group infrastructure.	◆ Embed the standardised QSE agenda at Directorate level across the UHB ◆ Standardise assurance reporting to UHB QSE Committee ◆ Develop the integrated QSE Board report to demonstrate robust reporting arrangements across the integrated healthcare system and cross organisational learning ◆ Implement Governance, Leadership and Accountability Standard	◆ Support Clinical Boards to strengthen assurance reporting from Directorate to Clinical Board ◆ Internal re-audit of QSE arrangements in Clinical Boards with specific focus on Directorate arrangements ◆ Further development of integrated QSE Board report ◆ Implement Governance, Leadership and Accountability Standard	◆ Implement findings of Internal Audit assessment ◆ Further development of integrated QSE Board report ◆ Implement Governance, Leadership and Accountability Standard
A strong safety culture is embedded at every level of the organisation	◆ Development of a Quality Governance training programme for senior leaders ◆ Publish Annual Quality Statement 16-17 ◆ Carry out Safety Culture Survey and develop improvement plan to address findings ◆ Develop a QSI quarterly newsletter reporting progress with the framework ◆ Develop a Communications plan to support implementation of the	◆ Implement a Quality Governance training programme for senior leaders ◆ Publish Annual Quality Statement for 17-18 ◆ Safety Culture Survey - implement improvement plan ◆ Continue QSI quarterly newsletter and evaluate ◆ Continue QSI Communications plan /evaluate ◆ Implement Human factors training	◆ Evaluate/Continue Quality Governance training ◆ Publish Annual Quality Statement for 18-19 ◆ Carry out Safety Culture Survey to establish whether there has been improvement ◆ Continue QSI quarterly newsletter building on output of the evaluation ◆ Continue QSI Communication plan building on evaluation ◆ Continue Human Factors

	framework/ explore use of social media to promote safety messages ♦ Explore the establishment of a Human Factors training programme		♦ training
Robust ways to monitor Quality Improvement and measurement are in place	♦ Develop an approach based on 'A framework for the monitoring and measurement of Safety' (Health foundation,2013) ♦ Lead National Quality Triggers Group	♦ Fully implement a framework for the monitoring and measurement of Safety' ♦ Implement National Quality Triggers	♦ Fully implement a framework for the monitoring and measurement of Safety' ♦ Implement National Quality Triggers
Local quality improvement capacity and capability building is developed to support and enable teams to identify and address local QSE improvement priorities	♦ Deliver LIPS x2 cohorts – build on number of joint projects with other UHBs ♦ Deliver RCA training x 3 cohorts ♦ Develop a UHB QSE leads network to share ideas and support implementation of the framework ♦ Strengthen links with 1000 lives programme ♦ Deliver Clinical Audit skills training ♦ Progress the establishment of CAV academy ♦ Implement Health and Care Standard 3.3 (self assessment and improvement plan)	♦ Deliver LIPS x2 cohorts - build on number of joint projects with other UHBs ♦ Deliver RCA training x 3 cohorts ♦ Further develop a UHB QSE leads network to share ideas and support implementation of the framework ♦ Further develop links with 1000 lives programme ♦ Deliver Clinical Audit skills training ♦ CAV academy ♦ Further Implementation Health and Care Standard 3.3 (self assessment and improvement plan)	♦ Deliver LIPS x2 cohorts - build on number of joint projects with other UHBs ♦ Deliver RCA training x 3 cohorts ♦ Further develop a UHB QSE leads network to share ideas and support implementation of the framework ♦ Further develop links with 1000 lives programme ♦ Deliver Clinical Audit skills training ♦ CAV academy ♦ Further Implementation Health and Care Standard 3.3 (self assessment and improvement plan)
QSE is embedded in all	♦ Develop a generic framework	♦ Implement a generic framework	♦ Further development of

commissioning arrangements	to strengthen QSE arrangements in commissioning ◆ Develop an improved process for the provision of QSE information to commissioners e.g. Welsh Health Specialised Services committee (WHSSC) and Powys	for QSE arrangements in commissioning	QSE commissioning arrangements
Safety Walkrounds take place as scheduled and provide a useful opportunity for Board members to understand safety issues across the UHB	◆ Review current approach and implement revised approach	◆ Continue schedule of Safety Walkrounds	◆ Continue schedule of Safety Walkrounds
The Health and Care Standards are embedded and aligned to work programmes of established groups/committees to move away from annual self assessment.	◆ Align 6 standards with well established committees/groups: ▪ Falls ▪ Nutrition ▪ Medication ▪ Medical Devices ▪ IP&C ▪ Safeguarding ◆ Reduce self assessment requirements for Clinical Boards	◆ Align the following standards with established groups/committees: ▪ Health Promotion, Protection and Improvement ▪ Managing Risk and Promoting Health and Safety ▪ Preventing Pressure and Tissue Damage ▪ Blood Management ▪ Safe and Clinically Effective Care ▪ Information Governance and Communications Technology ▪ Workforce	◆ Align the remaining standards with established groups/committees ▪ Record Keeping ▪ Patient Information ▪ Timely Access ▪ Listening and Learning from ▪ Feedback ▪ Dignified Care ▪ Planning Care to Promote Independence ▪ People's Rights
Regulatory compliance and	◆ Implement Health and Care	◆ Implement Health and Care	◆ Implement Health and

accreditation	Standard 2.1 ♦ Strengthen reporting of regulatory inspections to the QSE Committee and include in future work plan for QSE Committee	Standard ♦ Continue reporting of all regulatory inspections to QSE as appropriate	Care Standard 2.1 ♦ Continue reporting of all regulatory inspections to QSE as appropriate
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AIM 2 - SAFE CARE (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
Year on year reduction in same cause serious incidents that cause severe harm or death	♦ Continue monitoring of Endoscopy Improvement Plan ♦ Detailed review of themes and trends in SIs ♦ Near miss analysis exercise in each Clinical Board ♦ Review the integration of human factor considerations in all action planning ♦ Strengthen links to Clinical Board clinical audit plans to ensure that lessons learned are embedded and sustained ♦ Implement Health and care Standard 2.1; 3.1 ♦ Special QSE meeting in October 2017 ♦ Agree and set priorities for 18/19 depending on emerging trends	♦ Implement improvement plan for agreed priorities for 18/19 ♦ Implement Health and care Standard 2.1; 3.1 ♦ Special QSE meeting in October 2018 ♦ Clinical Board local clinical audit plans to reflect trends in SIs	♦ Implement improvement plan for agreed priorities for 19/20 ♦ Implement Health and care Standard 2.1; 3.1 ♦ Special QSE meeting in October 2018 ♦ Clinical Board local clinical audit plans to reflect trends in SIs

Year on year reduction in the number of same cause Never Events	◆ Undertake full risk assessment in relation to all known Never Events to ensure appropriate controls are in place ◆ Audit of Swab, Instruments and Sharps count ◆ Audit of NG insertion procedure in child and adult setting ◆ Audit of WHO checklist compliance in Theatres and in Dental School ◆ Establish infrastructure to implement NATSiPPs ◆ Link to clinical audit plan ◆ Special QSE meeting in October 2017	◆ Continue work to embed NATSiPPs ◆ Re - Audit of Swab, Instruments and Sharps count ◆ Re - Audit of NG insertion procedure in child and adult setting ◆ Re -Audit of WHO checklist compliance in Theatres and in Dental School ◆ Special QSE meeting in October 2017 ◆ Set priorities for focus in 19/20	◆ Implement improvements based on priorities for 19/20
Year on year reduction in avoidable healthcare acquired pressure and tissue damage	◆ Improve validation and reporting of pressure damage on Datix/increase Serious Incident reporting ◆ Implement the use of incident reporting data for KPI measurement ◆ Develop the Pressure Ulcer Group and agree a UHB plan for improvement ◆ Review Education programme ◆ Total bed management contract ◆ Revision of RCA pressure ulcer tool ◆ Implement Health and Care Standard 2.2	◆ Pressure Ulcer Group to focus priorities for 18/19 ◆ Implement education Programme ◆ RCA pressure ulcer tool ◆ Implement Health and Care Standard 2.2 ◆ Continue to monitor and report incidence of pressure damage ◆ Agree priorities for 19/20	◆ Pressure Ulcer Group to focus priorities for 19/20 ◆ Implement education Programme ◆ RCA pressure ulcer tool ◆ Implement Health and Care Standard 2.2 ◆ Continue to monitor and report incidence of pressure damage ◆ Agree priorities for 20/21

	◆ Monitor and report incidence of pressure damage ◆ Agree priorities for 18/19		
Year on year reduction in the number of falls and in the number of serious falls that cause severe harm or death	◆ Re-launch Falls Steering Group/develop overarching plan ◆ Baseline assessment against the Principles, Framework and national Indicators: Adult in-patient falls and develop improvement plan ◆ Appoint a Falls Strategy Implementation lead post ◆ Implement Health and Care Standard 2.3	◆ Falls Steering Group to oversee focus on improvements for 18/19 ◆ Implement Health and Care Standard 2.3	◆ Falls Steering Group to oversee focus on improvements for 18/19 ◆ Implement Health and Care Standard 2.3
A year on year reduction in the number of Healthcare Acquired Infections in line with or exceeding WG targets	◆ Antimicrobial delivery plan 17-18 (year 2) ◆ Multi-drug resistant organism procedure roll out/ managing anti-microbial resistance ◆ Primary care based RCA tool for staph aureus ◆ Aseptic Not Touch Technique (ANTT) roll out ◆ Fidaxomyxin –monitoring ◆ Consideration more interventions for IV drug abusers and wound management in the community (community acquired MSSA). ◆ Prevention of winter season outbreaks ◆ Delivery of WG targets for CDiff; MRSA,MSSA	◆ Antimicrobial delivery plan (year 3) ◆ Implement priorities for 18/19 ◆ Audit of ANTT ◆ Prevention of winter season outbreaks ◆ Delivery of WG targets for CDiff; MRSA,MSSA, Ecoli ◆ IP+C training -85% staff trained ◆ Implement Health and Care Standard 2.4 ◆ Agree priorities for 19/20	◆ Anti-microbial delivery plan 19-20 ◆ Implement priorities for 19/20 ◆ Prevention of winter season outbreaks ◆ Delivery of WG targets for CDiff; MRSA,MSSA, Ecoli ◆ IP+C training -85% staff trained ◆ Implement Health and Care Standard 2.4

	◆ 10% reduction in EColi ◆ UTI management and catheter care ◆ IP+C training -85% staff trained ◆ Revision of face to face training for Legionella ◆ Implement Health and Care Standard 2.4 ◆ Agree priorities for 18/19		
A year on year reduction in the number of deaths from Sepsis	◆ Re-design and launch of the sepsis pathway (NCEPOD;NICE) ◆ Evaluation of pilot wards ◆ Introduction of 'Making Sepsis personal' model (based on Nottingham feedback tool) ◆ Strengthen data collection methods in relation to Sepsis management compliance ◆ Education programme/training strategy ◆ Review and respond to the outcome of the Acute Care review across Wales ◆ Roll out NEWS in Community hospitals to achieve compliance with PSA002. ◆ Agree priorities for 18/19	◆ Audit of the Sepsis pathway ◆ Continue data collection ◆ Education programme/training strategy ◆ Sepsis group to oversee priorities for 18/19 and agree priorities for 19/20	◆ Audit of the Sepsis pathway ◆ Continue data collection ◆ Education programme/training strategy ◆ Sepsis group to oversee priorities for 19/20
All patients whose condition is deteriorating are recognised at the earliest possible opportunity Acute Kidney Injury (AKI) is	◆ RRAILS ◆ Full NEWS implementation ◆ Align with 1000 lives programme (wee wheel; kidney safe wristbands)	◆ Implement priorities for 18/19 ◆ Align with current 1000 lives priorities/initiatives ◆ Re - Audit of NEWS Compliance	◆ Implement priorities for 20/21 ◆ Align with current 1000 lives priorities/initiatives

prevented, detected and managed in line with NICE Guidance	◆ Assess current compliance with NICE guidance CG169 – AKI Prevention, detection and management ◆ Audit of NEWS compliance ◆ Audit of RRAILS ◆ Agree priorities for 18/19	◆ Re-audit of RRAILs ◆ Agree priorities for 19/20	
People are supported to meet their Nutritional and Hydration needs	◆ Introduction of new menus from April 2017 Nurse champion training (2 day programme) ◆ Multi-disciplinary nutrition and hydration audits ◆ Assurance reporting to Nutrition and catering steering group ◆ Model ward project – A4 (UHW); E2 (UHL) ◆ Introduction of person centred crockery ◆ Phase 1 – UHL, Barry, MHSOP ◆ Phase 2 –Children's Hospital ◆ Phase 3 –Rookwood, Iorwerth Jones ◆ Audit of 'Insertion of NG tube procedure' ◆ Implement Health and Care Standard 2.5 ◆ Identify priorities for 18/19	◆ Evaluation of new menu Scheme ◆ Implement priorities for 18/19 ◆ Multi-disciplinary nutrition and hydration audits ◆ Assurance reporting to Nutrition and catering steering group ◆ Implement Health and Care Standard 2.5 ◆ Identify priorities for 19/20	◆ Implement priorities for 19/20 ◆ Multi-disciplinary nutrition and hydration audits ◆ Assurance reporting to Nutrition and catering steering group ◆ Implement Health and Care Standard 2.5 ◆ Identify priorities for 19/20
People receive medication for the right reason, at the right dose and at the right time	◆ Use of e-prescribing – OPD Chemotherapy, electronic discharge (MTED) ◆ Prudent prescribing and de-	◆ Implement E-prescribing for in-patients ◆ Implement priorities for 18/19	◆ Implement priorities for 19/20 ◆ Work towards full implementation of Health and care Standard 2.6

A year on year decrease in the number of serious medication errors	- prescribing ◆ Implement the CODE ◆ Embed MARRS across the Multi-disciplinary team ◆ PSN 030 –annual re-audit ◆ E-learning programme ◆ Improve error data analysis ◆ Medical gases ◆ Agree audit programme for 18/19 ◆ Work towards full implementation of Health and care Standard 2.6 ◆ Agree priorities for 18/19	◆ Continue Prudent prescribing and de-prescribing ◆ Continue implementation of the CODE ◆ Embed MARRS across the Multi-disciplinary team ◆ Implement audit programme for 18/19 ◆ PSN 030 –annual re-audit ◆ E-learning programme ◆ Improve error data analysis ◆ Medical gases ◆ Work towards full implementation of Health and care Standard 2.6 ◆ Agree priorities for 19/20	
Medical Devices The UHB has in place safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems	◆ Medical equipment 5 year delivery plan – Well equipped to care' (year 1) ◆ Implement Health and Care Standard 2.9 ◆ Develop Datix reporting fields in relation to medical equipment related incidents ◆ Agree priorities for 18/19	◆ Medical equipment 5 year delivery plan – Well equipped to care' (year 2) ◆ Implement priorities for 18/19 ◆ Implement Health and Care Standard 2.9 ◆ Agree priorities for 19/20	◆ Medical equipment 5 year delivery plan – Well equipped to care' (year 2) ◆ Implement priorities for 19/20 ◆ Implement Health and Care Standard 2.9
There are suitable and sufficient numbers of staff working at all levels across the organisation to deliver safe, high quality care	◆ Implementation of the requirements of the Nurse Staffing levels (Wales) Act 2016 ◆ Implement Health and Care Standard 7.1 ◆ Weekly monitoring of reported staff shortages ◆ Delivery of Workforce and	◆ Monitor compliance with Nurse Staffing levels (Wales) Act 2016 ◆ Implement Health and Care Standard 7.1 ◆ Weekly monitoring of reported staff shortages ◆ Delivery of Workforce and Organisational Development	◆ Monitor compliance with Nurse Staffing levels (Wales) Act 2016 ◆ Implement Health and Care Standard 7.1 ◆ Weekly monitoring of reported staff shortages ◆ Delivery of Workforce and Organisational Development

	Organisational Development Framework priorities	Framework priorities	Framework priorities
The welfare of children and adults who become vulnerable or at risk is promoted and protected at all times	◆ Review of current resource ◆ Information sharing mechanisms ◆ Social Services Wellbeing (Wales) Act ◆ Deliver Female Genital Mutilation (FGM) agenda ◆ Deliver Domestic Abuse agenda ◆ Multi –Agency Safeguarding Hub ◆ Safeguarding training uptake >85% ◆ Implement Health and Care Standard 2.7 ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Social Services Wellbeing (Wales) Act ◆ Deliver Female Genital Mutilation (FGM) agenda ◆ Deliver Domestic Abuse agenda ◆ Multi –Agency Safeguarding Hub ◆ Safeguarding training uptake >85% ◆ Implement Health and Care Standard 2.7 ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20 Social Services Wellbeing (Wales) Act ◆ Deliver Female Genital Mutilation (FGM) agenda ◆ Deliver Domestic Abuse agenda ◆ Multi –Agency Safeguarding Hub ◆ Safeguarding training uptake >85% ◆ Implement Health and Care Standard 2.7
All patients are positively identified to ensure that the right person receives the right treatment Reduction in the number of patient mis-identification incidents Reduction in the number of Ionising Radiation (Medical Exposure) regulations (IRMER) breaches due to mis-identification	◆ LIPS project implementation ◆ Secure compliance with Patient Safety Notice (PSN) 026 – Positive Patient identification; NPSA PSN 024 Standardising wristbands improves patient safety ◆ Review of positive Patient ID Policy and associated launch ◆ Launch Patient ID logo ◆ Patient ID task and finish group ◆ Focus on addressograph label campaign ◆ Wristband audit	◆ Implement priorities for 18/19 ◆ Wristband audit ◆ Audit of Patient identification Policy ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20 ◆ Wristband audit ◆ Audit of Patient Identification Policy

	◆ Agree priorities for 18/19		
Risk formulation in patients with mental health problems	◆ To produce a Suicide and Self harm reduction action plan as a mental health collaborative in Cardiff and Vale ◆ Identify priorities for 18/19	◆ Implement priorities for 18/19 ◆ Identify priorities for 19/20	◆ Identify priorities for 19/20
Year on year reduction in the incidence of proven hospital acquired thrombosis (HAT)	◆ Mandated risk assessment/associated prescribing of thrombo - prophylaxis in each Clinical Board ◆ Audit of thrombo – prophylaxis practice ◆ Embed systems to demonstrate good practice and outcomes ◆ Identify active Clinical Board leads in anticoagulation and thrombo- prophylaxis who proactively review Clinical Board practice/procedures ◆ Fully funded thrombosis prevention nurse ◆ HAT reporting strengthened in Datix ◆ Identify priorities for 18/19	◆ Implement priorities for 18/19 ◆ Audit of thrombo – prophylaxis practice ◆ Identify priorities for 19/20	◆ Implement priorities for 19/20
Year on year reduction in peri-natal mortality Year on year reduction in maternal deaths and morbidity	◆ Diabetes in pregnancy ◆ Peri-natal mental health ◆ Sepsis ◆ Implementing recommendations from MBRRACE – UK report ◆ Prudent maternity care –	◆ Implement priorities for 18/19 ◆ Diabetes in pregnancy ◆ Peri-natal mental health ◆ Sepsis ◆ Implementing recommendations from	◆ Implement priorities for 19/20 ◆ Diabetes in pregnancy ◆ Peri-natal mental health ◆ Sepsis ◆ Implementing recommendations from

	continuity of care; home births/Midwifery led unit/45% of women eligible to start labour outside of obstetric unit ♦ Implement new model of Statutory Supervision of midwives in Wales ♦ Agree priorities for 18/19	MBRRACE – UK report ♦ Prudent maternity care – continuity of care; home births/Midwifery led unit/45% of women eligible to start labour outside of obstetric unit ♦ Statutory Supervision of midwives in Wales ♦ Agree priorities for 19/20	MBRRACE – UK report ♦ Prudent maternity care – continuity of care; home births/Midwifery led unit/45% of women eligible to start labour outside of obstetric unit ♦ Statutory Supervision of Midwives in Wales
Safe and effective delivery of point of care testing (POCT)	♦ Implement WPOCT to link up all POCT connectivity devices ♦ Training and competency ♦ Assessor training ♦ Work with GPs in primary care on POCT to support the anti-microbial strategy/review primary care Blood Glucose formulary ♦ Agree priorities for 18/19	♦ Implement priorities for 18/19 ♦ Continue to implement WPOCT to link up all POCT connectivity devices ♦ Training and competency ♦ Assessor training ♦ Work with GPs in primary care on POCT to support the anti-microbial strategy/review primary care Blood Glucose formulary ♦ Agree priorities for 19/20	Implement priorities for 19/20

AIM 3 - EFFECTIVE CARE (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
A year on year increase in positive findings in record keeping audits	♦ Introduce new Integrated Assessment Document ♦ Begin preparatory work for the standardisation of core documents across the UHB ♦ Education programme	♦ Implement priorities for 18/19 ♦ Record keeping audit ♦ Communication plan ♦ Implement Health and Care Standard 3.5	♦ Implement priorities for 18/19 ♦ Record keeping audit ♦ Communication plan ♦ Implement Health and Care Standard 3.5

	◆ Embedded Audit programme and feedback ◆ Agree a communication plan to promote good record keeping ◆ Record keeping audit ◆ Data quality group ◆ Implement Health and Care Standard 3.5 ◆ Agree priorities for 18/19	◆ Agree priorities for 19/20	
Demonstrable improvement in governance associated with the implementation of NICE Guidance	◆ Establish NICE implementation Group ◆ Revise current UHB Policy ◆ Support the work of the All Wales NICE liaison group ◆ Implement Health and Care Standard 3.1 ◆ Align Local Clinical Audit plan for 18/19 with key NICE guidance ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Implement Health and Care Standard 3.1 ◆ Support the work of the All Wales NICE liaison group ◆ Align Local Clinical Audit plan for 19/20 with key NICE guidance ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20 ◆ Support the work of the All Wales NICE liaison group ◆ Implement Health and Care Standard 3.1
The UHB demonstrates increasing compliance with all Patient Safety Solutions/notices/alerts (aiming for 100% compliance)	◆ Revise and refresh processes ◆ Establish Patient Safety Solutions Group ◆ Secure ring-fenced time for dedicated Patient Safety facilitator ◆ Implement solutions to address areas of outstanding non-compliance with priority	◆ Implement priorities for 18/19 ◆ Work towards full implementation of NATSIPPS ◆ Continue audit of compliance with historical alerts ◆ maintain intranet site ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20 ◆ Continue audit of compliance with historical alerts

	given to implementation of electronic wristbands to reduce Patient Misidentification and to full compliance with the Sepsis Alert. ◆ Work towards full implementation of NATSIPPS ◆ Develop UHB intranet site ◆ Implement audit programme to confirm compliance with key historical notices/alerts ◆ Agree priorities for 18/19		
There are systems in place to ensure that variation from best practice is properly recorded and audited and risk are identified and managed appropriately Increased compliance with agreed Local Clinical Audit Plans (CAPs) across Clinical Boards Year on year improvements in UHB performance in National Audit reports	◆ Introduction of electronic clinical audit system AMAT ◆ Implement Local Clinical Audit plan for 17-18 ◆ Improve reporting of compliance with Local CAPs ◆ Implement Health and Care Standard 3.1 ◆ Comply with requirement of the National Clinical Audit and outcomes Review programme ◆ Refine processes related to the reporting and monitoring of National Audit reports ◆ Agree local CAPs for 18/19	◆ Evaluate the introduction of AMAT ◆ Implement Local CAP for 18-19 ◆ Reporting of compliance with Local CAPs ◆ Implement Health and Care Standard 3.1 ◆ Comply with requirement of the National Clinical Audit and outcomes Review programme ◆ Agree Local CAPs for 19/20	◆ Implement Local Clinical Audit plan for 19-20 ◆ Report compliance with Local CAPs ◆ Implement Health and Care Standard 3.1 ◆ Comply with requirement of the National Clinical Audit and outcomes Review programme

The death of every patient is reviewed to identify whether there are lessons to be learned	◆ Implement a structured review method in line with Royal College Physicians guidance on mortality case records review and record on Electronic Mortality Audit tool ◆ Preparation for Medical Examiner Role ◆ Establish interface between Datix and Business Intelligence Service ◆ Ensure that learning Disability Icon features on EMAT ◆ Identify priorities for 18/19	◆ Implement priorities for 18/19 ◆ Identify priorities for 19/20	◆ Implement priorities for 19/20
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AIM 4 - DIGNIFIED CARE (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
The individual language and communication needs of services users are met and specifically those with sensory loss.	◆ Implement improved QA of public facing literature and leaflets ◆ Translation/interpretation services ◆ Deliver Being Open training ◆ Deliver Breaking bad news training ◆ Deliver Sensory loss plan	◆ Implement priorities for 18/19 ◆ Implement Health and Care Standard 3.2; 4.1;4.2 ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20 ◆ Implement Health and Care Standard 3.2; 4.1;4.2

	◆ Implement Health and Care Standard 3.2; 4.1;4.2 ◆ Agree priorities for 18/19		
People are supported to keep a clean healthy mouth and pain free teeth and gums Year on year improvement in the outcomes of mouth care audits	◆ Procurement of mouth care equipment ◆ Increase uptake of mouth care programme ◆ Develop and implement mouth care audit ◆ Committed to Care ◆ Build mouth care in to Preceptor ship programme ◆ Develop priorities for 18/19	◆ Implement priorities for 18/19 ◆ Continue moth care audit ◆ Develop priorities for 19/20	◆ Implement priorities for 19/20
Continence care is appropriate and discreet. Prompt assistance is provided taking into account peoples specific needs and privacy. Year on year reduction in the number of complaints which feature continence Year on year improvement in the quality of continence assessments	◆ Focus on the procurement of continence products ◆ Strengthen current education programme ◆ Focus on meeting OPC requirements to measure loss of continence and impact ◆ Develop a system of reporting o OPC requirements ◆ Develop a programme of audit in relation to continence assessment and care ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Improve reporting of OPC requirements in Board reports ◆ Deliver audit programme ◆ Agree priorities for 19/20	◆ Implement priorities for 18/19
People report that they are able to get enough rest and sleep when in hospital Year on year increase in expressed satisfaction with ability to sleep and rest	◆ Specialling project – trial in UHL ◆ Continue 2minutes of your time ◆ Introduce Hot drinks at night – UHW focus ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20

Implementation of Learning disabilities(LD) bundle	◆ Full roll out of the LD bundle ◆ Bring together commissioning functions ◆ Develop a more Integrated approach to services ◆ Strengthen processes for the review of the deaths of patients with LD in primary, community and acute settings ◆ Improve Access and support for patients with Learning disabilities ◆ Ensure Annual Health Checks are in place in primary care ◆ Implement Health and Care Standard 6.2 ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Review commissioning functions in relation to LD services ◆ Implement Health and Care Standard 6. ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20
End of life care A year on year increase in the number of people who die in the preferred place of care A year on year increase in the number of patients who receive specialist palliative care before they die A year on year increase in expressed patient family satisfaction with care A year on year reduction in the number of people who require emergency admission to hospital in	◆ Implementation of the End of Life Delivery plan ◆ Implementation of the paediatric palliative medicine delivery plan ◆ Agree priorities for 18/19	◆ Implementation of the End of Life Delivery plan ◆ Implementation of the paediatric palliative medicine delivery plan ◆ Implement priorities for 18/19 ◆ Agree priorities for 19/20	◆ Implementation of the End of Life Delivery plan ◆ Implementation of the paediatric palliative medicine delivery plan ◆ Implement priorities for 18/19

the year before they die			
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AIM 5 - TIMELY CARE (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
Referrals for treatment are met in line with national guidance, timescales and pathways. Areas for specific attention: Endoscopy Ophthalmology	Continue to: ◆ Deliver priorities for Planned care as set out in the IMTP ◆ Improve performance for our elective patients waiting more than 36 weeks for certain procedures. ◆ Reduce waiting times for cancer. ◆ Improve waiting times for patients waiting for certain diagnostic procedures. ◆ Explore the introduction harm reviews for patients who breach targets in selected high priority specialities. ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 18/19 ◆ Support targeted use of PROMS and PREMS	◆ Deliver priorities for Planned care as set out in the IMTP 18/19 ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 19/20	◆ Deliver priorities for Planned care as set out in the IMTP 19/20 ◆ Implement Health and Care Standard 5.1
Patients are followed up in line with national guidance, timescales and pathways. Areas for specific attention: Endoscopy Ophthalmology	◆ Deliver priorities for Planned care as set out in the IMTP 17/18 ◆ Reduce the number of patients overdue their follow up appointment.	◆ Deliver priorities for Planned care as set out in the IMTP 18/19 ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 19/20	◆ Deliver priorities for Planned care as set out in the IMTP 19/20 ◆ Implement Health and Care Standard 5.1

	◆ Continue to reduce the number of follow up patients recorded on PMS without a follow up date. ◆ Through implementation of the UHB's Endoscopy Plan, reduce the number of endoscopy surveillance patients waiting >8 weeks past their planned appointment date. ◆ Explore the introduction harm reviews for patients who breach targets in selected high priority specialities. ◆ Implement Health and Care Standard 5.1 ◆ Support targeted use of PROMS and PREMS		
Cancer targets Year on year improvement against Tier 1 targets Year on year reduction in cancer related serious incidents and concerns	◆ Delivery of the UHB Cancer Plan ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 18/19	◆ Delivery of the UHB Cancer Plan ◆ Implement priorities for 18/19 (IMTP) ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 19/20 (IMTP)	◆ Delivery of the UHB Cancer Plan ◆ Implement Health and Care Standard 5.1
Year on year reduction in the number of 12 hour waits in EU	◆ Develop and implement additional 'direct-access' care pathways via WAST in line with IMTP 17/18: ▪ Fractured NOF ▪ Ambulatory Emergency	◆ Implement priorities for 18/19 ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20

	- Care ▪ Emergency Gynaecology (PV bleed) ▪ Cardiology care (for certain conditions) ◆ Establish new trauma and emergency surgery pathways (IMTP) ◆ Establish new emergency care pathways (IMTP) ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 18/19		
A year on year improvement in ambulance handover times	As above	As above	As above
Improve access to primary care services - for specific attention: Access to Out Of Hours General Practitioners	◆ increase level of out of hours GP cover at peak times and weekends ◆ Carry out governance review of the Out of Hours service ◆ Introduce new rota system for health care practitioners ◆ Secure sustainable funding stream to support the OOH service ◆ Implement Health and Care Standard 5.1 ◆ Agree priorities for 18/19	◆ implement priorities for 18/19 ◆ Implement Health and Care Standard 5.1 ◆ agree priorities for 19/20	◆ implement priorities for 19/20
Safe discharge; A year on year reduction in the number of delayed transfers of care	◆ Deliver Sustainable Unscheduled Care Priorities as set out in IMTP for 17/18 ◆ Focus on pre-hospital support to people ◆ Single point of entry for	◆ Deliver Sustainable Unscheduled Care Priorities as set out in IMTP for 18/19	◆ Deliver Sustainable Unscheduled Care Priorities as set out in IMTP for 19/20

	children ♦ Widen the availability of alternatives to admission ♦ Re-launch central discharge support service ♦ Re-model selected medical wards at UHW and UHL ♦ Further develop community pathways ♦ Collaborative working between UHB, Local Authorities, independent and third sectors (Phase 2)		
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AIM 6 - INDIVIDUAL CARE (see detailed delivery plan)

OUTCOME	2017/2018	2018/2019	2019/2020
The UHB responds to a range of feedback methods from patients to ensure that services are shaped by and meet the needs of people it serves (this aligns with and will be delivered through implementation of the Patient Experience Framework) A year on year increase in expressed satisfaction with the quality of services and the patient experience	Implement the Patient Experience Framework ♦ Refine and develop how we gather service user feedback ♦ Develop systems to ensure effective triangulation of service user experience data ♦ Develop procedures to ensure service user feedback is shared as contemporaneously as possible ♦ Develop opportunities for service user involvement in service	• Implement the Patient Experience Framework ♦ Implement priorities for 18/19 ♦ Implement Health and Care Standard 6.3 ♦ Agree priorities for 19/20	• Full Implementation of the Patient Experience Framework ♦ Implement Health and Care Standard 6.3 ♦ Implement priorities for 19/20

	- improvement/development ◆ Equip staff with the knowledge and skills to engage with service users in a proactive, customer focused way ◆ Implement Health and Care Standard 6.3 ◆ Agree priorities for 18/19		
The UHB complies with the legislation and guidance to deal with concerns, near misses, incidents and claims as set out in the Putting Things Right arrangements A year on year increase in compliance with PTR targets	◆ Implementation of the revised PTR guidance when issued by WG ◆ Implement Welsh Risk Pool action plan ◆ Identify priorities for 18/19 ◆ Implement Health and Care Standard 6.3	◆ Implement priorities for 18/19 ◆ Implement Health and Care Standard 6.3 ◆ Identify priorities for 19/20	◆ Implement priorities for 19/20 ◆ Implement Health and Care Standard 6.3
Promotion of independence and care closer to home	◆ Implement Health and Care Standard 6.1	◆ Implement Health and Care Standard 6.1	• Implement Health and Care Standard 6.1
Achieve effective and efficient transition from childhood services to adult services for those with life limiting and chronic conditions	◆ An application has been submitted for a Transition Fellowship post for 2017 ◆ audit of current practice for transition services within acute child health ◆ development of service improvement plan ◆ Agree priorities for 18/19	◆ Implement priorities for 18/19 ◆ Agree priorities for 19/20	◆ Implement priorities for 19/20
The needs of people with Dementia and their carers are being met (link to Cardiff and Vale dementia 3 year plan)	◆ Delivery of Year 1 of the 2017-2020 Dementia 3 year plan ◆ Roll out of the 'Read about me –patient passport	◆ Delivery of Year 2 of the 2017-2020 Dementia 3 year plan ◆ Continue to roll out of the 'Read about me –patient	◆ Delivery of Year 3 of the 2017-2020 Dementia 3 year plan ◆ Continue to roll out of the 'Read about me –patient

	◆ Implement the recommendations of the Royal College of Psychiatrists review when published ◆ Ensure Clinical Boards are meeting the now mandatory Dementia training targets (>85% trained) ◆ Implement Health and Care Standard 4.1; 6.2	passport ◆ Ensure Clinical Boards are meeting the now mandatory Dementia training targets (>85% trained) ◆ Implement Health and Care Standard 4.1; 6.2	passport ◆ Ensure Clinical Boards are meeting the now mandatory Dementia training targets (>85% trained) ◆ Implement Health and Care Standard 4.1; 6.2
Boredom and loneliness	▪ Implement Health and Care Standard 4.1 ▪ Continue: ➢ Provision of activity kits, knitting needles and wool, puzzle books ➢ Provision of newspapers and magazines from the shops when they attend ➢ Lending library ➢ Provision of TVs, Radio, DVDs in dayrooms ➢ Activity Volunteers and befriending Volunteers ➢ Roll out of Digital Reminiscence therapy equipment introduced to UHW ward A7 ➢ Audio books, DVDs, DVD players purchased from Charitable funds ➢ Music therapy and creative art funded by Charitable funds ➢ “My Dementia” - two	▪ Implement Health and Care Standard 4.1	▪ Implement Health and Care Standard 4.1

	large touch screens and eight tablets enabling patients to access a variety of content such as a jukebox, films and old radio broadcasts ➤ Fiddle muffs/cuffs procured from local charities by Sister/Charge Nurses ▪		
Valid consent is obtained in line with best practice and people are assessed and cared for in line with the Mental Capacity Act and where appropriate Deprivation of Liberty safeguards 2009.	▪ Review current education programme ▪ Undertake annual UHB wide audit ▪ Implement Health and Care Standard 4.2	▪ Implement revised education programme ▪ Undertake annual UHB wide audit ▪ Implement Health and Care Standard 4.2	▪ Undertake annual UHB wide audit ▪ Implement Health and Care Standard 4.2
Psychological care model	▪ Reduce psychology/counselling waiting times from 6 months to 1 year ▪ Ensure WG funding from Psychological therapies supports direction of MATRICS Cymru ▪ Identify priorities for 18/19	▪ Implement priorities for 18/19 ▪ Identify priorities for 19/20	▪ Implement priorities for 19/20

HOW WILL WE MEASURE, MONITOR AND REPORT THIS?

The UHB will continue to develop a reliable and effective Quality, Safety and Experience dashboard as part of a range of evolving measures, designed to monitor implementation of the framework. We will base this work on the model for Safety measurement and monitoring (The Health Foundations, 2013 – Appendix 2) and will expect to be able to measure and monitor a range of indicators which will include:

- ◆ Evidence of a stronger Safety culture embedded at all levels and across the whole organisation
- ◆ Improvement in compliance with the Health and care Standards year on year
- ◆ A reduction in repeat cause serious incidents and Never Events
- ◆ A reduction in the incidence of hospital acquired infections in line with or exceeding WG targets
- ◆ Significant reductions in medication errors, blood transfusion incidents and IRMER breaches caused as a result of patient misidentification
- ◆ Reduced waiting times in line with WG targets
- ◆ Significant reduction in serious incidents related to out-patient follow up
- ◆ Significant reduction in the number of concerns which relate to a failure to recognise a deteriorating patient
- ◆ Harm reviews for patients who breach waiting time targets

- ◆ Improved compliance with our Sepsis 6 bundle and a reduction in mortality from Sepsis
- ◆ A reduction in the number of missed opportunities to appropriately engage patients in Mental health services in their care
- ◆ A year on year improvement in Mortality rates in key patient conditions e.g. stroke, heart attack and fractured neck of femur
- ◆ Reliable adherence with NICE guidance which the UHB has agreed to implement
- ◆ Positive feedback from unannounced visits by Healthcare Inspectorate Wales and the Community Health Council
- ◆ A reduction in formal concerns raised with the UHB
- ◆ Year on year increasing satisfaction with services expressed by our service users across the integrated healthcare system
- ◆ Full compliance with all NHS Wales Patient Safety Solutions and historical alerts and notices.

- Implementation of our Quality, Safety and Improvement Framework will be **monitored by our QSE Committee**, a sub-committee of the Board.
- **A detailed delivery plan to achieve each 'Aim'** will be developed and approved by the QSE Committee.
- The Board will be regularly appraised of key issues in an **Integrated Quality, Safety and Experience Board report**.
- Our **Annual Quality Statement** will provide an open and honest account of how we are progressing over the next three years.

[Appendix 1]

Implementing the Quality, Safety and Improvement Framework 2017/2018 – 2019/2020

Aim	Action	2017-2018				2018 -2019				2019-2020			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY To develop a structure in which accountabilities, roles and responsibility for the delivery of high quality, safer care is clear.	A well embedded QSE committee/group infrastructure.												
	A strong safety culture is embedded at every level of the organisation.												
	Robust ways to monitor Quality Improvement and measurement are in place.												
	Local quality improvement capacity and capability building is developed to support and enable teams to identify and address local QSE improvement priorities.												
	QSE is embedded in all commissioning arrangements.												
	Safety WalkRounds.												

	The Health and Care Standards are embedded and aligned to work programmes of established groups/committees to move away from annual self assessment.												
AIM 2 – SAFE CARE To protect people from avoidable harm and support them to protect themselves from known harm.		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Reduction in same cause serious incidents that cause severe harm or death.												
	A reduction in the number of same cause Never Events.												
	Reduction in avoidable healthcare acquired pressure and tissue damage.												
	Reduction in the number of falls and in the number of serious falls that cause severe harm or death.												
	A reduction in the number of Healthcare Acquired Infections in line with or exceeding WG targets.												
	A reduction in the												

	number of deaths from Sepsis.												
	All patients whose condition is deteriorating are recognised at the earliest possible opportunity												
	People are supported to meet their Nutritional and Hydration needs.												
	People receive medication for the right reason, at the right dose and at the right time.												
	There are suitable and sufficient numbers of staff working at all levels across the organisation to deliver safe, high quality care												
	The welfare of children and adults who become vulnerable or at risk is promoted and protected at all times.												
	All patients are positively identified to ensure that the right person receives the right treatment.												
	Risk formulation in patients with mental												

	health problems												
	Reduction in the incidence of hospital acquired thrombosis.												
	Safe and effective delivery of point of care testing (POCT)												

AIM 3 - EFFECTIVE CARE To give people the right care or support, based on best practice, to meet their individual needs.		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Excellent record keeping underpins effective and safer care and records are maintained in line with legislation and clinical guidance standards.												
	People receive high quality, safe care based on best available evidence.												
	The UHB demonstrates compliance with all Patient Safety Solutions/notices/alerts.												
	There are systems in place to ensure that variation from best practice is properly												

	recorded and audited and risks are identified and managed appropriately.												
	The death of every patient is reviewed to identify whether there are lessons to be learned.												

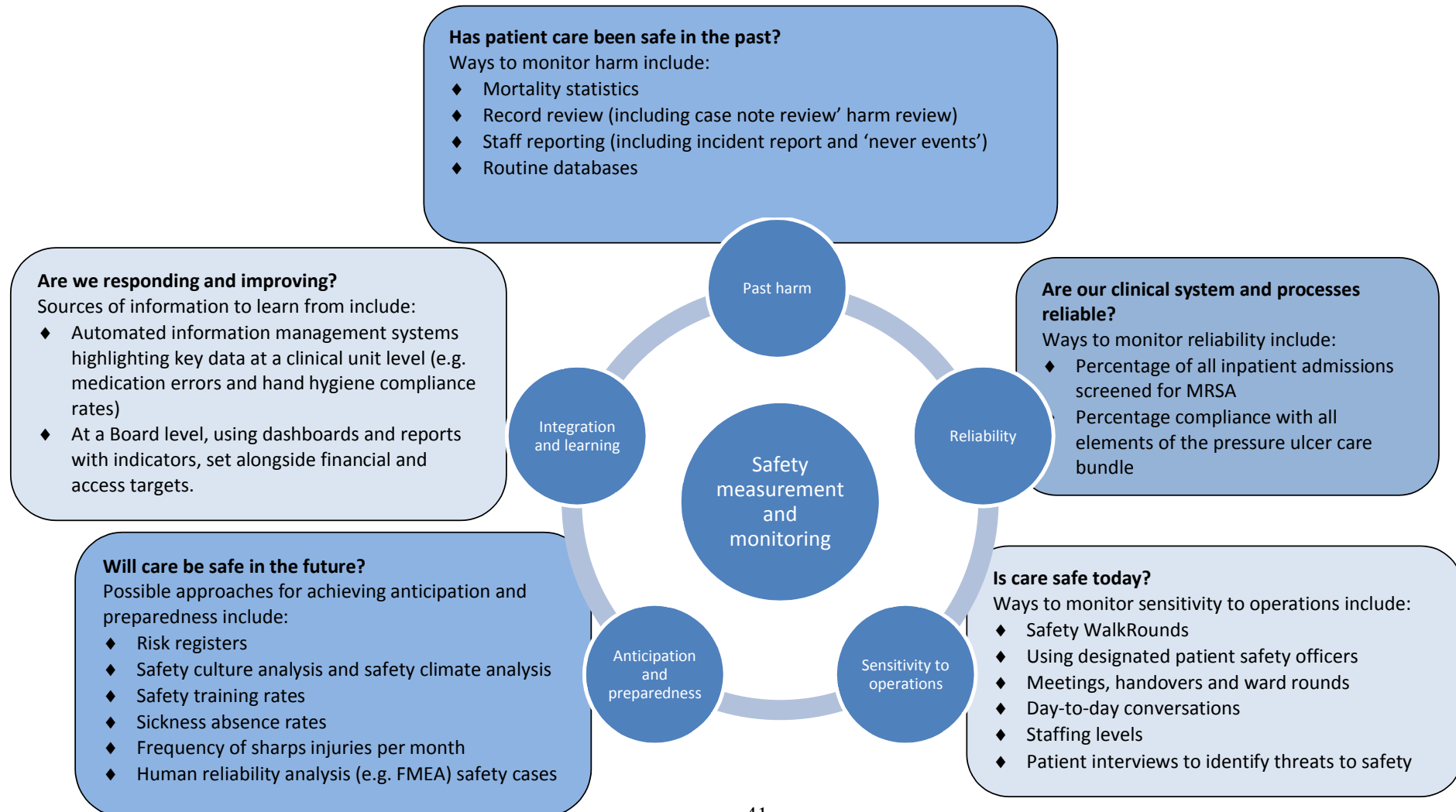
AIM 4 – DIGNIFIED CARE To ensure that people are always treated with compassion, dignity and respect.		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	The individual language and communication needs of service users are met and specifically those with sensory loss.												
	People are supported to keep a clean healthy mouth and pain free teeth and gums.												
	Continence care is appropriate and discreet. Prompt assistance is provided taking into account peoples specific needs and privacy.												
	People report that they are able to get enough rest and sleep when in												

	hospital.												
	Implementation of Learning disabilities (LD bundle.												
	End of life care												
AIM 5 - TIMELY CARE		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
To ensure that people have timely access to services based on clinical need and are cared for in the right way, at the right time in the right place by the right staff.	Referrals for treatment are met in line with national guidance, timescales and pathways. Areas for specific attention: Endoscopy Ophthalmology												
	Patients are followed up in line with national guidance, timescales and pathways. Areas for specific attention: Endoscopy Ophthalmology												
	Cancer targets.												
	Reduce the number of 12 hour waits in EU.												
	Ambulance handovers												
	Improve access to primary care services. For specific attention: Access to OOH GPs.												
	Safe discharge;												

	reduction in the number of delayed transfers of care.												
AIM 6 - INDIVIDUAL CARE		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
To ensure that people are respected as unique individuals and that this is an integral part of all care delivered.	The UHB responds to a range of feedback methods from patients to ensure that services are shaped by and meet the needs of people it serves. (This aligns with and will be delivered through implementation of the Patient Experience Framework).												
	The UHB complies with the legislation and guidance to deal with concerns, near misses, incidents and claims as set out in the Putting Things Right arrangements.												
	Achieve effective and efficient transition from childhood services to adult services for those with life limiting and chronic conditions.												
	The needs of people with Dementia and their carers are being met.												

	(link to Cardiff and Vale dementia 3 year plan).												
	Boredom and loneliness												
	Valid consent is obtained in line with best practice and people are assessed and cared for in line with the Mental Capacity Act and where appropriate Deprivation of Liberty Safeguards 2009.												

A FRAMEWORK FOR THE MEASUREMENT AND MONITORING OF SAFETY



/ 1

Based on the work of Vincent C, Burnett S, Carthey J.
The measurement of monitoring of safety. The Health Foundations, 2013

PATIENT EXPERIENCE REFRESHED FRAMEWORK 2017 – 2020	
Name of Meeting :	Quality, Safety and Experience Committee
Date of Meeting:	18 April 2017
Executive Lead :	Executive Nurse Director
Author :	Acting Assistant Director of Patient Experience
Caring for People, Keeping People Well :	The Framework has been refreshed to support and deliver the following elements of the UHB Strategy –Delivering Outcomes that matter to people; this approach will support the opportunity to work together to dramatically improve patient experience and drive equity of healthcare value for our patients and service users.
Financial impact :	Delivery of the framework has the potential to reduce costs by listening and acting upon positive and negative feedback
Quality, Safety, Patient Experience impact :	the framework has been written to deliver improvements in key areas of the patient experience framework and to align to each area of the quadrant .
Health and Care Standard Number :	this covers implementation of all Health and Care Standards.
CRAF Reference Number:	5.1
Equality and Health Impact Assessment Completed:	No but it is anticipated that full implementation of the Framework would lead to positive equality and health impacts

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The plans in place to monitor and evaluate implementation over the next three years.
- The collaborative working with internal and external stakeholders to deliver the framework

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Patient Experience Refreshed framework
- **AGREE** to monitor the implementation of the framework and to receive twice yearly progress updates

SITUATION

The purpose of this report is to present the Refreshed patient experience Framework 2017 - 2020.

BACKGROUND

In developing this framework consideration has been given to representing the views of all service users.

The framework will operate in conjunction with the Health Board strategy and the Quality and Safety Framework.

The triangulation of information from external inspections and reports such

-  Community Health Council
-  Health Inspectorate Wales
-  Public service Ombudsman
-  Third sector organisations

Will be considered with internal feedback.

ASSESSMENT AND ASSURANCE

Our priorities are aligned with some of the key domains within the Health and Care Standards framework 2015,

The framework will aim to ensure that we hear and actively listen to the voices of our service users. It will ensure that we can demonstrate our response to their feedback.

It will be applicable across all health care settings in primary and secondary care. We wish to work with the third sector organisations and we value their support with many of our patient experience activities

The framework is part of our quality assurance system

The clinical board submissions for each annual Health and Care standards report should demonstrate the embedded maturity of the framework.

Our Annual Quality Statement will account of how we are progressing with the implementation of the framework over the next three years.

Patient Experience Framework 2017 to 2020

Cardiff and Vale University Health Board wants to listen and learn from our Patients, Visitors, Carers and Staff.

2017-2020

The Health Board has refreshed the Patient Experience Framework to incorporate all elements of real time, retrospective, proactive/reactive and balancing patient experience across the UHB and primary care. Much of the detail in the framework has been informed by the All Wales Listening and Learning Group which has been established to embed the learning from the Evans Review "The Gift of Complaints" and to share good practice across Wales.

Real Time Short Surveys Used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment)	Retrospective Surveys post discharge or any clinical encounter in any setting to gain in-depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience measures (PROM/PREM)
Proactive/Reactive Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	Balancing Concerns and complaints Compliments Patient stories Focus groups Third party surveys such as Community Health Council and voluntary organisations

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Evans (2014) in his review of the Concerns processes in Wales proposed that in order to reduce complaints and improve the service user experience, there is a need to shift to a customer care focus within NHS Wales and recommended moving the patient care experience beyond snapshot audits and developing a culture whereby ***“...every individual having a contact within the NHS in Wales can have the opportunity to make comments, positive or critical”***

In order to capture service user feedback it is recognised that there is no single method that can provide the assurance that Health Boards require and that a number of methods are required for triangulation to verify findings and make improvements. To support this approach The All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback

Patients, families and carers can provide feedback in a wide variety of ways. Some may be specifically designed by organisations to encourage feedback; however there are many other ways in which feedback can be obtained. It is important that patients, families and carers feel that their views, positive, negative or neutral, are welcomed, that notice will be taken of what is said and improvements made where necessary. Organisations should use feedback from all sources to gain a balanced view of experience. There will be a difference between information solicited by surveys and information that has been provided by a user actively sending a compliment or raising concerns.

‘Listening’ must be a planned activity, built into the structures to ensure it happens. All staff must have a clear role in supporting this communication and in being able to highlight any issues through clear escalation arrangements.

Organisations must recognise that listening to patients and responding in a timely and effective manner can avoid some concerns progressing to a more serious level. It is essential that learning occurs from what has gone wrong. In these instances concerns need to be proportionately investigated to ensure that systems are put in place to minimise the likelihood of concerns recurring

This refreshed framework will outline how we wish to engage, listen, learn and action learning over the next 3 years.

Cardiff and Vale University Health Board is committed to creating a culture that welcomes and facilitates the involvement of patients and the public from all communities it serves in the development, improvement and monitoring of services and patient care.

To achieve this, this document recognises that involvement will have to be developed in many different ways, involving a wide range of people and linked to the requirements of the standards for health care and operational demands of the Health Board.

The Framework will ensure that there is a comprehensive infrastructure in place to gain regular and robust feedback that is used to plan and improve the services user experience. The methodology to gain feedback will be multi-faceted,

The framework is intended to support the Health Boards objectives

Improving patient and user experience must be at the heart of the delivery of care for NHS Wales. There must be a commitment that patients will be listened to and that feedback from the experiences of patients, families and carers will be obtained, published and acted upon by primary, community and secondary care. Equally there should be adequate support provided to those expressing a concern.

What does a good service user experience look like?

The Wales Audit Office (2016) outlines how listening to the experiences of service users should be a fundamental part of learning in the NHS and in order to learn effectively, there is a need for structured, planned activity that is built in to normal working practices.

The NHS Wales Framework for Assuring Service User Experience was initially published in May 2013 and updated in 2015. The requirement to update the Framework was in light of Keith Evans report 'Using the Gift of Complaints'. Additions therefore to the balancing quadrant included concerns and compliments data and Third party surveys for example those undertaken by our Community health Councils.

The key determinants of a good service user experience were unchanged and include;

Domain 1: First and Lasting Impressions

- Being welcomed in an appropriate manner
- Being able to access services in a timely way
- Being treated with dignity and respect – of which some of the core elements are not being too hot or cold, having support for eating, drinking and going to the toilet if needed, ability to call for help and freedom from pain.

Domain 2: Receiving care in a Safe, Supportive, Healing Environment

- Receiving care in a clean, clutter free environment
- Receiving good, nutritious, appropriate food
- Having access to drinks
- Having rigorous infection control practices in place

Domain 3: Understanding and Involvement in Care

- Receiving appropriate, timely information
- Being communicated with in an appropriate, timely manner
- Being involved in decisions about choice of treatment options and care plans, including discharge.

- Involvement of carers and families in decisions, especially about discharge/transfer
- Provision of information and support to carers

The National and Local Context for this Framework -The following have influenced the development of this framework:

- Health and Care Standards (2015)
- Listening and Learning to improve the experience of care (2015)
- All-Wales Framework for Assuring Service User Experience (2015)
- The NHS Outcomes Framework (2015-2016)
- Learning from Patient Experience: Key Questions for NHS Board Members
- Shaping our future well being

Scope of this framework The strategy is relevant to:

- All staff employed by Cardiff and Vale UHB
- Independent contractors
- Staff in nursing homes where Cardiff and Vale UHB funds care
- External contractors, stakeholders and partnership agencies including the Community Health Council, voluntary organisations and community groups.

In order to capture service user feedback it is recognised that there is no single method that can provide the assurance that Health Boards require and that a number of methods are required for triangulation to verify findings and make improvements. To support this approach the All Wales Framework for Assuring Service User Experience describes four quadrants which group together a wide range of feedback

Objectives

We aim to build and develop over the next the 3 years a range of methods to capture feedback which reflect the diversity of our service users:

- ✚ **Key Objectives To ensure there is an awareness with all staff that understanding patient experience is fundamental to providing a quality service**
- ✚ Patient experience is enhanced if staff all display the UHB Values
- ✚ To equip staff with the knowledge and skills to engage with service users in a proactive, customer focused way
- ✚ To enable the systematic and regular triangulation of service user experience data to identify themes, trends and lesson learnt
- ✚ To develop procedures to ensure that service user feedback is shared as contemporaneously as possible and use this information to drive change
- ✚ To develop opportunities for increasing service user involvement in service improvement/development.

Service User Experience where are we now?

**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



**GIG
CYMRU
NHS
WALES**

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

Since the introduction of the All Wales Framework for Assuring Service User Experience in 2013, the UHB has implemented a number of methods for obtaining feedback

The majority of this feedback is focussed on secondary care, there is very limited provision for real time feedback, the majority of systems that are in place are paper based and there are limited feedback mechanisms to inform the public of how we are doing.

Where Do We Want to Get to?

We have outlined where we are now; the next step is to outline “Where do we want to get to?” If we are to foster a customer care culture as described by Evans (2015), there is a need to move from just collecting feedback to demonstrating that we have listened to and acted on what we have been told.

The leadership required for the delivery of this framework can be described as “everyone’s business”, with three distinct levels of involvement and accountability; as outlined in the Framework of Accountability and Involvement below.

Board Responsibilities

One of the key questions for Board members outlined by Wales Audit Office (2016) is “*how does the organisation demonstrate commitment to learning from patients?*” The Board have responsibility for building the capacity to undertake feedback by ensuring sufficient resources are available and that staff are empowered to actively seek feedback. The Board also have a responsibility to get a whole system picture, to have appropriate assurances processes in place to ensure that they have the right data available and that this data is the driver for quality improvement and change (Spencer & Putoni 2015). The **Service User Experience Team** is delegated the responsibility for ensuring that robust systems and processes are in place for obtaining feedback, reporting on outcomes and supporting and advising staff and service areas to implement improvement actions.

Clinical Board responsibilities

Clinical Boards have a responsibility to ensure that patient feedback is part of the

day to day business, by utilising this feedback in service plans and holding staff to account to implement improvements. To support this flow of information the implementation of a balanced range of feedback methods will be necessary with regular opportunities for the team to share, discuss and act on the information.

Frontline Staff Responsibilities

All staff who come in to contact with service users have a responsibility to encourage feedback as a matter of course. In order to give feedback, service users need to feel that their opinion is welcomed and will be acted on. Evans (2015) advocates that creating the opportunities for feedback can be maximised by:-

- Acknowledging service users by greeting them in the manner they have chosen to be addressed
- Making eye contact and offering a friendly open face
- Asking questions that encourage a response

In addition staff have a responsibility to actively seek feedback by distributing feedback cards and surveys. In the event that negative feedback is given, staff have a responsibility to seek to deal with the problem if it is within their capability or escalate it to a more senior person. The adoption and implementation of strategies such as “hello-my name is” by all staff is congruent with the UHB values and behaviours and will universally have a positive impact on patient experience.

NHS Medical Director Sir Bruce Keogh recently recounted his story of the development of the NHS triple definition of quality, and how someone going into hospital for surgery could sum it up in three questions:

- Will it work?
- Will it be safe?
- What will it be like?

That third question tries to sum up patient experience from an acute care perspective but it does not do justice to the breadth of issues that are involved. Different people at different times and in different settings will have questions like:

- ✚ Will I be treated like a person?
- ✚ Will I keep my dignity and feel respected?
- ✚ Will I be cared for with empathy and compassion?
- ✚ Will my preferences be understood and met?
- ✚ Will I be listened to?
- ✚ Will I get the information I need?
- ✚ Will I understand what is going on?
- ✚ Will I feel fully involved in decisions about my care?
- ✚ Will everything be well co-ordinated?
- ✚ Will I be able to get help when I need it?
- ✚ Will my environment be clean and comfortable?
- ✚ Will I have enough to eat and drink?
- ✚ Will I get the pain relief I need?
- ✚ Will I die where I want to?

These questions and others like them form just part of a full understanding of patient experience, and yet each of them feels more meaningful, and more important, than that phrase ‘your experience of care’. The refreshed framework goes some way

towards capturing this breadth of issues, but different services will need to use a different mix of questions to understand the experiences of their particular group of patients

How Will We Get There—Framework

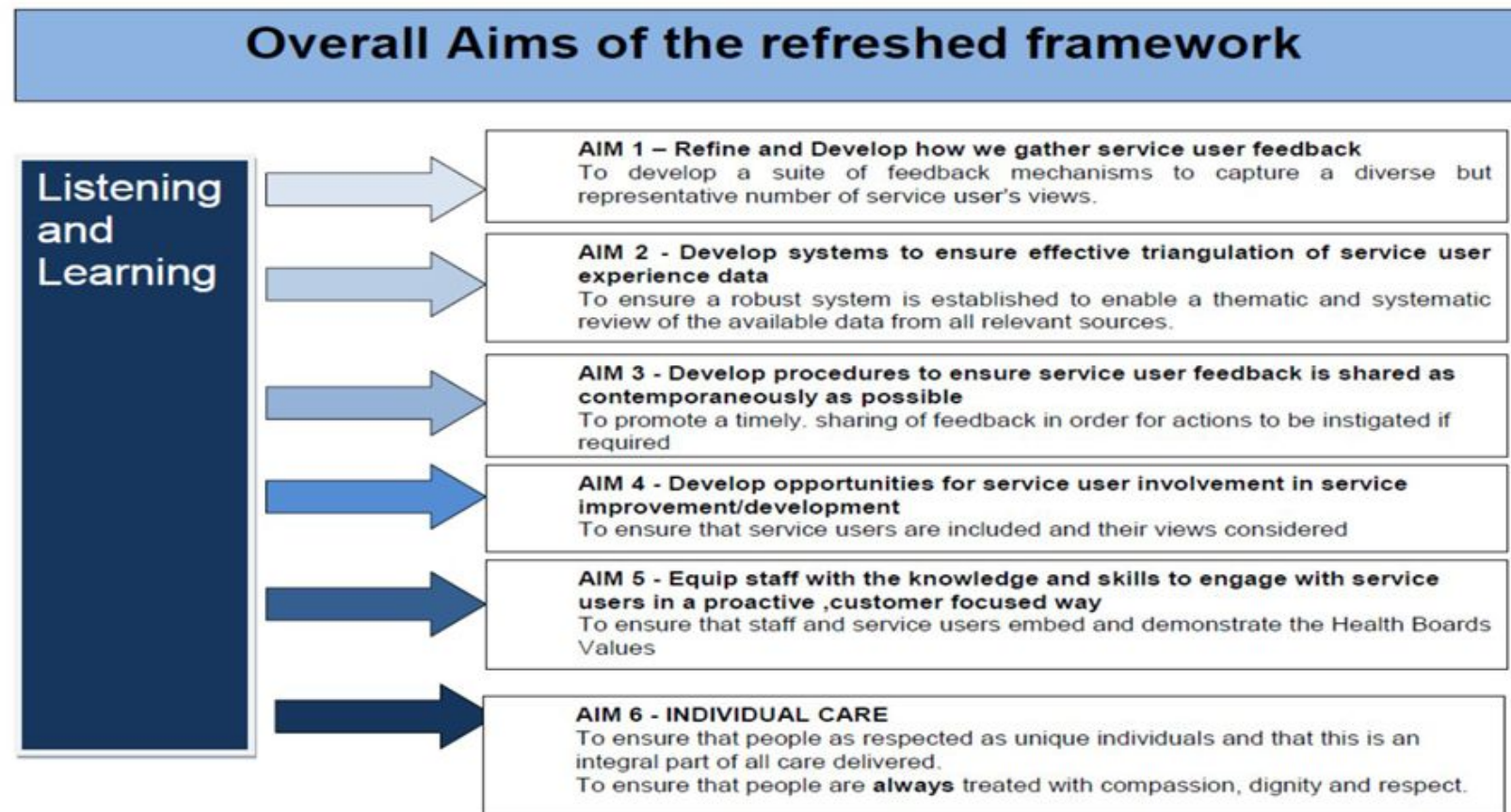
This Strategy sets out how the UHB will listen to the experience of its patients, service users and carers and describes how we will use this information to improve our services. By ensuring that service user opinions are taken into account, the UHB can make sure that service users are involved, listened to and responded to and that significant measurable improvement in the service user experience continues to take place.

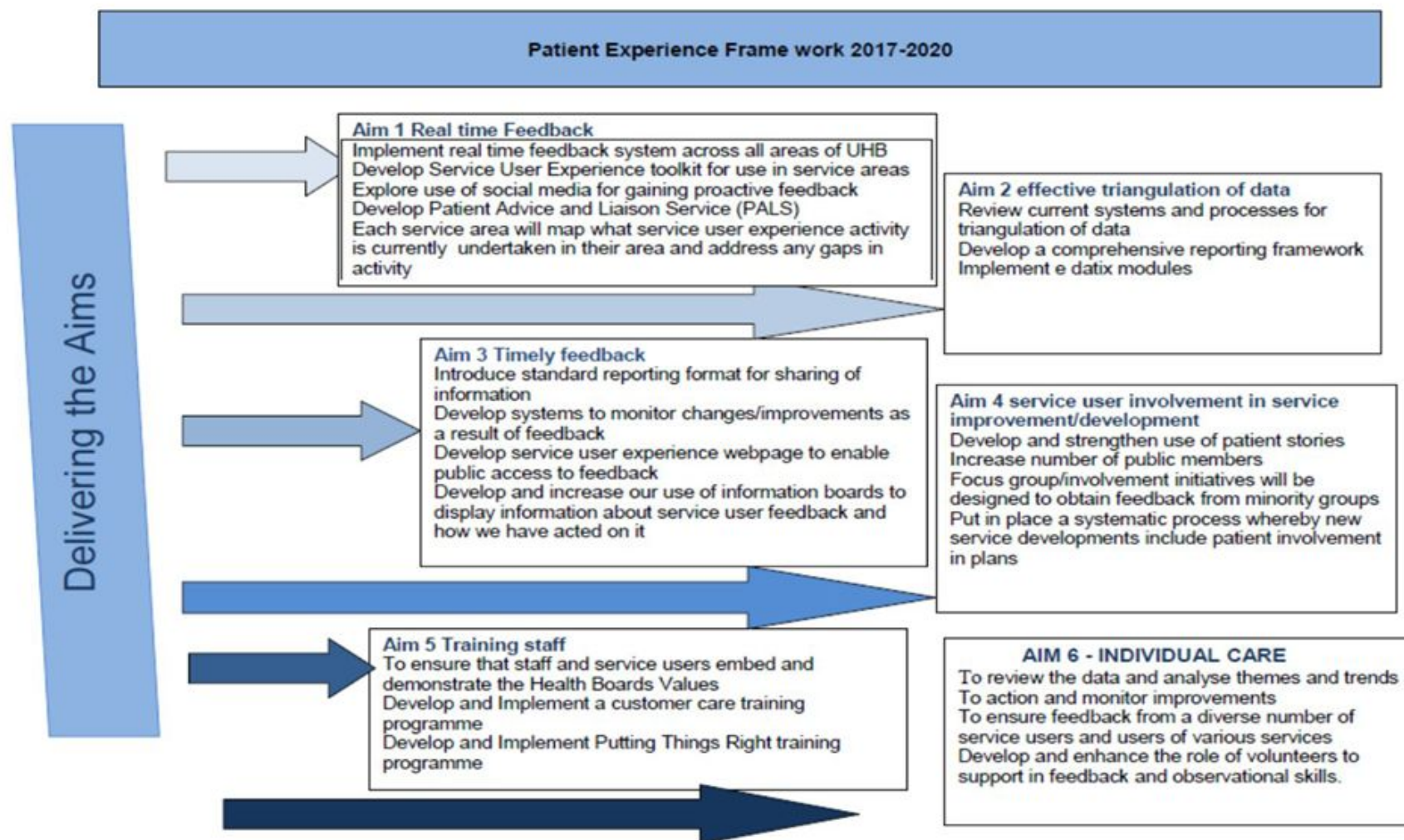
For some time the patient experience team have reported that communication is a theme raised in concerns - this can be a lack of communication, poor communication skills, staff attitude and manner. This information was reiterated by the Values into Actions workshops. Patients wanted staff to smile more, to listen and to communicate in an open, honest and clear way.

In Podiatry a Smile Campaign was developed which will be modified and rolled out with our Values into Actions Work



The initiative can be rolled out across the Health Board as good practice that clearly demonstrates the core values into actions. This approach is now being shared with the Clinical Boards as a tool they can use to improve communication within their clinical environments.





Key Measurements of the framework implementation for 2017/20					
QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
All Quadrants	Review each area to decide the range of feedback mechanisms required to capture feedback as contemporaneously as possible	A suite of patient experience feedback tools in use	Evidence of you said we did in a timely manner demonstrated in the integrated Board report Evidence of Clinical Board activity via the Standards for Health	Complete the review of feedback mechanisms Agree the tools to be used Increased maturity demonstrated in Standards for Health	Raise awareness across the UHB of the varied tools and methods to capture patient experience Evidence of activity in all quadrants of the framework
All Quadrants	To promote the voice of carers	To ensure that the carers voice is heard and listened to direct patient experience activity	To establish an internal carers group To review and implement the principles of the John's campaign To review any reports relating to carers To identify and monitor actions Regular updates provided to the Quality Safety and Experience committee	Some of the actions will be based upon the findings in 2017/18 To engage with the carers forum established following use of transitional funding and agree actions moving forward	Some of the actions will be based upon the findings in 2018/19

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
All Quadrants	Introduction of e datix systems	Triangulation of feedback information across patient experience and liaising with patient safety Development of the analysis of information through cross modular reporting	Evidence in the integrated board reports of using the data to inform of potential concerns more proactive rather than reactive Evidence in the Quality and safety committees of data analysis E datix modules for patient experience implemented	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19
All Quadrants	Develop the reporting structures	Evidenced in the Quality and safety minutes of Clinical Directorate and Board meetings	Evidence of actions taken in relation to themes	Evidence of actions taken in relation to themes	Evidence of actions taken in relation to themes
All Quadrants	Develop Service User Experience toolkit for use in service areas	Review the tools available Re focus the patient experience feedback steering group as an assurance group	Completion of review	Development of the toolkit Raise awareness of the toolkit	Evidence of the tools in action
All Quadrants	2017-2020 develop and implement the customer care training programme	To be launched end of 2017 and linked with values into action work	Each clinical board to encourage staff to attend training	Agree evaluation of training	Measure evidence of the impact of the training-measures to be agreed in each clinical board

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
Real Time 	Implement real time feedback system across all areas of UHB	Happy or not machines in UHW, Concourse , Children's Hospital and UHL Alternate between Barry and St David's	Analyse the data and target more in depth analysis of the themes and trends Review the questions Share feedback via the comms team	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19
Real Time	Rotate short survey kiosks across all UHW and UHL wards in 2017 to capture patient, staff and carers views	 will be placed weekly on each ward and feedback provided at the end of the week	Any improvement plans will be monitored via patient experience in conjunction with the Clinical Boards Funding is for one year to review cost benefit		
Real Time and retrospective	Explore use of social media for gaining proactive feedback	Develop the on line surveys Develop APPS	Development of short on line surveys Monitor HITS Monitor completion rates	Develop the APPS Promote the use of apps	APPS in use and data being analysed

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
Real Time	Pilot a short survey on a kiosk in the Out Patients Department 2017-18		To commence April 20 th 2017-Feedback via the Clinical Board Quality and Safety Meeting and the integrated Board report	Review the role of the kiosk Ask other clinical boards for plans for its use	Review the feedback and agree the plan for its future use
Retrospective	PREMS 2017 to 2020	Active engagement with the planning board Support targeted PREMS survey work	Completion of PREMS data Incorporate PREMS capture into patient pathways	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19
Proactive/ Reactive	Develop and support a carers forum	2017/18 scoping of the forum 2018 active forum in place	Carers feel listened to and can see actions being taken	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
Retrospective	Automation of surveys	2 weeks from completion of reports to comprehensive feedback	Commenced in January 2017 Measure number of surveys being completed Evidence of actions being taken Part of the Comms strategy is to share activity Aim for 60% compliance with survey completion Target volunteers to support clinical areas	Measure number of surveys being completed Evidence of actions being taken Part of the Comms strategy is to share activity Aim for 70% compliance with survey completion Target volunteers to support clinical areas Review future role of automation and consider a business case for sustainable future management	Measure number of surveys being completed Evidence of actions being taken Part of the Comms strategy is to share activity Aim for 80% compliance with survey completion Target volunteers to support clinical areas
Retrospective	Developing the KPI's for survey completion	Increased roles for volunteers in undertaking survey activity	Meeting the KPI's for completion of surveys	Monitor the KPI's	Monitor the KPI's

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
Retrospective	2017-2020 develop and strengthen the use of patient stories	Thematic analysis of patient stories	Evidence of you said we did based on the stories and themes Coordinate patient stories for board Clinical boards to advise of patient stories	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19
Balancing	Progress implementation of Putting Things Right Training Programme	Ongoing training subject to evaluation	Improved understanding of the regulations	Improved understanding of the regulations	Improved understanding of the regulations
	Ensure timeliness of responses to 30 day concerns investigations to achieve significant and sustained improvement.	On going	Monitored via performance reviews and integrated Board report Achieve 60% compliance with 30 day responses Monitor referrals to Public service Ombudsman Monitor the cases for investigation and those not investigated Monitor number of follow up letters related to the same concerns	Achieve 70% compliance with 30 day responses Monitor referrals to Public service Ombudsman Monitor the cases for investigation and those not investigated Monitor number of follow up letters related to the same concerns	Achieve 80% compliance with 30 day responses Monitor referrals to Public service Ombudsman Monitor the cases for investigation and those not investigated Monitor number of follow up letters related to the same concerns

QUADRANT	ACTION	OUTCOME	MEASURE FOR 2017 /18	MEASURE FOR 2018 /19	MEASURE FOR 2019 /20
Balancing and proactive/ reactive	Development of the PALS service	Work with the volunteers in the information centres to develop the service	Consistently meeting the KPI for use of informal concerns process and the conversion from informal to formal concern ratio Sessions in the information centres at UHW, UHL and Barry will commence and be evaluated in 2017 Monitored via performance reviews and integrated Board report Achieve 60% Monitor conversion rate to formal Evaluate the service	Some of the actions will be based upon the findings in 2017/18	Some of the actions will be based upon the findings in 2018/19

improving experiences of care

References

Department of Health (2009): *“Understanding what matters: a guide to using patient feedback to transforming services”*.

Evans, K (2014) *“Using the gift of complaints: A review of concerns (complaints) handling in NHS Wales”*. Cardiff: Welsh Government

Spencer, M & Putoni, S. (2015) *Listening and learning to improve the experience of care*. Cardiff: 1000 Lives Improvement

Wales Audit Office (2016) *“Learning from patient experience: Key questions for NHS board members”*

PATIENT SAFETY SOLUTIONS - ALERTS AND NOTICES	
Name of Meeting:	Quality Safety and Experience Committee
Date of Meeting :	18 th April 2017
Executive Lead:	Executive Nurse Director
Author:	Patient Safety Facilitator, Contact number 029 2074 6548
Caring for People, Keeping People Well:	This paper underpins the 'reducing waste, variation and harm' element of the University Health Board's strategy.
Financial impact:	Whilst there are no financial implications associated directly with this report, failure to fully implement patient safety alerts and notices has the potential to impact financially on the University Health Board (UHB) in relation to failure to manage clinical risk.
Quality, Safety, Patient Experience impact:	The work outlined within this report reflects the significant activity taking place to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number:	2.1, 3.1, 3.3
CRAF Reference Number:	5.1, 5.1.5, 5.6, 5.7
Equality Impact Assessment Completed:	Not Applicable

RECOMMENDATION

Limited ASSURANCE is provided by:

- A number of outstanding Safety Notices and Alerts that the UHB is currently unable to declare full compliance with.

The Committee is asked to:

- **CONSIDER** the update provided within the report.

SITUATION

This report has been written to provide the Committee with an update on the UHB's position relating to Patient Safety Solutions, which include alerts and notices from Welsh Government, as well as a number of outstanding notices from the now disbanded National Patient Safety Agency (NPSA).

BACKGROUND

The UHB regularly receives alerts and notices from Welsh Government. These cover a range of patient safety issues. Each notice or alert contains a list of actions to be completed before compliance can be declared. The timescale given to undertake these actions varies according to the content of the document. By the specified deadline, the UHB must report a position of compliance, non-compliance or not applicable.

The notices/alerts are issued to all Welsh Health Boards and Trusts. Each organisation's compliance status is published on a monthly basis by Welsh Government.

An internal flowchart was presented to the Quality, Safety and Experience Committee in April 2015 to compliment the UHB's Safety Notices and Important Document Policy and ensure the UHB complies with necessary Welsh Government requirements.

The UHB participated in an event hosted by Welsh Government and the Delivery Unit in November 2016 where challenges and opportunities for improvement in relation to the safety solutions process were reviewed.

ASSESSMENT

Patient Safety Alerts (PSAs)

Since April 2014, seven patient safety alerts have been issued. The UHB has reported compliance with four alerts and non-compliance with two alerts. One alert is not yet due for a response to Welsh Government.

Details of the alerts where the UHB is currently non-compliant are given below: The Committee should be advised that Patient Safety Alerts/Notices require compliance with several elements and in the majority of cases the UHB is compliant with the majority of what is required but is working towards full compliance with all elements of the Alert/Notice.

PSA002 – The prompt recognition and initiation of treatment for sepsis for all patients

Where are we?

One remaining action requires completion, which is the implementation of the National Early Warning Score (NEWS) in community hospitals. NEWS is partially implemented in St David's hospital, with some staff requiring training. Some community sites have individual challenges, such as Rookwood which has limited medical cover.

How do we compare to our peers?

One other Health Board is non-compliant and the alert is not applicable for Public Health Wales.

What are we doing about it?

The current status of the roll out of NEWS to the UHB's community hospitals is being reviewed to inform a training and implementation plan.

PSA003 – Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices

Where are we?

Since the previous paper to QSE on Safety Solutions (September 2016), an issue has emerged which is preventing a number of Health Boards from declaring compliance with PSA003. This relates to action 1a, which requires that “all epidural consumables, medicines and equipment are stored separately from intravenous (IV) consumables, medicines and equipment”.

Some epidural products contain controlled drugs, and therefore legally must be stored in a controlled drugs cupboard. Most wards and clinical areas only have one controlled drugs cupboard, necessitating the epidurals to be stored with other subcutaneous, intramuscular or IV medications.

How do we compare to our peers?

Cardiff and Vale UHB is one of four Health Boards who are reporting non-compliance. The alert is not applicable to three Health Boards/Trusts and three have reported compliance.

What are we doing about it?

In January 2017, all Welsh Health Boards and Trusts provided information to Welsh Government on which actions were preventing compliance.

The Patient Safety Team has approached other Health Boards for information as to how they have addressed compliance with action 1a and will consider what further actions need to be taken once this benchmarking is complete.

Patient Safety Notices (PSNs)

Since April 2014, 35 Patient Safety Notices have been issued¹. The UHB is compliant with 30 notices, and non-compliant with three notices. Responses for two notices are not yet due with Welsh Government.

Details of the notices where the UHB is currently non-compliant are given below:

PSN025 – Risk of death or severe harm due to inadvertent injection of skin preparation solution*How are we doing?*

Many clinical areas have moved to the use of self-contained chlorhexidine applicators which greatly reduce the risk of inadvertently injecting the skin preparation solution. The self-contained applicators are not suitable in all situations, so some areas continue to use bottled chlorhexidine. It is for this reason that the UHB is unable to declare full compliance.

How do we compare to our peers?

Cardiff and Vale is the only Health Board which is not yet fully compliant with the notice.

What are we doing about it?

Information has been extracted from the pharmacy ordering system (WOREQ) to establish which areas are using bottled chlorhexidine. Targeted information will be sent to these areas highlighting the requirement that skin preparation is removed from the procedure areas before any medications are administered. The Patient Safety Team will also explore options for tinted chlorhexidine to determine if this will assist with mitigating risk.

Work regarding the use of sterile saline ampoules/pre-filled syringes is feeding into the recent Patient Safety Alert 007 – Restricted use of open systems for injectable medication.

The Patient Safety Team has approached other Health Boards for information as to how they have addressed compliance and again will consider further actions once this benchmarking exercise is complete.

PSN026 – Positive patient identification*Where are we?*

The UHB is currently unable to report compliance with this notice due to historical non-compliance with related NPSA alerts number 24 and NPSA/2009/SPN002.

How do we compare to our peers?

One other Health Board is currently non-compliant with PSN026.

What are we doing about it?

A project is underway as part of the Leading Improvement in Patient Safety (LIPS) programme in conjunction with two other Health Boards.

The UHB Positive Patient Identification Policy is being revised and the Patient Safety team is developing solutions to try and mitigate key risk areas e.g. requesting of investigations, filing of results. A logo is also currently being designed ahead of a awareness campaign.

PSN030 – The safe storage of medicines: Cupboards*Where are we?*

The UHB was unable to report compliance with this notice due to the

prohibitive costs of purchasing medicine cupboards which meet the specifications required by the Notice. A paper was taken to the Quality, Safety and Experience Committee in December 2016 (QSE 16/211) by the Medical Director regarding this notice. Current standards for medication storage were audited and robust mitigation has been put in place. The requirements of PSN030 will be considered in all future refurbishment and new build planning of clinical areas.

How do we compare to our peers?

The UHB is one of eight Health Boards which has reported non-compliance with this notice. Only Velindre NHS Trust and Public Health Wales have reported compliance.

What are we doing about it?

The Quality Safety and Experience Committee approved the plan for storage of medicines and a continued audit programme to provide assurance in relation to the on-going storage and security of medicines. When future refurbishment is planned, the recommendations of PSN030 will need to be considered.

Historical National Patient Safety Agency notices

The UHB is currently non-compliant with elements of three notices which were issued by the now disbanded NPSA. These notices are detailed below:

NPSA/2007/16 – Early identification of failure to act on radiological imaging reports

Where are we?

The preferred position of the Clinical Diagnostics and Therapeutics Clinical Board is to implement an 'end to end' radiology software solution which allows important findings to be flagged to the requesting clinician. This option would also allow robust auditing to ensure that findings have been acknowledged by an appropriate clinician. The UHB is currently required to deploy the all Wales PACS solution, which does not include this functionality.

How do we compare to our peers?

One other Health Board is also non-compliant with this notice. A number of Health Boards have reported compliance with the notice based on a random audit of patient records. It is the opinion of the Clinical Diagnostics & Therapeutics (CD&T) Clinical Board that this approach does not provide adequate assurance to declare compliance with the notice and achieve the intended goal of reducing risks to patients.

What are we doing about it?

Progress on the implementation of a PACS solution is being reported to the Information Management & Technology Sub Committee. The Patient Safety Team has approached a number of Health Boards to ask for details of their manual audit processes for consideration following which Clinical Boards may be advised to adapt this into their clinical audit plans.

The Patient Safety Team is working with the CD&T Clinical Board to finalise a policy to support the actions required following significant unexpected radiological images. This issue features on the risk register for Clinical Diagnostics and Therapeutics Clinical Board who have shared the risk assessment with the Patient Safety Team as this may assist other Clinical Boards to adapt and adopt the risk assessment to suit their needs. It has also been agreed, the Clinicians in CD&T will continue, were able, to alert the referrer to significant abnormal results. Work is underway to establish a single point of contact in each Clinical board when the diagnostic clinician e.g. radiologist is unable to contact the referrer or responsible clinician.

No 24 – Standardising wristbands improves patient safety*Where are we?*

The UHB is unable to report full compliance with this notice as it does not have the required infrastructure in place to print ID wristbands from the electronic Patient Management System (PMS).

How do we compare to our peers?

All other Health Boards in Wales to which the notice applies are already using electronically printed ID wristbands. Cardiff and Vale is the only Health Board that is non-compliant with this notice which was issued in 2007.

What are we doing about it?

It will not be possible to declare full compliance with this notice until funding is identified and equipment in place to allow direct printing of ID wristbands. A business case has been agreed in principle as part of the Integrated Medium Term Plan (IMTP) process but a funding stream has not as yet been identified. (In 2012 when the case was presented, the implementation cost of the preferred option was £85,210. Annual savings of £13,000 after seven years were estimated). A paper is currently being prepared for the Management Executive.

Cardiff and Vale UHB has participated in an all Wales procurement exercise for patient ID wristbands.

NPSA/2009/SPN002 – Risk to patient safety of not using the NHS Number as the national identifier for all patients*Where are we?*

Significant work is required to update patient administration systems and associated procedures to use the NHS number as the primary identifier. It is an issue across Wales as there are a number of different systems which hold patient data.

How do we compare to our peers?

Cardiff and Vale is the only Health Board which is currently reporting non-compliance with this notice.

What are we doing about it?

The UHB reports monthly to Welsh Government on the performance of use of valid and traced NHS numbers. Whilst performance has improved, the UHB is short of the 95% compliance target. Investment is likely to be needed to build the necessary IT functionality, procedure development and associated training and audit requirements. Use of the NHS number is a priority area for Welsh Government's Information Quality Improvement Initiative working group and the Patient Safety Team is advised that other Health Boards are also striving to meet the challenges associated with use of the NHS number.

Appendix 1 – Summary of Patient Safety Solutions for Cardiff and Vale UHB

Patient Safety Alerts				
PSA Ref.	Date Issued	Title	Date for response to WG	Compliance Status
PSA007	January 2017	Restricted use of open systems for injectable medication	01/08/2017	(Not yet due for response – work underway)
PSA006	January 2017	Risk of death and severe harm from error with injectable phenytoin	10/03/2017	Compliant
PSA005	July 2016	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	14/10/2016	Compliant
PSA004	July 2016	Ensuring the Safe Administration of Insulin	28/10/2016	Compliant
PSA003	May 2016	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	01/07/2016	Non-compliant
PSA002	September 2014	The prompt recognition and initiation of treatment for sepsis for all patients	28/11/2014	Non-compliant
PSA001	June 2014	Legionella and heated birthing pools filled in advance of labour in home settings	30/06/2014	Compliant

Patient Safety Notices				
PSN Ref.	Date Issued	Title	Date for response to WG	Compliance Status
PSN036	November 2017	Reducing the risk of oxygen tubing being connected to air flowmeters	04/08/2017	(Not yet due for response – work underway)
PSN034	September 2016	Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPs)	28/09/2017	(Not yet due for response – work underway)

PSN033	June 2016	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	27/07/2016	Compliant
PSN032	May 2016	Risk of patient harm from an interaction between miconazole and coumarin anticoagulants	09/06/2016	Compliant
PSN031	April 2016	Risk of Patient Safety Incidents Resulting from Errors in the British National Formulary for Children 2015-2016 and British National Formulary 70	31/05/2016	Compliant
PSN030	April 2016	The safe storage of medicines: Cupboards	26/08/2016	Non-compliant
PSN029	March 2016	Standardising the early identification of acute kidney care	04/04/2016	Compliant
PSN028	February 2016	Medicines Reconciliation - Reducing the risk of serious harm	30/03/2016	Compliant
PSN027	February 2016	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	08/04/2016	Compliant
PSN026	April 2016	Positive Patient Identification	13/05/2016	Non-compliant
PSN025	February 2016	Risk of death or severe harm due to inadvertent injection of skin preparation solution	04/04/2016	Non-compliant
PSN024	January 2016	Risk of using different airway humidification devices simultaneously	01/03/2016	Compliant
PSN023	January 2016	The importance of vital signs during and after restrictive interventions/manual restraint	12/02/2016	Compliant
PSN022	December 2015	The risk of harm from the inappropriate use and disposal of fentanyl patches	31/01/2016	Compliant

PSN021	December 2015	Risk of death and serious harm by falling from hoists	15/02/2016	Compliant
PSN020	October 2015	Minimising risks of omitted and delayed medicines for patients receiving homecare services	27/11/2015	Compliant
PSN019	August 2015	Harm from delayed updates to ambulance dispatch and satellite navigation systems	30/09/2015	Compliant
PSN018	August 2015	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	31/08/2015	Compliant
PSN017	July 2015	Risk of using vacuum and suction drains when not clinically indicated	31/08/2015	Compliant
PSN016	July 2015	Risk of inadvertently cutting in-line (or closed) suction catheters	31/08/2015	Compliant
PSN015	July 2015	The storage of medicines: Refrigerators	31/08/2015	Compliant
PSN014	July 2015	Patient Safety Notice: Residual anaesthetic drugs in cannulae and intravenous lines	31/08/2015	Compliant
PSN013	July 2015	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	13/08/2015	Compliant
PSN012	May 2015	Advice sheet: Adrenal insufficiency (Addison's disease) in adults - information for general practitioners	12/06/2015	Compliant
PSN011	May 2015	Patient Safety Notice: Risk of associating ECG records with wrong patients	18/06/2015	Compliant
PSN010	May 2015	Patient Safety Notice: Failure to act on known contraindications to Low Molecular Weight Heparins	25/06/2015	Compliant
PSN009	April 2015	Awareness of NICE Clinical Guidelines on head injuries	28/05/2015	Compliant

PSN008	April 2015	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	28/05/2015	Compliant
PSN007	April 2015	Risk of death or serious harm from accidental ingestion of potassium permanganate	31/05/2015	Compliant
PSN006	March 2015	Risk of hypothermia for patients on continuous renal replacement therapy	30/04/2015	Compliant
PSN005	December 2014	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	30/01/2015	Compliant
PSN004	December 2014	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	19/01/2015	Compliant
PSN003	December 2014	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	31/01/2015	Compliant
PSN002	July 2014	The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse	31/07/2014	Compliant
PSN001	July 2014	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women	31/07/2014	Compliant

Outstanding NPSA Notices

NPSA Ref.	Date Issued	Title	Date for response to WG	Compliance Status
SPN002	June 2009	Risk to patient safety of not using the NHS Number as the national identifier for all patients	18/09/2009	Non-compliant
16	July 2007	Early identification of failure to act on radiological imaging reports	28/02/2008	Non-compliant

13

No 24	July 2007	Standardising wristbands improves patient safety	18/07/2009	Non-compliant
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FALLS ASSURANCE REPORT	
Name of Meeting:	Quality Safety and Experience Committee
Date of Meeting:	18 th April 2017
Executive Lead :	Director Therapies and Health Science
Author :	Assistant Director of Therapies and Health Science alun.morgan@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" "Values" and elements of the Health Board's Strategy. Further information can be found here	
Financial impact : included as part of Clinical Board IMTP plans	
Quality, Safety, Patient Experience impact : Improve patient safety and care	
Health and Care Standard Number 2.3, 6.1	
CRAF reference number: 5.1.6, 5.1.9	
Equality and Health Impact Assessment Completed: An EQIA was completed for the policy	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The UHB is currently demonstrating a stable trend in incidents relating to slips trips and falls. Significant work is underway particularly in the community in relation to falls prevention
- There is however limited assurance relating to serious incidents due to inpatient falls which continue to show an upward trend in Q1 of 2017. Urgent action is being taken to identify hotspots, analyse trends and provide focused support.

The Committee is asked to:

- **NOTE** that the UHB is continuing to hold the reduced trend seen in 2016
- **SUPPORT** the reconstitution of the Falls Delivery Group which will provide focus to falls prevention across the whole pathway

SITUATION

The UHB is required to comply with a number of directives, standards and guidelines, all of which overlap and require action, monitoring and reporting through Quality and Safety Committee.

These include;

- Welsh Health Circular (2016) 022 Principles, framework and national indicators: Adult inpatient falls
- Health and Care Standards 2.3 Falls and 6.1 Promoting independence

- National Audits; Falls and Fragility Fracture Audit Programme, National Audit of Inpatient Falls; Royal College of Physicians imminent
- NICE/NPSA Guidelines
- 1000 lives #STEADYONSTAYS SAFE Campaign to reduce falls in the community

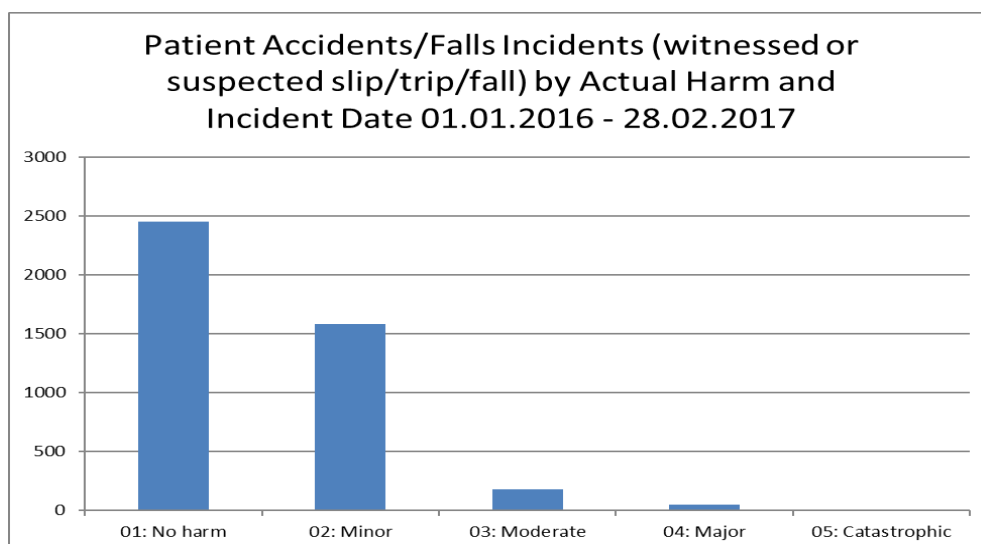
Despite significant amount of excellent work being done across the UHB the lack of central coordination has meant the assurance mechanism to QSE and the Board has been less than robust.

BACKGROUND

How are we doing?

The Patient Safety team is now able to provide additional information relating to falls which is presented for the first time to QSE committee. Further analysis is required to ascertain location of falls and reasons.

4,631 patient accidents/falls were reported between January 2016 and March 2017 where the slip/trip or fall was either witnessed or suspected.



The table below illustrates that the majority of accidents/falls do not result in injury to the patient. However, patient falls represents the highest volume of Serious Incidents reported to Welsh Government whereby patients have sustained significant injuries such as fractured limbs or head injuries.

Quarter 4 of 2016 (Oct-Dec) there were 11 SIs and the UHB currently had 1 Regulation 28 from Coroner's Office which has been responded to.

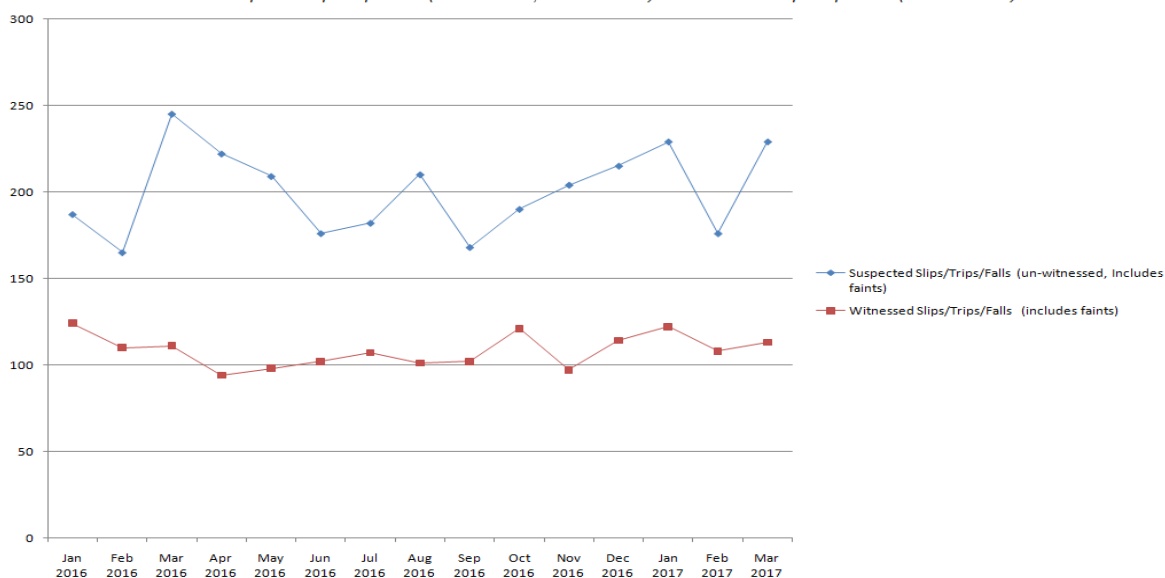
Jan-Feb 2017 we have had 13 SIs. The reasons are currently being analysed and will be discussed in the next Falls Delivery Group.

The UHB is currently reporting between 300-350 incidents relating to slips, trips and falls per month. The following table gives a breakdown of witnessed and unwitnessed incidents.

	Total Slips trips and Falls	Suspected Slips/Trips/Falls (un-witnessed, Includes faints)	Witnessed Slips/Trips/Falls (includes faints)
Jan 2016	311	187	124
Feb 2016	275	165	110
Mar 2016	356	245	111
Apr 2016	316	222	94
May 2016	307	209	98
Jun 2016	278	176	102
Jul 2016	289	182	107
Aug 2016	311	210	101
Sep 2016	270	168	102
Oct 2016	311	190	121
Nov 2016	301	204	97
Dec 2016	329	215	114
Jan 2017	351	229	122
Feb 2017	284	176	108
Mar 2017	342	229	113
Sub total		3007	1624
TOTAL	4631		4631

Patient Falls - January 2016 to March 2017

Based on Incident Date. Includes incidents Awaiting Review, Being Reviewed and Closed.
Includes Suspected Slips/Trips/Falls (un-witnessed, includes faints) and Witnessed Slips/Trips/Falls (includes faints)



How do we compare with our Peers?

At present there is no reliable All Wales benchmarking data available.

However, data presented by the NRLS in September 2016, which related to

the October 2015 – March 2016 reporting period, demonstrated that of the incidents uploaded to the NRLS by Cardiff and Vale UHB, 28.1% of those incidents were related to patient accidents. This was less than in the majority of other Welsh NHS organisations. It should be noted that the patient accident category contains slips/trips/falls and various other types of accident.

Patient accident incidents uploaded to the NRLS by Welsh NHS organisations October 2015 – March 2016		
Organisation name	N	% of total number of incidents uploaded to the NRLS
Betsi Cadwaladar University Health Board	2,280	31.6
Hywel Dda University Health Board	1,455	26.7
Abertawe Bro Morgannwg University Health Board	2,686	34.7
Cardiff and Vale University Health Board	1,988	28.1
Cwm Taf University Health Board	1,234	33.9
Aneurin Bevan University Health Board	2,284	35.6
Powys Teaching Health Board	228	32
Totals for All Welsh LHBs	12,155	31.8

ASSESSMENT

The previous falls group was hosted by Medicine Clinical Board with a specific remit to reduce falls within the inpatient setting.

There was also a falls prevention post which was aligned to the inpatient falls work stream but unfortunately the post holder retired at the end of 2016. The post has remained unfilled.

The first self assessment of Health and Care standard 2.1 identified a number of recommendations that required a different approach to falls prevention. The decision was therefore taken to move the resources associated with the vacant falls post into the Patient Safety Directorate and reconstitute the Falls Delivery Group with a wider remit.

A twin track approach has been adopted by the group with a focus on the following

- Prevention and reduction of inpatient falls.
- Community prevention programme with close links with Public Health Wales and 1000 Lives with a view to reducing hospital admissions from serious injurious falls.

The Falls Delivery Group has met twice since January 2016.

- All Clinical Boards are represented including Public Health.
- Focus is on the whole pathway rather than specific component.
- Wider stakeholder representation including WAST, Fire and Rescue, Local Authorities and Carer and Repair Cardiff.
- Support from Patient safety.

The following objectives have been agreed:

- Baseline assessment against the framework and standards in order to provide assurance to the Board.
- Engagement of all work streams and stakeholders to avoid duplication and ensure all public assets are used effectively
- Development of Datix reporting to monitor falls and share practice and lessons.
- Ensure key lessons learnt from investigation reports following Serious Incidents involving patient accidents/falls include:
 - ◆ Reinforcement of need for falls risk assessments to be undertaken and maintained.
 - ◆ Ensuring that actions are implemented following risk assessment where it is identified that risks to patients can be minimised.
 - ◆ Ensuring patient's call bells, hearing aids, spectacles and walking aids are close to hand.
 - ◆ The UHB has undertaken a campaign ahead of Christmas 2016 to highlight the importance of appropriate footwear.
 - ◆ Ensuring appropriate supervision and assistance to patients is in place to support their bathroom needs as falls en route or within bathrooms are a key risk factor.
 - ◆ The importance of accurate assessment and recording of specialising needs and implementation of this where deemed necessary.
 - ◆ Reinforcement of the UHB's policy and procedure to ensure correct care of patients is undertaken following a fall.
- Provide support to Clinical Boards and directorates.
- Recruitment to a falls lead post is progressing and will be a key appointment in terms of driving forwards the necessary improvement work.

A number of the members of the Falls Delivery Group are members of the National Falls Taskforce and therefore work closely with 1000 lives to deliver primary prevention.

The UHB ran a successful falls prevention day in February with 1000 lives and Public Health Wales which was a wider stakeholder engagement day.

One of the issues raised in the workshop was lack of a single falls pathway across Primary, Community and secondary care. The other key constraint is data sharing across agencies and the need for a common agreement between organisations. These have therefore been included in the Delivery Group work programme which will be reported at a future QSE committee.

HER MAJESTY'S CORONER REGULATION 28 PREVENTION OF FUTURE DEATHS REPORTS
Name of Meeting : Quality, Safety and Experience Committee Date of Meeting : 18 th April 2017
Executive Lead : Executive Nurse Director
Author : Patient Safety Manager, 02920 74 6387
Caring for People, Keeping People Well : This paper underpins the 'reducing waste, variation and harm' elements of the University Health Board's strategy.
Financial impact : Whilst there are no financial implications directly associated with this report, failure to address the clinical risks raised in the Coroner's Regulation 28 reports has the potential to impact financially on the University Health Board.
Quality, Safety, Patient Experience impact : The work outlined within this report reflects the continued significant activity underway to improve patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1; 3.1; 3.3
CRAF Reference Number 5.1; 5.1.5; 5.6; 5.7
Equality and Health Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The actions undertaken following conclusion of the internal investigations in conjunction with the responses provided to Her Majesty's Coroner.

The Quality, Safety and Experience Committee is asked to:

- **RECEIVE** the overview of the recommendations made by Her Majesty's Coroner.
- **NOTE** the actions undertaken in response to the internal investigations and Coroner's recommendations.

SITUATION

In November 2016 and February 2017 the University Health Board received two Regulation 28 Prevention of Future Deaths Reports, from Her Majesty's Coroner. The first related to the death of a patient following an in-patient fall, the second, to the death of a patient, following the insertion of an intercostal drain.

BACKGROUND

The Coroner has a legal duty to consider following an inquest if there is a risk of other deaths occurring in similar circumstances.

If the Coroner considers that future deaths could be prevented, s/he can write a report under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The report is directed to people or organisations who the Coroner considers are in a position to take action to reduce the risk of future deaths. A reply must be sent to the Coroner outlining the action they plan to take. This must be sent to the Coroner within 56 days.

The Regulation 28 report is also usually sent to the family, Welsh Government and any other interested parties determined by the Coroner. Responses received by the Coroner are usually shared by the Coroner's office with the family. The Patient Safety Team copies the Health Board's response to Welsh Government as associated matters have usually also been reported as Serious Incidents. Other external parties may also receive a copy of the response, for example, Welsh Health Specialised Services Committee (WHSSC) where the matter has involved commissioned services.

The Regulation 28 reports are also published on the Chief Coroner's website so there is a public record of the matter. Any non-responses will also be noted.

ASSESSMENT AND ASSURANCE

In November 2016 the Coroner returned a narrative conclusion that a patient had sadly died from the effects of a traumatic head injury which he sustained when he suffered one of eight falls whilst in hospital, against a background of dementia, declining health and frailty.

The Coroner raised concern regarding shortcomings in the way in which the patient's risk of falls was assessed and recorded. There were some occasions where the patient was given 1:1 care but on other occasions, enhanced patient monitoring was in place with 1:4 nurse:patient ratio as an alternative to 1:1 specialling.

There were also shortcomings in the way standard neurological observations were carried out. They were conducted by a Healthcare Assistant who had not been trained and who failed to conduct one part of the test. This omission was not identified by the qualified nurse whose duty it was to oversee the work of the Healthcare Assistant.

The Medicine Clinical Board has since reinforced falls risk assessment and care planning procedures with a focus on more frequent review and greater involvement with patients and their families/carers in the process.

Staff have been reminded of the need to complete documentation such as 'Reach Out To Me', behaviour monitoring and intentional rounding procedures to ensure patient needs, likes and dislikes are met. Patterns of behaviour can then be appropriately monitored with timely interventions where necessary.

Existing processes to support safe staffing levels have been reiterated to staff as it was evident that some junior nursing staff involved in this patient's care were not entirely familiar with the necessary procedures.

The Health Board has recently undertaken a project to review specialising of patients. A trial of an alternative model as a result of this review has recently concluded in the Medicine Clinical Board and an evaluation is underway.

The Deputy Executive Nurse Director is chairing a task and finish group in response to the requirements of the Nurse Staffing (Wales) Act 2016.

The Medicine Clinical Board undertook a review of delegated tasks that are completed by non-registered nursing staff and determined that neurological observations should be undertaken by registered nurses. The wider UHB is reviewing the clinical skills undertaken by Healthcare Support Workers and will consider neurological observations as part of that review. This is under discussion at the Clinical Skills and Innovation Group which is led by the Senior Nurse – Standards and Professional Regulation.

A revised Falls Delivery Group has been established which is chaired by the Assistant Director of Therapies and Health Sciences/Professional Lead for Quality, Safety and Patient Experience. The group is multidisciplinary and multi-agency and aims to work with key internal and external stakeholders to provide expertise, review and monitor practice and promote strategies to reduce the risk of injurious falls across the UHB. Recruitment to a Falls Strategy Implementation Lead post is progressing.

In January 2017, the Coroner returned a narrative conclusion following the inquest of a patient who developed a pleural effusion after a coronary artery bypass grafting procedure. During the procedure to drain the pleural effusion, the pleural drain penetrated his heart causing it to stop. Tragically, the patient did not survive emergency surgery to correct the defect.

The Coroner recommended that consideration be given to reviewing procedures related to chest drain insertion and induction programmes for all new medical and nursing staff. He also recommended that consideration be given to the acquisition of appropriate ultrasound equipment to allow real time guidance of chest drain insertion, pleural procedures and diagnostics. To support this, he added that consideration should be given to an ultrasound training programme and governance structure for all practitioners who are responsible for the insertion of intercostal drains.

The practice of inserting chest drains at a 'marked spot' identified by ultrasound undertaken by radiology has ceased. Interim arrangements are in

place to support doctors who require assistance whilst practice moves towards direct vision ultrasound guidance. A working group has been established with the specific remit to improve the UHB's compliance with the related guidance from the British Thoracic Society.

Induction arrangements are in place for a general induction for all new staff. As part of the recruitment process, the Workforce and Organisational Development Department ensures staff are allocated a day to attend a corporate induction programme for organisational induction. Senior medical staff are offered an opportunity to attend a Senior Medical Staff Induction programme.

A local induction checklist is available to support managers and new staff in induction to the new department. The requirements for the content of local induction will vary significantly across the many departments throughout the UHB. The content of these will therefore be overseen by the relevant Clinical Director for medical staff, by senior nursing staff for nurses and so forth, depending on the staff discipline.

The UHB is also linking with the Wales Deanery on this issue. Presently as part of Core Medical Training (CMT), Specialist registrar trainees have a number of identified core competencies that are considered essential (and the doctor must be able to perform these independently). This includes pleural aspiration or insertion of an intercostal drain for pneumothorax (a collection of air or gas in the chest or pleural space that causes the lung to collapse). There are other competencies that are considered to be desirable and this includes the ability of the doctor to insert an intercostal drain using a Seldinger technique with ultrasound guidance (excepting pneumothorax). The expectation is that the competency level of the doctor is established as part of the induction process.

Two additional ultrasound machines suitable for use in chest drain insertion have been purchased. A bespoke thoracic ultrasound training course was provided to the Cardiothoracic Directorate in March 2017. Arrangements for ongoing training and competence assessment will be overseen by the task and finish group.

As an invasive procedure, the task and finish group will also consider the Welsh Government Patient Safety Notice PSN034 'Supporting the introduction of the National Safety Standards for Invasive Procedures' which was published in September 2016. Welsh NHS organisations must report compliance by September 2017. A similar safety notice was published in NHS England in September 2015 and there are various tools available that can be adapted and adopted for use in NHS Wales, including tools to support safe insertion of chest drains.

It should also be noted that the Health Board received a report from the Public Services Ombudsman for Wales in October 2016 which related to chest drain insertion. In this case, a surgical patient sustained an injury to his liver during an out of hours chest drain insertion procedure. The Ombudsman outlined

recommendations for the UHB related to use of ultrasound during chest drain insertion procedures. He also highlighted the need for an appropriate accompanying training programme.

The task and finish group has encompassed the Ombudsman findings into the work of the group.

HEALTHCARE INSPECTORATE WALES UNANNOUNCED VISITS - UPDATE
Name of Meeting: Quality, Safety and Experience Committee Date of Meeting: 18 May 2017
Executive Lead: Executive Nurse Director
Authors: Acting Deputy Nurse Director - 02921 846167 Senior Nurse Standards and Professional Regulation - 02920 715440
Caring for People, Keeping People Well: Delivering outcomes that matter to people, offering services that deliver the improvements in population health that our citizens are entitled to expect, being a great place to work and learn.
Financial impact : NA
Quality, Safety, Patient Experience impact: External inspections provide valuable feedback and assurance in relation to the quality and safety of services. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff to input into the report.
Health and Care Standard Number: 2.2 Preventing pressure and tissue damage 2.3 Falls prevention 2.4 Infection prevention and control 2.5 Nutrition and hydration 2.6 Medicines management 3.2 Communicating effectively 3.5 Record keeping 4.1 Dignified care 6.2 People's rights 7.1 Workforce
CRAF Reference Number 5.1
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress is reported through the Clinical Boards Quality, Safety and Experience meetings
- Progress with Action plan reported through the UHB Quality, Safety and Experience Committee
- Verbal feedback from Health Inspectorate Wales

The Board is asked to:

- **NOTE** the progress made to address the findings of the HIW inspection at University Hospital Llandough in 2015 and recent verbal feedback following 2 unannounced visits in March 2016

SITUATION

It was agreed at the Quality and Safety Committee in February 2017 that a further progress report be presented in response to the findings of Healthcare Inspectorate Wales (HIW) unannounced inspection of 5 wards in the Medical and Mental Health Clinical Boards within University Hospital Llandough (UHL). The inspection had initially occurred between 9th and 11th February 2016.

Whilst this report was a planned update to Committee in March 2017, HIW undertook three unannounced inspections, two within UHL (one of these being a follow up inspection) and one at the University Hospital of Wales (UHW).

The follow up visit to UHL was undertaken to check the progress in the areas of Medicine and Mental Health for Older People wards following the adverse report received in February 2015, this occurred on day one of the inspection. Whilst a second team of inspectors conducted a full inspection focused upon Adult Mental Health Services in Hafan Y Coed over a further two days.

An unannounced visit also occurred the following week within the Emergency Unit at the University Hospital of Wales (UHW). It is important to note that the UHB were informed that both visits were part of routine inspection and not as a result of any concerns or issues raised to them.

This paper seeks to assure the Committee that actions have been implemented in response to the findings of the 2016 inspection and that appropriate monitoring of progress against the actions is being undertaken. It also provides for an opportunity to share verbal feedback from the inspections which occurred in March 2017.

BACKGROUND

HIW employ a variety of approaches and methodologies when they inspect NHS hospitals, and choose the most appropriate, according to the range and spread of services they plan to inspect. In-depth single ward inspections allow a highly detailed view to be taken on a small aspect of healthcare provision, whilst a revised approach with increased coverage provided by visiting a larger number of wards and departments is now being utilised to undertake a more robust assessment of themes and issues in relation to the health board concerned.

The focus and themes of the inspections however have not altered and continue to be as follows:

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

After each visit, HIW issues a management letter to the Chief Executive of the respective organisation outlining the findings of the visit and requesting the production of an action plan to address the issue identified. In some cases immediate assurance is sought if there are any issues identified which is cause for serious concern.

The inspection in UHL in 2016 focussed on patient areas associated with the Clinical Boards of Mental Health Services and Medicine respectively. The following wards were visited during this inspection:

- Mental Health Clinical Board: East 10, 14, 18
- Medicine Clinical Board: East 1 and East 4

The report and the improvement plan developed in response to the inspection findings were published on the HIW internet site on the 18th May 2016.

Following the follow up inspection undertaken in March 2017, the verbal feedback from HIW Inspectors was that there had been significant improvements across Medicine and Mental Health Services for Older People. They commended the staff for the care they provided which they stated “was provided though dignified and respectful interactions”. Whilst the UHB awaits the full written report it is pleasing to inform Committee that the initial feedback was of high praise for the care delivered and the recognition of the improvements made.

The second full inspection on the UHL site was a full inspection across Adult Mental Health in Hafan Y Coed and also examined our compliance to the Mental Health Act. Whilst the UHB awaits the formal reports it is very pleasing that the verbal feedback of the Inspection team was of high praise for the care delivered with some small requirements for action in relation to audit and confidentiality. Overall, the Inspectors stated that the service should be commended for the services changes which had occurred at pace, they also took away evidence of good practice for sharing across NHS Wales.

The following week to the UHL inspection saw HIW Inspectors undertake an Unannounced Inspection at UHW Emergency Unit. Once again verbal feedback from the Inspection team reflected a very positive inspection and highlighted good practice which included the staff's commitment to delivering good patient care. They stated that they had observed quality experiences of patients in the Department. That they had seen staff providing assistance to patients in dignified and compassionate ways. Further they reflected that they had seen effective leadership with clear lines of accountability with staff freely discussing with the Inspectors their ability to raise any concerns to managers.

As in the reviews in UHL, the Inspection team did identify some small areas for improvement but overall highly positive verbal feedback was provided.

ASSESSMENT AND ASSURANCE

In regard to the action plan developed in 2016 a review of the improvement plan was undertaken by the Directors of Nursing for Mental Health, Medicine Clinical Boards and the Corporate Nursing team and nearly all actions identified have now been completed. Progress with the improvement plan has been summarised under the following themes:

Delivery of Safe and Effective Care

For this theme, record keeping was the main focus of the findings of the HIW inspection team.

A review of progress with improvement plans for record keeping shows that good progress has been made. For the Clinical Boards, local improvement has been monitored through the completion of a number of audits to measure quality of record keeping. In addition to the progress reported to the committee in February, the following has been achieved:

- The Mental Health Clinical Board training programme for the prevention of pressure ulcers, has achieved 100% compliance by the target date of March 2017.
- The Mental Health Clinical Board have also achieved 100% compliance with falls training
- The newly revised risk assessment booklet was signed off in the Health Board Clinical Standards and Innovation group meeting in January 2017. This was launched in March 2017 with a request for all Clinical Boards to remove all previous versions from use by the end of March 2017.
- Revisions to the Integrated Assessment are being finalised with the aim to test in two wards by the May 2017. The complexity of ensuring that the document is useful to capture the patient data for nurses to plan in patient care, as well as ensuring that data required under the Social Care and Well Being Act 2016 has led to a delay with the revision process.
- Health Board nursing staff have contributed to the All Wales Pressure Ulcer reporting tool as well as contributing to the review of reporting criteria and pressure ulcer indicator definition.

Quality of the Patient Experience

HIW observed during their 2016 inspection that improvements were required in respect of maintaining the dignity and respect of patients and staff. As a result

- The Mental Health Clinical Board have implemented the Kings' Fund assessment for dementia environments with the aim that assessment across all wards will be complete by June 2017.

- Health Board nurses have contributed to the revision for the All Wales mouth care assessment and care plans. One presented at nursing and Midwifery Board in May 2017, the tools will be launched across all areas. Nursing staff will be invited to provide feedback on the ease of use and value of the tool in September 2017.

Dignity and respect was not an issue raised during the verbal feedback in March 2017.

Leadership and management

HIW inspection team found that improvement work was required regarding leadership and management. Both Clinical Boards have shown progress and recognise that monitoring will be required over a period of time to make sure that improvements are sustained. In particular:

- Mental Health Clinical Board have implemented a bespoke leadership programme
- The Sister/ Charge Nurses and Senior Nurses for Medical Clinical Board have commenced the Leadership Program, using PADR to identify the need.
- Both Clinical Boards have progressed with undertaking PADR, with the Medicine Clinical Board PADR's being up to date.

Again verbal feedback from the March 2017 inspection did not raise any significant issues.

Next steps

The Mental Health and Medicine Clinical Boards have progressed against their improvement plans and the majority of actions are now completed. The internal programme of Ward Inspections will continue as a means of providing monitoring and assurance that standards of quality are being met.

As there were no immediate assurances required from any of the visits inspections undertaken in March 2017 the UHB awaits the draft HIW reports.

CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT
Name of Meeting : Quality, Safety and Experience Committee
Date of Meeting : 18 th April 2017
Executive Lead : Director of Corporate Governance
Author : Health and Safety Advisor Rachael.sykes@wales.nhs.uk
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Not applicable – where a risk has a financial impact this should be known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact : The Corporate Risk and Assurance Framework (the CRAF) includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number : 2.1
CRAF Reference Number : Not applicable
Equality and Health Impact Assessment Completed : Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mitigation of the risk is being progressed and is being closely monitored by the Committee.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the Quality, Safety and Experience Committee Corporate Risk and Assurance (CRAF) Update Report and the reduction in the number of extreme risks assigned to the Committee.

SITUATION

The risks contained within the Corporate Risk and Assurance Framework are kept under review. At the beginning of each month the updated CRAF is published on the UHB intranet and internet pages. The latest published CRAF includes any amendments made up to 03 April 2017.

BACKGROUND

The purpose of this report is to update the Quality, Safety and Experience Committee regarding any notable amendments or additions to the CRAF since the February meeting.

ASSESSMENT AND ASSURANCE

There have been no changes to the total number of risks assigned to the Committee, however one score has reduced since the report presented in February. CRAF ref 6.4.12 has reduced to a score of 15 – detail in Appendix 1

The Committee had specifically requested that a review of extreme risks be undertaken. No update has been provided for CRAF ref 5.1.1 *Failure to recognise deteriorating patients resulting in avoidable harm*.

The profile of risks assigned to the Committee is as follows:-

Risk Category	Risk Score	Number of Risks Assigned to Committee
Extreme	25	0
	20	1
High	16	5
	15	6
	12	8
Total		20

The risk register process will be reviewed at Board development day on April 27th 2017.

The latest version of the full CRAF can be found at via the following link:-

<http://www.cardiffandvaleuhb.wales.nhs.uk/risk-register>

Appendix 1

Extreme Risks assigned to Quality, Safety and Experience Committee						
Risk Ref	Risk Descriptor	Controls	Previous Score	Revised Score (if applicable)	Change	Lead Committee
6.4.1 2	Risks to neonates and high risk mothers as a result of providing on-going care to neonates in a clinically unsuitable environment	The Unit has been relocated to interim facility on T1, to allow phase 1 of the creation of a new permanent neonatal unit with a significantly improved clinical environment. The interim facility has greater clinical space, and will allow stringent management of infection control measures. The capital business case (BJC2) for neonatal and obstetrics facilities have been approved.	25	15	↓	QSE
5.1.1	Failure to recognise deteriorating patients resulting in avoidable harm	ALERT training. Implementation of Critical Care Outreach Team (CCOT) in Surgery and Specialist Services at UHW Implementation of National Early Warning System (NEWS) / RRAILS tools and training Introduce staff working in Community Hospitals to NEWS training when they attend Intermediate Life Support (ILS) Training Learning from mortality review meetings All Resus/Cardiac Arrests are electronically recorded Record of all high NEWS scores Weekly review of Serious Incidents at meeting between Executive Nurse Director, Medical Director and Chief Operating Officer APRIL 17 – NO UPDATE RECEIVED	20	20	↔	QSE
	Total		2	1		

LEARNING DISABILITIES SPECIALIST, SECONDARY CARE AND PRIMARY CARE SERVICES COMMISSIONING UPDATE
Name of Meeting : Quality, Safety and Experience Committee
Date of Meeting: April 18 2017
Executive Lead : Executive Director of Therapies
Author : : Head of Outcomes Based Commissioning Tel 029 2183 2103
Caring for People, Keeping People Well
Financial impact : Nil
Quality, Safety, Patient Experience impact : the detail outlined in this paper reflects the ongoing work to assure quality of care delivery
Health and Care Standard Number 3.1 – Safe and clinically effective care 6.1 Planning care to promote independence
CRAF Reference Number 5.1 – Effective and efficient care 2.1 – Failure to embed a commissioning approach to ensure services are based on evidence and population needs to include the quality of commissioned care 2.5 Have robust governance/SLA arrangements in place (including quality standards) with all external service providers 8.1.3 Compliance with Mental Capacity Act and consent policies
Equality and Health Impact Assessment Completed: NA.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Continued work to progress the effective commissioning of NHS Learning Disability Services

The Quality, Safety and Experience Committee is asked to:

NOTE the progress update in relation to commissioning learning disability services.

SITUATION

A paper relating to Learning Disabilities services, and a work plan to progress improvement was approved by the Quality and Safety Executive in December 2016. This paper provides an update on the NHS commissioning element of the paper and approved plan

BACKGROUND

Cardiff and Vale UHB commissions' specialist Adult Learning Disabilities services from Aberatwe Bro Morgannwg University Health Board (ABMU) the service is provided across ABMU, Cardiff and Vale UHB and Cwm Taf Health Boards, and Bridgend, Cardiff, Merthyr, Neath Port Talbot, Rhondda Cynon Taf, Swansea, and the Vale of Glamorgan Local Authorities.

Funding for specialist Learning Disability Services originally passed from Welsh Government via the Vale of Glamorgan Local Health Board, but now as part of the reconfiguration into integrated Health Boards these financial flows are passed directly to ABMU as part of their allocation.

The current service model for specialist NHS learning disability services was established to facilitate the closure of Learning Disability Hospitals. There are three components to the service provided by ABMU:

- Community Teams
- Specialist residential Services
- Assessment and Treatment Services

Cardiff and Vale UHB also provides health care to patients within genetic primary and secondary care services, and provide packages of care, and community based placements for those presenting with more complex needs, utilising Continuing Health Care funding, either independently, or where appropriate jointly with the Local Authorities'

ASSESSMENT AND ASSURANCE

The Quality Safety and Experience Committee are requested to note the following progress in relation to commissioning NHS Learning Disabilities services for the population of Cardiff and the Vale of Glamorgan;

1. Bi-monthly joint NHS commissioning meetings have been established across Cardiff and Vale, Cwm Taf and ABMU to improve commissioning structures and communication. This will support the development of a joint understanding of the current provision and setting the future strategic direction for the services.
 2. A commissioning task and finish group has been established to deliver;
- A network wide assessment of complex healthcare needs informed by each UHBs HSCWB Act population needs assessment, with an analysis of current need of service users in all healthcare settings, and those supported by children's services A baseline (current) service specification

- An agreed set of Key Performance Indicators, including quality indicators.
Quality indicators have been identified and agreed by Cwm Taf UHB, and CAV UHB, and will be discussed with ABMU Health Board in the next four weeks. A copy of the proposed indicators are included as Appendix 1
 - An agreed set of strategic principals for future service commissioning and planning
3. A separate finance task and finish group will establish details and utilization of resource allocation per Health Board
 4. Governance arrangements for commissioning structures are being agreed, which will enable clear lines of accountability, particularly as regards progressing a vision for Learning Disabilities services with Local Authority partners
 5. An update to the commissioning elements of the HIW learning difficulties action plan is included as Appendix 2

The Quality, Safety, and Experience Committee is requested to note progress made to date in relation to adult learning difficulties commissioning, and to be assured that a joint programme of work is in place to ensure that services are effectively commissioned to meet the needs of the population, and which deliver high quality care

A further update will be made to the Quality Safety and Experience Committee in six months time

Draft NHS Learning Disabilities services; Quality Indicators

Measurement-separated into CAV, and Cwm Taf patients)	Reporting timescales	Responsible
1.Total number of Serious Incidents To include; 1.2 Injurious falls 1.3 Injuries as a result of restraint	Monthly All SI forms to be forwarded to CAV and Cwm Taf Health Boards as they occur	ABMU Health Board
2 Number of times physical restraint has been used	Monthly	ABMU Health Board
3.Total Number of never events	Monthly Verbally reported to relevant Health board at the time they are reported to WG	ABMU Health Board
4.Total number of medication errors	Monthly	ABMU Health Board
5 Numbers of POVA s involving staff	Monthly Verbally reported to the relevant health Board at the time the VA1 is raised	ABMU Health Board
6.1 Number of formal concerns 6.2 Number of informal concerns	Monthly	ABMU Health Board
7.1 Numbers of patient experience surveys issued 7.2 Numbers of returns 7.3 Themes identified	Monthly	ABMU Health Board

8 Infection prevention and control 8.1 Number of CDiff cases 8.2 Number of MRSA cases 8.3 Number of MSSA cases	Monthly	ABMU Health Board
9. MDT and Case note reviews of deaths	When a death occurs Narrative to be forwarded to relevant Health Board	ABMU Health Board
10. Response to new NICE guidance	Response proforma to be forwarded to relevant Q&S Assurance Manager of each Health Board as and when new guidance is issued	ABMU Health Board
11. External Inspections	Relevant Health Boards to be informed of inspections, and resulting reports	ABMU Health Board
12 Clinical Audit Programme	Audit results and ensuing action plans to be provided to the relevant Health Boards as they occur	ABMU Health Board
13.1 % of CHC funded patients who have had an annual review of their care plan 13.2 % of patients in NHS run placements who have had an annual review of their care plan	6 monthly	PCIC CAV PCIC Cwm Taf ABMU Health Board
14.1 % of individuals in NHS placements who have had an annual GP health check 14.2 % of individuals on Community LD services caseloads who have had an annual GP Health check	6 monthly	ABMU Health Board PCIC CAV PCIC Cwm Taf

Appendix 2 HIW Adult Learning Disabilities Action Plan update-Commissioning element only-March 2017

Recommendation	Identified action	Progress Update
Future planning of service provision for people with challenging/complex behavior takes account of the challenges highlighted in the HIW inspection	Progress provision of commissioning information from ABMU	Regional NHS bi-monthly commissioning meetings established. Terms of Reference agreed. Attended by Cwm Taf, Cardiff and Vale and Aneurin Bevan Health Boards.
	Analysis of need of current residents to be provided by ABMU	A Commissioning task and finish group has been established to progress this action jointly
	Work with local Public Health Team and Local Authorities to assess likely impact of population change, and need in local population	High level population needs assessment has been completed in partnership with the local authorities
	Work with Community Child Health to improve activity around transition and identifying future need	Improving transition for young people with a learning disability is included within the ICF programme of work with associated ICF funding Identification of future need is one of the objectives being taken forward by the commissioning task and finish group

C&VUHB must ensure that they plan resources and manage performance and value for money for learning disability services. Specifically, both health boards should ensure they are gathering relevant data and information with a view to planning service provision that can clearly demonstrate how it is meeting the needs of the current learning disability population. ABMU must ensure they share commissioning data with Cardiff and Vale UHB in order to move this process further.	A Financial framework for LD services to be developed including - Corporate overheads - Directorate overheads - Costs for bungalows and direct services	Finance leads from Cwm Taf, ABMU, and CAV Health Boards have established a finance task and finish group to progress this action, and will be establishing costs per health board population, and working through historic financial allocations
	Produce a description of current service delivery,	Description of service delivery in place. A draft high level specification for <u>current</u> provision is near completion. The three Health Boards are

	and a high level service specification	working together to sent to complete, and will be expedited by the Commissioning task and finish group
	Develop an outline Service Level Agreement and KPIs with ABMU	This is an objective being taken forward by the Commissioning task and finish group. KPIs are currently being worked through jointly. Quality Indicators have been agreed by Cwm Taf and CAV Health Boards, and will be discussed with AMBU health Board in the next 4 weeks
Health Boards must ensure that they engage and work with the local authority on a strategic level to plan services and promote joint working	Commissioning Group to review and develop a Framework for interaction with Local Authorities	Governance structures for the NHS commissioning group ,which reports to the HSMB and the strategic group which reports through the IHSCC is currently being worked through to ensure no overlaps , and that there are clear demarcation of work streams and responsibilities A joint Learning Disabilities Commissioning Framework will be developed once governance arrangements have been agreed

HEALTHY RESTAURANT AND RETAIL POLICY	
Name of Meeting: Quality, Safety & Experience	Date of Meeting 18 th April 2017
Executive Lead : Director of Public Health	
Author : Principal Health Promotion Specialist ; 02921 832149	
Caring for People, Keeping People Well: The aim of the Policy Standards is to ensure that all staff and visitors have easy access to healthy nutritious food at Cardiff and Vale UHB hospital sites. There has been a significant investment in improving the fabric of the Restaurant and Food retail outlets within the Health Board.	
Financial impact : Migration from Subsidised Non Patient Catering to Non subsidised Income Generation Patient Catering Business Model	
Quality, Safety, Patient Experience impact : Increase the availability of healthy food and drink options	
Health and Care Standard Number ... Standard 3: Health Promotion, Protection and Improvement	
CRAF Reference Number Objective 1 (1.2)	
Equality and Health Impact Assessment Completed: An Equalities Impact Assessment was completed when the Standards were originally developed.	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by

- The continuous monitoring of compliance with the Healthy Restaurant and Retail Policy by both the Public Health Team and Catering

The Committee is asked to:

- **NOTE** the positive impact of the Healthy Restaurant and Retail Policy on improving the healthy options available
- **NOTE** the continuous monitoring to assess the impact of the Policy on availability of healthy options and its impact on income

SITUATION

The paper is presented to provide an update on the impact of the Healthy Retail and Restaurant Policy on the availability of healthy options and income as requested by the QSE Committee in late 2015.

BACKGROUND

Rationale for the Policy

Obesity is increasing in the population – 54% of adults are overweight or obese in Cardiff and the Vale and 20% are obese (Welsh Health Survey, 2014-2015) and whilst we are showing a slight downward trend, we cannot afford to be complacent. Illnesses associated with obesity are estimated to cost the Welsh NHS more than £73m a year (2104). A quarter of the Cardiff & Vale population attends as an outpatient, inpatient or visitor annually and the UHB has a statutory duty to promote the health and wellbeing of its 14,500 staff.

The Policy Standards require a 75 – 25% split in favour of healthy options based on the Eatwell Guide and a summary of the Policy criteria is attached at Appendix 1. The Standards do not prevent the purchase of unhealthy foods but seek to ensure the overall balance of options available favour healthy food. Following success at Cardiff and Vale UHB, several other Health Boards have expressed an interest in what has been achieved to date and are looking to introduce similar policies.

Implementation of the Policy

A great deal of work has already been undertaken by Catering Staff to ensure that healthy options are readily available and accessible to all who visit the restaurants on site and training has been delivered to the Catering staff at Y Gegin and at UHL to support them to deliver healthy eating messages to customers. There have been some concerns from staff about the perceived increase in the cost of food and to address this, an exercise is being planned with the UHB Communications Team to raise awareness and inform staff of the Standards, the UHB's role in promoting health and the reinvestment of income back into patient services.

A significant investment of £1,000,000 has been made to improve the catering outlets on UHB sites. We now have 4 Aroma Coffee Shop outlets which are delivering an operating profit in its first year of £150k. The most significant investment and change is seen at Y Gegin, where the whole dining experience has been modernised and is operating within a commercial Healthy catering business model. In 2013-14, the cost of non-patient catering services totalled £1.9 million while the income generated was enough to recover 88 per cent of these costs, equating to a UHB subsidy of around £221,000 (Wales Audit Office Follow-up Review, 2015). In terms of the financial impact, sales have increased by £500,000 in the first year. Non Patient catering in the UHB is anticipated to be operating at a profit by 2017/18.

Monitoring of the Policy

The UHB Restaurant Standards Steering Group is responsible for monitoring implementation and compliance and has developed an audit tool to achieve this. Updates on the audits are provided to the quarterly UHB Nutrition and Catering Steering Group and audits have been carried out at both UHW and UHL Aroma Outlets, the restaurant at UHL and the Spar Convenience store.

At October 2016, the 3 Aroma Outlets in UHW were 85% compliant with cold food, 100% compliant with drinks, and 50% compliant with confectionery items. The next series of audits will begin in April 2017 with Y Gegin as the menus have now been finalised. In addition, an in-depth evaluation of the policy documentation and process is underway addressing implementation, content, documentation, and governance in particular.

Awards

A Gold Healthy Options Award was achieved by Y Gegin in January which is testament to the hard work of the staff and demonstrates success to date. In addition, the partnership work between Public Health and the Operational Services Board to develop and implement the Policy Standards has been shortlisted for the UK Cost Sector Catering Awards in April 2017.

ASSESSMENT AND ASSURANCE

In conclusion, the introduction of the policy and standards for healthy eating has had a positive effect on the non-patient catering services and the catering outlets within the UHB and has impacted positively on the financial situation of the service.

The UHB Restaurant Standards Steering Group will continue to monitor compliance and financial impact, provide training and information promoting healthy eating to customers and will continue to provide quarterly updates to the UHB Nutrition and Catering Steering Group.

Appendix 1

Summary of the hospital restaurant food standards:

8 key requirements:

1. A minimum of 75% of both the quantity and range of items available for customers to purchase within each product category, must comply with the requirements (product categories include: hot food, cold food, snacks and confectionary, and drinks)
2. Only food and drink items that are compliant with the requirements can be promoted, e.g. at till point, in special offers/meal deals, in window displays and via other promotional activities
3. Products that are not compliant with the requirements *cannot* be promoted, e.g. cannot be sited at till point, cannot be included in special offers/meal deals, cannot be displayed or promoted in windows or via other promotional activities
4. A compliant hot meal must be available for purchase every lunch time as the cheapest hot meal option available and promoted as, for example, the 'deal of the day'. Examples of such hot meals include jacket potato and beans, hot soup and a roll, etc.
5. Vended snacks and drinks must be 100% compliant with the Welsh Government Health Promoting Hospital Vending Guidance 2012 (Welsh Government 2012)
6. Drinking water must be freely available to all restaurant users and must be promoted, e.g. cups provided and location of drinking water highlighted to customers at till point
7. Salt must not be provided at lunch tables – sachets must be available at service counter only
8. Ensure that whole fresh fruit is available for purchase at all meal times, that it is cheaper for the customer to purchase than the majority of confectionary items, and that it is included as an option in all meal deals

Objective 3:

3) The fat and sugar content of all hot and cold meals served at Cardiff and Vale UHB provided restaurants and retail catering outlets are displayed to the customer. Meals will be displayed as being high (red), medium (amber) or low (green) for fat and sugar content as per the FSA traffic light system (Food Standards Agency 2007)

The 75:25 split explained:

Only 25% of items allowed in each food category to have any red (fat, sat fat or sugar)

	Low (amount per 100g)	Medium (amount per 100g)	High (amount per 100g)
Total fat	≤ 3g	> 3g and ≤ 17.5g	> 17.5g
Saturated fat	≤ 1.5g	> 1.5 g and ≤ 5g	> 5g
Total sugar	≤ 5g	> 5g and ≤ 22.5g	> 22.5g

References:

Welsh Health Survey (2016). From: <http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en>

Wales Audit Office (2015) Hospital Catering and Patient Nutrition Follow-up Review; Cardiff and Vale University Health Board
(http://www.audit.wales/system/files/publications/cardiff_and_vale_health_board_hospital_catering_patient_nutrition_english.pdf)

WALES AUDIT OFFICE – DELAYED TRANSFERS OF CARE REPORT REVIEW OF DISCHARGES

Name of Meeting : Quality, Safety and Experience Committee
Date of Meeting: 18th April 2017

Executive Lead : Interim Chief Operating Officer

Author : Head Of Integrated Care
Phone/ Ffôn: 029 2074 1778 Email: Judith.A.Hill@wales.nhs.uk

Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability", "Values" and Delivering Outcomes that Matter to People elements of the Health Board's Strategy.

Financial impact : Not Applicable

Quality, Safety, Patient Experience impact: External audit provides valuable feedback and assurance in relation to the quality and safety of services and how well organisations work together to affect the Patient experience. It also provides opportunity to consider the patient, family and carer experience, as well as providing staff the opportunity to input their views into the report.

Health Care Standard Number : Standard 3.1 5.1,6.1

CRAF Reference Number: 2.1.1, 6.2.1

Equality and Health Impact Assessment Completed: Not Applicable

RECOMMENDATION

ASSURANCE is provided by:

- The development, implementation and monitoring of improvement plans to address recommendations
- Confirmation from the Welsh Audit Office that Health Board and Local Authority Partnership arrangements have significantly improved in relation to the managements of effective Discharge processes

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the main findings of the Welsh Audit Office review
- **AGREE** that the action plan addresses the recommendations made with the Welsh Audit Office report.

SITUATION

This report is intended to inform the committee of the recommendations made following a Welsh Audit Office(WAO) review entitled - Review of delayed transfers of care – Cardiff and Vale Health and Social Care Community which was reported in November 2016 <https://audit.wales/publication/review-delayed-transfers-care---cardiff-and-vale-health-and-social-care-community>

This review sought to answer the following question: Are partners making a sustainable improvement in delayed transfers of care? The review was undertaken between March and June 2016.

Overall the review was positive and recognised the improved partnership relationships. However, two recommendations were made and an action plan agreed by the partnership to address the recommendations

The paper seeks to assure the Committee that action is being implemented in response to the findings of the review and that appropriate monitoring of progress against the actions is in place.

BACKGROUND

In 2007, the WAO carried out a review of Delayed Transfers of Care (DToC) in Cardiff and the Vale of Glamorgan, and in 2009, followed-up progress on the recommendations made, this review corresponded with the Welsh Assembly Government commissioned independent review of DToC in Wales. The findings from those reviews highlighted challenges across the whole system and recommended a more integrated approach to promoting older people's independence. It was recognised that if there was to be long-term improvement this would have to be supported by focussed attention from all partner organisations.

Although the current position has improved since last year, Cardiff and Vale still have a significantly high number of DToCs and March 2017 figure is 58 ranking the third highest in Wales during February, an improvement since the release of the WAO report. The Review noted that unlike other health board regions, Cardiff and Vale has no community hospitals to provide step-down intermediate care. In addition, the University Hospital Wales is a tertiary, specialist hospital, so demand from outside the region is greater. These two complications mean there is added pressure on acute hospital beds and extra demand on community services.

ASSESSMENT

The review concluded that the partners are now working well together and are establishing a whole systems approach to their plans. The Regional Partnership Board has been established and a multi-agency Strategic Leadership Group is also now in place the membership of which includes representatives from statutory and third sector partners. Two senior joint appointments have been made, the Assistant Director of Integrated Health and Social Care and the Head of Integrated Care (Operational) both posts are accountable to the Cardiff and Vale Local Authorities and Cardiff and Vale Health Board.

Main Findings of the Review

The review concluded that:

Independence of older people is being prioritised through joint working and the implementation of an integrated service model, however, continuity of joint funding is a risk:

Strategies are in place that guide short-term improvements and wider long-term transformation, and plans to integrate health and social care services are well underway;

Addressing limitations to effective joint working has been prioritised, although, it is recognised that some areas of improvements will take longer to realise;

New service models and hospital prevention activities demonstrate a commitment to promoting the independence of older people, there is intelligent use of the intermediate care fund, but there are no plans in place if the fund was to stop.

There is a maturing, dynamic partnership in place with strong governance, performance monitoring and evaluation arrangements:

There is a consensus that relationships between partners have improved over the past year and there is a strong and well integrated governance structure in place;

Partners jointly own delayed transfers of care and collective action is being taken to tackle the issue;

- the Partnership has a learning culture and a lot of energy has gone into identifying barriers to progress;
- performance is widely and regularly reported across the Partnership ensuring a sustained focus, but there are concerns about how it is measured; and
- findings from a recent audit on discharge planning supports plans to introduce a patient flow performance dashboard.

Performance is steadily improving though delayed transfers of care remain the second highest in Wales

WAO Recommendations

1. Discharge planning audit

Address the findings from the Delivery Units discharge planning audit either by:

Developing a separate action plan; or incorporating actions into existing service improvement action plans.

UHB Response to WAO recommendation 1

The main findings taken from the Delivery Unit (DU) Audit included:

- Opportunities within UHB to improve discharge planning processes which will:
 - enhance patient experience
 - reduce risk of harm
 - release significant inpatient capacity
- Most cases audited were 'simple discharge' – only 5% of cases across the UHB were deemed complex; 3% in UHL
- The majority of 'bed day saving opportunities' are within the

UHB's control

The actions relating DU audit i.e. releasing bed days, improving discharge and patient flow have been included in the Unscheduled Care Programme, in particular the In Hospital work stream which includes:

- Improved estimation of Predicted Date of Discharge
- Early identification of simple /supported/complex discharge planning requirements
- Early and enhanced patient/ family communication
- Therapy and Nurse led discharges
- Implementation of a Multi-professional training plan.

The action plan to support this work is monitored via the Unscheduled Care programme, In Hospital working group, which is a cross organisation representative group, meeting fortnightly and chaired by the Unscheduled Care Programme Director.

2. Intermediate Care Fund (ICF)

Explore ways of mainstreaming services funded through the ICF to ensure services remain resilient.

Partnership Response to WAO recommendations 2 :

The Regional Partnership Board via the Strategic Leadership Group have approved the strategic Home First plan which is included for information as attachment 2 .This plan monitors the implementation of Integrated Care Fund (ICF) projects along with reporting the development of aspects of the partnership agenda.

Alongside the Home first plan the Partnership has held a number of multi-agency, joint commissioning workshops supported by the Assistant Director of Integrated Care. These workshops have considered the long term plans to develop housing and alternative accommodation solutions for older people, Dementia care, plus consideration of the joint commissioning of care home placements via a pooled budget by 2018, which is requirement of the Health Social Care and Well Being Act.

The commissioning work programme will ensure that successful projects currently funded under ICF will inform the longer term strategic agenda for services provided for older people over the coming years.

Assurance

The attached management response action plan has been submitted by the Partnership and accepted by Walsh Audit office (attachment 1).The Regional Partnership Board will monitor the implementation of the actions agreed and receive regular reports in relation to the number of reported DToCs and the performance monitoring of the anticipated improved position of Cardiff and Vale in relation to other Welsh Health Boards.



Archwilydd Cyffredinol Cymru
Auditor General for Wales

Management response

Report title: Review of delayed transfers of care: Cardiff and Vale Health and Social Care Community

Completion date: October 2016

Document reference: 503A2016

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
R1	Address the findings from the Delivery Units discharge planning audit either by: - developing a separate action plan; or - incorporating actions into existing service improvement action plans.	Improved discharge planning to prevent delays in discharging patients	High	Accepted	There is already in existence a well developed Discharge /Transfer plan which includes many of the recommendations made as a result of Delivery Unit audit. The plan will be reviewed and any omissions will be added The Integrated Health and Social Care Home	End October 2016	Head of Integrated Care Integrated Health and Social Care

Management response

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
					First Plan also include aspects of the DU audit recommendations. Progress against this plan is regularly reported within the partnership governance arrangements		Partnership
R2	Explore ways of mainstreaming services funded through the ICF to ensure services remain resilient.	Strengthened service resilience and continuity	Medium	Partial	There are a number of projects, in particular posts, which have already been offered despite the risk of continued funding as permanent appointments. The continuation of projects currently funded via the ICF fund will be based the outcomes of a rigorous evaluation process which includes performance indicators of efficacy , cost	End March 2016	Regional Partnership Board

Management response

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
					effectiveness and improved quality of service to Patients/Clients The UHB is currently piloting an approach which aims to ensure the appropriate streaming of patients to the right care environments on admission. This may result in consideration of reinvestment opportunities within the organisation. Through the existing Partnership arrangements and reporting mechanisms, projects will be subject to ongoing scrutiny and decisions made to		

Management response

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
					secure funding streams which may include diversion of funding from existing mainstream services. For example the Discharge to Assess projects are aimed at testing new discharge pathways, which could support the reallocation of resources from the acute hospital setting to community based services		

Attachment 2



Home First Plan – February 2017 Update Home First Plan

1. INTRODUCTION

This regional plan is the latest version of the Delayed Transfers of Care Action Plan which has been updated to provide an overview of arrangements to:

- focus the development of services to expedite the progress of citizens using our acute and / or long term care services and;
- where possible, to reduce the number of people who require those services.

To achieve these aims, the plan outlines a variety of focused pieces of work to address key stages in the citizen journey when the need for additional support and care is required. The stages were identified in work by the Whole Systems Partnership to identify areas where further integration of services would be of mutual benefit to partners and citizens. These are:

First contact (FC) i.e. when people present with a potential need	<i>Users first contact with services may arise at different levels of need, which means this part of the system requires a high level of connectivity with statutory and third sector services. Increased connectivity will facilitate getting the individual to the right professional first time and assist in demand management through the provision of advice and sign posting to third sector and community resources. First contact may also result directly in the need for a Comprehensive Assessment (CA).</i>
Ongoing support (OS) i.e. when people have an ongoing, though relatively stable, set of needs	<i>These needs are not necessarily low, just stable. This service function should have a significant preventative or enabling element and should be provided in partnership with both the patient/client and, where appropriate, their carer.</i>

Crisis response (CR) i.e. when people have a crisis or short lived exacerbation of need	<i>Responding to crisis or exacerbation to ensure optimum recovery or rehabilitation of either a single condition or the cumulative effect of multiple needs. This service function requires timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when alternative support at home could have been provided.</i>
Comprehensive Assessment (CA) i.e. when people experience a significant and permanent stepped change	<i>Assessment, care planning and prescription is undertaken for people entering the care system or at points of recognisable transition as their needs change. Such services ensure that people with complex needs receive the right support on an ongoing basis as well as at times of significant change or crisis. This function often needs a degree of specialisation and therefore coordination is very important. It requires high levels of connectivity in order to avoid duplication or missed opportunities for appropriate care and support.</i>

At each point, our aim is to return the citizen to, or as close to their own home, as possible.

The Home First Plan is intended to provide a strategic overview of the work that is underway to reduce delayed Transfers of care and improve the overall care of citizens who require care and support. It forms a fundamental component of the Patient Flow workstream within the Integrated Health and Social Care (IHSC) Partnership for Cardiff and the Vale of Glamorgan.

2. GOVERNANCE FRAMEWORK

The Governance structure to deliver implementation of this plan is overseen by the Regional Partnership Board and comprises key partners across Cardiff and Vale UHB, Cardiff Council, Vale of Glamorgan Council, the Third Sector and independent service providers.

A Scrutiny Task Group consisting of the UHB Chair, and both Council Cabinet Leads for Adult Services oversee progress on a quarterly basis.

The Chief Operating Officer holds responsibility for Patient Flow on behalf of the Partnership with delegated responsibility to the Head of Integrated Care. An outline of the Governance arrangements is provided as **Appendix 1**.

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	November 2016 Update
Assurance of partnership-wide governance arrangements for patient flow.	Instigate Scrutiny Task Group	March 2015	IHSC Partnership	Complete
	Initiate Regional Partnership Board to include responsibility for Patient Flow.	April 2016	IHSC Partnership	Complete
	Appoint Head of Integrated Care as delegated lead for Home First Plan.	June 2016	IHSC Partnership	Complete: post commenced October 2016.
Assurance of partnership-wide policies for Patient Flow and Choice	Approve Discharge (Patient Flow) Policy for 2016-17	June 2016 Revised January 2017	Head of Integrated Care	Delayed: Policy is now in draft form and will be sent for formal consultation over the next few weeks.
	Implement Choice Protocol as part of Discharge Policy (to include public facing communications campaign).	May 2016	Chief Operating Officer, UHB	In progress: Protocol re-drafted and legal advice received. Further development underway to ensure compliance with Social Services and Wellbeing (Wales) Act 2014 before being launched formally as part of Discharge Policy.

3. OPERATIONAL ARRANGEMENTS

The IHSC Strategic Leadership Group maintains oversight of progress via this Home First Plan to ensure a strategic fit with other integration objectives.

An Operational Group, chaired by the Head of Integrated Care meets on a monthly basis to progress operational issues in relation to the management of Delayed Transfers of Care. This work is supported by weekly meetings with operational-level, multi-disciplinary staff to review all Non Mental Health and Mental Health patients with a length of stay of 100 days and over.

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	November 2016 Update
Assurance of partnership-wide operational arrangements for patient flow.	Delegation to Strategic Leadership Group for onward monitoring of Home First Plan	April 2016	IHSC Partnership	Complete
	Appoint Head of Integrated Care as delegated lead for Home First Plan.	June 2016	IHSC Partnership	Complete: post commenced October 2016.
Assurance of performance monitoring to support Home First Plan	Revise local monthly performance monitoring proforma to include trend analysis in addition to in-month performance.	October 2016	DTOC Operational Group	Complete: Final version now in circulation
	Appointment of Data Analyst to support development of Home First Data as part of wider Partnership Dashboard.	September 2016	IHSC Partnership	Complete: post commenced end October 2016.
	Implement full use of clinical workstation as a tool to monitor discharge across a multi-agency environment.	Ongoing roll out.	Deputy Director of Nursing, UHB	In progress. Training undertaken and compliance protocol implemented to ensure thrice daily updates with positive feedback.

4. DELIVERY PLAN

4.1 First contact (FC) i.e. when people present with a potential need AND Ongoing support i.e. when people have an ongoing, though relatively stable, set of needs

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	December 2016 Update
There is a need to ensure a structured approach to maintaining the health and wellbeing of people in the community to prevent, wherever possible, their escalation of need.	Evaluate current initiatives funded through the ICF and PCF in 2015-16 to gauge effectiveness.	10.03.16	Programme Manager, Health Social Care and Wellbeing, UHB	Complete. Ongoing review of outcomes for 2016/17 schemes are being monitored to inform investment in 2017/18
	Establish ICF funded region-wide preventative intervention priorities for 2016-17 to include day opportunities, assistive technology, rapid response adaptations, locality working, be-friending and establishing a Dementia Friendly Region.	Sep 2016	Assistant Director, Housing and Communities, Cardiff Council	In progress. Work programme initiated, supported by capital investment to provide new assistive technology and enhanced community centre accommodation. A range of initiatives to further support preventative interventions have also been approved in principle over the winter period. This includes the development of Good Gym across Cardiff and the Vale, support for Dementia Friendly Llanishen and signposting support for CaVAMH and the British Red Cross.
Increased connectivity will facilitate getting the individual to the right professional first time and assist in demand management through the provision of advice and sign	Evaluate the Vale of Glamorgan Single Point of Access and Cardiff First point of Contact, both funded through the ICF in 2015-16 to gauge effectiveness.	10.03.16	Programme Manager, Health Social Care and Wellbeing, UHB	Complete. Ongoing review of outcomes for 2016/17 are being undertaken to inform investment in 2017/18.
	Develop First Point of Contact /	March	Head of Adult	In progress. Work programme initiated.

posting to third sector and community resources. Assurance of comprehensive assessment in promoting wellbeing is required.	Single Point of Access arrangements across Cardiff and Vale.	2017.	Services/Vale Locality Manager, UHB; Operational Manager for Preventative Services, Cardiff Council	The Partnership is working to identify an admission avoidance pilot with WAST colleagues over the winter period. This commenced January 2017 with performance date to be provided within ICF Q4 return.
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4.2Crisis response (CR) i.e. when people have a crisis or short lived exacerbation of need

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	August 2016 Update
Need to ensure timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when alternative support at home	Implement 7/7 FOPAL in EU to interface with 7/7 CRT service as part of ICF investment priorities in 2016-17.	Sep 2016	Head of Operations and Delivery, Medicine Clinical Board, UHB	Delayed. Proposal to implement 7/7 day FOPAL service prepared but awaiting anticipated Older People / Mental Health Fund for investment. 1wte FOPAL nurse has been approved as part of ICF slippage for 2016-17. Further plans are also underway to extend the FOPAL team to provide additional immediate support to enable patients to return to their own home during out-of-hour periods. This will provide additional occupational therapy and care support to carry out visits to provide equipment, ensure safe environment re-establish at home for patients who may not require the care element of CRT over the winter period. This work commenced January 2017 with performance data to be provided within ICF Q4 return.

could have been provided.				
	Undertake needs analysis of 7/7 FOPAL requirement in MEAU as part of ICF investment priorities in 2016-17.	Sep 2016	Head of Operations and Delivery, Medicine Clinical Board, UHB	Delayed. Proposed to implement 7/7 day FOPAL service prepared but awaiting anticipated Older People Mental Health Fund for investment. This development remains paused.
	Inpatient Integrated Assessment processes to be reviewed and performance indicators established for ongoing monitoring.	June 2016.	Head of Integrated Care, UHB / Deputy Director of Nursing.	In progress. Assessment Documentation in final consultation stage when complete will inform completion of agreed Discharge Policy.
	Implement full use of clinical workstation as a tool to monitor discharge across a multi-agency environment.	Ongoing roll out.	Deputy Director of Nursing, UHB	In progress. Compliance protocol implemented to ensure thrice daily updates with positive feedback. Work ongoing to support the introduction of Simple/Supported/Complex discharge notification Feb 2017 -Simple /Supported/ Complex supported now launched and available on CWS
Need to ensure timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when	Establish partner-wide training programme for discharge planning across the organisations.	March 2017	Head of Integrated Care, UHB/ Locality Manager North/West Cardiff, UHB	In progress: Nurse now appointed to support Education and Training programme .Education programme now under development .Advice and information session currently being held weekly on both UHW and UHL sites. Feb 2017-Uptake remains inconsistent to review attendance each month with a view to revision of the delivery of the programme

alternative support at home could have been provided.				
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4.3 Comprehensive Assessment (CA) i.e. when people experience a significant and permanent stepped change

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	Update
<i>Assessment, care planning and prescription is undertaken for people entering the care system or at points of recognisable transition as their needs change. Such services ensure that people with complex needs receive the right support on an ongoing basis as well as at times of significant change or crisis. This function often needs a degree of specialisation and therefore coordination is very important. It requires high levels of connectivity in order to avoid duplication or missed opportunities for appropriate care and support.</i>	Establish the Discharge to Assess model of care (Domiciliary, residential).	Sep 2016	Clinical Board Director of Operations / Deputy Director of Primary, Community and Mental Health, PCIC, UHB	Suspended: Discharge to Assess model of care in both a domiciliary setting using ICF monies has been suspended. Complete: Residential Discharge to assess models are now in operation both in the Vale and Cardiff . Evaluation ongoing with performance data to be provided as part of ICF Q4 return.
	Establish enhanced Accommodation Solutions team and additional step down housing.	Oct 2016	Director of Environment & Housing Services, Vale of Glamorgan Council	In progress: Recruitment to embed Accommodation Solutions teams across the Region is underway. Additional step down accommodation in place by end March 2017 subject to evaluation of existing accommodation utilisation by end February 2017 7 .
	Domiciliary Care: stabilise market (financial and quality issues) and inform new longer term care model	Current implementation	Assistant Director (Adult Services) Cardiff Council. Head of Adult	• Actions being taken forward to include establishment of a bridging team; ongoing engagement with providers and review of brokerage systems • Locality focussed pilot being undertaken in

	across the region.		Services/Vale Locality Manager, UHB Interim Head of Service, Vale of Glamorgan Council.	supported accommodation in a ward of Cardiff to trial new approach - Outcomes based commissioning exercise to commence in the Vale of Glamorgan with providers – now initiated. - Introduction of minimum hourly rate introduced to try to stabilise the market in the Vale of Glamorgan to commence from 1st October, 2016.
	Care Homes – Older People – deliver requirements of Social Services and Well-Being Act - Part 9.	Current Implementation	Assistant Director – Integrating Health and Social Care.	- Following a Partnership workshop in May 2016 on joint commissioning, a new Joint Commissioning Project Board has been established to meet the SSWB Act requirement of developing pooled budgets for care accommodation by 2018. - Data collation across the region has commenced to inform the baseline and this will also include the WG Care home census on 1st August - The region has participated in the WG workshop on developing pooled budgets for care accommodation by March 2018 - Working group reconvened to discuss fee setting for 2017-18 for Care Home Placements. - A further workshop is planned for 8th March 2017.
	Care Homes – Younger Adults	Current implementation	Interim Head of Service, Vale of Glamorgan Council. Assistant Director (Adult Services) Cardiff Council.	The 2 Cardiff and Vale of Glamorgan LAs and HB are signed up to the OJEU Notice for the IHSCCP Framework contract for care homes for younger adults with LD / MH needs and independent hospitals. Following the IHSCCP Programme Board on 5th September, Partners will be considering the

			Head of Outcomes Based Commissioning, Cardiff & Vale UHB Integrated Operational Change Manager, Cardiff and Vale of Glamorgan Children's Services	implications of utilising the framework before any formal decision is made. As part of the Regional Programme established for Integrated Services for People with Learning Disabilities and Children with Complex needs (with support from ICF Funding) services are being developed for:- - Supported accommodation for young adults with complex needs –providing local and specialised accommodation for young adults with learning disabilities working towards lower cost delivery models of care and support at the earliest opportunity. - Bespoke flexible respite provisions – To support and maintain carers to be able to continue in their role. Adult Placement Schemes delivered regionally would provide more adults with the opportunity to receive their respite locally in a home based community environment. Existing provision will be enhanced in order to deliver this. For individuals who require more specialised respite, a remodelling of provision on a regional basis is required which this model would support.
	Intermediate Care – establish evidence based intermediate care services across Cardiff and Vale of Glamorgan.	Current implementation	Assistant Director – Integrating Health and Social Care.	• The Intermediate Care Fund for 2016-17 is being utilised as a pooled budget across the Cardiff and Vale region to further support key areas of work in relation to the priority areas, including an improved whole system approach supporting early intervention and prevention; accommodation solutions; first point of contact and single point of access; integrated discharge teams; discharge to

				assess models; integrated autism service and a joint service for learning disabilities and complex needs. • An ICF Programme Board has been established to review progress and identify opportunities for maximising collaboration across the whole system and prioritising any slippage within the Programme. Each project is reporting outcomes using Results Based Accountability. • Provision of capital funding has now been confirmed for the next 4 years and proposals are being sought for consideration with a closing date of 27th February 2017. However, concerns remain regarding the uncertainty / prioritisation of revenue funding going forward and the impact this has on recruitment and establishment of new services.
	Ensure delivery of WCCIS across region.	Autumn 2017	Deputy Clinical Board Director, PCIC, UHB	In progress: Programme team now in place to undertake preparatory work for WCISS with regular updates to Implementation Group. Further investment has now been allocated via the ICF for 2016-17 and future years to support ongoing development.
	Establish shared accommodation for Mental Health Move-on team	December 2017	Mental Health HOD.	In progress: capital development using ICF monies underway. On time scale for completion.



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Partnership

Gwasanaethau Cronfa Risg Cymru yn is-adran o fewn Partneriaeth Cydwasaethau GIG Cymru
Welsh Risk Pool Services is a division of the NHS Wales Shared Services Partnership

Welsh Risk Pool Services & Legal and Risk Services

Annual Review 2015/2016



CHAIR'S FOREWORD

The majority of people who receive care from NHS Wales receive an excellent service which is provided by a workforce of over 72,000 whole time equivalent employees. However, the demands on NHS Wales are growing with increases in life expectancy, more complex conditions, technological and clinical advances within a challenging financial environment.

Whilst NHS Wales should be justifiably proud of what it achieves there is no room for complacency and sadly when mistakes do happen or processes breakdown there are both human and financial costs. The human costs cannot be under estimated and can be difficult to capture and quantify.

The financial costs range from the need to provide remedial care through to the more visible costs associated with litigation. The cost of litigation is met directly from the budget available to deliver patient care and, therefore, there is a real incentive to ensure that wherever possible the need for litigation is avoided.

The rising cost of litigation, however, is placing an ever increasing burden on NHS finances and last year the Welsh Risk Pool incurred expenditure of £74.6m.

2013/2014 saw 1,170 new claims made in NHS Wales but this has reduced by 17.3% in 2015/16 to 990 new claims.

The total number of claims in the system stood at 2,607 at the end of 2015/2016. Whilst this represents a considerable workload and potential financial burden for NHS Wales we have seen this number stabilise after a period of significant increases between 2011 and 2014.

Even where it is not possible to repudiate claims, the proactive and robust management by Legal and Risk Services can support a reduction in the value of the claim to ensure a fair and equitable settlement. It is estimated that Professional influence savings recorded for 2015/2016, total £114m.

The introduction of Putting Things Right has provided NHS Wales with a real opportunity to address concerns at an early stage and make an offer of redress where appropriate but, where litigation is necessary, Legal and Risk Services provides a robust defence whilst ensuring fairness and efficiency in achieving a settlement. Putting Things Right is now embedded within NHS Wales and it is estimated that this has saved NHS Wales £5.75m in claimant's costs in the last three years.



The Legal and Risk Services team are further diversifying their remit. They provide an All Wales service for Employment, Commercial, Property Law and General legal advice. This is leading to increasing levels of savings year-on-year for NHS Wales.

We set ourselves a challenging strategic plan to increase our operational effectiveness whilst supporting the NHS to reduce harm through learning.

I am proud of our Service and believe it is efficient and effective, and we continue to drive a programme of improvement in all of our functions against a background of high volume of work.

The purpose of this report is to provide further information on the costs associated with litigation and highlight the work being undertaken with colleagues across NHS Wales to ensure quality and safety remain paramount.

Margaret Foster
Chair
October 2016



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OVERVIEW

The **Welsh Risk Pool Service** is based in Alder House in North Wales and Companies House in Cardiff and administers the risk pooling arrangement for NHS Wales through reimbursing members for losses over £25,000. The reimbursements mainly relate to clinical negligence and personal injury although the scope of the risk pool includes buildings and, in exceptional circumstances, equipment. A significant number of large value claims are now settled using annual payments to claimants over their lifetime and this scheme is managed by the Welsh Risk Pool Service.

The Welsh Risk Pool emphasis is on improvement and the team works with NHS colleagues to ensure that learning is in place for each claim. Also, the Clinical Assessors undertake a range of clinical assessments in high risk areas. The Welsh Risk Pool also undertakes an annual assessment of the arrangements for the management of concerns, claims and learning from events.

Legal and Risk Services is based in Companies House in Cardiff and provides a comprehensive legal service for NHS Wales. The traditional core business relates to the management of clinical negligence and personal injury claims against NHS Wales and significant growth has been experienced in both of these areas in recent years.

In addition to the core activities the department has specialist knowledge in a range of relevant areas including court of protection work, property and commercial work and employment advice.

Legal and Risk Services is integrated with the Welsh Risk Pool Service to ensure a co-ordinated approach to the management of losses arising from claims.

The work of the two services is overseen by the Welsh Risk Pool Committee which is a formal sub-committee of the NHS Wales Shared Service Partnership (NWSSP) Committee. The Committee meets on six occasions each year and considers all claims submitted for reimbursement.

The focus of the Committee is on ensuring a system wide approach to improvement and fully supports the provision of education and training for NHS Wales. The teams provide support and training across NHS Wales to a range of staff including Board Members, clinicians, claims managers and administrators.



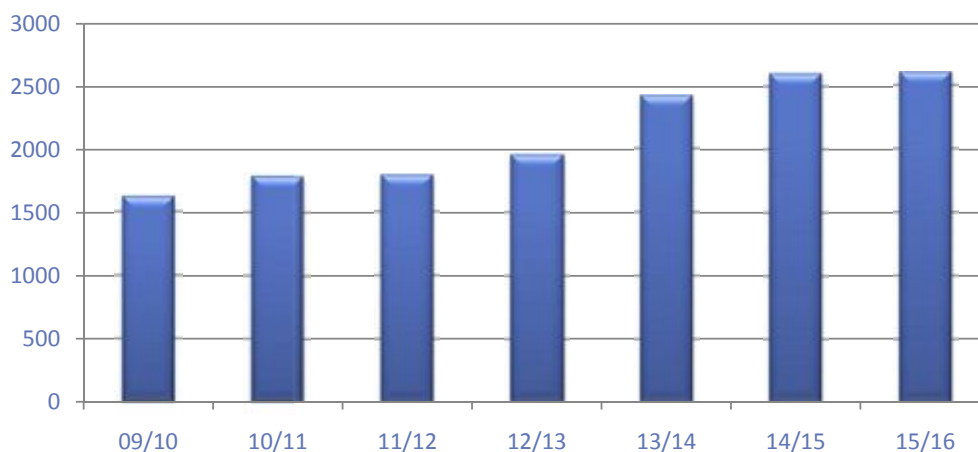
THE DEMAND

The WRPS administers the risk pooling arrangement and meets the cost of financial losses over £25,000. The most significant element of expenditure relates to clinical negligence matters which includes the annual cost of claims settled using a periodical payment order (PPO).

In recent years, NHS Wales has experienced a significant growth in the number and value of claims involving negligence, although there has been a slowdown in the rate of increase in 2015/16. All clinical negligence claims are professionally managed by Legal and Risk Services and the table below provides a summary of open clinical negligence matters by financial year. A 60% increase in open matters has been experienced between 1st April 2009 and 31st March 2015 which equates to an average of 10% each year. The rise experienced during 2013/14 was most marked at 23%.

However, after four consecutive years of significant increasing caseloads 2015/16 represented the growth has slowed. The table below does not include Putting Things Right cases passed to Legal and Risk Services which additionally utilises more resource to manage.

Open Clinical Negligence matters by Financial Year

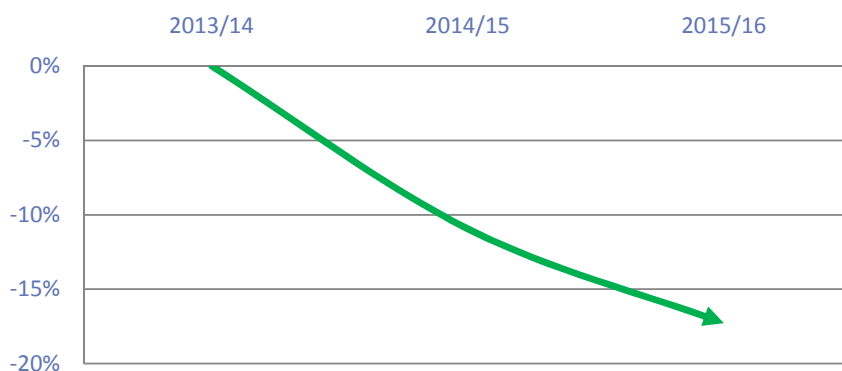


The number of new matters opened during 2015/16 was 990. For the second year running this represents a decrease in the number of new cases passed to Legal and Risk Services. There has been a 17% reduction in new cases since 2013/14.

However, the work required on the open cases has increased as those new matters from several years ago become highly active in litigation both following issue of Court proceedings or involving complex investigations or

negotiation. The clinical negligence workload of Legal and Risk Services has increased by 61% since 2009/10.

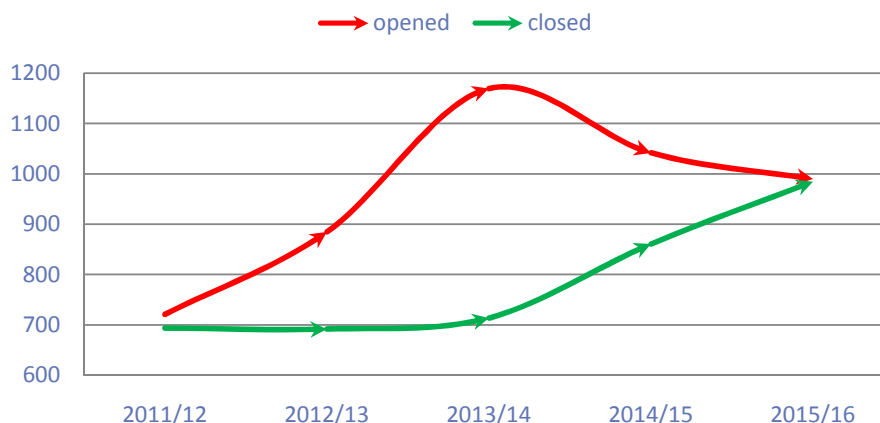
**% Reduction in number of new claims Clinical
Negligence Claims in Wales
(using 2013/14 as the baseline)**



Past experience suggests that a significant number of the 990 new cases will not result in damages being paid. However, the operational staff time required to properly investigate and repudiate such claims cannot be underestimated.

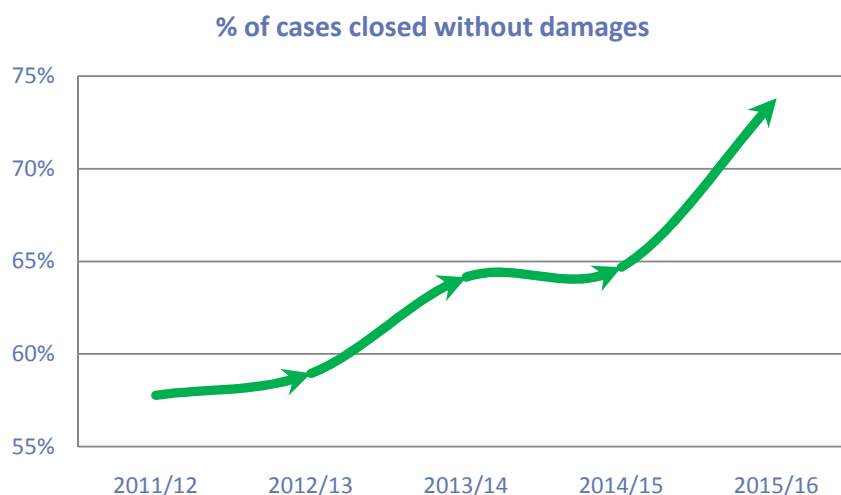
The graph below shows not only the reduction in new cases but also the increase in cases being closed. Legal and Risk Services closed 42% more cases in 2015/16 compared to 2011/12.

New Cases Opened and Closed by Financial Year 2011-2016



An important measure is the number of cases closed without an award of damages. In 2011/12 there were 694 cases closed by Legal and Risk Services. Of these 401 (58%) were closed with no award of damages. By 2015/16 this had risen by 81% to 727.

With the reduction to 258 cases settling with damages in 2015/16 this means the total percentage of cases that were closed with no damages paid has risen to 74% as illustrated in the graph below.



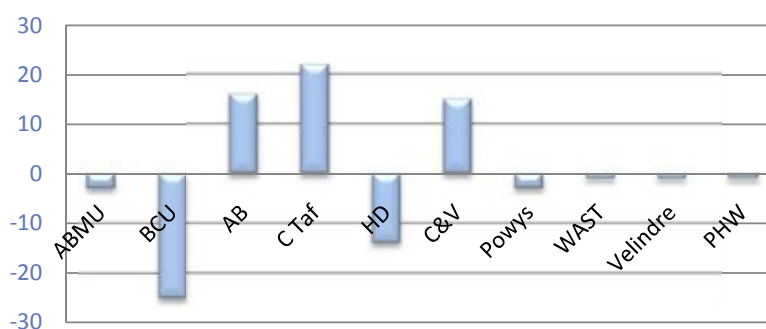
The increases in the number and value of claims experienced by NHS Wales are consistent with those of other nations and indemnity providers. The factors influencing the increases in number and value are wide ranging and include:

- There has been an increase in the value of claims for which it is necessary to make provision for ongoing care over the lifetime of the claimant.
- The provision has increased from £231M in 2014/15 to £281M in 2015/16 primarily due to the material impact of the change in the discount rate for long term provisions. The increase includes 6 new Periodical Payment Orders with a valuation of £14.8M.
- The significant claimant costs associated with smaller value claims, especially where a historic no win no fee arrangement is in place. For claims with damages below £25,000 the average costs paid to claimant solicitors is 2.3 times the value of damages (an increase of over 120% since 2006/07).

Whilst overall the number of open cases stabilised across Wales, there were significant differences between Health Organisations. Betsi Cadwaladr University Health Board and Hywel Dda University Health Board saw the biggest reductions of in-year open cases of 25 and 14 cases respectively.

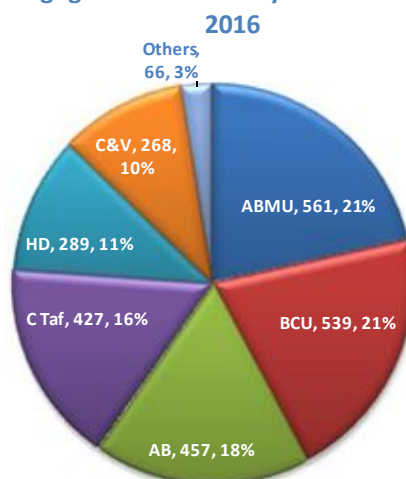
The biggest increases were in Cwm Taf University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale University Health Board with 22, 15 and 14 more cases than at the end of 2014/15 respectively.

2015/16 In-year movement of total Clinical Negligence Caseload per Health Organisation



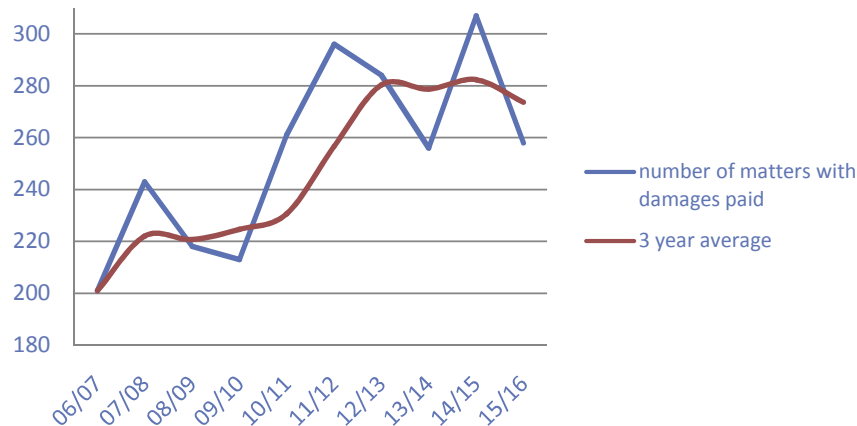
In recent years Betsi Cadwaladr University Health Board has had the highest number of open cases. However, this position changed with the reduction seen in 2015/16. ABMU Health Board now has the highest number of open cases and these two health boards plus Aneurin Bevan University Health Board comprise 60% of all open cases in Wales.

Clinical Negligence Caseload by Health Body @ March 2016



The graph below shows the number of clinical matters by financial year of closure and included a damages settlement. This confirms an increase of 28% since 2006/07 however the increase has, in previous years, been as high as 50% above the 2006/07 level. Historically approximately 80% of matters conclude with damages below £100,000 (including those that settle below the WRPS excess of £25,000).

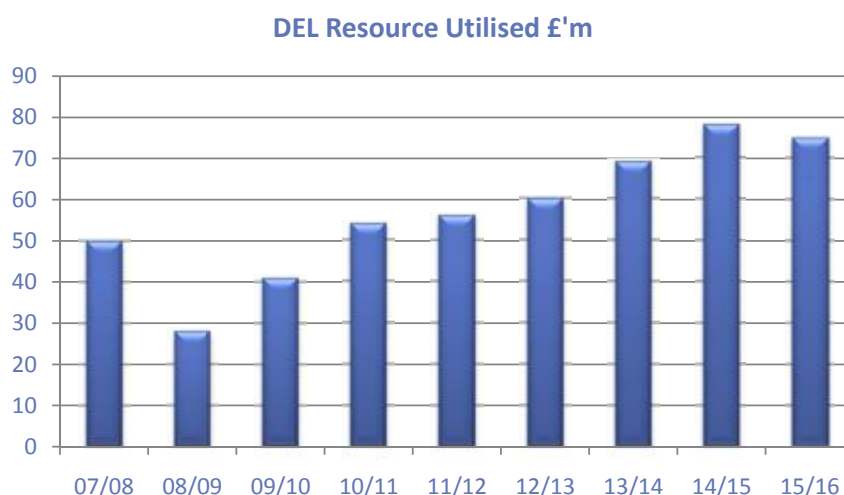
Number of matters settled per year with damages paid



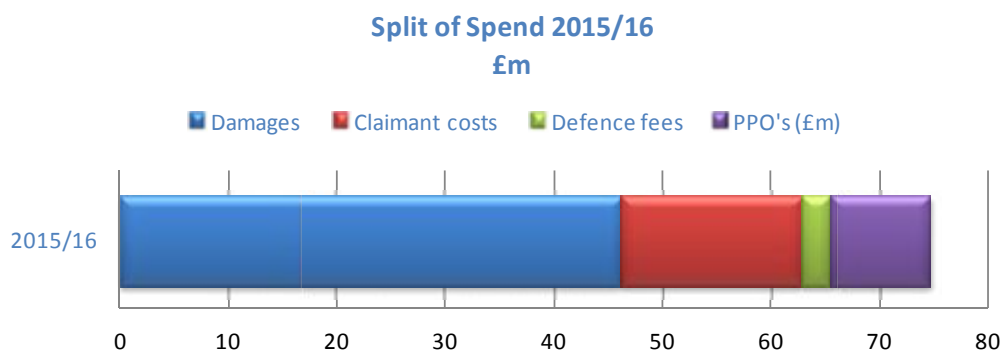
THE MONEY

In-year Spend: "The DEL"

The increase in the number of claims over the last six years has also impacted on the Welsh Risk Pool Service and the graph below shows the in-year resource utilised on settled claims and annual payments for claims settled using a periodical payment order (i.e. excludes increases in provisions for ongoing claims).



The above resource is sourced from the healthcare budget for NHS Wales and in 2015/16 the expenditure of £74.647m which represents 1.16% of the NHS budget. The graph below identifies the main components of spend.

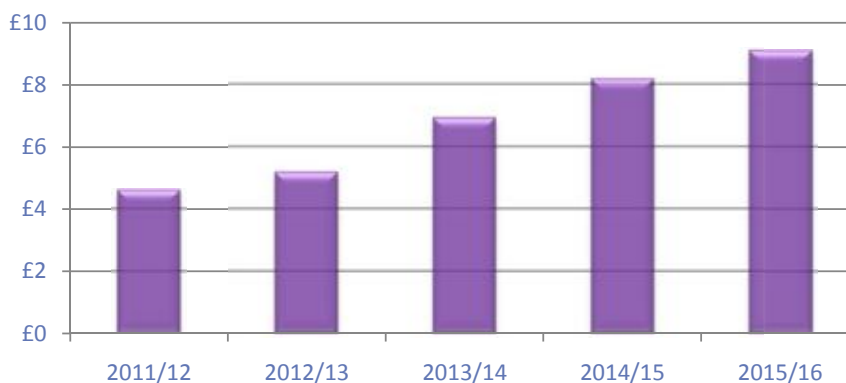


The table below provides a more detailed breakdown of expenditure.

	2015/16 £'m
Reimbursements to members for clinical negligence matters	40,617
Reimbursements to members for personal injury matters	2,331
Reimbursement to members - other claims	498
Former Health Authority claims managed by WRPS	727
Periodical Payments – annual payments	9,082
Movement on claims creditor (amounts paid by members but not yet claimed from WRPS)	21,392
Total	74,647

PPO's are increasingly utilising a larger percentage of the in-year budget. The cost of PPOs has almost doubled since 2011/12. PPOs cost NHS Wales £4.61m in 2011/12 and this has increased by 97% to the 2015/16 level of £9.08m.

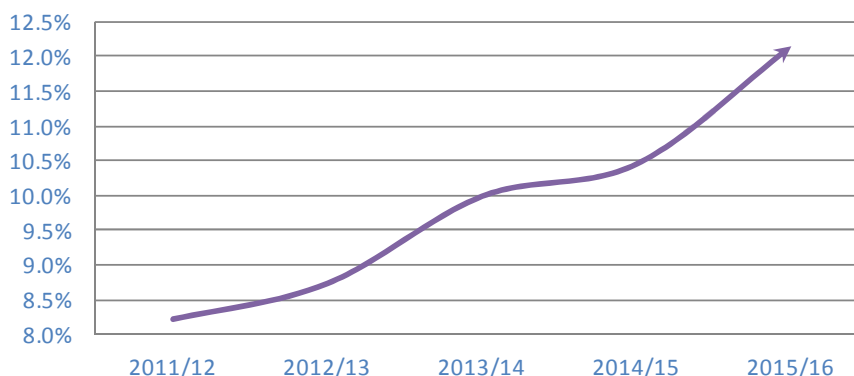
The rising cost of PPOs (£m)



In percentage terms an increasing proportion of the DEL budget is being utilised on PPOs which in theory reduces the funding available for in-year payments. The graph below identifies that in 2011/12 PPOs accounted for 8.2% of the available allocation. In 2015/16 this has risen by 48% to 12.2% of

the available budget. In effect 1/8 of the allocation is now required to fund PPOs.

PPOs as a percentage of in-year (DEL) spend



22

The increase in PPOs, coupled with the change in discount rate issued by HM Treasury, places a considerable and increasing future burden on NHS Wales as outlined in the next section.

Provisions: “The AME”

The WRPS also accounts for its share of long term liabilities and this includes a provision for ongoing matters assessed as probable or certain and also an estimate of future costs associated with settling claims using a periodical payment order (PPO). As at 31st March 2016 the value of the liabilities on the WRPS balance sheet was £682m.

A significant factor has been the change in the long term discount rate set by HM Treasury from +2.2% to minus 0.8%.

The discount rate is designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today's prices. It tells us how much we would need to pay out if we settled all of those future obligations today. In accordance with International Financial Reporting Standards (IFRS), HM Treasury has applied market rates which reflect the low cost of borrowing to government in determining the long term discount rate, giving rise to a negative discount rate for very long term obligations.

As a significant proportion of the WRPS provisions are expected to be settled over the longer term, the reduction of the discount rate by three percentage points has had a considerable impact on the valuation. However, this is an

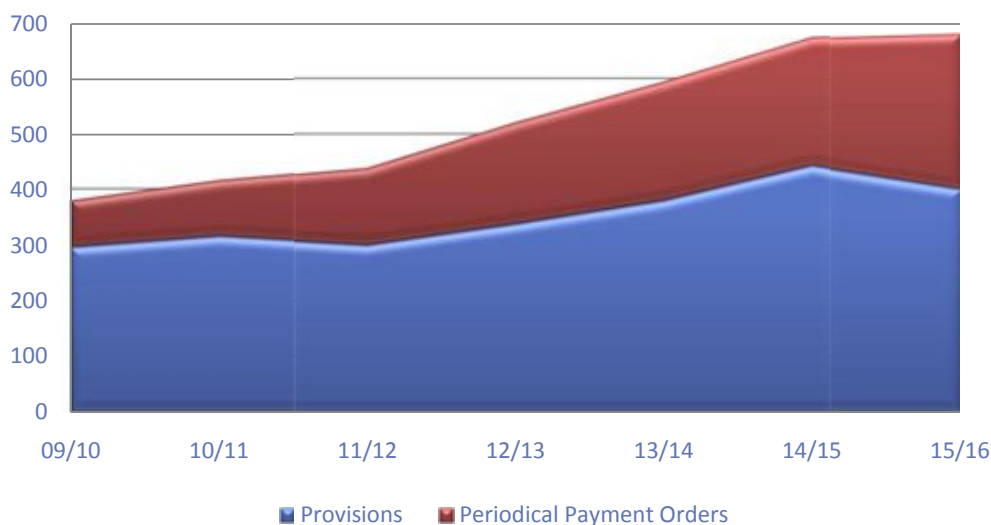
accounting judgment that does not change the underlying future costs that will be incurred in meeting the obligations arising from claims.

The PPO's have been significantly affected by this change. The future liability in relation to PPO's has risen consistently from £84m in 2009/10 to £281m in 2016/17 as shown in the graph below. The increase in the PPO provision in 2015/16 was £50m, 21.6% in percentage terms. This was due to both new PPOs and the change in the discount rates.

In-year expenditure on PPOs is now approaching £10m.

Despite the change in discount rates, the provision for current cases classed as "probable" and "certain" has reduced from £443m to £401m. This is good news for NHS Wales as the provision for probable and certain cases has risen for 4 years running up until 2015/16.

Increases in provisions 2009 - 2016
£m



Contingent Liabilities

The balance sheet for 2015/16 also disclosed as a contingent liability a further £787m in respect of estimates for claims currently assessed as possible.

For the first time remote contingent liabilities needed to be disclosed in the notes to the accounts in 2015/16. The total was £91m.

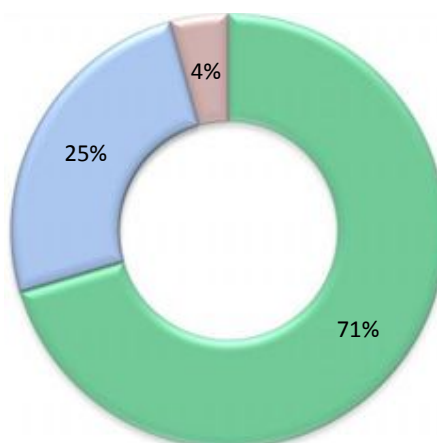
REIMBURSEMENTS & THEMATIC REVIEW

Total expenditure of the WRPS during 2015/16 was £74.647m of which £43.4m related to reimbursements to members in respect of 387 matters. During the course of a claim the responsible body will make payments which include damages, claimant costs and defence disbursements.

The table below identifies that in Wales 70% of payments were in respect of damages and 25% in relation to claimant costs. The corresponding damages percentage in England is 63%. The costs element of payments in England is therefore considerably higher than in Wales.

% split of spend on settled cases 2015/16

■ Damages ■ Claimant costs ■ Defence fees

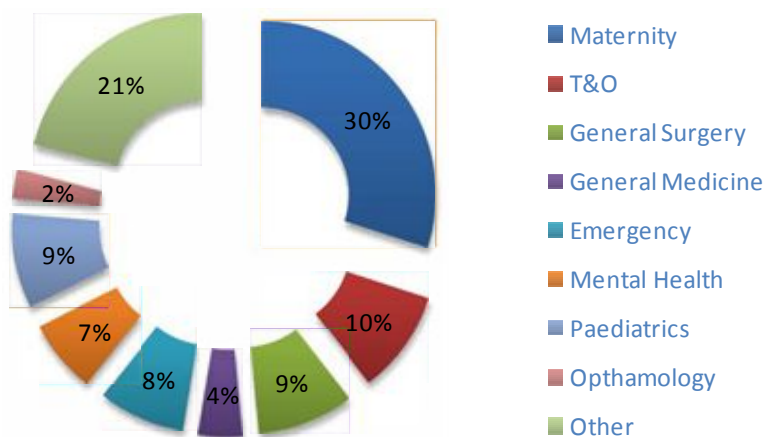


The life cycle of a claim may last many years, especially for large value claims and it is not uncommon for members to submit a number of interim claims for a matter before it is fully concluded. Therefore, the expenditure in year will relate to both finalised and ongoing matters.

Claims received for reimbursement are classified by speciality and the graph below provides a breakdown of the value of reimbursements made. It identifies that maternity cases account for 30% of spend in NHS Wales. This is three times higher than the next area.

In 2015/16 there were eight areas where there were more than 10 cases reimbursed with a total value over £1m.

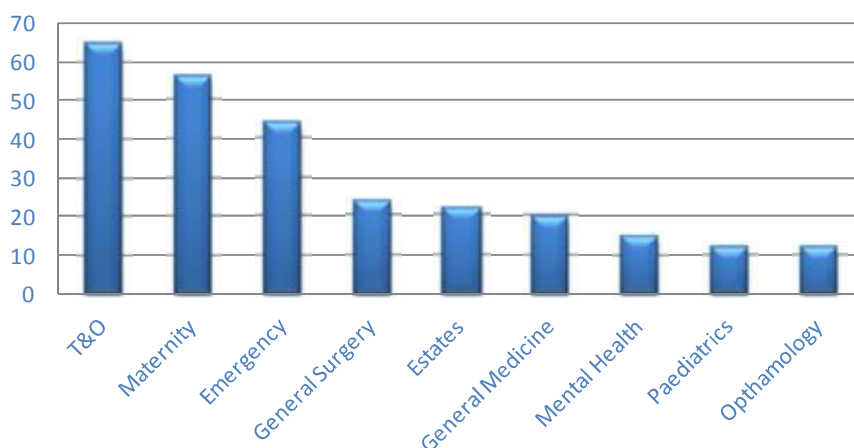
Value of CN and PI Reimbursements 2015/16 Identified specialties are > £1m and > 10 claims



Maternity cases cost the NHS the most money in 2015/16 and this was also the second highest area in terms of the number of cases that were reimbursed with 56 cases in total.

Trauma and Orthopaedics represented the highest number of pay-outs and in total nine areas had more than 10 cases that were reimbursed.

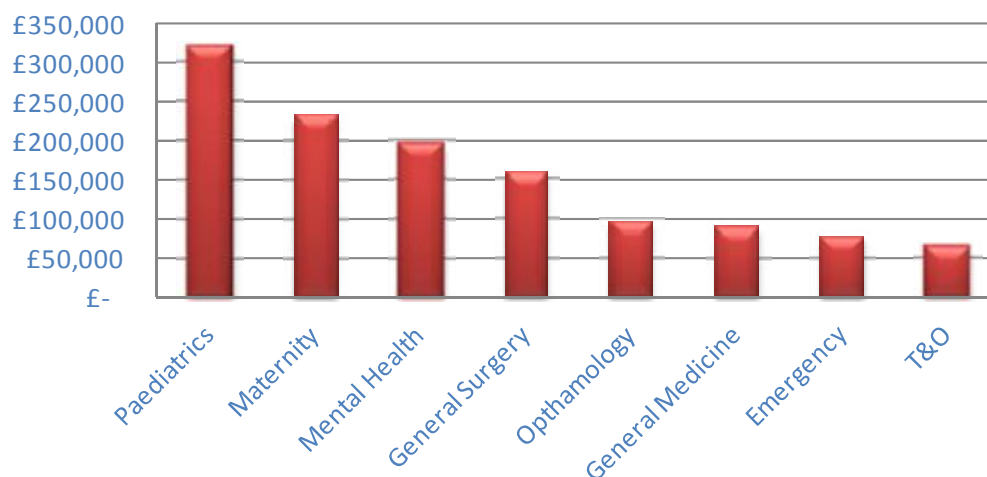
Number of Reimbursements to members (all areas > 10)



The highest average value of claims paid out was in Paediatrics with an average reimbursement in excess of £300k.

Average reimbursement 2015/16

Qualifying criteria: total payouts > £1m and > 10 cases



During 2015/16 the WRPS reimbursed amounts in excess of £1m in respect of 3 clinical negligence matters. The lump sum value of these reimbursements was £5m with ongoing annual payments for ongoing care with an estimated future value of £9.4m.

Whilst claims as a percentage of all care are low the financial impact is much greater and the expenditure of £74.647m represents 1.16% of the total health and social care budget for NHS Wales for 2015/16. This excludes the full cost of claims settled using a periodical payment order and including the £9.4m the percentage would increase to 1.23%.

Reimbursements Analysed by Damages

The number of cases closed with damages payable has risen since 2006/07. The total cases closed with damages payable in 2006/07 was 201 and the 2015/16 figure is 258. 2015/16 represents the lowest number of cases settled with damages since 2009/10 as highlighted in the graph below.

However, the cost of reimbursements has risen significantly in this period due to,

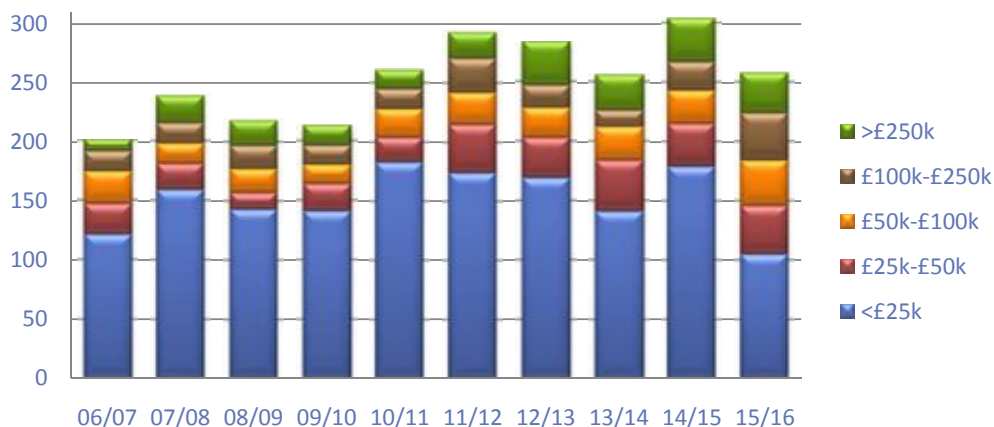
- Larger claimant costs
- An increase in the average damage pay-out

Whilst claimant costs are a lower percentage of total settlement costs in Wales compared to England, there has still been an increase in claimant costs. The graph below also shows the change in the number of cases when

split by the level of damage pay-outs. In 2006/07 cases settled with damages less than £25,000 represented 60% of all cases settled. By 2015/16 this has fallen to 41%. This is a combination of,

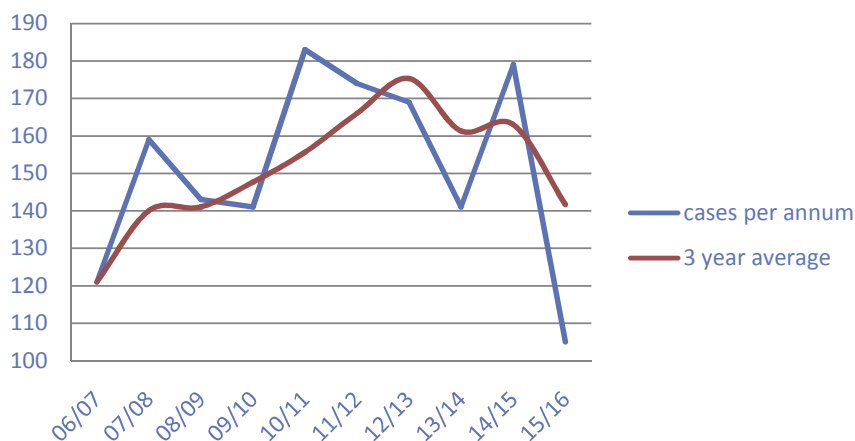
- The escalating cost of litigation and
- The impact of “Putting Things Right” (covered in the next section)

Number of Clinical Negligence Cases settled by Damages Value per annum



The graph below tracks cases settled with damages under £25k and highlights the reducing trend and significant reduction in 2015/16.

Number of cases closed with damages < £25k



CLAIMS MANAGEMENT

Claims against NHS Wales

The NHS in Wales has seen an unprecedented number of new clinical negligence claims in recent years, although the rate of increase has slowed in 2015/16. This growth is not restricted to Wales and has been experienced across the NHS in England, Scotland and Northern Ireland. The recent growth in England and Wales has been driven, in part, by changes to the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) which came into effect on 1st April 2013. The legislation has reformed the funding arrangements for civil litigation including the “no-win, no-fee” arrangements which allowed claimant solicitors to charge a 100% success fees on their costs. In order to offer some balance where costs recovery in a claim would be lower, general damages were increased by 10%. The changes have helped to introduce some degree of proportionality between the value of the damages awarded for harm and the costs recovered by the successful claimant for the payment of his legal team. 562 of the 2607 open claims at the end of the financial year relate to pre-April 2013. These are claims ongoing under the old scheme in which the value of the costs will continue to be disproportionately high as against the settlement achieved on damages. Immediately prior to the implementation of these changes there was a huge increase in claim numbers brought on behalf of claimants to guarantee the higher level of costs with success fees. A significant number of these have been successfully repudiated or settled rapidly but a sizeable number continue to be managed.

PUTTING THINGS RIGHT

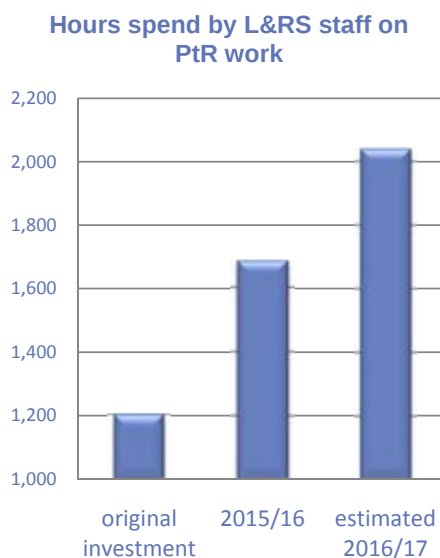
The introduction of Putting Things Right (PTR) in 2011 has provided NHS Wales with a simpler, more responsive and comprehensive complaints procedure which permits a health body to make an offer of redress where harm has arisen from treatment. Unfortunately most claims received by Legal and Risk Services still begin without any previous investigation into the circumstances and often some years after the treatment complained of. Regrettably, as identified in the review undertaken by Keith Evans, the Gift of Complaints, the perception is that NHS Wales has not, generally, been able to put sufficiently robust systems in place to underpin the principles of the Putting Things Right Regulations. Consequently, many firms of solicitors acting on behalf of potential claimants are advising their clients to reject the Putting Things Right process and proceed straight to litigation.



Legal & Risk Services has been providing training, guidance and support to each of the Welsh Health Bodies following the implementation of the Putting Things Right scheme (*NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*)

The Welsh Government funded one solicitor from 2011 for two years which enabled L&RS to provide the necessary support to Health Bodies to enable them to develop their own processes whilst benefiting from legal training and advice on the issues arising from concerns. That funding was then ended.

It was anticipated that the input being provided by L&RS would reduce as the Health Bodies gained experience within their own PTR teams. Despite considerable work within each health body to recruit and train sufficient staff to manage the concerns from beginning to end, it has not been possible for many to reduce reliance on Legal & Risk Services advice and support. The initial investment funded one solicitor that provided approximately 1,200 hours of support for NHS Wales per annum. However the graph below shows a 40% increase on this level in 2015/16 and projections indicate that the time spent will be 70% greater with over 2,000 hours of time invested by L&RS in 2016/17.

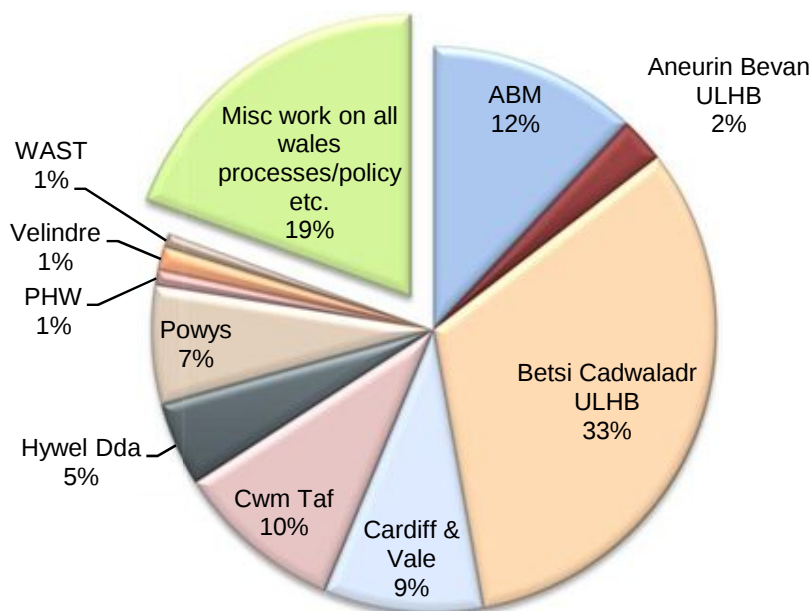


Therefore, in terms of support, whilst a decrease was expected in L&RS solicitors' time as the Health Boards developed their teams locally, the level of support required from L&RS has increased over the years.

This support comprises both general support in the form of providing training to PTR teams, investigators and clinicians and also provision of advice on

individual cases. Each of the Health Bodies has required a different level of support, as demonstrated below:

% Time invested by L&RS in PTR by Health Organisation since 11/12



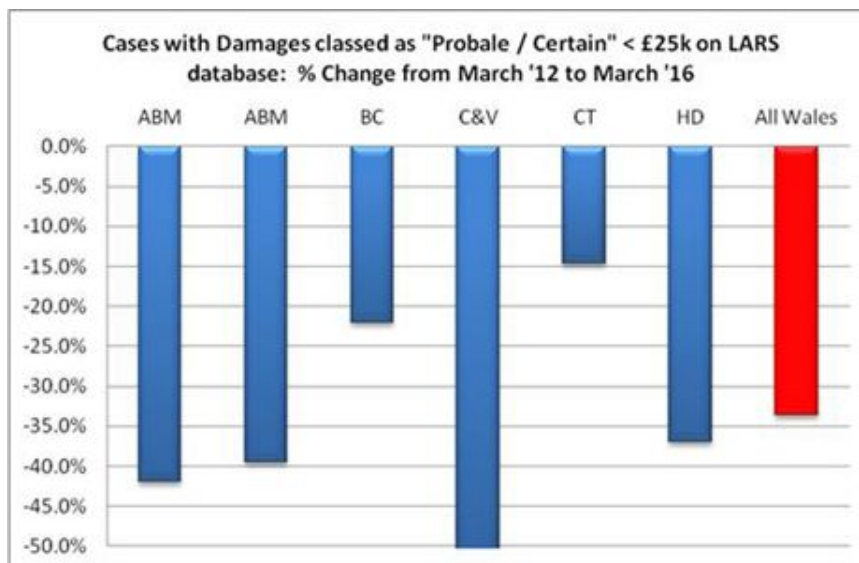
It is important to note that even for the Health Boards above which have needed lower levels of support, they have still benefited from the All Wales work undertaken within L&RS on processes, training and policy development.

The Value for Money Impact of PTR Solicitors within L&RS, NWSSP

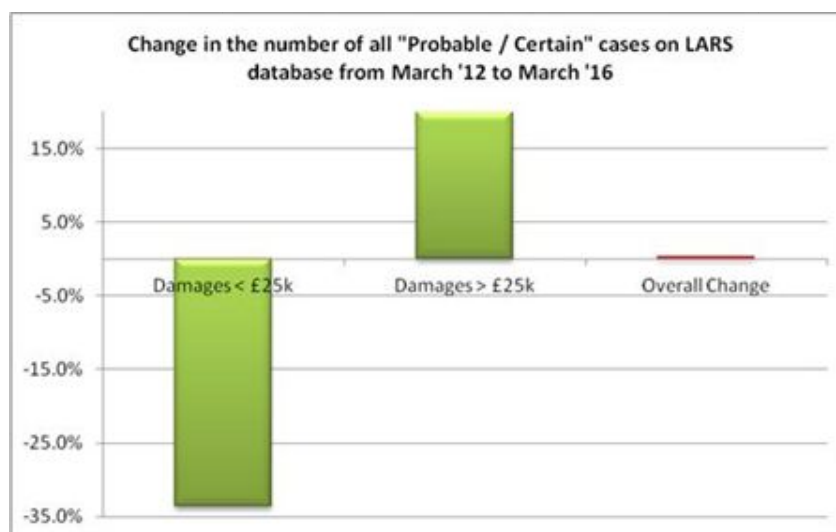
However, the three Health Boards identified above where there has been 10% or more of L&RS time spent on PTR have seen a **12% reduction** on cases reaching litigation since 2011/12 whilst Health Boards engaging less with L&RS PTR solicitors have seen a **rise of 24%** of cases reaching litigation. This demonstrates the added value of the time commitment of L&RS solicitors in leading on PTR as the average costs payable on cases where damages below £25k currently averages at £46k per case compared with £2k under PTR.

In determining value for money from this investment analysis has been undertaken reviewing the number of cases on the L&RS Clinical Negligence database classed as “probable or certain”. Over the 4 year period March 2012 and March 2016 there has been a significant reduction in the number of

“probable and certain” cases on the L&RS database with a damages value below £25k. There has been a 33% reduction on an All Wales basis (from 244 cases down by 82 to 162) with Health Boards varying from a 15% to 50% reduction.



During this 4 year period the total number of cases classed as probable and certain on the L&RS database remained constant. In March 2012 there were 664 probable and certain cases and this figure was 666 in March 2016. However, there was a 20% increase in cases where damages exceeded £25k (up from 420 to 504). During the same period the probable / certain cases with damages <£25k reduced by 33% (as highlighted in the graph).



It is reasonable to assume that without the promotion of PTR and the services of the L&RS solicitors the cases with damages <£25k would have increased at the same rate as the other cases, i.e. a 20% increase in probable / certain caseload. The impact of this would have been 293 cases with damages <£25k in the system as opposed to 162. The difference is 131 cases. The average costs on these cases are estimated at £45,926 per case. Under PTR the costs are £2k.

In financial terms the difference between the costs once the case enters full litigation as opposed to PTR is £43,926 per case. **This equates today to £5.75m of probable / certain claimant and defendant costs avoided in the system due to PTR and the L&RS support of the process.**

Report from the Legal & Risk Services PTR team

L&RS has been providing training, guidance and support to each of the Welsh Health Bodies on an ad hoc basis since the implementation of the Putting Things Right Scheme in 2011. However, since 2015, a dedicated team has been formed to offer focused support to NHS Wales, led by solicitor Gemma Cooper. In August 2015, this team was strengthened with the appointment of two additional lawyers, Charlotte Bayliss and Angharad Voyce.

Since their appointment, Charlotte and Angharad have met with all of the Health Bodies and developed individual plans for how to support their needs. Each of the Health Bodies now has a dedicated point of contact at L&RS, as well as the central team to advise on more general queries and all-Wales matters. Flexible and hands-on advice is provided to individual Health Bodies on the effective investigation and management of individual concerns, the process of determining a qualifying liability and quantifying damages.

The team has published a PTR handbook for use by concerns teams and investigating officers, to accompany the regular training lectures and workshops provided.

The PTR team is also publishing regular guidance to Health Bodies on areas requiring clarity, to date:-

- *Suggested wording to explain qualifying liability*
- *High value claims exceeding £25,000*
- *Consent to access health records and investigate concerns*
- *Legal Costs*
- *Establishing liability where patients have fallen in hospital*
- *Establishing liability and quantifying pressure ulcer cases*

A significant part of the team's work has also been in working towards

changing culture in respect of attitudes towards complaints, promoting PTR and educating Health Bodies as to its benefits, particularly learning lessons. Representatives from L&RS sit on the Welsh Government Evans' Review workstreams (now Learning and Listening from Feedback Group and subgroups), providing input from a legal perspective but also sharing experiences from across NHS Wales.

Feedback from individual Health Bodies has been excellent, in terms of training and support provided by the team. Clients have commented "they share their vast knowledge of the process with us in a way that we find easy to understand" and "what we appreciated most...is their ability to cut through the predictable politics, offer objective advice and deliver the expected results and then some". The support has also been recognised by third parties, including solicitors representing complainants, Community Health Councils and the Welsh Government.

For more information, please contact Gemma Cooper, Charlotte Bayliss or Angharad Voyce at NWSSP Legal & Risk Services.

Fixed recoverable costs

The Department of Health (DoH) was reported last year to be considering the introduction of fixed recoverable costs in clinical negligence cases because of concerns around the proportionality between the compensation paid to the victims of clinical negligence and the costs recovered by the lawyers instructed by the successful claimants. Already, the costs of defending such claims are subject to some capping in England though not in Wales. There was widespread condemnation of the proposal during the pre consultation period from all sides of the argument because it was perceived to herald further limitations on those who believe they have been the subject of poor care but do not have the funds to pursue a case which may not be clear cut which would lead to difficulty in finding legal representation.

Access to justice has, as a concept, been subject to significant attacks in recent years with the removal of public funding and the increase in court costs. The DoH proposal was that claims with a value up to £250,000 would be subject to costs restricted to a certain level according to value. No consideration would be given to complexity or importance either to the patient and their family or the public policy regarding lessons to be learned or legal principle. It was proposed that a formal consultation would be launched in October 2016. In fact there has been no launch of a consultation and the proposal now on the table is that claims up to the value of £25,000 would be subject to a fixed costs scheme. Compensation awarded under the Redress



element of Putting Things Right does just this: once again Wales is leading the way.

There is however a proposal by the DoH for a consultation on a Rapid Resolution and Redress (RRR) scheme which has been publicised in October which will deal with maternity claims, including brain injured baby claims. Under RRR claims will be assessed by independent assessors who will present their findings to a panel of experts who will decide whether compensation should be payable. This proposal is aimed at reducing the time such claimants have to wait to be compensated and improvement would be welcome but many such claimants benefit from time to mature to a stage when it is possible to assess what their future requirements might be. To settle a claim too early will lead to significant under compensation causing the claimant to access more NHS care to supplement the compensation awarded. The proposal is an interesting one; claims arising from stillbirth or neonatal death are highly emotive and difficult for the claimant parents. Rapid investigation and settlement would be of benefit to all involved. The rapid investigation of the causes of a child developing neurological disability is a much more difficult process. The outcome of the consultation will be interesting.

Reducing the burden

Legal and Risk Services encourages health bodies to engage as soon as a claim or potential claim is received. This enables an early assessment to be undertaken which may include a review of the Putting Things Right investigations and admissions or other internal investigations. Where it is clear that the claim has merit this enables an early admission to be made to limit the costs escalating. Other claims may need more extensive investigation including obtaining the comments of external experts as well as the treating clinicians and consideration of the merits with a barrister.

In every case the expectation is that the outcome should be fair and reasonable to the claimant who believes he has suffered harm whilst ensuring that the public purse does not spend more than necessary to achieve redress.

A significant number of cases have been taken to trial involving both clinical negligence and employer's liability claims with successful outcomes. Careful assessment must be made before proceeding to trial because the costs can very quickly exceed the value of the claim. However even the best case with excellent witnesses, good records and supportive experts does not have a guaranteed outcome in court and circumstances are beyond a good lawyer's control. Furthermore, matters in which only the value of the claim is at issue



very rarely succeed, when taken to trial, in reducing the financial cost to the NHS.

Mediation

Mediation is a form of alternative dispute resolution which was much talked of ten years ago when many barristers and solicitors including some staff at Legal & Risk Services qualified as mediators. Some mediation did take place, often with very good results and a high level of satisfaction expressed by those involved but this form of disposing of a matter fell quickly out of favour. This was in part due to perceived cost and in part because most lawyers in the litigation process want to win rather than accept a compromise. In fact, mediation is an excellent means by which claimants who do not believe they have had proper explanation of what went wrong during their treatment have the opportunity to explain their grievance to an independent person who can convey their grief and anger to the Health body, and if appropriate, facilitate a face to face meeting. Compared to the high costs of taking a matter all the way to trial, or pursuing a litigation course to an appropriate settlement, the costs of mediation are very modest and resolution can be achieved earlier.

It has been reported recently that the NHS litigation Authority in England is procuring a mediation service following a two year pilot of mediation focussing on claims involving infant and older persons' deaths which was deemed to be a success. This is an initiative which NHS Wales might well follow to assist in bringing down litigation costs. Mediation can also be used to good effect in difficult Putting Things Right matters.

Settlements

Even where it is not possible to repudiate claims the proactive and robust management by Legal and Risk Services can support a reduction in the value of the claim to ensure a fair and equitable settlement. The table below provides an overview of the professional influence savings which have been recorded for 2015/16 and reflect significant achievements in reducing the final settlements from that of the claimant's initial estimate.



PROFESSIONAL INFLUENCE SAVINGS 2015/2016

SAVINGS	£'m
Claims below £100k	5
Claims above £100k	91
Savings in relation to costs	2
Repudiated Claims	7
Miscellaneous Savings	9
Total	114



CASE LAW UPDATE: RECENT DEVELOPMENTS

Causation of harm and the law around this has always been more complicated in clinical negligence cases than in employer's liability accident claims where the person who claims to have been hurt in an accident can usually show he or she was fit and well before so the pain and bleeding must be as a result of that accident. In clinical negligence the "But for" test is commonly used, however the arguments and consequently the judgements have become increasingly more imaginative when it comes to deciding what harm following a breach of medical care is recoverable. The following case is an example of where this apparent latitude was challenged by Legal & Risk Services on behalf of the Health Board resulting in the Claimant receiving no payment but being required to pay back some of the costs incurred by the Health Board.

The Claimant attended the Accident and Emergency department complaining of back pain and saddle anaesthesia. The A&E doctor suspected cauda equina syndrome and referred her to the orthopaedic team. The impression there was that the claimant was having sciatic pain from a disc prolapse impinging on the S1 and S2 roots and that there were no signs and symptoms suggestive of cord (presumed cauda equina) compression. The plan was for an urgent MRI scan to be done as an outpatient in one to two weeks' time, followed by a clinic appointment after the scan.

Five days later the Claimant attended a private orthopaedic consultation with a same day MRI scan. This showed an L5/S1 disc prolapsed and the Claimant decided to proceed to surgery for discectomy, which took place some 11 days later. Unfortunately, the operation was complicated by breakage of the knife inside the disc resulting in a protracted attempt to remove this blade, leaving the Claimant with some weakness in the S1 distribution, some paraesthesia and also some pain.

The basis of the claim was that it was negligent for the orthopaedic surgeon not to admit for MRI at the time of the original attendance at A&E, had this happened she would have undergone discectomy on a different date and that the unusual complication (scalpel blade breakage) would not have occurred.

Independent expert evidence from an independent orthopaedic surgeon was not supportive, though the independent neurosurgery expert instructed to deal with causation felt that this was harsh. As the HB did not have a Bolam supportive expert to maintain a defence on breach of duty, this was admitted with causation to be vigorously defended.

There were two aspects to this issue – medical and legal causation. The



expert neurosurgeons were agreed on medical causation in that the Claimant sustained an injury to the nerve roots at S1-S2 during the operation. However they identified very few consequences of the injury, which, by the time of the expert discussion were minor; a complicating factor was that the claimant was an employee of the Defendant HB and previously had been retired on medical grounds as a result of the injury she had sustained. The claimant had found alternative employment, mitigating her loss, but there was still a claim for ongoing loss of earning and pension.

The main issue between the Parties was legal causation. The Claimant contended that if she had had the scan on the original attendance, she would have had a discectomy on a different date, and that on the balance of probabilities there would have been no blade breakage on that date. The Claimant was in essence seeking to extend the application of *Chester v Afshar* where there was a departure from normal “but for” causation principles. The Defendant’s view *Chester* was designed to have a narrow application in the specific context of a case where the breach of duty was a breach of the duty to provide sufficient information so as to allow the claimant to give informed consent to the procedure. This was not the case here and the HB argued that normal rules should apply; if not it would have wide ranging repercussions for the NHS generally,

This reasoning was highlighted to the Claimant early on in the process; the Claimant persisted in the hope that the Defendant HB would be worn down and it was the only remaining issue between the Parties two weeks before trial and the HB confirmed that it was fully prepared to argue these issues before the judge. The Claimant made a number of offers £110k Part 36 offer early on in the process; £145k inclusive of costs (said to be circa 250k with additional liabilities) 2 weeks before trial and when that was rejected the Claimant presumably now persuaded by the HB’s view on legal causation made a “ drop hand offer. ” Again this was rejected and the Claimant agreed to withdraw the claim and pay the Defendant HB’s costs of £30,000.

Recently reported cases

Williams v. Bermuda Hospitals Board (Privy Council, 25 January 2016)

This is a case involving one of the most difficult aspects of clinical negligence law; that of material contribution which developed from the cases involving mesothelioma. In essence, if a defendant has materially contributed to a claimant’s injury, and that injury is regarded by experts as being indivisible in terms of causation of harm: in other words it cannot be determined which part of the injury was caused by negligence and which was not, the defendant can



be held liable for the whole of the claim.

Mr Williams went to hospital with abdominal pain arriving at 11:17 and was examined at 11:40. A CT scan was ordered at 13:10 and performed at 17:27. It was reported and read by a doctor at 19:30. Acute appendicitis was suspected and Mr Williams was taken to theatre at around 21:30.

Mr Williams suffered injury to his heart and lungs as a result of the sepsis caused by rupture of his appendix. The sepsis had been developing over a period of about six hours, progressively causing medical ischemia.

The Privy Council upheld the Court of Appeal of Bermuda's decision to reverse the original judgement against Mr Williams which awarded him damages. Its decision was that the complications were as a result of a steadily worsening accumulation of sepsis over several hours, which was caused, in part by the negligent delay of the hospital board. The delay of at least two hours and twenty minutes "materially contributed to the process, and therefore materially contributed to the injury to the heart"

Reaney v. University Hospital of North Staffordshire NHS Trust (Court of Appeal, 2 November 2015)

Mrs R was paralysed below the mid-thoracic level as a result of an earlier devastating illness. She required a few hours care each week, which were predicted to rise to over 30 hours per week by the age of 75. During an extended period of hospitalisation due to her illness she developed a number of grade 4 pressure sores which severely increased her disability and her need for care. Liability for the pressure sores was admitted, and the issue was to determine what compensation was due for this harm. The Defendant Trust was found liable for all the consequential care as a result of the pressure sores on the basis of the concept of "you take your victim as you find him" or the "eggshell skull" principle. However the Court of Appeal disagreed finding that the tortfeasor need only compensate to the extent that the condition has been worsened by the negligence.

This is a helpful case to the Defendant but will require comprehensive investigation into any claimant's pre-existing condition and care requirements.



Ronayne v. Liverpool Women's Hospital NHS Foundation Trust (Court of Appeal, 17 June 2015)

Mrs Ronayne underwent a hysterectomy but as a consequence of negligence in the course of surgery a suture was misplaced in her colon. She developed septicaemia and peritonitis and remained in intensive care for nine weeks.

Mrs Ronayne's own claim was straightforward but her husband's claim for psychiatric trauma resulting from seeing his wife connected to equipment such as a ventilator, observing her in an unconscious state and noting that her arms, face and legs were very swollen was the aspect which challenged the Court. Since the "nervous shock" cases arising out of the Hillsborough disaster and the case of *Walters v North Glamorgan NHS Trust* in which the mother of the deceased child received damages for witnessing over a long period, her child's deterioration and death; 'secondary victims' have been successful in obtaining damages in a variety of circumstances.

In this case the claimant had not suffered a single shocking event as the law required but rather from a gradual realisation that his wife's life was in danger as a consequence of the initial surgical mistake. The appearance of his wife was such as might be expected in a hospital setting and was not exceptional..

In an earlier case a judge had observed that for a visitor to a hospital to be awarded damages in respect of seeing a loved one in a distressed state, the circumstances must be wholly exceptional so as to shock or horrify. This is the control mechanism adopted by the law to prevent large numbers of hospital visitors from recovering damages, which would be unsustainable for both the NHS and private hospitals

After Montgomery v Lanarkshire Health Board (Supreme Court March 2015)

Eighteen months after this Supreme Court decision confirmed what the GMC Good Practice Guide has been advising for some years the Royal College of Surgeons has just published guidelines on the importance of seeking properly informed consent before surgery by having an honest and sensitive discussion about their patient's options for treatment.

The Court ruling puts an additional burden on the medical practitioner to exercise judgement about what information will have an impact on a particular patient's health and well-being as well as how it will affect his decision making

ability. The process will add time to any consultation and consent process which will inevitably cause some difficulties. The penalty for not following the guidance, failing to take appropriate, informed consent and recording it, will be more, successful claims.

Claims managed by Legal & Risk Services

Birth Injury Claim (resulting in deafness)

This claim managed by a solicitor in Legal & Risk Services arose from the management of the Claimant's delivery during which she suffered a substantial period of perinatal hypoxia leading to mild hypoxic ischaemic encephalopathy. She was diagnosed with moderate to profound sensorineural hearing loss.

Whilst breach of duty was admitted early in the proceedings, causation remained in dispute for some time. The LHB's expert audiological physician advised that there were several possible causes for her deafness, one of which was hypoxic damage (other causes canvassed were genetic hearing loss, congenital anomalies of the inner ear, and infections). The lack of reliable audiometric info made the task of determining causation difficult.

As extensive genetic testing and examination did not show evidence of a genetic hearing loss and in the absence of any other cause, the expert concluded that, on the balance of probabilities, the Claimant's hearing loss was due to hypoxia and causation was admitted. The case then proceeded in relation to quantum only.

At a round table meeting just over a month before trial (and prior to the Claimant starting her University studies), the case was settled in the sum of £575,000 plus costs (the Claimant's Schedule totalled in excess of £1.25 million).

Vascular Damage Claim defeated at Trial

The allegations related to the Claimant's vascular care in 2010, following a deterioration in his vascular condition and ischaemic leg. In particular, it was alleged that an open sympathectomy procedure to improve blood flow in an attempt to save the leg from amputation, was wholly inappropriate. The claimant's evidence from Professor Peter Bell, was that the Claimant should have undergone an earlier angiogram and angioplasty.

The defence was that whilst a sympathectomy is a less commonly used option, the operating clinician was experienced in this procedure and the treatment options were discussed at Multi-Disciplinary Team meetings, which had initially, rejected angioplasty. The Health Board relied on a report from an interventional radiologist Professor P Gaines, as to the high risk of angioplasty, which went unchallenged.

The three day trial took place in Cardiff, before a Recorder, His Honour Judge Treverton-Jones, QC. He was pro-active in questioning where required, to clarify evidence and quick to grasp complex medical issues.

The Claimants vascular expert Professor Bell, made a very poor witness, a point which was made in the subsequent judgment. Whilst arguing his opinion, he contradicted himself and evidence produced by his own vascular department. He also belittled other published medical literature, describing some as based on "folklore" before reluctantly conceding that a responsible body of practitioners faced with a difficult clinical case such as this, may have tried a sympathectomy. Whilst he acknowledged it as a procedure of last resort, he maintained that it was a waste of time as it had a short lived effect of only days, an argument that the Judge stated did not in his view, makesense .

Vascular evidence for the Health Board, was given by Mr Jonathan Earnshaw who was later described as a measured and impressive witness. His opinion was that whilst an angioplasty was an option, so was amputation and that a sympathectomy was reasonable and the course decided upon by the MDT.

After the sympathectomy, an angioplasty was carried out successfully (contrary to expectations) but it was due to both procedures combined that the leg was saved albeit with nerve damage arising from a ruptured haematoma.

Potential Pitfalls Overcome

The operation note of the sympathectomy was missing. This was not fatal to this case because the allegation was not that the operation was performed negligently but that it was out of date.

There was no documentary evidence of the MDT meetings; it was necessary to call evidence from 3 witnesses as to the occurrence of these meetings

Summary

Upon giving a detailed summary of the evidence, the Trial Judge stated that he was satisfied that there was no negligence and that it would be a brave judge to hold otherwise, where a decision had been reached on the basis of a MDT decision, as it had, in this case. The Claimant's action was dismissed and an order for costs made in favour of the Health Board. (Costs are recoverable CFA 2012 & ATE).

PERSONAL INJURY

Andrew Hynes and his team have had a busy year taking many cases to Court with mixed success as is the way with litigation when much depends on the manner in which witnesses present their evidence and the mood of the judge on the day. Success is all the sweeter for the obstacles which have to be overcome. Denial of liability and strong resistance to allegations where the evidence suggests that the harm complained of by the claimant is not the fault of the NHS employer is important to manage what is perceived, by some, to be a claims culture. Training provided by the Legal & Risk personal injury team and internally has resulted in good lessons learned from all incidents and accidents and has helped to reduce the numbers of such claims in Wales over the last few years.

Winners

Occupier's liability TRIAL on the 4th October 2016

The Claimant on this occasion was a patient at the St Woolos Hospital, and was recovering following an operation on her left knee. She alleged that as she was making her way to the en-suite toilet within her room, she slipped on liquid on the floor, which caused her to fall and sustain an injury to her head, knee and back as a result.

The Claimant Solicitors made an offer to settle the claim for the global sum of £4000.00 in June 2013 however liability was denied in the July 2013 as there was no evidence of water on the floor. The Claimant Solicitors eventually issued and served proceedings.

Detailed investigations were carried out with witness statements being obtained from three members of staff who remained adamant that there was no water on the floor at the time of the index accident. At a pre-trial conference, Counsel confirmed that the Health Board had strong evidence to support a robust denial of liability and the matter proceeded to trial in October 2016.

The claim for damages was valued at approximately £1500.00, with the costs schedule filed by the Claimant Solicitors in the sum of £32,509.87.

At the trial, no real evidence was provided from the Claimant in relation to the presence of water. However, there were allegations made that the care provided by the nurses was inadequate. These allegations were disputed in full by the Defendants witnesses who provided clear evidence to support the defence.



The Judge concluded that there was insufficient evidence of the presence of water on the floor. The Judge also commented that the Claimant Solicitors had incorrectly pleaded the case and he was therefore unable to consider any arguments made in respect of the insufficient care provided by the nurses. The Judge subsequently dismissed the Claimants claim in full and made an order for the Claimant to pay the Defendant costs, assessed in the sum of £11,250.00.

Employer's liability-Discontinuance

The Claimant, who was an employee within the Health Board, alleged that she slipped on water on the floor, within the shower area on Ward 4.3 of the Nevill Hall Hospital. The Claimant alleged that the floor of the shower had been excessively wet. Upon further investigations, it became clear that the Claimant had entered the shower room intending to clean a domestic bin and members of staff confirmed that this was not correct procedure within the Health Board. Liability was denied in November 2014 on the basis that the Health Board had taken all reasonable precautions to prevent staff/patients from slipping and also advising that the Claimant was acting outside of the normal remit of her duties.

The Claimant Solicitors subsequently issued and served proceedings. Detailed investigations were then carried out and witness evidence was obtained from two members of staff. Throughout the course of the claim, the Claimant altered her version of events, which conflicted with the contemporaneous evidence and the evidence provided by the Defendants witnesses.

The Claimant Solicitors made an offer to settle damages in the global sum of £5000.00 in August 2016 however a denial of liability was maintained with the intention of proceeding to trial.

Ahead of the trial, the Claimant Solicitors made an offer to 'drop hands' with each party bearing their own costs however we believed that the Health Boards case remained strong and therefore invited the Claimant to discontinue the claim.

The Claimant Solicitors subsequently filed a Notice of Discontinuance a week before the trial and agreed to pay a contribution towards the Defendants costs in the sum of £7000.00.

The Claimant Solicitors had previously filed an estimate of costs in the sum of



£14,000.00 but is likely that the costs would have been more substantial as a success fee and ATE premium would have been recoverable.

Losers

22

Contact Dermatitis (COSHH) claim -Trial

The claimant alleged she suffered contact dermatitis as a result of exposure to hand soaps and gels while working as a nursing auxiliary. It was the claimant's case that she had to wash her hands repeatedly during the working day, as many as 30 times. This level of exposure to hand cleansers was alleged to be a breach of Regulation 7 of the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

The basis of the Health Board's defence was effectively three-fold; firstly, the Claimant had not properly established that hand soaps and gels were substances harmful to health within the remit of COSHH. Secondly, that the Claimant's medical evidence was not sufficient to establish a causal link between the Claimant's skin condition and the use of the soap (the Claimant suffered with a number of skin conditions with overlapping symptoms and the Expert failed to examine the Claimant). Thirdly, that the Health Board had sufficient control measures in place to monitor/limit exposure, in compliance with the regulations.

A significant amount of documentation was produced together with supporting statements from the heads of Health and Safety and Hotel Services. The documentation and supporting statements were evidence of the Health Board's systems in place to prevent injury. On examination of the evidence Counsel was of the view that the Health Board had better than a 60% chance of defeating the claim.

At trial the claimant's evidence was particularly poor, it was apparent there were a number of inconsistencies within her evidence for which she had little or no explanation. But, despite this, the Judge made a number of findings, which were surprising to the defence. The various legal arguments regarding inadequacies in the claimed case were flatly rejected.

In essence the judge found that hand soaps were a substance harmful to health and fell within the scope of the COSHH regulations. It was accepted that the claimant had suffered dermatitis as a result of exposure. The rules under COSHH are not strict therefore the Judge also found that the control measures demonstrated by the Health Board were not sufficient. This despite presentation of careful procurement process, screening, training and follow up procedures including monthly hand audits. In his judgement he concluded



that there was a failure to sufficiently monitor the claimant following exposure despite the fact that the claimant was offered alternative soaps and hand cream and was subject to monthly hand audits. The judge stated that there was insufficient evidence produced by the Health Board to demonstrate that once the hand condition was identified it was not sufficiently followed up.

In terms of lessons learned there were only limited issues to be raised. The judgement was a little unclear in that the Judge did not clearly identify the specific breach of duty other than suggesting a rather vague material contribution point regarding follow up procedures, as set out above. The first point would relate to the lack of response from occupational health and infection control in terms of supportive documentation. In addition there was a lack of supporting information on the claimant's treatment following her exposure.

Fractured wrist on opening door-Trial

The claimant is a Staff Nurse who works in the Intensive Care Unit. The doors to the Unit, are secure fire doors that are opened using a staff access card which is placed over a card reader.

It was alleged that when the claimant attempted to access the Ward on 9 July 2013 she placed her card against the card reader and then pushed the door, however the door did not open and she injured her wrist, suffering a possible fracture. The claimant stated that she had waited a sufficient time between scanning her card and attempting to push the door. She confirmed that she saw the green light illuminate on the card reader, she heard the card reader beep and that she heard the sound of the door's locking mechanism disengaging.

Initial reports of the incident from the claimant and Ward staff mentioned the fire doors in question but did not definitively state the door was defective or the door was the cause of the injury. On the claimant's return to work, around 12 September 2016, further reports were completed by the claimant and Ward staff and it was at this stage that the defective door was reported as being the cause of the injury and it was then also reported to the Estates Department.

The Estates Department hold extensive records for all inspections, maintenance, repairs, and reports of defects. Following the report to estates on 12 September 2016, a high priority request was made and the door was inspected the same day. There were no defects found. Records of the bi-annual inspections carried out on this door also did not detail any defects or repairs relating to the allegations.



Legal Considerations

Case law has determined that doors of the type are in fact 'work equipment' for the purposes of The Provision and Use of Work Equipment Regulations 1998. Regulation 5 states that employers must ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair. Since this case pre-dates the introduction of the Enterprise and Regulatory Reform Act 2013 there is strict liability if it is found that an employee has injured themselves whilst using defective work equipment (in incidents post-dating 2013 an employer will not be liable for defective work equipment if there is a reasonable system of inspection and maintenance in place).

Trial

No part 36 offers were made by either party prior to trial. Whether or not the door was defective remained in dispute between parties. In addition to this it remained unclear, given the claimant's account of events, how the claimant had suffered such severe injuries from attempting to push open a door which had remained shut.

The Judge stated that ultimately he had to make a decision based on the credibility of the claimant in this matter. The Judge stated he found her to be a credible witness and found in her favour. The Judge determined that the claimant had scanned her card correctly and waited the adequate amount of time and the door had then failed to open. The Judge did not address, or attempt to explain, how the claimant may have suffered the injuries in these circumstances.



TRAINING AND OTHER SUPPORT

As part of the aim to support NHS organisations in Wales to develop robust risk management arrangements, WRPS offer training support to clinical groups, concerns and claims management staff and national forum members. Recent sessions have included participation in the National Leadership Programme and the clinical assessors have recently embarked on a series of training meetings for claims and concerns staff. Training to specific groups is provided on request.

The Welsh Risk Pool Services has facilitated and supported a number of professional networks at a national level for risk, claims and complaints management. Such networks allow lead personnel to generate cohesion of systems and process and shared aims for the implementation of policies and strategy to deliver care in line with best practice. Examples of participation include:

- o National Quality and Safety Forum and related sub groups
- o Maternity Improvement Network
- o Concordat/HIW/WAO
- o Concerns and Claims Managers networks
- o Forums where national recommendations have been made, e.g. following the Evans and Andrews reports
- o National Clinical Leadership Forum

Concerns and Compensation Networks

Network groups for both those NHS staff managing claims and those investigating and dealing with concerns raised under Putting Things Right regulations have been in existence for many years. The meetings were originally all conducted in meeting rooms around the country with Llandrindod Wells and Bronllys being favoured as equally distant from everyone. With the introduction of video conferencing facility and the cost pressures on both travel expenses and training, the meetings have been taking place on a virtual basis. These have not been successful; attendance is poor and contribution to the meetings patchy depending on the reliability of the technology. There has been no opportunity to actually develop the relationships and support which a good network offers.

At a recent one day event in Llandrindod Wells, which was better attended, it was agreed that two meetings per year would be held in a meeting room to provide, training, feedback and information and would be a true network. It is important that these should be attended by all those involved at all levels in order to maximise the opportunities to learn from each other's experience and challenges.



Patient Information Leaflets

The WRPS have an ongoing requirement for a contract for the compilation of a suite of standard Patient Management Information Sheets for Consent purposes. The documents are required to conform to a series of criteria with the objective of addressing both Clinical and Legal risks. The intention is to ensure that patients are well informed and in doing so make the defence of any claim citing failure in this respect easier to carry out.

Such documents are currently in use across NHS Wales under an existing contract with EIDO which has operated for the last 5 years. EIDO have been reaccredited by the NHS England Information Standard and are endorsed by the Royal College of Surgeons.

This provided NHS Wales with a single licence to download leaflets. Key achievements during the current contract:

1. Almost 45,000 accesses of the Download Centre over the last 12 months. Most documents will be accessed and printed in multiple quantities, so actual usage will be significantly higher.
2. Usage across Wales up almost 500% compared to 2010/11 reports.
3. Responded to a Coroner's inquest in 2012 by rapidly rolling out a new 'Recognising problems after open abdominal surgery' document.
4. Approximately 80 feedback emails from NHS Wales patients received and reviewed.

The following areas are upgrades to the Service that have been introduced in the last 5 years.

Easy Read. As part of the Accessible Information Standard, EIDO have started to roll out versions of the library suitable for patients with a Learning Disability. There are currently 45 procedures covered and there is an ongoing development schedule to extend this coverage across most, if not all, of the library. Currently, one Health Board in Wales subscribes to this library directly with EIDO, but there has been interest from other HBs for the library to be included within the WRPS license.

Consent eLearning. Ensuring that staff that are involved directly in patient care are up to date with the law surrounding informed consent is crucial. For more than a decade, EIDO's eLearning course 'be INFORMED' has been used by NHS organisations across the UK to achieve this. It's authored by Prof Vivienne Harpwood of Cardiff Law School. Currently, two Health Boards in Wales subscribe to this course.

Pre-populated consent forms. Writing down the risks and benefits of surgery on patient consent forms can be a risky and time-consuming process,



particularly for high-volume operations. Sometimes it's possible that patients may not have been given, or retained, a copy of the EIDO leaflet which detail the potential risks and complications of surgery. Health Organisations can supply consent forms which are pre-populated with the information from EIDO's leaflets. Using these can remove the 'disconnect' between patient information leaflets and consent forms and can save up to 10 minutes per patient (based on current customer feedback). EIDO initially look at supplying the 'top 30' consent forms requested by Welsh Health Boards.

LITE patient information. EIDO produces summarised versions of standard leaflets for integration into public-facing websites. www.aboutmyhealth.org is run by EIDO and contains around 175 procedure-specific patient information sheets which NHS Health Boards and Trusts can direct their patients to.



ASSESSMENT OF CONCERNS, CLAIMS AND LEARNING FROM EVENTS

The Concerns and Compensation Claims Standard (the Standard) is designed as a framework to support the compliance by health bodies with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) and the Welsh Government's Guidance on Putting Things Right (the Guidance).

The Standard is drafted by the Welsh Risk Pool Service in conjunction with the Welsh Government and colleagues from the service to ensure that it properly reflects the spirit of the Regulations and Guidance. It is assessed annually by a joint team from the Welsh Risk Pool Service and Legal & Risk Services.

The Standard is broadly split into the following distinct areas:

1. Management of Concerns
2. Management of Redress cases
3. Claims Management
4. Learning From Events

At the request of the Welsh Government, additional information is also being collected and assessed in designated areas and separate scores for each area will be provided where appropriate.

The full standard covers both the documented arrangements plus testing of a sample of concerns and claims. Whilst the historical approach has confirmed that, with respect to concerns and claims management, the documented arrangements were largely in place, there were differing levels of implementation due to the volume of concerns and claims being managed and the significant pressures that this was placing on health bodies. Hence for the purposes of this assessment, there has been a re-visiting of certain arrangements regarding concerns management.

The need to learn from events has always been in place for NHS Wales in respect of claims management but the introduction of the Regulations has highlighted and formalised the need for robust and organisational wide arrangements. Previous assessments have highlighted that these arrangements were not mature across NHS Wales both in terms of documented approaches and implementation. However, there is evidence of some maturing and positive evidence of individual learning was present in all assessments.



The approach for 2015/16 has been to focus on key areas with an increased emphasis on the effectiveness of arrangements:

1. Management of concerns raised (Regulation 24)
2. Management of redress cases (Regulation 26-33)
3. Practical claims management and adherence to WRPS Claims Management
4. Learning from events

These key areas have been retained to provide some year on year comparison as against the assessment for 2014/15. Individual scores have been provided for each additional area of assessment.

This report is designed to summarise the All Wales key findings and operational leads have been provided with detailed feedback on findings to provide more information.

The table below confirms the average All Wales scores achieved for each area of assessment for the period of assessment covered by this report compared to the previous period of assessment.

Key Areas for assessment	Percentage achieved 2015/16	Percentage Achieved 2014/15
Management of Concerns (AFA 8)	69.35%	64.89%
Management of Redress matters (AFA 9A-11 inclusive)	70.92%	73.83%
Claims Management arrangements (AFA 18, 22 & 23)	91.23%	87.43%
Learning from events (AFA 24-26 inclusive)	60.00%	55.93%

Overall the indication is that standards have improved marginally albeit not with the management of redress cases, although the score in relation to redress cases may have been affected by a change in scoring for this year's assessment.

The additional Areas for Assessment included within the year's assessment indicate:



Additional Areas for assessment	Percentage Achieved 2015/16
Concerns Structures & Processes (AFA 4 & 6)	93.05%
Informal Concerns (AFA 6A)	78.28%
Primary Care Concerns (AFA 6B)	73.02%
Actions re Previous Assessment (AFA 27)	53.50%

Management of Concerns (Area for Assessment 8)

The key timescales for the management of concerns are:

- Acknowledgment within 2 working days
- Initial response within 30 working days
- Final report within 6 months if the matter cannot be concluded within 30 working days and no qualifying liability in tort is identified
- An offer of Redress within 12 months if a qualifying liability in tort is present.

The Regulations require that appropriate correspondence with the person raising the concern is maintained and that any delays are communicated with explanation. The Regulations are prescriptive in respect of what must be included within the response although the format, style and language is determined by the health body.

A random sample of matters was selected and testing undertaken against the requirement of the Regulations for each health body.

The emphasis in the assessment for concerns management for the period of assessment concentrated upon the practical elements of the process where the weightings were the highest. The elements included the timeliness and quality of the response, compliance with the contents requirements of the Regulations and whether an adequate decision had been made regarding the identification of harm and explanation of whether there was a qualifying liability or not.

The average score across Wales was 69.35% for the period of assessment which remains indicative that there is still an average level of compliance although it demonstrates an increase on the average score for the previous period of assessment which was 64.89%

The individual scores achieved ranged from 61.70% to 75.09% with three health bodies achieving scores between 74.70% to 75.09% and the remainder bar one, clustering between 64.63% and 71.50%.

The overall picture shows improvement.

The individual testing identified the following issues:

- There is a need to ensure that the databases are properly completed with all relevant information and that the information is complete and accurate
- Identification of allegations of harm and how these are considered under Regulation 24 need to be clarified
- Actions regarding remedial action and learning especially when it is accepted that there were failings should be considered when identified
- There is a need to consider the quality of explanations provided in addition to the tone and language used in responses. There are significant variations in the quality, tone, empathy and quality of the responses between health bodies and also frequently within health bodies which brings into question the efficacy of the quality assurance process
- There is a need to be consistent in terms of the content requirements of the Regulations e.g. regarding explanations of the investigation undertaken and provision of clinical records or offer relevant records should be made as part of the content requirements.
- Health bodies should ensure that the issues raised in the concerns are adequately addressed in each response.
- Many concerns indicate either a lack of or ineffective communication with the patient/family from receipt of the concern, contact throughout the duration of the investigation and/or upon sending the response to the concern.

Conclusions

Whilst the All Wales average compliance rate has increased slightly from the previous period of assessment, only one health body has achieved in excess of 75% against the standard which demonstrates the continued need for improvement. The current areas of weakness are in relation to the compliance rates for meeting the timescales for the provision of responses and also with the quality of the responses provided. This includes compliance with the requirements of the Regulations, particularly with regards to the identification of harm and explanation of qualifying liability where required.



Management of Redress Matters (Areas for Assessment 9 -11)

The Regulations require that, when undertaking an investigation where harm has been alleged, consideration is given to the possibility of a qualifying liability in tort. A qualifying liability in tort may be present if harm has arisen which was caused or materially contributed to by a breach of duty of care. The issue of liability requires consideration and application of strict legal tests.. Where it is considered that there is or may be a qualifying liability which would attract financial compensation of £25,000 or less, then the Redress arrangements should be engaged and a decision made as to whether or not an offer of Redress should be made.

A random sample of redress matters were selected and reviewed for each health body. The assessors attempted to select some cases where a Regulation 26 response was sent, Regulation 24 response was sent (no qualifying liability) and a Regulation 33 response was sent.

The emphasis in this part of the assessment was weighted towards the accuracy of the decision making process as to whether there was a qualifying liability in tort, whether there was good understanding and application of the legal tests involved and whether there was appropriate and clear explanation in the response letter of the tests and outcome. The general tone and appropriateness of the response letters was also considered.

The average score across Wales is 70.92% which suggests a reasonable level of compliance, although the scores achieved by individual health bodies ranged from 53.33% to 83.17%. The overall score is lower for this period of assessment than the previous, which was 73.83%. This may be due to the fact that this year, the assessors slightly changed the way in which some of the areas for assessment were scored. For example, in previous years credit was given if a response was not sent within 30 days but where this was considered reasonable. No such credit was given this year. Furthermore, the assessors this year were looking for an explicit conclusion in the response regarding qualifying liability, whereas in previous years an implied conclusion (acceptance of breach of duty and causation) had been accepted.

Conclusions

- Whilst most health bodies have demonstrated an improvement in their management and resolution of redress cases, particularly in the investigation and determination of the position on qualifying liability, there is still significant variation between them in terms of structure, process and quality
- There remain very different processes and systems in place across Wales between the health bodies regarding the model of the concerns



teams and the qualifications and experience of those dealing with Redress cases

- The impression is that health bodies with more formalised and centralised approached and input from staff with specialist legal knowledge, skills and qualifications perform more effectively with the management and consideration of Redress cases
- This is amplified as these are generally also the health bodies which have developed an impartial and robust quality assurance and validation processes.
- Where health bodies have adopted a delegated approach to the investigation, management and response of Redress cases, this continues to raise concerns regarding the quality assurance process and the need to impart an element of impartiality into the quality assurance process. This was a key criticism of stakeholders during the development of the primary legislation and then the Guidance and any erosion of this would be seen as detrimental to the credibility of the Regulations.
- All health bodies are offered support in the determination and application of the legal tests by Legal & Risk Services (L&RS). The level of support required varies significantly across health bodies. It should be noted that a number of the Health Boards are actually having much more support than just advice on qualifying liability and the legal tests.
- However, the need to ensure robust arrangements remains paramount given that around 40% of the cases reimbursed by the Welsh Risk Pool during 2015/2016 had damages below £25,000 which has remained at the same level from the previous period of assessment.
- Most health bodies experience issues with timeliness of responses. With some health bodies, particularly those which are scoring highly, this is because of the impartial review and decision making process adopted however, with other, there were few discernible reasons for the delays. Notwithstanding this, quality and the correct decision being made should not be compromised for speed. It did appear to the assessors that the emphasis from the Board of some health bodies was on complying with the relevant timescales, rather than ensuring that there had been a comprehensive investigation.
- There remain issues with communication regarding delays in the investigation and the provision of final responses. Whilst there were some improvements in the use of holding correspondence, there were still problems regarding the provision of information to patients and family regarding the reasons for the delays and the timescales for the provision of interim/final responses and the regularity of contact and communication where there were significant delays. In cases of personal contact, this should be recorded.
- The detail and tone of the letters was generally good but they were sometimes let down by the explanations and conclusions provided.



- There were many occasions identified where there was an indication of a lack of understanding of the relevant legal tests which resulted in failures to properly apply the test of qualifying liability. This resulted in delays whilst investigations were reviewed following review by L&RS or solicitors representing the complainant.
- A key area for improvement for some health bodies is to ensure that qualifying liability is clearly explained and is applied to the facts in all responses. It is very important when dealing with a Regulation 24 responses (save for those where finances will exceed the threshold) that all issues have been clarified as this is meant to be a final response.
- There is a lack of consistency between health bodies (and also within health bodies) in the definition of qualifying liability used in the response and some used are incorrectly. The L&RS template wording explaining qualifying liability should be used in all Regulation 24, 26 and 33 responses
- It was occasionally noted that some health bodies had made financial payments in cases where there was no qualifying liability in tort. These were described as 'ex-gratia' payments but sometimes there was no legal basis for the payment nor explanation as to why it was being made. In other cases, a payment was made or a re-investigation undertaken after a Regulation 24 response had been provided to the patient indicating there was no qualifying liability. In such cases, the general feeling was that there was a lack of robustness in terms of decisions and certain health bodies were too readily prepared to offer second opinions / independent expert evidence.
- Prior to making an offer, proper consideration needs to be given to causation, condition and prognosis and any applicable heads of loss. An assessment should be made as to whether it is likely that there are any special damages prior to asking the patient for details (and providing the standard wording explaining what heads of loss might be applicable). This is likely to confuse the patient and raise their expectations regarding what might be recovered. Conversely, there were other claims reviewed where an offer for pain suffering and loss of amenity was made where there might have been financial losses. This needs to be assessed on a case by case basis and a sensible approach taken.
- Many of the health bodies are reporting that the reason they are struggling with Redress cases is related to a lack of resources.

Claims Management (Areas for Assessment 18, 22 & 23)

In recent years, NHS Wales has experienced a significant growth in the number and value of claims. The growth in claims has put significant pressure on Claims Management Functions across Wales. However, this has indication some stabilisation during the period of assessment.

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**GIG
CYMRU
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WALES** | **Partneriaeth
Cydwasaethau
Shared Services
Partnership**

Gwasanaethau Cronfa Risg Cymru yn is-adran o fewn Partneriaeth Cydwasaethau GIG Cymru Welsh Risk Pool Services is a division of the NHS Wales Shared Services Partnership

As at 31st March 2016 the Legal and Risk Services database had 2607 open clinical negligence matters which is a fractional increase on 2607 as at 31st March 2015.

A random sample of ongoing claims were selected and reviewed with the findings set out below.

The average score across Wales is 91.23% which is an improvement on the previous period of assessment when the average was 87.43%. The scores awarded from this assessment range from the lowest of 82.79% to the highest at 100% with half of the health bodies achieving scores over 90%.

The average scores for the individual Areas for Assessment indicate very good compliance with the WRPS Reimbursement Procedure and audit arrangements, but that contained work is required on practical claims management in certain areas.

Area for Assessment	Percentage Scored
Reimbursement processes	97.90%
Management of claims	83.29%
Audit arrangements	82.50%

Conclusions

Some health bodies have significantly improved their performance and there is overall a good level of compliance with the conditions to be satisfied to enable all health bodies to exercise their delegated authority to manage compensation claims below £1million.

There has also been significantly improved compliance with the WRPS Reimbursement Procedures with scores ranging between 95.14% and 100%. In the area of claims management where there was reduced compliance, this was considered to be as a consequence of workload and capacity issues or organisational and process matters including some case file management whilst did not entirely meet the requirements of the standard.

Learning from Events (Areas for Assessment 24-26)

The need to learn from events is critical to ongoing improvements in quality and safety across NHS Wales. The Evans review highlighted the significant challenges being experienced by NHS Wales and recognised that it is a complex area and the basis of Putting Things Right is predicated on learning.



The focus of the assessment in this area was to consider the documented arrangements to ascertain whether they provided a cohesive approach to identifying issues and associated learning across health bodies.

Testing of the arrangements for learning was undertaken on the concerns and claims tested. This identified an inconsistent approach as often the identified learning was inadequate to provide assurance and not always clear on either the paper file or Datix. The claims files reviewed contained little evidence of lessons or follow up of actions.

This is a key part of the assessment as the success of the PTR Regulations is predicated upon learning from concerns. The assessment considered how each health bodies states that it learns from events then how this is evidenced from concerns (incidents, complaints and claims) and all other events at all levels including provision of Board level assurance.

The average score achieved in this area is 60% and the individual scores range from 20.58% to 81.75%.

The evidence indicates a slight marginal improvement in certain areas, this was primarily reflective of better quality evidence of learning being provided. The position remain that overall there have still been no significant changes or improvements from the previous period of assessment in terms of formalising and evidencing operation of the designated processes/pathways for learning from events.

Notwithstanding this, in certain health bodies there were clear indications that the quality of learning seemed more culturally embedded to create a more solid foundation for learning throughout the organisation.

Conclusions

The assessment indicated:

- Each of the health bodies are still at very different stages of development with different organisational structures and processes, procedures and pathways for learning
- Notwithstanding the above each of the health bodies have indicated a commitment to learning and practically evidenced some learning although it is questionable the extent to which this is individually driven rather than a systemic approach
- Still very few health bodies have formalised, mapped or set out their strategy and process for securing organisational learning and many reply on a collection of disparate documents which lack consistency of approach



- There was continued good practice and commitment of learning was evidenced where there is a Board/Executive level commitment but less evidenced at the ground level
- There was good evidence of specific learning from significant high graded concerns, serious adverse incidents, inquest and high value claims and some but less good evidence of trend analysis and actions taken in relation to low level graded concerns
- In many cases it was difficult cases to determine and trace through specific learning from concerns and claims



SAFETY AND LEARNING

The Clinical Assessment Team undertakes clinical assessments in respect of areas which are at high risk of litigation. For each area of assessment a clinical evidence criteria is developed which is based on current recognised good practice. The assessment comprises of a documentation review of each organisation's arrangement to gauge the extent to which the organisation can demonstrate compliance. The documentation review includes policies, procedures, training logs and also clinical audit reports. The Clinical assessors liaise closely with Health Inspectorate Wales amongst others to try to reduce duplication of effort and focus on universally recognised areas for improvement. In addition to reviewing the documented arrangements interviews with a range of staff are undertaken to gauge the level to which the documented arrangements are embedded in actual practice.

The 2016 /17 assessments will focus on Emergency Departments because a significant proportion of compensation payments arise from treatment and assessments undertaken there.

Example- A & E Claim – Liability Split

The Claimant attended the Emergency Department with abdominal pain in the early hours of the morning. Following investigations she was discharged home with painkillers. She then re-attended the Emergency Department at lunchtime the same day in septic shock and was transferred to ITU later that afternoon.

It was alleged that the LHB were in breach of their duty of care in discharging the Claimant after the first attendance at the Emergency Department. It was claimed that had she been kept in for proper assessment and observation, the signs of sepsis would have become apparent and antibiotic treatment could have been commenced a few hours earlier which would have avoided the development of septic shock, the need for intensive care and the use of high-dose inotropes that led to the gangrene in the patient's fingers. It was argued that if the Claimant been observed and treated earlier for the sepsis, on the balance of probabilities, she would not have gone into shock or developed gangrene.

Whilst breach of duty was admitted early in proceedings, causation remained in dispute on the basis that even had she been admitted at the time of her first admission it made no difference to the outcome.

Experts in the fields of A& E, Intensive Care, Nephrology, and Microbiology



were instructed by both parties. The LHB's experts were divided in their opinions – some of the view that it did make a difference to the outcome and others that it did not.

Following expert discussions and joint statements it became clear that the LHB's experts were more robust in their view that earlier treatment was unlikely to have made a difference and even it did, she would still have suffered some injury (partial loss of digits).

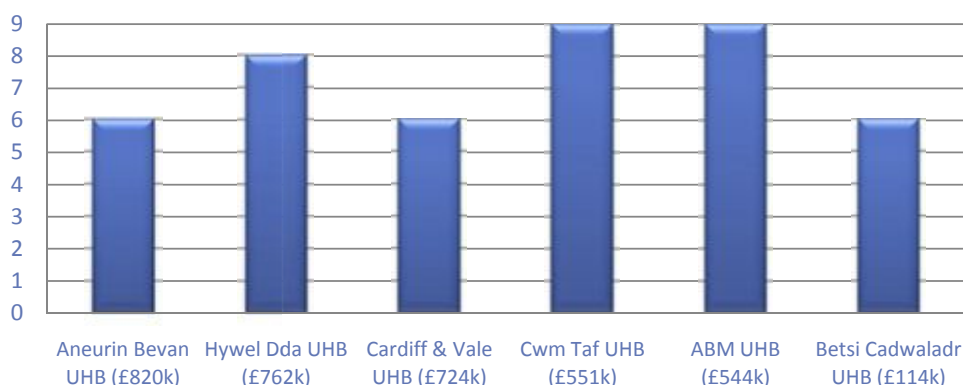
Alternative dispute resolution in the form of a meeting of the parties with their barristers but without a judge or mediator present took place at which a liability split of 65/35% in the patient's favour was agreed. The amount of compensation is still to be determined.

The total value reimbursed to Health Boards by the Welsh Risk Pool in respect of A&E cases in 2015/16 totalled £3.516m. This covered 44 cases and represents 11.4% of all cases reimbursed in 2015/16. This is the third highest area in terms of the number of cases reimbursed behind T&O and Maternity.

The graph below splits this between Health Boards and indicates the amount reimbursed to each.

Analysis of the 44 A&E cases reimbursed by the WRP in 2015/16

Number of cases per Health Board
(Value of total reimbursement)



Maternity

The WRPS is an active participant in the national Maternity Improvement Network. The Network has representation from all Health Boards and the Quality and Safety sub group is currently pro-active in developing an all Wales dashboard of clinical data and a consistent trigger list of events which should

be subject to investigation. As part of this work the group is also working to ensure that common definitions are used. The National Stillbirth Working Group is also part of this Network and has produced an All Wales Pathway and guidelines for reducing stillbirth in Wales. An information leaflet has been developed by an expert group brought together by the Department of Health and the stillbirth charity, SANDS, the purpose of this leaflet being to increase awareness to women of the risk of stillbirth and to highlight how women can reduce their risk of stillbirth.

The Maternity network has been contacted by the PROMPT team at Bristol to explore the possibility of working with them to implement PROMPT at an All Wales level. This has been done in Scotland as part of a joint project with PROMPT and the Health Foundation and the team in Bristol would like to explore the possibility of something similar in Wales. WRPS will work closely with the network to assist in delivering the benefits of the programme to Wales.

The Maternity Network has received correspondence from the Chief Nursing Officer regarding the national requirements for CTG training. There are challenges and both Legal & Risk and WRP services will contribute to the debate.



FUTURE FOCUS

Finance -The financial aspects of claims will continue to be a significant challenge to NHS Wales for the foreseeable future. The timing of settlements is often beyond the control of the defence team and therefore it is often difficult to predict with any certainty the value and timing of settlements. This is especially the case for the larger value claims which involve significant negotiations in relation to care needs.

A review of the Legal and Risk Services database has identified that approximately 11% of claims have an estimated quantum for damages of £750,000 or greater. These claims represent approximately 85% of future liabilities and highlight the financial impact of a small number of claims.

As identified in the thematic review section earlier in this report, maternity claims remain the single largest challenge to NHS Wales. These claims are likely to be settled using periodical payments over the lifetime of the claimant rather than a single lump sum. Due to medical advances life expectancies have continued to increase and therefore the cost of such claims will be borne by NHS Wales for many years.

More sophisticated forecasting tools are being developed to both inform the Integrated Medium Term Planning process and more accurately predict in year pressures and flexibility.

Putting Things Right – It is anticipated that fewer numbers of claims under £25,000 will be passed to Legal and Risk Services for litigation as Putting Things Right continues to embed itself within NHS Wales. This will assist with both prompter settlements and lower claimant costs.

Risk Sharing Strategy – A robust, equitable and transparent Risk Sharing Agreement will be introduced in Wales. Factors that will be considered in creating a new apportionment methodology, for any spend above the Welsh Governments allocation, will include Health Boards,

- Size and activity levels
- Paid claims over the last five years
- Known outstanding claims
- Population

This will provide a greater awareness of the drivers for clinical negligence claims and focus on improvement for the longer term. A risk sharing allocation which includes a weighting for recent claims history and imminent settlements will incentivise Health Boards and Trusts to embed good practice to reduce their potential liability.



Risk Management – a renewed focus on risk management during the litigation process to identify emerging themes and risks to support organisations in identifying areas for improvement. It is believed the provision of more timely support could enable earlier interventions and support service change. It will also increase efficiency of processes within Health Organisations.

Data Development – Intelligent use of data to provide clear focus on key risks and issues. This will be linked to national speciality groups to drive forward change on issues identified.

Clinical Assessments

The WRPS assessments have recently focussed on specialities considered to be at high risk of litigation and these have confirmed that organisations are pro-active in developing procedures and protocols in relation to recognised good practice. However, the operational implementation is more challenging and the claims indicate that often there are weaknesses in the fundamentals of care provided. These include communication, record keeping, undertaking risk assessment and acting on observations. Furthermore, the clinical audit and performance management arrangements are not necessarily well developed to provide management and governance assurance or highlight deviations from expected practice.

The WRP Committee confirmed the approach for 2015/16 that focussed on the essentials of care which are relevant to claims. This included a review within each Health Board (on designated medical and trauma and orthopaedic wards) of patient records and staff interviews to ascertain compliance with good practice in relation to:

- Risk assessments relevant to the patient (e.g. falls, continence, nutritional status) and evidence of compliance
- Compliance with skin care bundles
- Management of infection and sepsis
- Patient monitoring and escalation
- Evidence that test results have been acted upon
- General record keeping
- Staffing levels and acuity
- Availability and use of bariatric equipment
- Training provision of staff
- Compliance with incident reporting requirements
- Clinical audit arrangements for risk assessments, record keeping, essential nursing care.
- Action plans and follow up arrangements



The WRPS review incorporated a study of five sets of nursing notes per each of the two Assessors. One Assessor was allocated to Medical Wards, the other to Trauma and Orthopaedic Wards. The Assessors also reviewed ward acuity, medical review of outlier patients, staffing levels and the use of bank and agency staff.

Key findings from the themed reviews are highlighted below, with links to the main body of the report.

Recommendations:

Specific recommendations have been made to the individual health boards where shortfalls were identified but generically it has been recommended that the organisations all:

- Continue to expedite nurse recruitment as a priority.
Consider the acuity and dependency levels of patients when establishing staffing establishment numbers.
- Ensure risk assessments are completed for any patients being nursed in the ward on trolleys.
- Continue to regularly audit record keeping standards, the handover process and care provision to ensure that shortfalls have been addressed.
- That any concerns expressed in respect of safe discharge are taken seriously. WRPS have had a number of claims where unsafe discharge has led to successful litigation.

Good practice identified:

- Recruitment and Human Resources staff attend the open days and attendees who are successfully recruited can have their identification documents scrutinised and recorded and criminal record checks applied for on the same day. (ABMU)
- Nurse and Therapies Led Unit for patients who are medically fit for discharge (Aneurin Bevan UHB)
- Nurse identification stamp used in YsbytyGlan Clwyd Hospital (BCUHB)
- The documented weekend plan of care utilised on the medical ward at University Hospital Llandough that is reported to be working well in continuing treatment for patients in the out of hours period. (Cardiff and Vale UHB)
- Coloured zimmer frames + painting toilet doors yellow to help patients with dementia. (Cardiff and Vale UHB)



- Work ongoing in house and with outside agencies and charities to consolidate the discharge process and help ensure that patients are discharged to suitable environments with appropriate care provision. (Cwm Taf UHB)
- The password system in place for when relatives telephone the trauma and orthopaedic ward requesting information or updates on their relative. (Cwm Taf UHB)
- The Ortho-geriatric Consultant post that is ward based rather than shared care. (Hywel Dda UHB)
- The style of the newly introduced Nursing Assessment documentation in the form of a secure booklet and incorporates all patient risk assessments. (Powys tHB)

Summary

- Nurse staffing levels are of concern at all organisations reviewed. Most areas carry vacancies.
- Statutory and mandatory training has been adversely impacted by staffing levels and high ward acuity.
- Recruitment drives are taking place in the UK and abroad and are targeting Welsh Universities to recruit nurses as they qualify. This may have an impact on skill mix in the forthcoming years.
- Leadership skills at ward management level were apparent on several of the sites visited.
- Processes are in place to manage appropriate medical review of patients outlying in other speciality wards.
- All wards visited were seen to be very busy and it was apparent that bed availability continues to be a concern at operational and senior management levels.
- Record keeping standards were generally satisfactory, although some gaps and duplication were noted that impedes a chronological account of care delivery. Risk assessments were completed and inform care plans. Audits take place and where shortfalls have been identified action is taken to improve standards.
- Specific recommendations have been made to the individual health boards where shortfalls were identified.

Welsh Risk Pool Services thank all the staff involved in organising and the completion of the themed reviews for their help and assistance.



THE IMPACT OF COMMERCIAL, EMPLOYMENT AND PROPERTY ADVICE PROVIDED BY L&RS

In addition to all the other areas highlighted in this report Legal and Risk Services provides “in house” legal services to the whole of the NHS in Wales, offering a comprehensive, value for money, specialist legal service. Its role and remit has continued to expand and develop despite the introduction of the Welsh Government sponsored new NPS arrangement which came into effect on 1st February 2016.

A detailed report and guidance note have been issued which outline the process for NHS bodies in Wales to continue their engagement with Legal and Risk Services as the preferred supplier within the new framework contract and to facilitate access to the NPS arrangement where required. Our guidance note was issued in November 2015 and builds on the principles established in the National Procurement Service guidance (September 2015) entitled, “Legal Services by Solicitors Framework - Your guide to engaging advice and guidance from Solicitors.”

These documents have been circulated to the Board Secretaries of each Local Health Board and Trust and our report highlighted *inter alia* our value for money, past performance and competitiveness against the NPS framework providers.

The Public Accounts Committee (PAC), reinforced by the NPS framework, recommends that NHS Organisations should engage with Legal and Risk Services as their “first port of call”, in relation to legal service provision. The National Procurement Service guidance, described in the introduction above, quotes the PAC recommendations on buying consultancy Services stating that the new framework “fully supports the PAC Recommendations” and informs public sector bodies. The PAC guidance and recommendations are,

- Before engaging external services you should always assess the availability of internal or other public sector resource that may be available through a shared service arrangement.
- Many public sector organisations have in house Legal Services teams. Please ensure that you discuss any requirement for legal support with them first.
- A number of organisations have come together to deliver a shared service approach to legal advice and guidance. Again your Legal Services team will be able to advise you if this is the case.

As part of our national commitment to ensuring that all services provided to the NHS in Wales are of the highest quality, at fair and cost effective rates, Legal and Risk Services have developed a portfolio and a strategy building upon the PAC recommendations where all NHS Organisations in Wales

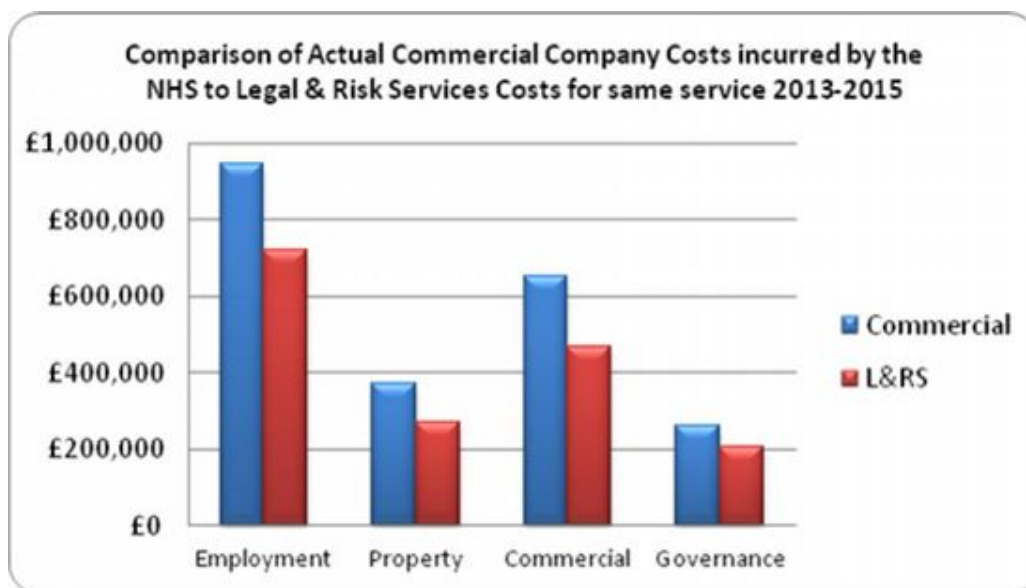


should, in the first instance, engage with Legal and Risk Services to determine the best course of action in procuring legal advice.

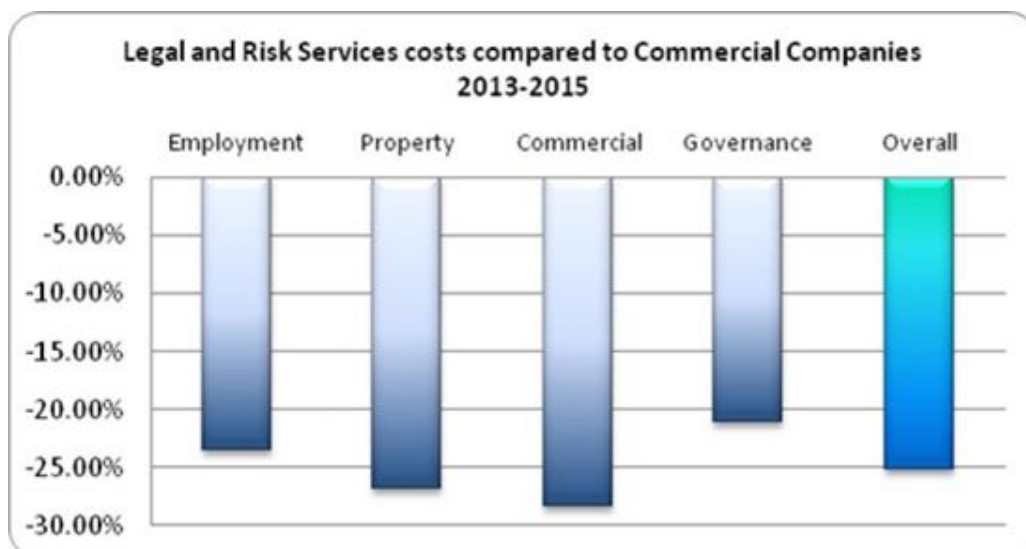
The graph below identifies actual costs paid to commercial law firms by Health Boards in Wales between 2012/13 and 2014/15. These figures are an extract from available data and cover 492 cases and 18,131 hours of work across Employment, Property, Commercial and Governance and are therefore not a complete list of all the hours utilised by NHS Wales with private law firms.

The graph contains information from two large commercial companies and clearly demonstrates that Legal and Risk Services could have offered the same service at a reduced cost impact on NHS Wales in all 4 specialties.

Total costs paid amounted to £2.231m compared to a Legal and Risk Services price of £1.668m, a difference of **£563k**.



The graph below shows the same information but analyses by percentage savings on costs. It identifies that in each of the four specialties Legal and Risk Services costs are between 21.1% and 28.3% lower than comparative Commercial Companies. On average, across the 4 specialties, Legal and Risk services are 25.2% lower than commercial competitors.



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In financial terms the cost per hour charged by Legal and Risk Services has been fixed at £92 whilst commercial companies averaged £123.

By purchasing in excess of 18,000 hours from commercial companies over the last 3 years both graphs demonstrate the level of costs that could have been avoided if Legal and Risk Services had been engaged in the first instance.

The continuing and increasing engagement with the Service has led to not only higher volumes of work for Legal and Risk Services but also cases that involve greater degrees of complexities. To ensure that LARS continues to provide quality and timely advice across a diversifying portfolio the hourly rate will increase by £5 to £97 for 2017/18.

This ensures that L&RS prices are in excess of 21% lower than our competitors. All additional income generated will be utilised in staff to work wholly on supporting the delivery of commercial and employment advice for NHS Wales.



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

MINUTES OF THE MEETING HELD ON 16TH JANUARY 2017

23.1

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Matthew Temby	Clinical Board Director of Operations
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Maria Jones	Senior Nurse, Outpatients
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Bolette Jones	Acting Head of Media Resources
Ian McMullin	Business Manager, Therapies
Rebecca Pettit	Medical Physics Quality and Safety Lead
Alexandra Scott	Patient Safety and Quality Assurance Manager
Carol Evans	Assistant Director of Patient Safety
Suzie Cheesman	Patient Safety Facilitator
Matthew McCarthy	Patient Safety Facilitator
Ceri-Ann Hughes	Head of Workforce and OD

Apologies:

David Lewis	Head of Finance
Sarah Jones	Pharmacy Quality and Safety Lead
Kathleen Morris	Clinical Audit
Rachael Daniel	Health and Safety Adviser
Lisa Griffiths	Quality Manager, Laboratory Medicine

Secretariat:

Helen Jenkins	Clinical Board Secretary
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PRELIMINARIES

CDTQSE 17/001 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 17/002 Apologies for Absence

Apologies for absence were **NOTED**.

CDTQSE 17/003 Approval of the Minutes of the Last Meeting

Page 7, first paragraph should read In30337. Otherwise the minutes of the previous meeting held on 9th November 2016 were **APPROVED**.

CDTQSE 17/004 Matters Arising/Action log

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

CDTQSE 16/147 Terms of Reference

The revised Terms of Reference for this Group have been circulated and no further comments have been received. Matt Temby will be reviewing the terms of reference as part of a wider review, however in the interim it is agreed that this document will be used for this Group going forward. Directorates can use this as a template for the terms of reference for their directorate meetings.

CDTQSE 16/277 Resuscitation Mandatory Training Module

Sue Bailey will email the Group with the rationale for the change in timeframes for the Resuscitation Mandatory Training module.

Action: Sue Bailey*CDTQSE 16/282 In30337*

An SBAR has been completed and Rebecca Vaughan-Roberts has asked the Communications Team for advice on how best to alert referring clinicians that mixed imaging modality requests would no longer be accepted. She will provide an update at the next meeting.

Action: Rebecca Vaughan-Roberts*CDTQSE 16/317 Therapies Risk Register*

The Therapies risk register is being signed off in January and will then be forwarded to the Clinical Board to update the Clinical Board risk register with any changes.

Action: Ian McMullin*CDTQSE 16/318 Purple Syringes*

No further information is available on the UK change of attachment to purple syringes. The Patient Safety Team will try to obtain information on what stock the Radiology department should have in place.

Action: Matthew McCarthy

CDTQSE 16/340 Non Medical Referrers

Ian McMullin to provide Maria Jones with a list of therapists that are Non-Medical Prescribers.

Action: Ian McMullin

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**23.1****CDTQSE 17/005 Patient Story**

A patient story was not presented to this month's meeting.

CDTQSE 17/006 Feedback from UHB QSE Committee 18th October 2016

Reference was made to the case of legionella and the lack of flushing of rarely used taps and showers. Directorates are requested to consider taking out outlets that are not in use. Directorates also need to review their flushing regime. A robust audit process for flushing has been devised and directorates should use this and confirm to the Clinical Board that appropriate measures are being taken. The Clinical Board will then report to the Water Safety Group.

Action: Directorates

It was noted that that the UHB is refreshing its approach to falls management and the UHB Falls Group is being re-established.

A report on the management of outpatient follow ups was presented.

CDTQSE 17/007 Health and Care Standards

Alexandra Scott reported that last year a revised approach was issued from Welsh Government. There was some degree of variability between the self assessments however robust actions were developed going forward. It was identified that there was a degree of duplication between Committees and therefore for this year it has been agreed to align healthcare standards to existing UHB Committees. 6 standards have been identified that clearly sit within appropriate committees:

- Falls prevention
- IP&C
- Medicines Management
- Nutrition and Hydration
- Safeguarding Children and Adults
- Medical devices equipment and diagnostic systems

The process will remain the same for the remaining 16 standards. Clinical Boards have 2 months to undertake the self assessment. There will be no flexibility on dates.

Matt Temby commented that there are a number of corporate leads that will be leading on specific standards that sit within this Clinical Board. Alexandra Scott will send Matt Temby the list of corporate leads and the standards they are leading on.

Action: Alexandra Scott

As discussed earlier, the UHB Falls Group is being re-established this month. Chris Cheetham and Tim Banner will be representing the Clinical Board. It was also noted that this Clinical Board will also be establishing its own Falls Group.

Carol Evans reported that the Patient Safety Team is developing a quality, safety and improvement framework looking at the key themes that cross-cut across Clinical Boards. 6 main aims have been identified and these aligned to the Health and Care Standards. This will form part of an overarching document which will also highlight the main objectives and this will be circulated when finalised. There are plans to set up an intranet site that will lead to a resource area. Comments are requested on the document when it becomes available. Matthew Temby requested for the UHB to review the governance and accountability arrangements for Point of Care Testing service.

CDTQSE 17/008 Risk Register

The Clinical Board and Corporate risk registers contain a new risk relating to the Telepath Servers. In December both the primary and back-up server failed and concerns were escalated to the Executives around the age of these servers. The costs of replacing the Telepath system are significant and indications suggest that Welsh LIMS will not be live until September. Health Boards have been asked to provide individual risk assessments by 27th January. The MHRA is visiting the UHB for an inspection in March and a solution will need to be identified prior to the visit.

CDTQSE 17/009 Exception Reports

Nothing to report from directorates.

CDTQSE 17/010 QSE Scorecard

It was noted that the Clinical Board is improving against the metrics on the scorecard with large number of metrics reporting a green status.

It was noted that the numbers of unactioned E-Datix entries are reducing.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/011 Initiatives to promote Health and Wellbeing

The Public Health Challenges in Wales Briefing for AMs was **RECEIVED**. The briefing sets out the steps needed most to aid the sustainable health and wellbeing for the people of Wales.

A report for implementing the UHB's No Smoking Policy was **RECEIVED**. A Tobacco Challenge Communication Plan has been produced which highlights the actions required to reduce the number of smokers.

It was noted that a lot of complaints have been raised from Medical Records staff around smokers gathering by library 2. Mike Bourne and Matt Temby agreed to visit the area and challenge the staff gathering there to smoke.

Action: Mike Bourne/Matt Temby

23.1

SAFE CARE

CDTQSE 17/012 Concerns and Compliments Report

In December 2016, the Clinical Board received 4 formal concerns. There were 0 breaches against response times.

There were 0 AM concerns received and in total there have been 6 AM concerns received since 1st April 2016.

15 compliments were received in December.

Since the 1st April 2016, the Clinical Board has received 42 formal concerns and 83 compliments. The key theme for formal concerns relates to communication between staff and patients. It was noted that difficulties in cancelling and arranging appointments fall within this category.

Parking issues are often raised by visitors. It was noted that where patients have missed their appointments due to difficulties with parking, a flag is placed on the PMS system so that the patients are not penalised. Consideration is being given to adding a sentence to patient letters to alert them to difficulties in parking on site and advising them to allow time for parking. It was suggested that links to public transport are also provided.

CDTQSE 17/013 Ombudsman Reports

The UHB is required to respond to an Ombudsman Report relating to the insertion of a chest drain.

It was noted that the UHB has recently reported 2 SIs relating to insertion of chest drains. A Task and Finish Group is being set up to look at this issue. The Clinical Board will provide input into this Group.

CDTQSE 17/014 RCA/Improvement plans for Serious Complaints

The Final Report was **RECEIVED** for IN35886. This incident related to a patient who was appointed 5 months too early for a CT scan due to a booking error. Opportunities to recognise the error were missed.

Lessons learned and recommendations have been identified and an action plan has been produced. The closure form has also been submitted to the Clinical Board.

Work is being held within Radiology to look at CT incidents as an overall theme. The department continues to report incidents related to handwritten referrals and addressographs.

CDTQSE 17/015 Patient Safety Incidents

The Serious Incident report was **RECEIVED**. Currently reporting 8 Sis:

- In20895 Lupus incident - final data is being collated.
- In33308 Unintentional IA injection of Noradrenalin – Clinical Board has received RCA report from the Investigating Officer.
- 5 IRMER incidents
- 1 possible IRMER incident

CDTQSE 17/016 Overall Trends

Nothing to report.

CDTQSE 17/017 New SI's

Nothing to report.

CDTQSE 17/018 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/019 WG Closure Forms – Sign Off

As discussed earlier, the closure form for In35886 was **RECEIVED**.

CDTQSE 17/020 Regulation 28 Reports

Nothing to report.

CDTQSE 17/021 Patient Safety Alerts

The Welsh Government feedback report for sharing lessons around Never Events for Invasive Procedures was **RECEIVED**.

Matthew McCarthy referred to a Patient Safety Alert that has not yet been circulated to Clinical Boards regarding restricted use of open systems for injectable medication. This relates to the issues raised in previous meetings around the use of gallipots in Radiology. Further discussions will be held at the next meeting when the alert has been circulated.

CDTQSE 17/022 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/023 IP&C Issues

A Cross Clinical Board session is being set up with Public Health to review this year's uptake and discuss taking forward the flu agenda for next year and improving compliance.

Latest figures for 10th January show that the Clinical Board is reporting 50.5% uptake. It was acknowledged that this year has proved more difficult in achieving the target despite providing emotive stories and clinical evidence supporting the effectiveness of the flu vaccination.

It was noted that a number of wards are now affected by the flu virus.

CDTQSE 17/024 Key Patient Safety Risks**Safeguarding**

Maria Jones reported that Domestic Abuse has been approved to be taken forward as an online mandatory training module. The target is for 100% of staff to be trained within 18 months. Mental Capacity has also been approved as a mandatory training module. Dementia Awareness will be approved in 2017.

MASH (Multi Agency Safeguarding Hub) has been launched for Cardiff (not the Vale) and the UHB referral process has been implemented. However directorates are encouraged to contact Maria Jones or Alun Morgan as Clinical Board Safeguarding Leads in the first instance.

An Independent Domestic Violence Advisor, Sarah Richards is now in post and will be working directly with EU until January 2017. Her role will then roll out to Maternity services followed by Mental Health services.

Human Traffic Training dates have been circulated.

An SBAR document for Covert Administration of Medication was **RECEIVED**.

Mental Capacity Act

Nothing further to report.

CDTQSE 17/025 Health and Safety Issues

Nothing to report.

CDTQSE 17/026 Regulatory Compliance and Accreditation

The Final Report from the Health Inspectorate Wales inspection of Nuclear Medicine will be presented to the next meeting.

The HTA will be undertaking an inspection in the Stem Cell Processing Unit next week.

The MHRA will visit Blood Bank on 31st February 2017.

CDTQSE 17/027 Policies and Procedures

Nothing to report.

EFFECTIVE CARE

CDTQSE 17/028 Clinical Audit

Clinical Audit Plans

Alexandra Scott reported that all directorates will be required to undertake 1 audit from the Clinical Board Clinical Audit Plan and report back on the results. It has been acknowledged that Clinical Boards rely on the Clinical Audit Department for audit information and an electronic solution is being looked at.

There will be a requirement to submit a clinical audit plan again this year. The Clinical Board will be issued with an annual summary including details of local and national audits. More robust guidance will be made available as there have been instances where Clinical Boards have been unclear if an audit is classed as a clinical or non-clinical audit.

Paediatric Radiologically Placed Gastro-jejunal Feeding Tubes

An audit undertaken in Radiology was **RECEIVED**. It was noted that the outcomes were in line with published series.

CDTQSE 17/029 Research and Development

The last Clinical Board R&D Meeting was postponed.

A meeting with Professor Chris Fegan is being held today to consider how best to take forward the Clinical Board R&D Group and discuss making best use of R&D funding.

CDTQSE 17/030 Service Improvement Initiatives

Any departments interested in undertaking LIPS Projects are requested to notify the Clinical Board Secretary.

Matthew McCarthy reported that as part of the LIPS Project on patient ID, there will be focussed work around addressographs.

It was noted that Spending Less Surgeries have been held across the Clinical Board which generated lots of ideas from staff.

CDTQSE 17/031 NICE Guidance

Nothing to report.

CDTQSE 17/032 Information Governance

Sion O'Keefe reported that the Information Commissioner's Office will be returning to visit the Health Board in April. An audit was undertaken in May 2016 within Health Records and 70 recommendations were made. Mike Bourne and Sion O'Keefe will discuss preparations for this visit outside of the meeting.

Action: Mike Bourne/Sion O'Keefe

It was noted that directorates are required to produce information asset registers and Keeley Baker is providing support on this.

DIGNIFIED CARE**CDTQSE 17/033 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans**

Nothing to report.

**CDTQSE 17/034 Initiatives to Improve Services for People with:
Dementia/Sensory Loss**

Nothing to report.

CDTQSE 17/035 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

TIMELY CARE**CDTQSE 17/036 Initiatives to Improve Access to Services**

Nothing to report.

CDTQSE 17/037 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Unified Rules relating to RTT are being reviewed by Welsh Government. The Health Board has received an early version of the document and this can be shared. Any department that would like sight of this to contact Sion O'Keefe.

INDIVIDUAL CARE

CDTQSE 17/038 National User Experience Framework

The National Patient Safety Report for November 2016 was **RECEIVED** and the Clinical Board received an overall patient satisfaction rate of 86%.

The Clinical Board achieved a 61% return rate.

STAFF AND RESOURCES

CDTQSE 17/039 Staff Awards and Recognition

A number of individuals from within this Clinical Board have been in the UHB Staff Recognition Awards, spread across different categories.

CDTQSE 17/040 Staffing Levels

The results of the staff survey have been received and plans are being put in place to take forward the results.

The Clinical Board is currently reporting a sickness rate of 3.05%. It was noted that long term and short term sickness cases are being managed down. Matt Temby commended directorates and the Workforce team for their efforts.

CDTQSE 17/040 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting a 91% compliance rate for medical appraisals. 6 doctors are outstanding and their appraisals are being scheduled .

PADR compliance has increased to 68%. Every directorate has been tasked to provide a plan to bridge the gap between now and end of March.

In terms of quality PADRs, Ceri-Ann Hughes is looking for examples of good practice in terms of preparation and paperwork. Directorates are asked, with permission from individuals, to share good examples for learning purposes.

It was noted that Pay Progression is now being rolled out to Bands 2, 3, and 4. Sion O'Keefe requested that it is acknowledged that this has a significant impact on Medical Records which has large numbers of staff within these bands.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

Laboratory Medicine Directorate QSE Minutes 22nd November 2016
Laboratory Medicine Directorate QSE Minutes 20th December 2016
Outpatients/Patient Administration Directorate QSE Minutes 5th January 2017

ANY OTHER BUSINESS

Alexandra Scott reported that the Annual Quality Report is being produced for submission to the UHB QSE Committee in February. She requested for the Clinical Board to send her any good news/success stories for inclusion in the report

Action: Sue Bailey

DATE AND TIME OF NEXT MEETING

13th February 2017 at 2pm in Seminar Room B, Upper Ground Floor, UHW

23.1



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

MINUTES OF THE MEETING HELD ON 13TH FEBRUARY 2017

23.1

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Rhodri John	Assistant Head of Workforce and OD
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Rachael Daniel	Health and Safety Adviser
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Maria Jones	Senior Nurse, Outpatients
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Bolette Jones	Acting Head of Media Resources
Rebecca Pettit	Medical Physics Quality and Safety Lead
Suzie Cheesman	Patient Safety Facilitator
Matthew McCarthy	Patient Safety Facilitator
Robert Bracchi	Medical Advisor, AWTTC

Apologies:

David Lewis	Head of Finance
Matthew Temby	Clinical Board Director of Operations
Sarah Jones	Pharmacy Quality and Safety Lead
Darrell Baker	Clinical Director, Pharmacy and Medicines Management
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/ Clinical Engineering
Ian McMullin	Business Manager, Therapies
Lisa Griffiths	Quality Manager, Laboratory Medicine
Ceri-Ann Hughes	Head of Workforce and OD
Stuart Egan	Trade Union Representative

Secretariat:

Helen Jenkins	Clinical Board Secretary
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PRELIMINARIES

CDTQSE 17/041 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting and introductions were made.

CDTQSE 17/042 Apologies for Absence

Apologies for absence were **NOTED**.

CDTQSE 17/043 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 16th January 2017 were **APPROVED**.

CDTQSE 17/044 Matters Arising/Action log

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

CDTQSE 16/282 IN30337 Communication Plan

Rebecca Vaughan-Roberts is awaiting response from the Communications Team for advice on how best to communicate across the UHB that multimodality imaging on diagnostic imaging request forms should be avoided.

Action: Rebecca Vaughan-Roberts*CDTQSE 16/318 Purple Syringes*

Matthew McCarthy is attending a meeting on Monday regarding the change of attachment to purple syringes and will feedback on what stock the Radiology department should have in place.

Action: Matthew McCarthy*CDTQSE 16/340 Non-Medical Prescribers*

Ian McMullin to provide Maria Jones with a list of Therapists that are non medical prescribers.

Action: Ian McMullin*CDTQSE 17/006 Flushing Regimes*

It was reported that flushing regimes has been raised at the Clinical Board IP&C Group and the Clinical Board Health and Safety Group and guidance and the audit tool has been circulated across directorates.

CDTQSE 17/011 Staff Smoking

Mike Bourne reported that he has challenged staff that are smoking by library 2 on separate occasions but noted that individuals have been verbally abusive when challenged.

CDTQSE 17/032 ICO Visit

Mike Bourne and Sion O'Keefe will be undertaking a gap analysis against the action plan. Any issues that do not allow the UHB to meet its commitment to the ICO e.g. issues that require capital and revenue will need to have a governed route.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**CDTQSE 17/045 Patient Story**

A patient story was not presented to this month's meeting.

CDTQSE 17/046 Feedback from UHB QSE Committee 13th December 2016

The minutes of the last meeting are not yet available.

Alun Morgan reported that the UHB is required to comply with a number of standards and guidance in relation to patient falls including WHC for adult inpatient falls, NPSA Alert for Inpatients Falls and Health and Care Standard for Falls Prevention. The UHB has therefore reconstituted the Falls Group. Tim Banner, Consultant Pharmacist and Chris Cheetham in Therapies represent this Clinical Board. The Group will undertake a baseline assessment against all the guidelines and frameworks. It will also monitor Serious Incidents and share lessons across the Clinical Boards. The Falls Group will link in to work being undertaken around falls by 1000 Lives and also to the National Taskforce on Falls Prevention.

It was **AGREED** that patient falls will be a standing agenda item under 'Key Patient Risks' for future meetings of this group.

CDTQSE 17/047 Risk Register

The Clinical Board risk register has been updated to reflect changes made to the Laboratory Medicine risk register.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT**CDTQSE 17/048 Initiatives to promote Health and Wellbeing**

The Clinical Board achieved 51.8 % uptake of the flu vaccination.

SAFE CARE**CDTQSE 17/049 Concerns and Compliments Report**

The Clinical Board received 6 formal concerns in January 2017. There were 0 breaches against response times.

No AM concerns were received and in total there have been 6 AM concerns received since 1st April 2016.

10 compliments were received in January.

Since 1st April 2016, the Clinical Board has received 48 formal concerns and 93 compliments. The main theme of formal concerns relates to communication between staff and patients.

23.1

CDTQSE 17/050 Ombudsman Reports

Nothing to report.

CDTQSE 17/051 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/052 Patient Safety Incidents

The Serious Incident report was **RECEIVED**. There are 10 Serious Incidents outstanding:

IN20895/ IN21631	Lupus incident
IN34781	IRMER right shoulder incident
IN33308/ IN34503	Unintentional IA injection of Noradenalin
In35886	IRMER incident involving CT Chest at UHL
IN35657	IRMER incident – chest x-ray
In37646	IRMER CT chest incident
In38935	IRMER CT colon
In38916	Physiotherapy Incident

CDTQSE 17/053 New SI's

There are 2 new IRMER incidents reported.

CDTQSE 17/054 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/055 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 17/056 Regulation 28 Reports

Nothing to report.

CDTQSE 17/057 Patient Safety Alerts

PSA006 Risk of death and severe harm from error with injectable phenytoin

This alert has been cascaded across the Clinical Board for noting.

PSA007 Restricted use of open systems for injectable medication

This is applicable to the Radiology department and work is ongoing.

CDTQSE 17/058 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/059 IP&C Issues

There are no issues to be escalated from the Clinical Board IP&C Group. The minutes of the last meeting were **RECEIVED**.

CDTQSE 17/060 Key Patient Safety Risks

Safeguarding

Feedback from the UHB Safeguarding Group was provided at the last meeting. Nothing further to report.

Mental Capacity Act

Nothing to report.

CDTQSE 17/061 Health and Safety Issues

There are no issues to be escalated from the Clinical Board Health and Safety Group.

CDTQSE 17/062 Regulatory Compliance and Accreditation

Nothing to report.

CDTQSE 17/063 Policies and Procedures

There are no new policies and procedures to report.

EFFECTIVE CARE

CDTQSE 17/064 Clinical Audit

Nothing to report.

CDTQSE 17/065 Research and Development

Sion O'Keefe reported that he and the Clinical Board R&D Lead are producing an SBAR report around funding issues for R&D. The SBAR will be circulated to the Clinical Board R&D Group for consultation.

CDTQSE 17/066 Service Improvement Initiatives

Information relating to LIPS Cohort 7 has been circulated across the Clinical Board. The Outpatients/ Patient Administration directorate is considering taking forward a project around communication/ patient information and dignity issues.

Sion O'Keefe suggested that if directorates cannot release a full team from their areas to participate in the LIPS Programme to consider working in collaboration with other directorates.

CDTQSE 17/067 NICE Guidance

Nothing to report.

CDTQSE 17/068 Information Governance

Sue Bailey welcomed Paul Rothwell to the meeting. From 1st January there has been a change of management arrangements around information governance within the organisation. The Information Governance department now sits alongside Performance and Innovation under Sharon Hopkins. Together with his current performance role, Paul Rothwell has taken over the role of Head of Information Governance. These arrangements will be reviewed in a year.

It was noted that Peter Welsh, UHB Board Secretary is appointed as the SIRO for the UHB and Clinical Board Directors are Deputy SIROs.

Following the ICO audit undertaken in May 2016, the main challenge facing the UHB is around data protection. The ICO rated the Health Board with limited assurance and 70 recommendations were made. Paul Rothwell's aim is to work proactively with Clinical Boards and provide help and guidance. Since taking on the information governance role he has been focusing on a number of areas:

- Codes have been identified on the Datix system to help identify information governance incidents. This will help inform whether the ICO needs to be notified of any breaches.
- Encouraging directorates to press ahead with completing information asset registers.
- Consider reviewing the policy and procedures related to information governance with a view to making them more relevant to directorates and how the UHB delivers its business.
- Looking to obtain more resources for the information governance department.

Mike Bourne agreed that resources should be prioritised for information governance and noted that a number of the recommendations made by the ICO cannot be addressed without capital and revenue. The UHB will need to demonstrate that it is delivering as best as is possible within the resources that are available. A robust plan around information security will be needed prior to the next ICO visit. He recommended that the IG toolkit is adopted and utilised.

Dilys Jones Training has spaces available on 23rd February and is intended for individuals with designated Information Governance responsibilities e.g. Senior Management Team/Directorate Managers. It was suggested that Sue Bailey, Tom Henderson and a representative from Laboratory Medicine with responsibilities around the Track system attends the training.

Mike Bourne suggested that core training is needed for individuals that will be required to undertake information governance incident investigations. He advised that Dilys Jones also provides a useful training session on this.

The Incident Reporting Procedure is currently under review and a discussion was held whether differentiation should be made between lost records as opposed to unavailable and missing records.

Paul Rothwell has received the dates of future meetings for this group and will attend as and when required.

DIGNIFIED CARE

CDTQSE 17/069 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 17/070 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

TIMELY CARE

CDTQSE 17/071 Initiatives to Improve Access to Services

Patient information posters are available for patients around accessing WIFI in the UHB.

Sue Bailey welcomed Linda Pritchard, Health and Social Care Facilitator for Glamorgan Voluntary Services to the meeting. She was in attendance today to promote and improve partnership working with volunteer organisations and health and social care. Based in the Vale, her role helps people set up charities and she provides advice on policies. She promotes what organisations do and runs a health and social care network. The post is funded by the Health Board alongside a further post in Cardiff. They attend inductions for new staff, raising awareness of the voluntary sector.

Linda's role is to help people find support. There are 33,000 groups across Wales with an income of £1.6bn in 2014. There are 931,000 volunteers across Wales.

A wide range of information is available for people to access including directories of services for older people and for carers. The directories are updated online and good feedback is received from individuals who are looking to access services. She referred to a number of organisations available locally and recommended Age Connect as the first point of contact which helps with discharges and post discharge from hospital. She will email Helen Jenkins the directories listing the organisations and services available for circulation.

Action: Linda Pritchard

She offered her support to help services link in with any organisations and is willing to visit services and attend meetings. She can also arrange for organisations to deliver presentations to directorates. Robert Bracchi will link in with Linda Pritchard in relation to the work the All Wales Toxicology and Therapeutics Centre undertake with patients around medicines.

CDTQSE 17/072 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Nothing to report.

INDIVIDUAL CARE

CDTQSE 17/073 National User Experience Framework

A poster was circulated to the group that can be displayed for patients explaining how they can report their experience.

The National Patient Safety Survey Report for January 2017 was **RECEIVED**. The Clinical Board received a response rate of 37%. 91% of patients surveyed rated their experience 8 out of 10 or above.

A number of issues raised by patients have been related to difficulties with car parking and the question has been asked whether a line could be added to patient letters to remind them to allow time to park. It was noted that it is technically possible for this to be done but may raise duplexing issues if text runs over to 2 pages.

STAFF AND RESOURCES

CDTQSE 17/074 Monitoring of Mandatory Training and PADRs

Rhodri John reported that the Clinical Board is reporting 81% compliance against mandatory training. Medical Appraisals rate is 93%.

He noted that there will be no access to the WIRED system from March. Managers will need to revert back to using the ESR system.

Compliance against PADRs is 65%. It was noted that Karen Stone will be assisting the Workforce and OD department to increase PADR rates across the Clinical Board.

The Clinical Board sickness rate is 3.61%

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The minutes from the following Groups were **RECEIVED**:

Clinical Board R&D Group Meeting 24th January 2017
Clinical Board IP&C Minutes 1st February 2017

ANY OTHER BUSINESS

Alun Morgan has sent an email to remind staff to rigidly follow the Bare Below the Elbow and Hand Washing procedures.

DATE AND TIME OF NEXT MEETING

13th February 2017 at 2pm in Seminar Room B, Upper Ground Floor, UHW

23.1



MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY
CLOSURE AND LESSONS LEARNED MEETING
19th January 2017
Seminar Room, Hafan y Coed, Llandough Hospital

Present: Mark Doherty, Lead Nurse MHSOP/Neuro (Chair)
 Miranda Barber, Clinical Psychologist
 Jayne Bell, Lead Nurse Adult Mental Health
 Owen Baglow, Clinical Lead for Quality, Safety & Governance
 Emily Boobyer, CPN Amy Evans CMHT
 Theresa Brook, Clinical Roster Co-ordinator & Bed Manager
 Neil Davies, HCSW, Cedar Ward
 Alison Edmunds, Concerns Co-ordinator
 Catherine Evans, Patient Safety Facilitator
 Hazel Ferdinand, Occupational Therapist
 Louise Flynn, Senior Nurse MHSOP In-patients
 Rachel Gibbons, Staff Nurse, Cedar Ward
 Martin Harper, Integrated Manager Links CMHT
 John Hyde, Lecturer, School of Healthcare, Cardiff University
 Paul Howells, Deputy Senior Nurse Manager, CMHTs
 Robert Kidd, Consultant Psychologist
 Mike Lewis, SIMA Co-ordinator
 Emma Morgan, Consultant Psychiatrist, Pendine CMHT
 Mary Morgan, Senior Nurse Adult In-patient Services
 Peter Murray, Integrated Manager, Gabalfa CMHT
 Yvonne O'Donnell, Ward Manager Oak Ward
 Kelly Panniers, ANP Adult In-patient Services
 Kathryn Pellatt, Staff Nurse, Cedar Ward
 Chris Sampson, Head Occupational Therapist MHSOP
 Andrea Sullivan, Concerns Co-ordinator
 Kim Tallett, Lead CPN Amy Evans CMHT
 Justin Williams, Team Leader, South Crisis Team
 Natalie Williams, Lead CPN, Gabalfa CMHT
 Craig Williams, Ward Manager, East 12
 Lowri Wyn, Ward Manager, Cedar Ward
 Norman Young, Consultant Nurse, Complex Needs

Apologies: Simon Amphlett, Senior Nurse Crisis & Liaison Services
 Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
 Daniel Crossland, Head Occupational Therapist Acute & Rehab
 Nicola Evans, Professional Head MH Nursing, Cardiff University
 Martin Ford, Directorate Manager PMHSS/Psychology/Veterans
 Isabella Jurewicz, Consultant Psychiatrist, Pentwyn CMHT
 Lisa Lane, Senior Nurse MHSOP Community/Neuro
 Mick McGeoch, Clinical Audit Administrator
 Sabari Muthukrishnan, Clinical Director MHSOP
 Bala Oruganti, Consultant Psychiatrist
 Annie Procter, Director Mental Health
 Suchitra Sabari, Clinical Director Adult Mental Health
 Somashekara Shiva, Consultant Psychiatrist Links CMHT
 Jayne Strong, ANP Rehab & Recovery
 Tayyeb Tahir, Consultant Liaison Psychiatrist
 Jayne Tottle, Director of Nursing Mental Health
 Ian Wile, Head of Operations & Delivery Mental Health
 Joanna Wilson, Directorate Manager MHSOP

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting and introductions were made.

1.2 Apologies for Absence

Apologies for absence were noted as above.

PART 2 : ACTIONS

No Actions

PART 3 : CLOSURES

3.1 SH

SH had been known to psychiatric services for several years. SH had a long history of depression secondary to substance misuse, namely alcohol. There had been little engagement with alcohol services despite numerous attempts by staff to arrange appointments for SH.

SH had attended regular out-patient appointments with the Consultant Psychiatrist.

Phone call received from Coroner's Office to advise that SH was found dead at home. Cause of death was unascertained.

Issues Identified:

- SH's Care and Treatment Plan was written in 2013 but there was no formal recording of it having ever been reviewed.
- The original Care and Treatment Plan was due for review in 2014 but had not been updated or altered to reflect current need.
- Inevitably, therefore, the question arises as to whether SH's needs were of sufficient complexity to warrant secondary mental health services.

Action:

Jayne Bell, Lead Nurse, to explore whether an alert could be inserted on PARIS to flag that the Care Treatment Plan is due for review.

TO CLOSE.

3.2 SA

SA was a male who presented with psychotic symptoms associated with polysubstance abuse. He had been involved with CAMHS until the age of 17 and had previous admissions to hospital. He was detained under Section 2 of the Mental Health Act. On the ward SA presented as thought disordered and delusional. His presentation was considered to be very similar to previous admissions. SA had not successfully engaged with mental health services in the community despite their assertive attempts to engage him. Given concerns about his vulnerability in the community, his clinical team detained him under the Mental Health Act. At the time of the incident he was not granted leave from the ward and was on general observations. Concerns about SA intentionally harming himself were not held by those who knew him.

SA was found in his room unresponsive with a plastic bag over his head. Attempts were made to resuscitate him and 999 Ambulance requested. . On arrival, the paramedics intubated and ventilated SA, administered adrenalin and transferred him to Intensive Care at UHW. SA very sadly passed away the next day, following switching off the life support. This was done after carrying out Brain Stem Test and confirming brain stem death.

Review Team:

The review team noted that the alarm was raised quickly.

Medical staff from neighbouring services came to the rapid assistance of ward staff.

The leadership of the resuscitation attempt was consistent with expected competency.

Rates of training in Basic Life Support were noted to be above average.

There was correct use of the AED.

The review team noted that staff, prior to paramedics arriving, did not include the provision of rescue breaths. This was not considered to be due to education or training factors, but due to a task familiarity factor, in that the provision of basic life support in mental health settings is a very rare event.

The plastic bag used in this incident seems to have been one obtained from a domestic's trolley. The review team did not feel that this was an environmental factor which needed addressing as other plastic bags would also be available on the wards.

Recommendations:

Following the incident the resuscitation team recommended the removal of Non-Rebreathe masks from oxygen cylinders and pocket masks be placed on top of the trolley with spares in the drawer of the trolley and one kept in the ward office. This recommendation had been completed across the Clinical Board.

Resuscitation training was discussed. Qualified staff will be trained to ILS standard and the training will be mental health specific, ie choking, ligatures. The Resuscitation team will deliver unannounced scenario training on the wards.

More explanation needed regarding carrier bags. Norman Young and Jayne Bell agreed to benchmark other areas.

Mark Doherty suggested sending a memo to Housekeeping requesting them not to leave plastic bags around unattended.

TO CLOSE.

3.3 GSi

GSi bumped into a fellow patient accidentally and fell to the floor.

GSi was on an Adult Mental Health ward waiting for a bed in the Mental Health Services for Older People (MHSOP).

Staff checked GSi for bruising, or redness, none noted. GS was initially not in pain and mobilising. No shortening or rotation noted. Vitals were monitored. GSi was encouraged to sit down but she refused and paced in her room, eventually encouraged to lie down however would not remain in her room and walked to the lounge.

Shift Coordinator contacted who advised contacting the GP. Whilst speaking to the GP, GSi started to scream that she was in pain. The GP attended the ward and GSi was transferred to UHW where it was found that her hip was fractured and required surgery.

GSi had been on the Adult Mental Health ward waiting for a bed within MHSOP for 6-8 weeks and had deteriorated in both mental and physical health during this time.

Notable Practice:

The staff on the Adult Mental Health ward did what they could in the environment that was unsuitable for an older person.

It was noted that a body map had been completed.

Recommendations:

Falls Management training for staff. (There is now a Falls training programme being rolled out).

Lesson Learned:

If there is no bed available on a MHSOP Ward, then MSHOP staff will help with the care of the patient on the Adult ward.

There is now a new LPOP (Liaison Psychiatry for Older People) RAID (Rapid Assessment, Interface and Discharge) Service; therefore there are more resources available now.

TO CLOSE.

3.4 GS

GS presented with a history of polysubstance misuse for several years, with symptoms of paranoia and delusions. In the past GS had been diagnosed with paranoid schizophrenia and also suffered from depression and had both formal and informal hospital admissions and was referred to drug and alcohol services many times. GS had been discharged from the Community Mental Health Team due to lack of involvement.

GS had significant substance misuse issues but would not engage with substance misuse services. GS was assessed by EDAS and signposted to appropriate services. It was not known if he engaged with those services.

GS discharged himself from Mental Health in-patient services, on the 5 day follow up appointment by the CPN it was discovered that the police had found GS dead. The death was drug related.

Recommendations:

Dual diagnosis should have shared care approach (if only for advice)

It was noted that individuals cannot be referred to EDAS whilst they remain an in-patient. However, at time of discharge an appointment can be made and given to the patient.

The discharge letter to the GP did not give any information as to the diagnosis and recommendations regarding on-going prescriptions and monitoring requirements. (There is now a Discharge Flow Chart).

A DSU should be taken at admission, especially when substance misuse is suspected to underlie presentation.

ECG results should be documented in a PARIS ECG case note for ease of location.

TO CLOSE.

3.5 VP

VP, a 93 year old patient, fell in the corridor of the ward. VP was checked and did not appear to be showing any signs of a fracture. The Out of Hours Doctor advised to call 999. The ambulance took a long time to arrive as they were busy and was prioritising the calls.

VP was checked again by the next shift and it was clear that VP had sustained a hip fracture. The 999 service was called again and when informed of the fracture they arrived within one hour and took VP to UHW.

There is reason to believe that the patient was not adequately checked the first time, and proper support and advice was not obtained. POVA referral submitted and disciplinary arranged.

The telephone call to the emergency service was not communicated properly; was not conveyed as an emergency.

Contributory factors:

Inexperienced qualified nurse working without enough support.

Do not use x ray facilities at Llandough Hospital. It would be better if used the x ray facility at Llandough Hospital as could exclude or confirm a fracture.

Ambulance service gave low response rate category as incident not conveyed as an emergency and VP was a hospital in-patient so was being looked after.

Recommendations:

Understand falls risk. Falls Management training for staff. (There is now a Falls training programme being rolled out).

Look at decision making process.

SHO to examine the patient and request an x ray. Clinical Directors to look at using the x ray facilities at Llandough Hospital

Lesson Learned:

How to communicate with GP/Emergency service

Conclusion:

The right things were done but not in the right way or conveyed properly (newly qualified nurse).

TO CLOSE.

3.6 CW

CW was detained under Section 2 of the Mental Health Act. Whilst an in-patient CW's mood had been aggressive and disruptive with drug induced psychosis/personality traits.

CW was discharged from Section 2 to Section 17 informal Day Leave but failed to return to the ward from Leave. The case notes indicated reduced risk.

Staff were informed that CW had jumped from a building whilst on Leave and had been taken to A&E for assessment (injuries included T4 stable fracture, L4 stable fracture and sternum fracture).

When medically fit CW returned to Cedar Ward and has since been discharged.

Contributory factors:

- Drug and alcohol use coupled with unstable personality traits
- Lack of motivation
- Lack of capacity

Issues identified:

The Management Plan, that had been agreed in ward round verbally, was “if she did not return she would be discharged in her absence rather than a need to escalate as a missing person”. This was verbally handed over to ward staff, however, was not documented.

Recommendation:

Actions on “failure to return from leave” should be added to the ward round case note.

There was discussion regarding the Missing Persons Policy and it was noted that this Policy is due for review.

TO CLOSE.

4.0 DATE OF NEXT MEETING

16th March 2017 at 9.30am in the Seminar Room, Hafan y Coed.



MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
16th February 2017
SEMINAR ROOM, LLANDOUGH HOSPITAL

23.2

Present: Jayne Tottle, Director of Nursing Mental Health (Chair)
 Owen Baglow, Quality, Safety & Governance Lead
 Jayne Bell, Lead Nurse Adult Mental Health
 Daniel Crossland, Clinical Lead Occupational Therapist
 Ellen Davies, ACNS, Infection Prevention & Control
 Mark Doherty, Lead Nurse MHSOP/Neuro
 Catherine Evans, Patient Safety Facilitator
 Mick McGeogh, Clinical Audit Co-ordinator
 Bala Oruganti, Consultant Psychiatrist
 Suchitra Sabari, Clinical Director Adult Mental Health

In attendance: Carol Evans, Assistant Director of Patient Safety & Quality

Apologies: Martin Andrew, Consultant Psychiatrist/Clinical Audit Lead
 Robert Kidd, Consultant Psychologist
 Sarah Lloyd, Directorate Manager Adult Mental Health
 Faye Mortlock, CNS, Infection Prevention & Control for MH
 Sabari Muthukrishnan, Clinical Director MHSOP & Neuro
 Annie Procter, Clinical Board Director, Mental Health
 Sunni Webb, Mental Health Act Manager
 Ian Wile, Head of Operations & Delivery Mental Health

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 15th December 2016 were received and approved.

1.4 ACTION LOG/MATTERS ARISING

Risk Register

The electronic medication transcribing and discharge system (MTed) does not contain information from PARIS.

Wendy Davies to update on the action required regarding Electronic Discharge/Prescribing at the next meeting. **Action Wendy Davies**

MHSOP staffing levels have been added to the Risk Register.

Hospital at Night Plan

This is on-going and an update will be given at the next meeting. **Action: Annie Procter**

Food Handling training

Jayne Tottle had discussed Food Handling training with Ruth Walker, Executive Nurse Director, who had suggested that Jayne write to Charles Dalton, Head of Health & Safety, requesting advice on the provision of training in the UHB.

It was noted that the Food Standards Agency website states that there is no legal requirement for staff to be trained.

MHSOP Community Teams

The MHSOP Community teams moved into the Llanfair Unit, Llandough Hospital in January 2017. Jayne Tottle commended the Directorate Team, especially Lisa Lane, Senior Nurse, for the very smooth transition. The move was very well organised and was completed without any disturbance to service delivery.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 PRESENTATION

Carol Evans, Assistant Director Patient Safety and Quality Presented the:

Quality, Safety and Improvement Framework (QSI) 2017-2020

Carol Evans explained that the QSI was being developed for the next three years, following the process of the Healthcare Standards.

Carol distributed a diagram of the six Aims:

- **Aim 1 – Governance, Leadership and Accountability**
To develop a structure in which accountabilities, roles and responsibility for the delivery of high quality, safer care is clear.
 Quality, Safety and Experience Performance Dashboard in place.
- **Aim 2 – Safe Care**
To protect people from avoidable harm and support them to protect themselves from known harm.
 Avoidance of Never Events, Falls Prevention, Staffing levels, good communication and mental health care in other settings was discussed.
- **Aim 3 – Effective Care**
To give people the right care or support, based on best practice, to meet their individual needs.
 Record Keeping, Patient Safety Solution Compliance, Clinical Audit, Mortality Reviews.

- **Aim 4 – Dignified Care**
To ensure that people are always treated with compassion, dignity and respect.
 Communication with patients and families, Care of patients with learning disabilities.
- **Aim 5 – Timely Care**
To ensure that people have timely access to services based on clinical need and are cared for in the right way, at the right time in the right place by the right staff.
 Waiting Times, Targets for follow-ups, Access to OOH GPs, safe discharge, delayed transfers of care.
- **Aim 6 – Individual Care**
To ensure that people are respected as unique individuals and that this is an integral part of all care delivered.
 Day to day working, listening and learning from patient feedback. It was agreed to include the Mental Health Act under this Aim.

Carol Evans said that she would highlight what was most important for each Clinical Board. The document will be circulated for comments in March 2017 and launched in April 2017.

2.3 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee dated 13th December 2016.

2.4 Health and Care Standards

Managing Risk and Promoting Health & Safety

Roll out of suicide risk assessment package across in-patient services and develop further for community services. It was noted that Robert Kidd, Consultant Psychologist, had rolled out the package to in-patient services; Miranda Barber and Dan Crossland would help to develop the package for community services. **Action: Robert Kidd/Miranda Barber/Dan Crossland**

Record Keeping

“Inadequate access to health records for MHSOP Community staff; provide PARIS to community teams” - this had been resolved; community staff now had access to PARIS.

2.5 Regulatory compliance and external accreditation - No report.

2.6 Risk Register

Community Mental Health Team premises - discussions are being held regarding re-housing Western Vale, Amy Evans and Hafan Dawel Teams to Barry Hospital.

“Unsuitable MSHOP Community base” to be deleted from the risk register as they have now moved to suitable accommodation in Llanfair Unit. **Action: Jayne Tottle**

MHSOP referral routes have been improved by the move to Llanfair Unit.

It was noted that the issue with the pinpoint alarm system has improved with additional modems being installed to increase the signal.

2.7 Directorate QSE Groups

The **Adult Directorate Quality & Safety** Minutes dated 26th January 2017:

Initiative for staff to cease smoking but few staff interested. Discussions are on-going regarding Hafan y Coed becoming smoke free.

Audit of Crisis Plans for patients in secondary mental health services – Owen Baglow will look at this.

There is about 30% of Band 6 and 7s on secondment across the Clinical Board at the moment. Looking at the impact of secondments.

Internal ward inspections: Hazel Ward is the first ward to receive an inspection report with no recommendations. Particular reference was given to the whole team on the ward demonstrating that they have embraced the values of the organisation. The team said they felt very welcomed by staff.

The **MHSOP/Neuropsychiatry Quality & Safety** Minutes dated 9th January 2017:

There is on-going consultation with CHC regarding moving Iorwerth Jones patients to Llandough Hospital.

There has been some success in transferring and discharging patients, which has resulted in more beds becoming available.

There are on-going discussions regarding medical cover.

Psychology & Counselling Quality & Safety – No Minutes available.

Pharmacy - No report.

Primary Mental Health Support Service (PMHSS) – No report.

Mental Health Act Report –

The Report on Invalid Mental Health Act Detentions was received.

Any exceptions highlighted in the Mental Health Act Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to supervised community treatment is only as the Act allows. There are no exceptions for this period from the main Mental Health Act Monitoring Report.

The number of patients detained without authority:

Period	Number of incidents
October – December 2016	4

Infection, Prevention & Control Report –

Infection, prevention & control environmental audits will be carried out in wards in the next few weeks. The Ward Manager or IP&C Link Nurse will be required to accompany the audit.

There has been no MRSA/MSSA outbreak for the period October 2016 to date.

There has been one C.difficile outbreak in St Barruc Ward.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Flu Vaccine

50.4% of mental health front line staff had been vaccinated, which meets the Welsh Government target.

SAFE CARE

4.2 Patient Safety Incidents

Risk Assessment/Risk Management Plan

There had been a LIPS project looking at the link between risk assessment and risk management plans, the work on this project concluded that the design of Form 4 plays a significant part in the failure to link the assessment to the management plan. Therefore, the form needs to be re-evaluated or re-designed.

Jayne Bell and Suchitra Sabari will consider this together with Paul Williams, ANP.

Action: Jayne Bell/Suchitra Sabari/Paul Williams

Welsh Government Closure Forms

Cath Evans, Patient Safety Facilitator, and Owen Baglow, Quality, Safety & Governance Lead, are working together on the completion of the backlog of Welsh Government Closure Forms.

4.5 Mortality Data Analysis

Public Health Wales looked at physical health care mortality review forms across Wales and identified that a question should be added enquiring whether the deceased person was known to mental health or learning disability services. This recommendation is being sent to Medical Directors in all Health Boards across Wales. Les Rudd, Public Health Wales, is facilitating this review.

EFFECTIVE CARE

5.1 Monitoring of MHCB Clinical Audit Plan

Bala Oruganti said that his role as GA audit lead is monitoring the submitted audit forms and being supportive to junior doctors and other health care professionals wanting to do an audit. At the moment we are unable to allocate Audits to junior doctors or other professionals and Bala would ask if this could be looked into.

The MHCB Audit Lead, Dr Martin Andrew is retiring in May 2017; the post will be advertised soon.

Mick McGeoch informed members that Clinical Audit half day workshops are held regularly to provide staff with a basic understanding of clinical audit processes. The next workshop is being held on 22nd February in Llandough Hospital at 9.15 to 12.30. Further information can be found on the Clinical Audit Homepage on CAVWeb.

Mick said that as a consequence of an internal audit, the proforma had been re-vamped to include equality. Mick said that the Clinical Audit Department was available to give advice.

DIGNIFIED CARE

6.1 Internal Inspections

Action plans from recent internal inspections were minimal and related to environment only.

TIMELY CARE

No report.

INDIVIDUAL CARE

8.1 Carer and Patient Feedback Survey

Adult Mental Health (24% received)

Positive feedback had been received from recent surveys; negative feedback had been lack of activities and Doctors not being available.

MHSOP (35% received)

Need to get more information about patient experience.

There was a discussion on how to achieve a better response rate and the design of the form. There was a suggestion to add a section on the form to advise on any for action taken from negative feedback.

8.2 Compliments

Plaudits received for:

East 10, Llandough – Thank you letter from the daughter of a patient.

East 18, Llandough – Thank you letter from the daughter of a patient.

MHSOP and Neuropsychiatry Services Plaudit Report dated January 2017

Willow Ward – Thank you letter from the mother of a patient.

Hafan y Coed and ECT Suite - Thank you letter from a patient.

Pine Ward - Thank you letter from a patient.

Phoenix Community – Thank you letter from a patient.

Outreach and Recovery Service - Thank you letter from a patient.

Student Placements on Gabalfa CMHT and Maple Ward

PART 2 : ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION**Policies and Procedures**

The Group were asked to receive and ratify the following:

10.0 Weekend Community Mental Health Nursing Procedure for Adult CMHTs

This Procedure is to ensure clarity of role for those referring into the weekend service as well as for the community mental health nurse working weekends.

Referrals made by a CMHT must have received face to face contact with a team member in the preceding week and a planned appointment for the week following the weekend CPN intervention. In addition clients must have had contact with a CMHT within the 48 hours prior to the weekend to confirm if weekend support is still required.

CPNs from each of the 8 neighbourhood CMHTs will contribute to the weekend rota. Two nurses will routinely be on duty. In the case of exceptional demand additional staff may be rostered to provide extra cover.

In the event of staff shortage on a weekend, either the working weekend CPN or Shift Coordinator should be provided the list of CPN staff available at short notice to work on weekends.

THE POLICY WAS APPROVED

The policy would be circulated to Doctors to support their on-call decision making.

10.1 Ligature Risk Assessment at Hafan y Coed

It was reported that Jayne Bell, Senior Nurse, and Rachel Sykes, Health & Safety Advisor, are preparing a Ligature Risk Assessment Protocol for Hafan y Coed. This Protocol will be discussed at the next Policy Group.

DATE OF NEXT MEETING

13th April 2017 at 9.30am in The Seminar Room, Hafan y Coed.

(next Clinical Board Q&S Lessons Learned Meeting is on 16th March 2017 in the Seminar Room)



**MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE
HELD AT 1pm ON TUESDAY 10th JANUARY 2017 IN ROOM 1, CRI**

Present : Dr Gareth Hayes Clinical Director for Clinical Governance (Chair)

Brendan Boylan	Clinical Board Director
Sue Morgan	Director of Operations PCIC
Kay Jeynes	Director of Nursing PCIC
Rhian Bond	Head of Primary Care
Helen O'Sullivan	Quality and Safety Manager
Alex Scott	Patient Safety and Quality Assurance Manager
Matt McCarthy	Patient Safety Facilitator
Karen May	Divisional Pharmacist
Denise Shanahan	Consultant Nurse
Anna Mogie	Lead Nurse, North and West Cardiff
Ceinwen Frost	Lead Nurse, Vale Locality
Nicky Hughes	Lead Nurse, South and East Cardiff
Harminder Prosser	Clinical Governance officer
Helen Earland	Senior Nurse Primary Care

In attendance - Alex Scott attended the meeting to update on health care standards process for 2017

Minutes typed up by Theresa Blackwell, Planning and Projects Officer

Preliminaries		Action
	Welcome and Introductions All present introduced themselves and were welcomed by Gareth Hayes.	
	Apologies for absence No apologies were noted	
	Declarations of Interest Gareth Hayes asked for any declarations of interest – none noted	
	Minutes of the previous meeting held 8th November 2016 The committee accepted the minutes as an accurate account. Whilst checking on the status of actions from the previous meeting KJ noted PCIC have achieved the highest flu immunisation rates across the UHB, currently standing at over 70%. KJ thanked the team, stating they have been very proactive in achieving this.	

	GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY	Action
	Healthcare Standards Update Alex stated that the UHB received revised standards last year from Welsh Government. There has been significant variance in the way people have measured compliance with these. It has been decided to align clinical standards among clinical boards within existing committees to avoid duplication. This will be implemented across 3 years as a staggered programme, beginning this year with Falls, Infection Prevention and Control, Medicines Management, Medical Devices, Nutrition and Hydration, and Safeguarding. Alex advised all clinical boards will not need to self-assess against these standards this year but the relevant committees may contact Business Units for information. Folders will be available from 23rd January – driver diagrams and scoring matrices will be revised by this point. Alex stressed the importance of quality of evidence over quantity and to submit core elements to demonstrate progress against the standards. There will not be flexibility around the timescales due to the tightness of the reporting window in order to be included in the Annual Board Report in June. Actions from last year's SBAR's have been compiled and gone to the Executives and Independent Members. Clinical Audit Plan 2017-2018 Last year Clinical Boards produced audit plans and in June identified one audit per directorate to be registered and reported to the Clinical Audit Team by November 2016. Compliance has been poor throughout the UHB. Submission of an annual Clinical Audit Plan will be requested again this year. The UHB are looking for similar audits to those presented last year – a small number of audits, focused on key clinical board priorities. An annual Patient Safety Performance Summary will be produced, similar to what is put on the dashboard each month to help identify what audits to focus on. Alex stated there is a large amount of audit work going on throughout the UHB which is not included in Clinical Audit Plan and so is not being recognised. Not all audits are addressing Clinical Board priorities and there are a large number of abandoned audits and a number of audits which are not formally reported on. NH stated the collection of data can be difficult, as well as reporting on it. Alex advised that support is only provided by the Audit Team for national audits. GH noted that many areas carry out reviews of activity but do not badge it as	

	an audit. An IT solution is being developed for next year - all audits will be registered on it to allow Clinical Boards to have oversight on audit activity within their areas. It will hold any reporting on the audits and allow action plans to be developed. Expected to be introduced early in the next Financial Year. Patient Story KJ reminded everyone of the importance to bring a patient story to each QSE meeting. KJ advised she will allocate each BU with a date to present on for 2017/18 meeting schedule. GH advised a pro-forma has been sent out advising what we are looking for from a patient story and KJ stated staff have been advised of the process and training has been made available.	
	QSE bring forward action log <u>PCIC CB Quality and Safety Group Action Log</u> The Clinical Board Quality and Safety group action log was reviewed. Members noted the content. Actions requiring further work : 316 Learning Disability – Enhanced Service uptake in practices RB advised this was being discussed nationally as part of work to improve uptake across all Health Boards. Will bring back to QSE once resolved but may take some time as recommendations going to WG. AM reported issues over Learning Disability had been picked up by Independent Member at UHB QSE meeting. Updated Concerns Report (No item ref number registered) KJ noted this is not received routinely at clinical board level, although is provided to business units through performance mechanisms. Uncertain if this needs to remain as an action as revised process to be put in place for 2017 and formal reports to be circulated to clinical boards. Risk escalation Western Vale (No item ref number registered) CF noted no poor discharges reported since last meeting Burgess House Update (No item ref number registered) KJ advised this action can be removed the home is no longer being monitored under safeguarding processes. Storage shelving (No item ref number registered) GH noted this can be removed	RB KJ CF

	Vale of Glamorgan Network Coverage CF noted still in same position. New admin support due to start this month so trial should begin shortly. DOSH Unannounced Visits by CHC (No item ref number registered) NH stated have not heard anything further regarding surveys from CHC – DOSH have conducted their own. First clinic at CRI is today since St David's clinic moved in and the service has already had 12 walk-ins. CHC were happy with the community service reconfiguration – less certainty over whether they have supported the Roath move, but plans are in place to move Roath clinic within the next month. Conversations with CHC continuing. SM agreed that consultations with CHC have been very good and the process seems to have gone well. Digital Cameras Usage KJ advised the HCSW focus group are having training to use photography equipment. CNS and Team leads need to get staff signed up for the training. PCIC – Pressure Ulcer Prevalence KJ stated only NW report received despite requests. NH stated report was prepared for last meeting. KJ advised she has given Ruth Walker assurances that PU reports will be brought to this meeting as Datix is currently unable to report as needed. CF advised they planned to report for February but this does not then tie in with this meeting – KJ advised reports should be presented to the QS&E committee bi-monthly. KJ stated it is important to update on this at QSE as the new process at MASH may lead to increased risks as Lead nurses are no longer involved at strategy discussions. AM said it would be interesting to look at the numbers reported going forwards. KJ advised there is likely to be a change in direction due to national discussions and it is important to have local discussions about this during the QSE meeting. CF mentioned that Datix has been updated and you can now pull all records reported as pressure ulcers. Quality Dashboard KJ advised that the clinical board be looking to develop a Quality Dashboard but as a great deal of this information is already reported to SDG we do not want to replicate information.	CF NH CF Lead Nurses
	Risk Register KJ advised a new risk highlighted in the last meeting concerning the TRAC recruitment system should have been added to the risk register but GH stated	

	this did not appear to have been added. GH queried what the column “Ranking” refers to – KJ advised she did not know and would need to find out and feed back. NH, AM and others noted they had updated their actions but these were not showing on the risk register. KJ apologised if updates had not been saved and advised these would be followed up after the meeting. <u>Review Risk Log using 4 Ts</u> Risks highlighted at the meeting for further discussion were : QS&E 000214 OOH’S KJ advised fill rates were good last weekend and we had two GP’s on-call overnight which ensured the workload was kept under control for the following morning. RB advised that comparisons with similar weeks (non-BH’s) showed a significant increase in call volumes which we would not have been able to cope with without the increased shift fill rate. Advised we are still in a challenging period so ensuring resilience is important. KJ noted that GP’s had provided positive feedback regarding CNP’s and ANP’s. QS&E 0000113 Independant Sector Still vacancies and sickness across localities within the nurse assessor teams, AM noted we will always have a small number of care homes with escalating concerns so risk does not reduce. New nursing home opening in N&W – business case has been completed as part of IMTP to increase Nurse Assessor resource in each locality but due to the financial climate it is unlikely we will receive this so risk remains. QS&E 020714 – CHAP NH stated she believes the risk had been reduced previously as demand is currently stable, shift fill rates and nursing hours filled has been planned in advance. Action plan following the governance review is completed, Awaiting the outcome of the tendering process. KJ and CD to review risk following todays meeting SM stressed the importance of development of resilience in the service, which we did not previously have. QS&E 160714 – Patient Flow GH noted a typo – saying moving from 16 orange to 12 red if improvements are made. KJ advised that delayed discharges of care are linked with DN’s, CRT’s and Discharge to Access, and stated that the latter two models were working well. KJ advised we do not currently have numbers on DTOC’s but SM stated she has been informed that they have reduced. KJ advised we have the highest number of our patients in nursing home beds that we have ever had, so efforts are being made to improve flow.	KJ KJ CD KJ
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QS&E 160714 – Equipment/JES Meeting on Thursday to pick up where we are with the action plan – meetings take place every 3 months so will be able to update after Thursday. QS&E 110914 – Complex packages of care AM stated the fragility of a number of packages exist particularly due to increasing demand. Care package for a complex patient has gone out to tender this week. Pressure continues for discharge from the inpatient area but due to complexity it is unlikely the package of care will be put together soon. KJ working with procurement to establish a framework around specialist care in the community which may provide opportunities to improve finance and efficiency. KJ advised multiple factors affecting improvement, including increasing complexity of cases, complex social issues, requests to be cared for at home when a placement would be cheaper, sustainability of retention of staff. GH queried if we have met with the executives regarding the most complex packages, and KJ stated that this has happened and the current focus is on the framework contract with procurement. Meeting with CHC Finance regarding this next week. Once the framework contract has been agreed than any cases over a set amount will need to be escalated and the framework can be used to aid decision-making. AM stated that sustainability is not just about finances but must consider fragility of care packages and that we already have a sustainability policy for CHC which provides a frameworking for making decisions regarding funding packages. KJ agreed this exists but more detail is required in order for the UHB to be happy to make equitable decisions on care. Follow-up meeting is planned. AM suggested there may be a case for psychology support for families and staff regarding transitions in order to manage expectations and ensuring care packages do not break down. KJ stated this has been discussed and would be considered in the framework contract as requires agreement with Women and Children clinical board. KJ also mentioned that in some cases there are safeguarding issues which need to be addressed before a package of care can be planned. PICC 160614 – Primary Care Estates RB states the IMTP has included the LDP and significant population growth. Has met with GPST to discuss the sustainability of practices and is looking to write a business case suggesting that some practices look at pooled premises and managed surgeries. Some practices are saying they can take extra capacity but they need to fully consider the practicality of this. GH enquired if there was a clear timeframe of when the building work will start and was advised possibly later this year.	KJ
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PCIC 051114 – DN Risk

KJ noted still challenges with DN despite recruitment of phlebotomy staff. Recruitment of DN's is still a challenge in terms of staff getting into post although there have been recent improvements. The impact of phlebotomists has not yet been assessed, plus the introduction of administrative support must also be reviewed. Currently looking at PARIS data for evidence of impact on activity.

Noted challenges across all areas due to workload demand and sickness, particularly in the Vale. Also noted levels of vacancies, particularly in Butetown (SE). Most teams are on level 3 or 4 re: demand capacity management, although a few are on 2. KJ stressed the need for more discussion around moving staff flexibly around localities.

Vale of Glamorgan Network Coverage - DN's

CF stated it would be useful to have some reports on usage of netbooks as accessibility is an issue in the Vale but uncertain how to take forward as it is an IT issue. AM advised IT are unavailable to support with this at the current time due to staffing vacancies.

KJ advised we spoke to WAST last year to gauge their issues with connectivity and they also tolerate this risk and had no solution to the problem in the Western vale.

PCIC - GMS Services/Primary Care Capacity and Sustainability.

RB advised work ongoing to evaluate current position of practices and then the PC team can then start to risk assess them.

PCIC – Pressure Ulcer Prevalence

KJ advised nothing else to add, PU reports to be provided by all Localities and discussed at the next QS&E meeting – discussed under Action Log

PCIC – Domicillary Care Provision

KJ stated we are not aware of the situation worsening. The clinical board experienced challenges around Christmas regarding getting people home with poor responses re availability but the position is still very fragile.

VL - Wound healing Teams delay for assessment

CF advised this has been temporarily resolved with the appointment of a new post so asked for this to stay on until the impact of this post can be assessed. KJ also advised that the clinical board has not heard anything about the RCN submission for funding which should impact on this.

HMP Cardiff

NH advised whole prison service across UK is volatile and HMP Cardiff have recently had an incident which was dealt with very well by the prison officers by de-escalation methods.

Issues around staffing have also de-escalated but there is the potential for this to escalate quickly.

The nursing workforce is very stable – a new Band 7 manager is in post supporting on a temporary basis but we still need to look at vacancies and

	skill mix. GH noted we do not currently have a Clinical Director in post. KJ stated she is in the middle of a governance review with Dr Maria Dyban and will share the outcome with Brendan Boylan and GH as actions and recommendations need to be discussed. NH stated that the S&E Locality lead Nurse is currently taking responsibility for quality and safety in the prison and have escalation cards around issues to do with the prison. GH clarified with NH that Nicola Goodfellow is looking at policies and procedures with the Senior Nurse in the prison and working with the nursing team but stressed the need for a CD in post. SI - Vaccine Breach KJ advised last meeting was productive and may be able to close this SI down shortly. No need for revaccination of any of the individuals for NHS vaccines and the practice has been advised to seek further advice regarding private work. Need to communicate messages to GP practices across the C&V area from a learning perspective. At next meeting will agree action plan toolkit for GP's and communications. KJ advised re: learning that VPDP and Public Health Wales have provided, expert advice around vaccines and there has been significant dialogue regarding fridges, maintenance, temperatures and monitoring. GH confirmed learning has been taken and shared already from the individual practice incident to apply to Cardiff and Vale. KJ clarified an internal investigation has taken place in the affected practice which reviewed the existing policies and compliance. The UHB has not had sight of this review and were uncertain if it is appropriate for us to do so as the GP practice is an independent sector provider. KJ has offered professional advice regarding the individuals involved and RB has advised the practice generally and clarified they have reviewed their wider processes. Wider learning will be discussed at the next meeting to ensure the correct messages go out across CAV. GH noted this was not on the Risk Log.	
	SI Log <u>Current SI's</u> Incident IN31038 HOS advised RCA almost completed, awaiting pharmacy assistance in looking at prescribing model of the practice. Learning may be for social services regarding identifying care planning around medication and expectations for providers Incident IN35262 NH advised two other incidents in this location need to be added to the SI Log and will be receiving updates soon.	HOS

	NH advised that a preliminary meeting has been carried out and statements are being taken from staff this week. NH is due to write up as an RCA and this incident will be externally reviewed. NH discussed a concern re a young man in healthcare, acutely ill from a MH perspective who passed away, statements from staff are being sought and awaiting toxicology reports. Incident re: Cold Chain Process Discussed under risk log – Vaccine Breach. Incident re: Paediatric - GP Surgery/Ambulance Response HOS in the process of undertaking an RCA with the practice and linking with paediatricians in UHW. <u>Closure Forms – Prison Healthcare</u> GH noted two closure forms submitted regarding HMP Cardiff (IN15125 and IN25612).	
	Risk Escalation Reports <u>Breach of Cold Chain</u> GH noted risk escalation report – this issue was discussed under the Risk Log – Vaccine Breach. <u>SALT Fluid Thickening</u> AM advised this was for noting with regards to a risk escalation form submitted by the CRT. AM stated there was a disparity regarding the thickening of fluids by local authority home carers. There have been discussions with the Local Authority over whether this is a health need and so suitable for domiciliary care staff to be involved with as it involves prescribed items. Previously the Cardiff Local Authority Service Manager was happy to look at these patients on a case by case basis and the speech and language therapists within CRT have provided training and support. Currently home carers are being told they cannot thicken fluids for clients and this is affecting a small number of patients. There is a need to review current policies regarding home care staff in order to include the thickening of fluids within this. <u>HMP Cardiff</u> NH advised a number of risk escalation reports have been submitted for noting: OOH GP Cover Previous OOH provider withdrew from service with no notice. Currently day GP's are covering OOH on a locum basis and so there is a need for a new	

	contract to be put in place. Procurement are involved. Volatility of Environment and Staffing Levels Due to staffing issues within the prison, prisoners are sometimes being “locked down” early so healthcare staff cannot go onto the wings except for emergencies and so night-time medication is being given early. Some mental health prisoners are being given medication to take away which could lead to it not being used by the patient. NH recommended this be discussed further in the Medications Management meeting to agree on a process and risk assessment. Primary Mental Health Care Provision NH advised this has been raised previously and is on HMP Cardiff’s risk log but may not have been raised to QSE so this would need to be noted. There is no dedicated primary care mental health provision in the prison, and a number of the prison population require low-level support. Discussions are ongoing with Welsh Government. KJ advised there needs to be a discussion regarding whether any of the funding aimed at supporting these needs in the wider community could be funnelled into this service within HMP Cardiff. GH noted that there is 6-week referral period for this service in the community, so prisoners would usually have passed through HMP Cardiff before they would be able to use this service. <u>Continence Team</u> CF advised that the activity levels of this team will reduce over the next 6 months due to number of staff who have left the service for a number of reasons. The closure of Lansdowne and relocation of the service has also caused unsettlement. The most significant impact is on the administrative team and Band 5’s within the team. This is likely to lead to increases in waiting lists and some clinics have been reduced. Services are running across all localities but the number of patients being seen is reducing so a prioritisation process has been implemented. CF advised the team have undertaken a significant amount of good work over the previous year, setting standards, reducing the waiting list and developing a good reputation, and these may suffer and could lead to a decrease in staff morale. Service is dependent on the length of time of the recruitment process and KJ advised this would need to be added to the risk register.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		Action
	Chief Medical Officer for Wales Annual Report 2015-2016 KJ wanted to bring this report to the attention of the group, stating it highlighted inequalities within the Welsh population and how this affects health outcomes. The report includes 8 recommendations which relate to how strategies are developed.	
SAFE CARE		Action
	Patient Safety Incidents <u>Interface Incident Update</u> HOS stated the Interface process was put in place last summer and needs to	

	be reviewed. Meeting planned for Thursday to look at planning and training, and a further meeting is planned in February to look at refining the process. At present approx 140 incidents have been reported, which is more than anticipated so there is a need to look at which need to be reported as a Datix incident and which need to be reported for “themed issue”. KJ also noted the clinical board also need to look at incidents being reported from other services within the UHB re GP’s, such as labs informing us of issues with samples sent from GP practices etc.. HOS advised she will look at meeting with labs at some point in the future and is in regular contact with them. An IT solutions needs to be explored to enable the information/incident reported can be managed more efficiently and prevent duplication, including how we link reporting to the patient journey on the various clinical systems. SM stated that in the Primary and Secondary Care Interface Meeting discussions around the length of time being taken by secondary care to respond to raised issues took place, including how GP’s liase with directorates and the impact this has on identifying themes and reporting. This was taken to a meeting with the Chief Operating Officer and other Directors of Operations and established procedures regarding follow-through were discussed.	
	Park View Patient Safety Visit AM advised a report has been provided regarding a WalkRound which took place at Park View Health Centre in November 2016. Key feedback concerned the environment and building maintenance. AM noted that another District Nursing team has moved in to this building since the WalkRound. The WalkRound also noted issues with regards to Syringe Pump Drivers in some Nursing Homes and protocols surrounding Lymphoedema patients. The report was positive regarding the team and how it operates within the community.	
	All Wales PRUDIC Report HOS stated that the audit feedback noted that GP’s provide the information required even if they cannot attend the PRUDIC meeting. The recommendations include causes of death not being notified to the relevant people. A recommendation surrounding parents being informed of the PRUDIC and attending if is relevant to Cardiff and Vale. KJ is currently being informed of PRUDIC’s and HOS links with the surgeries to support them and ensure they are informed of how to support the parents.	
	Revised DLM Process KJ stated this is a revised process in place due to the new MASH process, information has been circulated out to all relevant parties. It was noted that Lead Nurses have some concerns over this as they are not involved in multi-agency discussions as the UHB Safeguarding Representative is involved in place of the Lead Nurses and so may not have the same local knowledge but	

	are making decisions on our behalf of the UHB. A meeting is being arranged for Lead Nurses to discuss with the Safeguarding lead and Asst Executive Nurse Director for further discussions on the changes.	
	Locality Pressure Ulcer Reports As discussed under the Action Log. AM noted the new policy of recording and reporting certain grades of pressure ulcers via a VA1 before carrying out an RCA has created an increased workload and may result in cases of abuse or neglect not being accurately coded when initially reported. AM noted that this policy may work in a secondary care setting but not in a community setting. The referral may not be received until the ulcer has developed into a Grade 3 or 4 and there may be higher levels of non-compliance. It was also noted that patients may be discharged from inpatient care to a community setting with pressure ulcer damage and so the same incident may be reported several times through different settings and systems and may be graded differently/incorrectly. NH noted that patients may take a number of days to be admitted onto a ward when accessing emergency care but the VA1 is then raised against the Nursing Home when it must be considered that the pressure ulcer may have worsened whilst the patient was accessing emergency/secondary care. It was acknowledged that A&E is under a lot of pressure but body mapping on admission would help pinpoint where and when pressure sores/ulcers are developing.	
	C Diff / MRSA RCA Report 9 cases have been reported as linked to GP's, these have been reviewed with the RCA tool and 2 should be attributed to secondary care. Of the 7 GP cases, 4 had a clear causation to primary care but prescribing guidelines had been followed. 1 was unclear, and further investigation showed the antibiotics prescribed did not meet UHB guidelines for the specific circumstances. KJ stated we need to look at sharing the learning from these cases both within the practice and wider community by producing detailed reports and using various communications mechanisms. We also need to look at the quality of returns and frequency of returns from GP practices in order to ensure the accuracy of the reporting.	
	EFFECTIVE CARE	Action
	GPN/HCSW Framework Overview Emma Lewis (Workforce GPST) provided an overview on a piece of work regarding skill mapping for practice nurses and HealthCare Support Workers in order to support practices in understanding workforce ability, workforce development and long-term planning. This has been driven through the	

Education team and a Nursing Pathway has been developed alongside a Skill, Training and Qualification matrix which can be used for individual self-assessment and career—planning or organisation-level skills assessment and workforce planning. This will help with benchmarking and identifying areas where skills are duplicated or where there is a skills shortage. The documents also help ensure consistency with job descriptions and salaries.

Further work is ongoing to increase the robustness of the documents in terms of competencies. This could also be replicated across other departments for other roles but would require clinical input.

At present this is for noting and feedback, with the intention it will be brought back at a later date to be signed off so it can then be trialled and rolled out to practices. Discussions around the level of support that can be offered are ongoing with the Education team as the intention is to provide support such as workshops alongside the document.

GH noted a HCSW Pathway would also need to be developed alongside the Nursing Pathway.

EL advised she hopes to complete the document by the end of February and will include information on the training and support that is currently available. KJ will take to NMB in March. SM advised this could go through PCIC mechanisms and be presented at CD forum in February then NMB.

AM stated that independent contractors may choose not to engage with this and KJ advised that we would present this as a standard and hope to encourage practices to utilise this. EL stated this provides a workforce tool as well as having governance implications and so the GMS and GPST teams could use this when supporting practices so can be used by internal teams as well as contractors.

GPOOH Audit

HE stated the increasing skill-mix within the OOH's team means that audits will help ensure standards of care are maintained, skill-mix is utilised appropriately and the impact on service efficiency can be measured. All nurses were audited at the end of 2015 and the ANP's were audited between June and August 2016. GP audits were undertaken towards the end of 2016. Clinicians have reported they are using the feedback towards development, appraisals and re-validation.

Recommendations include the annual audit of all clinicians, CPD events reflecting common themes to be identified, uniformity in providing feedback, and clinical supervision in the form of case discussions.

Next cycle of audit has just begun. An action plan is being developed including levels of cases to be audited. Training sessions are being put into place regarding any development areas identified in the previous cycle of audits.

HOS informed the meeting that the nurse audits were all completed in 2016 however GP audits are not always done in a timely manner. The GP leading audits for OOH has resigned so SLM and JB will need to review GP audit

	process. SNAP KJ wanted to bring this audit to the meeting's attention – it is the third national annual audit looking at stroke performance. There has been an improvement in these services across the UK. No specific recommendations are applicable to PCIC services but the report is available if required. NICE Guidance MIB81 – Alere Afinion CRP for C-reactive protein testing in primary care KJ stated this has been provided for information HCSW in NH administering medicines KJ stated an SBAR has been tabled for people's attention. A similar SBAR was tabled at a previous QSE meeting which was looking for HCSW's to be assessed as competent to administer medications and PEG feeding. This was accepted by the clinical board and we are now looking how to assess staff as competent. This is going to NMB from a UHB-wide perspective to gain support for an overarching framework. A number of providers in Nursing Homes have approached us to see if they can implement something similar. A framework is currently in place for staff with NVQ's so we are looking to gain support from the board to agree that Nursing Homes are able to train their staff to administer medications orally as long as staff have an NVQ L3 and the home would be responsible for assessing and training staff (meting WEDS framework). This will also go to NMB for discussion and ratification. AM noted as we are contracting this we should have an established framework surrounding the competencies and training that Nursing Homes will need to meet. The WEDS framework provides the training framework required, each Nursing home would have to provide assurance to the clinical board that they have the required processes in place to safeguard the patients and staff involved. KJ also noted we can use other mechanisms such as safeguarding and POVA to ensure this is being used appropriately. NH noted some Nursing Homes are looking towards electronic medication systems which minimise drug errors which would further safeguard anybody providing or receiving medication.	
DIGNIFIED CARE		Action
	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans KJ advised nothing to discuss at this meeting.	
TIMELY CARE		Action
	No items to discuss.	

INDIVIDUAL CARE	Action
Mental Capacity Update An SBAR re: covert administration of medication was included in the documents for reference. GH advised this concerned a patient with an LPA but the designated person was overseas and objected to the medication being prescribed. This went to the GMC and no action has been taken against the GP. AM stated that covert medication needs to be looked at on an individual drug basis rather than an individual patient basis as some drugs may meet the grounds to be administered covertly whereas others may not for the same patient. GH advised there was confusion over best interests when applying covert medication. KJ advised information on this has been circulated to practices to share the learning and we will need to look at providing updated training on the Mental Capacity Act 2005. This could be rostered into CPET but as the learning refers to a specific aspect of the Mental Capacity Act we need to focus on the Nursing and Residential Homes rather than UHB-wide. GH queried whether a prescribing GP would be aware that a home was administering the medication covertly – advice given was that if the best interests decision was recorded formally then they would. KJ advised that the best interests meeting should include all relevant professionals and as the prescriber the GP should be involved.	
STAFF AND RESOURCES	Action
Dementia Awareness Training Update KJ advised that this is a priority and is mandatory for the UHB so we are looking to drive forward on this. KJ confirmed we will look to implement Champions in each team this will be monitored regularly through performance mechanisms. ANTT Update KJ advised there is a new aseptic technique/procedure which WG have advised is mandatory across all areas across the interface. There are project groups for inpatients and the community and we will meet with the inpatients group later this month to discuss our plan. The challenge around this implementation is the e-learning module is difficult to access for Independent contractors and is focused on inpatient care. There are also issues around assessing competence and advice on consumables to be used. An implementation plan to be brought to the May QSE meeting. Staffing – Recruitment and Retention Update AM advised we have recruited a number of Band 5's into vacant posts and are back into a reasonable level of turnover and will need to look into succession planning. NH advised DOSH has had some good applicants in recently but find attendance at interview is still lower than expected and once someone is	

	recruited it takes a long time to get them through their diploma and ready to practice so staffing is still an issue. NH also advised staffing in the prison is an issue but they are actively recruiting and will be looking at skill-mix. Despite active recruitment in District Nursing and the prison there are high levels of less experienced people coming into the services which creates risks. There has been an increase in a Locality-focus within District Nursing rather than a team-focus so there is the possibility of moving staff to mitigate these risks.	
SUB-GROUP REPORTS		Action
	Cardiff North and West Locality AM identified escalating concerns in 2 care homes in the area. All other issues have been discussed or identified in the report submitted to the meeting. Cardiff South and East Locality 2 Safeguarding points – there has been a hike in profound disability patients coming through CHAP with no advance notice. In some cases Links accommodation is unable to meet these needs and will not allow us to install equipment – we will be raising this with UKVI. 1 Nursing Home is going into Provider Performance within the next week. We are forging ahead with community clinic consolidation with DOSH and have just moved over to LabLink and this appears to be going well. Vale Locality CF advised that in addition to the pagers issue which has been discussed there is an issue around mobile phones – this has been raised but we are not progressing on this. Some of the solutions have cost implications and may not resolve the issue. Satellite phones would resolve the issue but the cost is excessive. Also discussed issue of Lansdowne closure and location of Wound and Continence teams – alternative accommodation needs to be sourced and they will need to leave Lansdowne by the end of March. Out of Hours All issues have been identified in the report submitted to the meeting Medicines Management KM advised looking to develop a matrix management model around cluster pharmacists' responsibilities. There is a slight block around getting agreement between clusters and localities concerning the areas they will look after. Palliative Care KJ flagged an action plan from the task and finish group regarding Diamorphine/morphine switch for use in the community. There will be a plan to be communicated out to all internal and external staff affected by the	

	chnage.. There is an issue regarding the oxycodine name change and the communication which has gone out regarding this. KM advised communication has not yet gone out to the practices but has gone to community pharmacies regarding stocks. It has been reported that some patients may have been discharged from acute settings with the new name of the drug and this is causing some confusion in the community by KM advised this should not be happening and will check this. AM queried when enhanced recruitment will take place for the expansion of Hospice at Home – KJ advised due to the value of the contract it needs to be signed off by Welsh Government and is currently with Procurement. KJ will request this is chased.	KM KM
PART 2: Items to be recorded as Received and Noted for Information by the Committee		Action
	The Committee Received and Noted the following :- • MDA Advice Alert – syringe alarms : MDA/2016/023 (Wales) • NHS Alert : GOS and Optical Charges and Payments (Amendment) (Wales) Regs 2016 • Public Health Alert : “Caution – Amoxicillin Sugar Free Suspension 250mg/5l and 125mg/5l” • NHS Alert : Patient Safety – Fire Risks – Paraffin Based Skin products • Public Health Alert : CEM CMO 2016 005 “Influenza Season 2016-17” • MDA Advice Alert – coolers/heaters : MDA/2016/022 (Wales) • NHS Alert – Never Event Update : Patient Safety Feedback Sharing Lessons, Improving Patient Safety – December 2016 • NHS Alert – Teleflex : Field Safety Notice EIF 000093 Teleflex MAD Recall • Public Health Alert : CEM CPhA 2016 016 ‘Evacal D3 500mg/400iu, PI 0289/1742’ • Welsh Health Circular – Carbon Monoxide Poisoning : WHC (2016) 052 • Public Health Alert : CEM CPhA/2016/15 Hydrocortisone 100mg/MI solution for injection • Public Health Alert : CEM CPhA 2017 001 ‘Sanofi-Aventis.Arava 10mg Film Coated Tablets’	
DATE OF NEXT MEETING		Action
Date and time of next meeting : Tuesday 14 th March at 1pm		



**Specialist Services Clinical Board
Quality, Safety & Experience Committee
3rd February 2017**

23.4

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Service Clinical Board- *chair*
 Jessica Castle (JC), Head of Operations and Delivery, Specialist Services Clinical Board
 Adam Didcott (AD), Ward Manager, Haematology
 Lorraine Donovan (LD), Senior Nurse, Neurosciences
 Steve Gage (SG), Clinical Board Lead Pharmacist
 Colin Gibson (CG), Clinical Engineer, Neurosciences & ALAS
 Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics
 Mark Jones (MJ), Directorate Manager, Nephrology & Transplant
 Archie Kaul- Mead (AKM), Service Manager, ALAS
 Claire Main (CM), Lead Nurse, Nephrology & Transplant
 Ceri Phillips (CP), Lead Nurse, Cardiac
 Mathew Price (MP), Assistant Service Manager, Neurosciences
 Sian Pring (SP), PA, Haematology, Clinical Immunology and Medical Genetics
 Hywel Pullen (HP), Assistant Director of Finance for Specialist Services
 Andrea Richards (AR), Directorate Manager, Neurosciences
 Martyn Read (MR), Consultant Intensivist, Critical Care
 Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead, Critical Care
 Maria Roberts (MRo), Patient Safety Manager, Patient Safety
 Vince Saunders (VS), Infection Prevention & Control Nurse, IP&C
 Sian Williams (SW), Senior Nurse, Cardiothoracics
 Keith Wilson (KW), Consultant Haematologist & QSE Lead, Haematology

PRELIMINARIES		ACTIONS
	<u>Welcome & Introductions</u> CF welcomed all and stated that today's meeting would be focussed on IP&C.	
	<u>Apologies for absence</u> Mary Harness (MH) Jonathan Kell (JK) Noreen Lewis (NL) Rachel Barry (RB)	
	<u>Minutes of the previous meeting</u> All amendment requests have been processed. <u>Updates</u> <i>Key Patient Safety Risks</i> <i>Falls Reduction</i> There is no more detail available on which beds are being replaced or if the new beds will replace those already in situ. Sign off for the new beds is expected to be completed next week.	
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY		

	<u>Feedback from UHB QSE Committee</u> None.	
	<u>Risk Register – review and revision</u> The January update has been completed, though 2 risks have to be added as per IP&C. All HB tier 1 targets are on the register, as well as individual risks pertaining to them. Some risks are due to be removed this year. The document will be circulated for review. All comments and amendments should be directed to CF.	
	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> JC discussed the ongoing cardiac issues related to the closure of the cardiothoracic theatres. Everyone should be aware of the problems with particulate matter in the environment in theatre 11, though a clear source has not been determined. Samples of said matter were collected and sent for analysis- they were found to be rust. Theatre 11 has been closed for several months now because regular attempts to deep clean the space proved unsuccessful in resolving the problem. The WAG and WHSSC have been informed, regular SI meetings are being held and activity has been moved to theatre 6. The latter is causing disruption to other specialities. Eleri Davies has suggested that the particulate matter may be the result of degradation of the ventilation system, meaning that the only option would be to replace it. Discussions with the executive team are ongoing to expedite this.	
SAFE CARE		
	<u>Patient Safety Incidents</u> <u>New SIs</u> An RCA is to be completed for an incident regarding a transplant patient discussed at M&M earlier this week. An investigating officer is to be appointed. <u>WG closure forms – sign off</u> One closure form was discussed regarding a clinic letter being sent to the wrong patient. MR confirmed that the incident was closed by the WAG yesterday. Work is ongoing to find a way to link Cardiac Base with PMS. KW suggested that this may be a wider problem as similar issues have been experienced in haematology. Referrals have been received and processed in medical records without patient demographics being verified via the NHS number or Welsh Demographic Service. Paul Rothwell and Sion O’Keefe to be contacted about attending a future QSE meeting to discuss the matter. <u>Regulation 28 reports (of relevance)</u> MRO provided an update on the inquest held earlier this week for the death of a patient following incorrect placement of a chest drain. The coroner concluded there was no neglect as the doctor who inserted the drain was competent (though this was not confirmed during the initial investigation), and advised a narrative conclusion and regulation 28 report. CF reported that an initial meeting to discuss chest drain management was held before the inquest. As this is a Health Board- wide issue, a task group will be set up going forward. Radiology have ceased their use of the “X marks the spot” practice for chest drain	MRO

	insertions.	
	<u>Patient Safety Alerts (internal/external)</u> <u>New alerts</u> <i>Risk of death and severe harm from error with injectable phenytoin</i> SG advised that there are no changes to guidance for use of phenytoin, the alert is merely highlighting the risk. A response to Matthew McCarthy will be prepared. <i>Restricted use of open systems for injectable medication</i> MR stated that Critical Care are still ordering packs that contain the gallipots, but staff are instructed not to use said pots. It was further stated that ordering packs with gallipots was cheaper than ordering those without. It was agreed that procurement should be involved to remedy the pricing. CF will feedback to Matthew McCarthy and liaise with Ian Sidney regarding a UHB- wide response.	SG CF
	<u>Health Care Associated Infections</u> <u>HCAI rates</u> The current outbreak remains ongoing. A total of 12 wards have been affected by a combination of flu and norovirus, which is having a major impact on services; a total of 117 bed days have been lost. In January, there were 37 cases of <i>C. Diff</i>, 3 MRSA and 34 MSSA. There is a slight improvement on the same period last year, where 46 cases of <i>C. Diff</i>, 4 MRSA and 47 MSSA were reported. This is also an improvement on November/ December 2016.	
	<u>Progress on Relevant Improvement Plans</u> <u>Hand Hygiene</u> Critical Care have been taking part in the "Gel, Please" campaign. Compliance results for January 2017 are currently under review. Other areas can sign up to the campaign too, a simple "Gel, Please" poster is to be circulated. VS reported that from April 2017, each directorate will be asked about hand hygiene as part of their improvement plans. CF highlighted an issue in cardiac theatre regarding the heater- cooler machines for patients on bypass. Contaminated devices have been linked to potentially fatal post-operative infections by mycobacteria chimaera. This information is now in the public domain and letters will be sent to patients who have potentially been affected. A UHB response is to be devised and PHW are looking to set up a patient helpline. Updated advice on multi- drug resistant organisms is now available. A more detailed checklist to guide staff will be circulated. VS to link in with lead & senior nurses.	CP/ SW
DIGNIFIED CARE		
	<u>Ward Inspection Reports and Improvement Plans</u> CF stated that there is money available for the bathrooms on B4 neuro to be upgraded by the end of the financial year. LD and VS will meet to discuss the logistics of managing patients during the refurbishment. CP suggested catching up with LD to discuss the issues experienced in cardiac during the B1 refurbishment. <u>Health and Care Standards</u> VS reported ongoing issues with cubicles in Llandough.	LD/ VS CP/ LD

Date and time of next meeting 23rd February 2017, 8am, Critical Care Resource Room

23.4



Specialist Services Clinical Board Quality, Safety & Experience Committee 23rd February 2017

23.4

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board- *chair*
 Jessica Castle (JC), Head of Operations and Delivery, Specialist Services Clinical Board
 Lorraine Donovan (LD), Senior Nurse, Neurosciences
 Steve Gage (SG), Clinical Board Lead Pharmacist
 Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
 Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics
 Noreen Lewis (NL), Lead Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
 Claire Main (CM), Lead Nurse, Nephrology & Transplant
 Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care
 Orla Morgan (OM), Lead Nurse, Critical Care
 Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services
 Sian Pring (SP), PA, Haematology, Clinical Immunology and Medical Genetics- *minutes*
 Hywel Pullen (HP), Assistant Director of Finance, Specialist Services Clinical Board
 Vinod Ravindran (VR), Consultant Nephrologist, Nephrology & Transplant
 Martyn Read (MR), Consultant Intensivist, Critical Care
 Vince Saunders (VS), IP&C
 Lisa Simm (LS), Service Manager, Neurosciences
 Sian Williams (SW), Senior Nurse, Cardiothoracic Services

Preliminaries		Actions
<u>Welcome & Introductions</u> CF confirmed that today's meeting would be focussed on the Risk Register.		
<u>Apologies for absence</u> Rachel Barry (RB), Lead Nurse, Neurosciences Rafael Chavez (RC), Consultant Surgeon, Nephrology & Transplant Nick Gidman (NG), Directorate Manager, Cardiothoracic Services Jonathan Kell (JK), Consultant Haematologist & Clinical Director, Haematology Mark Jones (MJ), Directorate Manager, Nephrology & Transplant Maria Roberts (MR), Patient Safety Manager, Patient Safety Keith Wilson (KW), Consultant Haematologist & QSE Lead, Haematology		
<u>Minutes of the previous meeting</u> The minutes of the meeting held on 3 rd February 2017 were agreed as an accurate record. <u>Matters Arising</u> Risk of death/sever harm from injectable phenytoin – Steve Gage confirmed that he had received assurance from all Directorates that the communication has been shared with staff. Gallipots – Carys Fox advised that Ian Sidney had provided the costs for different packs and that work was ongoing. • ACTION - Update at next meeting		MR

Hand Hygiene & Bare Below the Elbow – Carys Fox was not sure that Dr Masani had written to all CDs and Q&S Leads yet to remind them of their responsibilities. <u>ACTION</u> – Follow this up and draft letter Gel please – All Directorates confirmed that the poster from Critical Care had been circulated and was in use in their areas. Global Hand Hygiene Day –Vince will supply some supporting information and give aways. <u>ACTION</u> - All areas asked to arrange stands for 5th May. Improvement Plans – Carys Fox reminded all Directorates that they needed to have improvement plans in place for the tier 1 targets related to Q&S. <u>ACTION</u> -To be completed and submitted prior to next meeting B4 Bathrooms – A meeting has been arranged for Friday 3rd March to see if the work can be carried out on B4 prior to year end and how the patients will be managed during this period.	CF ALL Q&S Leads
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY	
<u>Patient Story</u> CF advised that we were going to have a patient story related to a Major Trauma case however; unfortunately we do not have it with us today. CF gave an update on the work being undertaken on C&V's bid to become a Major Trauma Centre and advised the group that on Tuesday, a senior team from C&V had presented to an Independent Panel who would be making a recommendation on whether C&V or ABMU should be the MTC for South Wales. <u>ACTION</u> - The patient story at the next meeting will be presented by Cardiac.	RW/CP
<u>Risk Register</u> Critical Care CC have substantial gaps across all levels of medical rota; both historic and some more recent. As a result of long- term sickness, retirement and departure at consultant Level, 308 sessions require filling between February and October this year. There are 3 vacancies at junior level. CC are unable to deliver 24/7 advanced airway cover for ICU, or cover transfers and cardiac arrest calls when at times on rota when only 1 senior medic is available. There are several vacant posts- an anaesthetic slot (February to May rotation), an anaesthetic/ clinical fellow post (filled by a junior level doctor with significant airway experience) and a research fellow post (currently out to advert). Medacs are currently providing 1 senior level doctor, with ad- hoc shifts being filled when possible. Other locum shifts are being completed by the current team and previous rotations. Opportunities to change funding to attract different posts are being explored; i.e. ACCPs, Faculty of Intensive Care Trainees but these are not immediately available to candidates recruited via Medical Training Initiative Appointments. Some registrar gaps are currently being filled by C&V consultants. In the short term, consultant gaps have being filled in-house and by known consultants. An honorary contract is being set up with an Aneurin Bevan consultant, there is a view to formalise a job plan. Directorate layout and sessional commitments are also under review.	

A Strategic Workforce Plan is being developed which includes medium and long term solutions. Adopting new ways of working strategy is being considered; i.e. shared job plans, military appointments and reviewing on call commitments. Development of said plan will review succession planning and agreements with Anaesthesia hosted positions. Develop an agreement with anaesthetics for inter/ intra hospital transfers and Cardiac Arrest cover.

There are plans to advertise for 1 WTE permanent consultant and 1 WTE locum consultant. Recruitment to gaps in the junior medic rota remains ongoing. Review of different workforce models and/or, if unit review indicates, a different rota model also remains ongoing. Support for Advanced Critical Care Practitioners overtime at Band 8a rate (short term solution – longer term plan to recruit and train further ACCPs).

Discussions remain ongoing with both the Clinical Board and Medical Director.

2 other risks were noted-

- Patient deaths associated with the Standardised Mortality Ratio (SMR) in Critical Care being 3 standard deviations above the national mean. (provided by ICNARC)
- Lack of capacity and infrastructure to meet demand for ITU

Cardiothoracics

Cardiac Surgery

Challenges to manage current Cardiac Surgery waiting list due to theatre environment (Theatre 10 & 11 closed for Cardiac surgery due to the presence of particular matter within the operating field environment) and inconsistent theatre staff availability to provide adequate cover to support cardiac surgery. Due to these constraints the projected activity for year end is 118 cases short of the commissioned profile of 803 cardiac procedures for the 2016/17 financial year. At the end of 2016 the number of patients with open cardiac surgery clocks was 226; the highest volume of open clocks since April 2014.

Current measures in place include daily validation of cardiac surgery waiting lists; weekly monitoring of booking and scheduling; utilisation and productivity; fortnightly cardiac surgery operational meetings to discuss cancellations, late starts, overruns and staffing constraint; re-provision of cardiac surgery being facilitated in theatres 1, 3 & 6 and weekly meetings with Estates/ Surgery to review situation and required action. There is a risk of commissioned activity not being achieved despite these measures; the financial hand back associated with not achieving the expected activity levels is projected as £380k

Assurance is being provided by Surgery Clinical Board to deliver 22 Cardiac sessions from 2017/18 per week. A 5th cardiac surgeon to be appointed. A permanent plan to resolve current environment constraints is being devised. The Surgery Clinical Board is to provide a paper outlining the logistics of replacing theatre ventilation systems in theatres 9, 10 & 11 and current theatre staff constraints. Ensure maintenance of C5 ward ring fenced criteria. The undertaking of waiting list initiatives at weekends to support activity is under consideration.

Administrative Support

3.0WTE Band 3 Cardiology secretarial vacancies which will increase to 4.0wte in March due to retirement. This has been identified as a significant risk within the Directorate, due to the increased delay in appointment letters and potential impact on patient clinical management.

Recruitment & retention has been historically challenging for this group of staff plus a significant number of retirements over the last 2 years decreasing the skill mix within the team. Also changes to the work base structure have resulted in staff raising concerns over current roles & responsibilities and workload.

A full review of the secretarial structure in cardiology has been undertaken and a briefing paper has been presented and agreed at Cardiology Consultant meeting. Ongoing recruitment processes for all posts have been actioned; though additional challenges as a result of applicants withdrawing following successful appointment resulting in time delays in appointment. Interim support via bank/ agency administration support has been employed.

Recommendations include expediting of vacancy approval and recruitment processes and consideration further bank/ agency admin support in view of interim constraints. To seek advice from the Clinical Board regarding aid from other directorates and advice on ways of working to support the interim concerns. A review of the current plans to implement digital dictation is planned.

ALAS

4 models of powered wheelchair, comprising 1770 of the 3250 of the powered wheelchairs on issue from Cardiff ALAS Posture and Mobility Service, have been declared obsolete by the manufacturer. Manufacturer support for spare parts to ensure the equipment is safely maintained and clinically appropriate will cease within 3 years. Additionally, due to age, the recyclability of these models is already declining and impacting on costs and activity. New, full cost models must be issued and additional clinical technical assessments undertaken.

The replacement of the obsolete models is unavoidable. A managed program balancing the risk, cost and practicality is required to replace them with new equipment to coincide with the obsolescence date. Reconditioning and reissue of Harriers and Spectras has offered a significant cost benefit over purchasing new equipment- approximately £600k in 2015-16.

ALAS has highlighted the issue of the obsolescence since 2014, including 'ALAS HCS 16 SBAR' (September 2014 CG/ MI), and risk 'ALAS 01(2104)' added to the UHB Risk Register 12.01.15.

The recommended option is to replace 100% of obsolete models over 4 years [80% over 3 years, and 20% in 4th year]. A proactive and managed replacement programme, undertaken from 2017, requiring estimated additional funding of £4.75m (£4.1m equipment and £650k assessment resource). This option proposes replacing the obsolete models in a structured and achievable way and allows for realistic start up and trialling of new models.

Focus on replacing 80% of obsolete models by end of year 3, managing remaining 20% by end of year 4 due to considerations such as difficulty in contacting clients, client resistance to change and clinical/technical reasons for replacement with new models being inappropriate.

Neurosciences

Neurosciences have experienced an increase in the inability to admit both elective and emergency patients in a timely manner, mainly because of bed unavailability. In the last year, over 200 patients had their neurosurgical procedures cancelled due to bed unavailability, contributing to an increase in the number of patients waiting over 36 and 52 weeks for their surgery (the majority in the last 6 months). There is a clinical risk associated with the delay in admitting patients, due to a potential deterioration in their health whilst waiting, potentially leading to A&E visits and/or emergency admissions.

Due to the tertiary nature of the service, patients often need to be repatriated to their local hospitals for ongoing care once they are fit from a neurosciences point of view. However, bed pressures at these sites results in patients staying longer than is medically necessary, which impacts on the ability to admit further patients.

The complexity of patients requiring ongoing rehab care at Rookwood Hospital has contributed to delays in them being transferred from the acute wards at UHW. These patients often have tracheostomies, and Rookwood are only able to take a limited number of these

patients at any given time for a combination of reasons – lack of out of hours medical support and a lack of medical gas supply (only 12 beds have access to oxygen and suction). There are also delays in repatriating tracheostomy patients to their local hospitals, as there is no tracheostomy pathway in place.

There has been a steady increase in emergency patients being admitted to the acute wards, and due to the increased complexity of these patients their Length of Stay in high care areas are longer than for elective cases, impacts directly on our ability to admit elective patients on a pre-planned basis.

The Directorate Management Team liaise with the two Specialist Services patient access co-ordinators on a daily basis, including attendance at Health Board bed meetings when required to help manage patient flow and highlight potential constraints to the Clinical Board. Further work will be undertaken to look at the reasons for the increased impact of bed unavailability. Data will continue to be collected in regard to RTT Performance and number of cancelled admissions, to form part of a monthly performance report to WHSCC.

Following the successful approval of a number of business cases submitted to WHSCC, the Directorate are now able to increase their Nurse Practitioner numbers.

There are ongoing discussions in regard to instigating a formal pathway for tracheostomy patients, with involvement from the Clinical Board Director of Nursing.

I was agreed some time ago that C&V clinicians need to liaise with other hospitals regarding agreement of an admission and discharge criteria, and linking with the Commissioning Team to consider penalties (e.g. financial) if local hospitals do not take patients back in the agreed timeframe. The Directorate is to review the policy for repatriation/discharge of traumatic brain injury patients.

Nephrology & Transplant

Suite 19 Haemodialysis Unit (UHW) environment falls below recommended standards, is not fit for purpose and is unable to comply with or maintain adequate infection prevention control standards. In addition patient experience is compromised as the environment is not suitable for its large population of medically/ physically dependant patients.

Turnover of patients is also high as a consequence of transient medical instability or reduced mobility. Higher patient frailty was naturally associated with higher mortality compared to other peripheral haemodialysis units under the supervision of the Nephrology and Transplant Directorate across South East Wales. These factors impact upon morbidity, mortality and patient experience, culminating in low staff morale and motivation. This has led to poor nursing staff recruitment and retention.

Suite 19 has increasingly been used to deliver haemodialysis to clinically complex patients. The environment, staff numbers and skill mix was not adequate to deliver this service. Work is in progress for Capital Bid to WG to enable a refit of the unit. This will facilitate both a fit for purpose environment on Suite 19 and the implementation a new model within peripheral haemodialysis units in South East Wales to dialyse more physically dependant patients.

The proposed strategy will increase capacity in peripheral units for dependant patients by improving staffing levels and facilities. Reserve a refurbished main unit for medically unstable/ most dependent patients. Resize the UHW main unit to focus on the highest dependency patients and acute dialysis support; and possibly accommodate the Renal Day Unit.

There has been earlier work focused on restructuring the nursing leadership of the Unit and providing Psychologist support to staff.

There is a plan for a tendering bid to be completed by the end of March 2017. WG monies will be released in new financial year. Work will commence in mid-2017.

CEPOD – The Transplant Surgeons have had difficulties accessing a theatre list at times. This delay in access can increase the cold ischaemic time of the donated organ and decrease the likelihood of a positive outcome in the transplant, loss of a potential organ or releasing the organ to another centre. The team require guaranteed timely access to theatre lists to avoid losing opportunities for solid organ transplantation (pancreas and/or kidney).

C&V UHB continue to work with the Welsh Renal Clinical Network to support the development of out of hours theatre access for transplantation be it via additional CEPOD or dedicated transplant twilight sessions. There are on-going issues with recruitment within theatres which has frustrated this development.

Recently the Nephrology & Transplant Directorate has been very successful in recruiting their own scrub team for the national organ retrieval service, creating attractive posts and conditions to facilitate recruitment and staff retention.

C&V UHB now have a monthly, minuted CEPOD User Group Meeting that has good Consultant Surgeon, Anaesthetist and Senior Theatre Staff membership. This provides a good platform for Directorates to provide prioritisation/escalation criteria for their respective services.

The UHB is working to confirm the plans for the new CEPOD provision in the Childrens' Hospital for Wales which should be fully functional by April 2017 and create additional capacity in the adult CEPOD list. Dr Shortland has confirmed that a Business Case is being currently processed to enable two CEPOD theatres 24/7. Work is ongoing through the SCRUM process to see if we can release any additional capacity for CEPOD.

The Executive Medical Director has requested that the Directorate ensures that this issue is represented in their risk register and that this is escalated and registered into the UHB's risk register. A Task and Finish group will be created to resolve this issue.

ACTION – N&T to finalise their Risk Register and send to CB by end March 2017

Dialysis Vascular Access surgery - Risks include performance reporting the service activity and access to adequate provision of a clinical scientist service with an expertise in Doppler examination of upper limb vessels.

Dialysis Vascular Access surgery is a key component of a successful haemodialysis service. The provision a good vascular access service requires the creation of a robust vascular access team which includes adequate vascular imaging services.

The service is currently constrained by its reliance upon a single handed Clinical Scientist to provide the pre-fistula assessments and surveillance scans – therefore a second post is required to cover any type of leave required by the clinical scientist. Secondly, there are insufficient Medical Coding criteria to capture the variety of Vascular Access Surgical Procedures leading to an under-reporting of activity. The funding allocated to Vascular Access Surgery by WRCN is arbitrary as a consequence of under-reporting of activity.

A business case has been submitted to the Clinical Board for a second Clinical Scientist. Vascular Access Nurse Specialists have been trained to undertake portable Vascular Access scans in Haemodialysis Units, albeit with limited expertise. Discussions with WRCN and WHSC are ongoing to secure equitable funding for this service by demonstrating activity.

ACTION – N&T to ensure this is on the Directorate RR

<i>Haematology</i> The Haematology and BMT service is currently delivered from facilities within UHW that are inadequate from a configuration, environmental, patient safety and capacity perspective and have been criticised by JACIE and HTA inspections in 2013. There is an urgent need to improve and increase the service's accommodation in order to comply with JACIE regulations and ensure accreditation to maintain our status as a transplant centre. JACIE are due to re-visit in January 2019, there is a real risk that the transplant programme will close if significant progress has not been made since their last inspection. UHW is the only BCSH Level 4 Centre in Wales, and is one of the busiest centres in the UK. The unit originally consisted of 6 purpose- built cubicles, but due to the growth of the BMT programme and increased availability of treatment this has now been increased to 10; which impacts on general haematology capacity. Over the past year, haematology has been utilising the facilities of the Tenovus Mobile Unit which has created some capacity within day unit and provides an option to explore ambulatory care within the Directorate. Staffing issues have been addressed with a nursing establishment increase, appointment of BMT CNSs and a third BMT consultant is due to commence in post shortly. A dedicated PICC service has also been implemented to free- up day unit capacity. Planning for the sustainability of this service is essential for the patients requiring transplant as well as for the organisation. In the medium term an area should be sought to increase inpatient, day- attendance and clinic capacity. The long term plan is to fully relocate to an area where all the departments within the Directorate can co- locate. A plan that is fully supported by WHSSC. <i>Medical Genetics</i> No representative from Medical Genetics was present to discuss their high risk items. HP noted that the Rookwood estate remains a 25 on the Neurosciences and CB RR and that it has been discussed many times at Q&S and a variety of other forums.	
<u>Health and Care Standards</u> Standard assessment is due in May. CF has developed a matrix of the standards with a lead identified for each one. The documents haven't been uploaded yet, the expectation is that the assessment will be in the form of an SBAR. <u>ACTION - Leads to start gathering information and all Directorates to supply information to the leads</u>	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT	
<u>Initiatives to promote health and wellbeing of:</u> <u>Patients</u> CM reported ongoing issues with the bathrooms on T5. A board has now been put up to cover the rotting wood in one of the bathrooms. Repeated flooding into one of the 4 bedders was also reported due to a leaking shower. This requires the use of towels etc to prevent slips in the water, however, they present a trip hazard to staff and patients. The flooding is affecting T4 as the water comes through the ceiling resulting in bed closures. <u>Staff</u> The Health Board seasonal flu vaccine profile illustrated that Specialist Services exceeded the	

	50% target for vaccination of front- line staff.	
SAFE CARE		
	<u>Health Care Associated Infections</u> <u>HCAI rates</u> VS reported that there have been 3 cases of C. Diff, no MRSA and 2 cases of MSSA in Feb to date. This is a slight reduction on the same time period last year. VS reported a possible case of rubella on T5. This has been escalated to Jason Roberts, Sarah Follows and Rebecca Aylward. It has also been flagged with Bernie Steer. A new RCA form is currently being tested to get better information from the process including lessons learnt. ACTION - <u>The form will be circulated for information by VS.</u>	
DIGNIFIED CARE		
	<u>Initiatives to improve services for people with:</u> <u>Dementia</u> The e-learning dementia training has been made mandatory by HSMB 16/02/2017, further information is to follow as received.	
INDIVIDUAL CARE		
	<u>National User Experience Framework</u> <u>Feedback from surveys – relevant improvement plans</u> For information and relates to email sent 21/02/2017 ACTION – <u>To be discussed at Directorate Q&S meetings</u>	

Date and time of next meeting Friday 17th March at 8am in the Critical Care Resource Room



Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 5TH January 2017 08:45 – 10:30
Venue: Seminar Room A

23.5

Present	Richard Evans (Chair)(RHE) Jane Murphy (JM) Kath Prosser (KP) Lisa Harwood (LH) David Pitchforth (DP) Alex Scott (AS) Alison Hayes (AH) - Minutes	Jill Adams (JA) Denise Shanahan (DS) Linda Edwards (LE) Ben Durham (BD) Helen Ronchetti (HR)	Sharon Parkhouse Carol Evans Andy Davidson Tara Cardew
Apologies	Delyth Jones Gillian Spinola Sian Brookes Barbara Davies Rebecca Owen	Gemma Murray Debbie Hendrickson Gaynor Jones Sharon O'Brien Jo Mower Sarah Follows	Jason Roberts Cathy Green Vicky Stuart Caroline Frain Jeff Turner James Coulson

		Action
A1	Welcome & Introductions RHE welcomed all present and passed on Jason Roberts' apologies. Secondary to the huge bed pressures experienced across both sites today he was needed in the Medicine Group hub and the meeting would be tailored to essential items to release staff to focus on bed pressures.	
A2	Apologies for absence Noted above.	
A3	To receive the Minutes of the previous meeting An amendment was needed to the minutes – KP to pass on the details to AH for amendment.	Completed
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	Patient Story SP presented the patient story – In October a patient on Sam Davies Ward with Parkinson's/Dementia and hard of hearing was very reluctant to interact with other patients/staff and required specialising in a cubicle 24/7. The ward approached a volunteers Music and Arts Group based in the Vale to support the ward, and reported that it had made a huge impact not only with this individual patient, but other patients by introducing painting and music with the patients in day to day activities. The patient now participates in singing solo and painting and has been transferred to a 4 bed bay where he is now happy to interact with other patients and is waiting to be transferred to an EMI nursing home. This has proven to significantly reduced the need for specialising this patient. The Music and Arts Group have had a positive effect on all patients participating. Funding is being sought from charitable bids for £9000 for them to continue with this work for a further	All to note

	12 months. SP reported that when patients take part in the activities in the day room this frees up time for the nurses to spend more time with other patients remaining on the ward. The group are also offering free courses for staff. RE asked if this story has been shared, it is a good example of how we can invest to save money and asked if SP could provide an A4 sheet of this patient story and details of the group for further discussion. LH also suggested that a poster be designed for the next submissions for Nursing Conference.	
1.2	Feedback from UHB QSE Committee Positive feedback had been received following the Clinical Boards paper being submitted and positive patient story.	
1.3	Directorate Risk Register's	B/f to next meeting
1.4	Directorates Terms of Reference QSE meetings progress up date–	B/f to next meeting
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	Up-date on Flu programme KP advised that the Board have currently achieved 44% up take for the Flu vaccine, but another 97 members of staff would be needed in order to achieve 50% target. It was noted this is a significant improvement from last year and thanked all of the Flu Champions for their dedicated input. KP felt that the flu champion spread was not quite right and suggested Ward managers or Deputy Ward managers be included as Flu Champions next year, this would enable the Directorates and Board to monitor accurate up take within areas which is not currently available. A flu video highlighting the risks of flu showing young adults as well as the elderly is available to watch and KP would like to share this at the next QSE meeting in February. The uptake-up for junior doctors has been quite good, however TC expressed that there was lack of Consultant uptake. RE asked how PCIC had achieved target but KP stated their total staff numbers were a lot lower than the Medicine Board so it would be easier for them to achieve the 50% target.	
2.2	QSI Framework CE shared the quality & Safety Framework which is being developed for 2017. In 2012 the framework looked at the main quality and safety priorities including complaints, claims and the outcomes of the internal inspections and audits. Big national reviews have been telling us about our main priorities and what we need to tackle as a UHB. The UHB Shaping our future, health and wellbeing aligned with the current Health and Care Standards Model would continue with the main aims being pulled from this, eg, Safe Care, Timely Care etc. Embedding QSE at Directorate level is important so Directorate support will be an area of focus. Working with specialist leads to see what their priorities are and where do we want to be in 3 years. Objectives for 2017-18 will be sent out in the next week and by the end of March we will have a fairly high level view of where we can be in 3 years' time, with the objectives hopefully signed off in February. Hyperlinks will be set up on the internet for all staff to see. The intranet page that will be set up will be a hub of information to share all the fabulous work throughout the UHB. JM agreed that we needed something like this to create consistency of standards	

	but how do we create this? How do we embed some of the ideas? As a Board we need to focus on this. CE advised that when objectives have been agreed a team will be aligned from the Patient Safety Team to provide support and mentioned the work going on around falls to provide the same consistent message and approach across the UHB. Recent HIW visits to two wards with the Clinical Board identified consistency issues. RE asked about one of the criteria's Point of Care Testing. CE advised that this is deemed a high risk area, and gave Blood Glucose Monitoring as an example. RE elaborated around the risks to UHL and Point of Care Testing in relation to the potential withdrawal of Laboratory Services and the potential risks associated with point of care testing.	
2.3	Local audit plan/ Health & Care Standards Assessment The Health and Care standards were discussed and it was noted that there were variations of self-assessment across the UHB, lack of recognition, probably over-recognition and over-scoring – however feedback was used to plan work and come up with priorities. Medicines management, medicine devices will need a different approach. The remaining standards process will be the same as last year with the same RAG rating score being applicable. It was highlighted that the Clinical Board Health Care Standards should be used as a tool using a brief SBAR for each standard focusing on the quality rather than quantity of the key areas that are doing well and those areas that need further development. Clinical Audit – AS shared that a new system for clinical audit will be in place by February and how this could support the Clinical Board. There are currently 200 audits within Medicine Clinical Board recognising that some of these are not be captured accurately. RE shared that there is generally a large number of audits often carried out by interested clinicians but not done through Directorate teams therefore not reflected within the audit figures. It was also noted that there were two streams of audits, encompassing both nursing and medical. AS explained the IT solution will be a more transparent system with all activities on there so you will be able to see what has been abandoned. There is an enormous amount of resource going in to audits but nothing is getting done with it. There are only a few people in the audit team and they undertake the national programme as discussed previously. Some support can be offered but it can't be guaranteed. 200 audits are going on within Medicine Clinical Board and how do we prioritise these audits against national audits.	
2.4	Top ten Health Technology Hazard 2017	b /f next week –
2.5	NICE guidance proforma request Dr J Mower: <i>Title of Guidance: CG155 - Psychosis and schizophrenia in children and young people: recognition and management</i>	b/f to next meeting
SAFE CARE		
3.1	New Serious Incidents KP shared with the group that there are currently 17 open SI's for the Medicine Clinical Board with 4 new SI's reported for December. These included 2 Injurious Injuries and 2 delays with diagnostics and treatment.	

WG closure forms for discussion and shared learning

In355403 - Patient on Sam Davies Ward Barry suffered a fall and injurious injury. Following the completion of the Injurious Assessment the root cause of the fall was deemed to be secondary to poor fitting foot wear. The investigation noted that the patient had not been assessed for inappropriate foot wear on transfer, and the transferring ward has not shared this information with the receiving ward. Since this incident all patients are assessed on admission for appropriate footwear and documented within the MDT notes. The Ward keep a small supply of footwear within the ward area for patients until relatives or carers can provide new footwear. The Injurious Assessment was also shared with the transferring ward at UHW to share learning.

In235442 – Patient admitted with alcohol liver disease was nursed in the Assessment Unit Lounge overnight and prescribed CIWA. Unfortunately this was not given as prescribed and the patient had an alcohol related withdrawal fit the following morning, was admitted to Critical Care and sadly died. Following the completion of a Root Cause Analysis investigation the following was noted: The lack of inpatient bed capacity and extreme pressures experienced within the Emergency and Acute Medicine Departments contributed to the patient remaining in the Lounge in a chair overnight. There was uncertainty from the staff involved if a patient could receive CIWA treatment whilst sat in a chair, which resulted in this not being completed as per guidelines. The patients observations were not accurately recorded with the NEWS chart which may have alerted the staff to the patient beginning to withdraw from alcohol. Prescribed Vitamin K had not been clearly transcribed within the patients drug chart therefore nursing staff sought medical advice regarding the correct prescription, therefore there was a delay in this being given to the patient. As a result of this incident the Assessment Unit have developed a Standard Operating Procedure for patients who are being nursed within the Lounge area which allows staff a clear means of escalating via a Matirx score identifying patients who require a trolley space in order to commence treatment. There is a clear line of escalation in hours via the Medicine Control Hub and out of hours via the Site Manager. The Clinical Board continue to work of timely flow of patients and patient discharges including deep dives within ward areas to escalate discharges. Joint working continues across all Clinical Boards to ensure timely patient flow with dedicated members of staff being available to escalate constraints. The AEC is due for completion in January which will improve the flow of patients through the Assessment Unit Lounge. All staff have received CIWA training and NEWS training. A Substance Misuse Nurse is available within the Acute Assessment Unit for advise and support. All staff involved have written a reflection as part of their NMC/GMC revalidation.

In360353 – Injurious Injury East 4. A patient had been transferred from an Orthopaedic Ward for treatment of an unstable INR. The Injurious Assessment found that the patient was known to be sat out in the chair early in the morning, stood and lost their balance and fell sustaining a fracture. The assessment noted that the patient had appropriate footwear in

	place, was deemed a risk of falls and that the risk assessments had not been re-evaluated on transfer to the ward. The Hover jack was also not utilised as per NICE 2015 guidelines. All staff have been reminded of the requirements to ensure timely completion of risk assessments, and regular audits continue to monitor compliance. Education regarding the correct use of the Hover jack for an un-witnessed fall continues.	
3.2	Patient Safety Alerts National Safety Standards for Invasive Procedures (NatSSIPs) – An update on progress within Directorates is needed. There were a number applicable to us but not all and these are with CDs and DMs to identifying procedures and get them written up.	
3.3	Health Care Associated Infections HCAI rates CDiff/MRSA RCA reports were noted. KP raised concerns regarding the six cases of MSSA reported in December and requested that the RCA's be completed in a timely manner to understand any areas of potential concern, themes. Learning from MRSA RCA Flu outbreak Mental Health and associated learning	<i>b/f next meeting</i> <i>b/f next meeting</i>
3.4	Acinetobacter outbreak up date A7 HR updated the group regarding the Acinetobacter outbreak on A7 before Christmas. The area has been re-commissioned and the ward is open. Areas for further improvement work were noted as not being completed but it was reported that these will be rectified.	
EFFECTIVE CARE		
4.1	Care indicator guidance	<i>b/f next meeting</i>
4.2	Datix Pressure Damage – pivot table available for staff to review	
4.3	Director of Nursing Quality & Safety Report November and dashboard	<i>b/f next meeting</i>
4.4	Anti – biotic Health Check	<i>b/f next meeting</i>
4.5	ANTT up date Papers available for staff to up date. Whilst ANTT is well embedded within Acute and Emergency Medicine the UHB with the LED department are implementing the role out programme. Caroline Jones is the Board lead for this.	
4.6	Thromboprophylaxis re-assessment VTE up date	<i>b/f next meeting</i>
DIGNIFIED CARE		
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans Progress update East 4/East 1 HIW report RE requested that the timescales be up dated to reflect changes. JM to send KP updated action plan.	JM

	C6/C7 – DP advised that the immediate actions required were to remove patient identifiable information from the Boards visible within the ward areas. Patients full names have now been replaced by initials on all Boards. Sheila Harrison is discussing the corporate response to this request.	
TIMELY CARE		
6.1	Waits within Emergency/Acute Medicine RE discussed the pressures experienced over Christmas and the new year there has been lots of good work being done under huge pressure with deep dives are continuing to promote timely patient flow. JM shared that these are currently identifying a lack of social services secondary to the Christmas period which is impacting on current flow.	
6.2	Waiting list assurance up date RE reported that improvements were noted, recognising that there are still difficulties within Gastroenterology which is reflected within the Serious Incidents reported. A further update will be shared at Formal Board this month.	
INDIVIDUAL CARE		
7.1	National User Experience Framework Feedback from surveys – relevant improvement plans	<i>b/f next meeting</i>
7.2	Complaints and trends – no one available from the concerns team to present. Compliments shared and available to staff	
Staff and Resources		
8.1 8.2	Staffing levels/Winter pressure wards RE discussed that Winter Capacity has been opened noting the staffing pressures associated with this. Assistance has been given from other Clinical Boards to support with staffing. JM advised that from a C2 perspective the biggest risk is that there is no flex in the system when asked to flex bed capacity balanced against nurse staffing which has been noted as being difficult, but the risks are being well managed on a day to day basis. LH advised that W3 was planned to open this weekend and there are still some therapy input concerns which may result in the model not being correct. RE wished to convey his thanks to all the staff for their hard work and his gratitude to the other clinical board for their help.	
8.3	Mandatory Training categories paper circulated for staff	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		

Date and time of next meeting: KP informed attendees that as from February the Board QSE meetings will be rescheduled for the 3rd Thursday every month. The next meeting would be on Thursday 16th February 2017 14:00 – 16:30.



MINUTES
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 16th February 17 14:00 – 16:30
Venue: Classroom 2 Upper Ground Floor

23.5

Present	Jason Roberts (Chair) JR) Rebecca Aylward (RA) Jane Murphy (JM) Lisa Harwood (LH) David Pitchforth (DP) Alison Hayes (AH) - Minutes	Ben Durham (BD) Helen Ronchetti (HR) Gemma Murray (GM) Gillian Spinola Alun Morgan Vicky Myson (VM)	Sharon O'Brien Jo Mower Suzie Cheeseman
Apologies	Delyth Jones Sian Brookes Barbara Davies Rebecca Owen	Denise Shanahan (DS) Andy Davidson Sharon Parkhouse	Kath Prosser (KP) Richard Evans (RHE) Sarah Follows Sarah Dix Cathy Green John Peters

			ACTION
A1	Welcome & Introductions	Jason welcomed everyone to the meeting.	
A2	Apologies for absence	Noted above	
A3	To receive the Minutes of the previous meeting	AH confirmed there were no actions from the previous meeting other than agenda items b/f to this meeting.	
	Matters Arising		
1.1	Patient Story Emergency/Acute Medicine	VM presented a patient story for a 31 year old male with newly diagnosed Diabetes who presented to their GP unwell with a history of lethargy. The patient arrived in AEC at 12.00 midday and was triaged at 12.15. Routine investigations and observations were carried out. At 5.15 the patient was reviewed by the medical team and diagnosed with Type 1 diabetes and agreed that the patient could be discharged home with a follow-up appointment for the following day. The patient re-attended the AEC department at 09.00 a.m. and had a diabetes specialist review, was given a prescription at 10.10 a.m., this was not dispensed until 13:45. Feedback from the patient following their attendance to the department was reported as: - 'When he attended the AEC on the 1 st day he was scared after being diagnosed with Type 1 diabetes, and was told he needed insulin injections but was sent home without any information or contacts numbers. He went home feeling scared and was worried that in the event of him feeling unwell overnight he would not know what to do or who to contact. The following day he saw a diabetes specialist and nutritionist but had to wait for 2 hours for a prescription which was a concern. He received no senior medical review for that period of time. There was no vending machine available to purchase food/drinks, as the Vending machine wasn't working. The patient (accompanied by his wife) were sitting by the discussion board and they felt they could hear private patient information. The chairs were uncomfortable	All staff to note

		and they felt their visit to AEC was a waste of time. Overall patient waited for 5 hours, 2 hours for the prescription. SOB – Discussed that if we didn't have the AEC area the patient would have stayed overnight on a trolley within the main Assessment Unit. Most patients would prefer to go home. The patient saw the diabetic specialist team and nutritionist in the same area, previously if he had been admitted to a ward this would have taken a few days. Learning points – - Patient expectations need to be managed. - Dietician and Diabetes and CNS – this could have been done on a hot clinic. - Extend pharmacy opening hours.	
1.2	Feedback from UHB QSE Committee	Positive Feedback had been received.	
1.3	Directorate Risk Register's	As KP the lead on this wasn't in attendance it was decided to b/f this to the next meeting.	. b/f
1.4	Directorates Terms of Reference QSE meetings progress up date	As KP the lead on this wasn't in attendance it was decided to b/f this to the next meeting.	
2.1	Up-date on Flu programme	Medicine had achieved 47.8% just missed the 50% target. In order to have achieved the 50% target a further 36 vaccinations would have been required. This is a significant improvement from the Clinical Boards performance last year, and the increase in the number of Flu Champions is noted as being a major contributing factor. After discussion it was noted that if staff are declining they should be filling in the forms and sending to occupational health as these can be counted in the figures.	All staff to note
2.2	NICE guidance proforma request Dr J Mower: <i>Title of Guidance: CG155 - Psychosis and schizophrenia in children and young people: recognition and management</i>	(JM) We are non-compliant, this is reported back up and it goes to individual leads.	
2.3	Falls up-date: Steady on Stay Safe campaign	(AM) gave a talk on the Falls Delivery group. Everyone is aware of the issues around falls. The Patient Safety Team reported 3637 patient accidents and inpatient falls in the organisation, noting this is an improvement on 4500 the previous year. One issue we continue to have are patients who sustain significant injuries i.e. fractures. October to December 2016 there were 11 SIs that were reported to the Welsh Government, this is the highest volume reported. It has been reported within the Clinical Board of a Regulation 28 which relates to the correct completion of neurological observations post injurious injury in line with NICE 2015 guidelines. The reconstituted falls group sits within the Patient Safety Team and Alun Morgan and Karl Davis are the main leads with representatives from all Clinical Boards forming part of the group as well as Primary Care colleagues. KP will be linking with all Directorates to implement falls champions. It was noted that there is good work going on in the Medicine Clinical Board around falls such as the recent Sensor Matt and slipper sock trials. The falls delivery group are looking at all the information available to make it simpler to share. To get engagement from all stakeholders to avoid duplication. DATIX development of this gives high levels of information of falls. Hopefully we should be able to	Training around risk assessments – b/f next month – (AM)

		do this for the directorates as well as the clinical boards to see hotspots. Key messages - lessons learned from SIs. – - Reinforcement of falls risk assessment, actions to be implemented when risks are identified. – - Campaign at Christmas 2016 – Footwear - Proper supervision in place to support bathroom needs as this is a key risk factor. - Accurate assessment of specialising needs. It is variable across the organisation but these messages need to be shared. National leads sit on our delivery group. . – - (JM) Risk assessments/lack of – it has come up in claims/concerns that they aren't being completed but they are not particularly user friendly (Falls Assessment), how are the group looking at how we get staff to comply. It is a big concern. Is the group linked with a specialising group. (AM) – In terms of training he will take this back to the group. There are so many forms for completion they are very lengthy/time constraints/ quite complex. We can aim to streamline these. Training and compliance with risk assessment is the theme that is coming through. This is the purpose of the group bringing things together. – Training around risk assessment to be put on AM next meeting	
2.4	NCEPOD Report "Treat as One" - Mental Health in General Hospitals	We completed what we shared in last Q&S – briefing from ED point of view. Around service level hours - people are waiting for a long time. Psychiatry liaison team and out of hours service is where we are not compliant.	
3.1	New SIs WG closure forms for discussion and shared learning	In33388 – GP referred patient with skin lesion that turned out to be a squamous cell. The issue at the time was with the time delay with Tele/dermatology referrals. The Teledermatology Service is no longer being used within the Health Board and there is only one route of referral for all patients which means that there should be no issues. In37347 – Fall - fractured right ankle – All risk assessments had been completed in line with best practice. Whilst no concerns were noted in relation to this fall, it is important to share and learn from all inpatient falls.. In37936 – Fall – fractured rib and subsequent Hameathorax. The Injurious assessment found that of the required risk fall falls assessment had been completed. The patient was known to be fully independent whilst mobilizing and that a low sodium may have resulted in the patient falling. Post Injurious Injury it was noted that the preferred means of lifting a patient from the floor following an un-witnessed fall with the Hover jack was not utilised. This has been reinforced with all staff. In23923 Patient transferred to EU following a fall at home with a known history of non-compliance with Haemodialysis, and had missed several dialysis sessions prior to attending the department. The patient was non-compliant whilst in the department secondary to wanting to leave the department to have cigarettes despite being advised not to by nursing and medical staff. There was a delay in obtaining bloods and the sample being batched within the laboratories, noting the patient had a high potassium level which required urgent medical treatment. It was also noted that the patient was difficult to cannulate but the patient had a central line in situ that was used for dialysis. Unfortunately whilst the medical clinician who was caring for the patient recognised the high potassium result once reported there was a delay in starting the required treatment, the patient collapsed and sadly died following an unsuccessful resuscitation attempt. The learning identified from this incident is that a pathway is in the process of being developed between Transplant and Nephrology and Emergency Medicine for all Dialysis patients who attend the Emergency Department. Any	

	Endoscopy Risk Briefing Paper	patient that has a blood potassium result greater than 6 should be referred to the most senior clinician within the Emergency Department to ensure that all required actions are undertaken. This wasn't discussed. – b/f to next meeting	
3.2	Patient Safety Alerts	National Safety Standards for Invasive Procedures (NatSSIPs) – update on progress within Directorates WHC 2016-052 Carbon Monoxide Patient Safety Alert January 17: PSA007 Restricted use of open systems for injectable medication	- JR to discuss with Richard Evans For information -
3.3	Health Care Associated Infections HCAI rates CDiff/MRSA RCA reports Progress with relevant improvement plans Learning from MRSA RCA	(HR) C6 – There is currently a C difficile outbreak on ward C6. WAG targets – January there were 6 cases of C difficile attributed to the Clinical Board. All RCA's have been escalated for completion. Noted that there has been an increase in the number of C difficile cases on Ward East 4, meeting planned with IP&C to review the RCA's Patients with cannula – 26% compliance with VIP scoring, it is useful to have this information. In UHW some wards are doing better than others but compliance is on average 26%. This is based on an audit of 3 patients per ward /per week. – Some MRSA admission screening reports 11% compliant with admission screening. RCA completion – 6 outstanding in total for CDIF, 0 for MRSA and 6 for MSSA – (JR) any trends? Usual VIP scores/care of line and a couple outstanding from assessment unit from AU. There are 5 action plans outstanding since December. The need to be completed after audits but we are still chasing up action plans. NEW – MDRO procedure – new admission risk assessment approved by IPCG, (SOB) – This assessment is so long it is not being done. Swabs are being done but we have to have an awareness of practicalities of what we want done on these assessments it is weighing up prioritisation. (SOB) we can complete the risk assessments but we have to ensure we are isolating on the Ward. We keep Infected patients in open areas at the front door. When winter beds close we need an empty ward on site to flex up if we needed to. IP&C – (JR) we need a Clinical Board Group this needs to be revamped.	(JR) to set up IP & C Clinical Board Group
3.4	Covert Medication	For information and circulation to the group. Each health board needs to reflect covert medication can only be given in the best interests of the patient. There is a policy in place. Specialing – DOLS assessments are undertaken – there is also a prompt on the clinical workstation that a DOLS assessment is required.	
4.1	Anti-biotic Health Check	Shared with the group.	
4.2	Director of Nursing Quality & Safety Report January and dashboard	Medication errors – noted to be stagnant Concerns –January – 16% in January – This performance needs to be improved. (JR) to arrange with Sarah Dimond-Garcia and Sarah Cornes Payne a meeting to discuss how we push for more responses. Complaints are now Graded 1 to 3 – Complaints graded 1 to 3 the Nurse Directors have the final say and responses can be signed off and posted straight out to relatives/carers. The Executives will keep concerns graded 4 and 5 and Assembly Members responses. (JR) to agree new process for complaints to avoid delays. - Concerns to delegate who deals with the complaint.	

		- Copies of final responses to be sent back to directorates/lead nurses, at the moment once final response is ready they don't receive copies. 30 new concerns were received in January / 5 have gone out on target 22 are ongoing but within target. (LH) a couple of meeting cancellations haven't helped. – Falls 156 and 159 are up again – 72 FTE nursing vacancies + Extra winter Beds have added to operational pressures.	
4.3	Thromboprophylaxis re-assessment VTE up date	For information	
4.4	Look out! Bedside vision check for falls prevention	Discussed at falls 2.3	
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans	J Murphy/L Harwood Progress update East 4/East 1 HIW report HIW visits C7/C6 – East 4 – having reviewed the action plan the majority of actions have been implemented, with one significant area based around oral care. Are the actions implemented being sustained? – JM wanted to ensure that things will be sustained long-term – JM to meet with Ward Sisters to discuss Action Plan/need to continue with this but there are some issues around culture. There have been lots of good practice and learning noted on East 4 that needs to be shared i.e. pain management/pain charts and how this can be implemented across the Clinical Board. This is an ongoing project and the learning and actions continue to be shared at Board QSE. East 1 – All actions completed. C6/7 – CHC action plans all completed	To note
5.1	PSOW report shared learning		Not discussed b/f next meeting
6.1	Waits within Emergency/Acute Medicine	Chair/K Prosser Waits – to be noted	
6.2	Stroke up-date	All work that is being done with the stroke team and EU seems to have dramatically improved our performance. We have gone from an E to a B (A being the top score) which is a significant improvement. The constraints are on bed availability. Protecting stroke beds are the issue. Out of hours are far better than in hours, getting patients in the right beds are an issue as beds are being used for outliers on a frequent basis. Thanks to all the staff for all their hard work.	All to note – Thanks to all staff for their hard work
7.1	National User Experience Framework Feedback from surveys – relevant improvement plans	K Prosser	
7.2	Complaints and trends Compliments	C Frain/V Stuart Themes were noted to be around the lack of communication with patients, medical intervention and discharge planning.	To note
8.1	Staffing levels	Medicine have a 72 FTE nursing vacancy rate across the board. Anticipation is that between now and July, 38 staff should be recruited. There is a considerable amount of work ongoing. It is noted that there are a number of overseas registered nurses working through their adaptation programme. We still have a dribbling of overseas nurses being recruited. It was noted that the Skype event in Cardiff -numbers are not being seen. A recruitment	

		event has been planned for March in Edinburgh which JR is attending. We need to try and pull together a process where we can sign the nurses up at these events / LN to do Skype interviews. Twitter and Facebook. Adverts can be done via Twitter and Facebook - could this be done with all nursing vacancies. To discuss with CMcA (JM) – There are concerns about B7 staffing levels as there are currently 12 Band 5 vacancies. It is noted that this is proving really difficult to manage, there are 3 Band 5's coming in to post. There is also a newly appointed Ward Sister. JR and JM to meet to discuss B7 in greater detail. GS reported that there had been 14 applicants for the Band 5 Endoscopy Nurse.	CMcA – To advertise all nursing posts on Twitter & Facebook JR to arrange meeting with JM to discuss B7 staffing
8.2	Winter pressure wards	Winter pressure wards remain open at UHL and UHW. It is thought that C2 may have to de-commissioned earlier than planned due to operational pressures.	
8.3	Mandatory Training categories	B/F to next meeting	
8.4	Congratulation to the Parkinson's Team – shortlisted for Parkinson's Excellence Network Awards	Well done to Parkinson's Team they have been shortlisted for 2 awards. Shortlisted in the first ever UK Parkinson's Excellence Network Awards. The awards, which are the first of their kind, aim to recognise and celebrate outstanding services that make a difference to people in the UK affected by Parkinson's. Of more than 40 entries, seven finalists have been chosen to be recognised as part of the inaugural awards ceremony.	All staff to note.

Date and time of next meeting: 16th March 14:00 – 16:30 Wound Healing Seminar Room UHW



Medicine Clinical Board
Quality, Safety & Experience Committee
Held on Thursday 16th March 2017 14:00 – 16:30
Venue: Wound Healing Seminar Room

23.5

Present	Rebecca Aylward (Chair) Richard Evans Katherine Prosser Gillian Spinola Sharon O'Brien Helen Ronchetti	Helen Ludlow David Pitchforth Gemma Murray Suzie Cheeseman Sarah Dimond-Garcia Lisa Waters	Joseph Grey Denise Shanahan Alison Hayes
Apologies	Gaynor Jones James Coulson Hannah Rix Angela Hughes Jeff Turner Jason Roberts	John Green Cari Randall Delyth Jones Wendy Roberts Barbara Davies Lisa Harwood	Jane Murphy Gareth Edgell Angela Jones Jo Mower Tara Cardew

Preliminaries		ACTION
A1	Welcome & Introductions – Rebecca welcomed everyone to the meeting she was chairing the meeting as Richard Evans was on Ward C2 and would be arriving a little later. Jason Roberts was on Leave.	
A2	Apologies for absence – All the apologies were noted	
A3	To receive the Minutes of the previous meeting Matters Arising – Minutes to be amended to show Suzie Cheeseman and Gemma Murray as attending. IP&C Operational Group – This group has been set up and the initial meeting took place on 09 March. Video Conferencing will be used for the next meeting on 13 th April on Llandough and UHW sites. The HIW inspection feedback session coincided with this meeting so Emergency Medicine unfortunately were not represented at this meeting. Adverts – Twitter and Facebook to be used with external adverts – Caroline McArdle has organised this and adverts are also going out via twitter and facebook. B7 staffing – Jason Roberts to meet with Jane Murphy to discuss B7 staffing. B7 staffing has been discussed at the weekly scrutiny panel.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
1.1	Patient Story Gastroenterology, Hepatology & Endoscopy - Patient attended emergency unit on 06 October 2016 with increased abdominal distension. He had ascitic drain inserted this was undertaken but management plan for drain was not reported. He was reviewed on Monday 10 October. The incident was reported due to inadequate ascitic drain and inadequate management plan in place. Action plans to be put in place: - Root causes for concern - Why do we need to transfer patients from UHW to UHL during weekend periods? Was handover adequate between hospitals and was ascitic drain managed appropriately i.e. how long can the drain can be left in? - The service fell below expected standard. Due to number of acute admissions insufficient capacity at UHW required transfer of patients to UHL. Patients with chronic liver disease are managed on West 1 appropriately that is why patient was transferred to this area, however there is acute cover only on weekend so nobody to say whether patient was stable for transfer. Handover would have allowed ascitic drains, the drain was left in situ – there was	

	evidence decompensated liver disease but the outcome may have been unchanged but avoidable patient harm. The patient died as a consequence of a fall, hospital acquired pneumonia. - Lessons learned – Patient flow team - Existing capacity to support transfer of patients to UHL to create capacity on UHW but the right team needs to be in place. Medicine Clinical board handover processes need to be reviewed, medical review of patients before transfer of patient should be documented when they leave one site to go to another. An audit of notes to be undertaken in the assessment unit as well as receiving ward in Llandough. An anaesthetic procedure chart has been developed and is available on the internet. An action plan is being developed based on these recommendations. From an AU perspective nurses in charge on shift will do a spot check on documentation that includes risk assessments, nursing documentation and news and pain scoring. There is something that needs to be initiated to ensure consistency. With regard to patient access the weekends are still not addressed. Patients in AU aren't looked at pre-weekend. Who made decision to transfer this patient as there were no names in the notes. It is Not about blame it is about improving the process. During the week senior nurses would be involved but weekends are different and an action plan needs to be developed.	
1.2	Feedback from UHB QSE Committee – CD & T had to present at Exec this month. This is available on the internet.	
1.3	Directorate Risk Register' Not discussed	
1.4	Clinical Board Risk Register review Not discussed	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	Falls and Fragility Fracture Audit Programme – The next audit is in May and they will also be looking at community hospitals as well. Denise Shanahan is looking for volunteers to participate in this, Alex Scott is co-ordinating but it is really useful for people to take part. The next advisory group meeting is in April, they are not sure how they are going to capture all the data yet.	
2.2	Gastroenterology Clinical Specialist Nurse Helen Ludlow presented "Outcomes of Macmillan Role" - The last 2 years Llandough hospital have had a MacMillan Funded Nurse (inflammatory bowel specialist nurse) The patients that are being seen are patients with bowel problems, pelvic radiation that has affected a patient's life. Helen has electronic posters that need to be put up in patient areas to advertise this service. BJN article published –Stories of patients are devastating. Patients destroyed not by cancer but destroyed by the treatment. Promoting round south wales. 90% of patients continue having bowel problems up to 30 years after treatment. Many gastroenterologist don't know what to do with them. Nurse led service is provided. It is a new service but Helen can only see the numbers growing. Up until 10 march 101 patient have been dealt with, patients with low vitamin B12, low Vitamin D, patients with bleeding vessels, adenoma polyps and 10 cases of diverticular disease have been picked up. We have picked up a few cancers, pancreatic cancer, renal cancer and 2 colorectal cancers and patients are back on the road to recovery. Bacterial overgrowth 9 – 1/5 of the diarrhoea symptoms are sorted by cheap medication and it is changing lives.	Helen Ludlow to email Lisa Waters posters to put up in A&E
2.3	Look out!! Bedside vision check for falls prevention "Look Out" – National audit we did badly. The visual tool has just come out and we are going to do badly again because nothing has been implemented. We need to pull something together that works. There are	

	10 questions that you can follow to check the visual field to prevent falls. Newly qualified staff – Visual loss needs to be known to manage care to reduce the risk of falls. Sharon Parkhouse, Lisa Harwood and Kath Prosser to link in with Denise Shanahan to discuss implementing Look Out. (SOB) Feedback from staff is that it is too much to do. Lie and Standing BP and standard BP - Clear instructions are needed to incorporate this and we also need to give common sense direction to staff, sensible messages need to be given out.	
SAFE CARE		
3.1	New SIs 26 SIs in Feb -1 MRSA on part 1 Death certificate, 1 treatment/diagnosis delay and 5 injurious and a further 4 have been reported to date which includes 2 further injurious and 2 Grade 3- 4 which were hospital acquired pressure damage. All Falls pathways are visible but for whatever reason Neuro Obs aren't being completed. How do we instil this process, how many people have suffered harm. The staff involved need to realise the consequences of not completing the Neuro/Obs as they should. Do we issue an SBAR as a Board on what Neuro Obs are to be done in line with NICE guidelines? WG closure forms for discussion and shared learning • In35358 – 73 year old male with history of rectal cancer in 2014, he had a post op colonoscopy in September 2015 for renal polyps, advanced endoscopy showed low grade dysplasia, he was reviewed in March 2016 - a 7 month wait for an urgent cancer patient where the 2 week referral should have taken place. - Key points – Lack of escalation within the directorate and ongoing timeous issues, identify urgent / routine cases. This has been fed back to individuals - Outcome - Recommendations that a clinical/clerical validation of all patients on waiting list, suspected cancer patients be reviewed weekly at Directorate Meeting. Patients to be sent letters with existing waiting times and to seek advice in change of symptoms and we need to increase the amount of endoscopy being done. We can't cope with the increased volume of procedures. • In35542 – Patient referred for priority urgent procedure list, pathway was logged as cancer processes – pre-dates cancer flag • In35640 – 79 year old male iron deficient – GP sent in an urgent colonoscopy referral in June 2016 as cancer was suspected. Patient was advised by St Josephs hospital in November 2016 (treatment was outsourced) that he had cancer, it was felt that iron deficient anaemia patients should have been seen within 2 weeks not waited for 5 months. • In36978 – Patient treated in private sector for rectal bleeding. After CT and recurrence was referred for urgent colonoscopy, referral was vetted as urgent on 07 march and seen in May, discharged from clinic. After an 8 month delay (but vetted as urgent cancer patient) for colonoscopy, patient was diagnosed with colon cancer, original private CT cancer was evident at that point • In37740 – Patient with previous history of surge colorectal cancer was due for follow-up in June 2016, he was seen in October 2016 and referred for colonoscopy which was done in December 2016. Patient is waiting for staging, he was a high risk patient and was 6 months overdue for surveillance appointment. • In40809 – Patient underwent planned colonoscopy surveillance due in May 2016, patient seen in Jan 2017 he was diagnosed with colorectal cancer. 8 months past surveillance dates he was over 80 years old as a result of this SI combined action plans have been put in place - Root causes – Limited capacity due to high number of patients on waiting lists. We are exceeding RTT and JAG targets due to	

lack of endoscopy, lack of review of waiting list for specialist procedure and lack of consultants, resulting in cancer. Not tracked by the Gastro Directorate and a number of appropriate referrals are being tracked but with outdated procedure codes on PMS lists.

- Outsource centres are now informed of suspected cancer on the day of procedure. Patients prioritised outside NISE guidance.
- Direct feedback – Cases and guidance presented at directorate team meetings, all issues are being addressed. We are trying to do something about these waiting times.
- Assurance – It will take us 18 months to catch up on the surveillance backlog.

- **In39771** – Patient had a witnessed fall on Elizabeth Ward and suffered laceration to the head and right wrist. He was transferred to Emergency Unit where he had a CT scan and neuro-obs were done. Reading through history he had suffered a previous fall in Royal Glamorgan hospital, Patient had an **acute subdural** hematoma but was this a result of the fall on Elizabeth Ward or as a result of the previous fall, this couldn't be evidenced. All risk assessments had been completed but there was inconsistency in timelines. Lessons Learned – Staff have been reminded of accurate and timely documentation. Fall stickers are being used. Everyone needs to be doing the same.
- **E-learning falls training on-line** is out of date this needs to be updated as we are measured against this. (DS)
- **In39000** – Grade 3 pressure damage. Patient had previous history, prior to transfer to B7 patient was cared on surgical ward. Patient wasn't repositioned on B7. It was noted during investigation that pressure damage was deteriorating whilst on surgical ward. Ward has practice development nurse and there is good education on the ward re pressure damage and they are raising safety briefings. There is a lot of staff undertaking good learning on this ward. B7 are under pressure with the amount of agency usage.
- **In39877** – MRSA septicaemia – Following completion of root cause, patient had previous history of MRSA and was last screened in March 2016.
- MRSA Learning –Any wounds, any previous history patients should be screened on admission. Stickers on patients notes are used, they are considering if board or corporate. It needs to be carte blanche, continuity is needed throughout - BIP stickers on the drug chart.
- **In24032** – **EU Dept** - Anaphylaxis – Clinician gave a dose of adrenaline to patient who became unresponsive. A defibrillator was used and the patient was kept overnight for observation. **Intravenous accidental prescribing** – the clinician is aware and was noted to be distracted at the time as they had come from clinical care and they weren't explained to properly. Was that 2nd dose of adrenalin required? Staff have since met with patient and no further feedback has been obtained. The Nursing staff involved have attended immediate life support anaphylaxis training. It is now closed.
- **In26352** – EU Department - Mental health patient was found wandering, patient was known to the crisis team, he had absconded from them. While in the EU department he was assessed by the EU team, unfortunately patient left the mental health room, patient had been assessed by the mental health room and they said she was free to go. Unfortunately patient left the department and jumped over the bridge, she sustained serious injuries.
- **Learning** – Could she have gone back to crisis team/Hafan

	Coed? Patient absconded from the mental health area in Emergency Unit, there is an escape mechanism in place in this area but if they aren't detained under the Mental Health Act we aren't able to hold them. A scoring system is done for mental health patients (Bristol Mental Health Matrix) to identify high risk patients. They should see patient within 1 hr but the Mental Health Team can't get here within the hour. CCTV funding has been sought, a bid has been put in for a CCTV camera. Mental health booklet to include DOLS and Bristol mental health matrix is waiting to be authorised to print. Emergency unit is not the appropriate place for a mental health patients. If we feel the patient is high risk we will ask for 1 to 1 specializing. Endoscopy Risk Briefing Paper – Procedures are in place (see above) we are looking at outsourcing but it is going to take a long time. Weekend initiate lists are being done but it is going to take about 18 months to catch up.	
3.2	Patient Safety Alerts National Safety Standards for Invasive Procedures – (NatSSIPs) – In a standardised way set by the Welsh Government – some standards are straight forward but there are a couple of niggly ones. We need to agree what needs to be done in multiple departments. Meetings can be attended by clinical nominations on our behalf. Diane (Respiratory), John Green (Gastro) – Jo Mower (EU) – things that are specific. – Problems with - - can you re-circulate in your area	
3.3	Health Care Associated Infections HCAI rates CDiff/MRSA RCA reports Progress with relevant improvement plans Learning from MRSA RCA IPCF Meeting has now been set up – 2 wards have been selected.	
EFFECTIVE CARE		
4.1	Anti-biotic Health Check – ongoing.	
4.2	Medicine Antimicrobial audit – ongoing.	
4.3	Director of Nursing Quality & Safety Report February and dashboard – Key messages – Please can wards close down their patient safety incidents – we need to push on this. IPC – New Group has been set up by the Board B7 procedure room – Ruth made a directive at Executive Review this is not to be used for additional patient capacity, it must be locked out of hours and senior nurses put in charge of the key. Patient access have been informed. HIW feedback – EU and Llandough HIW Inspection – Feedback has been given verbally but we are still waiting for the formal report. HIW - EU – EU had great feedback from HIW, they had a good experience in EU and were delighted. SOB was on leave but conveyed her thanks to all the senior nurses for all their hard work as the volume of stuff requested by HIW was incredible, off duties, training records, databases, it wasn't just clinical assessment they wanted to see everything. The visit was unannounced, there were positive comments re the interaction between staff and patients and the care being provided, excellent nurse communication and patients felt they were aware of what they were waiting for and the care received was of a high standard. Sepsis work, nurses meds management, education team and development of staff, senior leadership was good. Room for improvement – a lot of databases for PADR records, it would help to have less databases for recording training. Paeds environment – This needs redecorating, Pain scoring – Nurses were giving pain control and this wasn't recorded clearly enough. It wasn't felt that patient were in pain, unnecessary painkillers given. HIW (Llandough) This was also a positive report.	

4.4	Clinical Audit – We will pick this up at the next Q&S Meeting	
4.5	LIPS update	
DIGNIFIED CARE		
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans Patients are cold – Extra blankets are available from the Linen Room.	
5.1	PSOW report shared learning	
TIMELY CARE		
6.1	Waits within Emergency/Acute Medicine – Despite the pressures the Emergency Unit performance is the best in Wales. RE thanked all the staff for their continued hard work. Although it is not where we want to be nobody is doing better. Fewer people are waiting 12 hours than anywhere else in the UK.	
INDIVIDUAL CARE		
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – Relevant improvement plans. A patient wasn't seen by cardiology – If they refer the patient they should come down and see them before discharge. – Patient are cold all the time- Extra blankets are available from the linen room.	
7.2	Complaints and trends Compliments – Compliments were received for Ward A7, Endoscopy UHL and Emergency Unit and St David Elizabeth Ward. Complaints – There are 28 active concerns for medicine, 2 over 100 days but compared to last year we had 11. Jan to 10 March 42% were issued within target. We had 65 informal concerns and they have all been dealt with.	
Staff and Resources		
8.1	Staffing levels – We are continuing to monitor staffing levels. We need to keep an eye on levels to report to Executives. 27 April there is an Evening session 5pm – 7.30 p.m. if there are any enthusiastic member of staff to call on students to work in medicine, any band 5s that would be good at this can they send the names forward.	
8.2	Winter pressure wards – Evaluation –We should have the answer by the end of week. How do we wind down? Some money will be stopping on 31 March from the Welsh Government. We are hoping that we will do something to slow down use of the winter wards over the next few weeks.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	Risk register – all directorates to review this financial year and this will feed up to the board. Tara Rees won a British Journal award for services to Hepatology, she was presented with the award on Saturday.	

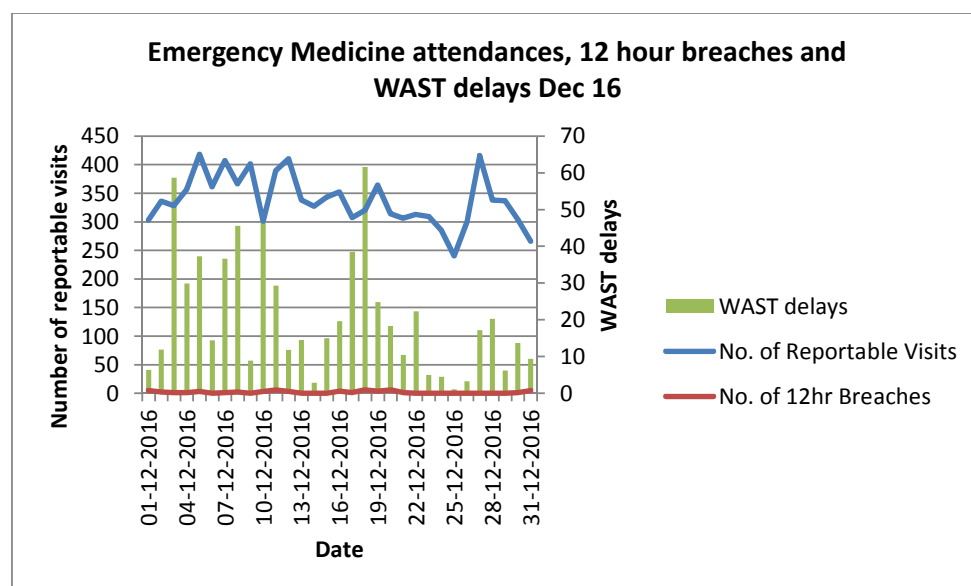
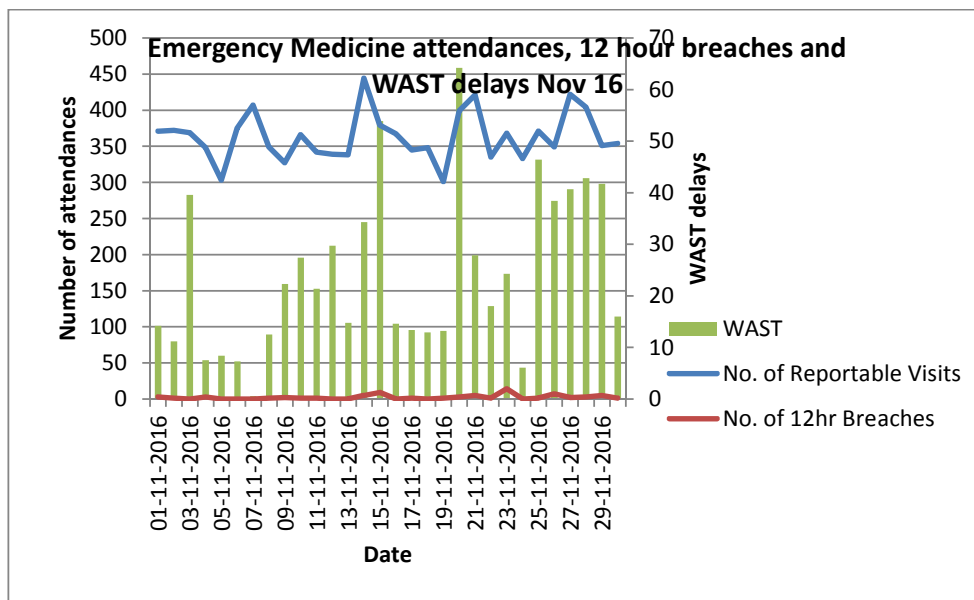
Date and time of next meeting: 20th April Classroom 2 UHW



Medicine Clinical Board QSE November/December 2016

UHW/UHL Acute and Emergency waits

23.5



23.5



GIG
CYMRU
NHS
WALES

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

**SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP**
Tuesday 17th January 2017, 08:00-10:30 hours
Council Room, UHW

CONFIRMED MINUTES

23.6

Present:

Richard Hughes
Linda Walker
Andy Jones

Catherine Evans
Rhian Davies
Chris Williams
Mark Bennion
Michael Bond
Susan Mogford
Rafal Baraz
Leanne Saddler
Claire Mahoney
Carol Evans
Adrian Turk
Judith Smith
In attendance:
For Item 1.4

Edwina Shackell

Chair, Consultant Anaesthetist
Co-Chair, Clinical Board Director of Nursing
Lead Nurse, General Surgery, Urology, ENT,
Ophthalmology
Patient Safety Facilitator, Patient Safety Team
Acting DM, Urology
Consultant Ophthalmologist
Clinical Governance Facilitator, Perioperative Services
Director of Operations
Senior Nurse, Pain Service
Consultant Anaesthetist & CG Lead
DM, Trauma & Orthopaedics
CNS, IP&C
Patient Safety & Quality
Pharmacy
Lead Nurse, Perioperative Care

Dr Eleri Davies, Acting Director WHAIP, Public Health
Wales
PA, Surgery Clinical Board

PART 1: PRELIMINARIES		Actions
16/165	Welcome and Introductions Dr Hughes welcomed colleagues to the meeting and introductions were made around the table.	
16/166	Apologies for Absence Clare Wade, Denis Williams, Jayne Thain, Mr Chavez	
16/167	Declarations of Interest Nil	
16/168	Urology patient story Deferred due to time constraint. Agenda for next meeting.	ES/LW
16/169	IP&C Procedures <u>Multi Drug Resistant Organisms (MDRO) Procedure</u> To be implemented imminently. The procedure describes effective treatment and control of MDROs including:	

	Carbapenemase producing organisms (CPO), Meticillin resistant <i>Staphylococcus aureus</i> (MRSA) and Glycopeptide resistant Enterococci (GRE) The groups of organisms are: Gram positive: eg <i>Staph aureus</i>, including MRSA, Vancomycin Resistant Enterococci (VRE) Gram negative Enterobacteriaceae: e.g. <i>E. coli</i>, <i>Klebsiella</i>, <i>Enterobacter</i>, <i>Proteus</i>, and Gram negative Non-fermenters e.g. <i>Acinetobacter</i> & <i>Pseudomonas</i> sp. Dr Davies explained that the driver for the MDRO Procedure has been the increasing resistance of Gram negative organisms. All Wales data for <i>E.coli</i> bacteraemia shows increasing resistance over time, and is the most common bloodstream infection in Wales. There has been a marked increase in resistance across the UK in recent years, with e.g. Manchester cancelling cardiac surgery due to untreatable infection. Cardiff & Vale UHB, April 2016 – October 2016: - MDRO Gram negative, 15 admissions, 6 of which were associated with hospitalisation abroad, the remaining 9 picked up incidentally, 5 of which were linked to an index case of admission (1 night) from abroad. - One case of NDM picked up resulted in the cancellation of cardiac surgery for contacts. - Carbapenem Resistant Organism (CRO) screening has increased significantly since the index case in October 2016. The main defence is effective identification and isolation. Treatment options are limited. Screening is carried out if patients have a risk factor, e.g. hospitals abroad, and outside Wales, e.g. some English hospitals. The time period is 12 months since admission. There is therefore an impact on the availability of side rooms. It should be understood that Gram negative genetic material spreads as well as the organism. Dr Davies emphasised that it is imperative that a way is found of isolating patients with the highest risks. Cardiff & Vale had already had the temporary closure of some services Dr Davies described the draft Infection Risk Assessment document, which can be circulated to colleagues if required. This highlights any risk of infection, e.g. influenza, D&V. <u>VRE Outbreak in Orthopaedics</u> Not a new gram positive organism, but new to C&V. There was a high prevalence among inpatients when screened. CAVOC had closed as planned over the Christmas period which allowed for the orthopaedic theatres at UHL to undergo repair and cleaning. A review of equipment had been completed. Affected patients will be monitored with weekly screening, possibly using Bethan as an isolation ward. Discussion: 1. Staff are not screened as this is a gut organism. It would be expected that IP&C mechanisms would prevent spread. It is believed that the organism was acquired in hospital. Prevalence in the general population would be approximately 5%. 2. Microguide. Dr Davies emphatically confirmed that the microguide had	
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	been agreed with all clinicians. Adherence to the guidance is key in addressing MDROs and would be audited. 3. Hand soap. Colleagues advised that some dispensers, whilst full, did not function. Action: Claire Mahoney to address with Housekeeping to ensure dispensers have been changed to a new type. Alcohol Gel: non-working dispensers to be addressed with Housekeeping. <u>C.diff PII surgery</u> There is evidence of increase in cases and cross-infection over the summer period. Junior doctor antimicrobial audits are being carried out. Dr Graham Shortland is leading a patient safety walk around, focussing on antimicrobial stewardship. Much good work had been done before Christmas. <u>Theatre Discipline</u> Dr Davies stressed the need to remove PPE before entering public areas. It is not acceptable to wear PPE in the concourse area. Dr Davies emphasised that Theatres has a Procedure with regard to PPE which is not being adhered to. When offenders are challenged their reaction is not always good. A review of whole areas is underway regarding standards of IP&C and theatre discipline. Dr Davies was emphatic that this was not good enough. Theatre staff are compliant. Doctors appear to be the Staff group that need a focused piece of work. Signage and red lines in theatres are under consideration. <u>Bare Below the Elbow / Hand Hygiene</u> Hand hygiene standard 5 moments. The moment most often missed is after contact with patient surroundings, e.g. handling notes in a patient area, not using hand gel prior to moving to next patient area. BBE is everyone's business. No watches, plain wedding ring only. Richard Hughes thanked Dr Davies.	CM
16/170	Draft QSE Improvement Framework 2017/18 – 19/20 Carol Evans tabled the Framework. Triangulation work had been undertaken reviewing Quality and Safety themes to focus on those which the central team will provide support with. SIs, Complaints and concerns etc had been reviewed. Collaborative work had been undertaken with the stakeholder reference group and the CHC. The main aims were described, including those aligned to Healthcare Standards, with the exception of Public Health, staffing, and resources. The key themes and aims were summarised. Including QSE Accountabilities and structure. The good arrangements at Surgery CB level were acknowledged, with the need to strengthen these at directorate level noted. The full draft document would be circulated when completed. An intranet page will be eventually be developed.	

	Discussion: 1. Nursing staffing bill 2. Job planning 3. Broken kit unable to replace due to financial constraints – the mechanism in place is to place on the directorate risk register. Risk registers are update monthly and go to the corporate team. 4. Delay in recruiting to vacant post due to recruitment processes. CE advised this is reported to the management executive who see any reported staffing level incident.	
16/171	LIPS presentation from Resuscitation Deferred	
16/172	Approval of the minutes of meeting held 15th November 2016 Amendment: Page 1 Mark Goodson was present (delete Goodwin) Subject to the above amendment the Minutes were approved as an accurate record.	ES – completed 31/1/17
16/173	Matters Arising: To receive Action Log from the above meeting <u>2.1.3 17/5/2011 – NPSA/2020/2011 - Checking pregnancy before surgery</u> LW had chased again for the policy with Children & Women CB. This was held up awaiting approval by the Equality & Diversity Group. Action: CE to liaise with Avril Gowman. An issue had arisen where wards are not wanting to do pregnancy tests on 12 year olds. <u>16/144 15/11/16 - NATSSIPS workshop.</u> A plan was in progress to invite the chair of the Implementation Group in England, Dr Harrop Griffiths, to lead a half day, cross Clinical Board, event. Date to be advised. <u>16/146 15/11/16 CB Risk Register</u> LW confirmed that directorate annual risk register reviews were underway. The Risk Registers continued to be updated monthly. CLOSED <u>16/150 15/11/16 - Blood Transfusion Policy</u> – dissemination of briefing The Briefing had been circulated. The Policy had been discussed in Anaesthetics. here was a need to raise awareness across the clinical boards, both trainees and consultants. CLOSED <u>16/157 15/11/16 - Open SIs</u> – follow up process for Cancer patients This linked to the planned patient story. LW had emailed all directorates, to ensure that cancer tracking is incorporated into junior doctor training and that systems are robust. CLOSED <u>16/157 15/11/16 - Falls Report</u> A database is in place. Pressure Damage and falls are taken to the Surgery Nursing Board, and reported back to this Group via the Director of Nursing Q&S report.	CE

23.6

	definition of a 'never event' but is being treated as one internally. <u>Patient experience:</u> Patients are being adversely affected due to lack of bed capacity; patients are waiting in day rooms for very long periods of time and then finding their surgery is being cancelled. This situation is being micromanaged by the directorate and CB teams to try and mitigate this as much as possible. <u>ODPs</u> –Ten ODPs have been appointed for theatres who will take up post in July/August 2017. The lack of anaesthetic practitioners remains a concern but as much as possible is being done to manage the situation and prevent any cancellations. LW reported that there had been no success in purchasing training modules from NHS England. LW had gone back to WEDS to emphasise the critical need to take action. ▪ Trauma and Orthopaedics – nil reported.	
16/177	Policies and Procedures for approval Nil received	
16/178	Alerts and other Safety Notices <u>Welsh Health Circulars</u> 1. WHC (2016) 052 – Raising Awareness of Carbon Monoxide Poisoning and Action Required by Health Professionals. Noted <u>NICE guidelines:</u> 2. Summary of NICE guidelines – outstanding responses Action: all to review. Response to advise if applicable/non applicable. Where applicable, please confirm actions taken. Respond to ES 3. NG59 – Low back pain and sciatica in over 16s: assessment and management - Sashin Ahuja 4. IPG568 – Percutaneous insertion of craniocaudal expandable implants for vertebral compression fracture 5. IPG567 – Endoscopic transluminal pancreatic necrosectomy 6. IPG569 – Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy for treating morbid obesity 7. IPG566 – Single-incision short sling mesh insertion for stress urinary incontinence in women <u>NICE Audits</u> 8. National Clinical Audit Assurance Proformas (for noting) 9. Summary of WG mandatory submission of assurance proformas following publication of national clinical audits. Clare Wade is compiling national audits. Failure to respond in time will result in directorates being invited to report the Medical Director. Clinicians to be reminded. <u>Patient Safety Alerts</u> 10. PSA006/January 2017: Risk of death and severe harm from error with	CDs/Clinical Leads

	injectable phenytoin. AT referred to 2 recent incidents in Wales. Areas keeping stock in C&V have been identified, as well as areas that should stock phenytoin and don't. Some stock holding areas did not hold the filters. Action: RB to alert anaesthetists as per the Microguide. JS queried whether this should be in Recovery only. Action: RB to contact the Neurosurgery Lead to ascertain whether this is needed in that theatre. Remove from everywhere else, and keep in Recovery only.	RB RB
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
16/179	Key Messages from Board/ Committees/ Groups 1. UHB Medicines Management Group Minutes 17th November & 15th December 2016 November meeting: Audit of medicines storage. There is an ongoing discussion with WG, with the Corporate team proposing replacement of cupboards with steel when/if areas are refurbished, due to financial cost. Item 5 – medicines management enabling project. A computerised prescribing system. The Medical Director has directed that this is to be used in all areas. Currently in all Ophthalmology suites. This will now be embedded with training carried out by Service Improvement. Paper systems will be withdrawn. The exception will be SSSU which will move to MTEC Inpatient System. December meeting: Wound dressing guidance. Contract agreed in June 2016. WG agreed in January, will be published next week. An A4 guide has been produced. Current stocks are being used up, and new products purchased. Rib fracture tool, lignocaine patches for frail older patients. There is disquiet from primary care regarding increasing use. Agreement has therefore been reached to use solely for inpatients, only in T&O. The pathway will be amended and circulated. AT will feed back to primary care in 6 months. 2. Surgery Clinical Board IPC Group. Next meeting 23rd January 2017. The Clinical Board HCAI report was received 16/1/17: One MSSA in December 2016 One C Diff in January 2017 The Clinical Board has reached its 21 cases maximum for C.diff for the financial year. 3. Surgery Clinical Board H&S Sub Group. Approved Minutes 19th October 2016 Neuraxial connectors: RB had presented at the last meeting.	

	Prescription laser goggles: Surgeons have glasses. 4. Decontamination Committee Minutes – December meeting cancelled 5. Water Safety Group 19th July 2016 Minutes. Key message: request Estates to cap off unused baths/showers/sinks to avoid the need for flushing. Contact Clare Mahoney if there are delays. 6. Safeguarding Steering Group 24th November 2016. To note: MASH referral flowchart Independent Domestic Violence Adviser for the UHB is Sarah Richards. 7. Safeguarding Team Newsletter Autumn 2016. Received. 8. CMO Update 86: Wet AMD issue is ongoing. A pilot is underway to determine the most appropriate model. 9. Montgomery: A New Dawn for Consent in Clinical Negligence? Dr Tony Turley is leading. The presentation has been shared with the Clinical Board. This has a huge impact on the Surgery CB. Patients will need to be consented at the preadmission stage, which will have an enormous impact on current practice. LW explained the guidance, which entails presenting all options to all patients, whether a particular treatment is provided by C&V or not. It was noted that Junior Doctors will not be aware of all options. For example the MAGIC programme (Breast, ENT) shares this type of information with patients currently. Anaesthetic component of consent: RH advised that there are no plans to introduce anaesthetic consent. Chris Williams agreed that the consenting Dr was gaining consent on behalf of the anaesthetist – the patient does not consent separately to anaesthetic. RB advised that this will be discussed at audit on 15th February. 10. Welsh GP Record (letter from Adam Cairns) This is NWIS led and was rolled out from November 2016. This logs who has viewed patient records and when. Will now cover outpatients as well as acute care. 11. Public Health Link: CEM/CMO/2016/5: Influenza Season 2016-17. Use of antivirals now recommended in line with NICE Guidance. LW reported that there had been ward closure due to flu infections. The Surgery CB is trailing significantly behind other CBs' flu vaccination uptake which is protective against the current strain. If staff decline, or have had GP vaccination, this needs to be logged in order to increase the CB compliance. It was noted that e.g. anaesthetists and surgeons were unwilling to complete the form declining vaccination. MB advised that the Clinical Board Director was willing to broach this with clinicians. The Board does need a mechanism to ensure all staff have been asked. The CMO letter circulated in 2016, with the GMC link, was very clear with regard to clinicians' duty of care for their patients and the importance of the flu vaccine in meeting that requirement. Strategies to communicate the message for 2017 were briefly considered. 12. Covert Administration of Medicine	
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	LW asked CD colleagues to read this. Ensure MDT care is planned around the patient as per the guidance. Action: CDs	CDs
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
16/180	Surgery Clinical Board Director of Nursing Quality & Safety Report November 2016 and dashboard The report was verbally summarised. Key issues were: Falls – a significant number which is of concern and are currently being investigated Vascular SI – meeting w/c 23/1/17 regarding 4 patients Awareness under anaesthetic Pressure Damage: the prevalence of Grade 3's and 4's is unusually high. C Diff – an unusual increase in numbers. SIs – good work by the directorate teams in closing these One recent Never Event Bank & Agency/Recruitment; One ward in transition to on-contract agencies but it has 7 vacancies until April 2017. Hand hygiene – compliance not 100%. Medical Staff in particular are failing to comply.	
PART 5: GOVERNANCE		
16/181	Concerns (Clinical Incidents, Complaints, and Claims) 1. Welsh Government Feedback Report – Sharing Lessons, Improving Patient Safety – December 2016 Noted. Themes of Never Events from invasive procedures across Wales. 2. <u>Open SIs, No Surprises</u> 19 in total. Good progress closing, new ones. 3. <u>Regulation 28 report & Open Inquests</u> One for the CB – inquest reported natural causes. 4. <u>Closed SIs:</u> Four closure forms sent to WG since 01/11/16 Learning points. - Pt fall – Unique to patient and circumstances so no general learning from the event. Arterial line snapped on removal. An unpredictable event. Nil specifically to learn. 5. <u>Falls Report</u> Deferred to next meeting. 5. <u>Complaints, Claims and other Concerns</u> (i) Clinical Negligence Claims Closed 1/11/16 – 9/1/17 Five closed with learning noted. (ii) Clinical Negligence Claims Open 1/11/16 – 9/1/17 – 10 actively managed. No themes identified. (iii) Personal Injuries Negligence Claims closed 1/11/16 – 9/1/17 – nil	

	(iv) All New Personal Injuries Negligence Claims 1/11/16 – 91!7 - nil 6. <u>Ombudsman's Reports received:</u> (i) 201600131. A patient fell on a general surgical ward and sadly subsequently died. The Ombudsman has directed that the Clinical Board apologise to the family for the failings in care. The key issue for communication out from the report is to remind clinicians to discuss DNAR decisions at the appropriate time and in an appropriate manner with patients and their families. (ii) 201506359. Hernia procedure. The Surgeon decided the treatment option, which they still feel is correct. However expert opinion is that the surgeon failed to consider all options in this particular patient's case. The Ombudsman's recommendations were for the case to be shared with this group for wider learning. Reminders to relevant medical staff to make an adequate record of decision making processes and treatment carried out in the medical record.	
16/182	Internal Audits 1. <u>Consent Audit – Perioperative</u> 'Right' or 'Left' must be printed. Do not use abbreviations and print for legibility CE cited a Never Event where the writing on the consent is such that the procedure could not be deciphered. LW advised that further to this Never Event, it may be necessary to issue an Internal Safety Notice to the UHB on how to write consent forms. The investigation is underway and will be reported at a later meeting. A re-audit will be undertaken in 6 months. It was agreed that an electronic consent form would be the way forward. 2. Laterality Audit – Perioperative, December 2016 Themes as for (1) above. Way forward: Ophthalmology consenting procedures to be reviewed as a starting point. Action: Colleagues to provide assurance that the above actions at (1) have been communicated to their teams.	ALL
16/183	Patient Surveys 1. National Survey Report for Surgery (November 2016) RECEIVED for information.	
16/184	Research & Development Nil reported.	
PART 6: DATES OF NEXT MEETING Tuesday 14th March 2017, 08.00 – 10.30, Council Room, UHW		
PART 7: URGENT BUSINESS		
7.1		
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
8.1	Alerts and Other Safety Notices <i>Nil received</i>	
8.2	Recent Reports & Communications	

	Rebalancing Healthcare: Working in partnership to reduce social inequity RECEIVED for information.	
8.3	Directorate Reports Q&S meeting report received: 1. Perioperative Services, 24/11/16 2. ENT	



MINUTES

**CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 24 January 2017
8.30am, Surgery Seminar Room, A Block, 2nd Floor, UHW**

23.7

Preliminaries		ACTION
1.1	Welcome & Introductions Cath Heath (CH), Director of Nursing (Chair) Rachel Burton (RB), Director of Operations Matthew McCarthy (MM), Patient Safety Alex Scott (AS), Patient Safety Cheryl Evans (CE), Directorate Head of Operations & Delivery, O&G Lois Mortimer (LM), Senior Midwife Laura Bassett (LB), Risk Manager, O&G Diane Rogers (DR), Interim Head of Operations & Delivery Rim Al Samsam (RAS), Acting Clinical Director, Acute Child Health Heather Gater (HG), Head of Therapies, Acute Child Health Jane Maddison (JM), Mary Glover (MG), Lead Nurse Acute Child Health Paula Davies (PD), Lead Nurse, Community Child Health Michelle Abel (MA), CNS Infection Prevention Control In attendance Kirsty Hook, Board Secretary (minute taker)	
1.2	Apologies for absence Suzanne Hardacre, Angela Jones, Louise Young, Jenny Thomas, Rose Whittle	
1.3	To receive the Minutes of the previous meeting 22 November 2016 The minutes of the previous meeting were agreed to be an accurate record. Discussion ensued in relation to C1 where it was noted that the plan was try to reduce beds over the Christmas and New Year period with a view to reduce over the weekends going forward. It was requested that this was refrained from through the winter period in order to help manage the medical and surgical flow, however it was noted that there were concerns in relation to the appropriateness of the patients that are being admitted within C1. CH agreed to discuss issues with Patient Access.	CH
1.4	QSE bring forward action log / Matters Arising See updated action log of 22.11.16	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	Blended Diet -LIPS presentation Deferred to next meeting.	
2.2	Local Audit Plan & Health and Care Standards Health & Care Standards AS provided an update on the new approach and self assessments for Health & Care Standards. It was noted that there is duplication across the Health Board and	

	it was therefore decided that health and care standards would be aligned to workplans and committees. There is no longer a requirement to self assess against Falls Prevention, Medicines Management, Nutrition & Hydration, Safeguarding Children & Adults, Infection Prevention Control, Medical Devices and Equipment and Diagnostic Systems. All driver diagrams were now available and there is a three month deadline for completion of the standards (28th April 2017). Discussion ensued with regards to feedback on the last self assessments as no feedback has been received. It was noted that within the Safeguarding standard it was acknowledged that the Clinical Board had under-represented themselves and therefore this was updated to ensure that it accurately reflected the work that is undertaken. Discussion continued with regards how much evidence needs to be included and it was noted that if there is a piece of work that is being undertaken that cannot be appropriately reflected and demonstrates compliance against the standards include this evidence, however there is no need to include copious amounts of evidence. The group were asked to review and update the standards in view of the impending deadline. Clinical Audit Plan Discussion ensued in relation to the Clinical Audit Plan for this year. It was noted that very few of the audits identified have not been registered, however it was noted that there are audits that are being undertaken. It was felt that the process needs to be made more robust and being linked to audit programmes, a clinical audit dashboard is being set up where all audits can be registered on and these can be monitored through RAG rating etc. Work is underway to set up a free trial of the new system and the group were asked to identify some nominations to view the trial and the accessibility of the system prior to implementation. DR noted that with regards to the suggested audit programme, it was acknowledged that for junior doctors and students the focus has changed from clinical audits to service improvement audits hence the decrease in the number of clinical audits being undertaken. It was agreed that the audits needs to be for a quality perspective, rather than quantity and this was the best focus to take. The findings of the audits are now being circulated to the Clinical Boards in order to review whether action plans are required as a result of the findings and may need to be noted and discussed at QS&PE for any lessons learnt.	DMT's
2.3	Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues) Acute Child Health - Flu Champions are continuing to vaccinate and the Clinical Board are currently reporting 55% which is above the target original target of 50%. - Meetings have been arranged with JPS and SG to discuss the RCA reports. The Never Event that was reported received positive feedback from the actions undertaken and it was felt that the good practice should be shared with others. MM agreed to action. 1 pressure area was reported however it was acknowledged that child came with the pressure area from ABMU. This has been reported back to the Health Board for appropriate actions to be completed. - Island Ward was closed for almost a week with Norovirus - Recruitment Event is scheduled for 04th February 2017. - RTT position has decreased slightly and work continues to further improve the year end position. Paeds Surgery Cases It was noted that following three RCA's being reported concerns were raised in relation to commonality and themes. From the findings it was felt that there were similarities and further investigation has been undertaken in order to ascertain if	MM

there were any lessons to be learnt from the RCA's. It was noted that an improvement plan is being developed and meetings are arranged to review actions that need to be undertaken going forward. A medical registrar will also be undertaking joint ward rounds on a daily basis to review how ward rounds are undertaken. It was noted that there is a meeting arranged this week with a view to start the closure forms for the incidents that have been reported and the relevant actions that are being undertaken.

WAST Serious Incident

RAS advised that an RCA is being undertaken in relation to a recent case involving a child death in which the child had a cardiac arrest at the GP practice and was subsequently admitted to PICU. It was acknowledged that concerns were raised that from current findings of the internal investigation it was felt that there would have been a different outcome if there was no delay in the ambulance arriving. It was noted that this case has been reported to Welsh Government via WAST as a Serious Incident. Discussion ensued and it was agreed that prior to sharing the report with the family, this will need to be shared and signed off by the Executive Director of Patient Safety in the first instance.

Obstetrics & Gynaecology

- 5 ongoing RCA's within Obstetrics, one of which is a pressure area. It was felt that there seems to be a theme and work is being taken forward with regards to the robust use of the skin bundles and further audits will be undertaken in order to monitor these cases which will be undertaken as part of the teaching package for midwives on pressure care. An annual audit will also be undertaken. It was noted that a new pressure area toolkit is being developed.
- 2 ongoing RCA's within Gynaecology.
- The overview of the recent RCA's that were signed off at a designated RCA meeting in December was noted. The findings and the lessons learnt from the investigations have been noted as part of the overview in order to share lessons. LB provided an update in relation to the ESSURE case and the specific recommendations that were found through the investigation. It was acknowledged that as a result of these recommendations the service has been disbanded and there will be a number of actions that would be required if this service is to be reinstated.
- WAST Pathway for Pregnant Women for <16weeks gestation has been developed and it was noted that ratification is now awaited from WAST prior to implementation.
- LIPS project for "Babies don't Bounce" has been completed. The Paediatric guidelines are in hand and once this is received, there will be a uniformed practice across both areas. It was requested that the presentation would be brought to the next meeting for sharing with the group.
- Charitable bids for the reclining chairs to promote open visiting for further support of mothers and babies have now been delivered.
- Water machines have been implemented as part of nutrition and hydration. It was acknowledged that this was implemented as part of "2mins of your time feedback.
- Theatre tables have been received and lights are on order following recent risks being highlighted.
- Information Governance breach was reported recently following patient data being left in a car and subsequently stolen. This has been reported to Welsh Government and the ICO.
- Parent education classes are now being offered in Welsh and are proving very successful.
- Caring for You campaign continues.

Fire Risk Assessments

Fire risk assessments are being taken forward and the feedback received has been

	positive to date. It was agreed that the flowchart for fire risk assessments will be circulated following the meeting in order for all to be aware of the actions that need to be completed. Community Child Health - Difficulties were highlighted in relation to staff inappropriate DBS checks and work is ongoing to check relevant DBS checks within community. It was noted that there will be a financial implication associated with this; however concern was raised that this needs to be completed. Discussion ensued with regards to personal responsibility of staff and it was agreed that there is a need to ensure that this is part of PADR and revalidation process going forward. SME agreed to circulate the information to the Directorates in order for this to be reviewed and actioned appropriately. - Ysgol y Deri action plan is being progressed. Joint safeguarding within the school needs to be managed in order to ensure that this is progressed appropriately. A protocol will be circulated to all staff in order for clarity on responsibilities. - LAC service - concerns with regards to increase in delays of children being seen that are placed outside of the Health Board. A letter has been drafted to all Health Boards across Wales as a reminder of responsibilities. - Medicines Management – a number of errors have been noted and a recent audit has been undertaken. There have been some improvements however further work is required going forward. A scoping exercise is also being undertaken with regards to training. - Pressure ulcers have been reported within Community and work has been provided on the cases to social services who have been leading on the investigation. Discussion ensued and it was agreed that it would be reviewed in order to ascertain whether this needs to be retrospectively reported. It was noted that there is learning that needs to be shared from the cases. PD agreed to provide further details to MM outside of the meeting. - New group regarding increasing immunisation uptake for Primary Immunisations is being put forward for the next LIPS programme. - RCA ongoing in relation to patient JW. Further meetings needed - Verbal aggression issues reported and work is ongoing to address this. - Consultation with families in Ty Gwyn initially regarding Complex Care, further update will be provided when available.	CE SME PD
2.4	Risk Registers – Exception Reporting / New Risks to be considered No new risks to be noted for inclusion; however it was noted that the risks for paediatric surgery will be reviewed in light of the recent concerns previously mentioned under item 2.3.	DR/MG
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	No specific items to note for this meeting.	
SAFE CARE		
4.1	Patient Safety Incidents Closure Forms: In20385 – for sign off This closure form relates to a Maternal death which will be shared as a patient story for lessons learnt to be shared. A brief background to the case was noted and a number of the actions identified, some of the actions have already been completed and further actions identified are in progress. This was signed off by the Clinical Board for submission to Welsh Government. In27585 V2 – for sign off The incident relates to a baby fall due to mum falling asleep whilst feeding. It was	MM

	noted that actions have been undertaken a further recommendations identified through the LIPS Project “Babies don’t Bounce” are being progressed. Lessons learnt have been shared also. This was signed off by the Clinical Board for submission to Welsh Government. In 30175 – for sign off The closure form relates to the incident regarding a retained vaginal pack. It was noted that a meeting has taken place and an improvement plan is now in place including joint working with Surgery Clinical Board. In34449 V2 – for sign off Discussion ensued in relation to the reasons for the SI being reported as it was felt that this was expected. It was noted that as this was involving another health board via PRUDIC it was felt that this needed to be reported. All actions necessary actions have been undertaken and the closure form will be submitted to Welsh Government for sign off. In30517 V2 and In31464 – for noting The closure forms were noted for information. It was advised that both have been submitted to Welsh Government within timescales and all actions completed. Discussion ensued and all were asked to ensure that all lessons learnt would be shared appropriately throughout the Clinical Board.	MM ALL
4.2	Patient Safety Alerts (internal/external) - Welsh Government Feedback Report - Sharing Lessons, Improving Patient Safety - December 2016 edition - Welsh Health Circular 2016 052 - Raising Awareness of Carbon Monoxide Poisoning and Action Required by Health - Public Health Link - Influenza Season 2016-17 Use of antivirals now recommended in line with NICE guidance The alerts above were noted for information and it was reiterated of the actions that would be required if necessary. It was agreed that any lessons learnt would be shared as appropriate throughout all areas.	
4.3	Updated guidance re covert administration of medication Noted for information. It was agreed that this would be shared widely for awareness.	ALL
4.4	Infection Prevention Control Update The report was noted for information. - Audit and surveillance is ongoing and Children & Women will be prioritised. - RCA’s for MSSA, MRSA and C Diff are ongoing/completed - Norovirus has been reported on Pelican and Island Wards - O&G Theatre plans are being reviewed, Cystoscopy decontamination is being reviewed and it was noted that further discussions are taken place in order to ensure that the process is robust for decontamination. - Decontamination of equipment in the Community has been reviewed and guidance has been shared. It was noted that further meetings are taking place due to concerns being raised on cleaning. - Tracheostomy care for Infection Control is being reviewed and it was noted that training days are being implemented. - Infection Control group has been set up on NICU. - FIT Testing is ongoing on NICU and Gwdihw and it was noted that a plan will be put in place for the summer for further training to take place.	

	• HPV cleaning continues. • Mandatory training sessions have been commenced within Maternity.	
4.5	Safeguarding Latest minutes from the Safeguarding Steering Group for information The latest minutes of the meeting were noted for information. Children's safeguarding will now form a standing agenda item for future meetings.	
4.6	National neonatal assurance proformas Noted for information.	
EFFECTIVE CARE		
5.1	CSSI Infection Work has been undertaken in order to validate the information. All Wales antibiotics have been implemented and regular reviews will be undertaken in order to review the impact.	
DIGNIFIED CARE		
6.1	Latest Cleaning Scores Report – for information Noted for information. Some areas of concerns were highlighted in relation to the scoring of some areas within Community and PD agreed to review.	PD
6.2	Dementia Care Training Training is progressing and it was reiterated that there is a need to ensure that this training is being undertaken across all areas. All were asked to encourage staff to complete.	ALL
TIMELY CARE		
7.1	Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes – for information The recent dashboard was noted for information. Very positive work is being undertaken and a number of the targets are being met. Thanks were expressed to all for the hard work undertaken by all. It was noted that there have been significant improvements within Therapies. Work is ongoing with regards to follow ups with the Directorates. Discussion ensued in relation to PADR and it was noted that work continues to improve. Queries were raised in relation to medical staff and it was noted that PADR is showing as out of date and this is undertaken via MARS which is a different system. SME agreed to check the data to ensure that this is reported separately. Concerns continued to be raised in relation to performance targets not being appropriately managed. It was requested that this information be forwarded to SME in order for clarification to be sought with LED.	SME
INDIVIDUAL CARE		
8.1	Update on latest 2 minutes of your Time feedback This will be discussed separately with the Lead Nurses following the meeting and a plan will be put in place as to how this will be managed going forward.	CH/LN's
Staff and Resources		
9.1	Staff awards and recognition All nominees from the Clinical Board Celebration Event were put forward for the UHB Staff Recognition Awards.	
9.2	Staff surveys No further update to report for this meeting. All actions are being managed within	

	the Directorates and are reported as part of the action plans.	
9.3	Latest Workforce Report for information Noted for information.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
10.1	Mental Health and Capacity Legislation Deferred to next meeting.	
ANY OTHER BUSINESS		
	Transition A draft document and guidelines has been received and work will be taken forward as to implementing a Multidisciplinary improvement plan for the Clinical Board. This work will then be shared with the group as this work progresses. UHL Antenatal Clinic It was noted that this clinic will be relocating from July 2017. Scoping exercise is being undertaken in relation to the work that is being undertaken within the Clinic and the need to ensure that this is appropriately relocated. Further feedback will be provided when available. Ulipristal Prescribing Further to a review being undertaken with regards to Ulipristal prescribing, it was noted that this will be stopped and any new prescription requests will be robustly monitored going forward. Annual Programme for IPC This will need to be provided to the next IPC committee. It was agreed that the Clinical Board would work with IPC in order to produce a joint programme for implementation.	CH/MA
DATE AND TIME OF NEXT MEETING		
The next meeting is scheduled for Tuesday 28 February, 8.30am, Surgery Seminar Room, A block, 2nd Floor, UHW		

23.7



DENTAL CLINICAL BOARD

MINUTES OF QUALITY, SAFETY & PATIENT EXPERIENCE GROUP MEETING 12th January 2017 at 8.00 AM Annexe Seminar Room

23.8

Present: Mr Andrew Cronin (Chair) (AC) B Chadwick (BC) Prof I Chestnutt (IC) Eira Yassien (EY) Julia Charles (JC)	Prof M A O Lewis (ML) Dr G Bhamra (GB) Carol Evans (CEV) R Griffiths (RG) Dinah Jones (DJ)	Jayne Collier (JBC) Catherine Evans (CE) N Drage (ND) S Merrett (SM) S Bhatia (SB)
In attendance: Jonathan Peck		
Apologies Received from: J Gillespie		

		ACTION
1.1	Welcome & Introductions AC welcomed everyone to the meeting of the Quality, Safety and Patient Experience Group and introduced Mr Nicholas Drage who has taken over the role of Oral Surgery, Medicine and Pathology Audit lead.	
1.2	Apologies for Absence Received as above. CE and SM noted that their apologies were passed for the last Q&S meeting but not recorded.	
1.3	Declarations of Interest - None	
1.4	To receive the minutes of the previous meeting The minutes of the Quality & Safety meeting held on the 24 th November 2016 were accepted as an accurate record. Matters Arising IC requested that the effective use of clinical audit time be discussed at this meeting.	
2.1	Oral Surgery, Medicine and Pathology - Mr A Cronin Minutes from the OSMP Audit Group meeting on the 6 th December 2016 were received and noted. ND noted that the meeting was disappointing so far as participation. There were no patient stories and no audit presentations. ML commented on the short length of recent audits and noted in particular the last Restorative Dentistry audit on the 13 th December 2016 which lasted less than 10 minutes. ML recognised that there had been many successful audit projects of which some had been published but stressed the importance of all staff attending the meetings, contributing and carrying out new audits otherwise the sessions may be reduced or stopped altogether. RG noted that if audit sessions were stopped it would also effect training sessions which utilised the meetings. IC requested that all staff be made aware of the importance of attendance	

	at the next audit meetings. Non-attendance at following meetings is then to be recorded for staff not on study leave, annual holidays, etc. ML will send a letter to members of staff underlining the importance of undertaking and engaging in the audit process.	ML
2.2	Restorative Dentistry - Dr G Bhamra Minutes from the Restorative Dentistry Audit Group meeting on the 13 th December 2016 were received and noted. There was nothing in particular to report. GB informed the group that as a result of the recent DCAF meeting an email was sent to all consultants regarding engagement in the clinical audit process. Restorative consultants have agreed to meet at the end of the next Restorative Dentistry audit meeting in February to discuss the matter further.	
2.3	Joint Orthodontic and Paediatric Dentistry - Ms S Merrett & Mrs S Bhatia Minutes from the Joint Orthodontic and Paediatric Dentistry Audit Group meeting on the 6 th December 2016 were received and noted. SM informed the group that consent was presently a main issue with good discussions at the last audit group meeting. From these discussions it has become apparent that, from an Orthodontic perspective, it was possible that not all necessary consent was being gained and SM would welcome any feedback regarding the subject. SM noted that Julie Andrus had taken lead on the Hand Hygiene audits and will present an update at the next audit meeting. Patients BMI were also discussed. JC noted that it had been stated at the last meeting the problems with weighing and calculating a patient BMI due to time restraints. JC informed the group that time restraints should not be an issue as the process is very quick and straightforward using a mobile app. ML also commented that patients who weigh more than 21 stone should not be seated in a dental chair. EY informed the group that the new referral forms have been updated to include a section on BMI and suggested that if this section is not being completed then the referral should be returned as incomplete. The group further discussed the management of patients weighing more than 21 stone and the possible data collection of bariatric chair usage. AC stated that if there are any concerns so far as patient weight then the weight must be checked.	
2.4	Community Dental Service - Mr J Gillespie JBC informed the group there have been no recent meetings. The next meeting will be held in February. JBC commented that CDS was slightly different so far as audit meetings, instead holding locality meetings six times a year with generally good attendance and a high level of participation. AC commented that he has recently had discussions with ND about junior staff not being released to attend UDH audit as he had noticed quite a bit of clinical activity when audits are being held. IC commented that he was under the impression that there were no student sessions when there was audit. ML clarified that all clinical activity was to stop with the exception of skeleton staff on Paediatrics and Exam and Emergency.	
2.5	DSG HSC: Minutes of the Dental Division and School H & S Advisory Group - Prof I Chestnutt IC noted a 48% uptake for the flu vaccine. This was an improvement on last year which was only 27%.	
2.6	Draft QSI Framework – Carol Evans Carol Evans presented to the group an overview of the Quality, Safety and Improvement Framework 2017/18 – 2019/20. There will be posters in the future as well as further development of internet	

	resources. IC queried how the framework will be implemented and monitored. CEV noted that it would be monitored through the UHB Quality and Safety Committee. AC commented that audits were already being aligned to themes but he would also like to see more engagement in national audits.	
2.7	Never Event Summary – Rowena Griffiths RG summarised a recent Never Event and its outcomes. RG thanked CE for help in implementing the improvement plan which is progressing very well. AC commented that an audit to assess compliance with the completion of the WHO checklist is ongoing. Results of the last audit carried out were poor. BC noted that the lessons learnt so far have not yet been transferred to other specialities. IC commented that a more effective mechanism was needed for the Dental Hospital as a whole. ML added that Mountain Ash and St David's hospitals were also to be included. ML also thanked RG for a thorough report.	
3.1	Patient Story	
3.2	QSE bring forward action log	
3.3	Feedback from UHB QSE Committee	
3.4	Health and Care Standards – sign of self assessment / ongoing review of implementation / improvement plan	
3.5	Risk Register- review and revision	
4.1	WHC/2015/001 - Improving Oral Health for Older People Living in Care Homes in Wales WHC 2008 (008) – Designed To Smile	
4.2	Bring forward – progress on relevant improvement plans (previously approved/discussed)	
5.1	Compliments received The document was received and noted. Concerns received The document was received and noted. RG informed the group that she has taken over responsibility from Ailsa Pritchard for concerns / complaints.	
5.2	Patient Safety Incidents The document was received and noted.	
5.3	Medicines management issues/incidents/audit findings JC highlighted the ongoing lighting issue in Theatre 2. There has been an issue for some months and Theatre 2 cannot be used until the problem has been resolved.	
5.4	New Medical alerts Actions from previous alerts	
5.5	Medical devices/equipment issues BC informed the group of inhalation sedation equipment that has not been serviced since last summer. EY noted that a service was planned for Monday 16 th January 2017. DJ noted that the issue had come to light as there had been a similar incident in CDS. RG informed the group that an incident report has been raised.	
5.6	Decontamination issues WHTM01-05 DSDU Accreditation	

	RG commented that a DSDU audit was to be carried out the week after next. RG anticipates issues as the Estates department are not up to date with the servicing and testing of equipment. RG also commented that work had recently been carried out in PHDS with instrumentation being pulled in and processed.			
6.1	Monitoring of CB Clinical Audit plan AC has recently met with EY and Debra Preece regarding the introduction of electronic referrals from GMP's. The system will effectively rely on red flags for suspect cancer patients to be picked up by clinicians signing into the system and viewing which was highlighted as a concern. The process has been discussed to ensure these red flags are not missed.			
6.2	Research and development BC informed the group that Tuesday 13 th June 2017 was National Research and Development day.			
7.1	HIW/DSDU/WHTM 01-05 reports and improvement plans			
7.2	Ward inspection reports and improvement plans EY informed the group of two CHC visits planned in the coming months for the GA and Paediatric departments.			
7.3	Health and Care Standards Monitoring data			
7.4	Initiatives to improve services for people with: Dementia Sensory loss			
7.5	Any initiatives specifically related to the promotion of dignity			
8.1	Complaints Trends			
8.2	Feedback from surveys – relevant improvement plans			
9.1	Staff awards and recognition			
9.2	Staffing levels			
9.3	Staff surveys			
9.4	IMPAX - Generic screen saver time out RG informed the group that this was still a work in progress and was being dealt with area by area. ND confirmed that it was still an issue in the E&E department.			
Items to be recorded as Received and Noted for Information by the Committee				
	Ongoing Audits - The document was received and noted.			
	FINAL VERSION - FEEDBACK - NE - Invasive Procedures - December 2016 - The document was received and noted.			
	DLM PROCESS 2016 - The document was received and noted.			
10	Date of Next Meeting			
	TBA	TBA	TBA	

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE**18th April 2017****Corporate Meeting Room, HQ, University Hospital of Wales****AGENDA**

1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Private Committee held on 21 st February 2017	Chair
5	Action Log – no outstanding action	Chair
6	Chair's Action Taken since the last meeting	Oral-Chair
7	Items to bring to the attention of the Board/other Committee	Oral – Chair
8	Review of the Meeting	Oral – Chair
9	Date of next meeting Tuesday 20 th June 2017	