QUALITY, SAFETY AND EXPERIENCE COMMITTEE

9am on Tuesday 20th June 2017
Corporate Meeting Room, UHB HQ
University Hospital of Wales

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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 18th April	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral – *Chair*
Governance, Leadership and Accountability		
7	Patient Story	*PCIC Clinical Board*
8	Primary Community and Intermediate Care Clinical Board Quality, Safety and Experience Assurance Report	*Clinical Board*
9	Community Health Council Scrutiny Overview Report	*CHC*
10	Charges for Lost Hearing Aids Policy	*Director of Therapies and Health Science*
11	External Regulatory and Accreditation Visits to Clinical Disagnostics and Therapeutics Services	*Executive Nurse Director*
12	Annual Quality Statement 2016-17	*Executive Nurse Director*
13	Health and Care Standards Self Assessment 2016/17	*Executive Nurse Director*
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
14	Safeguarding Report Update	*Executive Nurse Director*
15	Infection Prevention and Control Exception Report	*Executive Nurse Director*
16	Cleaning Update	*Director of Planning*
17	Independent Review of the Management and Response to Acinetobacter Outbreaks in 2015	*Executive Nurse Director*
18	Point of Care Testing Exception Report	Oral *Medical Director*
19	Corporate Risk and Assurance Framework Update	*Director of Corporate Governance*
20	Care of the Deteriorating Patient	**Oral** *Interim Chief Operating Officer / Executive Medical*

		& Nurse Directors
21	Patient Wristbands	**Oral** *Executive Nurse Director*
Theme 3: Effective Care		
22	Cancer Peer Reviews – Brain	*Medical Director*
23	Mortality Data and Mortality Review	*Medical Director*
Theme 4: Dignified Care		
24	Update on Health Inspectorate Wales Activity	*Executive Nurse Director*
25	Carers Information and Consultation Strategy	*Executive Nurse Director*
Theme 5: Timely Care		
26	Management of Outpatient Follow Ups and Endoscopy Surveillance	*Interim Chief Operating Officer*
27	T&O Joint Revision Rates	*Medical Director*
Theme 6: Individual Care		
Theme 7: Staff and Resources		
28	Single Rooms, Decant Facilities and Isolation Rooms at UHW	*Director of Planning*
29	CMHT Accommodation – Update on Plans	*Director of Planning*
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		
30	HM Coroner Regulation 28 Prevention of Future Deaths	*Executive Nurse Director*
31 1 2 3 4 5 6 7 8	**Minutes from Clinical Board Quality Safety and Experience Sub Committees** Clinical Diagnostics and Therapeutics – April Mental Health –March and Lessons Learned May Primary, Community and Intermediate Care - March Specialist Services – no report since February Medicine – April Medicine A&E waits in December/January & April Surgery – March and April Children and Women – February and March Dental – March	*Chief Operating Officer*
33	Agenda for the Private QSE	
34	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
35	Review of the Meeting	Oral – *Chair*
36	Date of next meeting 9am on Tuesday 12th September 2017	

UNCONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9am ON 18 APRIL 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Maria Battle (part)	UHB Chair and QSE Chair
Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Margaret McLaughlin	Independent Member – Third Sector
Martyn Waygood	Independent Member - Legal
Cllr Susan Elsmore (part)	Independent Member – Local Authority

In Attendance:

Alun Jones (Observer)	Director of Inspection, Regulation and Investigation, HIW
Angela Hughes	Interim Assistant Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Ian Wile (part)	Director of Operations, Mental Health
Jayne Tottle (part)	Director of Nursing, Mental Health
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Stephen Allen	Chief Officer, Cardiff and Vale CHC
Steve Curry (part)	Interim Chief Operating Officer
Stuart Egan	Staff Representative
Tony Turley	Representing the Medical Director

Apologies

Abigail Harris	Director of Planning
Alice Casey	Chief Operating Officer
Fiona Kinghorn	Acting Director of Public Health
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance

Secretariat Julia Harper

QSE 17/044 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular Mr Alun Jones, Director of Inspection, Regulation and Investigation from Health Inspectorate Wales who was attending as an Observer. In addition, Mr Stuart Egan was attending his first meeting in his capacity as a Staff Representative.

The UHB Chair, Ms Maria Battle, advised Members that she was taking over the Chairmanship of the Committee since Prof Treasure had been appointed to lead Aberystwyth University. She thanked Professor Treasure for her many years of service chairing the Committee.

QSE 17/045 APOLOGIES FOR ABSENCE

Apologies for absence were noted

QSE 17/046 DECLARATIONS OF INTEREST

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

QSE 17/047 MINUTES OF THE COMMITTEE HELD ON 21st FEBRUARY 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED** subject to the following amendments:

Page 9 QSE 17/014 Review of Outstanding Policies
The third sentence would be amended to read:
A member of staff within the team had been identified to manage this particular project via a risk based approach and set priorities.

Page 16 QSE 17/027.9 WHSSC Quality and Patient Safety
The word *share* would be inserted before the words *good practice* on the last line.

QSE 17/048 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 17/005 Trends and Themes in SIs – The Executive Nurse Director agreed to present a report for funding consideration of patient wristbands to the Management Executive and to provide more detail for the next meeting.
Action – Mrs Ruth Walker

QSE 16/192 Care of Deteriorating Patients – In response to a request from the Chair for a timeline, it was agreed to present an action plan with dates at the next meeting.
Action – Mrs Ruth Walker and Dr Graham Shortland

QSE 17/009 CHC Report – Boredom and Loneliness – The Executive Nurse Director advised that she would have to approach WRVS Head Office for clarity on Strategy.
Action – Mrs Ruth Walker

QSE 17/011 Committee Work Programme – A session with new Independent Members would take place on 28th April.

QSE 17/013 Annual Quality Statement – This action was complete.

QSE 17/024 – Ward Bathroom Refurbishment – It was agreed that the Vice Chair would prepare a letter for Ms Battle with the support of the Executive Nurse Director, stressing the urgent need for a decant ward and single rooms.
Action – Mr Ivar Grey with Mrs Ruth Walker
It was recognised that in the event of ward closure or change, engagement with CHC would be required. It was noted that this had been on the agenda for a number of years and it had not yet been possible to make progress. It was also noted that work would commence shortly on B2 Duthie Library to provide more accommodation for decant and winter pressures.

Given that there were already some plans in place, it was agreed to ask for a brief summary from the Director of Planning for the next meeting.
Action – Mrs Abigail Harris

An analysis of comparative data remained outstanding. It was hoped that this data could be linked to the work undertaken by Mrs B Steer and used to justify funding requests (requested because the UHB had a higher than normal infection rate over winter).

QSE 17/027 Medicine QSE Minutes – The Interim Chief Operating Officer advised that the data referred to was quite old. Since that time, the UHB had developed an orthopaedic geriatric service and the average length of stay had reduced by 5 days. In addition, the percentage of patients discharged home was favourable.

QSE 16/046 Care for Patients with Learning Disability – The Chair asked for further discussion with the Executive Nurse Director and the Director of Therapies and Health Sciences to ensure that any deaths involving people with a learning disability were identified in mortality reviews
Action – Dr Fiona Jenkins

QSE 17/049 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

With the support of 2 Independent Members, Chair's action had been taken to approve the Equality Impact Assessment for the Patient Property Policy – the Policy itself had been approved by the Committee in September 2016.

QSE 17/050 PATIENT STORY – MENTAL HEALTH

Mrs Jayne Tottle, Nurse Director, Mental Health Clinical Board, presented Sally's story. This was a very sad story of a young and vulnerable lady who had a history of self-harm and had been diagnosed with an emotionally unstable borderline personality disorder. After committing several offences,

she served a prison sentence. On release just before Christmas, a risk assessment was undertaken and a plan of care was put in place. This required Sally's co-operation as there were no powers to force her to participate as her license had expired. The plan went reasonably well and her engagement with the complex trauma service and CMHT services progressed. Sadly Sally would not give consent to allow health professionals to share information about her use of ligatures with her mother, with whom she was living, (although her mother was aware that she used other methods to self-harm). In this difficult position, Sally's Mum was offered support as a carer. Following a family holiday, Sally used a ligature, and hanged herself. It was believed that this was not an intentional suicide attempt.

Mrs Tottle explained to the Committee the ethical dilemma the Clinical Board had been in regarding the issue of confidentiality and the decisions made about the best method of care. Following Sally's death, the family did not want to meet with the Clinical Board and so the information regarding her ligaturing behaviour that emerged at the Inquest came as a complete surprise and upset and angered the family. Reassuringly, the Coroner was of the opinion that health staff had acted appropriately.

The Committee often discussed suicides but did not receive this level of detail from the closure of Serious Incidents. The story and explanation highlighted that however hard staff tried, it was sometimes impossible to prevent a death by self-harm.

The Chair thanked Ms Tottle for presenting. The Committee **NOTED** the patient story.

QSE 17/051 MENTAL HEALTH CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions on the report:

- Asked about the sustainability of the workforce given its age profile, it was noted that quarterly recruitment was ongoing but there was a national shortage of mental health nurses. The situation would ease in a few years given that the agreement for mental health nurses to retire at age 55 had been rescinded. In addition, the expansion of care in the community would support recruitment as would attempts to "right size" the bed provision for older people.
- In terms of the administration of medicines, it was noted that better training was being provided in college, but this was enhanced with role play during the bespoke 2 week induction programme developed and delivered in the Mental Health Clinical Board
- In terms of safeguarding, this was discussed along with lessons learned at monthly meetings. Behaviour, culture and codes of conduct were also discussed with staff.
- Concern was expressed that staff from outside Mental Health Clinical Board were subjected to acts of violence and aggression and they had

not received adequate training. It was noted that permanent members of staff from, for example, portering or housekeeping, who were working in mental health areas, could access the training provided to mental health staff, but this would be reiterated to Facilities Management.
Action – Ms Jayne Tottle
Staff were supported post incident through debriefing and were given the opportunity to access Employee Wellbeing Services or Occupational Health. Senior staff also supported colleagues.

- Progress had been made with services for Deaf patients. Loops and an information pack were also available. The Clinical Board Director of Operations agreed to refresh the work and invite representatives from the deaf community to walk the wards and community team bases.
Action – Mr Ian Wile
- In terms of the Estate, there were 17 community mental health teams (CMHT). Outpatient CMHTs were now co-located at the Llanfair Unit. The poorest accommodation in adult services was being reviewed in line with the UHB Strategy. It was agreed to request an update on estate issues.
Action – Mrs Abigail Harris
In addition, 8 teams would be combined into 3 Locality teams and a bid had been submitted for funding.
- With regard to advocacy, the UHB complied with the Mental Health Measure and had included in the SLA the need to communicate advocacy services to clients and offer them to community clients.
- The new reassurance observation system in Hafan y Coed was working well. The system was explained to patients on admission. On the whole this was well received as it avoided the need for staff to enter bedrooms at night and all activity was recorded to reassure both patients and staff.
- Supportive administration had worked well and it was suggested this may continue to MHSOP. Feedback from HIW had demonstrated that this had worked well for the Clinical Board.
- It was noted that the NMC had requested a visit to Hafan y Coed in May. In addition, the Chair asked for a visit to be arranged for the new Independent Members.
Action – Mrs Julia Harper

ASSURANCE was provided by:

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

The Quality Safety and Experience Committee:

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

QSE 17/052 COMMUNITY HEALTH COUNCIL REPORTS

The CHC had nothing to report to the Committee at this time.

QSE 17/053 DONATION OF ORGANS AND TISSUES AFTER DEATH POLICY AND PROCEDURE

Dr Turley explained that minor tweaks had been made to the Policy and comments received most recently had been addressed in the Standard Operating Procedures. These may have some operational impact.

In terms of communication, it was noted that specialist staff spent a long time with donor families prior to the retrieval of organs. Sensitive conversations were bespoke to individual families, whilst Public Health Wales was responsible for national communications. Staff training involved role play with actors. It was noted that since the law change, staff had detected that families were more aware of their loved ones wishes. The wishes and the faith of the family were always respected. It was agreed to provide a patient story linked to faith for a future Board meeting.
Action – Angela Hughes

It was noted that an Annual Statement was being prepared on organ donation, though there were no plans to bring this to the Committee.

It was agreed to provide greater clarity on the qualifying relationship of (h) “friend of longstanding” on Boardbook page 54 of the procedure.

ASSURANCE was provided by:

- The document adhered to the Human Tissue and Transplantation Act 2013 (Wales).
- The documents complied with good practice guidance of the General Medical Council; Treatment and care towards the end of life.
- The documents supported clinical practice in line with National Institute for Clinical Excellence Clinical Guideline 135.
- The documents supported 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:

- **APPROVED** the Donation of Organs and Tissues After Death Policy and Procedure subject to making the small change to the Procedure mentioned above.

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

QSE 17/054 QUALITY SAFETY AND IMPROVEMENT FRAMEWORK

The Executive Nurse Director, Mrs Ruth Walker introduced the following two Frameworks that brought together all the quality, safety and experience work needed for the UHB Strategy.

Mrs Carol Evans, Assistant Director Patient Safety and Quality presented the Quality, Safety and Improvement Framework. It was noted that the Committee had previously discussed this Framework in private. Since then, much engagement had been undertaken and the Framework now reflected the work priorities for the next 3 years. A number of comments were made on communication, use of the Welsh language, sensory loss and the need to include an explanation on page 106 about ambulance handover times and these would be included.
Action – Mrs Carol Evans

The Executive Nurse Director thanked Mrs Carol Evans for all her work on the Framework and advised that the Committee workplan was aligned with this Framework, the Integrated Medium Term Plan and the Annual Quality Statement.

ASSURANCE was provided by:
- The triangulation work that had been undertaken to date to identify key areas that the QSI Framework would 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:

- **APPROVED** the Quality, Safety and Improvement framework.
- **AGREED** to monitor the implementation of the framework and to receive twice yearly progress updates.

QSE 17/055 PATIENT EXPERIENCE REFRESHED FRAMEWORK 2017 – 2020

Mrs Angela Hughes, Interim Assistant Director of Patient Experience explained that the Framework was aligned with the Values into Action work. There were, variances in the maturity of Clinical Boards, but all focus was on what it was like to be a patient in the UHB and feedback would be used to deliver service change.

Where negative comments were clustered around certain times in the day, volunteers were being used to identify the reasons why.

In response to a number of comments, it was agreed to hold further discussions with Mrs McLaughlin outside the meeting and to share the methodology of the Framework with new Independent Members.
Action – Mrs Angela Hughes

ASSURANCE was 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:

- **APPROVED** the Patient Experience Refreshed Framework
- **AGREED** to monitor the implementation of the framework and to receive twice yearly progress updates

QSE 17/056 PATIENT SAFETY SOLUTIONS ALERTS AND NOTICES

The Executive Nurse Director, Mrs Ruth Walker reiterated that a financial allocation had not yet been found to implement the Safety Alert on patient wristbands. The report highlighted where there was limited or no progress on some of the Alerts.

The Committee was concerned that other health boards had managed to implement some of the Alerts - in particular the wristbands. The crux was whether the Board felt that implementation was the highest priority for investment.

Mrs Carol Evans highlighted that the UHB was not completely non-compliant with all of the outstanding notices. There were instances where only a small part of the recommended action had not been taken. She circulated an example of a Patient Safety Notice to members to illustrate the complexity of what was required to declare full compliance, noting that often it was only one criteria that the UHB was not meeting. She also pointed out the practical difficulties of implementing some of the notices, for example in the case of the provision of a second controlled drug cupboard on all wards, there would be a financial implication as no wards currently had two such cupboards. With regards to Safe Storage of Medicines: Cupboards –no Health Board was able to declare compliance and it was likely that this particular Notice would be revised to be more achievable.

However, it was highlighted that the UHB was not completely non-compliant. There were instances where only a small part of the recommended action had

not been taken – particularly in the case of the provision of a second medicine cupboard on all wards and this was because there was no decant ward to enable the removal of asbestos in order to fit the cupboards. In this instance, no Welsh health board was compliant and it was likely that the notice would be withdrawn.

The potential requirement for the UHB to procure a more expensive PACS system was highlighted as an area where around £400k could be spent on safety solutions instead. The Chair would be writing to the Minister about the PACS proposal.
Action – Ms Maria Battle

With regard to the notice on spinal, epidural and regional devices, Dr Turley urged caution. Common sense was required to ensure that changing devices did not cause other problems. It was more beneficial to take action to reduce risks to all patients.

With regard to action on the early identification of the failure to act on radiological imaging reports, it was noted that the Welsh system was unable to record the necessary information. Other health boards had undertaken a random audit only and were unable to guarantee all patients were safe.

In terms of patient wristbands it was important to balance the risk to patients against the constraints of installation on the wards. Implementation required manpower as well as the technology. Mr Allen of the CHC offered to share evidence provided by patients about the lack of safe identification.
Action – Mr Stephen Allen

It was noted that the report did not contain timeframes. It was therefore agreed to receive a further report at the July Board with reasons for non-compliance, mitigating assurance actions and time scales noting that changing practice often took some time to complete.
Action – Mrs Ruth Walker

LIMITED ASSURANCE was provided by:

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

The Committee:

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

QSE 17/057 PATIENT FALLS EXCEPTION REPORT

The report was presented by the Director of Therapies and Health Sciences, Dr Fiona Jenkins. Currently there was no reliable Welsh benchmark against which the UHB could make comparisons but the UHB was in the middle of the Welsh figures for accidents/incidents. The Falls Group was therefore focusing with partners on the prevention of falls. It was noted that patients were

actually more vulnerable in hospital where the environment was unfamiliar and longer than necessary admission increased a patient's risk of falling. In addition the distance to ward bathrooms, particularly in UHL was cited as a difficulty.

It was agreed that analysis of the data would be undertaken to identify hotspots and the reasons for the fall and whether it was appropriate for the patient to be on that ward. Once available, this information could be shared with other stakeholders to reduce harm to others.
Action – Mrs Carol Evans

ASSURANCE was provided by:

- The UHB was currently demonstrating a stable trend in incidents relating to slips trips and falls. Significant work was underway particularly in the community in relation to falls prevention.
- There was however **limited assurance** relating to serious incidents due to inpatient falls which continued to show an upward trend in quarter 1 of 2017. Urgent action was being taken to identify hotspots, analyse trends and provide focused support.

The Committee:

- **NOTED** that the UHB was continuing to hold the reduced trend seen in 2016.
- **SUPPORTED** the reconstitution of the Falls Delivery Group which would provide focus to falls prevention across the whole pathway.

QSE 17/058 HM CORONER REGULATION 28 – PREVENTION OF FUTURE DEATHS REPORT

The Executive Nurse Director had nothing to add to the report but confirmed that much work had been undertaken on the safety of chest drains and this had been shared widely. The Committee was pleased to note evidence of this in the minutes of the Clinical Board Quality and Safety sub Committees.

ASSURANCE was 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:

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

QSE 17/059 HIW VISITS UPDATE

The Executive Nurse Director, Mrs Ruth Walker commented that these reports were brought to the Committee regularly and full reports were received as required. Issues identified with regard to the lack of documentation and poor documentation were being driven nationally. With regard to the inspection process, staff were being reassured that inspections were not something to fear.

As a result of last year's report from HIW, the number of internal peer inspections had been increased to 120 and these were targeted with learning cascaded. However, there was still more work to do on integration of adult and older peoples mental health. In addition professional performance reviews were held with the Executive Nurse Director. Mr Allen confirmed that the CHC was not currently identifying any significant issues of concern.

ASSURANCE was provided by:

- Progress was 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 Committee:

- **NOTED** the progress made to address the findings of the HIW inspection at University Hospital Llandough in 2016 and recent verbal feedback following 2 unannounced visits in March 2017.

The Chair left the meeting and the Vice Chair, Mr Ivar Grey took over.

QSE 17/060 CORPORATE RISK AND ASSURANCE FRAMEWORK

Concern was expressed that "no update had been received" with regard to item 5.1.1 which was unacceptable and this would be relayed to the Director of Corporate Governance.
Action – Mrs Julia Harper

It was suggested that it would be useful for the Committee to consider some of the lower scoring risks at a future meeting to ensure the risks were being managed appropriately.
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 17/061 CANCER PEER REVIEWS

There were currently no reports outstanding.

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

QSE 17/062 LEARNING DISABILITIES SPECIALIST, SECONDARY CARE AND PRIMARY CARE SERVICES COMMISSIONING UPDATE

It was noted that the Learning Disability service was provided by ABMU Health Board. In addition, since the bundle had been implemented, no serious incident involving a patient with learning disabilities had been reported.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **NOTED** the progress update in relation to commissioning learning disability services.

QSE 17/063 HEALTHY RESTAURANT AND RETAIL POLICY

It was suggested that better promotion and advertisements for healthy food could be displayed in the UHB's catering facilities. This would be relayed to the Facilities department.
Action – Dr Fiona Jenkins

Concerns had been raised by staff about the cost of food and the opening times of the facilities. This resulted in inequality of access particularly for staff who worked nights and weekends. There was a double whammy of reduction in subsidy and an increase in costs at a time where a pay rise had been very limited for some years. In addition, facilities were not always open for the duration of visiting hours and this forced people into using more expensive facilities in the Concourse.

It was noted that the dining facilities were not yet breaking even and it was reported that the number of staff using the facilities had dropped due the reasons cited above. The comments would be reported back to the Facilities department.
Action – Mrs Fiona Jenkins

It was also agreed to ask the PPP Committee (or its replacement) to consider these views and to look into comments that had been made regarding the value for money of the all Wales food contract.
Action – Mrs Julia Harper

ASSURANCE was provided by

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

The Committee:

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

QSE 17/064 WAO REVIEW OF DELAYED TRANSFERS OF CARE IN THE CARDIFF AND VALE HEALTH AND SOCIAL CARE COMMUNITY – REVIEW OF DISCHARGES

Asked when it was anticipated that progress would be seen (the UHB had the third highest number of delayed transfers of care) in Wales, it was noted that Mrs Alice Casey was taking the lead on length of stay through the transformation work and this would be reported to the UHB Board through the Transformation Board.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **CONSIDERED** the main findings of the Wales Audit Office review.
- **AGREED** that the action plan addressed the recommendations made with the Wales Audit Office report.

QSE 17/065 WELSH RISK POOL SERVICES AND LEGAL AND RISK SERVICES ANNUAL REVIEW

The low number of clinical negligence claims in Cardiff was welcomed and it was suggested that this was probably as a result of the work undertaken through Putting Things Right (PTR). It was noted that the PTR solicitors had withdrawn the service. This would not heavily impact the UHB with 9% usage, (the Welsh average was 24%) however, legal fees would increase.

UHB 17/066 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The Minutes were received and noted. The Executive Nurse Director agreed to discuss the attendance of the CHC at these meetings with Mr Allen separately.
Action – Mrs Ruth Walker

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – JANUARY AND FEBRUARY**

   The attendance of Ms Pritchard was welcomed.

2. **MENTAL HEALTH - JANUARY AND FEBRUARY**

3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - JANUARY**

   Mobile coverage within parts of the Vale of Glamorgan would be discussed separately as staff were unable to use their equipment in some places.
   Action – Mrs Ruth Walker and Dr Fiona Jenkins

4. **SPECIALIST SERVICES – FEBRUARY X 2**

5. **MEDICINE (AND ACUTE AND EMERGENCY WAITS) – JANUARY, FEBRUARY AND MARCH**

6. **SURGERY – JANUARY**

7. **CHILDREN AND WOMEN – JANUARY**

8. **DENTAL – JANUARY**

   It was noted that there was more work to be done on the depth and breadth of the agenda in the Dental Clinical Board and this was being pursued.
   Action – Mrs Carol Evans

QSE 17/066 AGENDA FOR THE PRIVATE QSE

The agenda was noted.

QSE 17/067 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

- Funding for Patient Wristbands to be considered at Management Executive.
- Report to Board in July on Patient Safety Solutions, Alerts and Notices with timeframes and mitigating actions.
- Request PPP Committee (or its successor) to consider the comments from Staff Representatives on catering and the value for money of the all Wales catering contract for food.

QSE 17/068 REVIEW OF THE MEETING

There was nothing to add to the meeting, however, the Chair invited Mr Alun Jones of HIW to provide his observations on the meeting. Mr Jones said it was interesting to see the range of items discussed at the meeting, particularly the items that had concerned HIW, in particular patient falls and suicides. He found the debate on patient wristbands interesting and welcomed the discussions on HIW inspections and the themes from these contained in a number of the reports. In addition, the sharing of lessons learned was valuable. He acknowledged that it was evident the UHB was trying to identify issues before HIW.

The Executive Nurse Director recommended that HIW look at the regular Patient Safety, Quality and Experience reports to the Board for more detail and thanked Mr Jones for the HIW recommendation to ABMU of the need to share their learning disability data with the UHB.

QSE 17/069 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 20th June 2017.

ACTION LOG FOLLOWING QSE COMMITTEE APRIL 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/066	18.4.17	Minutes from Clinical Board QSE Sub Committees PCIC		Discuss mobile coverage in the Vale.	R Walker and Dr F Jenkins	IT team aware of issues and exploring options to work 'off line'. Vale has geographical issues re mobile coverage outside control of IT service.
QSE 17/024 QSE 17/048	21.2.17 18.4.17	Ward Bathroom Refurbishment		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.	I Grey C Evans	See Item 28 on June agenda Link to work undertaken by B Steer. **Verbal update to be provided at the June meeting.**
QSE 17/027	21.2.17	Sub Committee QSE Minutes		Bring together the Clinical Board quality and safety Leads to review good practice with regard to minutes.	C Evans	Carol Evans will be attending the Directors of Nursing weekly meeting on 20th June to discuss.
QSE 17/051	18.4.17	Mental Health CB QSE Report		Remind Other Clinical/Corporate Boards that staff in MH areas can access violence and aggression training.	J Tottle	

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				Refresh work on sensory loss and arrange walkround with representative of the deaf community.	I Wile	
QSE 17/055	18.4.17	Patient Experience Refreshed Framework		Hold further discussion with Mrs McLaughlin and share methodology with Independent Members.	A Hughes	A meeting has been set up with Mrs McLaughlin and others to discuss alignment with engagement activity.
QSE 17/56	18.4.17	Patient Safety Solutions Alerts and Notices		Share with the UHB evidence obtained from patients regarding wristbands.	S Allen, CHC	
QSE 17/066	18.4.17	Minutes from Clinical Board QSE Sub Committees		Discuss depth and breadth of the Dental agenda with the CB.	C Evans	Meeting arranged for 23rd June
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/192 QSW 17/048	18.10.16 18.4.17	Critical Care Outreach Team (Identifying and Managing the Deteriorating Patient)		Clinical Model for managing the deteriorating patient to be agreed. Discuss at Management Executive the options for strengthening on site clinical and managerial support.	R Walker and Dr G Shortland S Curry	This item had been considered at Committee several times without agreement on a way forward for an action plan and timeline. Full discussion to be held at at **QSE meeting in June 2017**.

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				Finalise ongoing shape and purpose of services at UHL through the acute medicine review with the Planning Team.	S Curry	
QSE 17/023	21.2.17	Care of Deteriorating Patient		Ensure all differing views are taken into account when scoping the way forward	Dr G Shortland	(Linked to the above work)
QSE 15/135 QSE 16/006 QSE 16/202 QSE 17/023	01.09.15 23.2.16 13.12.16 21.2.17	Corporate Risk and Assurance Framework Exception Report - Care of the Deteriorating Patient : Critical Care Outreach Service		Business Case for Critical Care Outreach (CCO) and Hospital at Night to be considered at Investment Panel. Need to resolve Critical Care Service issues at UHL.	A Casey changed to S Curry Dr G Shortland / S Curry	December update: Awaiting funding for Advanced Nurse Practitioners to address Hospital at Night February 2017 - Reported to HSMB in December that more work was required to make the plan resource neutral. Update agreed for **September 2017** (Linked to 2 items above)
QSE 15/171 QSE 16/148 QSE 17/005 QSE 17/048	20.10.15 13.9.16 21.2.17 18.4.17	Trends and Themes in SI's		Revisit decision on patient wristbands.	R Walker	Feb 2017 - Solution agreed but funding yet to be identified for 2017/18. Present report for funding consideration to the **Management Executive** and provide more detail for the next **QSE meeting in June**. Business case now going to

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						BCAG 13TH June 2017
QSE 17/048	18.4.17	Ward Bathroom Refurbishment		Report requested on plans for single rooms and a decant facility for the next meeting.	A Harris	**June QSE** On June Agenda - **Complete**
QSE 17/051	18.4.17	Mental Health CB QSE Report		Update report requested on the Mental Health estate and future plans in light of some very poor accommodation.	A Harris	**QSE in June** Verbal update on June agenda **– Complete**
QSE 17/56	18.4.17	Patient Safety Solutions Alerts and Notices		Provide a further report for the Board in July with reasons for non-compliance, mitigating assurance actions and time scales.	R Walker	**Board in July** (deadline 12th July for report)
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		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 each policy amendment	C Evans C Evans	Decision taken not to reconstitute the Group. **Closed** . **QSE September 2017**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/017	21.2.17	HIW Ophthalmology Thematic Review		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		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		Update report to be received in September	Dr G Shortland	**QSE September 2017**
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness		Receive an update in 6 months to a year.	R Walker	**QSE September or December 2017**
QSE 17/057	18.4.17	Patient Falls		Undertake analysis of the data to identify hotspots, reasons for the fall and whether it was appropriate for the patient to be on that ward.	C Evans	Work is underway by Falls Delivery Group. Proposed to consider analysis at the Special meeting of the **QSE in October 2017.**
QSE 17/054 and QSE 17/055	18.4.17	Quality Safety and Improvement Framework Patient Experience Refreshed Framework		Receive monitoring report in October or December.	C Evans A Hughes	**QSE in October or December 17**
QSE 17/063	18.4.17	Healthy Restaurant		Request PPP Committee	J Harper	**Referred to PPP Committee**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		and Retail Policy		to consider the comments and review value for money of all Wales food contract.		**Secretariat (or its successor on 19/4/17)**
QSE 17/053	18.4.17	Donation of Organs and Tissues after Death Policy		Identify a Patient Story linked to faith for a future Board meeting.	A Hughes	**November 2017 Board meeting**
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/013	21.2.17	Annual Quality Statement		Provide advice on stakeholder engagement opportunities	M McLaughlin	**Complete**
QSE 17/011	21.2.17	Committee Work Plan		Set up induction for new QSE IMs with Assistant Nurse Directors	R Walker	Carol Evans preparing a draft programme for the session on 28th April. **Complete.**
QSE 17/027 QSE 17/048	21.2.17	Medicine QSE Minutes		Investigate reason why length of stay (National Hip Fracture database) had reduced in England but was not replicated in Wales.	S Curry	The data was old. Since this time the UHB has developed an orthopaedic geriatric service and the average length of stay had reduced by 5 days. **Complete**
QSE 17/060	18.4.17	CRAF		Advise author that it was not acceptable “no update had been received”.	J Harper	**Complete**
QSE 17/56	18.4.17	Patient Safety Solutions Alerts and Notices		Write to the Minister about PACS .	M Battle	**Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/009 QSE 17/048	21.2.17 18.4.17	CHC Report – Boredom and Loneliness		Check WRVS long term strategy for trolley service.	R Walker	The RVS provides a service Monday to Friday to UHW and Rookwood wards. There are also shops at Rookwood, Barry and Llandough Hospitals. Trolley service ran inconsistently at UHL due to limited number of RVS volunteers. When it visited MHSOP wards, it returned very little revenue. Feedback from volunteers was that demand for the service was very low. Thus, the trolley was transferred to UHW to enable several rounds at once. **Complete**
QSE 17/048	18.4.17	Care of Patients with a Learning Disability		Chair requested further discussion with Dr Jenkins and Mrs Walker.	Dr F Jenkins and R Walker	Meeting arranged - **CLOSED**
QSE 17/051	18.4.17	Mental Health CB QSE Report		Arrange a visit for new Independent Members to Hafan y Coed.	J Harper	Visit arranged for 6th July. **Complete**
QSE 17/053	18.4.17	Donation of Organs and Tissues after Death Policy		Request clarity to definition of “friend of longstanding” then publish Policy and Procedure.	J Harper	**Complete**
QSE 17/066	18.4.17	Minutes from Clinical Board QSE		Discuss with Mr Allen the attendance of CHC	R Walker	**Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Sub Committees PCIC Dental		at these meetings. Discuss mobile coverage in the Vale. Discuss depth and breadth of the Dental agenda with the CB.	 R Walker and Dr F Jenkins C Evans	 IT team aware of issues and exploring options to work 'off line'. Vale has geographical issues re mobile coverage outside control of IT service. **Complete**
QSE 17/060	18.4.17	CRAF		Consider lower scoring risks at the next meeting.	P Welsh	**QSE in June** **Complete** – on the agenda
QSE 16/215	13.12.16	Mortality Data and Mortality Review		To include in next report the mortality/death rate differences between weekends compared to other times	Dr G Shortland	**QSE June 2017** **Complete –** on the agenda
QSE 16/204 QSE 17/005	13.12.16 21.2.17	Medicine Clinical Board, Quality Safety & Experience Report		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. **CLOSED to QSE**
QSE 17/066	18.4.17	Minutes from Clinical Board QSE Sub Committees Dental		Discuss with Mr Allen the attendance of CHC at these meetings. Discuss depth and breadth of the Dental agenda with the CB.	R Walker C Evans	**Complete** **Complete**
QSE 17/054	18.4.17	Quality Safety and		Include comments made	C Evans	**Complete**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Improvement Framework		at the meeting in the Framework.		
QSE 17/063	18.4.17	Healthy Restaurant and Retail Policy		Advertise healthy eating in UHB catering areas.	A Harris	Information relayed by Dr Jenkins.to Abi Harris. Abi Harris has relayed this information to the Estates Team. **Complete**
				Report comments from Staff Representatives back to the Director.	A Harris	Abi Harris has relayed this information to the Estates team **Complete**

QUALITY, SAFETY AND EXPERIENCE BRIEFING PRIMARY COMMUNITY AND INTERMEDIATE CARE CLINICAL BOARD
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20 June 2017

Executive Lead: Executive Director of Nursing
Author: Director of Nursing – Primary, Community & Intermediate Care Clinical Board
Caring for People, Keeping People Well: This reports supports all aspects of the Health Board – empowering the person, home first, outcomes that matter to people, avoiding waste variation and harm
Financial impact: No current direct measurable financial impact that has implications for the Clinical Board agreed allocated budget. A financial update will be required in 2017 in relation to the LDP and GMS sustainability.
Quality, Safety, Patient Experience impact: Substantial assurance (PCIC Internal QS&E Audit Report 2016)
Health and Care Standard Number … QS&E agenda encompasses all of the Health Care Standards within its scope.
CRAF Reference Number: 1.1, 1.2, 1.3, 2.2, 2.5, 3.1, 3.1.2, 4.2, 4.3, 5.1, 5.1.2, 5.1.5, 5.1.6, 5.1.12
Equality and Health Impact Assessment Completed: Yes / No **/ Not Applicable** .

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Internal Audit Department has provided substantial assurance on the processes in place for quality, safety and experience within the Primary, Community & Intermediate Care (PCIC) Clinical Board (2016).

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the contents of the brief report of the PCIC Clinical Board QSE Sub Committee
- **NOTE** the areas for further action:
  1) Increase the PPI activity across the breadth of the clinical boards provider and commissioned services
  2) Note the ongoing work required to ensure that a comprehensive and responsive interface system of incident reporting is in place
  3) Note the clinical boards top 5 risks and the work required to treat and mitigate these risks
  4) Note the ongoing safeguarding work and monitoring of commissioned placements that is being undertaken across the commissioned nursing homes through the Locality Teams.

SITUATION

This report provides information on the Primary, Community & Intermediate Care (PCIC) Clinical Board Quality, Safety and Experience (QS&E) agenda and activity over the last 12 months. The report will highlight work undertaken and identify future areas of work. The QS&E agenda is based on and supported by the UHB Strategy Caring for People, Keeping People Well (2015-2025) and the Health Care Standards (Welsh Government 2015).

BACKGROUND

PCIC Clinical Board has a formal QS&E Committee in place that meets bi-monthly, which is co chaired by the PCIC QS&E Lead Medical Advisor and Director of Nursing. The Clinical Board business units (Directorates in other clinical boards, Primary Care, North and West Locality, South and East Locality, Vale Locality, Pharmacy, Palliative Care) have separate QS&E committees that also meet bi monthly and feed into the Clinical Board Committee. All committees have updated terms of reference and membership is representative of the services that operate within the business units. A standard UHB agenda is used for all of these meetings with minutes and action logs in place. Separate risk registers are held in the business units which are discussed each time the committees meet.

Within the PCIC Clinical Board there a number of directly delivered services as follows:

- District Nursing (In and Out of Hours)
- Community Resource Teams (two in Cardiff and one in the Vale)
- Specialist Nursing Services - Acute Response Team (ART), Continence and Wound Healing
- Homeless Services
- Department of Sexual Health
- Cardiff Health Access Service (CHAP)
- HMP Cardiff Healthcare
- GP OOH Services
- Pharmacy Advisory
- GP Sustainability Services

There are also a significant number of commissioned services for the local Cardiff and Vale population which include

- (Independent Contractors – GP's, Dentists, Optometrists & Pharmacists)
- Specialist Palliative Care Services
- Independent Sector care home placements

A number of national processes are in place to support the QS&E agenda for the commissioned services through regulatory mechanisms monitored by the Clinical Board and through Welsh Government agreed delivery plans.

The Clinical Board has a formal board meeting held bi monthly attended by the Senior Management Team, Executive representative, independent members and staff side organisations. The formal board requires assurance from all its committees in relation to the effective, safe and sustainable operation of all delivered and commissioned services.

ASSESSMENT AND ASSURANCE

The Clinical Board has an agreed QS&E agenda and plan for the next 12 months. The plan includes monitoring service delivery against the health care standards and managing the identified risks within appropriate tolerances through the risk register.

A number of actions have been identified through the recent Health Care Standards self assessment and an action plan for the Clinical Board will be received by the July PCIC QS&E committee.

Assurance is provided through the robust mechanisms that are in place within the Clinical Board and through the Clinical Boards QS&E and Board committees and through the Internal Audit Department assurance (2016).

ASSESSMENT

Governance, Leadership and Accountability

The PCIC Clinical Board QS&E committee is led by the Director of Nursing on behalf of the Clinical Board. The Director of Nursing takes the lead role for QS&E and is supported by the Senior Management Team. Specific roles within the Clinical Board supporting the Director of Nursing and involved in the QS&E agenda and subsequent committees are:

- Medical Advisor for QS&E - Dr G Hayes
- Assistant Director of Operations - C Darling
- Patient Safety Manager - H O'Sullivan
- Patient Safety Officer - H Prosser.

The Lead Nurses and Head of Primary Care within PCIC Clinical Board also have a lead role in supporting the QS&E agenda. The Clinical Board works very closely with the Corporate Patient Safety Team and Patient Experience team. There are also close links in place with Safeguarding teams both within and external to the organisation and CSSIW.

The Vale Locality has an integrated structure and work in partnership with the Local Authority.

There is good attendance and representation at the QS&E committees and non attendance and committee membership is reviewed on a regular basis. A Health Care Standards action plan is being developed following self

assessment in 2016, this will be presented to the July PCIC QS&E Committee and progress monitored through this committee.

The 5 top risks for the Clinical Board score all above 20 on the risk register. These are:

- Impact of the Local Development Plan (LDP)
- Primary Care Estates
- Complex Care package sustainability

With the following two scoring 25:

- GMS sustainability
- GP OOH Service

A great a deal of work has being undertaken to reduce risks within these areas including,

- comprehensive actions plans
- engagement with stakeholders
- escalating risks to the Executive Team
- discussion at Executive Performance review
- focus within the Clinical Board IMTP
- engagement with Welsh Government

Despite this the risks remain high.

Staying Healthy (Theme 1)

The main agenda for the commissioned services is promoting prevention, self care and well being from a physical, emotional and psychological perspective. Making Every Contact Count (MECC) programmes and training is in place throughout the commissioned services. There is evidence of sustained and high level prevention action which is identified through the performance measures monitored through QOF indicators and the PCIC dashboard - smoking cessation, healthy BMI, immunisations rates, chronic conditions management, cancer diagnosis and management of particular conditions through established ambulatory care sensitive pathways in place i.e. Diabetes, COPD.

Expert Patient Programmes (EPP) and sensory impairment strategies are in place for service users. The Clinical Board also has a dementia plan and is working closely with Public Health and Mental Health to provide support to reduce waiting times and improve access to early diagnosis.

The Pharmacy Teams have undertaken significant work in reducing antimicrobial prescribing across the GP community, demonstrating a 34% reduction. District Nursing, Community Resource Teams, Wound Healing and Continence Services promote prevention, self care and rehabilitation where possible with falls programmes, continence assessment clinics for the population and healed leg ulcer clinics to prevent chronic wound care and further skin breakdown.

Safe Care (Theme 2)
Sepsis good practice guidelines have been communicated out through the Clinical Board and the Skin Bundle is well established and in place within provider services such as District Nursing.

The Clinical Board has one SI open relating to an incident within the GP OOH service which involved a bank member of staff. There have been four SI's in total in the last 12 months and three have been closed. The three closed incidents relate to

- another GP OOH incident in relation to poor telephone triage, which has led to a disciplinary investigation
- a HMP Cardiff patient who deteriorated whilst in custody and was transferred and died within UHW
- a cold chain incident within a GP practice which led to a significant amount of investigation work with Public Health Wales and the Vaccine Preventable Diseases Department (VPDP).

Incidents are primarily investigated through the business units. Pressure damage is the highest reported incident as per All Wales Pressure ulcer guidance (Welsh Government 2013). Patient non compliance within the community setting is a significant theme. The Locality Lead Nurses work closely with the UHB and Local Authority Safeguarding teams (MASH) to work through all reported cases. A revised process for reporting 'Interface Incidents', (incidents reported by GP's relating to discharge or transfer of care across the patient interface) was established in 2016. The process has been subject to review through improvement methodology to ensure it is as robust as possible given the complexity of the issue being raised and multiple stakeholder involvement. Further meetings are in place through the summer of 2017 with stakeholder involvement in an attempt to agree the final process. The number of incidents reported is very high and the Clinical Board currently does not have sufficient resource to maintain the level of support required for the existing process. Many of the incidents raised would not be classified as true incidents and this is why the current process requires reviewing to ensure all issues can be captured appropriately through the correct mechanisms.

The monitoring of nursing homes placements by the PCIC Nurse assessor staff has been put under a great deal of strain over the last 18 months with a number of nursing homes being involved in formal safeguarding and performance monitoring joint agency processes. Plans are in place and monitoring of these homes has increased to ensure patient safety. Consequently, this has had an impact on the statutory requirement to undertake regular reviews.

Recruitment and retention of staff has proved to be challenging in the last two years with high turnover in band 5 and 6 staff across the Clinical Board nursing services. The high level of vacancies has had a negative effect on the nursing services ability to meet demand and teams are operating below establishment (District Nursing, Department of Sexual Health and HMP Cardiff).

A recruitment event undertaken in April 2017 was very successful with most band 5 vacancies at that time recruited to. A recruitment and retention plan is in place and every effort is being made to ensure that staff are retained.

A robust system is in place within the business units to comply with the patient safety alerts which is recorded through all QS&E committees.

Complaints management within the clinical board has been reviewed due to poor compliance with the required targets. A significant amount of work has been undertaken to ensure the Clinical Board is continuing to improve in particular with respect to formal concerns. The revised UHB complaints process has been implemented with the Director of Nursing signing off the formal complaints on behalf of the Clinical Board. The Clinical Board received 12 formal complaints and 14 informal complaints between 1/02/17-05/05/17. The majority of formal complaints were in relation to primary care services (In and out of hours). There are no particular themes in the current complaints. However, waiting times particularly for GP OOH has been a theme in the past.

Anticoagulation work undertaken within the ART service over the last financial year has been highly effective and efficient, with over 1139 patients being supported by the service and over 8000 face-to-face contacts made by staff within a clinic or home setting. A significant proportion of the patients supported by the service have been the group deemed as unstable anticoagulation patients who would have previously remained in hospital until therapeutic, the average length of time the service takes to stablise these patients is 4.9 days. Bridging patients (those patients who require surgery whose anticoagulation requires ceasing prior to surgery) would have previously been admitted for their treatment to cease and wait for reloading of medication post surgery, then ART service support this group of patients at home, the average length of time supported at home with the service is 9.8 days (full report is available).

Glucometre roll-out for District Nursing and other PCIC nursing teams has taken place in 2016/2017. Previously district nurses and other community staff would have used the patient's own machines which were unreliable and variable which was a significant quality and safety issue.

A Health Inspectorate Wales (HIW) and Prison Ombudsman Report following a death in custody (end of life patient) was highly complementary regarding the partnership working between Specialist Palliative Care Services, prison staff and local district nurses care for this inmate in his last days.

An Ombudsman Report relating to a concern raised regarding a GP in Cardiff and the subsequent death of a patient has been shared wider throughout general practice in relation to lessons learnt. The Ombudsman made particular reference to the need for contemporaneous record keeping and the use of best practice guidance in relation to constipation and acting on red flag symptoms.

There has been an ongoing issue with HIW not informing the UHB of planned inspections for Independent Contractors (GP's and Dentists). This is being raised in the formal meetings with the Executive Nurse Director and Assistant Director of Quality and Safety.

Effective Care (Theme 3)
There are a number of Ambulatory Care Sensitive (ACS) Pathways that have been developed that have been clinically led and agreed across the patient pathway. These include:

- Atrial Fibrilation
- Advanced Care Planning
- COPD
- Dehydration and Gastroenteritis in under 5's
- Heart Failure
- Diabetes
- Polypharmacy
- Uptake of Pneumovax and Flu for at risks groups

These have been identified and implemented to improve outcomes for patients and to ensure the patient is seen closer to home in line with the UHB strategy.

There are number of national audits that the Independent Contractor Services (GP's) have been involved in, such as COPD, Diabetes and Chronic Kidney Disease. The learning from these audits has been shared with the Independent Contractors and reported through the Clinical Board QS&E committee.

A revised NICE process has been agreed within the board , the NICE Institute have complemented the clinical board R&D Community Director for the NICE summaries that have been developed and are circulated out to GP's on a quarterly basis.

There is a formal Audit Plan in place for the clinical board which involve local audits, these audits are presented and fed back to the PCIC QS&E Committee. There are also a number of smaller service based audits being undertaken that are linked to the business unit QS&E committees, such as staff diary, documentation audits, prescribing audits and clinical triage audits.

The Clinical Board is involved in an All Wales Macmillan Cancer Project involving working with GP's to improve cancer diagnosis and access to treatment in a timely manner which is hoped to improve outcome for patients linked to the cancer standards.

The District Nursing service is also working collaboratively with Marie Curie Research and development team in scoping a project looking at supporting informal carers to support End of Life patients within their own home by administering pain relief.

Dignified Care (Theme 4)
The Board has recently formalised the patient engagement plan and established an engagement group.

An audit plan has been developed to formalise patient engagement and feedback through formal PPI audits and patient stories. The QS&E Committee has patient stories provided at the meetings.

The catheter bundle has been in place for some years and the catheter passport was developed by the Director of Continence for use across the inpatient and community areas. The Director of Continence has also worked with WAST and EU to develop a pathway to support dignified toileting.

The Clinical Board has undertaken significant amounts of work in ensuring patients who choose to die at home are supported. An investment in the Hospice at Home Service has seen a significant increase in the numbers of patients supported in partnership with district nurses.

The Clinical Board also actively promotes Advanced Care Planning through Ambulatory Care sensitive (ACS) pathways for GP's. Also, working with Macmillan to develop a bid for ACP trainers for 17/18.

Timely Care (Theme 5)
A significant amount of work has been undertaken across PCIC services to improve access for the public. Due to the demand on GP's in particular there is more work required to improve equitable access for all Cardiff & Vale of Glamorgan residents. The Head of Primary care is currently working on the development of an improved access plan following the Older Persons Commissioners survey.

Work is in place within the GP OOH service and the Department of Sexual Health to improve waiting times and access to services. The Community Health Council has been involved in looking at a number of different options for feedback. One improvement has been the implementation of a twitter account for the Department of Sexual Health service users can feedback to the staff.

Further areas of work would involve developing new agreed pathways linked to choose wisely and the UHB Big priorities and the continued the review of performance against local and national performance.

Individual Care (Theme 6)
The Clinical Board has a patient engagement plan in place. The newly recruited Patient Safety Officer will be overseeing the progress of this plan and working with the corporate patient experience team and other important stakeholders in support of the national framework for user experience.

The business units within the Clinical Board are undertaking patient engagement in all four quadrants of the framework. There is still further work to be undertaken and actions plans need to be developed to ensure we are learning from the feedback we receive.

Real time – short surveys and feedback cards are being used in many of the patient facing services
Retrospective – Patient stories are now being undertaken within all business units and a patient story is provided at each PCIC QS&E Committee. Quality of life surveys are also being undertaken in Continence Services and Community Wound Healing Services.
Proactive/Reactive – Department of Sexual Health has recently launched a twitter account for their service users. The UHB Communication team often share positive compliments and patient feedback via the UHB twitter account. The Specialist Palliative Care providers are involved in the national 'I want great care survey'.
Balancing – Concerns, compliments, clinical incidents, Community Health Council and voluntary sector feedback are used to constructively feedback to the Clinical Board services and assist in service planning and redesign

Staff and Resources (Theme 7)
The Clinical Board has an aging staff profile particularly within the nursing services with over 42.7% of the nursing workforce over 51, which is higher than any of the other clinical boards. Workforce planning is taking place within district nursing and general practice nursing, which are the clinical boards largest nursing areas (one a provided service and the other a commissioned service). The workforce plan will assist in understanding the requirements for education and competence for the workforce and support succession planning and pre and post registration commissioning numbers for the future. A recruitment and retention plan is being refreshed and a number of recruitment events have taken place to support vacancies within district nursing and HMP Cardiff health care.

The Clinical Board is actively scoping the introduction of new and extended roles within provider and commissioned services. The progress and evaluation of theses posts is being fed through the primary care investment process with Welsh Government.

A staff engagement group is established within the Clinical Board with good representation from stakeholders. The results of the staff survey are being fed back through staff meetings and a schedule of joint walkabouts has been agreed. Volunteers are currently used in some of the Clinical Board areas (for example Barry Hospital and inpatient palliative care). There is a plan to introduce volunteers into the nursing home sector to support feedback to the locality teams from patients placed by the UHB for funded nursing care and continuing health care.

Improvement methodology and supporting the avoidance of harm, variation and waste is well embedded into the Clinical Board. There is approximately 30 senior staff within PCIC that have undertaken the Silver IQT training and each LIPS programme cohort has had PCIC staff in attendance.

A number of staff have received recognition for their hard work and dedication in the recent UHB awards ceremony (Vale Community Resource Service, Cardiff Community Resource Team, HMP Cardiff, Splott District Nurses). The Community Wound Healing CNS has had a number of papers accepted for European and UK wide wound care conferences and an occupational therapist from the Vale Community Resource Service has had a poster accepted for a national therapy conference.

The quality and compliance rate for PADRs is a priority for the Clinical Board and after a dip in compliance rate this is now starting to improve. The PADR compliance rate is 73% currently, with plans in place to ensure further improved compliance by July 2017.

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

9

Scrutiny Overview Report

CHC Visiting Activity

Reporting Period – 01/01/17 to 03/03/17

May 2017

Index

Summary of Scrutiny Activity

Reporting Period – 01/01/17 to 03/03/17

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 1st January 2017 and 3rd May 2017. In total 6 visits were planned to be undertaken and all were completed.

Next Reporting Period – 04/03/17 to 05/05/17

The November Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 4th March 2017 and 5th May 2017. In total 8 visits were planned for this period.

Looking Forward

The CHC has a schedule of visits planned until 30th September 2017 and each visit will be incorporated in to future overview reports.

In order to represent the views of the local community, we actively seek experiences in advance of, or during, our visits. We welcome all experiences, positive or negative. If you do wish to share your views/experiences on any of our planned visits, please contact us using the details below:

Telephone: 02920 750112
Email: cavog.chiefofficer@waleschc.org.uk
Address: Pro Copy Business Centre
Parc Ty Glas
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Visiting Overview

Concerns – Cardiff and Vale UHB

Upon review of the visiting reports in the reporting period, the CHC has mapped the concerns and identified the following themes and/or noteworthy issues:

- **Accessibility** – In 3 of the 5 visit reports relating to the UHB, comments were made in relation to accessibility. These are broken down as follows:

  Owl Ward: The emergency pull cord in one of the toilet areas has been tied up and could not be reached from the floor.
  General Anaesthetic Day Surgery: The corridor is extremely narrow and, when the spring seating is used for an overflow waiting area, accessibility for patients in a wheelchair is compromised.
  Short Stay Surgical Unit: The wash chambers and shower is noted as lacking adequate aids and adaptations for the less able patients to use the facilities. It is also noted that the shower/wet room would be better equipped with a grab rail.

  As an overarching issue, that spans the entire UHB domain, it is disappointing that this is the third Overview to comment on Accessibility, in different forms.

- **Infection Prevention & Control** – In 2 of the 5 reports, members noted that signs relating to hand washing were lacking in the patient toilets. This links back to the November 2016 Scrutiny Overview Report that highlighted the same issue. It should be noted that both reports expanded on this issue by indicating a need to provide notices in all ward/department areas.

  Linked to hygiene, there are further issues identified in other reports that compound this concern further. This includes:

  Ash Ward: It was noted that there is a 'foul' odour in four rooms (medication, store, sitting and shower rooms), coming from sealed drainage inspection hatches. Furthermore, patients do routinely access a number of these areas.

- **Repatriation** – Following similar issues raised in the September 2016 Scrutiny Overview Report, the CHC visit to the Owl Ward on identified further issues in this regard. It is noted in the report that 'there is a problem in repatriating tertiary patients due to the lack of knowledge in the outer hospital'.

- **Hospital Environment** – It is noted in the report of the visit to Ash Ward that patients do miss the garden facilities that were available at Whitchurch

Hospital. However, it is noted that the UHB are working with key partners to ensure some form of social provision is available on the Llandough site.

- **Hot Topics** – There are a number of on-going work streams, within the UHB, that the CHC are aware of and have made comments in a number of reports linked to these. The following points raised should be noted and incorporated in to any future activity as appropriate:

  Food & Drink – Following the baseline assessment undertaken in 2015/16, the CHC is routinely asking patients, in ward environments, for their thoughts on the current provision. It is noted in the Ash Ward report that a relative, of a long term patient, has queried whether food/menus can be varied for any long term patients.
  UHW Traffic Management – During their visit, members noted concerns relating to the road access to the Dental Hospital. Concern was raised that parents should not have to drive off site and re-enter via a different entrance to collect their children. It is a concern that this practice may be perceived as 'rat-running' and therefore may unduly influence further adaptations to traffic management on site.

Concerns – Velindre NHS Trust

There was only one scrutiny visit report produced within this reporting period, in relation to the Velindre NHS Trust. Therefore, it has been published independently in Council papers and will be covered under discussion by exception. This will also cover any stand-out examples of good practice that the visiting team wish to identify.

Concerns – Welsh Ambulance Service NHS Trust

There were no reports, in relation to WAST, in this period.

Good Practice

The CHC has been able to identify the following elements of good practice from its visiting reports in this period:

- **Patient Experience** – It is pleasing to note that in all of the visit reports, members were able to comment on the positive experiences of patients and their satisfaction with the care being provided. It should also be noted that this is echoed in the report on the First Floor Ward, Velindre Cancer Centre.

  To further support this good practice, comments have also been recorded in relation to the commitment of staff to enhancing the patient experience. Coupled together, these elements offer assurance that the care patients

receive is paramount to the way in which Health Services are delivered within Cardiff and the Vale of Glamorgan.

Further, specific initiatives to be commended include:

- **Short Stay Surgical Unit** – Bare Below the Elbow is an issue that the CHC focus on during visits. As a result, it is positive that in such a critical area, this policy is being complied with. Whilst the preference would be to read of compliance in all visit reports, it is worth noting that no reference was made of non-compliance
- **Ash Ward** – The CHC have previously commented on the lack of family interaction in regard to catering for patient needs. However, it is extremely pleasing to note that "staff within the unit maintain close links with patients' families, incorporating the whole family when considering the patients' needs". Furthermore, due to the nature of the patient cohort, staff have been commended for "promoting the development of appropriate interventions" to meet the needs of long term patients.

Follow Up Visits

Resulting from our visits, members make recommendations for the improvement of the health service they have scrutinised. In turn, the Health Board/NHS Trust formally responds to these recommendations, identifying how they will action them and, in most cases, allocate a timeframe.

In order to sign off on these recommendations, the CHC undertakes follow-up visits 6 months after the original visits, purely to determine whether recommendations have been actioned or not.

We are pleased to announce that our first unannounced follow-up visit, under this new process, took place on Monday 3rd April 2017 and, as such, will allow us to report back on visit recommendations from the July 2017 Scrutiny Overview Report onwards.

Recommendations

Any recommendations made in this section of the report are additional to the recommendations made by members in regard to individual visits. They arise from thematic issues identified within this overview report.

Cardiff & Vale University Health Board (UHB) Visits

1. **UHB** – The Cardiff and Vale UHB is asked to consider the CHC's concerns over poor accessibility and inform the CHC what level of accessibility it believes its service areas should be attaining in relation to both sensory and physical impairments.
2. **UHB** – The Cardiff and Vale UHB is asked to provide a briefing on what it promotes as good practice in regard to Hand Hygiene and to explain how this is cascaded throughout the organisation.
3. **UHB** – The Cardiff and Vale UHB is asked to provide a breakdown of which wards/departments are experiencing repatriation issues back to other Health Boards, inclusive of the numbers per Health Board area, and the impact this has on capacity.
4. **UHB** – The Cardiff and Vale UHB is asked to provide a briefing on its Orchard project at the Llandough Hospital site and any plans to enhance the communal atmosphere at the Hospital.
5. **CHC** – Council is asked to note the comments relating to Food & Drink and UHW Traffic Management, in order to incorporate this in to the relevant processes in the future.
   UHB – The Cardiff and Vale UHB is asked to provide assurances that genuine patient/visitor/family journeys, however short, are not inappropriately included in future 'rat-running' data.

Visit Details

Reporting Period – 01/01/17 to 03/03/17

Type	Date	Service	Site	CHC Team	Appendix.
Announced	09/01/17	Gwdihw (Owl) Ward	Children's Hospital for Wales	Val Evans (Lead) Matthew Wedlake	01
Announced	16/01/17	Audiology Clinics	University Hospital of Wales	Jane Jenkins (Lead) Williams Payne	02
Announced	01/02/17	Ash Ward	Llandough Hospital	Eleri Jones (Lead) Gareth Williams	03
Announced	09/02/17	General Anaesthetic Day Surgery	University Dental Hospital	Rob Henley (Lead) Shaun Ablett	04
Unannounced	13/02/17	Short Stay Surgical Unit	University Hospital of Wales	David Turner (Lead) Brenda Chamberlain	05
Announced	20/02/17	First Floor Ward	Velindre Cancer Centre	Alison Walker (Lead) Malcolm Latham	06

Next Reporting Period – 04/03/17 to 05/05/17

Type	Date	Service	Site	CHC Team	Stage
Announced	17/03/17	Cystic Fibrosis Centre	Llandough Hospital	Judy Simove (Lead) Paul Davies	UHB to Respond
Announced	20/03/17	Paediatric Dentistry	University Dental Hospital	Rob Henley (Lead) Gareth Williams	UHB to Respond
Announced	25/03/17	Emergency Dental Service	St Davids Hospital	Val Evans (Lead) Judy Simove	UHB to Respond
Unannounced	03/04/17	Minor Injuries Unit	Barry Hospital	Alison Walker (Lead) Gayna Morris	Awaiting Report
Unannounced	10/04/17	Neonatal Intensive Care Unit	University Hospital of Wales	Pat Mathews (Lead) Rob Henley	Awaiting Report
Unannounced	25/04/17	Rhydlafar Unit	St Davids Hospital	Jill Shelton (Lead) Brenda Chamberlain	Awaiting Report
Announced	28/04/17	Paediatric Critical Care Unit	Childrens Hospital for Wales (CHfW)	Val Evans (Lead) Gareth Williams	Upcoming Visit
Announced	03/05/17	Ward A2	University Hospital of Wales (UHW)	William Payne (Lead) Matthew Wedlake	Upcoming Visit

Forward Planning

Date	Service	Site	Date	Service	
05/06/17	Ward East 1	Llandough Hospital (UHL)	06/09/17	Ward A5 North	University Hospital of Wales (UHW)
09/06/17	Cardiff Breast Unit	Llandough Hospital (UHL)	11/09/17	Endoscopy Unit	University Hospital of Wales (UHW)
12/06/17	X-Ray Department	Cardiff Royal Infirmary (CRI)	20/09/17	Suite 19 (Dialysis)	University Hospital of Wales (UHW)
19/06/17	Bethan Ward	Llandough Hospital (UHL)	22/09/17	Radiology Department	Dental Hospital @ UHW
21/06/17	Ward A4	University Hospital of Wales (UHW)	25/09/17	Eye Clinic(s)	University Hospital of Wales (UHW)
27/06/17	Ward T4	University Hospital of Wales (UHW)	26/09/17	Rainbow Ward	Childrens Hospital for Wales (CHfW)
17/07/17	Physiotherapy Department	Cardiff South East			
18/07/17	Ward A5 South	University Hospital of Wales (UHW)			
24/07/17	Orthodontic Department	Dental Hospital @ UHW			
31/07/17	Pelican Ward	Childrens Hospital for Wales (CHfW)			
01/08/17	Outpatients Department	Cardiff Royal Infirmary (CRI)			
07/08/17	Outpatients Department	St Davids Hospital			
11/08/17	Ward West 2	Llandough Hospital (UHL)			

*** Please note, unannounced visits are not publicised in advance**

CHARGES FOR REPLACEMENT OF LOST HEARING AIDS POLICY
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Director of Therapies and Health Sciences
Author : Principal Clinical Scientist (Audiology) – 02920 743011
Caring for People, Keeping People Well : This Policy supports the UHB's sustainability goal by avoiding waste, harm and variation.
Financial impact : £20,000 per annum (approximate)
Quality, Safety, Patient Experience impact : The policy is in line with the all Wales Policy ensuring consistency of treatment across Wales.
Health and Care Standard Number 2.9 and 3.2
CRAF Reference Number not applicable
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Compliance with all Wales Policy
- An independent Appeals process is available so exceptional circumstances can be taken into account

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Charges for Replacement of Lost Hearing Aids Policy **and**
- **APPROVE** the full publication of the Policy in accordance with the UHB Publication Scheme *or*

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SITUATION

The University Health Board is required to amend its existing Policy as it was originally stated, in error, that charges would not be made for initial losses.

Approval of the Policy is a decision reserved for the Committee in accordance with the Written Control Documents Development and Approval Procedure or UHB Scheme of Delegation.

BACKGROUND

The University Health Board is amending its existing Policy as it was stated, in error, that we would not charge for replacement of hearing aid(s) in the case of the first loss.

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 May and 31 May 2017;
- The document was shared with the Community Health Council (March 2017)
- The Audiology Patient Forum had been advised that a charge would be levied on first loss, and supported this action.

Where appropriate comments were taken on board and incorporated within the draft document.

- The policy and procedure will be reviewed on a regular basis, and in response to any changes in the All Wales Policy.
- Audiology management monitors charges and appeals closely

The primary source for dissemination of this document Policy 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.

Reference Number: *TBA* **Version Number:** 2	**Date of Next Review:** *To be included when document approved*

Charge for the Replacement of Lost Hearing Aids Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will work alongside the Audiology Department to charge patients for the replacement of hearing aids which have been lost. The local policy was originally set in line with the All Wales 'Charges for Replacement of Lost Hearing Aids' Policy, however, this document has recently been withdrawn.

To achieve this, we will ensure that:

- The patient will be informed at that time of hearing aid fitting, that they may be charged if they lose a hearing aid.
- The policy is widely promoted through posters (at all adult Audiology facilities), and on the Departmental Internet Site.
- A flat rate fee of £65 will be charged (this fee is refundable if the aid is subsequently found, and the fee is subject to review).
- Patients will not be charged if they meet certain criteria:
  - Have a recognised cognitive impairment, including Dementia
  - Are a War pensioner
  - Are under 18 years of age
  - Have a terminal illness
  - Are Registered Blind
  - Are in Hospital or are resident in a Care Home at the time of the loss
  - Are a victim of a house theft or mugging
  - Have lost your hearing aid(s) in a house fire
- Patients have the right to appeal (the process is documented in the 'Replacement of Lost Hearing Aid(s) and Appeals' Procedure)
- Patients will always be provided with replacement hearing aid(s), whether or not they agree to pay.

Policy Commitment

The UHB aims to ensure compliance with the 'Charges for Replacement of Lost Hearing Aids Policy'.

Supporting Procedures and Written Control Documents

This Policy and the supporting documents describe the following with regard to the replacement of lost hearing aids

- Advice given to patients at initial fitting with regards to charges incurred for loss
- The fee charged

Document Title: *Charge for the Replacement of Lost Hearing Aids Policy*	2 of 3	Approval Date: 23 Feb 2016
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality and Safety Experience Committee		

- Exclusion criteria
- The appeal procedure
- The process followed

Other supporting documents are:

- 'Replacement of Lost Hearing Aid(s) and Appeals' Procedure
- Standard Operating Procedure for Replacement of Lost Hearing Aids

Scope

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

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EqIA) has been completed and this found there to be minimal impact.

Policy Approved by	Quality and Safety Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	ENT and Audiology Collaborative Group
Accountable Executive or Clinical Board Director	Director of Therapies and Health Science

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee 23/02/2016	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			Revision to 'Charge for the Replacement of Lost Hearing Aids Policy', March 2016. An error was recently found in the original

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Document Title: *Charge for the Replacement of Lost Hearing Aids Policy*	3 of 3	Approval Date: 23 Feb 2016
Reference Number:		Next Review Date: dd mmm yyyy
Version Number: 1		Date of Publication: dd mmm yyyy
Approved By: Quality and Safety Experience Committee		

			version of the policy, and therefore, the statement 'Patients will not be charged for the loss of their hearing aid(s) on the first occasion' has been removed.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved*

Replacement of Lost Hearing Aid(s) and Appeals Procedure

Introduction and Aim

This procedure outlines the steps to be taken when an adult patient contacts the Department due to a lost hearing aid(s). A charge has been levied, as in other Audiology Departments in Wales, since 2009. Exemption criteria are in place, and are outlined in the policy and this procedure. The appeals process is also documented. In all circumstances, a patient will be provided with replacement hearing aid(s), irrespective of whether or not he/she can pay.

Patients under the age of 18 are not charged for hearing aid losses.

This document supports the 'Charges for the Replacement of Lost Hearing Aids Policy', giving further detail of the procedures to be followed within the Audiology Department.

- **Objectives** To standardise the replacement of lost hearing aid(s) procedure to ensure equity in the charging of patients, and in the consideration of exemption criteria.

Scope

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

1. PATIENT INFORMATION

All adult patients are informed at the time of hearing aid fitting (or replacement of lost aids) that the hearing aid remains NHS property on loan, and that they may be charged if they lose a hearing aid.

This information is also displayed on posters around the Department and on the Departmental inter- and intra-net sites.

2. DEPARTMENTAL PROCESS

- Patient contacts Department, or attends open repair session, and informs staff of loss of hearing aid(s).

- Staff member takes impression of ear(s) and adds notes in Journal that aid(s) lost and replacement needed.
- Staff member makes note in Earmould screen that earmould is to be posted to patient, who then attends open repair session for re-fitting.
- Replacement Open fittings can be carried out on day of attendance if time permits.

Staff member reminds patient that a charge of £65 is due for replacement of each lost hearing aid, unless exemption criteria are met (see 2.1).

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2.1 Exemption Criteria

Patient (or carer) should be asked whether they meet any of the following criteria:

- Recognised cognitive impairment, including Dementia
- War pensioner
- Under 18 years of age
- Terminally ill
- Registered Blind
- In Hospital or resident in a Care Home at the time of the loss
- Victim of a house theft or mugging
- Hearing aid(s) lost in a house fire

If any of these criteria are met, the patient should be advised that they are not liable to be charged for replacement of hearing aids. This should be noted in the patient Journal.

If no exemption criteria are met, see 2.2

2.2 *Charging for Replacement of Lost Hearing Aid(s)*

University Hospital Wales
The patient is advised that when they receive notification of earmoulds/readiness to fit, they should visit the Cashier's Office in Concourse to pay the relevant charge prior to visiting the appointment. The receipt should be brought with them to the Open Access Clinic and the replacement hearing aid(s) will then be issued.

West Quay Medical Centre (WQMC)
Senor Assistant Technical Officers are able to take cash/cheques from patients in WQMC immediately prior to issue of replacement aids. The staff member then pays this into the Cashier's Office at UHW on return to the Hospital, and posts a receipt to the patient.

2.3 *Hearing Aids Found After Payment*

If a hearing aid is found after payment has been made for replacement, the Head of Audiology should be contacted, who will arrange reimbursement once the hearing aid has been returned to the Department.

3. APPEALS PROCESS

If a patient feels that they should not be charged, or are unable to pay for the replacement of the hearing aid(s), he/she should be advised of the right to appeal.

Patients should be advised that they will automatically be fitted with a replacement hearing aid(s) when attending the Department and the appeals process will be followed outside of the Audiology Department.

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Document Title: *Insert document title*	3 of 3	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

If a patient wishes to appeal against the charge, he/she should be asked to complete an appeal form and the Staff Member should also complete the relevant section.

The form should be given, by the Staff Member, to the Head of Audiology, who will pass the appeal onto a panel independent of the Audiology service, who will carefully consider the circumstances of the individual case.

Patients should be advised that if the appeal is unsuccessful, they will be invoiced by the Health Board, who will pursue non-payment.

Equality & Health Impact Assessment	*An Equality and Health Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found there to be minimal negative impact, with steps taken to further mitigate this.*
Documents to read alongside this Procedure	All Wales Charges for Lost Hearing Aids (2009) – *currently under review (May 2017)*
Approved by	*Quality Safety and Experience Committee*

Accountable Executive or Clinical Board Director	Director of Therapies and Health Science
Author(s)	Principal Clinical Scientist (Audiology)

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*Date of Committee or Group Approval*	*TBA*	*This is a new document as it has been split from the Policy.*

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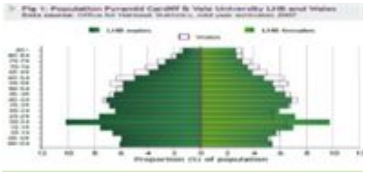
Equality & Health Impact Assessment for

Charges for Replacement of Lost Hearing Aids Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Charges for Replacement of Lost Hearing Aids Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Surgical Services Clinical Board Wendy Rabaiotti, Director of Audiology, Ext 43011
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To amend the existing 'Charges for Replacement of Lost Hearing Aids Policy' for adult patients (2016) due to the author becoming aware of an error in the policy. A charge *is* levied at the first loss (in error, the policy states that there is *no* charge for a first loss). This formally corrects the written policy.
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 • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively  The Adult Audiology Department has over 23,000 contacts per year.

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	designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Around 2,500 patients are fitted with hearing aids for the first time, and another 4,000 patients attend for a reassessment of their hearing each year, at Cardiff and the Vale UHB. Other contacts are made via drop-in repair sessions and hearing assessments. An 'All Wales' policy for replacing lost hearing aids was developed by the Heads of Audiology Services, with the input of Action on Hearing Loss, and was approved by Welsh Government in 2009. In light of the error identified in the policy by the Cardiff and Vale Audiology Team, this document has recently been withdrawn. Action on Hearing Loss have no national policy statement on charges being made for the replacement of lost hearing aids. The National Deaf Children's Society position statement on 'Audiology Service Provision in the UK' states that hearing aids '....will be replaced or repaired free of charge when lost or damaged during the course of normal family life'. In line with this policy, there is no charge made to individuals under 18 for replacement of lost hearing aids. The Audiology Department at Cardiff and Vale UHB have charged for replacement of lost hearing aids since 2014. Over the past three years, 873 individuals have been charged for replacement of lost hearing aids. Of these, 8 have appealed against the charge and following consideration, none had to pay. Over the past year, 3 individuals have found their hearing aids after paying for a lost aid, and the money has been refunded. All exemptions and exceptional circumstances are considered by the Head of Service. Patients are informed at the time of initial hearing aid fitting that there may be a charge for replacement of lost hearing aids. This information is also documented in the handbook given at issue, and on

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		posters displayed within the Department. As per Health Board procedure, consultation on the document ran for 4 weeks on the internet. • As part of good practice, a recent informal survey of all other Adult Audiology Services in Wales has found that all services are charging for replacement of lost hearing aids on initial loss, but the charge varies from £65-£90. • Stakeholders were not engaged in the EHIA, however, patient satisfaction surveys are carried out biennially and there has never been a comment on charges being made for replacement of lost hearing aids. • The Audiology patient forum was consulted on charges for replacement of lost hearing aids in March 2016 with the following minutes taken: 'The group were very supportive of the charges and suggested that it should be double what is being charged. It was explained that we will only charge in line with other Trusts'. • The Community Health Council were also provided with an opportunity to comment on the policy in March 2017. There was no opposition to the policy, and the following feedback was given '…to reinforce that every patient knows the policy very clearly when aids are issued and replaced, both orally and in writing so there is something to take home and that relatives may be aware of this as well'. Patients are always made aware of potential charge at appointments for issue and replacement of hearing aids. Patient take-home information will be reviewed to ensure that this is fully covered. • Feedback from Keithley Wilkinson, Julia Harper and Susan Toner was taken into account in completing this EHIA, with the views of Reg Cotter and Alun Williams also sought. The policy sits as part of the Strategic Equality Plan 2016-20 Fair Care

		(SEP) outcomes/objectives for accessible services and would tie into our work with patients who have a sensory loss.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All adult hearing aid users are affected by this policy

6. 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	Under 18s – no impact (no charges made for lost aids under 18) The policy will have a positive impact on this age group 18-65 and over 65s are eligible for being charged for loss of a hearing aid, however, exemptions are made for War Pensioners and for those with cognitive impairment, such as dementia.	All efforts will be made to recognise people's age and all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.	

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
	For persons who are in Hospital, or a Care Home, at the time of the loss, no charge will be made.		
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	Although a charge will be incurred (if exemption criteria are not met), replacement hearing aids are ***always*** provided in a timely manner by the Department. Charging, and appeals, are dealt with outside of the Audiology Department, and a replacement hearing aid would *not* be refused if a patient was unable to pay. For persons with cognitive impairment or terminal illness, no charge will be made. For patients with significant	All efforts will be made to recognise people with disabilities and all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.	

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
	visual impairment/who are registered Blind, no charge will be made and patients are offered two hearing aids as a matter of course.		
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 a potential positive impact as the aim of the policy is to be able to provide consistent advice, practice and support to the users of our service regardless of their gender identity.	All efforts will be made to recognise people's gender identity with disabilities and all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.	
6.4 People who are married or who have a civil partner.	There is a potential positive impact as the aim of the policy		

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
	is to be able to provide consistent advice, practice and support to the users of our service regardless of their married or civil partner status.		
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.	There appears to be no specific impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential positive impact, as staff will always ask if an Interpreter is required, and appointment letters request patients to contact the service for an Interpreter to be arranged, if required. With the patient's permission, a record is made of the need for an Interpreter and one is	All efforts will be made to recognise people's race with all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of	

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
	automatically arranged for subsequent appointments. Language Line is used if an Interpreter is needed, but has not been booked.	relatives and carers and giving relevant information at the right time and in the right way.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is a potential positive impact as the aim of the policy is to be able to provide consistent their religious belief.	All efforts will be made to recognise people's beliefs with all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or	There appears to be no specific impact.		

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
gay); • both sexes (bisexual)			
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	A number of the Audiology Team are Welsh Speakers and we are able to ensure that patients are seen by Welsh Speakers if this is their preference.		
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	All patients will be fitted with replacement hearing aids and have the right to appeal, against the charge. These are considered by the Head of Service initially, and an appeals panel will be set-up to hear the case if it is felt appropriate to consider pursuing charging.	All efforts will be made to recognise people's race with all steps taken to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and	

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
		giving relevant information at the right time and in the right way.	
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	Patients who feel that they are unable to pay the charge are automatically fitted with replacement device(s) but can appeal against the charge.	All efforts will be made to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.	
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Where hearing aids are lost as a result of loss in a house fire, or theft/mugging, no charge will be made.	All efforts will be made to minimise any negative impact on the individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication	

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
		needs of relatives and carers and giving relevant information at the right time and in the right way.	

7. 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	Patients who feel that they are unable to pay the charge are automatically fitted with replacement device(s) but can appeal against the charge.	All patients will automatically receive a replacement hearing aid irrespective of their ability to be able to pay.	

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
7.2 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, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	As a policy, there will be no impact. All patients will automatically receive a replacement hearing aid and will therefore, be able to continue to communicate with health professionals about their lifestyle (giving up smoking, being more active, changing diet, taking medication appropriately etc).	All patients will automatically receive a replacement hearing aid irrespective of their ability to be able to pay.	
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid	Exemption criteria exist, and an appeals policy is in place.	All patients will automatically receive a replacement hearing aid irrespective of their ability to be able to pay	

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
employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	As a policy, there will be no impact.		
7.5 People in terms of social and community influences	As a policy, there will be no	All patients will automatically	

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 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.	receive a replacement hearing aid irrespective of their ability to be able to pay and this will prevent social isolation which could arise if the hearing aid was not replaced.	
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	As a policy, there will be no impact.		

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	By being made aware of the possibility of a charge, if a hearing aid should be lost, the patient will be more aware of the value of the device and may take better care of it. This policy confirms that patients will be charged following first loss of a hearing aid. A significant number of lost hearing aids are reported to the Audiology Department, and these aids are replaced from the Hearing Aid budget. The costs of replacements then potentially impact on the number of new patients who can be fitted with hearing aids during the course of the year. The charge for replacement of hearing aids means that some of the additional outgoings will be recouped, enabling other patients to be fitted with hearing aids. In collaboration with the Audiology Heads of Service in Wales, a range of exemption criteria have been set to minimise the impact of the charge in cases felt to be particularly vulnerable, and an appeals process exists for those who do not meet exemption criteria. In all cases, a replacement hearing aid(s) will be provided, irrespective of whether or not the patient is willing/able to pay.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All efforts will be made to minimise any negative impact on any individual and their family. The UHB recognises the importance of providing skilled and sensitive communication, including the communication needs of relatives and carers and giving relevant information at the right time and in the right way.			
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			

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	As there appears to be no significant impact and mitigatio has been allowed for, it would expected that the policy will go ahead but will be discussed at the QSE meeting in June, whe it will hopefully be approved. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.			

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EXTERNAL REGULATORY AND ACCREDITATION VISITS **TO CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD SERVICES**
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Executive Director of Nursing
Authors: Clinical Board Lead for QSPE, CD&T Director of Operations, CD&T
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Deliver Outcomes that Matter to People" elements of the Health Board's Strategy
Financial impact : £ ……..actual figure or approximate
Quality, Safety, Patient Experience impact: The work outlined within this paper reflects the regulatory and accreditation activity taking place within the Clinical Board. This will lead to improvements in patient safety and experience leading to improved quality and care outcomes for patients.
Health and Care Standard Number 2.1, 2.9, 7.1
CRAF Reference Number 8.1.4, 8.1.7, 8.2.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The findings of the inspection visits, and completion and closure of action plans.
- Accreditation awards

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **NOTE** the report made by the Clinical Diagnostics and Therapeutics Clinical Board to date and its planned actions
- **APPROVE** the approach taken by the Clinical Diagnostics and Therapeutics Clinical Board

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SITUATION

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

The Clinical Board consists of 7 directorates:

- Laboratory Medicine
- Therapeutics and Toxicology
- Radiology, Medical Physics and Clinical Engineering
- Media resources
- Outpatients/Patient administration
- Therapies
- Pharmacy

CD&T is one of the most highly regulated Clinical Boards in the UHB. There are numerous external agencies which require assurance on compliance including Welsh Government, Health Inspectorate Wales, Medicines and Healthcare products Regulatory Agency (MHRA), Human Tissue Authority, Natural Resources Wales, Health and Safety Executive, Office for Nuclear Regulation and the United Kingdom Accreditation Service (UKAS).

Compliance with regulation and accreditation ensures safe delivery of services, technical competence, and timely, accurate and reliable results.

BACKGROUND

During the year 2016-2017 CD&T services have been subject to a number of regulatory inspections and accreditation visits.

ASSESSMENT AND ASSURANCE

The Committee are asked to note the inspection visits, key findings and the completion and closure of actions shown in the table below.

To date, only one future regulatory visit has been notified for the coming year which is an inspection by the Human Tissue Authority in Cellular Path/Mortuary UHW on 9th August 2017.

There will be a follow-up surveillance visits in Biochemistry and Haematolgy/BTL to ensure continuing compliance with the ISO standard to maintain accreditation in November 2017.

Type of inspection	Agency	Location/service	Date	Key findings/actions
Accreditation CPA and ISO15189	UKAS	Biochemistry	May 16	Successful accreditation following closure of non-conformances (Dec 2016)
Accreditation CPA and ISO15189	UKAS	Haematology, Blood Transfusion, Specimen Reception, Phlebotomy	June 16	A number of actions required to meet the standards in particular improved quality of RCA and closures of incidents, lab procedures, strengthening the quality role, and minor adjustments to SOPs On a positive note, the validation procedures in Automated Haematology were reported as 'the best they've ever seen'. To be reassessed in April 2017.
Accreditation CPA and ISO15189	UKAS	Lab Genetics	July 16	Successful accreditation following closure of non-conformances (Dec 2016)
Regulatory IR(ME)R	HIW	Nuclear Medicine	Oct 16	Breach of Regulation 4(1) Schedule 1(b) identified, specifically, the Employers procedures did not identify any individuals 'entitled' to act within nuclear medicine services either as a referrer, practitioner, or operator. This action is complete with the exception of scheme of delegation letters which will be issued in June 2017. 9 other actions required which included issues with

				patients' privacy, dignity and confidentiality, revision of the Safe Use of Ionising Radiation Safety Policy, review and consolidation of IRMER procedures, labelling of radiopharmaceuticals is to be improved, clinical audit information and activity within nuclear medicine services to be shared and updating staff training records. These have been completed. The inspectors were complimentary about the care provided to patients and the safety of the service
Regulatory GMP/GDP	MHRA	St Mary's Pharmacy Unit	Jan 17	5 major deficiencies and 9 'others'. The MHRA Inspector has confirmed that the response we submitted, the prioritisation of the deficiencies and the support we have been able to demonstrate from Senior Management within the UHB are on the whole satisfactory. However, they have expressed concern over the design of the autoclaves themselves, the design of the autoclave cycle and the control of the autoclave cycle. The case was referred to the MHRA's Inspection Action Group (IAG). The purpose of this is to escalate our case within the MHRA and to provide more direction towards compliance. This did not involve any regulatory action. In May 2017 we had a positive response from the IAG to our proposed remedial actions on the autoclaves. One of the other issues raised at the inspection was the

				integrity of data from our laboratory testing equipment. This is a relatively new focus for the MHRA. The team at St Mary's have a good handle on the concepts and the problems and are starting to explore solutions.
Regulatory	HTA	Stem Cell Processing Unit	Jan 17	4 minor findings. Very positive inspection feedback.
Regulatory Blood and Safety Quality Regulations	MHRA	Blood Transfusion	March 17	3 major findings – incident management, data security, product recall SOP and 5 'others' relating to QC checks, technical agreements, change control, training records and sample acceptance protocol. All actions have been accepted and inspection closed. The inspector recognised the improvement that has occurred in Blood Transfusion Laboratory over the last 12 months.
Accreditation CPA and ISO15189	UKAS	Cell Path/Mortuary follow-up visit	March 17	Accreditation maintained This was a very successful assessment. No critical findings with a few actions to close which have been completed. The assessor recognised that the service has a number of strong points but especially the staff who are very engaged and enthusiastic. Continued service improvement was recognised.

Regulatory Environmental Permitting Regulations	Natural Resources Wales	Radioactive Waste (Medical Physics) Compliance with permits, radioactive waste management and the regulations concerning storage of sealed radioactive sources	March 17	2 minor actions Overall, a very good outcome and reflection of good practice
Regulatory Transport regulations	Office for Nuclear Regulation	Radiopharmacy	March 17	4 minor findings – desktop exercise for emergency procedures, refresher training, signage in vehicles and restraining straps. All now in place and action plan closed. The inspector said he was impressed with the organisation of the material/evidence and that we benchmarked very well against our peers.
Accreditation CPA and ISO15189	UKAS	Haematology, Blood Transfusion, Specimen Reception, Phlebotomy	April 17	Successful visit with accreditation offered subject to normal UKAS quality control.

ANNUAL QUALITY STATEMENT 2016-2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 20th June 2017

Executive Lead : Executive Nurse Director
Author : Patient Safety and Quality Assurance Manager (Alexandra.scott2@wales.nhs.uk – 029 2074 4018)
Caring for People, Keeping People Well : The Health and Care Standards underpin all elements of the Health Board's Strategy.
Financial impact : This report carries a financial implication in the region of £2.5K for production of hard copy versions to be made available to patients, the public and staff and for Welsh translation.
Quality, Safety, Patient Experience impact : The Annual Quality Statement provides the opportunity to inform the public of what action is being taken to deliver safe, effective, patient centred care. Sections are aligned with the seven domains of the Health and Care Standards.
Health and Care Standard Number : Applies to all standards.
CRAF Reference Number : 5.1
Equality and Health Impact Assessment Completed : No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The provision of the draft Annual Quality Statement 2016/2017

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Annual Quality Statement for 2016/2017 in draft; prior to full design work being undertaken in readiness for endorsement at the public Board session in July 2016.

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SITUATION

The purpose of this report is to present the Annual Quality Statement 2016-2017 for approval prior to full design work being undertaken.

BACKGROUND

NHS bodies are required to publish an Annual Report and accounts. An important element of this will be the publication of the Annual Quality Statement (AQS). Welsh Government has issued guidance on production of the AQS with an additional requirement that it should include the organisation's Wales for Africa disclosure.

The AQS is intended to provide an opportunity for the organization to inform the public about what and how it is doing, including how it is making better use of resources to provide and deliver safe, effective and user/patient centred services and care that is dignified and compassionate. The AQS is not intended as a Board assurance document, although the Board must assure itself through internal assurance mechanisms, including its internal audit function, of the accuracy and triangulation of data and evidence to ultimately sign off the AQS. Development of the AQS is subject to Internal Audit assessment.

The AQS for 2016/2017 is required to be published no later than 31st July 2017.

ASSESSMENT AND ASSURANCE

Development of the AQS provides an opportunity for the organisation to let its local population know in an open and honest way how it is doing to ensure all its services are meeting local need and reaching high standards and to demonstrate the range of services provided by the University Health Board. In developing the AQS this year, a task and finish group was established and corporate leads identified in order to gather relevant evidence for each section.

Development of the AQS has also been carried out in partnership with the Community Health Council and also through engagement with the Stakeholder Reference Group, Action on Hearing Loss, RNIB Cymru and the Older People's Forums within Cardiff and Vale of Glamorgan so that they have had an early opportunity to influence the content and also to comment on an early draft.

Welcome from the Chair and Chief Executive

We are pleased to bring you the fifth Annual Quality Statement for Cardiff and Vale University Health Board (UHB) in which we will give you an overview of the work that has been undertaken in the past year, reflect on the commitments that we made in last year's Annual Quality Statement and acknowledge the work that is underway or is planned to meet our priorities.

We are constantly working to improve the quality and safety of the services that we provide and the Annual Quality Statement will give you an open and transparent account of the successes and challenges that we have faced in the past 12 months. We work closely with Health Care Inspectorate Wales and the Community Health Council who help us to ensure that the care we are providing is of a high standard. We have systems in place that allow us to recognise when things go wrong and to help us to learn from these events.

We are very proud of the innovation shown by all of our staff when considering how best to deliver care. This year we have seen some excellent examples of how services can be delivered differently, often resulting in services being accessed closer to home. Cardiac services are now delivering heart failure clinics from General Practitioner (GP) surgeries and Audiology services are providing many of their pathways in the community from diagnostic tests to treatment and monitoring.

The financial environment proved to be extremely challenging in 2016/17. The Health Board was unable to gain approval of its three year Integrated Medium Term Plan and instead it agreed a one year operational plan with Welsh Government. Despite incurring a significant deficit in 2016/17 the quality and safely of services provided by the Health Board has remained a priority.

If you would like more information about the quality and safety of our services then the Quality, Safety and Experience papers can be accessed: http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-experience-committee

Maria Battle – Chair

Len Richards Chief Executive

Cardiff and Vale of Glamorgan Community Health Council

To be inserted .

Introduction

2017 has seen the 45th Anniversary of the University Hospital of Wales. In 1971 the focus for delivering health care was very much centred on secondary care or hospital sites and we continue to see extensive activity undertaken in all of our hospital sites. However, as we witness the advancement and changes in technology as well as the increase in the number of patients that use our services we are working with our public, patients and staff to design and deliver services that can be delivered closer to home .

Our 10 year strategy, Shaping Our Future Wellbeing, identifies the need for us to deliver care closer to home for our patients wherever possible. In 2017 we saw the opening of a new state of the art renal dialysis unit, moving this service away from a hospital site to a more accessible area and this development, mirrors changes in the way we are delivering many of our services. There are further examples within this publication.

The vision of Shaping Our Future Wellbeing, (which has been produced together with staff, local communities and the voluntary sector) is that anyone in our community should have the same chance of a healthy life no matter where they live. This is an ambitious vision but one that we are committed to achieving. We have already started to make progress towards improving the health of our communities enabling people to live longer and healthier lives:

- We have fewer patients waiting for elective treatments than at any time in recent years
- We are able to provide the majority of cancer treatments in time
- Our primary and community services have made significant advances, including the establishment of seven days working for our community resource teams and a new pathway to help patients get the treatment they need more speedily and reliably.

The next steps to improving our vision include three key priorities. These are our Bold Improvement Goals (BIG) and this year we have made good progress against each of them.

BIG 1 – Reorganising the way we use our medical inpatient beds in UHW to ensure that our patients receive the right care, in the right place at the right time and from the right people.

Big 2- Designing the perfect locality with the aim of caring for people and keeping them well at home as their first choice.

Big 3- Embarking on a three year programme of work to reduce waste, harm and unnecessary clinical variation.

The work underpinning these Bold Improvement Goals is highlighted further within the Annual Quality Statement.

This year we launched a project to identify a set of values which will guide the way all staff work and the way we behave with others. During 2016 and the early part of 2017, the project called Values into Action, was undertaken to hear from patients and their families about their experiences in our care. We engaged with almost 3000 patients and staff with the aim of improving the experience our patients have in our care and the experience of our staff working within the organisation. The feedback has helped us to develop a revised set of values and a clear set of behaviours that we expect to see

Treating People As Individuals

In 2016 – 2017 We Said We Would		How Do We Know
Develop a carers forum as part of our implementation of the social services and wellbeing act 2014 which puts the wellbeing of citizens, including carers at its heart		Carers Trust Wales is leading work to understand the range of services that are supporting young carers
Young carers project support officers will work with schools to identify young carers at an early stage and put in place appropriate support mechanisms. This will be evaluated in March 2017		.A young carers in school accreditation scheme is being trialled in 12 schools across Cardiff and the Vale of Glamorgan to ensure that young carers are identified, given support and signposted to suitable resources and services. It is hoped that this will them be extended to all remaining schools in the area.
Develop more interactive and real time patients' feedback systems. For example use portable "smiley Face" machines on hospital sites and wards to gain some timely feedback		***Happy or Not*** feedback machines are being used and allow service users to give us real time feedback A kiosk will offer service users an opportunity to undertake a short survey and to provide any narrative
Improve access to the PALS (patient and liaison Services) informal concerns resolution team and ensure that where possible we provide timely and effective resolution to concerns		Since March 2017 the Patient Advice and Liaison Service (PALS) have been based in all 3 information centres for weekly sessions

Virtual Blood Disorder Clinic

The development of a new blood disorder clinic has meant that patients are able to receive their care closer to home. Some patients were travelling up to 150 miles to attend a 15 minute appointment in Cardiff. The development of virtual clinics means that patients now have pre arranged telephone appointments to discuss their health and treatment.

One of our patients told us that the service is "*amazing and saved me so much time and saved me having to come down to Cardiff*"

Age Awareness

The physiotherapy department celebrated Older People's Day by encouraging people over the age of 60 to increase their levels of activity to enable them to stay fitter for longer. The team carried out fitness assessments for staff and visitors in the concourse at UHW and University Hospital Llandough, discussing simple ways of increasing activity levels as well as giving out a range of information on exercise classes in the local area.

I think I knew I should be doing more, but I had no idea how much exactly, and now I know, and I can do something about it. thank you."

Patient Experience

Nearly ten thousand surveys have been completed by patients during the past 12 months across all of our clinical areas. These surveys are very useful in informing us about how we are doing and helping us to identify areas where we could improve.

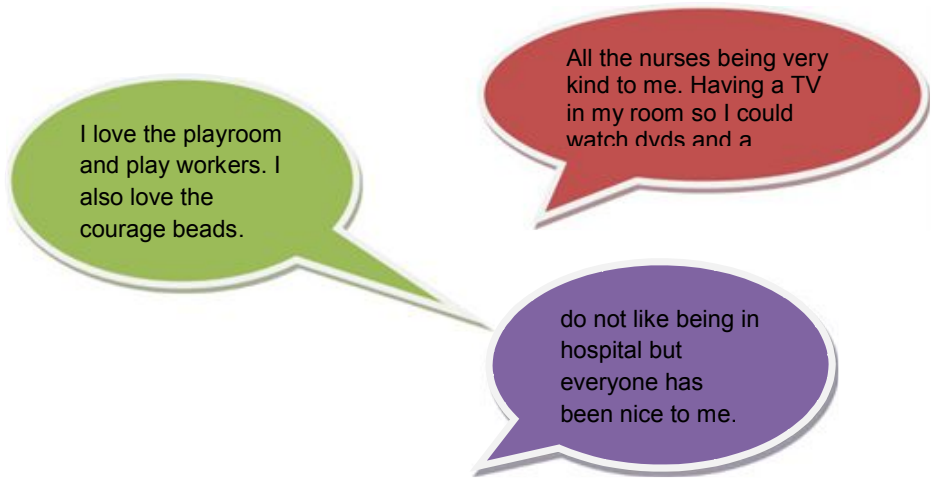
Positive themes include:

- Staff attitudes and behaviours
- Healthcare in general, first class, excellent
- Positive communication and information sharing

Examples of where we can improve:

- Waiting times; too long to be seen, took 4 hours to find a bed
- Car Parking/Facilities e.g. nowhere to park, more toilets, lifts not working
- Poor communication, not informed of delays, not explaining medication
- Environment , for example noise

We invite children to tell us about their experience in our services using words and pictures



Concerns

By understanding why patients have raised a concern we can improve the quality of care and treatment provided to people using our services. During 2016-2017 we received 2701 concerns, and over 58% of these were informal complaints. The most common themes were about communication, clinical diagnosis and treatment, waiting times and cancellations, however, we have noted an increase in car parking complaints and the waiting times and cancellations in our Ophthamology Clinics. The health board is undertaking a great deal of work to improve the way that patients are given appointments in Opthamology, and the way that visitors are able to access our hospital sites, details of this work are included later.

You Said	We Did
Lack of changing facilities in paediatric out patient department for children with additional needs.	Changing places are now available in the paediatric outpatients department
Patient rang and felt she was not being provided with any information while she was on the ward	Arranged for her Consultant to go and see the her to addressed all of the concerns.
Patient belongings were not put away properly because the wardrobe was broken	New wardrobes were provided

This concerns form is available on the Cardiff and Vale website, along with a feedback form that invites people to tell us how they found the complaints process

http://www.cardiffandvaleuhb.wales.nhs.uk/document/301984

The Patient Advice and Liaison Service

The PALS team are able support people raising an informal complaint and have been based in the information centres since March 2017 for weekly sessions to ensure that they are accessible to patients and visitors. The team can be contacted **on** 029 2074 3301 **or** 029 2074 4095.

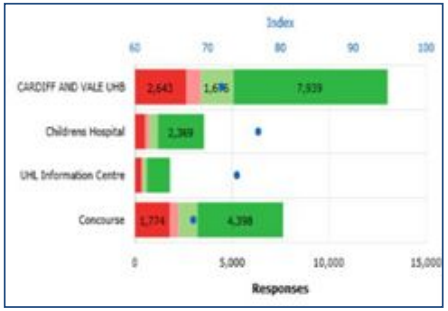
Compliments

Compliments help us learn more about what we do well, and allow us to spread good practice. Along with our formal compliments, we also get numerous thank you cards and letters which are sent directly to clinical areas. We acknowledge and thank every individual that sends a compliment and we also ensure the staff and relevant areas are notified.

	2014 -15	2015-16	2016-17
Formal Compliments	558	740	645
Informal Concerns (resolved within 2 working days)	1324	1220	1583
Formal Concerns (requires some investigation)	1170	1079	1118

Real Time Patient Feedback

During February 2017 the 'Happy or Not' feedback machines were introduced into the Concourse at the University Hospital of Wales, University Hospital Llandough Information and Support Centre and the Children's Hospital of Wales. Since the introduction of the machines, during the first four weeks there have 32,258 responses over the three sites and 75% of responses have been positive



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Vehicle Access and Car Parking

We have seen a significant increase in the number of people who access our sites in the past five years. Cardiff is one of the fastest growing cities in the UK and this results in higher levels of traffic. In 2016 a traffic survey undertaken in UHW identified that over 15,000 vehicles drove onto the site each day, almost half of these vehicles remained on the site for less than 5 minutes. Despite there being 3,121 car parking spaces at UHW and 1,617 at UHL in addition to parking at all of our other hospitals and clinics, we still have a shortfall.

Work is underway to find a long term solution to the problems of congestion and parking, much of it undertaken jointly with the Local Authority.

- ✓ Ensuring that parking facilities in St David's Hospital and Barry Hospital are protected for the use of patients, visitors and staff using those sites.
- ✓ By closing the road in front of the Emergency Unit to all but emergency vehicles and buses we have been able to ensure that Ambulances are able to access the unit without a delay
- ✓ The Pentwyn Park and Ride started in May 2017 and has meant that people accessing UHW site have an inexpensive and fast alternative to parking on the UHW site.
- ✓ The proposed development of a Bus Hub on the UHW site will mean easier access to the hospital by public transport. The Hub will also include cycling facilities including secure bicycle storage and shower facilities.
- ✓ Changes to the traffic light timings outside UHL at peak times has meant reduced congestion on the site.
- ✓ Consideration of alternatives ways and locations to deliver outpatient appointments clinics.

Sensory Loss

In 2015 the Community Health Council in partnership with Royal National Institute for the Blind and Action on Hearing Loss undertook a review of services for people with sensory loss. Following this, a Sensory Loss Group was formed to ensure that sensory loss matters are being addressed across the Health Board. The following examples of excellent work have been undertaken:

- Sensory Loss leads and champions have been identified within each of the Clinical Boards
- The University Dental Hospital in Cardiff has recently installed hearing loop systems in all its reception areas, making it easier for those with hearing impairments to communicate efficiently
- Best practice has been shared across the Clinical Boards e.g. Tips for Communicating with a Service User who has a Sensory Loss briefing

To read more about the RNIB Design Standards visit:

http://www.rnib.org.uk/wales-cymru-how-we-can-

Radiology

The new Radiology reception area has been designed along with RNIB Cymru to ensure that it meets the 'Visibly Better' design standard. The area has been designed to improve accessibility by ensuring that surfaces, colour schemes, light levels etc meets the needs of those with visual loss. Insert Photo

Holocaust Memorial Day Service

This year the Holocaust Memorial Day was attended by approximately 40 people. Eva Fielding-Jackson retold her family's tragic, yet inspiring story. Like her, both of Eva's parents were deaf. Before they married they experienced the horrors of the Holocaust. She told how her father had survived seven different concentration camps, among them Auschwitz and Buchenwald. Following Eva's extraordinary address, candles of remembrance were lit for the victims of the six recognised genocides and the hospital community choir closed the emotional service.

Annual Paediatric Memorial Service 2016

The Annual Paediatric Memorial Service offers families who have loved and lost their beloved children, to come and reflect on the memories they created as a family. Each family is sent a gold star before the service, which they can decorate, and bring to the service where they can then place it on the Christmas Tree which is then lit, reminding them of the light and joy their child brought into their lives. For many families, this service allows them to have a Christmas celebration with the child they have lost.

Timely Care

In 2016 17 We Said We Would		How Do We Know
Improve performance for our elective patients waiting more than 36 weeks		There were 452 fewer patients waiting more than 36 weeks for treatment this March compared to last - a 28% in-year reduction and the lowest number of patients waiting more than 36 weeks for six years
Reduce waiting times for cancer		• The Health Board met both national cancer targets in March 2017 - for the first time since November 2013. • We have seen continuous improvement in performance for patients on the 62 day urgent suspected cancer pathway this year. We have treated 167 more cancer patients on the pathway in 2016/17 and 270 more within the 62 day target.
Improve waiting times for patients waiting for diagnostic procedure		There were 1,012 fewer patients waiting greater than 8 weeks for diagnostic test in comparison to last year - a 36% in-year reduction and the lowest volume waiting greater than 8 weeks since November 2011.
Play an active role in the National Planned Care Programme		The Health Board is represented and plays an active role in all of the National Planned Care speciality boards and the Outpatient Transformation steering group. The main focus of our work is balancing demand and capacity and pathway improvement.

Ensure our emergency care services can respond to local needs, including considering alternative models of care and providing more services in our communities to facilitate early discharge from hospital or prevent the need of a hospital admission		We have implemented a number of improvement initiatives in 2016-17 to improve performance and ensure our emergency care services can respond to local needs. Some examples are: • Commissioning of three additional resuscitation bays into service • Commissioning of an Ambulatory Emergency Care (AEC) unit in UHW, thereby further refining our 'front door' streaming processes • In conjunction with the Welsh Ambulance Services NHS Trust, development of a number of new Emergency Unit attendance avoidance pathways • Moving to 7 day working across a number of medical specialties and within Community Resource Teams • Improved resilience in our Primary Care GP Out of Hours service In conjunction with our partners, agreed and implemented an Integrated Winter Plan. This provided additional resilience this year resulting in better performance this winter compared to last
We are considering future roles for Mental Health Care support workers and Mental Health Nurse Practitioners		New roles have being developed, such as the Hospital Flexible Resource Team and Dementia Navigators. Mental Health nurse practitioner roles are being developed in partnership with Primary Care to work in GP Clusters in assessing and signposting to appropriate services.

Elective Care

Measure	March 2016	March 2017
Referral to Treatment Time: No. of patients waiting > 36 weeks	1598	1146
% of patients on an urgent suspected cancer pathway and with confirmed diagnosis of cancer treated within 62 days	79.00%	95.37%
% of patients on an non-urgent suspected cancer pathway and with confirmed diagnosis of cancer treated within 31 days	94.90%	98.79%
Number of patients waiting over 8 weeks for a diagnostic test	2849	1837

Unscheduled Care

Measure	2015-16	2016-17
% of people waiting less than 4 hours in EU	81%	84%
Number of people waiting more than 12 hours in EU	1098	685
Number of patients delayed from being transferred from a hospital bed to their next stage of care	March 2016 - 107	March 2017 - 58

Prostate Cancer

The urology department won an NHS Awards for a project aimed to reduce the amount of time that patients with suspected prostate cancer waited from referral until the time that they received treatment. By changing the order in which tests and investigations occurred and by changing the clinic timetable the team successfully cut waiting times from 90 to 61 days. The project was also successful in reducing the number of unnecessary investigations that patients might have previously had to undergo.

They took the time and trouble to get to know each

"My Father has dementia and doesn't understand where he is ,it is very comforting for the family to know that he is not just sitting by his bed but is being encouraged to interact with other people and try new things."

Intermediate Step Down Care BIG 1

We know that patients who are unable to return home after a stay in hospital or patients who need extra support to enable them to return home, can remain in hospital for a long time after they are medically fit to be discharged .Last year we trialled a new way of caring for these patients. Those who were medically fit were transferred to a 19 bed ward where they were looked after in a safe and caring environment while plans were made for their discharge. This meant that beds on acute wards were made available for patients who were unwell and needed more acute care. Because the patients were well, activities were arranged every afternoon, something that is often not possible on the acute wards. Activities including afternoon tea, Tai chi and Bingo were enjoyed by many of the patients.

Community Cardiology Clinic

Two community clinics for patients with suspected heart failure are being run from GP practices in Cardiff. All tests to diagnose heart failure are undertaken at the initial appointment and patients who are diagnosed with heart failure are followed up in cardiology services based in UHW while the remaining patients are referred back to their GP.

Audiology

Until recently patients were often seen in Ear Nose and Throat clinics before being referred to the audiology department. This pathway has changed and now all referrals are reviewed and where appropriate patients are offered appointments directly with audiology services. This has meant that 78% of patients now attend one appointment rather than two and patients with tinnitus wait 4 weeks rather than 26 weeks to be seen. Many of the appointments are delivered in a community clinic meaning that at present 6500 patients are seen closer to home and plans to duplicate this services in another areas of Cardiff will mean that a further 17000 patients will no longer have to come to UHW for their care.

Hearing Aid services

Over 11000 patients per year attend UHW and West Quay for hearing aid repairs, servicing and replacement. Until this year these appointments were only available by appointment. Since February patients needing to access hearing aid services no longer need an appointment and are able to turn up to clinics 5 days a week. Over 200 patients are seen each week with no more than a few minutes wait. Earlier this year this service was extended to allow two days of open access clinics in the Vale of Glamorgan.

Community Resource Teams

The Community Resource Teams increased the provision of their services to provide care and therapy to patients in their own homes over seven days a week (moving from a five day service). During the first 12 months operating as a seven day service between December 15 – December 16, the teams supported a total of 457 patients at the weekend, enabling hospital discharge or providing support to prevent admission to hospital on Saturdays or Sundays.

Staying Healthy

In 2016 17 we said we would		How Do We Know
Create 6 growing centres (fruit and vegetables) in City of Cardiff Council Hubs. We will develop a plan to create growing spaces in each of the 6 neighbourhood partnership areas, growing up to 200 fruit trees and training 60 community members to propagate plants in Cardiff		There are plans to develop and deliver a 10 month community training programme, family and community and school engagement days and an “apple a day campaign” with the aim of planting 1000 apple trees and fruit bushes across Cardiff.
Support Older people to live well. We will continue to develop the provision of strength and balance classes for older people to help prevent falls. We will deliver and evaluate the “Citizen Driven Health” project, to support older people to remain living independently in their own home through accessing services and support from volunteers to achieve their goals and ambitions.		There are now 14 strength and balance classes running across Cardiff & Vale, attended by approximately 120 people every week. “Citizen Driven Health” (CDH) was delivered and evaluated demonstrating that older people improved their health and wellbeing through being supported to remain living independently and accessing services and support from other organisations.
Ensure any new UHB facilities are designed and built to support and promote the health of staff, patients and visitors and encourage healthy lifestyles and sustainable transport. This will be done by carrying out health impact assessments on all new designs which are submitted for capital funding		Discussions with Estates have progressed with a view to ensuring that the health impact of new facilities is considered as part of the Equality and Health Impact Assessment process. The aim is to support healthy lifestyles including active travel and access to healthy foods.
Increase the number of people aged 65 and over who are screened for risk of falls when accessing Unscheduled Care		All patients attending Unscheduled Care aged over 65 are screened for falls risk if they have fallen or are at risk of falling.

Deliver Making Every Contact Count (MECC) training to public and third sector staff so they can engage their patients and clients in 'healthy chats'		Over 1300 people have received training since MECC was introduced in Cardiff and Vale. Training has been delivered to staff in health service, third sector, local authority and wider public sector organisations. Within the health board MECC is included in plans to support staff health and wellbeing. We have also contributed to the development of MECC across Wales working with other health board public health teams and Public Health Wales.

Staff flu immunisation

All staff who have direct patient contact are encouraged to get the free flu vaccine every year, to protect patients under our care. More staff have been vaccinated each year for the last 5 years and in 2016-17 over 50% of our staff were vaccinated. We had over a hundred Flu Champion vaccinators throughout the Health Board who helped vaccinate their colleagues There were some really good examples of team working across the Health Board to increase uptake. We don't plan to rest on our laurels though – we are already planning how to further improve uptake among staff in 2017-18.

First Vale of Glamorgan childcare organisations complete the Healthy and Sustainable Pre School Scheme

The Healthy and Sustainable Pre School Scheme aims to promote the health of pre-school aged children, their families and carers by working through the childcare settings they attend. The scheme has been running in the Vale of Glamorgan since 2012, and encourages positive health behaviours in children from the very earliest age, that they will continue throughout their lives. Childcare organisations are required to collect evidence to show progress across a variety of topic areas such as nutrition and oral health, physical activity and active play, mental and emotional health, well being and relationships, environment, safety, hygiene and workplace health.

Slippers for Christmas

With around 500 people over 65 attending Cardiff and Vale's Emergency Unit for falls each month, a new campaign was designed to remind people that falls are preventable and are not an inevitable part of ageing. Old, worn or ill-fitting slippers are one of the main causes of falls in older people, so Slippers for Christmas aimed to encourage people to buy new slippers for their loved ones. The campaign was hugely popular, with members of the public, the media and other health boards across Wales showing their support. It also had backing from politicians and sporting stars and reached over 100,000 people on social media.

Food and Fun

Food Cardiff rolled out its Food and Fun programme in summer 2016, following its successful pilot in 2015. The programme delivered healthy meals, physical activity and nutrition education to children in areas of social deprivation during the summer holidays. It was designed to ease the pressure on families who may face extra challenges during the school break, especially those in receipt of free school meals during term time. The programme in Cardiff was so successful that it was adopted by four other local authorities across Wales, including the Vale of Glamorgan, culminating in Welsh Government pledging £500,000 to fund similar programmes.

Stop Before Your Op

Dr Anthony Funnell, an anaesthetist at University Hospital of Wales, developed an animated film called 'Stop Before Your Op' to encourage people to quit smoking before planned surgery. The video aims to maximise successful surgery by offering weight-loss and smoking cessation support to patients. As well as attracting attention on social media, the film was also shared by media partners including Wales Online and featured in a segment about smoking on ITV Wales News. It was also supported by Stop

Smoking Wales and other health boards across Wales, who shared the film through their social media channels. The film provoked conversations on Facebook, with patients sharing their success stories around weight-loss and smoking cessation.

Stop Before your Op' Can be viewed on YouTube

https://youtu.be/V61v6BXg8aw

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Health and Wellbeing within our Localities – **Big 2**

We are looking at how facilities within our community can be best arranged to support health and wellbeing. We know that this does not stop with health and social care providers, the third sector and wider community plays an important part in supporting health and wellbeing. One of the options being considered is the development of Community Hubs that provide access to community services and resources to improve health and wellbeing. It is anticipated that as well as incorporating health services including pharmacy, outpatient clinics and diagnostic services there will also be independent living services, information and advice services, library services, computers and a cafe as well as meeting rooms.

Effective Care

In 2016-17 we said we would		How do we Know
1 Develop a 24 hour emergency helpline for children with diabetes and their families		This work is being undertaken by the Diabetes and young person's network and is ongoing.
2 Develop a clinical audit programme that will give us assurance around the quality and effectiveness of the care that we deliver and will inform quality improvement in all clinical boards		In 2016 /17 clinical audits were undertaken to give us assurance around the safety and quality of our services and we took part in the National clinical audit programme.
3 Stroke services will enhance their rehabilitation and discharge processes by increasing the number of Rehabilitation assistants		A successful pilot was completed and work is underway to secure the necessary resources to be able to continue this work

Clinical Audit

Clinical audits are a way of measuring the quality of the care that we provide. Each year we take part in the National Clinical Audit programme; this programme helps us to understand the quality of the care we are providing and how we are performing in comparison to other hospitals in UK. We also undertake many audits within other clinical areas to ensure that they are effective and safe.

Many of the National Clinical Audit Reports can be accessed at http://www.hqip.org.uk

Cancer

Our Cancer Delivery plan has been developed to allow us to provide care to meet the needs of people at risk of Cancer or diagnosed with Cancer. Cancer prevention is an important part of the plan and public awareness campaigns are being run to inform people about smoking, obesity and alcohol intake. Cancer screening rates have improved in breast and bowel cancer; however, there are lower numbers of women having cervical screening in socially deprived areas of Cardiff and the Vale but there is work underway to raise awareness of the importance of screening in these areas.

Stroke

There are approximately 900 incidence of new strokes in Cardiff and the Vale of Glamorgan each year and more people are surviving each year.

- Over 50% of people discharged from the Acute Stroke Ward go home with Early Supported Discharge.
- Code Stroke is a system that activates a dedicated team of health professionals to attend to a patient as soon as they come into the emergency unit with a suspected stroke.

Liver Disease

Over the past 10 years the number of cases of liver disease has increased by half, this is because of increasing alcohol intake, obesity and hepatitis. Changes to the way that services are organised means that patients are waiting less time to be seen in specialist outpatients clinics.

You Can read our Delivery Plans at:
http://www.cardiffandvaleuhb.wales.nhs.uk/delivery-plans

Neonatal Services

A brand new neonatal unit has been built that offers more space and capacity to care for more babies. Insert photo

In 2015 the spread of an infection led to the closure of the existing unit. Following the infection an independent expert review was undertaken to examine the management of the process. This has been discussed at the Quality, Safety and Experience Committee and there is an action plan in place to address the recommendations, many of which have already been achieved.

Link to neonatal report

Dialysis Services

258 patient receive Renal Dialysis within the Cardiff and Vale dialysis units each week. This year the Cardiff South base has moved from Cardiff Royal Infirmary to a bright and modern unit on Penarth Road. The new base is more spacious and patients attending the unit are able to control the temperature of their individual treatment areas. This is important as previously patients have told us that they felt cold when they received dialysis. In response to feedback from patients using the dialysis unit we have worked with our partner agencies to ensure that patients are able to travel to and from the unit as quickly as possible.

Falls

Physiotherapists have been supporting patients in the community who are at risk of falls to undertake a six month Individualised Strength and Balance Programme. The patients undertake a programme of exercises designed to strengthen muscles and to improve balance, they are assessed and reviewed at regular intervals throughout the six month programme. The programme has been successful in reducing the number of times that these patients fell by almost two thirds from the six months period prior to the exercise programme.. The programme has also been successful in reducing the numbers of Emergency Unit attendances

Paediatric Diabetes

This year a diabetes school educator was appointed to work with Schools in Cardiff and the Vale of Glamorgan to ensure that staff had the knowledge and skills required to support children with diabetes. In the first 5 months the school educator visited 103 schools to give training, education and support to staff, children and parents. The service has meant that schools are more confident in managing diabetes including acute complications eg low blood glucose levels, giving insulin and carbohydrate counting. This has meant that more children with diabetes are participating safely in all elements of school life including playing sport and going on school trips'

Reducing Variation in Eye Care and Musculoskeletal services - BIG 3

The aim of BIG 3 has been to create better outcomes that matter to people and to provide safer and more effective care. This work has started with two areas, eye care and musculoskeletal service (MSK).

Eye Care

This year work has started to develop the way that care is provided to patients with Age-related Macular Degeneration (AMD), cataracts and patients with oculoplastic needs (surgical procedures that deal with the eye socket, eyelid, tear duct and face). We want to ensure that the right people are looking after these patients at the different stages of their diagnosis, treatment and monitoring. We also want to, where possible, reduce the number of times that eye care patients have to attend appointments by ensuring that all of the right people and right services are available at outpatients clinics. By developing the way that information is shared between GPs, secondary care and community Optometrists we can avoid repeating tests and patients having to attend appointments unnecessarily.

MSK

This year we have started a project to ensure that people who are referred to our musculoskeletal services are seen by the right people in the right place at the right time. We know that some our patients have had to wait longer than they should while others receive their care quickly. The project will mean primary care and secondary care services working closely together to ensure a fairer and more equitable referral system that allows all patients to be seen with the shortest possible wait and are seen by the most appropriate clinician. Alternative settings for these services are also being considered to allow this care to be provided closer to home.

In September 2016 Healthcare Inspectorate Wales undertook a thematic review of Opthamology services across Wales. You can access the Cardiff and Vale UHB improvement plan resulting from the inspection at:

http://hiw.org.uk/docs/hiw/reports/170524cardiffandvaleopreviewen.pdf

Safe Care

In 2016-2017 We Said We Would		How do We Know
Complete the development of the Quality and Safety Framework		This has been achieved and was published in April 2017 at the Quality, Safety and Experience Committee. Details of the framework are explained in the Moving Forward chapter of the Annual Quality Statement
Establish a Patient Safety Alerts Group to deliver compliance		A Patient Safety Alerts Group has been formed to ensure that the health board is responding appropriately to Patient Safety Alerts.
Further develop the Electronic Mortality Review Tool (EMAT) to include mental health patients		EMAT has now been developed to allow it to be used in mental health services.
Establish a process for the Chief Executive to meet with clinical teams after a Never Event		The Surgical Never Events were presented to the Executive team along with the Welsh Government Delivery Unit to discuss the learning from each investigation. There will be opportunities to further strengthen this process with our new Chief Executive.

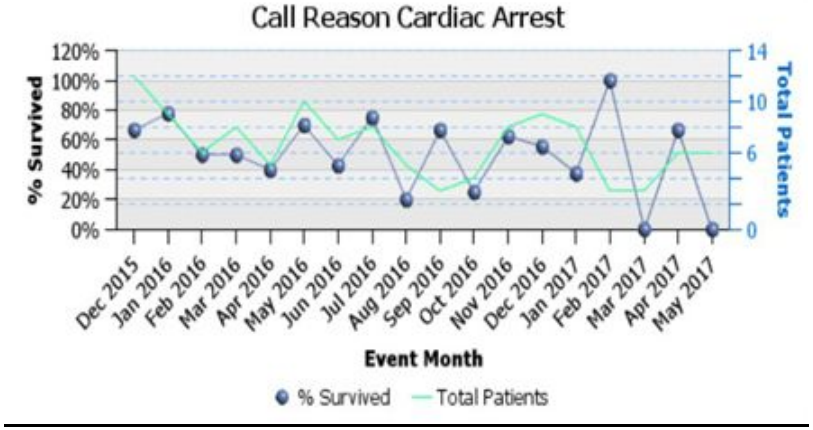
Safer Chemotherapy Prescribing for Children

An electronic system of prescribing chemotherapy for children is now being used. The system minimises the risk of error by ensuring that the correct type and dose of chemotherapy is prescribed and allows clinicians to safely access blood test results regardless of where the tests are taken. This is important as the Noah Ark Children's Hospital of Wales looks after patients from across South Wales.

Resuscitation

Unfortunately it is inevitable that some patients within our wards will have a cardiac arrest due to the severity of their condition. After each cardiac arrest the emergency care given is reviewed, to ensure that the deterioration of the patient is recognised early enough and that the best care and treatment is given prior to and during the cardiac arrest. This has meant that *** % of patients survive a cardiac arrest within the health board as opposed to ***% nationally.

The graph shows the number of patients who survive a cardiac arrest and go on to be discharged.



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Endoscopy

An endoscopy is where a long thin flexible camera is used to look at the digestive tract; it can be one of the investigations undertaken if a patient has suspected cancer. The number of people being referred for endoscopies is increasing and as a result waiting times are getting longer. Unfortunately during 2016 -2017 it came to light that a number of patients had not been seen or followed up in a timely way. To make things safer, the clinical team are reviewing the waiting list to ensure that those at greatest risk are prioritised. Improved communication with GPs has meant that patients are kept informed of the waiting times and that patients can be reviewed if their symptoms change. In addition to this nurses are also being trained to perform some endoscopies so that patients can be seen more quickly. .

Infection Control;

Preventing and controlling infections is a key priority for us. Some infections can be very serious such as blood stream infections related to Methicillin Resistant Staph Aureus/Methicillin Sensitive Staph Aureus and Clostridium difficile (C-diff), which can cause severe diarrhoea. In 2016 some Clinical Boards achieved 6 months free from MRSA blood stream infections, however, since December 2016 we have seen a number of cases across several of our Clinical Boards. The Health Board has continued to achieve a reduction in the numbers of C'difficile and Staph. aureus but have unfortunately we did not achieve the reduction expectations set by Welsh Government, narrowly missing the C'difficile target by 2 cases and the Staph Aureus target by 42 cases. This year a new target to reduce E-Coli has also been introduced. Much work is underway to prevent infections including standardising the way and the equipment we use to undertake some common procedures eg using sterile packs when we insert cannulas into patient's veins as well as the rollout of Blood Culture procedure packs across the Health Board. Some of our policies have also been updated this year and will result in more patients being screened and swabbed when they are admitted into one of our acute hospitals. Our regular spot check audits will also continue to ensure that expected standards are being met

Sepsis

Sepsis is caused by the body's response to severe infection and can lead quickly to death if untreated. It is thought that at least 44,000 people each year die from Sepsis in the UK. This year we have run 4 Sepsis simulation days, teaching clinicians how to recognise and treat Sepsis quickly and effectively and have launched a new Sepsis Inpatient Screening and Action Tool to support clinicians in recognising and reacting to Sepsis within the hospital settings. We have made more sepsis trolleys available on our wards containing all of the equipment and drug therapy required to treat a patient with sepsis and we are involved in a joint project with primary care and Welsh Ambulance Service to support pre hospital recognition and antibiotics for 999 patients with severe sepsis.

Patient Safety Incidents

During 2016 – 2017 staff reported over 15,000 patient safety incidents. The majority of these incidents were no or low harm incidents, which is in similar to other health organisations. We reported 238 incidents to Welsh Government due to their serious nature. While this is a small proportion of all incidents reported, a great deal of time and effort is taken in investigating them thoroughly to ensure that lessons are learnt and improvements are made.

Patient Safety Incidents	Actions
Reduction in the level of harm following injurious falls	A Falls Group has been set up. This allows the health board and partner agencies to work together to ensure that we are preventing falls from occurring whenever possible and to ensure that everyone living in Cardiff and the Vale of Glamorgan can access the same support to reduce their risks of falling.
Pressure damage that has occurred as a result of health care.	There is work underway to review the way that Pressure damage is prevented, identified and managed
Identify themes and trends from reported medication incidents to ensure opportunities for learning are identified	There is a Medication Safety Group that reviews serious medication errors and trends. A Safety briefing is issued to staff several times a year.
Unexpected Deaths	There are many processes in place for us to review and understand the care that patients are given so that we can understand why they might have died. We work closely with HM Coroner and implement actions when there are lessons to be learned. We also work very closely with colleagues in the police, education and social services following the unexpected death of a child in hospital or in the community

Never Events –A number of serious incidents are classed as 'Never Events'. These are serious and largely preventable patient safety incidents. We reported 7 Never Events between April 2016 and March 2017; some of these incidents continue to be investigated.

Some examples of action we have taken include:

Never Event	Causes and Contributory Factors	Lessons learnt
Wrong tooth extraction	• Failure in pre procedure checks	By undertaking a set of formal checks before, during and after a procedure the risk of human error is reduced. These checks are being reinforced in areas where they are already used and introduced to dental services. We will undertake audits to ensure that we are adhering to these checks. To read more about the WHO safety checklists visit: http://www.who.int/patientsafety/safesurgery/checklist_implementation/en/
Retained foreign objects	• Failure in swab counts	
Wrong site surgery	• Failure in pre operative checks	

<u>WHSSC</u>

Patient Safety reports including all serious incidents can be read in our Board report Minutes : http://www.cardiffandvaleuhb.wales.nhs.uk/board-meetings

Welsh Health Specialised Services Committee (WHSSC) is a Joint Committee of the seven Health Boards in Wales. WHSSC works closely with the Health Boards to ensure that any specialised service commissioned is of a high standard and that there are no concerns identified from a quality perspective. They do this through the quality assurance frame work which is reported into the Health Board. This framework ensures a systematic approach to assuring quality, good patient experience and good health outcomes of commissioned services. It utilises the contracting process, quality

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schedules, standards and clinical quality indicators to support effective healthcare delivery, quality improvement and innovation across the health system for specialised services

Dignified Care

In 2016 – 2017 We Said We Would	How We Know

Deliver the action plan to improve patient nutrition and hydration to avoid malnutrition and dehydration		This year we introduced a nutrition champion role, to improve nutrition and hydration of hospital patients within the health board. Every clinical area was asked to nominate a qualified nurse and a health care support worker to undertake 2 days of training to become “champions” supporting their colleagues on the wards to ensure the nutrition and hydration needs of their patients are met. In November 2016 the care of every inpatient on the UHW site was reviewed to ensure that they had received an assessment within 24 hours of being admitted to identify those at risk of malnutrition and dehydration. The accuracy of these assessment was also reviewed to help us to identify where further training in the use the assessment tool was needed
Complete the year 3 actions within the dementia 3 year plan You can view the three year dementia Plan by visiting: http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Dementia%20Report%20201516.pdf		The majority of the actions in the Dementia 3 Year Plan have been completed, including pilot dementia friendly communities with now over 15,200 Dementia Friends created across Cardiff and the Vale. However there is work ongoing around increasing Memory Team capacity to cope with demand.
Implement the recommendations from the Older Peoples Commissioners Report Dementia More Than Just memory Loss and embed them in the new dementia 3 year plan. You can view the older peoples commissioners report by visiting: http://www.olderpeoplewales.com/Libraries/Uploads/More_Than_Just_Memory_Loss.sflb.ashx		Many of the recommendations have been completed; however, some actions will need to be embedded into the new Dementia Strategy, such as increasing the proportion of frontline staff who have received dementia awareness training (33.0% at March 2017).

Increase the number of ward inspections undertaken so that 90% of wards and departments are inspected by March 2017		This has been achieved with 96 inspections being undertaken
Revise existing nursing documentation and improve compliance in completing it		This work is progressing with the final changes made to the Integrated assessment document. The compliance of use of this document is monitored during ward inspections. We will work with a national teams move forward with digitalisation of nurse documentation by 2020

Continence

Incontinence is a common problem that affects both men and women. It is thought that between 3 and 6 million people suffer with urinary incontinence in the UK. Individuals living at home or in residential care within Cardiff and the Vale of Glamorgan who experience continence issues are assessed, and treated by a specialist team of nurses. Continence products are supplied and delivered to 4000 individuals in Cardiff and Vale to manage their continence needs. To ensure that we achieve the same high standards of assessment, treatment and management of incontinence for patients on our ward the continence nurses participate in ward inspections.

'I was very embarrassed by the problem but the Nurse was very pleasant and informative and made me feel at ease'

Chaplaincy Music Project

The chaplaincy service ran a six month music project with patients in Hafan Y Coed and the Stroke Rehabilitation Centre to encourage reminiscence and social interaction as well as offering a change from the daily ward routine. A chaplaincy volunteer led weekly music session. The sessions were particularly valued by visitors of patients suffering from dementia, as it enabled them enjoy and participate in a shared activity.

Nutrition and Hydration

Ensuring that patients in our care have a nutritious diet and are enough to drink is vital to their recovery and wellbeing. The ” Model Ward” is a project being undertaken to ensure that food and drinks are provided in the best possible way for patients. There are many examples of great work throughout our hospitals, for example protected mealtimes, snacks available to patients on request and dietetic support workers in a number of clinical areas assisting patients to eat and drink at mealtimes. The model ward pilot project aims to take existing examples of good practise, build on these and ensure that these are embedded in all of our areas of care to ensure our patients physical and mental health and well being across the Health Board.

Ward Inspections

Ensuring the quality and safety of the care that we provide is paramount. There is a significant programme of announced and unannounced inspections delivered on top of the regular supervision and support offered by senior nurses. These all help to provide us with regular information about the quality and safety of our services on a day to day basis.

In 2016 94 Safety Walkrounds by Board members were undertaken, providing insight and understanding into the quality and safety of our services and to identify areas of good practice. This year, Action on Hearing Loss, have supported the Safety Walkrounds visiting clinical areas to ensure that we communicate effectively with patients who have sensory loss.

96 ward inspections have also been undertaken by senior clinical staff, to focus on seven essential areas of care; hydration, basic continence care, administration of medicines, health care associated infections, falls, pressure ulcers and use of night time sedation. Overall the reports issued following the inspections provided a positive picture of staff working with patients to provide care in a professional and dignified manner. There have been a number of actions undertaken where areas for improvement have been identified. These have included:

- ✓ Responding to estates issues
- ✓ Improving documentation
- ✓ Standardising information displayed on ward patient information boards

Information and evidence is gathered through observation of ward/care areas, speaking to staff, patients and their families and carers and when applicable, focusing on bed side charts

Healthcare Inspectorate Wales (HIW) Inspections

HIW work closely with us, reviewing the care that we provide in our hospitals, community services, dental surgeries and GP surgeries. These inspections help us to recognise what we are doing well and where we need to make improvements. All

inspection reports and improvements plans are reviewed by the Quality, Safety and Experience Committees. Some of the improvements that have resulted from these inspections include:

- Improved advice for patients to raise a concern in specific GP surgeries
- improved decontamination processes in specific dental Practices
- Review of patient information displayed on ward white boards Essential maintenance to ward areas

Following a visit to Llandough in 2016, the Health Board put in place a very comprehensive action plan to address the findings. We are pleased to say, that during inspections during the rest of 2016-2017, the feedback has been very positive and they have told us that we have learned the lessons and put in place the necessary changes.

In May 2017, HIW presented a very positive annual report to our Board members. They told us that there inspections during 2016-2017 had generally indicated that the care provided to patients is kind, compassionate and effective, being delivered by kind and enthusiastic staff. They have asked us to focus on documentation and the condition of some of our clinical environments this year.

Health Care Inspectorate Wales reports can be read on the HIW website :

http://hiw.org.uk/?lang=en

Hearing into **Action: A Patient Story**

Gill has been a diabetic for over 40 years and has had difficulty in controlling her condition. Her Diabetic Nurse suggested that she attend the DAFNE Course (Dose Adjustment For Normal Eating) - this is a course that provides people with Type 1 Diabetes with the skills to manage their diet and blood sugar levels. As well as having diabetes Gill is also deaf and has a cochlear implant which gives her some hearing, but she has to lip read to be able to make sense of the sounds. This initially caused some concern for Gill as she was concerned that she might not be able to follow in a classroom situation. Gill explained that people who know her, know that they need to face her when speaking to her and tend to use their lips more rather than mumble. Gill's concerns were addressed after meeting with the two Dieticians who gave her an overview of the course content.

. More importantly for Gill she was given the course material to look through before she attended, If she had received them on the day it would have been very difficult for her to read and listen to what was being said. It was also important for Gill that any communication between her and the dieticians was done via email.. Gill was taken to see the room in which the course would be taking place in advance allowing her to choose a seating position ensuring the sunlight was behind her as shadows over people's faces can make it difficult for her to lip-read. Due to the relationship Gill had built up with the dieticians and all the preparation before the course she felt comfortable attending. Gill was also pleased that the dietician's presenting style was easy to follow, they were always happy to repeat anything she had missed, and answer any of her questions.

Gill said that as a patient it was important for her to raise her concerns, to allow for adjustments to be made. With her concerns dealt with Gill said she enjoyed the course and found it interesting and informative and it would help her with her diabetes.

"I felt comfortable on the course and that's quite important....its nerve wracking meeting the other people who are strangers to me

All in all it was a positive experience and I can't really think of anything negative."

To see Gill's full patient story please visit: https://youtu.be/3i3_R-n8pu8

Creating the Right Environment

Ensuring that we provide the right environment to support the health and wellbeing of our patients is important. Mental Health Services for Older People have created several areas that will be recognisable to patients with dementia and provide a safe and familiar place to relax. The Cwtch on ward East 18 is a 1950s style sitting room complete with record player, glass cabinets and ornaments. Both the bar, complete with pool table and magnetic darts board and the cafe both located on ward East 10 offer a sociable alternative to the ward environment.

The nurses were fantastic and allowed me to be part of the team in caring for my Mum with dementia. They empowered me to know what to do. I built a relationship with them and it eased my anxiety. Mum said "keep me clean and coordinated" and that was 100% achieved in a caring and professional manner. I

Our Staff and Volunteers

In 2016 – 2017 We Said We Would		How Do We Know
Work with our staff and patients to develop and embed our values and behaviours with a series of workshops		Values into Action was a project that involved us working with patients and staff to hear about their experiences within the health board and to develop a set of values that underpins how we treat people.
Improve nursing and medical staffing deployment through new ways of working and recruitment campaigns		We are continuing to implement our plan to improve nurse recruitment and are taking action to improve retention of qualified nurse. We also have plans to address hard-to-fill medical posts
Improve staff engagement which will be measured through the staff survey		The results from the NHS Wales Staff Survey 2016 were announced in December and our feedback shows an overall improvement in staff engagement. These results, together with those from the Medical Engagement Survey and our local values survey provide an insight to areas in which the UHB is performing well and where focused improvement is required.
Enable care to be provided closer to home by progressing the primary care plan		The primary care plan has been progressed over the past year with developments to the care provided in out of hospital settings.

What have we achieved in 2016 - 2017?

- Further reductions in staff sickness to 4.84%
- 60% of our staff have received a Personal Appraisal Developmental Review this year
- Medical appraisals have risen to 83%
- Recruitment - over 95% of our posts are filled

Training figures April 2016 – February/March 17

- Improving Quality Together (IQT) (bronze and more advanced) - 850
- Treat me fairly 3939
- Infection Prevention & Control 4543
- Safeguarding children 3564
- Safeguarding adults 3707
- Mental capacity act 681

Challenges

Turnover of staff has increased to 9.16%. Staff leaving the organisation are now being invited to complete an exit questionnaire to help us to understand the reasons for this increase

Recruitment

We are continuing to implement our plan to improve nurse recruitment. Key elements include:

- European recruitment (109 offers have been made to European applicants. 85 offers have been accepted and 78 staff have started).
- Local Clinical Board led recruitment events, using social media to advertise and promote events
- Increasing the numbers on Return to Practice Programmes
- Introducing local adaptation programmes in Medicine and Surgery
- Improved collaboration with Cardiff University

In addition to the increased recruitment activity taking place, the Clinical Boards are also taking action to improve retention of qualified nurses.We also have specific workforce plans to address hard-to-fill medical posts:

- We helped to staff the Wales (Welsh Government) stand at the BMJ Career event in London during October 2016
- We attended the Acute Medicine event in Excel London in November 2016
- Our Medical Workforce Manager co-chaired an All-Wales initiative to recruit doctors from India to work in various specialties across Wales
- A successful Medical Training Initiative scheme was set up in Paediatrics
- Rotas are devised and changed in response to service demands

Employer of the Year at the Understanding Disability Awards

Staff at UHW have been awarded at the Understanding Disability Awards for their work in supporting staff with learning disabilities to gain employment. Two members of staff now employed in the new hospital restaurant, Y Gegin, started as interns under the "Project Enable " scheme. Pranav Rathod and Alice Bryant are fantastic members of the team, both have developed their confidence to work with other staff and customers at the restaurant. The award shows how we have been able to create a culture that welcomes people with learning disabilities into our organisation.

Equality

We have again made the Stonewall Workplace Equality Index Top 100 Employers list as one of their gay friendly employers. We are the TOP Health & Social Care Organisations in Wales and are in the 5 Top Health & Social Care Organisations in the UK as well as the being in the Top 10 Employers in Wales.

Royal College of Midwives Awards

We have had fantastic success at the Royal College of Midwives annual awards this year. Laura Wyatt won both the Welsh and the UK Mother's Midwife of the Year Award. She was nominated by mum, Jody Vaughan, for the care that she gave Jody and her partner Karl when their son died during Jody's labour. When Laura met Jody and her partner Karl, she put them at ease straight away, not overwhelming them with information but ensuring that they understood what was being explained. Laura went on to provide antenatal care to the family, demonstrating tremendous advocacy skills and instilling confidence during an understandably anxious second pregnancy.

Karen Jewell and Mwenya Chimba along with Ruth Mullineux from the NSPCC won the Award for Partnership Working for a project to tackle and raise awareness of female genital mutilation (FGM) with young people in Wales. They brought together a group of young people from schools across Cardiff who worked on girls' rights and issues related to FGM, empowering and encouraging this group of young people to become cultural change-makers on FGM, raising awareness in their own places, schools and colleges and producing materials to spark conversations

Volunteers Celebration Event

Hundreds of volunteers have been thanked for their work supporting health in Cardiff and the Vale of Glamorgan. A special celebration event was held to acknowledge the hard work and dedication of the health board and third sector colleagues that volunteer. The Director of Nursing and the Vice Chair opened the event and gave their heartfelt thanks to those who give up their time to volunteer and support the patients and service users of the Health Board. If you have some spare time and would like to volunteer then please contact our volunteer service manager on 029 21 847867.


Royal Volunteer Service Award

Royal Volunteer Service Volunteer Les MacNeil awarded the British Empire Medal in the New Year's honours list. This is in recognition of all her support and dedication to the service over 25years at the University Hospital of Wales
Les said "I feel very privileged to have been given this honour as I work with so many people at the hospital who are deserving of such recognition."

"*Volunteering definitely gives you a buzz; everyone should do it if they can. People have said to me 'you deserve a medal for all the volunteering work you do' – and now I have one!"*

Cardiff and Vale College Student Project

Access to Health Care students have been recruited to support across a number of wards and hospital sites offering support to the patients and staff within our organisation by being part of the befriending and activity volunteer programme. This project was developed in partnership with the college to enable students who are studying towards a career in Heath to gain vital experience of a hospital environment but at the same time

Ward Activity Volunteer Project

Structured activity sessions enable us to support patients, assisting to reduce loneliness and isolation, bringing stimulation and structure to what can be a long day. We are developing a volunteer programme of activities to support patients on many of our wards across the Health Board. Digital reminiscence equipment and activity equipment designed specifically for supporting patients with cognitive impairment are available on some of the wards. Providing the right environment alongside meaningful activities including afternoon tea and group sessions makes a difference to the patient's experience.

Hospital Radio

Radio Glamorgan, the hospital radio station based in University Hospital of Wales celebrates it's 50th anniversary this year while Rookwood Sound, based in University Hospital Llandough celebrates it's 30th anniversary. Both radio stations play an important role in making patients' stay in hospital as pleasant and stress free as possible and helping combat feelings of isolation and loneliness.

Radio Glamorgan is broadcasted online and therefore can be accessed using the free Wifi available within our hospital sites and Rookwood sound can be accessed on channels 1 and A in UHL and 9.45AM in Rookwood Hospital. Information regarding the events and news stories will be posted on their websites: www.radioglamorgan.com and studio@rookwoodsound.co.uk and on their twitter accounts: @radioglamorgan and @rookwoodsound

LOOKING FORWARD

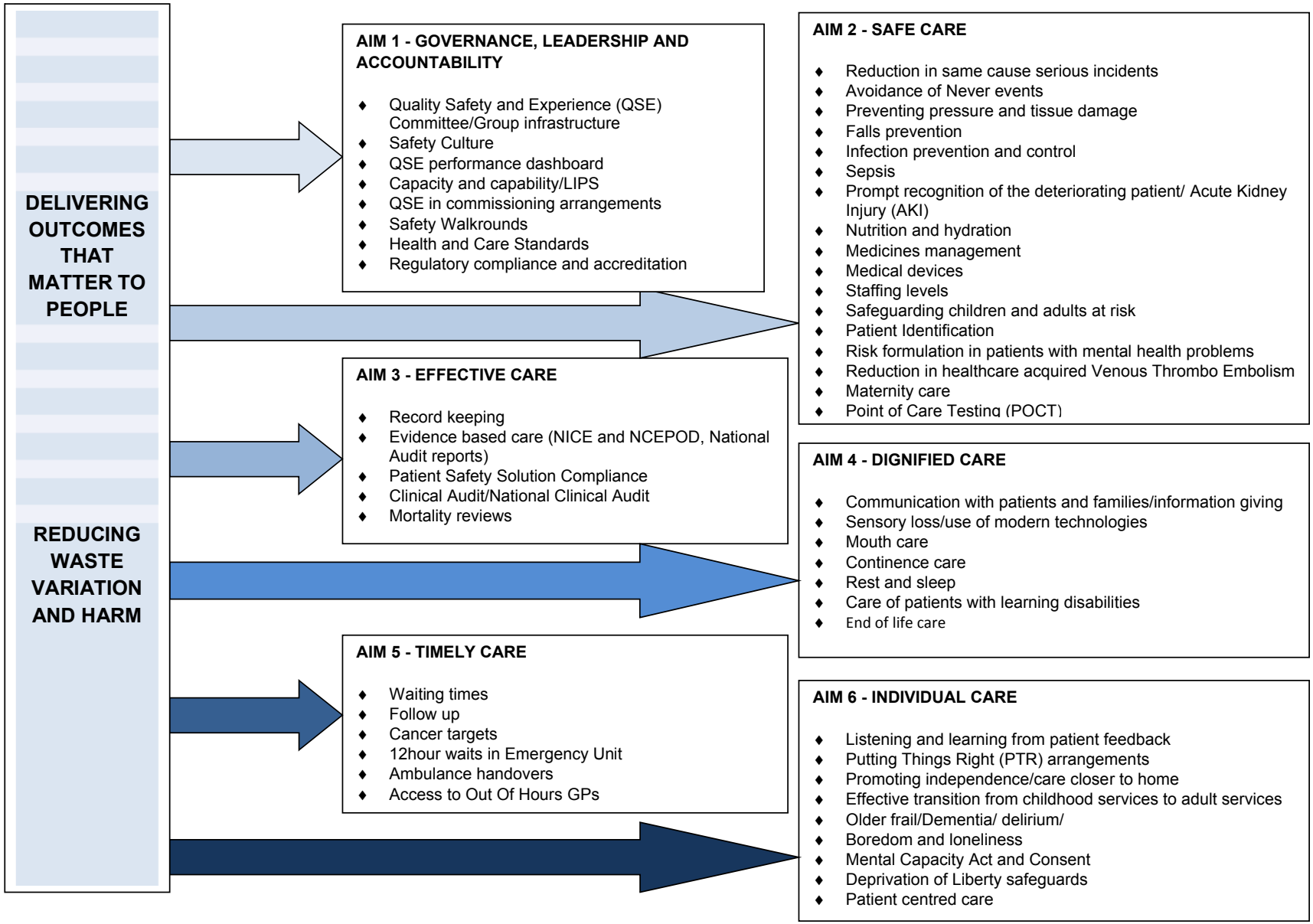
In the previous pages we have described some of our main achievements and challenges over the last year. During this time we have also been undertaking a lot of work to develop a Quality, Safety and Improvement (QSI) Framework for the next three years.

In deciding what areas we need to focus on we took a lot of different information in to account. We looked at local and national information and asked a number of questions:

- What type of patient safety incidents are most common? Are there are any serious types of incidents that we need to focus more on?
- What do patients complain about most?
- What are our most common clinical negligence claims?
- What are our patient surveys telling us? What makes people happy? What contributes to a poor experience of our services?
- What have been the findings of external inspections over the last two years?
- What are some of the national reports e.g Older People's Commissioner, Andrews report, Evans report, Community Health Council thematic reports telling us?
- What issues do our Quality, Safety and Experience Committee discuss and require more work on?
- What did our self assessment against the Health and Care Standards for Wales tell us?

We also spoke to a lot of people including members of the public, staff and other organisations that we work with. 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' – it should not be difficult for people when they visit our services or when they are dealing with lots of different departments and staff. The patient must be put at the centre of everything that we do. We know that every day, across all of our services, staff are working hard to make this happen, and we now need to build on all the fantastic work that is already being undertaken to ensure that the priorities we have identified remain an area of focus and improvement over the next three years. We have identified a range of measures that will help us monitor whether we are improving and we will report these regularly to our Quality, Safety and Experience Committee and also in our Annual Quality Statements over the next three years.

The diagram below summarises our QSI framework. To read more detail you can access the Framework via the following link on our UHB website.(TBC) There will be more information available over the next year as we report on our progress.

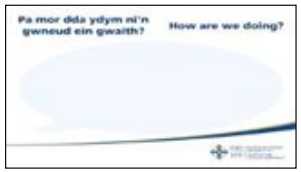

DELIVERING OUTCOMES THAT MATTER TO PEOPLE
REDUCING WASTE VARIATION AND HARM
AIM 1 - GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY
Quality Safety and Experience (QSE) Committee/Group infrastructure
Safety Culture
QSE performance dashboard
Capacity and capability/LIPS
QSE in commissioning arrangements
Safety Walkrounds
Health and Care Standards
Regulatory compliance and accreditation
AIM 2 - SAFE CARE
Reduction in same cause serious incidents
Avoidance of Never events
Preventing pressure and tissue damage
Falls prevention
Infection prevention and control
Sepsis
Prompt recognition of the deteriorating patient/ Acute Kidney Injury (AKI)
Nutrition and hydration
Medicines management
Medical devices
Staffing levels
Safeguarding children and adults at risk
Patient Identification
Risk formulation in patients with mental health problems
Reduction in healthcare acquired Venous Thrombo Embolism
Maternity care
Point of Care Testing (POCT)
AIM 3 - EFFECTIVE CARE
Record keeping
Evidence based care (NICE and NCEPOD, National Audit reports)
Patient Safety Solution Compliance
Clinical Audit/National Clinical Audit
Mortality reviews
AIM 4 - DIGNIFIED CARE
Communication with patients and families/information giving
Sensory loss/use of modern technologies
Mouth care
Continence care
Rest and sleep
Care of patients with learning disabilities
End of life care
AIM 5 - TIMELY CARE
Waiting times
Follow up
Cancer targets
12hour waits in Emergency Unit
Ambulance handovers
Access to Out Of Hours GPs
AIM 6 - INDIVIDUAL CARE
Listening and learning from patient feedback
Putting Things Right (PTR) arrangements
Promoting independence/care closer to home
Effective transition from childhood services to adult services
Older frail/Dementia/ delirium/
Boredom and loneliness
Mental Capacity Act and Consent
Deprivation of Liberty safeguards
Patient centred care

How are we doing? – help us hear your voice

Your feedback is very important to us because as a Health Board we want to give you the best possible care and treatment. We want to ensure you are treated in clean, safe surroundings and that help is always there when you need it.

There are different ways in which you can provide feedback;

- By completing paper surveys
- On the website via the QR code or www.cardiffandvaleuhb.wales.nhs.uk
- By joining a patient group
- By undertaking a patient /carer story
- By talking to our Concerns, Compliments and Complaints Department 029 20744095
- Completing a 'how are we doing feedback card'



For more Information please contact the Patient Experience Team on; 029 20745692.

The Cardiff and Vale of Glamorgan Community Health Council provides an independent advocacy service to people aged 18 years or over, and will provide you with independent support with your complaint. You can get further detail on their website or ring their office on 02920 377407

HEALTH AND CARE STANDARDS SELF ASSESSMENT 2016-2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Executive Director of Nursing
Author : Patient Safety and Quality Assurance Manager
Caring for People, Keeping People Well : The Health and Care Standards underpin all elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact : The Health and Care Standards are the cornerstone of the quality and safety agenda and provide a framework for the UHB to assess the services we provide.
Health and Care Standard Number All standards
CRAF Reference Number. 5.1 Safe, effective and efficient care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE
is provided by:

- The comprehensive assessments of each standard.
- Corporate validation of Self Assessments

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the outcomes of the Health and Care Standards Assessment for 2016/2017

SITUATION

The Health and Care Standards set out the Welsh Government's framework of standards to support the NHS organisations in providing effective, timely and quality services across all healthcare settings.

The standards provide a consistent framework that enable health organisations to look across the range of their services in an integrated way to ensure that the care that they provide is of the highest standard and they are doing the right things, in the right way, in the right place at the right time with the right staff.

BACKGROUND

In December 2016 the committee agreed a revised approach to assessing performance that aligned the standards to existing groups or committees within the UHB. The aim was to support a system that promotes continuous monitoring and development of the services underpinning each of the Health and Care Standards. It was agreed that this process would be implemented over a three year period with 6 standards being aligned to committees in 2016/2017 and that Clinical Boards would undertake self assessments for the remaining 16 standards rating themselves as **Getting Started, Getting There, Meeting the Standard** or **Leading the Way**. Corporate validation of the self assessments would be undertaken to provide assurance and to support improvement actions.

NB - Please be advised that since the self-assessment, the UHB has taken the decision to replace the definition of **Getting There** with **Progressing towards the Standard,** and hence the Committee should note, that this definition has been replaced in the table in Appendix 1

Standards Aligned to Committees

Standard	Standard	Group / Committee	Corporate Lead
2.3	Falls prevention	Falls Prevention Group	Assistant Director of Therapies
2.4	Infection prevention control and decontamination	IPC group	Director of Infection prevention and Control
2.5	Nutrition and Hydration	Nutrition and Catering Steering Group	Head of Dietetics
2.6	Medicines Management	Medicines Management group	Director of Pharmacy
2.7	Safeguarding	Safeguarding Steering group	Head of Safeguarding
2.9	Medical Devices, Equipment and Diagnostic Equipment	Medical Equipment Group	Assistant Director of Therapies

The process was subject to scrutiny by the Internal Audit department who awarded a level of Reasonable Assurance.

ASSESSMENT

Corporate Assessments detailing the level of compliance and required improvement action for standards **2.3, 2.4, 2.5, 2.6, 2.7** and **2.9** were

completed using the agendas of the associated committees as evidence. It is anticipated that the improvement actions will form part of the work plans for these committees and progress will be reported within the 2017/2018 Health and Care Standards Assessments.

Corporate assessments for the remaining 16 standards were evidenced using the Clinical Board self assessments. Progress against clinical Board improvement Actions will be reported in 2017 /2018 self assessments.

The Rating and Corporate assessments for each standard are detailed in Appendix 1.

Appendix 1

Health and Care Standard Rating and Corporate Assessments

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assessments
1.1 Health Promotion Protection and Improvement		Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
2.1 Managing Risk and Promoting Health and Safety		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
2.2 Preventing Pressure Damage		Progressing toward the standard	Progressing toward the standard	NA	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Link to Assessment
2.3 Falls Prevention	Meeting the Standard									Link to Assessment
2.4 IPC and Decontamination	Progressing toward the standard									Link to Assessment
2.5 Nutrition and Hydration	Progressing toward the standard									Link to Assessment
2.6 Medicines Management	Progressing toward the standard									Link to Assessment
2.7 Safeguarding Children and Adults at Risk	Progressing toward the standard									Link to Assessment
2.8 Blood Management		Progressing toward the standard	Meeting the Standard	NA	Progressing toward the standard	NA	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Link to Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assessments
2.9 Medical Devices Equipment and Diagnostic Systems	Progressing toward the standard									Link to Assessment
3.1 Safe and Clinically Effective Care		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the standard	Meeting the Standard	Progressing Towards the Standard	Meeting the Standard	Link to Assessment
3.2 Communicating Effectively		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
3.3 Quality Improvement Research and Innovation		Meeting the Standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
3.4 Information Governance and Communications Technology		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Meeting the Standard	Meeting the Standard	Meeting the Standard	Progressing Towards the Standard	Link to Assessment
3.5 Record Keeping		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Link to Assessment
4.1 Dignified Care		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Meeting the Standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
4.2 Patient Information		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Getting Started	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Link to Assessment
5.1 Timely Access		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Meeting the Standard	Meeting the Standard	Link to Assessment
6.1 Planning Care to Promote Independence		Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Meeting the Standard	Meeting the Standard	Meeting the Standard	Meeting the Standard	Progressing toward the standard	Link to Assessment
6.2 People's Rights		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Link to Assessment

Standard	Corporate rating	C&W	CD&T	Dental	Med	MH	PCIC	Specialist	Surgery	Corporate Assessments
6.3 Listening and Learning from Feedback		Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Progressing toward the standard	Link to Assessment
7.1 Workforce		Progressing toward the standard	Meeting the Standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Meeting the Standard	Progressing toward the standard	Progressing toward the standard	Link to Assessment

SAFEGUARDING REPORT UPDATE
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20th June 2017

Executive Lead: Nurse Director
Author: Head of Safeguarding - 029 218 32001 Acting Deputy Nurse Director
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. Further information can be found on the Safeguarding web pages of the UHB.
Financial impact: There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact: Not Applicable
Health and Care Standard Number Care Standards for Wales- Standard 2.7- Safeguarding Children and Safeguarding Adults at risk and the National Quality Outcomes Framework for Safeguarding Children
CRAF Reference Number:
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The provision of a detailed Safeguarding report
- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee is asked to:

- **NOTE** this report

SITUATION

The Safeguarding Report 2017 captures the depth and breadth of safeguarding activity within Cardiff & Vale UHB over a three year period from April 2014 to March 2017. The report will provide an outline of safeguarding work undertaken during this time period and provide recommendations for future work from April 2017.

BACKGROUND

Safeguarding teams are mandated to provide a report to Board outlining the details of all aspects of safeguarding. The Safeguarding report provides a synopsis of the work undertaken, the resources to deliver the increasing depth and breadth of the safeguarding agenda. Further the report outlines the achievements and service modernisation work that the team is leading on, as demonstrated through the innovative group supervision of Health Visitors (a first in Wales).

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-b A) and the Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales during this time period. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other Statutory Agencies.

In addition to the Acts there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation in October 2015 and Home Office Multi- Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9 (3) of the Domestic Violence, Crime and Victims Act (2004).

As part of progression and to acknowledge the emphasis of the SS&W-b Act to bring safeguarding children and adults at risk on an equal footing, the safeguarding team moved towards creating an integrated team during 2015.

ASSESSMENT AND ASSURANCE

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team whilst working within the UHB, also liaising and working with GP's, Local Authority, Police, and Education, Probation and Third Sector agencies. Since the introduction of the Cardiff Multi Agency Safeguarding Hub (MASH) the safeguarding referral process across the UHB has been restructured and is transferred to LA and Police by the Safeguarding Team electronically via secure e-mail. This has provided the UHB for the first time with a clear indication of where referrals within the UHB are generated and the amount submitted. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/ meetings, multi-agency investigations and often legal advice.

The safeguarding agenda continues to evolve, during this time period we have seen the progression and awareness of Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Homicide Review (DHR) and an increase in training around the CONTEST (anti-terrorism) agenda. Further development is expected in Modern Slavery and training for Domestic Abuse in line with the Welsh Government National Training Framework (NTF). The training is structured across six groups within organisations and places a duty on the bodies to comply with the VAWDASV Act.

Highlight achievements in the report period include:

- The appointment of a Head of Safeguarding
- Appointment of a Senior Nurse Safeguarding
- Continuing to build on the improved training figures
- Strengthening links with each Clinical Board through alignment of a Safeguarding Nurse Advisor
- Successful evaluation and roll out of safeguarding group supervision with the Health Visitor service
- Regular safeguarding supervision for Clinical Board DLMs and development sessions
- Robust and effective information is shared with all practitioners to improve the quality of safeguarding referrals for children and adults at risk
- Safeguarding Nurse Advisors attending Paediatric Peer Supervision

Further work to be progressed in 2017-18 includes:

- Developing reasonable assurance that training data for Mandatory Safeguarding Training is supported by CB Training Needs Assessments to measure compliance
- Plan, deliver and implement Domestic Violence training as set out in the Welsh Government National Training Framework five year plan
- Continue to develop and deliver FGM training across the UHB to targeted groups
- Work in partnership with our Regional Safeguarding Board partners to deliver on targeted priority areas
- Participate in the development of a multi-agency local strategy for domestic violence
- Work collaboratively with the National Safeguarding Team to design and improve the Quality Outcome Framework (QOF) for children and adults at risk

Cardiff and Vale University Health Board

Safeguarding Children and Adult's at Risk

Report 2017

Contents Page

1. Introduction

Cardiff and Vale University Health Board (C&V UHB) provides health services across the population of Cardiff and the Vale of Glamorgan. In 2015 there were an estimated 357,160 people living in Cardiff and 127,592 living in the Vale of Glamorgan. The population of Cardiff is projected to increase by 10% between 2016 and 2026; this is higher than the average growth across Wales and the rest of the UK. This forecasts an additional 35,000 people will live in and require access to health, well-being and possible safeguarding services. The proportion of infants and children (0-16 years) and the over 65s are expected to increase significantly. This will impact on the 14,025 staff employed by C&V UHB and will affect the capacity of the service provided by the UHB Safeguarding Team.

This safeguarding report will consider the work streams undertaken by Cardiff and Vale University Health Board Safeguarding Team over a three year period from 1st April 2014 to 31st March 2017. This report will serve as a replacement to the usual annual report, give an outline of the work undertaken during the time period and provide a forecast for future work from April 2017.

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-b A) and the Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other Statutory Agencies.

In addition to the Acts there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9 (3) of the Domestic Violence, Crime and Victims Act (2004).
As part of progression and to acknowledge the emphasis of the SS&W-b Act to bring safeguarding children and adults at risk on an equal footing, the safeguarding team moved towards creating an integrated team during 2015. The current structure within the team consists of:

- 1.0 WTE Head of Safeguarding
- 0.3 WTE Named Doctor for Safeguarding Children
- 1.0 WTE Senior Nurse Safeguarding
- 4.8 WTE Safeguarding Nurse Advisor
- 1.0 WTE Safeguarding Nurse Advisor (Flying Start)
- 0.5 WTE Safeguarding Nurse Advisor (Midwifery Services)
- 0.5 WTE Safeguarding Nurse Advisor (Domestic Violence)
- 1.0 WTE Safeguarding Trainer
- 1.0 WTE Specialist Safeguarding Liaison Nurse
- 1.0 WTE Health Independent Domestic Violence Advocate (IDVA) Fixed Term Contract
  Total: 12.1 WTE

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- 2.7 WTE Administration Team to support

The Cardiff Multi Agency Safeguarding Hub (MASH) launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children and Adult services, South Wales Police, Cardiff Local Authority Education, Health, Probation and CRC services. The purpose of the MASH is to ensure that safeguarding of children, adult's at risk and domestic abuse has a timely, appropriate and multi-agency response and approach. By co- locating agencies and providing a platform to share information immediately that a concern is raised, safeguarding measures are considered and put in to place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH each day, sharing appropriate health information to ensure the safety of children and adult's at risk across the UHB locality.

The introduction of the MASH has stretched the resources of the Safeguarding Team to provide support to staff across three sites, the Children's Hospital for Wales, Community and Cardiff MASH.

The Safeguarding Team continues to work to provide assurance to the Board that the UHB is discharging its duties in line with Health Care Standards (2.7 Safeguarding) as well as National legislation and guidance.

The governance arrangements of the Safeguarding Team is unchanged. The Executive Nurse Director is the executive lead for Safeguarding, whilst the Deputy Executive Nurse Director chairs the Safeguarding Steering Group on a bi-monthly basis. The meeting has a multi-professional membership from across all UHB Clinical Boards and Statutory Agency partners. This reflects the ethos of safeguarding being everybody's business and provides assurance to the Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team whilst working within the UHB, also liaising and working with GPs, Local Authority, Police, and Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to LA and Police by the Safeguarding Team electronically via secure e-mail. This has provided the UHB for the first time with a clear indication of where referrals within the UHB are generated and the amount submitted. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/ meetings, multi-agency investigations and often legal advice.

The safeguarding agenda continues to evolve, during this time period we have seen the progression and awareness of Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Homicide Review (DHR) and an increase in training around the CONTEST (anti-terrorism) agenda. Further development is expected in Modern Slavery and training for Domestic Abuse in line with the Welsh Government

National Training Framework (NTF). The training is structured across six groups within organisations and places a duty on bodies to comply with the VAWDASV Act. At present the Safeguarding Team does not have the capacity to lead on this training.

2. Training

Safeguarding Children, Safeguarding Adult's and WRAP 3/PREVENT training is developed and delivered by the UHB Safeguarding Team. The report also includes training data for Safeguarding Children and Safeguarding Adult's e-learning training modules completed online.

Since September 2014 a Safeguarding Trainer has been in post initially coordinating and delivering training for safeguarding children. Subsequently from November 2015 this has been extended to include the planning and delivery of training for safeguarding adults, previously known as Protection of Vulnerable Adults (POVA) training.

The Safeguarding Team provides a number of classroom based training days for staff across the safeguarding agenda. Topics covered are:

- Level 2 Safeguarding Children and Safeguarding Adults
- Level 3 Child Sexual Exploitation
- Level 3 Safeguarding Themes
- Level 3 Domestic Violence
- Level 3 Legal Aspects
- Level 3 Parental Mental Health and the Impact on Children
- Level 3 Safeguarding Adults and WRAP 3/PREVENT training

Level 3 Children's Rights has been incorporated in more recent times to the Safeguarding Themes training. Level two training is a half -day session, level three training is a full day session. WRAP 3/Prevent (counter-terrorism) training is delivered in a 1½ hour training session and is available to attend on a monthly basis; delivered by the Safeguarding Trainer who has been approved by the Home Office to deliver this training.

An Annual Safeguarding Training Programme is agreed with the UHB Learning and Educational Department (LED) to ensure that staff are offered adequate level two safeguarding children and adult sessions to comply with the Mandatory Training Core Skills and the Intercollegiate Document (2014). Level two training is also available via Learning@NHSWales, additional level one introduction sessions are available on the Mandatory May and November sessions organised by the UHB LED.

Safeguarding Adults and Adults at Risk training day

Since December 2015 a 'Safeguarding Adults and Adults at Risk' training day has been made available with the aim of increasing training compliance particularly for Mental Capacity/Consent training and Deprivation of Liberty Safeguards (DoLS)

training. The training day includes four separate training sessions. Staff are able to select to attend one or all of the training sessions which includes the following: Level 2 Safeguarding Adults, Consent and Capacity, DoLS and WRAP 3 training. This training day is delivered 2-3 times a year.

Female Genital Mutilation (FGM) training

Female Genital Mutilation (FGM) training has been introduced in Midwifery and continues to be rolled out to other areas during 2016-17.

Designated Lead Manager (DLM) training

In addition to organised training the Senior Nurse for Safeguarding Adults has provided Designated Lead Manager Training (DLM) for staff taking on this role within the safeguarding adult's process of their Clinical Board.

Safeguarding Training Data

Table 1 and Table 2 below identify Safeguarding Children and Safeguarding Adults Level 1 and Level 2 training that has been undertaken both electronically and classroom based. The figures indicate training undertaken and training compliance overall across the UHB within a three year period. The figures shown are collated by Shared Services and LED. More specific safeguarding training compliance data is available for each Clinical Board through LED and ESR.

As indicated below in Table 1 the percentage of staff compliant with Level 1 and Level 2 Safeguarding Children training over a three year period has increased between 2015- 2017.

NB Level 1 and Level 2 - classroom based and online training; including GPs, Independent Contractors and additional staff.

Table 1: Safeguarding Children - Three-year Compliance Trend

Year	Headcount (UHB Total)	Number trained	% trained
February 2015	13,374	6727	50.30%
February 2016	13,877	6309	45.46%
February 2017	14,073	9281	65.95%

As indicated below in Table 2 the percentage of staff compliant with Level 1 and Level 2 Safeguarding Adults training over a three year period has significantly increased between 2015- 2017. Level 1 and Level 2-classroom based and online training; including GPs, Independent Contractors and additional staff.

Table 2: Safeguarding Adults - Three-year Compliance Trend

Year	Headcount (UHB Total)	Number trained	% trained
February 2015	13, 374	2183	16.32%

February 2016	13,877	4474	32.24%
February 2017	14,073	7321	52.02%

Additional Training Sessions

Table 3: Additional Training Sessions Delivered by Staff Group - 2014-2017

Level and type of training	Staff Group	Number of training sessions	Total number of staff in attendance
Safeguarding Children			
2014-2015			
Level 2 Safeguarding Children	Flying Start Staff	01	16
Level 2 Safeguarding Children	Nurse Foundation Programme	02	43
Level 3 Children's Rights	Various	01	22
Level 3 Child Sexual Exploitation	Various	02	30
Level 3 Current Themes in Safeguarding Children	Various	03	70
Level 3 Domestic Abuse and the impact on children	Various	02	36
Level 3 Legal Aspects of Safeguarding Children	Various	03	62
Level 3 Parental Mental Health and the impact on children	Various	01	13
2015-2016			
Level 2 Safeguarding Children	Clinical Psychology Students Cardiff University	01	15
Level 2 Safeguarding Children	Community Addictions Unit	01	29
Level 2 Safeguarding Children	Dental Teaching Unit Mountain Ash RCT	02	66
Level 2 Safeguarding Children	Dental Undergraduate Students Cardiff University	01	50
Level 2 Safeguarding Children	GPOOH staff	02	54
Level 2 Safeguarding Children	GP Surgery Staff	01	14
Level 2 Safeguarding Children	GP trainees (GPVTS)	01	23
Level 2 Safeguarding Children	Nurse Foundation Programme	04	68
Level 2 Safeguarding Children	Student Physiotherapists Cardiff University	01	85
Level 2 Safeguarding Children	Theatre Staff	01	33

Level 2 Safeguarding Children	Trauma and Orthopaedics Doctors	01	35
Level 3 Child Sexual Exploitation	Various	03	66
Level 3 Current Themes in Safeguarding Children	Various	03	61
Level 3 Domestic Abuse and the impact on children	Various	02	30
Level 3 Legal Aspects of Safeguarding Children	Various	03	68
Level 3 Parental Mental Health and the impact on children	Various	02	29
Safeguarding Adults			
Level 3 Safeguarding Adults	Various	02	81
WRAP 3/Prevent training	Various	13	256

2016-2017			
Safeguarding Children	**Staff Group**	**Number of Training Sessions**	**Total Number of Staff in Attendance**
Level 2 Safeguarding Children	GP OOH staff	01	14
Level 2 Safeguarding Children	Nurse Foundation Programme	06	147
Level 2 Safeguarding Children	Student Physiotherapists Cardiff University	01	73
Level 3 Current Themes in Safeguarding Children	Various	01	34
Level 3 Domestic Abuse and Sexual Violence	Various	02	47
Level 3 Legal Aspects of Safeguarding Children	Various	02	43
Level 3 Parental Mental Health and the impact on children	Various	01	16
Safeguarding Adults			
Level 2 Safeguarding Adults	GPOOH staff	02	43
Level 3 Safeguarding Adults	Various	01	42
WRAP 3/Prevent training	Various	12	159

Safeguarding Training Sub-Group Meeting

The Safeguarding Training Sub-Group is a sub-group of the UHB Safeguarding Steering Group. This meeting is chaired by the UHB Safeguarding Trainer. The vice chair is a Community Paediatrician and Senior Lecturer at Cardiff University who sits on the group as an educational advisor. The sub-group meets bi-monthly and has developed a safeguarding training strategy. The sub-group is currently updating its terms of reference, training strategy and developing a work plan and will now change its name to the 'Safeguarding Training Quality and Assurance sub-group' and focus on quality assuring all level 2 and level 3 safeguarding training developed and delivered by the Safeguarding Team.

Cardiff and Vale Regional Safeguarding Children Board (RSCB)

The Health Board represented at the RSCB training sub-group. The training sub-group reports to the RSCB Executive Board and is responsible for developing and delivering a programme of training which at present is primarily Working Together to Safeguarding Children multi-agency training. Members of the UHB Safeguarding Team contribute to developing and delivering RSCB training courses. However no Working Together training days have been delivered since 2015.

3. Safeguarding Activity

Collation of safeguarding data for children has previously been difficult to obtain prior to the launch of the Cardiff Multi-Agency Safeguarding Hub (MASH) in July 2016. To ensure a streamlined referral process existed for the UHB to share concerns with both Local Authorities in a timely and secure way a new electronic referral pathway has been introduced. All referrals for safeguarding children, adults and domestic abuse are sent electronically by practitioners to a central safeguarding referral e-mail address, the referrals are not screened and are sent directly by secure e-mail to Cardiff MASH, Vale of Glamorgan Local Authority teams and Police as appropriate. The referral pathway and referral forms are available on the Safeguarding Children and Adult Web pages.

SAFEGUARDING CHILDREN ACTIVITY

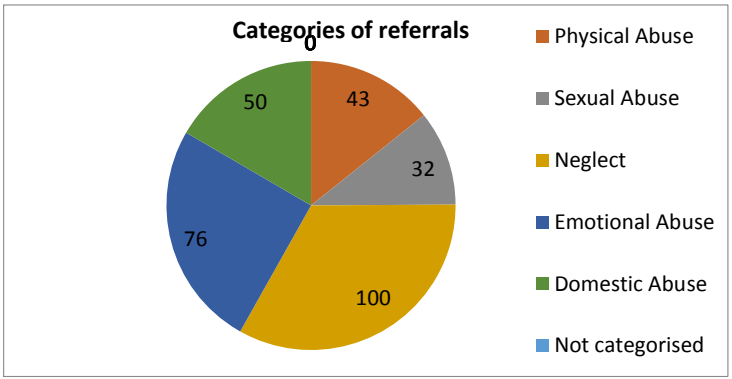
Data for safeguarding children referrals for the period April 2014-March 2015 and April 2015-March 2016 are not a true reflection of the UHB referrals to Children's Services as only data from Paediatric Emergency Unit was collated at the time. During the period of April 2014 - March 2015, 118 referrals were made to Children's Services.

Safeguarding Children Activity 2015-16

April 2015 - March 2016, the referrals during this time period were not all categorised under type of abuse, those that were categorised were identified under more than one category of abuse. There were 280 referrals known during this time period:

Table 4:

Clinical Board	Health Referrals
Children and Women	198
Therapies	1
Mental Health	27
Primary Care	9
SARC	20
Unscheduled Care	24
Corporate	1
TOTAL	**280**

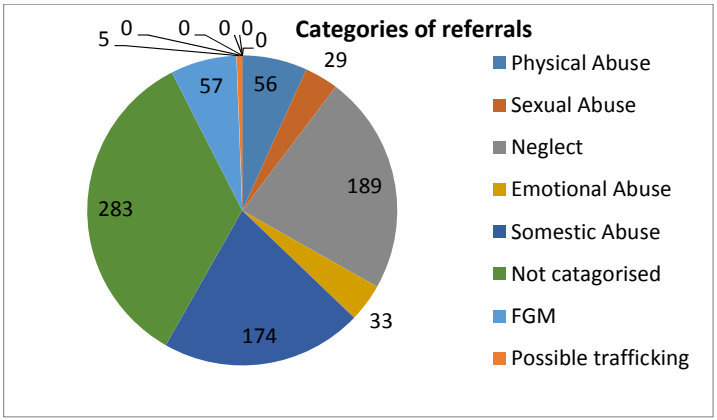


Safeguarding Children Activity 2016-2017

A marked difference in data collection is reflected in the number of known referrals during the period of April 2016 to March 2017. This data is attributed to the change in the referral process and the implementation of MASH. The majority of referrals made were not categorised (1,270). There were 2,096 made to Children's Services.

Table 5:

Clinical Board	Health Referrals
Children and Women	855
Therapies	5
Mental Health	128
Primary Care	66
Medicine – Unscheduled Care	1007
Surgical	2
WAST	11
Home Office	1
Corporate	21
TOTAL	**2096**



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SAFEGUARDING ADULT ACTIVITY:

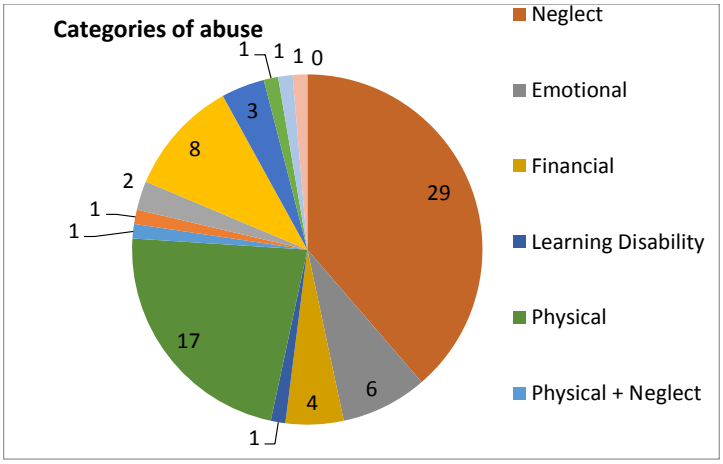
The safeguarding adult data is collated by the number of health led referrals across the UHB. Each Clinical Board (CB) has Health Designated Lead Managers (DLM) that take responsibility to lead on the Adult at Risk process for their own area, DLMs are usually Senior Nurses or Advanced Nurse Practitioner's. DLMs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding to undertake this role. An electronic shared drive has been established to enhance the process allowing DLMs in each CB area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named DLM be on annual or sick leave. There are 34 DLMs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH.

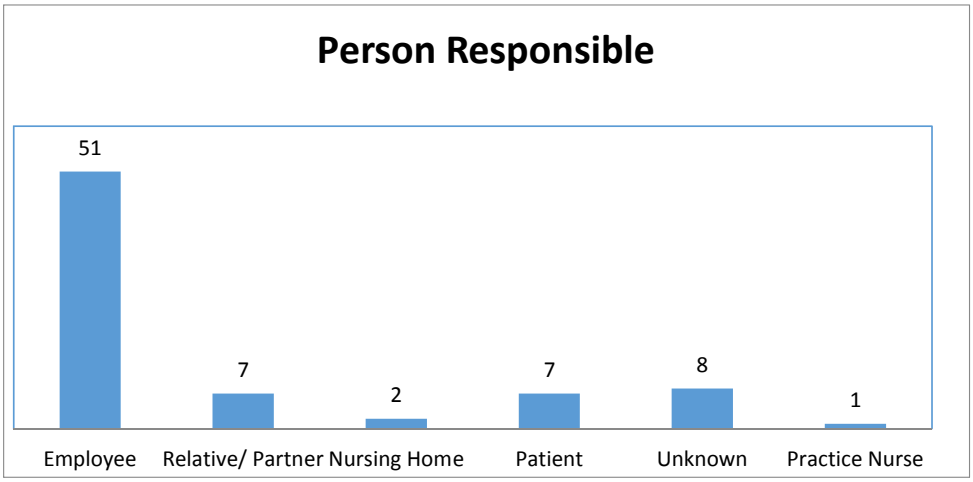
Safeguarding Adult Activity 2014-2015

There were a total of 76 health led cases during 2014-2015, the data shows referrals for each CB the categories of abuse and the person alleged to be responsible for the abuse.

Table 6:

Clinical Board	Health Referrals
CD&T	1
Medicine	23
Mental Health	29
PCIC	13
Specialist	5
Surgery	5
TOTAL	**76**



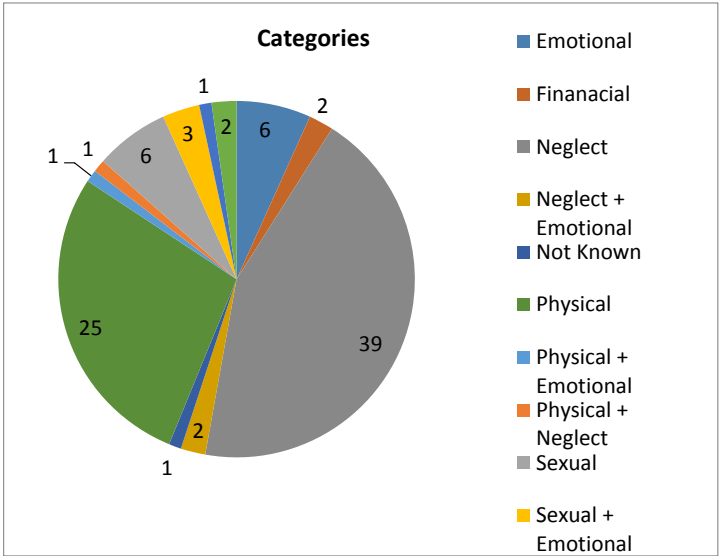


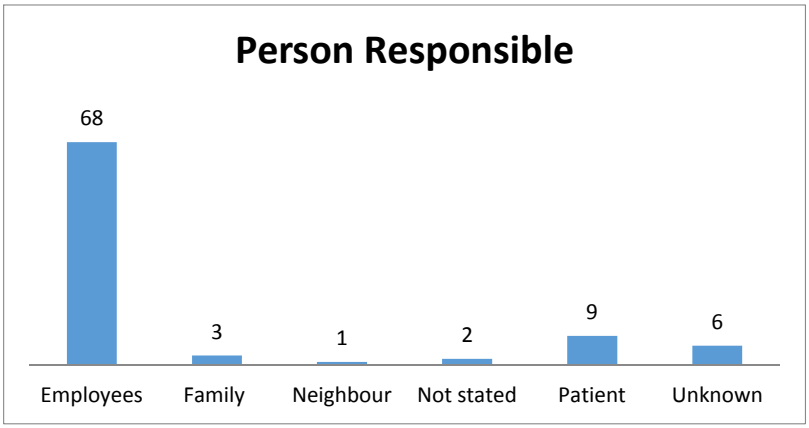
Safeguarding Adult Activity 2015-2016

A marginal increase in referrals are seen in 2015-2016. There were 89 health-led referrals during this period.

Table 7:

Clinical Board	Health Referrals
Medicine	31
Mental Health	37
PCIC	12
Specialist	4
Children and Women	2
TOTAL	**89**



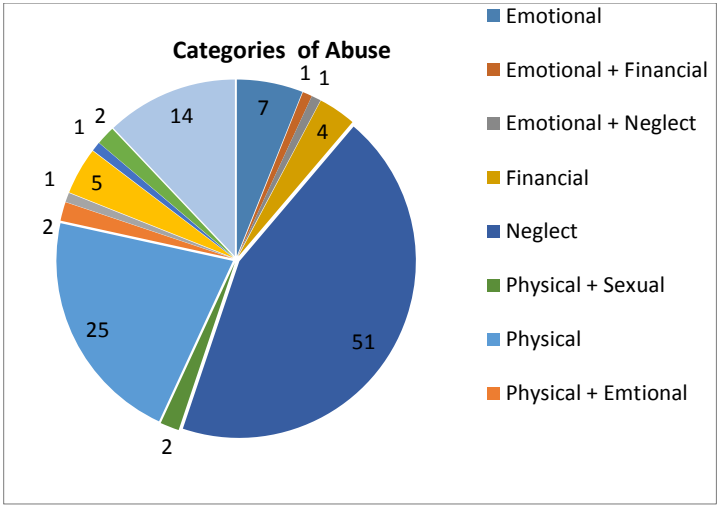


Safeguarding Adult Activity 2016-2017

The increase in adult safeguarding referrals rose to 116 during 2016-2017. This is likely to be attributed to the compliance of the duty to report and investigate in the SS&W-b Act (2014) as well as the change to the referral pathway in July 2016. A number of the referrals will be credited to the reporting of all grade 3 and 4 pressure damage, although not directly reflected in the category of abuse most pressure damage is reported as neglect. It is evident in the data that neglect is the most acknowledged form of abuse, this is in line with national trends.

Table 8:

Clinical Board	Health Referrals
Medicine	40
PCIC	9
Mental Health	31
Specialist	18
Surgery	11
Not Stated	7
TOTAL	**116**



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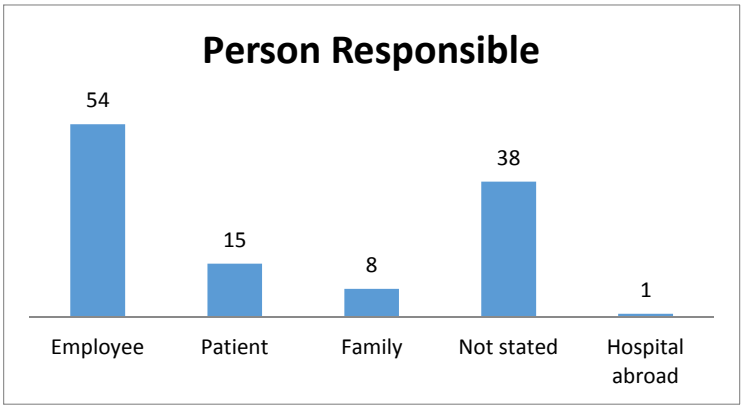

The data identifies employees of the UHB as the alleged perpetrator in the majority of cases for each period shown. The person responsible for the abuse is often not known or not stated on the referral, this is not completed in some referrals as the allegation will be made against a ward area and not one individual person. Further effort is required in the safeguarding adult process to ensure that each referral is completed fully to certify information effectively and monitor themes and trends across the UHB.

Professional Concerns Strategy Meetings and Part 1V investigations

The Professional Concern process ratified by the Regional Safeguarding Boards in 2016 has formalised the approach within the UHB to address concerns of employee's behaviour in or outside of work. The process is in alignment to the Part 1V of the All Wales Child Protection Procedures (2008) although chaired by the Head of Safeguarding within health for a health employee. Police and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Cases will involve staff working predominantly with adults; concerns will include arrest and police investigation around domestic abuse, sexual assault, physical assault etc outside the workplace. Some cases will proceed through the disciplinary process following closure by police and the Court process. Part 1V strategy meetings are held under the All Wales Child Protection Procedures (2008) and led by the Local Authority. Data detailed below evidences the total number of meetings held:

Professional Strategy Meetings

Table 9:

Period	Number of Meetings
2014-2015	24
2015-2016	20
2016-2017	19

4. Audit

Public awareness of Child Sexual Exploitation (CSE) has increased since cases at Rotherham and Oxford were highlighted in the media.

Health involvement in Child Sexual Exploitation

A six month audit has been undertaken between 1st June and 30th November 2016 following an increase in time required by health staff to attend CSE strategy meetings in Cardiff. This followed a Cardiff Council and South Wales Police initiative to tackle suspected cases of CSE in Cardiff amongst the child population. The action taken is a multi-agency strategy meeting arranged promptly to share information and put in place safeguarding measures in an attempt to provide safety, protection and support to the child involved. The staff most affected by the new process are: School Health Nurses (SHN), Looked After Children (LAC) Nurses, Sexual Health Nurses and the Safeguarding Team Nurse Advisors. In total 132 strategy meetings were held during this six month period. 51 were attended by LAC Nurses, 31 by (SHN) and 28 by the Safeguarding Team. Health were unable to meet demand and was present at 21 of the meetings. Of these, 52 were initial strategy meetings and 80 were review strategy meetings. This audit indicates the level of growth in the workload of CSE in a short review period, highlighting the additional pressure placed on identified groups to participate in the safeguarding process to ensure the safety of children within our communities.

Shortened SERAF

The CSE Prevention Strategy for the NHS in Wales 2016-2019 has a number of objectives that are aimed specifically at health professionals. These include identification of children and young people who are at risk of sexual exploitation and act to protect them and to work in collaboration with police, social services and others by sharing information appropriately and contributing to a proactive, co-ordinated, multi-agency approach which will be effective in safeguarding children and young people at risk of sexual exploitation. The audit was undertaken in Paediatric Emergency Unit (EU) between March-May 2015 using research previously undertaken elsewhere and developing a shortened Sexual Exploitation Risk Assessment Framework (SERAF) tool to use in a busy acute setting. The SERAF was originally implemented by Barnardo's Cymru in 2005. Following adaption of the SERAF tool, staff were provided with CSE training and guidance on completing the form. Children between the ages of 10 -16 years old presenting at EU with a history of self- harm, overdose, alcohol or drug misuse, pregnant, sexually transmitted infection (STI) or history of sexual activity were asked four subsequent questions from the SERAF. 30 questionnaires were collected over a three month period, six referrals were made to Children's Services and three cases proceeded to CSE strategy meeting. Recommendations following the audit included; a referral to Children's Services be completed for all children with one positive disclosure and the Shortened SERAF to be used in Adult EU for 16-18 year olds. A further 60 SERAF assessments have been completed with 20 children identified by Children's Services as at risk of CSE. It is expected that the Psychiatric Crisis Liaison Team will use the tool during spring 2017.

Public Health Wales Quality Outcome Framework (QOF) for Children

This work has been implemented across Health Boards and Trusts in Wales since Professor Sir Mansel Aylward identified the need for robust monitoring and evaluation to improve and develop services in 2010. Health Boards have participated in the completion of four QOF data tools and reported back to Public Health Wales with the intention to self- assess safeguarding measures for children and ensure standards and best practice is maintained across Wales. The collation of data from each Health Board is analysed by Public Health Wales and published to demonstrate compliance, activity, standard and good practice to drive the motivation to improve services for safeguarding children across each of the identified dimensions.

The safeguarding team has worked collaboratively with CBs to complete the QOF and identify areas where improvements are required. This is demonstrated by improving routine enquiry questions within Midwifery and Health Visiting, ensuring that the number of children under 18 years old admitted to adult mental health wards are monitored, the number of children who may have been abused or neglected receive medical assessments under the AWCPP and many more examples. The UHB has been pleased to demonstrate that most dimensions were RAG rated as amber or green, further work is required to guarantee that amber rated dimension are progressed to green demonstrating that the outcome has been achieved, is being maintained and is contributing to improved cooperation and effectiveness of safeguarding.

5. Supervision

Safeguarding children supervision has historically been provided to health visitors (HV) on a 1:1 basis every three to six months depending on their experience and their caseload. Supervision is provided to midwives, school nurses and community therapists through a group supervision approach. Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice.

During 2015 the Safeguarding Team proposed a bold idea, supported by the Executive Nurse Director to undertake a pilot study with the HV service to consider group supervision with HVs in four locations across Cardiff and the Vale of Glamorgan. This is the first pilot in Wales around safeguarding supervision of HVs and has raised much interest from other Health Boards across Wales. The aim of the pilot is to ensure a safe supervision pathway exists that reduces the allocated time required of the Safeguarding Team to provide supervision to 183 HVs on a 1:1 basis.

The pilot idea advanced and progressed through the UHB Leading Innovation in Patient Safety (LIPS) headed by the Senior Nurse for Safeguarding and joined by two team leaders from the HV service. The pilot pathway commenced in October 2015 and is overseen by a Lecturer in Cardiff University to provide accreditation to

the pathway and to undertake group forum's with the HVs involved. It is anticipated that once the pilot is evaluated the pathway will be rolled out across the HV service.

In adult services safeguarding supervision is provided by the Senior Nurse for Safeguarding to the health Designated Lead Manager (DLM) as required and through arranged sessions within each Clinical Board and through Development Day sessions. The supervision is proposed on a three monthly basis, 1:1 with DLM or ad hoc when required. All open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a monthly basis and discussed at Nurse Director Professional Performance Review. Cases involving staff are reported through the bi-monthly Executive Quality and Safety meetings.

Nurses within the Safeguarding Team are encouraged to seek individual clinical supervision on a regular basis. Safeguarding supervision is arranged with the Head of Safeguarding on a six monthly basis unless required for specific cases or on request. The Head of Safeguarding receives supervision from a Designated Nurse within the National Safeguarding Team of Public Health Wales.

In addition to the safeguarding supervision provided to Health Visitors, supervision is also provided by the safeguarding team to Midwives, School Nurses, Therapists and Mental Health Nurses on a regular basis.

The current Public Health Wales All Wales Safeguarding Children Supervision Strategy (2014) states that:

"*the aim is to provide a safeguarding supervision framework which enables NHS organisations in Wales to develop and maintain a confident and competent workforce in safeguarding and promoting the welfare of children"*

This approach has been adopted with safeguarding children and adults at risk within the UHB.

Flying Start Safeguarding Supervision

Safeguarding supervision is provided in the main by a dedicated full-time Flying Start (FS) Safeguarding Nurse Advisor supported when required by the Safeguarding Team Nurse Advisors. The FS post provides group supervision to Community Nursery Nurses working within the team and to the FS Health Visitor Service. The safeguarding supervision is implemented using the same model as that in the generic health visiting service. One to one supervision is provided on a three monthly basis, the safeguarding pilot is undertaken with two groups within the FS service.

"Signs of Safety" Training has been introduced in Cardiff Children's Services during 2016-17. The training has been shared with the Safeguarding Team and rolled out across the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families.

Peer Review

Within the UHB, peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that Drs undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.
Peer reviews are held for suspected cases of physical abuse at St David's hospital, additionally a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by either the Named Doctor or the Designated Doctor for safeguarding children.

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi- agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases.

6. Expert Advice

Partnership Working

The implementation of new legislation SS&Wb Act and VAWDASV (Wales) 2015 has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff and Vale Regional Safeguarding Children and Adult Board.

The Health Board has close strategic and operational links with both the Regional Safeguarding Children and Adult Board. Representation at each Executive and |Main Board meetings are made by the Executive or Deputy Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for both meetings are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub- groups of the main Board include Training, Child and Adult Practice Review, Audit and Communication and are attended by safeguarding nurse advisors.

The SSWB Act places a duty on health to report and investigate situations where a child or an adult at risk may be at risk of significant harm through abuse or neglect. In line with the Act and in alignment with the launch of Cardiff Multi Agency Safeguarding Hub (MASH) the safeguarding referral process for the UHB changed in July 2016. All safeguarding referrals for children and are adults are collated electronically by the Safeguarding Team using a central point of contact and sharing the referrals with Local Authority by means of a secure e mail address. For

the first time this allows mapping of referrals and referral themes from each Clinical Board providing data that will enhance training needs to particular areas as required.

The Cardiff MASH launch in July 2016 has brought strategic partners including Local Authority Children's Services, Adult Services, Police, Health Safeguarding Team, Education, Probation and Community Rehabilitation Company together in one co- located venue hosted by South Wales Police. This allows sharing of information using a multi-agency licensed platform to address concerns in a timely manner by gathering information from each agency to make decisions around safeguarding measures required.

Many challenges were experienced during the planning stages, this included agreed funding of the MASH, buying equipment, additional police vetting for staff working at Cardiff Bay Police Station, change of base for many etc. The Cardiff MASH is still in its infancy and evolving on a weekly basis. Referrals are considered in the Cardiff MASH for safeguarding children, adults at risk and domestic abuse. At the beginning of the launch one Safeguarding Nurse Advisor and Administration Support were allocated to the MASH. However within four months it became apparent that the workflow required the expertise and professional knowledge of two Safeguarding Nurse Advisor's to be placed in the MASH on a daily basis to consider appropriate information sharing, decision making at strategy discussion and plan appropriate response from health relating to emergency safeguarding situations. This has placed additional strains on the team however it is deemed necessary to ensure that the rise in workflow is managed in a professional, timely and robust way. Flying Start provide representation within the MASH by the Safeguarding Nurse Advisor working on a rotational basis of one week in five.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken down barriers.

Partnership working is evident in the RSCB/RSAB training and audit sub groups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) action plans.

Recommendations and learning from CPR will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows each professional to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. There are currently eight CPR in the process; the safeguarding team are involved in the collation of information and submitting a chronology in all cases.

Similarly Domestic Homicide Review (DHR) is a multi-agency approach and requires collation of notes and submission of a chronology by the safeguarding team. There has been six DHRs commissioned since 2015.

Female Genital Mutilation (FGM)

The United Kingdom (UK) Government and UNICEF hosted the first "Girl Summit" in July 2014 aimed at mobilising National and International efforts to end FGM as routine practice in some countries across the World. The UK Government also made a number of commitments for new legislation to tackle FGM.

In 2015 a number of amendments were made to The Female Genital Mutilation Act 2003 through The Serious Crime Act 2015. Section 4 of the 2003 Act specifies that extra-territorial jurisdiction extends to prohibit acts done outside the UK *by* a UK national or a person who is resident in the UK. Considered with that change, section 70 (1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so that it extends to acts of FGM done *to* a UK national or a person who is resident in the UK. This has placed a mandatory reporting duty on all health professionals to report "known" cases of FGM in under 18 year olds to the police, this duty has been instigated since 31st October 2015.

The All Wales Clinical Pathway for FGM was created and completed by a task and finish group in October 2015 and ratified in July 2016.

Specific mandatory training for Midwives has been in place since 2014, 300 midwives received the training during that year. Additional sessions were introduced to other health professionals through an introduction in Level 3 Safeguarding Current Themes training three times during that year involving 90 members of staff.

During 2015 training continued with 300 midwives and the Level 3 training captured a further 60 staff members. Bespoke training was also delivered to targeted areas across the UHB in Sexual Assault Referral Centre (SARC), Department of Sexual Health (DoSH) and Gynaecology.

2016-2017 has seen a continued drive to ensure UHB staff are aware of the duty to report cases of FGM. This has been strengthened through the implementation of the Violence against Women, Domestic Assault and Sexual Violence (Wales) 2015 Act. An FGM page has been developed on the CAVweb intranet, included are the protocol, procedures, training information and referral documentation along with useful links for further reading.

Online FGM training is available endorsed by the Home Office, this is accessible to UHB staff.

Since October 2016 Welsh Government has requested quarterly updates from all Health Boards across Wales identifying FGM, this also includes referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may also experience FGM in the future. The table below demonstrates the numbers identified during quarter three and quarter four in 2016/17.

Table 10:

Quarter during 2016-2017	Number of Women Identified	Child Protection Referral Made
Q3	40	17
Q4	55	25

Training will continue through 2017-2018. An FGM working group led by the Head of Safeguarding as the UHB lead and the Lead Midwife working closely with representatives from midwifery, Health Visiting and Safeguarding team are developing a training programme that will provide a regular monthly rolling programme to identified areas across the UHB. This will include “Train the Trainer” sessions for some areas in May 2017. Sessions aim to capture approximately 20 staff at one time. An FGM pathway has been completed and ratified for Midwifery by the Safeguarding Midwife, this will be accessible online and will be adapted for Health Visiting service as required.

Child Sexual Exploitation (CSE)

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sector consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB has recently endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This will challenge the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly prevalent as a Child Practice Review Multi- Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator.

Within the UHB an increase in the workload associated with CSE has been noticed during 2016 following the introduction of additional staff in Children’s Services and police to tackle the problem in Cardiff. This has led to regular weekly CSE strategy meetings for individual children suspected to be at risk of CSE. Health professionals involved or working with the age group such as school nurse or Children Looked After nurses are expected to attend the meetings to share information that may be available within health to support the concern raised. As with all strategy meetings held through the All Wales Child Protection Procedures (2008) a plan is implemented to support the child and an attempt made to prevent the child from risk of significant harm. No additional resources are available within Children and Women Clinical Board or the safeguarding team to assist with the increase in workload; this has been identified as a cause for concern.

Procedural Response to Unexpected Death in Childhood (PRUDIC)

The process was first introduced across Wales in 2010 with the aim to "*ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales".*

The National Safeguarding Team in Public Health Wales revised the document in 2014, and an audit has been undertaken in 2016. Recommendations for all Health Boards and Trusts in Wales were that the PRUDIC process should be rewritten in 2017 to take account of:

- Attendance of parents at PRUDIC meetings, distribution of minutes and retrieval of the child's body and it's transportation to the appropriate place
- Documentation to be developed to include meeting minute templates, care pathway and checklists for all professionals
- Introduction of a governance framework to ensure a consistent approach across Wales. However there is no clarity at present of where this should sit. Consideration should be given to Regional Safeguarding Boards or possibly the Safeguarding Network sub- group within Public Health Wales.

The process within the UHB is established, the Head of Safeguarding liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, attendance includes representatives from Children's Services, Education when appropriate, psychology and appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

Cardiff and Vale UHB are fortunate to have a Bereavement Nurse that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the mortuary, registering the death and making funeral arrangements. Families are sign posted to counselling and support services. Referrals are made to charitable organisations to support the family long term and a memory box is created. The table below identifies the number of child deaths in the UHB locality and also includes children that have died at UHW from out of area:

Table 11:

Period	Number of Child Deaths
2014	15
2015	20
2016	19

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Child and Adult Practice Reviews (CPR and APR)

Guidance for child and adults practice reviews were updated and came in to force from 6 April 2016 following the implementation of the Social Services and Well-being (Wales) Act 2014. The guidance is addressed at all Safeguarding Children and Adult Boards and their partner agencies. The purpose of the review is to

promote a positive culture of multi-agency child and adult protection learning and reviewing in local areas when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended practice reviews. The criteria for child practice reviews are laid down in the *Safeguarding Boards (Function and Procedures) (Wales) Regulations 2015.* The outcome is expected to generate new learning to support continuous improvement in inter-agency protection practice.

The process involves agencies, staff and families to reflect and learn from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Named Doctor for Safeguarding Children participate in the Regional Safeguarding Board sub-group for Child Practice Reviews when consideration is given to new referrals and the commissioning of a new review. Safeguarding nurses and paediatricians participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agencies information has been submitted.

There has not been any Adult Practice Reviews however the process within the UHB would follow the same pathway as that of the Child Practice Reviews.

There are currently eight Child Practice Reviews open with Cardiff and Vale Regional Safeguarding Children Board. The Safeguarding Team and Named Doctor are involved with each case timeline, the Head of Safeguarding is the Reviewer for one case.

Domestic Homicide Review (DHR)

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13th April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/ 10, domestic violence accounted for 14% of all violent incidents and affects both men and women. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly to CPR and APR the DHR will consider what lessons can be learnt by professionals and organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic

homicide by improving services to individuals and their children through improved inter-agency working.
The DHR's are commissioned through Partnership Boards in Cardiff and the Vale of Glamorgan localities. Referrals are received from South Wales Police and consideration is given at the Partnership Boards to undertake a DHR. The UHB Executives are formally notified of the commissioning of the DHR, the Head of Safeguarding attends a multi-agency meeting to agree the Terms of Reference for cases.

As with CPR and APR safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. There has been five DHRs undertaken in Cardiff since 2015 and one recent case in the Vale of Glamorgan.

Sexual Assault Referral Centre (SARC)

Cardiff and Vale UHB hosts the multi- agency Sexual Assault Referral Centre (SARC), Ynys Saff, in Cardiff Royal Infirmary, which sits within the Children and Women Clinical Board. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan; the role of the Safeguarding Team is to support and assist this service with its safeguarding activity.

The number of referrals of both adults and children to the SARC are increasing.

- Referrals to Cardiff and Vale SARC January- December 2015: 440Referrals to Cardiff and Vale SARC January- December 2016: 587

  This represents an increase of 33% in referrals in 2016, this is corroborated by South Wales Police which notes overall a 16% increase across the area with 26% in Cardiff SARC in 2015/16 compared to 2014/15. This increase in workload puts pressure on the existing service without an increase in resources.

  The NHS Wales Health Collaborative SARC Project for South, Mid and West Wales will be completed in March 2017. A service model has been proposed comprising three hubs and spokes located in Cardiff, Swansea and Carmarthen, with children's services located in two hubs in Cardiff and Swansea. Cardiff and Vale UHB has been identified as the lead Health Board to implement the model responsible for:

  - Ensuring successful transition to the agreed service model across South Wales
  - Develop and maintain the sexual assault service network across Health Boards, third sector, Police service and Police and Crime Commissioners (PCC)
  - Ensure the appointment of clinical lead and regional manager as identified in the agreed service model on receipt of agreed funding
  - Ensure mechanisms are in place to maintain regular engagement with service users

Commissioning arrangements have yet to be finalised but this has significant implications for the UHB.
The SARC team were nominated in the UHB Staff Recognition Awards 2017 in two categories. The Chair and Chief Executive award and the Going the Extra Mile award in recognition of their work for victims of sexual assault and the wider community.

Domestic Abuse

The implementation of the Violence Against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales.

Local multi-agency Domestic Abuse Strategies are in the process of development incorporating a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area, with a view to completion and preparation for implementation by the end of 2017. Welsh Government has provided guidance for all organisations to consider a five year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target.

During 2016, Cardiff and Vale UHB were able to secure a post for a Health Independent Domestic Violence Advisor (IDVA) through joint funding with the Police and Crime Commissioner on a two year fixed term contract. The role delivers advocacy support to clients who are experiencing domestic abuse within the communities of Cardiff and the Vale of Glamorgan. The development of this new role is in line with the legislation which aims to improve the public sector response to domestic abuse and sexual violence through the theme of “Ask and Act” which places a duty on all public sector professionals to ask the patient/ client about domestic abuse where this is suspected and act on any disclosure made.

The initial work plan of the health IDVA has been to establish the role within the Emergency Unit (EU) at University Hospital of Wales and work closely with the Domestic Abuse Lead Nurse, Psychiatric Liaison Nurse and the Frequent Attender Service. The Ask and Act Domestic Abuse pathway has been in use within EU prior to the commencement of the post, however adaptions have been made to incorporate the IDVA post and additional information resources, contact details and referral forms have been introduced.

During 2017 the IDVA has extended her role to incorporate Barry Minor Injury Unit and Midwifery at UHW attending management meetings and ward rounds to generate awareness of the role.

In the first three months of the IDVA role, November 2016- January 2017 there were 36 Ask and Act referrals made. This has shown an increase in referrals with an average of 12 referrals per month compared with four per month prior to the

introduction of the IDVA role. Safety planning has been completed for 19 clients, 11 initial assessments completed 9 of which were deemed to be at high risk of domestic abuse. The safety planning includes markers and security measures placed on properties through liaison with third sector agencies, reporting to police, referrals for counselling and referrals to specialist support services. In addition the IDVA has made 10 referrals to Multi Agency Risk Assessment Conference (MARAC) in either Cardiff or the Vale.

MARAC are held on a fortnightly basis in both Local Authority areas. All statutory agencies and third sector are represented at the meetings. High risk cases of domestic abuse are discussed at the meeting where safeguarding measures are identified to provide safety and support to victims and children. The safeguarding team attend all meetings, there is 100% attendance.

Contest

Contest is the UK Government's counter-terrorism strategy. Part of the strategy, PREVENT is designed to tackle the problem of terrorism at its roots, with the aim of preventing vulnerable people from becoming radicalised. The Safeguarding Team, working directly with the Strategic Partnership and Planning Manager have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation. Training in this area is disseminated to UHB employees via a workshop designed to help make staff aware of their contribution in preventing vulnerable people from being exploited for terrorist purposes. The Safeguarding Team play a key role in this agenda, working closely with Clinical Boards and the UHB Strategic Partnership and Planning Team.

Human Trafficking/Modern Slavery

Modern slavery is a serious crime in which people are treated as commodities and exploited for criminal gain. The true extent of modern slavery in the UK is unknown. Modern slavery in particular Human Trafficking, is an international problem. Modern slavery includes human trafficking, slavery, servitude and forced and compulsory labour. Exploitation takes a number of forms, including sexual exploitation, forced manual labour and domestic servitude; victims come from all walks of life. The Modern Slavery Act 2015 outlines front line staff responsibility to identify potential victims of modern slavery and human trafficking, refer potential victims and ensure that victims have access to services that they are entitled to. UHB employees are identifying victims and are following the Multi-Agency Response Pathway for suspected Cases. Human Trafficking Multi-Agency Risk Assessment Conferences (HT MARAC) are held in Cardiff on a quarterly basis, the Safeguarding Team represent the UHB at the meeting.

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council through a Partnership Management Board consisting of senior representatives of each supervisory body.

The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

Monthly awareness training sessions are provided at UHW and UHL sites.
There has been an increase in requests for assessments since March 2014 when a Supreme Court Judgement clarified DoLS. This is evidenced in the table below, during 2013-2014 pre judgement there were 55 requests made:

Table 12:

Period	Number of requests made
2014-2015	406
2015-2016	661
2016-2017	983

The DoLS coordinator is a Band 7 nurse employed by the UHB and supervised/ professionally managed by the Head of Safeguarding. Safeguarding training sessions have been arranged across the UHB incorporating safeguarding adults, MCA and DoLS to increase awareness of the correlation with some vulnerable people within our communities.

7. Forecast 2017/2018

2016 through to 2017 has been a challenging time for Cardiff and Vale UHB Safeguarding Team. This period has seen the integration of safeguarding children and adults within the existing team structure with no additional resources, a change of structure within the existing team, decommissioning of the safeguarding team base at Lansdowne and the launch of Cardiff MASH requiring additional Band 7 resource to enable safe practice to be maintained. It is anticipated that during 2017 stability within the team and embedding of Cardiff MASH, the referral pathway and implementation of the new legislation will ensure that the service provided across the UHB will be maintained and improved. During the reporting period there has been progression with

- The appointment of a Head of Safeguarding
- Appointment of a Senior Nurse Safeguarding
- Continuing to build on the improved training figures
- Strengthening links with each Clinical Board through alignment of a Safeguarding Nurse Advisor
- Successful evaluation and roll out of safeguarding group supervision with the Health Visitor service
- Regular safeguarding supervision for Clinical Board DLMs and development sessions
- Ensure that robust and effective information is shared with all practitioners to improve the quality of safeguarding referrals for children and adults at risk
- Safeguarding Nurse Advisors attending Paediatric Peer Supervision

Further work to be progressed in 2017-18 includes:

- Developing reasonable assurance that training data for Mandatory Safeguarding Training is supported by CB Training Needs Assessments to measure compliance
- Plan, deliver and implement Domestic Violence training as set out in the Welsh Government National Training Framework five year plan
- Continue to develop and deliver FGM training across the UHB to targeted groups
- Work in partnership with our Regional Safeguarding Board partners to deliver on targeted priority areas
- Notify the Executive Board of any priorities raised by the National Safeguarding Board
- Participate in the multi-agency local strategy for domestic violence
- Work collaboratively with the National Safeguarding Team to design and improve the Quality Outcome Framework (QOF) for children and adults at risk

8. Summary

Since April 2014 the National and indeed International safeguarding landscape has broadened. We have seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding work stream across the UHB requiring significant changes in process, additional training and supervision as well as re-location of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners ensuring that communication and decision making is embedded in open, honest and transparent practice.

INFECTION PREVENTION & CONTROL REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Executive Director of Nursing
Author : Director of Infection Prevention and Control 029 21 841772
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy, particularly focused on avoiding waste, harm and variation.
Financial impact : Excellence of IPC practice reduces costs to the UHB
Quality, Safety, Patient Experience impact: Good infection prevention and control positively impacts upon patient experience and outcomes.
Health and Care Standard Number 2.4
CRAF Reference Number 5.2 (CRAF total = 16)
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** and note the content of the paper

SITUATION

This report serves to update the Quality Safety and Experience Committee of the current position with regard to our experience of healthcare associated infections across Cardiff and Vale University Health Board (UHB) and our position in terms of infrastructure to minimise the risks of healthcare associated infections for our patients and staff.

Welsh Government (WG) Reduction Expectations for Health Care Associated Infections (HCAI) to be achieved between October 2016 and March 2017 were set in WHC/2015/058. Specifically each LHB needed to:

- Reduce *C. difficile* disease to no more than 28 cases per 100,000 population
- Reduce *Staph. aureus* bacteraemias to no more than 20 cases per 100,000 population.

At end March 2017 the Cardiff and Vale UHB position was as shown below:

C. difficile :

At the end of the target period the UHB had 2 cases in excess of the required number to meet the reduction expectation. The rate for the 6 month period was **28.55 cases per 100,000 population.**

When 2016/17 performance is compared with 2015/16 the picture is of a plateau in improvement. 161 cases of *C. difficile* were diagnosed during 2016/17 against 150 in 2015/16 a 7% increase.

***Staph. aureus* Bacteraemia**

At the end of the target period the UHB had 42 cases in excess of the required number to meet the reduction expectation. The rate for the 6 month period was **37.23 cases per 100,000 population.**

Within the *Staph. aureus* bacteraemia cases, after seeing an improvement in incidents of MRSA bacteraemia between July and December, numbers of cases increased again. For the financial year 2016/17 when compared with 2015/16 a 31% increase in cases was seen (17 cases vs 13 cases).

For MSSA bacteraemia there was some improvement to see between 2016/17 and 2015/16 with a reduction of 8% in the number of cases (129 vs 140 in 2015/16).

There are new challenges for the UHB in the Welsh Health Circular (WHC/2017//011) issued on 31st March 2017. In addition to further reductions expected in *C. difficile* and *Staph.aureus* bacteraemia rates, a new reduction expectation to reduce *E.coli* bacteraemia has been introduced. In summary the requirements for Cardiff and Vale UHB are as follows:

C.difficile:

To reduce to 26 cases per 100,000 population by end March 2018.

***Staph. aureus* bacteraemia**:

To reduce to 20 cases per 100,000 population by end March 2018.

***E.coli* bacteraemia**:

To reduce to 60 cases per 100,000 population by end March 2018.
This target has been agreed with WG and is bespoke to the UHB as the rate of *E.coli* bacteraemia seen in the baseline year of 2015/16 (against which the all Wales 10% reduction is required), was at 67 cases per 100,000 population; this is the target rate for all the other HBs in Wales except Aneurin Bevan UHB and ourselves.

In terms of numbers of cases to achieve these targets over the course of 2017/18 the UHB will need to deliver as follows:

Target Organism	Total number for the year 17/18 (no more than)	Average Monthly numbers to achieve this
C. difficile	126	10
Staph. aureus **(Total)**	96	8
MRSA	0	0
E. coli	290	24

Results April – May 2017:

C. difficile	April: 12	May: 10
Staph. Aureus (total)	April: 14	May: 13
MRSA	April: 2	May: 1
E.coli	April: 34	May: 27

Infections other than those targeted under the WG reduction expectations have also challenged the organisation over the last financial year:

Impact of Diarrhoea & Vomiting and flu 2016/17

- Wards affected 106 (includes part of ward and full ward closures – some wards affected more than once)
- Number of bed days lost 1575
- Number of Patients affected 820
- Number of Staff affected 135

Outbreaks of multi-drug resistant organisms:
Acinetobacter baumannii

Caused the closure of the neonatal unit in 2015 with continued impact on services into 2016/17.

An imported case onto A7 ward resulted in 5 further cases of colonisation / infection. Ward closed and then refurbished 04/11/2016 – 02/12/2016 (250 bed days lost).

A patient linked to the A7 outbreak, admitted onto another ward at UHW and isolated throughout resulted in 4 further cases. Ward closed 24th April, now to be refurbished.

Vancomycin Resistant Enterococcus:
Outbreak in elective orthopaedic service resulted in closure of wards and loss of surgery end December 2016 / January 2017. 534 bed days lost. Refurbishment of theatre flooring and other repairs undertaken.

BACKGROUND

The key WG documents relevant to this area are:
Commitment to Purpose: Eliminating Preventable Healthcare Associated Infections (HCAIs). December 2011
http://wales.gov.uk/docs/dhss/publications/111216commithcaien.pdf
Code of Practice for the Prevention and Control of Healthcare Associated Infections. June 2014
http://wales.gov.uk/topics/health/cmo/publications/cmo/2014/cmo-june14/?lang=en
The antimicrobial delivery plan for Wales was introduced in 2016 in response to the UK antimicrobial resistance strategy to attempt to reverse the increasing trend in antimicrobial resistance:
http://www.wales.nhs.uk/sitesplus/documents/888/Antimicrobial%20Resistance%20Delivery%20Plan.pdf
This delivery plan reinforces the need for joint working across Clinical Board multi-disciplinary teams supported by IP&C, Microbiologists and Antimicrobial pharmacists to reduce the risks of multi-drug resistant organisms and reduce the burden of healthcare associated infections.

ASSESSMENT AND ASSURANCE

The data presented in this report show that whilst there has been considerable improvement in the burden of healthcare associated infections over the last 5 years: 69% reduction in *C.difficile*; 66% reduction in MRSA blood stream infection and a 17% reduction in MSSA blood stream infections since 2010/11. Improvements have been minimal in this last financial year and new challenges have emerged.

Initiatives that have been implemented and need to be sustained with continuous improvement are:

- Introduction of peripheral vascular cannula insertion packs
- Care bundles for central venous catheter insertions
- Roll out of Aseptic Non-Touch Technique (ANTT) to all invasive interventions
- *C. difficile* ward rounds
- Introduction of fidaxomicin as an option for *C. difficile* treatment
- Medical Director led Antimicrobial Stewardship Patient Safety Walkrounds
- New, easier to use Root Cause Analysis tool currently being developed by the IP+C team to incorporate the new WG reduction expectation pertaining to E coli
- RCA's to be reviewed and lessons learned to feed into the Clinical Board IP+C/QSE meetings

- PCIC to work with the IPC team review and agree the RCA for community acquired bacteraemias
- Consideration being given for more interventions for IV drug abusers and wound management in the community (community acquired MSSA)
- Implement plans to screen for sensitive *Staph aureus* in defined areas
- MRSA admission screen compliance audits undertaken by the IP+C team with results reported to CB IP+C meetings and the IPCG
- Continued reinforcement of isolation of patients with diarrhoea, hand hygiene, antimicrobial stewardship and more effective management of the disease.

New Challenges:

Learning from recent outbreaks has identified the following common themes:

- challenging staffing levels
- poor environment / infrastructure
- poor practices in relation to medical equipment management / replacement / decontamination.

The introduction of a new reduction expectation to reduce E. coli blood stream infections to 61 cases per 100,000 population is a particularly challenging target with a significant proportion of these cases emanating from the community. The Health Board will focus on improving UTI management across the whole health care system as a first measure towards addressing the necessary reductions and also continuing the drive to improve antimicrobial stewardship to reduce the risk of resistance.

Assurance:

As we enter the new financial year a refreshed approach is needed to deliver on these new and challenging reduction expectations for HCAI during 2017/18. The Infection Prevention and Control (IP&C) team are currently supporting clinical boards as they develop their annual programmes and will be highlighting the new challenge of the *E.coli* bacteraemia reduction expectation.

There are specific interventions that need to be implemented both corporately and within Clinical Boards and are linked to particular organism targets. However, there is also a need to address learning points from major outbreaks / incidents of 2016/17 and the winter season to develop a whole system response to improving HCAI and antimicrobial resistance rates across this health board.

Corporately work which will progress led by the IPC team in 2017-18 includes:

- MDRO procedure and Admission Risk Assessment to be formally launched. Education and training has been ongoing since January 2017

- Ensuring basics of equipment cleaning including commodes is optimised. Training video has been produced by the IPC team
- Improve UTI management and care of Urinary Catheters.
- New cleaning technologies including HPV and UV to be evaluated and where appropriate case made for purchase
- A more effective detergent wipe has been introduced Health Board wide. This will result in standardisation of products and cost savings long term.
- IPC team are working with procurement to standardise products which may lead to cost savings I
- IPC working collaboratively with the Medicine CB and Patient Flow team on Winter Preparation Plans to identify possible decant areas for infectious patients being admitted and training for staff re patient placement

Whilst within the Clinical Boards in addition to addressing the HCAI reduction expectations set by WG Clinical Boards (CB) have been asked to include and implement the following in their annual programme of work to reduce the risk of healthcare associated infections and antimicrobial resistance (AMR):

- A need to set **Standards** – clinical leadership
- **Staffing**
  - Numbers
  - Flu vaccination
- **Side Rooms**
  - More needed, to be considered in refurbishment plans for any units
  - Decant ward needed.
- **Equipment**
  - Replacement programme
  - Decontamination
  - To recognise as possible source of infection.

CB Directors need to take ownership of their annual programme for HCAI and AMR reduction, supporting the implementation of specific interventions required. The Clinical Boards will be held to account through the Infection Prevention and Control Group, which is in place to oversee the work of the Health Board to reduce the burden of HCAI.

Clinical Boards will present their programme of work to reduce HCAI and address the WG reduction expectations and AMR delivery plan at the next IPCG (26th June). It is expected that this programme will demonstrate engagement of all staff across the breadth and depth of the CB with clear demonstrable outcomes.

CB's will also be challenged on this agenda through the performance review processes. Professional performance reviews held by the Executive Nurse Director with the Clinical Board Directors of Nursing will continue to focus on areas relevant to the HCAI agenda. Whilst the Executive Performance reviews will also hold the totality of the CB's to account for their performance against the reduction expectations and their annual programme of work in this area.

The Chief Executive and Executive Nurse Director review of cases of HCAI will be re-considered with the arrival of the new CEO in June.

CLEANING UPDATE
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20th June 2017

Executive Lead : Director Strategy & Planning
Author: Head of Estates & Facilities. Tel 029 2074 6593
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact: Cleaning review to ensure patients have a clean and safe environment to ensure optimum care.
Health and Care Standard Number: 2.4
CRAF Reference Number: 5.2 & 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- KPI scores on Very High and High Risk areas are meeting targets.

The Board Committee is asked to:

- **AGREE** the implementation of the Credits for Cleaning and Welsh Government Standards are being embedded and scores have improved to meet targets (or are being managed for immediate improvement) in the high priority areas (Very High and High Risk) given the current resource profile.

SITUATION

The UHB monitors its cleanliness using the all Wales "Credits 4 cleaning" system, deployed across all sites. Areas and departments are categorised as being very high risk, high risk, significant risk or low risk based on the potential consequences to patient outcomes. For example the intensive care unit is a very high risk area.

Cleanliness audits are undertaken weekly, with the 4 week average being used to determine for each clinical area, and as a UHB as a whole, whether the acceptable level of cleanliness has been achieved.

The required cleaning standards are generally being met in the significant and low risk areas. The UHB has set a priority therefore for high risk and very high risk areas to ensure we get up to WG standard and meet targets as soon as possible.

WG Standard Very High Risk Areas	98%
WG Standard High Risk Areas	95%

This report is to provide the Board via the Committee that the strategic plan for cleaning is resulting in improved cleaning scores

BACKGROUND

Ensuring our estate is clean, is essential to achieving both good clinical outcomes and patient and carer satisfaction with their environment of care.

Working in a clean, smart environment improves the morale of staff and can influence in general, behavior, culture and attitudes.

Any perception of lower standards of any of the UHB's estate and services does reflect badly on the reputation of the UHB and has an overall negative impact on patients, visitors, staff and overall culture and image.

One of the challenges to improving the environment is the ongoing pressure with the ongoing demand for beds and as a result, the clinical boards are not being provided with the opportunity to close facilities for cleaning, improvements and repairs to be made.

A further risk to the delivery of our service lies with the ability to recruit on time and in full. Work is however underway to try and develop a bank of housekeeping staff to ensure continuity and numbers on the front line are maintained.

A RRT (Rapid Response Team) is also being mobilised to tackle immediate and urgent cleaning issues)

Priorities are known and the RRT are helping sustain and gain small advantages in reaching standards.

Waste Management and the Rapid Response Teams are working closely together to offer a de-clutter of each ward area before the RRT undertake a deep clean.

Whilst it is recognised that storage is a problem on most wards it is evident by de-cluttering this creates opportunity for areas to be full cleaned and maintained. The initial feedback from Ward Managers is that cleaning standards are improving.

The following bathroom refurbishments have taken place, which include B2, C3n and A7 with the addition of refurbishment of the isolation cubicles on A7.

The Healthcare Environment Steering Group has been reconvened and a cleaning strategy and a cleaning operational plan has been approved All Very High Risk and High Risk areas, as defined by the National Standards for Cleaning in NHS Wales, continue to be monitored on a weekly basis until the levels of cleanliness attain the levels required by the National Standards. In order to deliver against this requirement it is imperative that the monitoring is carried out as a joint exercise involving ward staff and operational services supervisory staff.

Senior Nurses have been approached in the very high risk areas to have a deep clean plan that will improve standards but not hinder patient care where the patient group is particularly vulnerable.
A cleaning strategy document has been completed and approved at the recent Quality Safety and Experience Committee.

The publication of the cleaning scores on entrances to wards will be implemented shortly. The initial frames have been put up in areas covered by the trial of the handyman. (C5, C3, B1, CCU, Cardiac OPD, Cardiac Cath Labs Cardiac Day Case and the Pacing Theatres)

Clinical Boards are supplying ward equipment so that this can undergo the HPV treatment. Further work is underway to establish a programme utilising the spare equipment the UHB funded to increase the use of machines and the disinfection of ward equipment.

By implementing the above actions it is expected that there would be an improvement in the cleaning in clinical areas as a result of ward managers having responsibility for the day to day management of the housekeeper and the opportunity to stipulate what priorities they have within the clinical area when they have the RRT This would mean that the housekeeper could be deployed in areas of most need. It is also expected that morale amongst housekeeping staff would improve as they would hopefully feel part of the ward team.

How do we compare with our peers? - No benchmarking information is presently available.

ASSESSMENT AND ASSURANCE

Latest Performance:	**May 16th**	**4 Week Avg**	**13 Week Avg**
UHW Very High Risk	**98%**	**97.5%**	95%
UHW High Risk	**97%**	**97%**	95%
UHL Very High Risk	**98%**	**98%**	98%
UHL High Risk	**97%**	**95.75%**	95%

Performance to date has been significantly raised following a concerted effort from supervision and management focus across the UHB. Both the 4 week average and latest week scores are meeting target or just a half percentage point below target for VHR and HR areas at UHW and UHL.

This is in contrast to the performance in March which as 94.7% in the very high risk areas, 94.4% in the high risk areas. This was also a deterioration on the previous peak performance noted in February, and was adversely affected by infection outbreaks on the wards, above average levels of resignations from the cleaning team and technical issues with the Credits 4 Cleaning system.

REPORT OF THE INDEPENDENT REVIEW OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S MANAGEMENT AND RESPONSE TO THE ACINETOBACTER BAUMANNII (AB) OUTBREAKS IN AUGUST AND NOVEMBER 2015
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 20th June 2017

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality – Carol.A.Evans 2@wales.nhs.uk
Caring for People, Keeping People Well : Avoiding waste, variation and harm and delivering outcomes that matter to people**.**
Financial impact : Total capital funding for the neonatal unit to date is £44.563m. Revenue funding for staffing is yet to be secured and a business case has been submitted to Welsh Government. Investment in the IP&C Team is also a recommendation within the report.
Quality, Safety, Patient Experience impact : The outbreaks had a significant impact on the quality, safety and experience of neonates and their parents. However the development of the new Neonatal Unit, improvement in staffing levels and a renewed focus on infection, prevention and control practice will mitigate many of the issues that contributed to the outbreaks in 2015.
Health and Care Standard Number Standard 2.4
CRAF Reference Number 5.1
Equality and Health Impact Assessment Completed: Not

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Findings of the Independent review
- The development of a robust improvement plan to address the recommendations

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the contents of the report and
- **APPROVE** the improvement plan

SITUATION

The purpose of this report is to present the committee with the outcome of an independent review which was commissioned following outbreaks of colonization and infection with Acinetobacter baumannii (AB) on the Neonatal Unit (NNU) in August and November 2015.

A detailed improvement plan to address the findings is also attached for consideration and approval by the Committee.

BACKGROUND

Prior to the outbreaks under investigation, several smaller outbreaks involving a number of different organisms occurred on the NNU between 2011-2015. The condition of the neonatal unit (size, cot spacing and staffing) had been recognized as a significant risk and documented on the Corporate risk register as 25 since 2012.

AB is commonly found in the environment. It can withstand drying and remain in the environment for weeks and months and it is difficult to eradicate. It is a particular concern because it is usually resistant to antibiotics that are commonly used to treat infection. In this instance the organism was relatively sensitive. The risk of an outbreak may increase when infection prevention and control measures break down or when neonatal units (and other care settings) lack space.

The Executive Nurse Director and Medical Director jointly commissioned an external review of the management of the infection prevention and control outbreaks in the Neonatal Unit (NNU) at the University Hospital of wales during 2015, from the period from the first AB outbreak in August 2015 to the re-opening of the NNU on 18.12.15, following the second outbreak. The Terms of Reference for the independent review were agreed with Welsh Government and with Welsh Health Specialised Services committee.

ASSESSMENT AND ASSURANCE

The external review was asked to consider four questions outlined within the Terms of Reference;

Question 1 – Were the August and November 2015 AB outbreaks effectively managed?

The review noted that effective management involves several components that are outlined in the document “Managing and preventing outbreaks of Gram-negative infections in UK neonatal units”. Using one standard for management the review found that 6 of 8 recommendations were met completely and 2 or 8 recommendations were met partially.

The reviewers stated that of particular note were the many elements of good practice. These included:

- Once the outbreak had been identified there was a rapid development and implementation of interim estates solution. This was very impressive.
- There was also impressive devotion to the care of the babies by a wide variety of staff – clinical and non-clinical.

- There was honest and transparent communications with parents, with staff and with the broader community.
- The maternity and neonatal units made changes in clinical practice.
- There was outstanding leadership of Infection Prevention & Control (IP&C) by one doctor and the Neonatal Unit IP&C nurse, but not a resilient system. The team needs to be strengthened and a system-based approach developed so that if specific individuals are absent the system still works.

Of concern were the elements of poor practice. These were:

- There are opportunities for improvement of surveillance and early detection and early implementation of interventions.
- Optimal surveillance might have identified the outbreak earlier.
- The review team felt that on the balance of probabilities the outbreak resulted from a perfect storm of unit issues and other issues.
  - The unit issues were space and staffing. Since these issues were subject to decisions by the Welsh Government the unit issues were, at least in part, beyond the control of the Health Board.
  - A number of factors that were under the control of the Health Board contributed to the causation and impact of the outbreak. These avoidable factors were: infection prevention and control systems that lacked resilience and were critically vulnerable to the absence of key individuals. These vulnerabilities related to cleaning and the identification and control of infections.

The review team felt that if the Neonatal Unit was in its current setting and if adequate IP&C measures were in place the outbreak would have been significantly less likely and any outbreaks would have much less impact.

The continuation of weak IP&C systems leaves the Health Board open to the continued risk of outbreaks in other clinical areas.

Question 2a – (Taking all relevant factors into account) Was the closure of the Neonatal Unit in August and November 2015 reasonable?

The reviewers concluded that, yes, this was reasonable. The minutes of the early meetings relating to the August 2015 outbreak report many difficulties in implementing control measures and logistic difficulties. Separation of infected and uninfected babies could not be achieved. In addition, with the ongoing level of occupancy and continues maternity unit activity services could not be maintained at a safe level.

In November 2015 further risks could not be taken when there was a recurrence of the organism in the new interim facility and further transmission events were thought to have occurred.

2b – Was the closure done in a timely manner?

Again, the reviewers concluded that, yes, once the outbreak was recognized and the difficulties in implementing control measures were identified the August closure was done in a timely manner. However, as discussed in the report, the outbreak could have been identified sooner.

2c – Was the decision to reopen the Neonatal Unit on both occasions reasonable?

The conclusion was that, yes, the decision to open the NNU on both occasions was reasonable given that continued, prolonged closures would have compounded risks in other areas.

Question 3 – Has the UHB demonstrated learning and put in place robust arrangements?

The reviewers concluded that arrangements have changed since the outbreak but further developments are still needed in:

- Value of IP&C at the team level and at Clinical Boards and corporate level.
- Value of communication between staff.
- Value of clear laboratory processes and leading onto information for action.
- Value of having sufficient staff on the NNU.

Question 4 – Are the proposed new Neonatal Unit plans fit for purpose in mitigating future risks of IP&C outbreaks?

The reviewers concluded that the environmental plans for the NNU are fit for purpose with respect to mitigating the risks of similar neonatal outbreaks. The weak links in the plans are obtaining revenue to maintain adequate staffing and maintaining capital to complete the plans. The review team were impressed by the speed with which new plans were prepared and executed.

The full report is included at **Appendix 1** and the improvement plan at **Appendix 2**.

Please be advised that the reviewers specifically highlighted and praised the cleaners, nurses, IP&C team and neonatal doctors, particularly Dr J Calvert. In addition they highlighted the exceptional work done by Dr E Davies and her team.

Report of the INDEPENDENT REVIEW OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S MANAGEMENT AND RESPONSE TO THE ACINETOBACTER BAUMANNII OUTBREAKS IN AUGUST AND NOVEMBER 2015

Mark Turner

Martin Kiernan

Bharat Patel

April 2017

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Acknowledgements

The Review Team is grateful for the hospitality and logistic support provided by:

Carole Evans

Alexandra Scott

Julie Evans

Glossary

Term	Explanation
Acinetobacter baumannii	A species of bacteria that can cause serious infection in newborn babies and adults.. Also known as A. baumannii, this bacteria can survive inside hospitals for many weeks and can be very difficult to remove (or eradicate) from hospitals.
Alliance	In this setting, an alliance is the form of organization that has been proposed to deliver health care services for children in South Wales. Health Boards will work together with alliances.
Antibiotic	A medicine that treats infections caused by bacteria
Bacteria	One type of germ that can survive outside the cells of the body and spread between people.
Catastrophic risk	A risk that could cause a major impact on health care, or could cause a hospital to close
Clinical Board	Within Cardiff and Vale University Health Board clinical services are organized so that they work together well. The combinations of clinical services are managed by Boards of health care professionals and administrators in Clinical Boards.
Closure of the neonatal unit	A neonatal unit is closed when it is not able to admit as many babies as usual. Closure can be partial or complete. Partial closure occurs when some babies that would be admitted under normal circumstances cannot be admitted. Partial closure can be managed by looking after babies in another part of the hospital, or by moving babies to other hospitals. The best way to transfer babies to other

Term	Explanation
	hospitals is to move a pregnant woman before she gives birth. Full closure occurs when absolutely no babies are admitted to the neonatal unit. Some babies are very sick when they are born and can be too sick to move. This means that full closure can only be done if no babies are born in a hospital. It is impossible to prevent admissions to a neonatal unit without stopping babies from being born in a hospital, or reducing the number of babies being born by a large amount.
Collaborative	The South Wales Project led to the proposal that neonatal services provided across Health Boards should be managed through a collaborative process
Colonisation	Colonisation occurs when a germ (usually a bacteria) is found on the skin or in other parts of the body, without causing an infection. We are all colonized with many bacteria.
Effectively managed	An outbreak of infection is effectively managed if the number of new infections declines rapidly and all reasonable steps to treat the outbreak are taken as soon as possible.
Health Board	The organization that has responsibility for the health of people in a defined part of South Wales
Independent review	A look at events by a qualified group of people who do not work at the hospital being reviewed
Infection	An infection occurs when a germ causes problems for a patient or makes her / him feel unwell
Infection Prevention and Control (IP&C)	IP&C aims to protect people receiving health care from harm by stopping infections from starting and by ensuring

Term	Explanation
	that infections do not spread.
Isolate	An isolate is a bacteria that is found in a sample taken from a patient or the environment. Samples may be taken from skin, blood or other parts of the body. Samples can also be taken from cots, walls, floors etc. An isolate from a sample from a patient can indicate colonization or infection depending on what happens to the patient.
Mitigating risks	Reducing the impact of something if a risk becomes a problem.
Neonatal unit	A hospital ward that looks after newborn babies
Neonate	A newborn baby. In this report a neonate is a baby who has not been discharged from hospital after birth.
Outbreak	An outbreak occurs when the same germ is found, or causes illness, in more than one baby at the same time.
PFGE	A way to work out whether two bacteria are the same. PFGE = pulsed field gel electrophoresis
Reasonable management	One or more patients are treated in a way that can be justified and that would have been done by a respectable group of doctors and nurses
Resistant	A resistant bacterium is one that does not does not respond to an antibiotic. A bacterium that does not respond to several different antibiotics has “multiple resistance”
Risk	If there is a chance that something bad will happen, the risk of the bad thing is a summary of how likely the bad thing is and how bad it can be.
Risk register	A collection of all the important risks in a

Term	Explanation
	hospital.
Risk score	A number that summarizes a risk. A score of 0 means that there is no risk. The maximum score is 25 which means that the bad thing is very likely and would have a catastrophic impact if it does happen.
Serious incident	In the English NHS, a serious incident is an "adverse event, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified"
South Wales Project (SWP)	A consultation between 2013 and 2014 about the best way to deliver health services to children in South Wales
Typing	Tests that allow the laboratory to determine whether bugs are the same. One of the methods used to do this is pulse field gel electrophoresis (PFGE).
Welsh Health Specialised Services Committee (WHSSC)	The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales. WHSSC was established in 2010 by the seven Local Health Boards in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services.

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Executive Summary

An outbreak of colonization and infection with a bacterium called *Acinetobacter baumannii* on the Neonatal Unit was declared by Cardiff and Vale University Health Board on August 25th 2015. This independent review was commissioned by the Board to investigate the management of the outbreak.

Prior to the outbreak under investigation, several smaller outbreaks involving a number of different organisms occurred on the neonatal unit between 2011-2015. The condition of the neonatal unit (size, cot spacing and staffing) had been recognized as a catastrophic risk and documented as such on the Health Board risk register since 2012.

A. baumannii is commonly found in the environment. It can withstand drying and remain in the environment for weeks or months and is difficult to eradicate. It is a particular concern because it is usually resistant to antibiotics that are commonly used to treat infection. In this instance the organism was relatively sensitive. The risk of an outbreak may increase when infection prevention and control measures break down or when neonatal units (and other care settings) lack space .

This report summarizes the events during the recognition, management and closure of the outbreak.

The external review was asked to consider four questions:

Question 1. Were the August 2015 and November 2015 AB outbreaks effectively managed?

The review noted that effective management involves several components that are outlined in the document "Managing and preventing outbreaks ofGram-negative infections in UK neonatal units" (Anthony et al.)[1] . Using one standard for management the review found that 6 of 8 recommendations were met completely and 2 of 8 recommendations were met partially.

Of particular note were the many elements of good practice. These included:

- Once the outbreak had been identified there was a rapid development and implementation of interim estates solution. This was very impressive.
- There was also impressive devotion to the care of the babies by a wide variety of staff – clinical and non-clinical

[1] Anthony M, Bedford-Russell A, Cooper T, et al. Managing and preventing outbreaks of Gram-negative infections in UK neonatal units. Arch Dis Child Fetal Neonatal Ed 2013;98: F549–F553.

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- There was honest and transparent communications with parents, with staff and with the broader community
- The maternity and neonatal made changes in clinical practice
- There was outstanding leadership of IP&C by one doctor and the neonatal unit IPC nurse, but not a resilient system. The team needs to be strengthened and a system-based approach developed so that if specific individuals are absent the system still works

Of concern were the elements of poor practice. These were:

- There are opportunities for improvement of surveillance and early detection and early implementation of interventions
- Optimal surveillance might have identified the outbreak earlier
- The review team felt that on the balance of probabilities the outbreak resulted from a perfect storm of unit issues and other issues.
    - The unit issues were space and staffing. Since these issues were subject to decisions by the Welsh Government the unit issues were, at least in part, beyond the control of the Health Board.
    - A number of factors that were under the control of the Health Board contributed to the causation and impact of the outbreak. These avoidable factors were: infection prevention and control systems that lacked resilience and were critically vulnerable to the absence of key individuals. These vulnerabilities related to cleaning and the identification and control of infections.

The review team felt that if the neonatal unit was in its current setting and if adequate IPC measures in place the outbreak would have been significantly less likely and any outbreaks would have much less impact.

The continuation of weak IPC systems leaves the Health Board open to the continued risk of outbreaks in other clinical areas.

Question 2

Taking all relevant factors into account

2A. Was the closure of the NNU in August and November 2015 reasonable?

Yes.

The minutes of the early meetings relating to the August 2015 outbreak report many difficulties in implementing control measures and logistic difficulties. Separation of infected and uninfected babies could not be achieved. In addition, with the ongoing level of occupancy and continued maternity unit activity service could not be maintained at a safe level.

In November 2015 further risks could not be taken when there was a recurrence of the organism in the new interim facility and further transmission events were thought to have occurred.

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2B. Was the closure done in a timely manner?

Yes.

Once the outbreak was recognized and the difficulties in implementing control measures were identified the August closure was done in a timely manner. However, as discussed in the report, the outbreak could have been identified sooner.

2C. Was the decision to reopen the NNU on both occasions reasonable?

Yes

Continued, prolonged closures would have compounded risks in other areas.

3. Has the UHB demonstrated learning and put in place robust arrangements?

Arrangements have changed since the outbreak but further developments are still needed in:

- Value of IP&C at the team level and at Clinical Boards and corporate level
- Value of communication between staff
- Value of clear laboratory processes and leading onto information for action
- Value of having sufficient staff on the neonatal unit

4. Are the proposed new NNU plans fit for purpose in mitigating future risks of IP&C outbreaks?

The environmental plans for the NNU are fit for purpose with respect to mitigating the risks of similar neonatal outbreaks.

The weak links in the plans are obtaining revenue to maintain adequate staffing and maintaining capital to complete the plans.

The review team were impressed by the speed with which new plans were prepared and executed.

Reflection

Low birth weight neonates are known to be prone to infections and can die from infections that would not be fatal in other age groups. *Acinetobacter baumannni* infections in intensive care can lead to mortality. The fact that infections in this unit did not lead to deaths associated with Acinetobacter may have been related to the nature of this particular bacterium. In particular, it did not cause infections in all the babies who were colonized (it had low virulence) and it was susceptible to antibiotics that are used commonly. The outcomes could have been a lot worse. In similar outbreaks there has been significant number of deaths. This was a lucky escape for the babies and the hospital.

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The review team noted in passing that many stakeholders in the neonatal services in South Wales had been extremely frustrated between 2012 and the end of 2015. The circumstances that led to the outbreak (overcrowding and inadequate staffing on the neonatal unit) were widely recognized but no adequate actions were taken despite exhaustive discussions.

Recommendations

Eighteen recommendations were made in total.

The most important of these are shown in bold:

A. Recommendations specific to the neonatal unit

1. **Secure revenue for staffing**
    a. **If this is not done then the full benefits of capital investment for infection control and prevention (and other benefits) to date will not be realised**
2. Secure capital for the remaining beds in the current plan
3. Share experiences with the Neonatal Network and the broader health economy
    a. The health economy did not benefit properly from the learning arising from the Singleton ESBL *E.coli* deaths
    b. The neonatal network would benefit from closer working arrangements with the maternity network and the commissioners
    c. The 12 hours dedicated neonatal transport service should be extended to 24 hours. If another serious outbreak were to arise, additional transport services may need to be commissioned short term

B. Recommendations that are relevant across the Health Board

4. **Increase engagement of medical staff in IPC at all levels of the organization**
    a. **During clinical work all doctors need to follow IPC measures at all times including effective hand hygiene and bare below the elbow**.
5. **Improve methods for linking isolates and identifying outbreaks.**
    a. **Implement electronic methods for linking isolates, for example IC Net.**
    b. **Implement a system that is not reliant on one person**
    c. **The IPC Team should have access to information about isolates so they can look it up for themselves**
6. Document meetings, risk assessments and completed actions more effectively
7. Maintain multiple ways for staff to raise concerns
8. Review cleaning practices
    a. Training and competence assessment
    b. Methods
    c. Review of methods (is Actichlor being used effectively)
9. Consider quantitative assays of cleaning effectiveness
10. Maintain close monitoring of infections at all levels of the organization
11. Ensure robust ways for the Health Board to become aware of troublesome isolates
    a. Review arrangements with PHW about information flow from the labs to health care facilities in the Health Board
12. **Assure capacity and capability of IPC team**

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a. **The IPC team is too small, banding of staff is extremely low for a major teaching hospital and lacks a middle tier between DIPC and operational staff. It should be recognised that the DIPC role is not full-time and that the postholder has additional external responsibilities.**

13. Improve hand hygiene audits
14. Improve hand hygiene practice and personal ownership
15. Review whether the risk register is useful: the Neonatal Unit was rated as 25 out of 25 for 4 years. What is the point of the risk register if an intolerable risk can be carried for so long?
16. Develop ways for nurses to be reassessed in cleaning skills
17. Recognize tremendous work by cleaners, nurses, DIPC team and neonatal doctors, particularly Dr. J. Calvert
18. Highlight exceptional work done by Dr. E. Davies and recognize the value of that work by strengthening the IPC team

Report of the Independent Review Cardiff August – November 2015

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Chapter 1 Introduction

There were two outbreaks of *Acinetobacter baumannii* on the neonatal unit (NNU) at University Hospital of Wales (UHW) in Cardiff during 2015.

The outbreaks were managed by the Health Board responsible for the hospital: Cardiff and Vale University Health Board (CVUHB). Once the outbreak had been completed CVHB commissioned an external review: this is the report of the review . The review's terms of Reference are included as Appendix 1.

The Independent review was asked to answer four questions:

Question 1

Were the August 2015 and November 2015 AB outbreaks effectively managed?

Question 2

Taking all relevant factors into account:

A. Was closure of the NNU in August and in November 2015 reasonable?
B. If so was it done in a timely manner?
C. Was the decision to re-open the NNU on both occasions reasonable?

Question 3

Has the CVUHB demonstrated learning and put in place robust arrangements?

Question 4

Are the proposed new NNU plans fit for purpose in mitigating future risks of IP&C outbreaks?

The review was asked to consider:

- Compliance with national guidance and standards (before, during and after);
- Workforce and environmental influencing factors;
- Governance and accountabilities;
- Working relationship with the Neonatal Network.

The review team included:

A Neonatologist with an interest in infection and antibiotics (MT)

An Infection Prevention and Control (IP&C) specialist (MK)

A Medical Microbiologist with experience of managing and investigating outbreaks (BP).

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None of the review team had worked in Cardiff, or in Wales.

The review team described their previous associations with South Wales as:

MT: one research collaboration with Prof. S. Kotecha at UHW that involved planning a clinical trial of an antibiotic

MK: No relevant disclosures

BP: Between 2008-2014 member of review teams for Healthcare Inspectorate Wales for outbreak reviews (including ESBL E coli cross infection in a maternity/neonatal unit) and peer review visits. Similar work for Abertawe Bro Morgannwg University Health Board on a hepatitis B transmission between two patients.[2]

The review was conducted between September 5th 2016 and October 31st 2016.

The review started with a three-day visit to Cardiff between September 5th and September 7th 2016.

The timetable for the three-day visit is shown in Appendix 2.

The review team met with the Cardiff team (Director of Nursing, DIPC, Lead Neonatologist) to share their initial review on September 7th.

A draft report was prepared by MT and revised by the review team.

The draft report was reviewed by relevant members of UHB between November 27th 2016 and March 16th 2017.

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[2] 2008 HIW SPECIAL REVIEW OF THE OUTBREAK OF CLOSTRIDIUM DIFFICILE AT THE FORMER NORTH GLAMORGAN NHS TRUST IN MARCH/APRIL 2008

2009 Healthcare Inspectorate Wales – "All Wales" review of the management of patients with diarrhoea and vomiting

Jan 2012 Abertawe Bro Morgannwg University Health Board, NHS Wales – Expert External Report on the transmission of hepatitis B between two patients who underwent cardiac surgery at Morriston Hospital in Swansea in March 2011

2014 Healthcare Inspectorate Wales - A Review Of Abertawe Bro Morgannwg University Health Board's (AMBU) Response to the ESBL E.coli Cross Infection in the Maternity/Neonatal Unit at Singleton Hospital in November 2011

Chapter 2 Background

Description of the unit and its activities before the outbreak

The Unit

The WHSSC Commissioned neonatal ICU and HDU services. The historic and recognised commissioned cot capacity during the period for ICU/HDU was 17+1 (split 10 HDU, 8 ICU).

Unit activities included all types of ventilation (including high flow oscillatory ventilation and inhaled nitric oxide), surgery and family support.

The current estate opened in 1971.

Neonatal activity from the nearby Llandough Hospital was transferred to UHW in 2005 without an increase in the footprint of the unit. There have been significant changes in neonatal practice since 2005 and significantly more equipment is used now compared to a decade ago.

In England, current recommendations for the design of existing neonatal units are that each intensive care cot is allocated a minimum $16m^2$. Current recommendations for new units are $20m^2$ per cot, not including staff areas. It should be noted that the specifications for neonatal units have changed over the past decade, with increasing understanding of how infections spread within units.

One of the intensive care areas on the Unit that was operational prior to the first outbreak in 2015 had floor space of $60m^2$. This space accommodated seven intensive care cots so that the allocated space was 8.6 m^2 per cot.

The first detailed documentation of the problems with the size of the neonatal unit was prepared by the Lead Neonatologist in 2009 and presented to the Clinical Board.

The Unit was widely recognized as being too small and a significant risk of infection was identified in 2011 and escalated to a catastrophic risk on the corporate risk register in 2012.

A plan and justification for investment (a business case) for redevelopment of the Neonatal Unit was developed in 2013 and submitted to the Welsh Government. A decision was delayed because of the South Wales Project. The South Wales project was a collaborative approach to reviewing the provision for neonatal services in South Wales. The review took place between 2013 and 2014. During this time no decisions were made about the Neonatal Unit at UHW. Following this process a business case for expansion of the neonatal unit at UHW was sent to WG in March 2016

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Infections before the current outbreak

Before 2015 the background rate of infection on the neonatal unit at UHW was similar to the rate of infection at other units. The Unit is part of the Vermont Oxford Network (VON). VON is the leading method for comparing neonatal units globally and membership of VON reflects a commitment to quality improvement. During 2014 VON included data about whether or not 53,423 babies with a birthweight < 1500g had an infection 4 or more days after birth (late infections), and these were compared to 57 babies admitted to UHW. There was no evidence that UHW had more late infections than other units with similar activity. The Neonatal team had undertaken several quality improvement initiatives to address late infections: these initiatives were similar to actions taken by similar units in the rest of the UK.

However, the number of outbreaks was higher than the review panel expected.

Previous outbreaks included:

November 2011 *Pseudomonas aeruginosa* – a bacterium than can be difficult to treat

April 2015 Methicillin Resistant *Staphylococcus aureus* (MRSA) – another bacterium that can be difficult to treat

July 2015 Influenza – a virus that can make premature babies very sick

The number of outbreaks was significantly higher than expected particularly during 2015 and it is evident that the frequency of outbreaks was increasing.

The clinical problem: neonatal infection and bacteria that can be resistant to multiple drugs

Neonates are more prone to infection than other people. This is partly because they handle infections differently and partly because they are exposed to a large number of invasive procedures that are needed as part of their care.

Infections make people feel unwell, prolong hospital stay and therefore need other resources for successful treatment. Neonates suffer from infection as well. In addition, neonates can suffer long-term consequences of infections. The infection, and the body's response to it, can disrupt the development of the brain. This means that babies with infections are more likely to have brain damage than babies who do not get infections. This is a unique feature of neonatal infection that needs to be accounted for in risk analysis.

Given that most neonates who are discharged from hospital have a long lifespan, the proper horizon for benefit-risk assessments of neonatal treatments is 70 years. Disability Adjusted Life Years (DALYs) or similar measures need to be calculated on this

basis. Health care systems need to base services around high quality care thereby averting many decades of ill-health.

There is increasing recognition that bacteria are becoming more resistant to antibiotics. Multidrug resistance is a particular problem in neonates because many antibiotics have not been studied in neonates and so we don't know which doses work and how to minimize side effects.

A. baumannii is commonly found in the environment. It can withstand drying and remain in the environment for weeks or months. This persistence makes it extremely difficult to eradicate. It is a particular concern because it is usually resistant to antibiotics that are commonly used to treat infection.

The UK context

With the increasing recognition of antimicrobial resistance (AMR) and its particular impact on babies there has been increased scrutiny of neonatal infections. A number of recent events have been reviewed and reports have been issued.

Infection Events

Northern Ireland *Pseudomonas aeruginosa* outbreak. This outbreak was related to water-borne infections but the enquiry identified a number of general issues including the need to share information about infections between units and to develop effective networks to manage infection across a population.

Singleton Hospital ESBL *E. coli* outbreak. The report concluded that a lack of space made infection more likely; the report included a specific recommendation effort was made to ensure that no other units in Wales had the same problems.

Reports

Under the auspices of the Neonatal Infection Sub-Group of the ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) Committee of DH England, a group developed some guidelines entitled "Managing and preventing outbreaks of Gram-negative infections in UK neonatal units" (Anthony 2013).

In England, DH issues a building note for neonatal units in 2013 (80% of 20m^2 should be enough for existing units)

The South Wales context

The best way to organize neonatal services in South Wales has been under discussion for some time.

All interviewees reported considerable frustration about the delay in decision-making about neonatal services in South Wales

The Singleton report prompted review of infection across South Welsh neonatal units. This included reviews by CVUHB and the Neonatal Network followed by action plans.

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CVUHB were aware of the issues and tried to follow the recommendations in the report about the Singleton hospital. Staff from CVUHB told the review panel that external factors prevented them from following all the recommendation of the report about Singleton hospital.

Chapter 3 What happened?

Overview of Chronology

Outbreak detection

The first isolate related to the outbreak was from an eye swab in May 2015. The neonatal unit were informed. That isolate was not retained. This was in line with standard practice for isolates from skin or eyes so that this isolate was not available for comparison with bacteria that were isolated later in the year (i.e. subsequent typing).

The second isolate was from two sites in the same patient in June 2015: secretions from an endotracheal tube (ETT) and a positive blood culture. The neonatal unit were informed about these findings and infection control measures were reinforced. Crucially, the link between the first isolate and the second isolate was not made.

The third isolate occurred at the end of July 2015 when the neonatal Infection Control Nurse was on annual leave. When she returned from holiday she manually searched back through the isolates that had previously occurred and identified the first and second isolates. This led to a discussion with other senior members of the IP&C team. It would have been possible to identify a potential connection, "linkage", between the isolates at this time if the isolates had identical antibiotic resistance profiles, even if advanced methods such as typing were not used,.

The fourth isolate occurred in August 2015 just before the DIPC and Senior Infection Control Nurse went on Annual Leave. All the available isolates were sent for typing in case there was an outbreak, however the antibiograms of all of the isolates was identical.

The fifth isolate occurred later in August 2015 just before the DIPC and Senior Infection Control Nurse returned from Annual Leave. The DIPC organized an outbreak meeting and screening of all the babies on the neonatal unit was undertaken. At this stage an outbreak was declared.

Linkage and Outbreak identification

It is important to find out whether isolates are the same bacterium that has spread between patients, to find out whether isolates are linked. Linkage between isolates is central to the identification and control of outbreaks. However this does not preclude the implementation of control measures at an early stage prior to these results becoming available. An outbreak is when the same bacterium is found in more than one baby – if an outbreak is not recognized it will not be controlled and avoidable infections will not be prevented.

When the second isolate occurred the neonatal Infection Control Nurse was on sick leave. Although the isolate was noted by one of her colleagues, and the neonatal unit was notified, there was no attempt to search for a previous isolate that might be linked to the second isolate. This meant that an opportunity to identify the outbreak was missed. The

clinical team would have discussed the possibility of an outbreak and might have changed their plan.

At the time of the first opportunity, linkage between isolates was identified by the Infection Control Nurse attached to the Neonatal Unit. The Infection Control Nurse received an e-mail each day with all the positive isolates from the hospital. Each day the Infection Control Nurse had to transfer the contents of the e-mail to a spreadsheet for that day and then identify the isolates that were relevant to her/his clinical areas. If the Infection Control Nurse identified an isolate that might be associated with an outbreak she/he had to review all the previous spreadsheets in which a similar outbreak might be found. This depended on the memory of specific nurses and the ability of the nurse to search through previous spreadsheets looking for an isolate that might be similar to one she had just come across.We note that the system of outbreak detection based on personal recollection informed by e-mails and spreadsheets is inadequate and is significantly below best practice. The Infection Control Team did not have access to the laboratory system operated by Public Health Wales, despite requesting this. We note that other Boards in Wales do have access to this system. Computerised systems are available to automate the process and ensure that multiple people can access the data relating to a clinical area. The systems can be set up to raise triggers when similar isolates are identified in the laboratory, providing automated alerts about possible outbreaks.

A Public Health Wales Microbiologist suggested to us that the IPC team may not have the authority to request screening and typing in the absence of the DIPC: this was apparent when the SICN and DIPC were on leave at the same time. This is possibly due to perceived status, since the team is extremely small for the level of activity and the bandings of team members are considerably below what would normally be found in a major teaching hospital in a capital city. Also, there was a lack of clarity about how the responsibilities were shared between the Health Board and Public Health Wales.

The chronology of this outbreak is summarized in Figure 1 which illustrates the cumulative number of *A. baumannii* isolates by time annotated with significant events.

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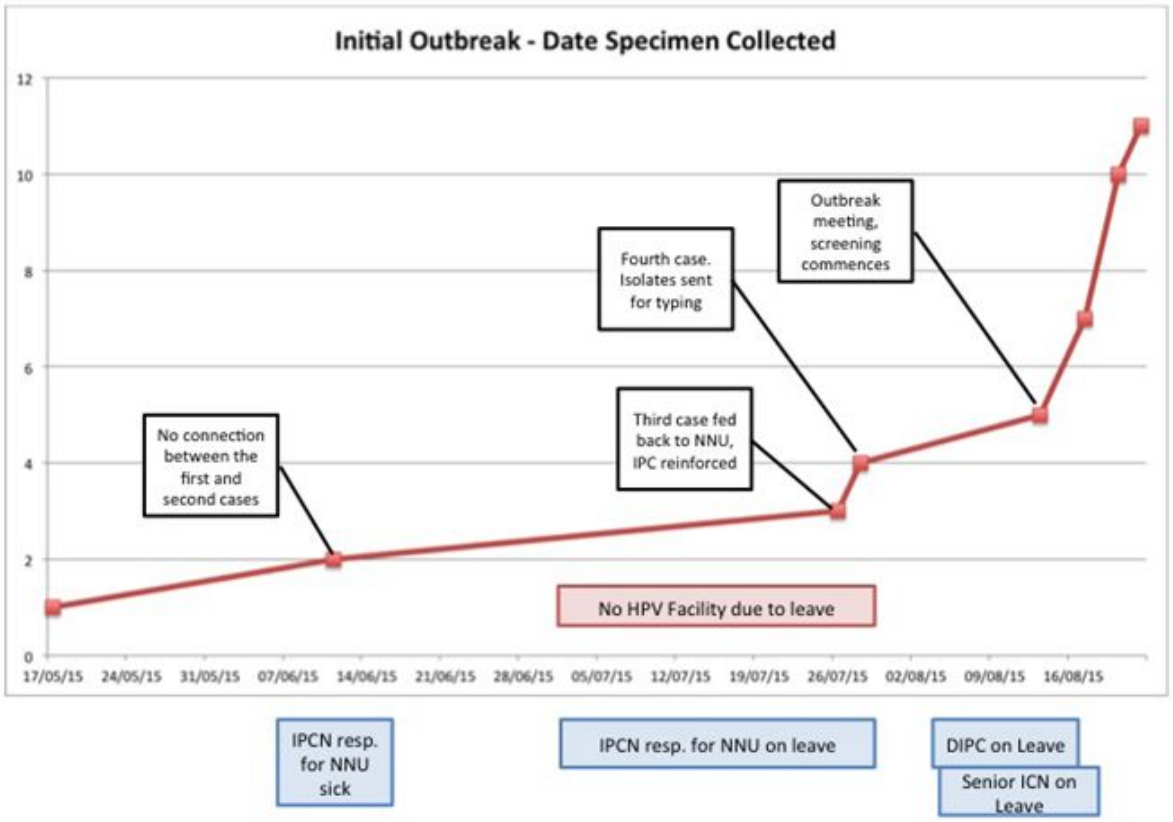

Figure 1. Time and event curve for the outbreak

The review team felt that there were two occasions early in the first outbreak where interventions could have been implemented earlier.

1. The Review team felt that best practice would have been to order screening of all babies on the neonatal unit and to call an outbreak at an earlier stage, possibly after the third and probably after the fourth isolate.
2. The delay between fourth and fifth isolates was associated with a delay in instituting measures to halt the outbreak. This could have reduced the total number of babies affected by the outbreak and the burden to the babies, families, staff, population of South Wales and Hospital Board.

Other factors contributed to the outbreak.

One was a shortage of staff on the unit. This included insufficient nursing staff and medical staff. This was due to a combination of sickness, pregnancy and recruitment difficulties.

In the case of medical staff in training grades, the staff shortages were longstanding and reflected, in part, negotiations with the authorities with oversight of doctors in training about the number of doctors in training and the nature of their training.

Another factor was the effect of the environment. The unit did not meet the standards for bed spacing recommended for NNUs at the time and this had been repeatedly documented. Coupled with an air handling system that did not meet the recommended number of air changes, this increased the risk from environmental contamination. At this time, no environmental specimens were taken and this would have been good practice.

A further factor was that the practice for cleaning equipment (particularly incubators) was to clean them on the unit with a chlorine-based solution and then to fumigate them with Hydrogen peroxide vapour (HPV). This system was inoperative for most of August 2015, as the only worker that could operate the HPV system was on leave. In practice it is difficult to maintain the 5 minutes contact time with the chlorine-based disinfectant necessary for disinfection to take place and it is likely that this contributed to the outbreak, since no risk mitigation measures were implemented whilst the staff ember was on leave.

Steps taken to control the outbreak

Once the outbreak was called there was a comprehensive reaction including:

- An outbreak team was convened. The minutes from the first few incident meetings show that the team were struggling to make progress implementing various control measures. There were a number of pressures on the team and it was not until around the time of the first Serious incident meeting that the minutes reflect some progress towards control.
- High-level Serious Incident (SI) meetings two or three times a week during the initial phases of the outbreak with appropriate changes in the frequency of the meetings as the outbreak was resolved and when it returned.
- Meetings of the Infection Prevention and Control team
- Identification of alternative estate

  - This was done with admirable speed and efficiency. A number of options was rapidly identified. The options were appraised, taking account of the needs of the neonatal service and other services – work which should be specially commended.
- It was decided to develop an interim unit. Plans for the interim unit were developed rapidly.
- A business case for the interim unit and part of a definitive solution was prepared.
- New estate was developed with unheard of speed.
- Transfer of the babies and staff from the old to the interim unit were made expeditiously and with due account of the need to cohort the babies colonized with *A. baumannii*.
- In parallel to these actions the number of babies admitted to the unit was reduced in order to reduce the likelihood of further cases. This proved to be difficult because the number of births in the hospital was not reduced markedly. Where possible mothers who were expected to give birth to babies with problems requiring neonatal intensive care were transferred out of UHW. This was not possible in all cases. On occasions babies had to be transferred out of Wales to Bristol and beyond.
- Communications with staff, families and with the broader community. Clearly very effective and well-received by staff, families and the media. It is striking that there were no formal complaints
- Care pathways for babies who required neonatal care but not admission to the neonatal unit were modified. This included increasing the capacity for babies to receive intravenous antibiotics on the postnatal wards.
- Senior management and Hospital Board engagement had a clear impact and expedited decision-making.

Impact of the outbreak

1. Disruption to families and staff

A large number of families experienced new conditions for neonatal care and was subject to uncertainty about the care their baby would receive. Families were distressed by segregation / cohorting of babies.

The staff found the outbreaks very stressful. The contributors to staff stress included: extreme uncertainty about source and duration of the outbreak; frustration that the outbreak could have been prevented by changes they had been arguing for since 2009; limited changing areas and coffee room in interim area

2. Transfers out

Between 1st August 2015 and 27th September 2015 a total of 57 mothers were transferred out of South Wales antenatally because of reduced capacity for neonatal care at UHW. This included one to Oxford (for expected neonatal surgery), one to Taunton, two to Gloucester (including one mother carrying twins), one to London (Chelsea and Westminster), one to Southampton

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Between 1st August 2015 and 27th September 2015 a total of 26 babies were transferred out of South Wales antenatally because of reduced capacity for neonatal care at UHW. This included one each to Birmingham and London (St. George's) and two to Oxford,

3. Neonatal surgery

This was reported to be a major source of stress for staff and families across South Wales.

Cardiff is the only site that can provide neonatal surgery in South Wales.

The alternative is to transfer babies to England. The first choice would be Bristol. However, Bristol was often full and so babies had to move to other parts of England, including Southampton and Birmingham.

The obvious solution would have been to place surgical babies on the PICU in Cardiff. This is widely done in many other centres. This solution had been discussed by the relevant medical staff extensively in the years before the outbreak. We were told that the skills mix among PICU Consultants was not suitable for the care of babies with neonatal surgical conditions, that there was insufficient capacity on the PICU and that there was not sufficient capacity among the NICU Consultants to provide shared care for babies on the PICU.

This situation is very disappointing and contributed to the preventable harm arising from the outbreak.

It may be worth reconsidering the components of this problem, namely skills mix among PICU Consultants, PICU capacity and capacity among NICU Consultants.

More generally, the surgical issues highlight the value of contingency plans. The Board should develop contingency plans for the placement of neonatal cots should another threat to the service arise. Threats to the neonatal unit are not limited to outbreaks of life-threatening infection. Contingency plans should be developed proactively in collaboration with internal and external stakeholders. There is a need for network-wide contingency plans for when any part of the South Wales neonatal service is threatened.

4. Neonates with antibiotics on the postnatal wards

A large number of relatively healthy babies receive antibiotics after birth because of maternal or neonatal risk factors. Prior to the outbreak there had been extensive discussions over several years about avoiding unnecessary admissions to the neonatal unit by administering antibiotics on the postnatal wards (this is done in many maternity hospitals). This process was expedited during the outbreaks. This was a considerable burden for the neonatal nurses as they were already stretched dealing with the outbreak.

5. Clinical Impact

We did not review the clinical records of the babies who were colonized or infected but internal assessments by the clinical teams were conducted and found that no significant clinical harm arose from the outbreak

One baby who had been colonized died subsequently. We were told that this baby had multiple conditions some associated with prematurity and some associated with underlying conditions. The combination of conditions was sufficient to cause mortality. The baby was not infected with AB before death and there is no reason to link the death to AB colonization.

Key points

There were some aspects of excellent practice.

There are opportunities for improvement of surveillance and early detection and early implementation of interventions

Optimal surveillance might have identified the outbreak earlier

Once the outbreak had been identified there was a rapid development and implementation of interim estates solution. This was very impressive.

There was also impressive devotion to the care of the babies by a wide variety of staff – clinical and non-clinical

There was honest and transparent communications with parents, with staff and with the broader community

The maternity and neonatal made changes in clinical practice

There was outstanding leadership of IP&C by one individual and one IPC nurse but a resilient system was absent. The team needs to be strengthened and a system-based approach developed so that if specific individuals are absent the system still works

The review team felt that on the balance of probabilities the outbreak resulted from a perfect storm of unit issues and other issues.

The unit issues were space and staffing. Since these issues were subject to decisions that were part of a long-term planning process for neonatal services supported by the Welsh Government, the unit issues were, at least in part, beyond the control of the Health Board as long as the Health Board contributed to the long-term planning process.

A number of factors that were under the control of the Health Board contributed to the causation and impact of the outbreak. These avoidable factors were: systems that lacked resilience and were critically vulnerable to the absence of key individuals. These vulnerabilities related to cleaning and the identification and control of infections.

The review team felt that if the neonatal unit was in its current setting and if adequate IPC measures in place the outbreak would have been significantly less likely and any outbreaks would have much less impact.

On the other hand, the continuation of weak IPC systems leaves the Health Board open to the continued risk of outbreaks in other clinical areas.

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Low birth weight neonates are known to be prone to infections and can die from infections that would not be fatal in other age groups. *Acinetobacter baummanni* infections in intensive care can lead to mortality. The fact that infections in this unit did not lead to deaths associated with Acinetobacter may have been related to the nature of this particular bacterium. In particular, it did not cause infections in all the babies who were colonized (it had low virulence) and it was susceptible to antibiotics that are used commonly. The outcomes could have been a lot worse. In similar outbreaks there has been significant number of deaths. This was a lucky escape for the babies and the hospital.

Chapter 4 Review Questions

Question 1 Were the August 2015 and November 2015 AB outbreaks effectively managed?

The review team adopted the standard for management of Gram Negative outbreaks provided by Anthony et al. (Antony 2013) This was also described as the standard adopted by the Health Board.

Table 1 shows the recommendations provided by Anthony et al. and the reviewers' opinions of compliance with each recommendation.

The Health Board met all 8 recommendations related to the management of the outbreak. Six recommendations were met in full and two recommendations were partly met. The Health Board's response to two recommendations was hampered by external factors.

On balance, the August 2015 and November 2015 AB outbreaks were effectively managed once the outbreaks were recognized. That is, the management of the outbreak can be justified. A respectable body of professional opinion would have handled the outbreak in a similar way.

But:

- Documentation of risk assessment and action plans was weak, in particular the recording of completed actions
- Cleaning should have been assessed more rigorously than a simple visual check
- Cleaning was not resilient because of dependence on a limited number of staff
- The outbreak broke through existing measures – there was suboptimal implementation of chlorine based cleaning and HPV
- Systems that enable early detection and allow early implementation of intervention were lacking
- Hand hygiene was, and remains, inadequate.

Issues with cleaning had not been resolved at the time of the visit by the review team.

At the time of the visit by the review team the instructions for cleaning were ambiguous. The use of Actichlor was suboptimal. It should be left to dry and needs to be in place for at least 5 minutes. Senior members of the UHW staff were under the impression that housekeeping staff left Actichlor in place for 5 minutes. However, observation of unit practice suggested that Actichlor was often wiped off after a minute or so to prevent smearing.

Hand hygiene remained inadequate at the time of the review. The review team noted good practice among many staff. However, the review team noted poor practice. For example members of the surgical team did not remove their watches before examining a baby.

In summary, the outbreak was effectively managed with some room for improvement.

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Table 1

Recommendations from the paper by Anthony et al. 2013 and the review team's assessment of compliance with each recommendation.

Recommendation	Compliance	Comment
Management of outbreaks		
Activate an organisational response and establish a control team when an outbreak is suspected	Yes, in part	Apparent delay due to staff absence. The systems were not robust, and continue to lack resilience
Screen for the specific organism only during an outbreak	Yes	
Undertake multidisciplinary reviews of cleaning routines, hand hygiene and Gram-negative bacteria transmission risks	Yes, in part	There were, and continue to be, gaps in the review. For example, IPC staff finding dust on the radiators despite internal cleaning audits demonstrating high compliance. The review team found unauthorized cleaning materials on the neonatal unit The cleaning instructions were ambiguous and at the time of the review were implemented in a way that undermines their effectiveness Effectiveness of cleaning was only assessed in a subjective manner Opportunities to perform environmental sampling were missed
Consider deep-cleaning	Yes, in part	At the time of the first outbreak it was not possible to undertake HPV fumigation due to the layout of the unit
Cohort colonised and infected babies preferably but not necessarily in isolation cubicles	Yes	
Consider reducing beds or closing a unit to new admissions as a way of improving spacing and staff:patient ratios until the outbreak is under control.	Yes	The Health Board acted appropriately once the outbreak was identified. The Health Board was hampered by issues with neonatal services across South Wales.
Establish mechanisms to communicate effectively across the network	Yes	The Health Board acted appropriately once the outbreak was identified. The Network acted appropriately but was hampered by its

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Recommendation	Compliance	Comment
		narrow remit, lack of power and very limited resources
Inform parents of the outbreak as early as possible, and providing prewritten 'infection outbreak' information sheets	Yes	This was done well.
Prevention of outbreaks		
Meet national staffing and cot-spacing requirements	No	Standards set by the Network, and relevant standards operational in England, were not met for a considerable period of time
Follow a Water Action Plan	Yes	
Use infection reduction care bundles	Yes	The Neonatal Unit conducted these but other parts of the organization appeared not to recognize this
Benchmark	Yes	The Neonatal Unit conducted these but other parts of the organization appeared not to recognize this
Introduce breast milk early	Yes	http://www.nhs.uk/conditions/pregnancy-and-baby/pages/breastfeeding-first-days.aspx
Limit antibiotic use	No	Hampered by lack of 36 hour reporting. The delay in implementing 36 hour reporting was beyond the Hospital Board's control

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Question 2A. Was the closure of the NNU in August and November 2015 reasonable?

The Review team considered a standard for "reasonable" and adopted "a defensible practice that would have been followed by a respectable body of professional opinion".

In this light, the closure of the NNU was reasonable on both occasions.

In fact, the closure was not just reasonable but essential.

Any criticism of the closure would be unreasonable.

The minutes of the early meetings relating to the August 2015 outbreak report many difficulties in implementing control measures and logistic difficulties. Separation of infected and uninfected babies could not be achieved. In addition, with the ongoing level of occupancy and continued maternity unit activity service could not be maintained at a safe level. In this situation closure of the unit was required.

In November 2015 further risks could not be taken when there was a recurrence of the organism in the new interim facility and further transmission events were thought to have occurred.

Question 2B. Was the closure done in a timely manner?

Yes.

Once the pattern of colonization had been recognized the unit was closed and the SI called. However the review team felt that that the August outbreak have been recognised a month earlier if robust surveillance systems had been in place.

The recurrence of the outbreak in November 2015 was a very difficult time for all staff involved. They felt that they had taken every possible step to end the outbreak and prevent another outbreak. Once the outbreak was recognized then the unit was closed appropriately.

Again, the risk assessment for the second closure was not documented.
The risk assessment for the second reopening was documented in detail and illustrated a reasoned case and responsible decision-making.

Question 2C. Was the decision to reopen the NNU on both occasions reasonable?

Question 2C: Was the decision to re-open the NNU on both occasions reasonable?

Yes.

Continued, prolonged closures would have compounded risks in other areas.

However, documentation of risk assessment before the first re-opening could have been better

Question 3. Has the UHB demonstrated learning and put in place robust arrangements?

Yes. Learning has already started and is ongoing

Some initiatives have been implemented

- The Big Room

Arrangements have changed since the outbreak but further developments are still needed in:

- Value of IP&C at the team level and at Clinical Boards and corporate level
- Value of communication between staff
- Value of clear laboratory processes and leading onto information for action
- Value of having sufficient staff on the neonatal unit

Question 4. Are the proposed new NNU plans fit for purpose in mitigating future risks of IP&C outbreaks?

The review team were impressed by the design of the new NNU and the speed of construction. The Estates department and their contractors are to be congratulated on the work they have done for the NNU since the start of the outbreak.

The plans for the NNU were fit for purpose with respect to mitigating the risks of infection

The review team had concerns about:

- Revenue for staffing the new neonatal unit: this is yet to be obtained
- Capital to complete all the phases of the neonatal unit: this is yet to be obtained
- Staffing model: yet to be finalised

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It should be noted that the risks of failure in training issues and other aspects of staffing issues, particularly doctors in training, are beyond the control of CVUH Board control

We did not receive effective assurances that these concerns would be addressed.

Relationship between CVHB and the broader health economy with respect to neonatal services remains unclear and this is a significant risk to the sustainability of the neonatal services at UHW.

Compliance with national guidance and standards (before, during and after)

See Question 1.

Workforce and environmental influencing factors;

Workforce: the issues are complex but there was a good response in the circumstances.

Nursing workforce planning is complex because of the high need for specialist staff. Any reduction in the numbers of nurses being trained in Wales will place further strain on the system.

Medical workforce planning is complex because of training issues that are the responsibility of Deanery and the review of the number of neonatal units needed in South Wales.

Environment: there was an excellent response to the challenges raised by outbreak

Governance and accountabilities

Governance and accountabilities were good within CVUHB.

Governance and accountability outside CVUHB were not clear to the staff who spoke to us: see Chapter 5.

In particular it is not clear who is accountable for the gaps in the neonatal service across South Wales

The working relationship with the Neonatal Network

The neonatal network is a subgroup of the Wales Health Specialist Services Committee (WHSSC). The Neonatal Network has an advisory role with no power. The Neonatal Networks identifies standards for neonatal care, informs units about those standards and convenes meetings to promote compliance with those standards. However, the Neonatal Network has no mandate, resources or capacity to enforce standards. Similarly, the Neonatal Network can identify how many neonatal cots are empty or are being used at any one time. The Neonatal Network can share information about cot availability and can convene discussions about how to handle cot shortages. However, the Neonatal network cannot solve cot shortages. The Neonatal Network has very limited resources and staff. Given the constraints on the Neonatal Network the arrangements made by the network appear to be appropriate. However, these now need to be formally agreed in the South Wales Network to ensure that should a future outbreak occur in any of the South Wales neonatal units capacity and service issues will be maintained.

We were told that at the clinical level, neighboring Health Boards collaborated well during the outbreak. Some informants told us that there is no way to coordinate neonatal units across South Wales. The neonatal transport team for South Wales was aware of bed status and could coordinate the movement of babies between units.

There appeared to be some confusion in the Health Board about the scope of the Neonatal Network. Senior staff in the Board appeared to attribute unrealistic capabilities to the Network while being unaware of the work done by the Network. Informal relationships between clinicians were mistaken for actions of the Network. The information we received from the network and the clinicians indicated that the informal relationships worked as well as could be expected during the outbreak. Any apparent shortcomings in joint working between neonatal units were not due to a lack of will to collaborate, or to any failings of the staff badged as Network staff. The lack of coordination between units results from structural and governance failings in the neonatal service across South Wales. The commissioning arrangements for neonatal services are very unclear with Health Boards and commissioners having some input, but no one taking clear responsibility for governance.

The Network was beyond our scope but the broader health economy may like to consider whether the Network needs to be strengthened. Public Health Wales is a unitary agency across Wales that is a good example of subsidiarity (some actions need to be taken across Wales while other actions should be taken locally). A combined approach to neonatal services in South and Mid Wales could also benefit from a formal, unitary approach.

Chapter 5 Other observations

It proved impossible to answer the review questions without examining the broader context of neonatal care in South Wales. Some observations beyond the scope of the review are offered to the CVHB, WHSSC and the Welsh government.

A) The South Wales context.

We were told several times that the governance of neonatal services is opaque, even to staff who have worked in South Wales for a decade.

Our understanding is that the Health Board has responsibility for the health of its population. This is done with a block grant from the Welsh Government (WG).

WHSSC commissions specialist services. It did not have a quality framework at the time of the outbreaks although we were told that one is under development.

The Neonatal Network has an advisory role. It has neither mandate nor funding to actively manage clinical care. The Network sets standards for WHSSC but we were told that when the standards are not met the Network has no way to influence clinical care.

The Neonatal Network provides reports to each Health Board and convenes regular meetings at which the Health Boards, represented by the Neonatal Units, compare practice in the light of the reports from the Network. The Network informally supports discussion between the clinicians about care and issues such as this outbreak.

We note that there are effective feedback loops within CVUHB that were used effectively to manage the outbreaks. In contrast, incomplete compliance with standards identified by the Neonatal Network has not appeared to influence the commissioning of neonatal services across South Wales

A root cause analysis of the outbreaks would implicate poor environment and staffing

The poor environment had been recognized in 2011 and escalated to the highest possible risk rating within CVUHB in 2012. We were repeatedly told about the frustration felt at all levels of the organization because of the delay in addressing that risk. We were told about factors beyond the control of CVUHB that contributed to the delay in remedying this risk but these external factors were outside our remit and scope.

The fundamental root cause of the outbreak is the failure to address the issues with poor environment and staffing. This means that some of the responsibility for the outbreak lies with organizations, other than CVUHB, that control the resources for specialist neonatal services in South Wales.

The South Wales health economy might like to consider whether the governance arrangements for neonatal care contributed to the delay in addressing the risk posed by the neonatal unit at UHW and whether different governance arrangements might lead to safer and higher quality services in future.

These issues are important because the opacity of governance arrangements with respect to neonatal services reported by staff at UHW may be relevant to other clinical services in South Wales.

Many facets of the outbreak impinge on external stakeholders. The findings and recommendations of this report have implications for stakeholders beyond CVUHB, including the neonatal units in Wales that all need to consider how to learn from this episode.

B) The Neonatal Unit and CVUHB

Historically, the Neonatal Unit appears not to have been given the recognition it deserves in the organization. We wonder which funding schemes received funding ahead of the NNU given the risk rating, previous reports such as Singleton Report and the number of outbreaks on the Unit.

We would like to pay tribute to the unceasing dedication of Jenny Calvert, Lead Neonatologist since 2009: others would have given up faced with such intransigent difficulties. Her energy and commitment have sustained the Unit through exceptional problems over many years. She has supported, and been supported, by a dedicated team.

The NNU worked under totally inappropriate and unacceptable conditions for many years and all staff deserve considerable praise and recognition.

Some interviewees hinted that the Neonatal team may have been the authors of their own misfortune to some extent. There was a perception that the Neonatal team continued to admit babies even when the Unit was closed and that such admissions were somehow unreasonable. If it existed such a judgment would be unfair. Admissions to the Neonatal Unit are by definition unpredictable and unavoidable. The only way to prevent admissions to the Neonatal Unit is to stop women giving birth in the hospital. The use of stabilization cots was a useful measure during the outbreak but would never be a sustainable way to manage admissions beyond the outbreak situation. The difficulties facing the neonatal unit were caused by inadequate space and staffing, exacerbated by the absence of a coherent system for managing neonatal services across South Wales. Some babies will come to harm if they are transferred within hours of birth but it is not immediately clear which babies these are. Neonatal stabilization is not the same as triage in the Emergency Department or stabilization of a child with meningococcal septicaemia in a District Hospital. During the interviews there were some suggestions that senior medical staff in the hospital did not understand the subtleties of neonatal stabilization. If such a lack of understanding informed policy during, or before, the outbreak it would have added to the difficulties faced by the Neonatal team.

C) Senior medical roles

When responding to questions about how IPC was led the CEO / MD referred to the IPC team. After a number of statements the review team concluded that leadership of

infection prevention and outbreaks through the various structures (IPC team and across Directorates) could be strengthened even further

Chapter 6 Recommendations

Eighteen recommendations were made in total.

The most important of these are shown in bold:

A. Recommendations specific to the neonatal unit

1. **Secure revenue for staffing**
    a. **If this is not done then the full benefits of capital investment for infection control and prevention (and other benefits) to date will not be realised**
2. Secure capital for the remaining beds in the current plan
3. Share experiences with the Neonatal Network and the broader health economy
    a. The health economy did not benefit properly from the learning arising from the Singleton ESBL *E.coli* deaths
    b. The neonatal network would benefit from closer working arrangements with the maternity network and the commissioners
    c. The 12 hours dedicated neonatal transport service should be extended to 24 hours. If another serious outbreak were to arise, additional transport services may need to be commissioned short term

B. Recommendations that are relevant across the Health Board

4. **Increase engagement of medical staff in IPC at all levels of the organization**
    a. **During clinical work all doctors need to follow IPC measures at all times including effective hand hygiene and bare below the elbow**.
5. **Improve methods for linking isolates and identifying outbreaks.**
    a. Implement electronic methods for linking isolates, for example IC Net.
    b. Implement a system that is not reliant on one person
    c. The IPC Team should have access to information about isolates so they can look it up for themselves
6. Document meetings, risk assessments and completed actions more effectively
7. Maintain multiple ways for staff to raise concerns
8. Review cleaning practices
    a. Training and competence assessment

   b. Methods
   c. Review of methods (is Actichlor being used effectively)
9. Consider quantitative assays of cleaning effectiveness
10. Maintain close monitoring of infections at all levels of the organization
11. Ensure robust ways for the Health Board to become aware of troublesome isolates
    a. Review arrangements with PHW about information flow from the labs to health care facilities in the Health Board
12. **Assure capacity and capability of IPC team**
    a. **The IPC team is too small, banding of staff is extremely low for a major teaching hospital and lacks a middle tier between DIPC and operational staff. It should be recognised that the DIPC role is not full-time and that the postholder has additional external responsibilities.**
13. Improve hand hygiene audits
14. Improve hand hygiene practice and personal ownership
15. Review whether the risk register is useful: the Neonatal Unit was rated as 25 out of 25 for 4 years. What is the point of the risk register if an intolerable risk can be carried for so long?
16. Develop ways for nurses to be reassessed in cleaning skills
17. Recognize tremendous work by cleaners, nurses, DIPC team and neonatal doctors, particularly Dr. J. Calvert
18. Highlight exceptional work done by Dr. E. Davies and recognize the value of that work by strengthening the IPC team

Appendix 1 Terms of Reference

TOR – external review NNU – v 6 (13 -05 - 16) FINAL

INDEPENDENT REVIEW OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S MANAGEMENT AND RESPONSE TO THE ACINETOBACTER BAUMANII OUTBREAKS IN AUGUST AND NOVEMBER 2015

Terms of Reference and Scope of the review

The Medical Director and Chief Nurse/Executive Nurse Director of Cardiff and Vale University Health Board have commissioned an external independent review of the management of the infection prevention and control outbreaks in the Neonatal Unit at the University Hospital of Wales during 2015. This will cover the period from the first *Acinetobacter baumanii* outbreak in August 2015 to the re-opening of the Neonatal Unit on 18.12.15, following a second outbreak of *Acinetobacter baumanii.*

Terms of reference

The review will specifically consider:

Were the August 2015 and November 2015 AB outbreaks effectively managed?

Taking all relevant factors in to account:

- Was closure of the NNU in August and in November 2015 reasonable? If so was it done in a timely manner?
- Was the decision to re-open the NNU on both occasions reasonable?

In determining this, the review should consider:

- Compliance with national guidance and standards (before, during and after);
- Workforce and environmental influencing factors;
- Governance and accountabilities; and
- the working relationship with the Neonatal Network.

Has the UHB demonstrated learning and put in place robust arrangements?
Are the proposed new NNU plans fit for purpose in mitigating future risks of IP&C outbreaks?

Scope of Investigation

This will cover the period from the first *Acinetobacter baumanii* outbreak in August 2015 to the re-opening of the Neonatal Unit on 18.12.15, following a second outbreak *of Acinetobacter baumanii.*

Investigation process and methodology

The review will involve a review of key documentation, interviews with key staff and on-site visits to the neonatal Unit. The reviewer will have access to all relevant documentation and evidence.

Publication and Information Sharing

The final report will be presented to the public session of the UHB Quality, Safety and Experience committee.

The report will also be shared with Welsh Government, Welsh Health Specialised Services Committee and with the Neonatal Network

Governance

The draft report will be shared with named individuals who have participated in the review. A controlled distribution method will be used to ensure that the draft report is seen only by those who need to comment on factual accuracy of the contents.

The report, as previously stated will be presented at the UHB Quality, Safety and Experience Committee and noted at the following Board session. Progress reports, as appropriate, will be monitored through the QSE Committee.

Timescale of the review

The review should be concluded within 4 weeks of commencement with a final report to Cardiff and Vale UHB, within 12 weeks of commencement.

Improvement Plan

Datix ref/ WG SI reference: IN16905/647202DEC15

Executive Directors responsible: Executive Nurse Director/ Medical Director

Date agreed: 9-06-17

Approved by: to be approved at Quality Safety and Experience Committee on 20-06-17

Monitoring arrangements: Quality Safety and Experience Committee

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
1	Secure revenue for staffing a. If this is not done then the full benefits of capital investment for infection control and prevention (and other benefits) to date will not be realised.	Children and Women Clinical Board to secure the necessary revenue to staff the Neonatal Unit (NNU) to required staffing standards.	Clinical Board Director /Director of operations/ Director of Nursing Children and Women	Review September 2017	A business case has been submitted to Welsh Government as part of the South Wales planning arrangements. There has been agreement for the additional funding for 6.6 WTE band 6 posts which will allow the conversion of 2 SCBU beds to 2 HDU beds. The NNU is now staffed in accordance with British

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					Association of Perinatal Medicine (BAPM) Standards.
2	Secure capital for the remaining beds in the current plan	The UHB will secure planning for completion of the Obstetric and Neonatal Unit project	Executive Director of Planning	December 2016	Final funding was confirmed in December 2016 to complete the entire project which included development of a 50 cot NNU at University Hospital Wales. Estimated completion of the NNU will be December 2018.
3	Share experiences with the Neonatal Network and the broader health economy a. The health economy did not benefit properly from the learning arising from the Singleton ESBL *E.coli* deaths. b. The Neonatal Network would benefit from closer working arrangements with the maternity network and the commissioners.	Independent review report to be presented to the UHB Quality Safety and Experience Committee Independent review report to be presented to the National Quality and Safety forum Report to be shared with the neonatal network and UHB to work with and support the Neonatal Network with any required action.	Executive Nurse Director Executive Nurse Director Executive Nurse Director	June 2017 By September 2017 June 2017	

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
	c. The 12 hours dedicated neonatal transport service should be extended to 24 hours. If another serious outbreak were to arise, additional transport services may need to be commissioned short term.	There should be a review of the current dedicated neonatal transport service to consider whether an extension of the service to 24 hours is required.	TBC (? Neonatal Network and partner organisations?)	By September 2017	There is a dedicated neonatal transport team for South wales known as CHANTS which has been commissioned for over 5 years. Currently the service is provided in a partnership arrangement by Aneurin Bevan, Abertawe Bro - Morgannwg, Cardiff and South East England for 12 hours per day/ 7days a week/365 days per year. Most transfers are carried out within these hours. Out of hours transfers, when necessary and appropriate, will be carried out by a Cardiff and Vale Consultant with a Neonatal Unit nurse who is caring for the child, by WAST transfer.
4	Increase engagement of medical staff in IPC at all levels of the organisation a. During clinical work all doctors need to follow IPC measures at all times including effective hand hygiene and bare below the elbow.	All medical staff in the NNU will be reminded of the need to follow IP&C measures at all times including effective hand hygiene and bare below the elbow.	Medical Director	Completed	All medical staff in the NNU now wear uniform and are bare below the elbows at all times. There is appropriate challenge in place now for those staff who are observed as not complying with acceptable standards of IP&C practice in the NNU.

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
		A job specification for an Anti-Microbial Resistant (AMR) stewardship post in each Clinical Board has been agreed and is currently being piloted in Specialist Services The Medical Director and Executive Nurse director are currently piloting a zero tolerance policy for Bare below elbow and hand washing in Specialist Services with a view to rolling this out across the organisation	Medical Director Medical Director/Executive Nurse director	Review September 2017 Review September 2017	On an organisational basis the Medical Director supports work on delivery of the Antimicrobial Delivery plan including regular Anti-microbial Walkrounds with the Director of IP&C. All medical staff at induction are reminded of the need for robust IP&C practice.
5	Improve methods for linking isolates and identifying outbreaks a. Implement electronic methods for linking isolates, for example IC Net. b. Implement a system that is not reliant on one person. c. The IPC Team should have access to information about isolates so they can look it up for themselves.	a) The UHB will implement ICNet b) Identify further resource within the team c) Implement ICNet as above	Director of IP&C	Review end July 2017	IP&C team are currently receiving training to use the system. When in place, it will help in terms of increasing the resilience in the system.

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
6	Document meetings, risk assessments and completed actions more effectively	The UHB will review strengthen it's current processes for the management of serious incidents to include guidance on the recording of meetings and the consideration of risk assessment throughout the process.	Assistant Director Patient Safety and Quality	September 2017	The Patient Safety and Quality department now records all Serious Incident meetings to allow for more accurate minutes. In addition audio files are stored as required.
7	Maintain multiple ways of staff to raise concerns	The UHB will continue to promote the ways in which staff can raise patient safety and quality concerns.	Executive Nurse Director	Review September 2017	There are a number of mechanisms in place for staff to raise concerns about care: Electronic incident reporting Freedom to Speak up process Safety Valve process –which gives staff direct access to the UHB Chair Safety Walkrounds Staff can also raise concerns directly with their line managers, other senior managers and with executive colleagues directly.
8	Review cleaning practices a. Training and competence assessment		Director of Capital and Estates	Completed by end September 2017	

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
	b. Methods c. Review of methods (is Actichlor being used effectively).	The UHB will review the processes in place for: Training and competence assessments for Hotel Services staff Methods of cleaning practice The effective use of Actichlor	Head of Facilities	Review end Sept 2017	There is a training package in place for all new staff and robust competency assessment, forms part of that. Refresher training is aimed primarily at staff when there is a concern, or to all staff when there is a change in practice All efforts are made to maintain the same cohort of staff on the NNU, all of whom have been specifically trained and competency assessed. Best practice is applied across the NNU, in that every specific area, is allocated a single mop and bucket. These are never transferred between areas within the NNU. Additional cleaning time is already allocated to the NNU following IP+C outbreaks prior to the Acinetobacter outbreaks. There is now daily HPV cleaning of equipment in the NNU.

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					Actichlor is now used as a cleaning agent across the UHB and this issue with regards to incorrect dilution was addressed at the time, with all staff being updated with Achtichlor tool box talks. These issues are all under constant review as part of work falling out of the Association of Healthcare Cleaning Professionals (AHCP) working group Cardiff and Vale UHB is represented on the All Wales HCSW group looking at standardised training for cleaning. High level results presented to IPC as part of Senior Nurse report
		Introduce joint audits so that Credit for Cleaning scores and environment audits results are more representative of environmental conditions.	Senior Nurse IPC/ Head of Facilities	Review end Sept 2017	
		Participate in the review of the All Wales Cleaning Standards	Senior Nurse IPC/ Head of Facilities	Review end Sept 2017	

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					Cardiff and Vale staff will influence the new standards to capture environmental issues within the new standards
9	Consider quantitative assays of cleaning effectiveness	The UHB will explore the options for introducing a robust system for evaluating the effectiveness of cleaning.	Director of Infection, Prevention and Control/Head of Facilities	Review September 2017	Review completed and decisions made
10	Maintain close monitoring of infections at all levels of the organisation	The UHB will continue with and improve upon it's current processes for the close monitoring of infections at all levels of the organisation The UHB will continue to strengthen it's approach to Root cause analysis of IP+C incidents.	Executive Nurse Director Director of IP+C/Assistant Director Patient Safety and Quality.	Review September 2017 Review September 2017	There are already robust arrangements in place for the close monitoring of infections at all levels of the organisation. This includes: A robust IP&C group with strong Clinical Board engagement An Anti-microbial group (sub group of the Medicine Management Group) IP&C rates are monitored at Professional performance reviews and at Clinical Board Executive Performance reviews Clinical Board monitoring is carried out through QSE arrangements There are regular IP&C reports to both the QSE Committee and to Board

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					Introduction of ICNet end June/July 2017 will improve monitoring by enabling the development of standardised reports.
11	Ensure robust ways for the Health Board to become aware of troublesome isolates a. Review arrangements with PHW about information flow from the labs to health care facilities in the Health Board.	The UHB will work with Public Health Wales to review current arrangements for information flow between the laboratories to health care facilities in the Health Board	Director of IP&C	September 2017	Work has already been undertaken with PHW on the definition of Multi-drug resistant organisms to be captured on the ICNet system. Reporting of these will be robust and consistent across Wales.
12	Assure capacity and capability of IPC team a. The IPC team is too small, banding of staff is extremely low for a major teaching hospital and lacks a middle tier between DIPC and operational staff. It should be recognised that the DIPC role is not full-time and that the post holder had additional external responsibilities.	The UHB will review the structure of the IP&C team to ensure that it is resourced to meet the size and complexity of the organisation including Primary Care and Community.	Executive Nurse Director	Review end September 2017.	Review completed and recommendations made.

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
13	Improve hand hygiene audits	The UHB will continue to monitor, report and address areas where poor hand hygiene is identified and take steps to ensure that all clinical teas are carrying out their hand hygiene audits. (see also actions for R4)	Executive Nurse Director	Continue to review on a monthly basis	Hand hygiene rates are reported monthly through the Health and care standards monitoring audit. These are monitored at both Clinical Board professional Performance reviews and Executive Performance reviews. There is high compliance win the NNU with hand hygiene scores consistently >95%. A high presence of IP&C support has been maintained in the NNU. Across the UHB, the IP&C team conduct as may audits as possible but specifically in areas where there is an outbreak. The UHB participated in Hand Hygiene day on 5th may 2017. An IP&C multi-professional interest group has been established with the support of the IP+C team. There are very active IP&C link practitioners in place who attend

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					3 study days a year and act as pro-active IP&C champions in their clinical areas.
14	Improve hand hygiene practice and personal ownership	As above (R13) Implement standardisation of signage at ward entrances	As above (R13) Executive Director of Nursing	As above (R13) Review September 2017.	As above (R13)
15	Review whether the risk register is useful: the Neonatal Unit was rated as 25 out of 25 for 4 years. What is the point of the risk register if an intolerable risk can be carried for so long?	Proposals for review and renewal of the Risk Management Process to be presented to the Board. Meet all Clinical Boards and Corporate areas and support them in review/amendment of their registers. Define our objectives and risk appetite at all levels (via the meetings/support described above).	Director of Corporate Governance Head of Corporate Governance Head of Corporate Governance	Complete May 2017 January 2018 January 2018	A Board development session on Risk Management and the Risk Register was held on April 27th 2017. Clinical Boards were in attendance First of these meetings is to take place on 08/06/17, with Capital Estates & Planning

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
		Produce more visual, less text based standardized reports that reflect all risks not only extreme ones. .	Head of Corporate Governance	September 2017	Testing a new approach with report for June 2017 QSE Committee
		Standardize agendas for key groups in Clinical Boards to ensure the risk register is included and analysed.	Head of Corporate Governance	June 2017	
		Have one system of capturing risk and providing reports.	Head of Corporate Governance	April 2018	E-module purchased for the risk register on Datix
		~~E~~ Review and revise the Risk Management Policy and Risk Assessment and Risk Register Procedure.	Head of Corporate Governance	November 2017	
16	Develop ways for nurses to be reassessed in cleaning skills	Explore options for the assessment of nurses in cleaning skills	Deputy Executive Nurse Director	Review end September 2017	
17	Recognise tremendous work by cleaners, nurse, DIPC team and neonatal doctors, particularly Dr J Calvert	This will be highlighted as part of the report to the QSE Committee in June 2017	Assistant Director Patient Safety and Quality	June 2017	The work by everyone in the team of the NNU was highlighted in the feedback session following the review and was extended to staff at the time.

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
					Thanks was extended to staff by the Executive Nurse Director throughout the management of the outbreak. She also visited the NNU to offer support and thanks to staff.
18	Highlight exceptional work done by Dr E Davies and recognise the value of that work by strengthening the IPC team	This will be highlighted as part of the report to the QSE Committee in June 2017	Assistant Director Patient Safety and Quality	June 2017	The work of Dr E Davies and the IP+C team was highlighted in the feedback session following the review and was extended to staff at the time.

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20 June 2017

Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@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: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: 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 our risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF requires strengthening.

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the CRAF Update Report and the high risks assigned to the Committee.
- **CONSIDER** whether the risk descriptors and controls identified are adequate to provide assurance to the Committee.

SITUATION

Each risk contained within the Corporate Risk and Assurance Framework is assigned to Board or a Lead Committee for oversight.

A report was presented to the May Board following the Board Development Day on Risk Management seeking agreement to review and renew the Risk Management Process. It is difficult to be entirely confident of our assurance and that provided to our stakeholders as the CRAF currently stands. Recent feedback from the Cardiff and Vale Community Health Council, and comment in the NNU independent review report illustrates this.

As part of the risk review, meetings will be held with Clinical Boards and Corporate areas to provide support in review/amendment of their registers so that we can strengthen the risk descriptor and controls narrative. Duration of risks will also be looked at as this is not always apparent from the CRAF.

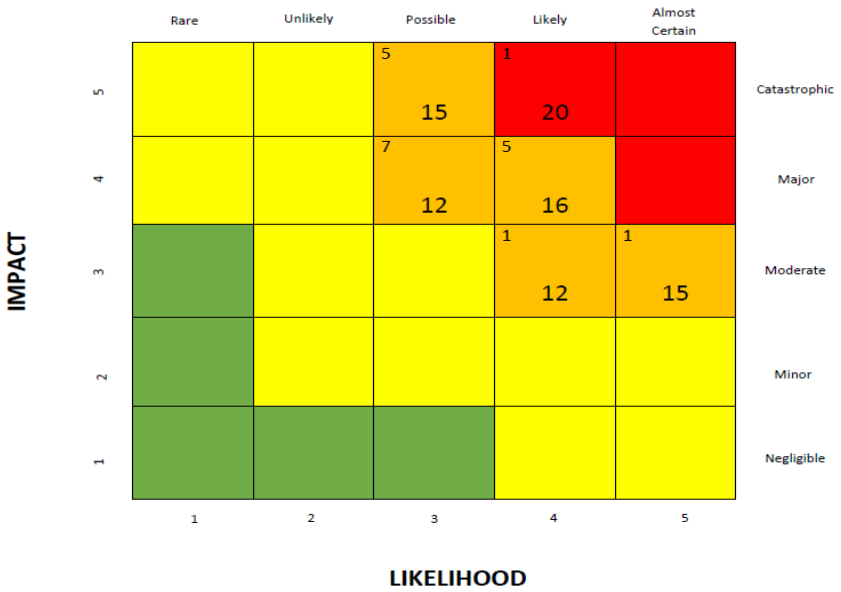
The Board agreed the production of more visual, less text based standardized reports that reflect all risks not only extreme ones. This report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 9 June 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

BACKGROUND

The April Quality, Safety and Experience Committee asked to consider the lower scoring risks assigned to it at this Committee meeting.

ASSESSMENT AND ASSURANCE

The below Heat Map provides the profile of all risks currently assigned to the Committee including the “high” scoring risks i.e. scoring 12 – 16.



The table at Appendix 1 details the high scoring risks.

Risk 7 Patient harm resulting from inadequate management of medication 2 additional risks have been added to the CRAF by PCIC Clinical Board relating to a risk of increased volatility of patients due to medication in HMP Cardiff not being dispensed in accordance with policy (scored at 15) and a risk of aspiration due to carers from the Community Resource Team being unable to thicken patients' fluids (scored at 12). It is not considered that these additions increase the overall CRAF score of 12.

Risk 10 Avoidable harm to patients caused by pressure damage (Zero Tolerance standard) increased from 12 to 16 in November 2015.

Risk 15 Identify clinical failures and patterns from information and data sources was reduced from 20 to 15 in February 2017.

Risk 18 Risks to neonates and high risk mothers as a result of providing on-going care to neonates in a clinically unsuitable environment was reduced from 25 to 15 in March 2017.

The latest version of the full CRAF can be found at:

http://www.cardiffandvaleuhn.wales.nhs.uk/risk-register

Appendix 1							
		High Risks assigned to the Quality, Safety and Experience Committee					
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
Objective 2 - 2014/15 - Commissioning - Services are commissioned to ensure access to services is equitable and based on needs							
1.	2.2	Failure to comply with National Policy Directives and NICE requirements including NPSA Alert 20 - Promoting Safe Use of Injectable Medicines	Delivery plans cross-cutting service priorities included within UHB Annual Plan 2017-18 (section 13). DoT is UHB Executive Lead with focus on Stroke, Diabetes, Dementia, End of Life and Cancer. Spec Services - Staff do not administer IV drugs if they have not been trained. - Audit of practice within Neuro by Pharmacy Nurse Advisor and required action taken. Cardiff and Vale Neuraxial Group in place. Plans under development for changeover, Task and Finish Group formed to ensure planning and risk assessment in place.	12		↔	QSE

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 4 - 2014/15 - Co- production and partnerships - Services are co-produced with staff, the public and partners to shape the best possible experience of care.							
2.	4.1.1	Failure to capture and listen to staff concerns relating to patient safety	Incident reporting (DATIX) Raising concerns/ Whistle blowing policy Safety Net Chair / CEO arrangements Food for Thought events Audience with Adam Regular Executive meetings with Trade Unions, Local Medical Committee, Local Medical Advisory Group, Healthcare Professionals Forum Task and Finish Group meeting to consider adequacy of current arrangements and best practice recommendations within the "Freedom to Speak Up" Report.	12		↔	QSE
3.	4.2	Involve and engage with Patients and Carers	Patient / User feedback surveys Putting Things Right processes Public / patient advice and support arrangements Carers framework Welsh Government Patient Feedback Framework Clinical Board Planning arrangements SRG advice on communication of patient experience and concerns reporting Communication and engagement plans developed	15		↔	QSE

			and implemented for the SOFW Programme and other major capital schemes Internal Practical Guide to Engagement developed in partnership with CHC Population Needs Assessment as above will involve extensive consultation and engagement. Similarly engagement on Wellbeing Assessment supporting Wellbeing of Future Generations Act requirements.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
Objective 5 - 2014-15 - Operational and Clinical Excellence - High quality services will be delivered sustainably through a committed and engaged workforce which meets targets within available resources.							
4.	5.1	Deliver safe, effective and efficient care	Policies, procedures and other control documents Professional codes and regulatory standards IMTP and operational plans Chief Operating Officer and Clinical Board operating arrangements Clinical Board authorisation, freedoms and delegations process Performance Review process Service redesign & improvement programmes Health and Care Standard 3.1: Safe and Clinically Effective Care A number of actions to improve recruitment and	12		↔	QSE

			reduce sickness absence (see 6.2 and 6.2.1) Medicine - 4th Endoscopy Suite established. Weekend initiative lists and outsourcing being completed. Clinical validation of referrals undertaken. C&W - Acute Child Health - provision of specialist services - Clinical Board in discussion with WHSSC. Defined pathways for paediatric oncology services to be developed - Peri Natal Mental Health nurse post in TRAC going to internal FTA until March 17 then for review. HOM Meeting with Families First in Sept 16 - funding likely to cease - ongoing meeting to align service to ACE report - interpretation of fetal and neonatal brain MRI is challenging: few undertaken and currently a selected few are referred for expert interpretation (Guys and St Thomas' Hospital, London). Currently, the scans selected for referral are arbitrary, and depends on consultant choice. This may result in missed, or errors in, diagnoses. SBAR sent to CB. - Significant issues have been identified with ACH directorate's ability to provide safe and sustainable Paediatric Surgery services at the CHFW - action plan developed. Discussions ongoing with Exec team.				

			Specialist services - Failure to follow up patients when abnormal written blood test results received by clinical areas: Process put in place to ensure derranged results are given to medical staff only.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
5.	5.1.5	Compliance with Professional Standards / Best practice	Clinical Board Improvement Plans Staff appraisal Peer Review Clinical Audit Guidance issued to all Clinical Boards advising of need to ensure arrangements in place to capture and respond to standards. Medicine - agreed and implemented Nursing Framework in partnership and in place from 1 Nov 2015. Surgery - meeting with C&W CB to work through the business case to move all surgery to the CHFW. Children are managed in non CHfW areas in the same way as the guidance recommends on non-specialist hospitals. - NICE guidance states that the medicines reconciliation process should be in place - business case to fund a 0.5 WTE pharmacist in SAU.	16		↔	QSE

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
6.	5.1.6	Compliance with Health and Care Standards (previously Health Standards for Wales)	Annual Review undertaken by each Clinical Board and lead Executive against each Health Standard, outcomes to inform IMTP priorities. QSE Committee agreed programme for 2015/17 in December 2015.	12		↔	QSE
7.	5.1.7	Patient harm resulting from inadequate management of medication	New comprehensive policies and procedures implemented in 2014 and kept under review Appropriately qualified prescribers Safeguards within Pharmacy Department to try to prevent dispensing errors All nurses are appropriately trained All nursing staff managed through appropriate protocols RCA investigations of all serious incidents Regular medication audits undertaken in Directorates and results reviewed at Nursing Board and Quality and Safety meetings All registered staff attend infusion pump workshops prior to using Infusion pump checklist completed hourly Devices checked annually or as appropriate Integrated health record is available for medics to review.	12		↔	QSE

			Surgery - Business case underway to look at remodelling emergency pathway for patients in line with NELA audit and CEPOD access - implementing the guidance around storage of fluids thickening agents at patient bedsides. Investigating use of tamper proof lids. PCIC – monitoring of prescribing incidents in HMP Cardiff, governance review complete and action plan being implemented. Thickening of fluids - each situation risk assessed and alternatives considered/put in place. SALT providing a session on swallowing and thickening of fluids to all CRT Carers, all swallowing assessments communicated in writing to other healthcare providers.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
8.	5.1.8	Meet patients nutritional and hydration needs	Implementation of AWMF recipes used for all menus Dietician advice Protected mealtimes Fundamentals of Care Appropriate staff numbers at mealtimes to assist with feeding / Clinical Workstation identifies if	15		↔	QSE

			patient needs assistance with eating Health and Care Standard 2.5 - Nutrition and Hydration MDT mealtime audits Training programme for Ward based caterers Weighing scales audit.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
9.	5.1.9	Failure to protect patients from injury resulting from falling/falls	Prevention of Falls In Vulnerable Adults Procedure Falls risk assessment tool Root Cause Analysis Fracture Tool in Use Intentional rounding Specialist equipment Staff training Older Peoples Framework Some falls (injurious injury) reported as Serious Incident to WG. Full Root Cause Analysis investigation where incident classed as a Serious Incident. Injurious Injury Risk Assessment Tool redeveloped by Falls Prevention Manager Medicine - capital bathroom refurbishment project for 2016/17. Further Sensor mat trial undertaken as an alternative to the sensor mats currently available to all ward inpatient areas if needed.	15		↔	QSE

			Slipper sock trial being introduced to prevent patients at risk of falls being undertaken. Specialist Services - CB Senior Nurse lead in post.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
10.	5.1.12	Avoidable harm to patients caused by pressure damage (Zero Tolerance standard)	Assessments using Waterlow tool and SKIN bundle. Appropriate mattresses. Manual handling guidance. Where damage is found this is reported in accordance with incident reporting procedures Monthly reporting of number of pressure ulcers Pressure Ulcer Prevention Forum meets to discuss learning from RCAs eDatix which allows for more timely response to reports and more accurate data. PCIC - Skin Bundle developed for use in Community settings which is reviewed and audited through pofessional supervison and through audit of the Paris IHR. Wound Healing team delays for assessment - Referrals for category 3 and 4 are prioritised - LIPS project underway	16	12 (increased 09.11.15)	↔	QSE

			Medicine - Falls Sensor Equipment evaluation completed and due to report in June 2016.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
11.	5.1.17	Provision of therapeutic care to Children with Special Needs in Special Schools and Community provision	C&W Community Child Health: update training for nurses to cascade to school staff re: suction completed. Nursing requirements for Ysgol y Deri being scoped as per action plan.	12		↔	QSE
12.	5.2	Failure to protection patients and staff against health care acquired / cross infections	IPC & decontamination policies and procedures Healthcare Acquired Infections (HCAI) Framework (approved Aug 14) WG Cleaning Standards Infection Control Group Mandatory Training Health and Care Standard 2.4 - Infection Prevention and Control (IPC) and Decontamination IP&C Committee Monthly performance reports Discussed at Weekly Big room if appropriate Chief Executive and Executive Nurse Director when MRSA occurs Daily IP&C Reports	16		↔	QSE

			Level of Decontamination and plan PVC Packs being implemented CVC Bundle embedded within Critical Care Rolling HPV cleaning commenced at UHL and UHW in conjunction with Operational Services and IP&C. Full implementation of the Sharps Management Policy following issue of H&S Improvement Notice Medicine - HCAIs and learning from RCAs are discussed at Board Nursing Forum. Specialist services - CB line service implemented 4th July 2016, trial in Haem completed now rolling out to cardiac then roll out across CB. CCOT undertaking training and support in line management. Fidaxomycin protocol introduced. Critical Care and Haem now routinely change patients from PPI to H2 antagonist. PPE training provided. Short RCA tool being developed for trial in SpS. C&W - 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. Phase 1 has been finished and is awaiting handover to				

			the directorate following completion of the link corridor. The SCBU has been upgraded and awaiting handover to the directorate following additional minor remedial work.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
13.	5.5	Recognise and act upon safeguarding concerns in a timely manner	Policies and procedures Strong links developed with partner agencies Health and Care Standards 2.7 - Safeguarding children and vulnerable adults at Risk C&W - preparation of medical records for legal purposes prioritised where possible. - additional hours agreed to support administrative capacity and get records redacted within manadatory timescales.	15		↔	QSE
14.	5.6	Recognise, address and learn from patient concerns, clinical failures and serious incidents (see also 4.2 and 5.7)	"Putting things Right" Complaints / concerns policies and procedures Concerns Team supported by DATIX system Patient feedback mechanisms Serious Incident Reviews Learning from concerns raised Health and Care Standards 6.3 - Listening and Learning from Feedback Concerns Claims and Compliments Assurance	16		↔	QSE

19

			Group established Implementation of the findings of the Evans review Patient Safety Team Weekly Executive Concerns meeting to review all serious incidents and concerns Serious Incident Report presented to Board.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
15.	5.6.1	Identify clinical failures and patterns from information and data sources	Assistant Nurse Director for Patient Safety update - E-Datix fully implemented with immediate escalation to Clinical Board Nurses and Patient Safety Team (for most serious incidents) - Weekly Concerns meeting (with Executive Nurse Director, Medical Director and Chief Operating Officer to monitor all Serious Incidents, complaints and emerging trends and themes) - Well embedded Serious Incident processes and closure processes - Well embedded Quality, Safety and Experience infrastructure throughout the organisation (subject to internal audit) - Quality, Safety and Experience dashboard - Weekly Patient Safety/Corporate Nursing Updates to Management Executive - Monthly Executive Performance reviews - Monthly Nursing Professional Performance reviews	15	20 (reduced 09/02/17)	↔	QSE

			- Integrated Quality, Safety and Experience Board report - Annual schedule of Internal Observation of Care visits and associated reporting and monitoring - Healthcare Inspectorate Wales (HIW) and Community Health Council external inspections and visits - Mortality/morbidity reviews - Freedom to speak up process/whistleblowing policy - External reviews of services e.g. commissioned independent reviews, Royal College Reviews. - Coroner and Ombudsman reports - Peer reviews of cancer services Specialist Services - Excess patient deaths associated with the Standardised Mortality Ratio in Critical Care being 3 standard deviations above the national mean. Potential delays in decision making/treatment prior to admission: Peer review undertaken, 46 sets notes underwent NCEPOD style review.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
16.	5.7	Provide patients with a good experience (see also 4.2 and 5.6)	Policies, procedures and protocols Professional Codes of Conduct Fundamentals of Care Health and Care Standard 4.1 - Dignified Care	12		↔	QSE

			BIG priorities developed to better serve our patients in hospital and in the community. Strategic Planning - Balanced set of metrics being developed to monitor the impact of the BIG priorities, including patient experience. Medicine - Single sex accommodation: Work with estates to design new facilities for Emergency Medicine and agree UHB signage for all clinical areas for hygiene facilities etc.				

Objective 6 - 2014/15 - Resources - All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care.

b) Estates and facilities

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
17.	6.4.8	Failure to comply with Welsh Government Cleaning Standards with potential to impact on patient care and experience	Baseline assessment against revised standards completed and gap between current and required staffing identified. Cleaning reduced in non-clinical areas to maximize cleaning in clinical areas. Cleaning scores available for all clinical areas and high risk areas are reviewed weekly by the Head of Operational Services. Scores also shared with Clinical Board Nurses.	16		↔	QSE

			Cleaning scores included in performance report on the ward dashboard. Options paper prepared for ME consideration to meet revised Standards. Cleaning Report presented to UHB Board. Two rapid response teams created to support housekeeping team and to carry out deep cleans. Cleaning Strategy approved September 2015.				
No	**Risk Ref**	**Risk Descriptor**	**Controls**	**Score**	**Previous Score (if applicable)**	**Change**	**Lead Committee**
18.	6.4.12	Risks to neonates and high risk mothers as a result of providing on-going care to neonates in a clinically unsuitable environment	C&W Contingency for escalation agreed with executive team, Neonatal Network and both Directorates. 1. Maternity Escalation Protocols in place. 2. Joint interface meetings with Maternity & Neonatal services set up to maintain close liaison. 4. database to record maternal & in-utero transfers in place. 5. Review of All Wales NNU Cot provision is 0n-going. Strategic Planning - The capital business case (BJC2) for neonatal and obstetrics facilities have been approved. C&W - The Unit has been relocated to interim facility on	15	25 (reduced 02/03/17)	↔	QSE

			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. Phase 1 has been finished and is awaiting handover to the directorate following completion of the link corridor. The SCBU has been upgraded and awaiting handover to the directorate following additional minor remedial work.				

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Objective 8 - 2014-15 - Governance - To have effective governance arrangements ensuring the UHB is compliant with relevant legal and regulatory frameworks and its processes for decision making are robust.

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
19.	8.1.7	Failure to comply with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) due to identification errors	Patient Identification Policy Training and induction for all staff. Staff should undertake positive ID checks of patients. All incidents reported to HIW and Welsh Government. Root Cause Analysis investigation undertaken. Rolling patient ID compliance audits.	12		↔	QSE
		Total		**19**		**0**	

CANCER PEER REVIEW - BRAIN
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 20 June 2017

Executive Lead : Medical Director
Author : Lead Manager Cancer Services, Telephone 02920 746682
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not applicable
Quality, Safety, Patient Experience impact : The work outlined within this paper reflects the significant activity taking place to improve patient experience for patients with cancer leading to improved performance, quality and care outcomes.
Health and Care Standard Number 3.1Safe and Clinically Effective Care
CRAF Reference Number 5.1 Deliver safe, effective and effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The level of scrutiny applied internally and externally to the Healthcare Inspectorate Wales Cancer Peer Review assessment and Peer Review reporting process. Any concerns identified are addressed via an action plan and are regularly reported within the required process; at the Clinical Board performance reviews and by WG and the South Wales Cancer Network

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report and
- **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

SITUATION

The purpose of this report is to present the Committee with an analysis of the findings and actions required following the Healthcare Inspectorate Wales Cancer Peer Review processes reported to Welsh Government and the South Wales Cancer Network following the review or re-review of each of the cancer tumour sites within the Health Board. This review is the first one being undertaken of the rare cancer tumour sites and represents service provision

across South Wales with specific components provided by Cardiff and Vale UHB. Of note in the
concerns the MDT and service is a South and Mid Wales Regional service which currently has no formalised organisational ownership which leads to confusion surrounding issues of governance. The recommendations include those specific for Cardiff and Vale UHB as well as across the whole of the MDT and South Wales services in general.

BACKGROUND

This review was performed in November 2016 and was designed to review the neurological services available to the people of North and South Wales simultaneously. In doing so the clinical teams reviewed each other hence providing the required expertise to inform the review, whilst addressing the access required to neurological cancer services for the vast majority of the population. The Review process was facilitated by the Wales Cancer Network with input invited from Health Boards in South Wales, Primary Care, Palliative care and the Commissioners (WHSSC).

ASSESSMENT AND ASSURANCE: Summary of Peer Review Report for Brain Cancers

Good Practice/Significant Achievements:

- Providing a very good service with comparable results to other centres, with very limited resources.
- Well structured links and relationships between key stakeholders at a clinical level.
- Good engagement with Executive team and ongoing dialogue with WHSSC to move the service forward.
- Maintaining a good service despite the tertiary centre being part of a large hospital dealing with and negotiating with, other competing health board services and departments.
- Stereotactic surgery repatriated from Sheffield and now available in the South Wales region.
- Provision for in-house molecular genetics testing There were no immediate concerns reported.

Serious Concerns noted were:

- Oncology provision at the South West Wales Cancer Centre. - Single handed 0.6 WTE oncologist at the South West Wales Cancer Centre with no cover for absence. Patients in the SW region (ABMU & Hywel Dda) are disadvantaged when the consultant is absent at the discussion or more importantly absent to provide treatment.
- Insufficient CNS provision at the South West Wales Cancer Centre and Velindre NHS Trust. 0.6 WTE CNS at the South West Wales Cancer

Centre, ABMU and Hywel Dda and 0.5 WTE at Velindre Cancer Centre both of whom do not attend the MDT meeting. Unable to support the service and the level of risk increases with their absence at the MDT.

- Lack of Post operative MRI Scans – standard practice is for post operative MRI to establish adequacy of surgery, the need for any more treatment and prognostic assessment. Currently patients may be receiving inadequate surgery or post surgical treatment plans due to the failure to assess surgical effectiveness
- Neuro radiology - Single handed neuroradiology is provided at C&V with only informal cross cover between the SE and SW. However the service in the SW is fragile and this cover cannot be adequately assured. In addition radiological confirmation of diagnosis and imaging interpretation is essential to treatment planning. The absence of a fully supported (with time in job plans for preparation) sustained radiological assessment/opinion needs to be addressed and leads to delayed treatment.
- Neuro pathology - Single handed pathologist
- Neuro psychology - There is a 0.5 WTE neuropsychologist shared across all neurosciences at the UHW site with no MDT representation (Welsh Cancer Standard) or specialist clinic cover

Concerns noted were:

- Accountability for the Brain CNS Service - The MDT and service is a South and Mid Wales Regional service currently has no formalised organisational ownership which leads to confusion surrounding issues of governance
- AHP support and MDT attendance -There is no attendance at the MDT and access is via generic services. AHP input is essential to optimising the impact of treatment and maintenance of living.
- Velindre Cancer Centre CNS does not attend Brain CNS MDT Meeting
- Lack of sub – specialisation amongst neuro-surgeons
- Lack of communication between the MDT and GPs, Palliative care
- Lack of business meetings with the referring health boards.
- Local Patient Experience surveys - need to look at carrying out a local patient experience survey.

Where appropriate, overarching actions have been identified and an action plan has been formulated and implemented to address the concerns outlined above. In addition to the concerns of the review team the MDT have recognized further concerns and actions that need to be highlighted within their action plan. Further detail is provided in the full action plan appendix 1.

CARDIFF and VALE UHB

Brain - Cancer Peer Review Action Plan 2016

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
SERIOUS CONCERNS						
1	**Oncology provision at the South West Wales Cancer Centre** Single handed 0.6 WTE oncologist at the South West Wales Cancer Centre with no cover for absence. Patients in the SW region (ABMU & Hywel Dda) are disadvantaged when the consultant is absent at the discussion or more importantly absent to provide treatment.	Appointment of a second consultant neuro-oncologist at SWWCC (ABMU/Hywel Dda) (increase provision from current 0.6 WTE)	High	(Cancer Lead ABMU)	July 2017	Letter to Cancer Lead ABMU April 2017 to propose meeting
2	**Insufficient CNS provision at the South West Wales Cancer Centre and Velindre NHS Trust** • 0.6 WTE CNS at the South West Wales Cancer Centre, ABMU and Hywel Dda • 0.5 WTE at VCC Both of whom do not attend the MDT meeting. Unable to support the service and the level of risk increases with their absence at the MDT.	ABMU and VCC to develop a business case to increase their CNS WTE to meet needs across South and West Wales.	High	(Cancer Lead ABMU) Consultant Oncologist (VCC)	July 2017	Letter to Cancer Lead ABMU April 2017 to propose meeting Letter to Consultant Oncologist VCC April 2017 ABMU CNS proposal submitted to WHSCC 2017-18 ICP (not

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Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
						prioritised for inclusion)
3	**Lack of Post-operative MRI Scans** Standard practice is for post-operative MRI to establish adequacy of surgery, the need for any more treatment and prognostic assessment. Currently patients may be receiving inadequate surgery or post-surgical treatment plans due to the failure to assess surgical effectiveness	Increase MRI capacity at UHW site to allow routine post-operative MRI (200/yr)	High	Head of Operations and Delivery(HOD) CD&T Clinical Board	July 2017	Meeting held with HODs for both CD&T and Specialist Services Division. May 2017 WHSSC commissioning responsibility Revenue costs submitted to WHSCC 2017-18, however ICP not approved by Joint Committee
4	**Neuro radiology MDT cover** Single handed neuroradiology is provided at C&V with only informal cross cover between the SE and SW. However the service in the SW is fragile and this cover cannot be adequately assured.	Allocation of dedicated sessional commitment to the NOMDT meeting and required preparation time by the host health board (CAV). Option: Formalise cross cover SLA with ABMU	High (MDT meetings cannot proceed without radiology cover)	Head of Operations and Delivery(HOD) CD&T Clinical Board Head of	July 2017	Meeting held with HODs for both CD&T and Specialist Services Division. May 2017

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Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	Radiological confirmation of diagnosis and imaging interpretation is essential to treatment planning. The absence of a fully supported (with time in job plans for preparation) sustained radiological assessment/opinion needs to be addressed and leads to delayed treatment.			Operations and Delivery(HOD) CD&T Clinical Board		WHSSC commissioning responsibility The following has been submitted to WHSCC 2017-18 ICP (not prioritised for inclusion): A) 1 weekly session of ABM Radiology Consultant time to prepare for the MDT meeting – 13k B) 1 weekly session of C&V Radiology Consultant to prepare for the MDT meeting - £13k This does not include provision for ABMU radiologist attending the weekly MDT (1

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Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
						session)
5	**Neuro pathology service** Single handed pathologist	Appointment of second neuropathologist and interim external expert service provision to provide cover.	High	Head of Operations and Delivery(HOD) CD&T Clinical Board	July 2017	Meeting held with HOD for CD&T Clinical Board. May 2017 Post advertised and interviews in progress. Offer made. Awaiting start date. Formal absence cover arrangements from Bristol in place
6	**Neuropsychology** There is a 0.5 WTE neuropsychologist shared across all neurosciences at the UHW site with no MDT representation (Welsh Cancer Standard) or specialist clinic cover	Appointment of neuro-oncology dedicated Neuropsychologist (1.0 FTE Band 8b) and a 1.0 FTE Band 4 Assistant Psychologist to ensure all aspects of service provision and MDT presence at UHW	High	Neuropsychology Clinical Director UHW	2017-18	Letter to Neuropsychology CD UHW. April 2017 WHSSC commissioning responsibility Submitted to WHSCC 2017-18 ICP (not prioritised

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
						for inclusion)
CONCERNS						
1	Accountability for the Brain CNS Service The MDT and service is a South and Mid Wales Regional service currently has no formalised organisational ownership which leads to confusion surrounding issues of governance	The governance risk of the service not being owned by a single organisation on behalf of its partners needs to be discussed and a way forward agreed by all HBs. Clarity regarding accountability needs to be agreed.	High	Brain MDT Lead	2017-18	In discussion with CAV cancer lead for discussion at Cancer Delivery group (network). Letter to Cancer Lead ABMU April 2017 to propose meeting (cc Cancer Network Director & Cancer Lead Clinician Cardiff and Vale UHB)
2	AHP support and MDT attendance There is no attendance at the MDT and access is via generic services. AHP input is essential to optimising the impact of treatment and maintenance of living.	Appointment of neuro-oncology dedicated: • 1.0 WTE band 7 and 0.5 WTE band 6 Speech and Language Therapist • 1.0 WTE band 7 and 1.0 WTE band 4 Occupational Therapist	High	Head of Operations and Delivery(HOD) CD&T Clinical Board with support of Occupational Therapy CD UHW and Speech and Language Therapy CD UHW	2017-18	Meeting with Head of Operations and Delivery(HOD) CD&T Clinical Board May 2017 WHSSC commissioning responsibility

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
						The following has been submitted to WHSCC 2017-18 ICP (not prioritised for inclusion): A) 1.0 WTE band 7 and 0.5 WTE band 6 Speech and Language Therapist dedicated to neuro-oncology B) 1.0 WTE band 7 and 1.0 WTE band 4 Occupational Therapist dedicated to neuro-oncology
3	Lack of sub – specialisation amongst neuro-surgeons.	Failure to sub specialise dilutes the level of expertise but more importantly means that time is not preserved for specialist interest such as research, audit, ability to get to specialist oncology conferences	Intermediate	Brain MDT Lead	2018	In WHSCC 5-year plan – should be a priority for 2018-19 plan Potential to appoint new oncological surgeon in 2017-18. Jess Castle to

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
		etc. this needs to be reviewed.				discuss with Claire Nelson in WHSSC.
4	Communication with GPs and supporting teams. Lack of communication between the MDT and GPs, Palliative care etc, and lack of business meetings with the referring health boards.	Ways of improving timely communication between the members of the MDT, GPs and Palliative care etc need to be identified and addressed. Regular business meetings need to be set up.	Intermediate	Primary care AMD for CAV		Letter to Clinical Board Director Primary Care and Macmillan cancer lead for primary care at CAV April 2017
5	Local Patient Experience surveys Need to look at carrying out a local patient experience survey.	Need to carry out a local patient experience survey using patient feedback to understand the patient perspective and the challenges they face. Such feedback will identify any actions required as a result.	Intermediate	Neurosurgical CNSs supported by UHB Cancer Lead Nurse	December 2017	
6	Lack of attendance of Velindre Cancer Centre(VCC) CNS at the MDT meeting	CNS should attend MDT meeting where possible	Intermediate	VCC Cancer lead with support from VCC Lead Nurse	July 2017	Brain MDT lead to discuss with VCC Cancer lead

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MORTALITY DATA AND MORTALITY REVIEW
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Medical Director
Author : Quality and Safety Improvement Manager. Email joy.whitlock@wales.nhs.uk Phone 029207 45099
Caring for People, Keeping People Well : This report underpins the Health Board's "Delivering Outcomes that Matter to People" and "Being a great place to work and learn" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: This provides an opportunity for organisational learning and improvement.
Health and Care Standard Number 3.1 – safe and clinically effective care
CRAF Reference Number 5.1 Safe, effective and efficient care.
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Monitoring of Mortality measures reviews
- Mortality Data

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the ongoing proposed plans for mortality reviews.
- **NOTE** the planned introduction of the Medical Examiner Role.
- **NOTE** the discussion about weekend mortality.

SITUATION

The Mortality Data and Mortality Review paper seeks to update the Quality, Safety and Patient Experience Committee about current issues and key data relating to the monitoring of Mortality, one of the important ways in which the Committee is assured about patient safety and quality of care. The current issues and areas under development are discussed below.

Reforms to death certification and the introduction of the Medical Examiner (ME) role are proposed for England and Wales[1]. The current focus of the mortality and harm collaborative across NHS Wales is to become 'Medical Examiner Ready'. Previous papers to this committee have described the Medical Examiner role which will be established some time after April 2018. This will effectively extend the Stage 1 Mortality Review system to cover all patient deaths, including primary and community care services. There is a joint committee to develop the all-Wales approach which is working jointly with

the committee in England. A single medical examiner fee will be introduced for deaths scrutinised by a medical examiner irrespective of whether the body of the deceased is cremated or buried.

Whilst this is an initiative spanning England and Wales, it is expected that Health Boards will be responsible for appointing MEs and collecting fees. Logistical challenges will need to be addressed – particularly where there are no pre-existing bereavement offices and in rural areas. Future updates on national and local progress will be provided to this committee.

Following an iterative development process across NHS Wales, two stage mortality reviews have been taking place for people who die in hospital in Cardiff and Vale University Health Board (UHB) since 2013. These provide assurance of appropriate decision making and that good quality treatment and care is provided. Ultimately this is to ensure there is a check in place to detect unwarranted harm and preventable deaths of which it is estimated 3-5% of acute hospital deaths are potentially preventable[2].

The major implication of the Mazars Review of the Southern Health NHS Foundation Trust[3] is the need for all Health Boards (HBs) to immediately establish a routine
system for the investigation and reporting of all deaths of patients receiving Mental Health and Learning Disabilities services, with the routine involvement of families and carers in investigations. A pilot study is being developed for testing and implementation in all HBs.

Concerns have been raised in the UK about the possible differences in weekend care leading to increased (possibly unnecessary) deaths. This paper includes the latest evidence and discussion of those concerns. This item was specifically at the request of the Quality, Safety and Experience Committee.

BACKGROUND

The death certification system had been unchanged for fifty years. The Shipman Inquiry[4] and Francis Report[5] accelerated the need for reforms. Various approaches to understanding mortality and harm have been in existence for several years.

An independent review was carried out by Professor Stephen Palmer on the use of the risk adjusted mortality index (RAMI) and standardised hospital mortality index (SHMI) data for Welsh hospitals in a report to the Welsh Government Minister for Health and Social Services[6]. He concluded that they may be misleading and could divert attention away from more meaningful measures. Professor Palmer suggested that a crude count of deaths is a useful measure which should be supported with systematic reviews of patient care by multi-professional teams. (Stephen Palmer Mansel Talbot Professor of Epidemiology and Public Health Cardiff University 5 June 2014). This is the approach adopted by NHS Wales and forms an important part of the data/information submitted regularly to the Quality Safety and Experience Committee.

There is an improvement programme on *'Sharing the Learning from Untoward Incidents'* in Mental Health, Learning Disability and related NHS services. The programme includes people of all ages, with analysis focused upon suicide, self-harm, homicides and other serious untoward incidents. The National Steering Group for the improvement programme reviewed the findings and implications of the NHS England commissioned report into the deaths of people with LD and MH problems at Southern Health NHS Foundation Trust[1] and the recent Care Quality Commission review of mortality investigation processes. The steering group recommends that all HBs now establish systems and capacity for routinely undertaking Mortality Reviews for all specialist mental health and learning disability services.

A separate national steering group is established to develop standardised mortality review tools and to prepare Wales for the introduction of Medical Examiners and is closely linked with the mental health and learning disabilities work.

Of the 180 deaths that occur in hospital in the UHB each month between 70% and 80% have a mortality review recorded. This provides an initial summary of any concerns which have been described in previous papers at Quality, Safety and Experience.

Improvement activities to address these issues continue, such as the work on the rapid response to acute illness, the prevention, early detection and timely treatment of sepsis.

ASSESSMENT AND ASSURANCE

Routine Mortality Data.

The UHB regularly updates on a three monthly basis for publication its public website details of mortality statistics. The latest updated information on hospital deaths is shown in appendix one. There is much more detailed information, including community mortality statistics available on: http://www.cardiffandvaleuhb.wales.nhs.uk/our-safety-systems

These data are regularly reviewed prior to publication by the Medical Director.

Information Management

Since September 2014 stage one reviews have been recorded along with the death certification details in the Electronic Mortality Audit Tool (EMAT) which is linked to the patient management system. This system helps to identify which patients should have a more in-depth stage 2 review and of those what the additional issues and learning is.

The Health Board is able to monitor the % of patients who have a mortality review (figure 1) recorded and to capture some patient safety themes for improvement (figure 2).

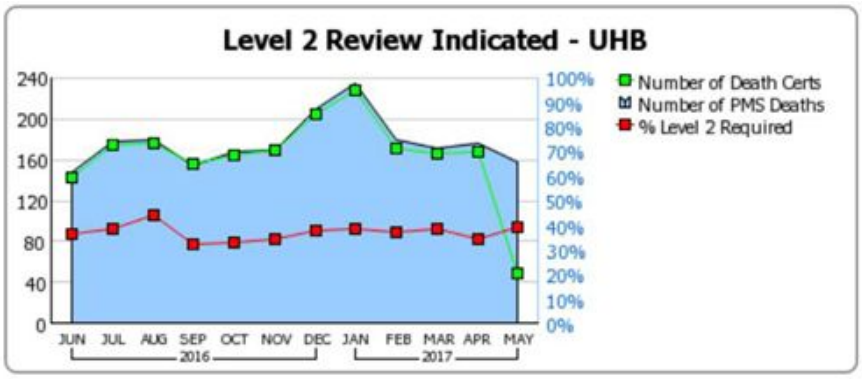


Figure 1 - % patients requiring a level 2 review

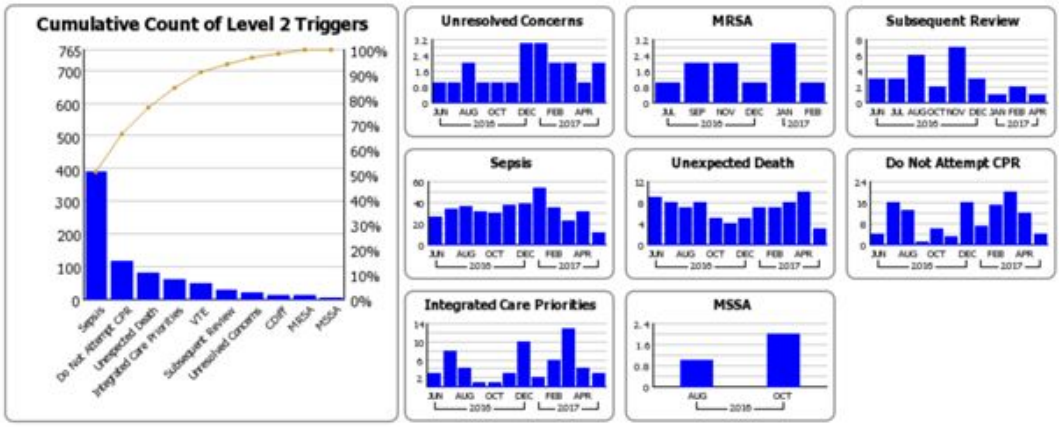


Figure 2 – safety themes

EMAT has been developed to provide a graphical and visual view of deaths (figure 3 below) and to alert when the number of deaths are higher than expected so that a prompt enquiry can ensue.

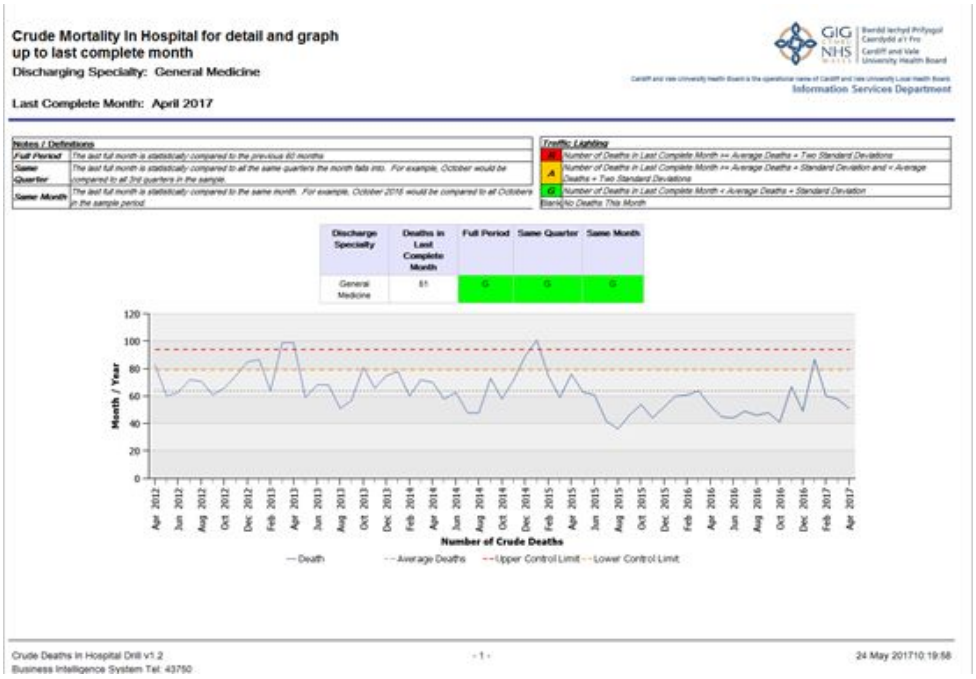


Figure 3 - EMAT view of deaths.

NHS Wales is considering how to electronically record patients with learning disabilities. From 1st December 2016 an icon on PMS flags patients with learning disabilities. This will need to be identified in EMAT to enable automatic escalation to level 2 reviews.

The PARIS IT system has been developed to record stage one mortality reviews for mental health patients. Further amendments will be necessary pending a pilot of mortality reviews specifically for mental health and learning disabilities.

We will be commencing electronic notification of all patient deaths to Consultants and the Directorates and Clinical Boards as a consequence of data available on EMAT.

Quality of mortality reviews

There is variation in the quality of mortality reviews being undertaken within the UHB and across NHS Wales. The current process for level 1 reviews does not necessarily provide the opportunity to scrutinize the quality of care. Too often, particularly in Medicine Clinical Board, stage two reviews are falsely triggered. Improvements are being made to address these issues.

To improve consistency of the quality of mortality reviews a standardized approach is being established across Wales. One option is to adopt the National Mortality Care Record Review[7]. This mainly focuses on deaths in hospitals. It is a structured judgment review method which is currently being considered to replace the current level one review tool. It is a validated,

structured qualitative approach and that it is firmly linked to robust governance[8] and can support the assessment of quality of care even when the death is predicted.

Currently there are a variety of approaches to completing more in-depth level two reviews. A priority for the national steering group is to design a national tool for second stage reviews. A workshop will be held in July where representatives from each NHS Wales organisation will review potential stage 2 tools including those published along with tools being used in Health Boards to inform the development of a national tool. The Maternity Network is currently developing a tool to include causation and system of errors.

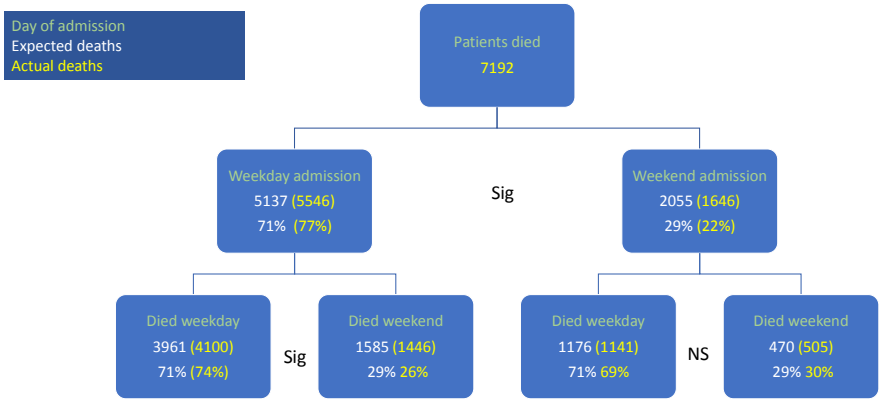
Any tool developed would need to be future proofed for the commencement of the Medical Examiner service.

Special Topic - Mortality risk associated with weekend and bank holiday admissions

There has been a medical and public focus on the possible increased risk of mortality associated with weekend admissions. A review of data on this subject was specifically requested by the Quality, Safety and Experience Committee.

Recent research published in the Lancet[9] suggests that it is patient-level differences at admission rather than reduced hospital staffing or services at the weekend that produce this effect.

Intake deaths weekday variation three year period 2013-2016



The chart demonstrates the variation in intake of patients admitted who subsequently died across the Health Board.

There is a significant difference between the number of patients admitted on the weekdays compared to the weekends who subsequently die – suggesting along with the national data that the patient populations are clinically different depending on whether the emergency admission was on a weekday or weekend.

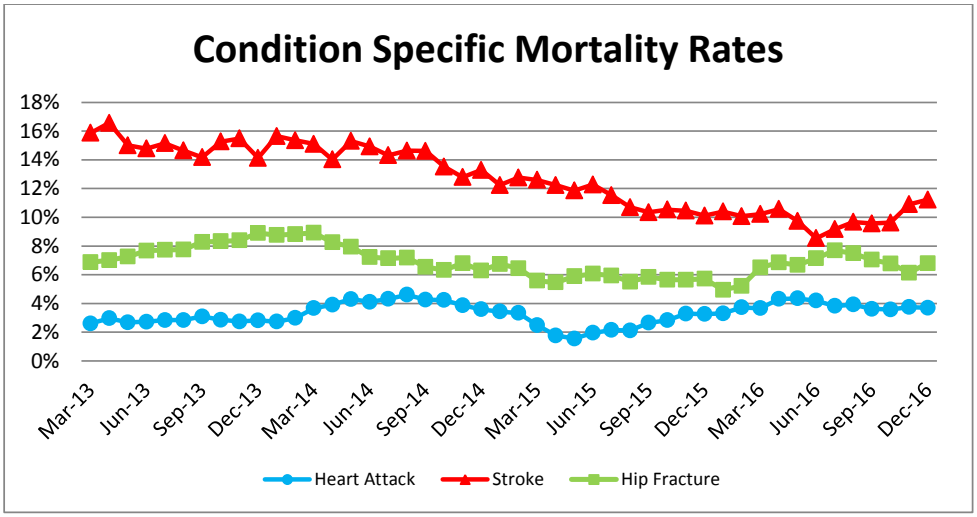
Statistically far more patients who subsequently die are admitted on weekdays.

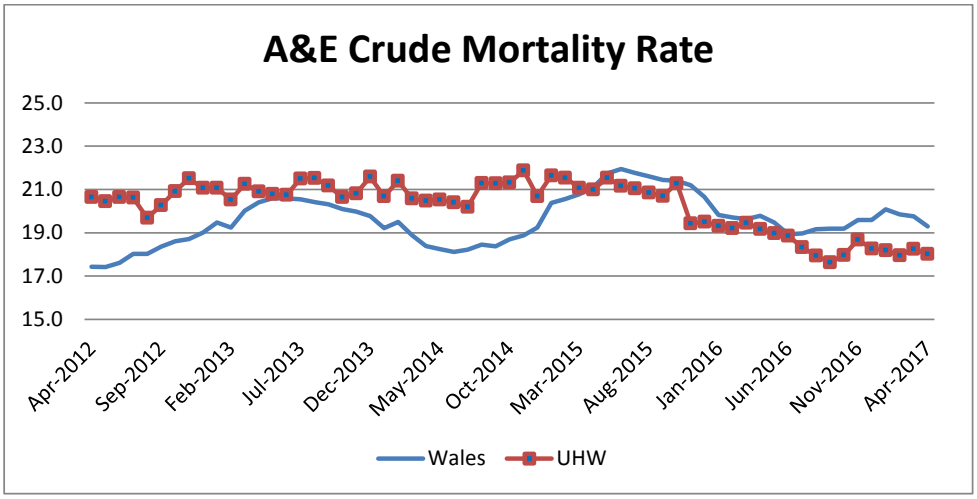
The significance persists in the cohort of patients who get admitted on a weekday and then either die on the weekday or weekend. 71% would be “expected” to die on a weekday but the data suggests 74% actually die. Weekend deaths are 3% fewer than expected in the cohort of patients who had been admitted on a weekday. Again these are both statistically significant.

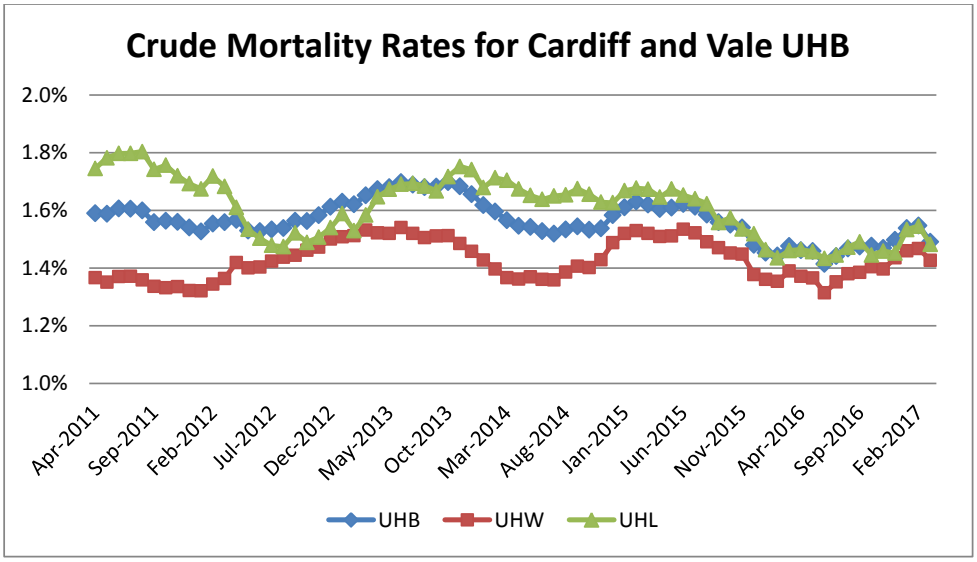
A weekend admission has no statistically significant impact on either a weekday death or weekend death. 2% fewer subsequently die on the weekday following and 1 % more on a weekend.

Appendix One

Cardiff and Vale UHB Mortality Data







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UPDATE ON HEALTHCARE INSPECTORATE WALES ACTIVITY
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20th June 2017

Executive Lead : Executive Director of Nursing
Author : Patient Safety and Quality Assurance Manager, Senior Nurse Standards and Professional Regulation, Deputy Executive Nurse Director
Caring for People, Keeping People Well : Offer services that deliver the improvement in health that our citizens are entitled to expect
Financial impact : None
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 All standards
CRAF Reference Number. 5.1 and 5.1.6
Equality and Health Impact Assessment Completed: A specific Equality Impact Assessment is not required. Delivery of care which is dignified, respectful and compassionate will ensure equality for all patients receiving care from the UHB.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the inspections that have been undertaken
- **AGREE** that the appropriate processes are in place to address the recommendations
- **AGREE** that a future report, outlining progress should be presented at the October 2017 committee

SITUATION

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the unannounced Dignity and Essential Care inspections undertaken by Healthcare Inspectorate Wales (HIW) at Cardiff and Vale University Health Board since February 2017.

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

BACKGROUND

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

The Dignity and Essential Care Inspections (DECI) are a means of providing assurance that a patient's dignity is being maintained whilst in receipt of care. It is a structured inspection and supports the view of Francis (2013) who emphasised the importance of undertaking direct observations of care. The reports focus on providing independent assurance improvements, by reporting openly and clearly on inspections and investigations, encouraging and supporting improvements in care through the reporting and sharing of good practice;

The unannounced inspections undertaken by HIW focus on the following themes:

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

Since February 2017, HIW have published the following reports for inspections undertaken and the initial findings from each of these have been reported previously to the Committee.

- University Hospital Llandough (UHL) East 10, East18, East 1 and East 4
  - This was a follow up inspection date 27 February - 2 March 2017
    Report published 31 May 2017

- Hafan y Coed, Alder Ward and Cedar Ward, UHL
  - Inspection date 27 February - 2 March 2017
    Report published 31 May 2017

- Emergency Unit, UHW.
  - Inspection date 7 and 8 March 2017
    Report published 9 June 2017
    http://hiw.org.uk/docs/hiw/inspectionreports/170609uhwen.pdf

ASSESSMENT AND ASSURANCE

Overall, the reports issued following inspection provide a positive picture of staff working with patients to provide care in a professional and dignified manner.

East 10, East18, East 1 and East 4

The follow up inspections to UHL were undertaken to check the progress in Medicine and Mental Health for Older People wards following the adverse report received in February 2016. This visit found evidence that the care delivered across the four wards was safe and effective and identified that there were marked improvements since the previous inspections in February 2016. Verbal feedback was presented to the Committee in May 2017 and the inspection report and improvement plan developed by the Medicine and Mental Health Clinical Boards in response to the findings has since been published on the HIW web site on the 31 May 2017.

The following are examples of what HIW reported that the Health Board did well:

- Appropriate action following our inspection in February 2016 to address the concerns we identified
- Staff treated patients with respect and kindness
- Appropriate monitoring of Deprivation of Liberty Safeguards (DoLS)
- legislation
- Good physical health and pain assessment and monitoring
- Generally timely and adequately completed risk assessments and
- Falls prevention documentation

HIW also made recommendations as to what the health board could improve:

- That the default position for bedroom door observation panels is closed
- Remedial works required to the designated female patient shower room on East 1
- Infection control process and monitoring on East 10
- Staff engagement on the future health board provision of Mental
- Health Services for Older People
- Unified care between mental health services and medical services.

The inspection report has been reviewed by Medicine and Mental Health Clinical Boards and an improvement plan has been developed in response to the findings. The report and improvement plan was published on the HIW website on the 31 May 2017.

Hafan y Coed: Alder and Cedar Wards

HIW also undertook an unannounced inspection to Alder and Cedar wards at Hafan y Coed, and the inspection on this occasion included a review of compliance with the Mental Health Act. The verbal feedback provided by the HIW team following the inspection was in the main positive and was also reported to the Committee in May 2017.

Overall, HIW found evidence that Alder Ward and Cedar Ward provide effective care for the patients. The following are examples of what HIW found that the service did well:

- Staff provided care to patients on both wards in a respectful manner
- On the whole the wards provided patients with a safe environment to receive care
- Patients were provided with up-to-date information in writing or by speaking to staff

HIW also made recommendations for service improvement:

- Patients to have an up-to-date Care and Treatment Plan
- That staff follow procedures for the storage and administration of medication
- Privacy measures to maintain personal information private within nursing offices

The inspection report and improvement plan developed by the Mental Health Clinical Board in response to the findings were published on the HIW website on the 31 May 2017.

Emergency Unit

The HIW inspection team visited the Majors, Minors, Resuscitation and Paediatric areas of the Emergency Unit at University Hospital Wales on 7 and 8 March 2017. The inspection found the care provided to be of a good standard, safe and effective. These findings were supported by the positive feedback given to the inspectors from the patients and their relatives within the department at the time. The verbal feedback received following the inspection was provided again to the Committee in May 2017.

The following are examples of what HIW found that the EU did well:

- Patients were generally happy with the care and treatment received
- Patients were observed to be assisted in a dignified and courteous manner
- Visibity of senior nurses monitoring safe and effective care

HIW also made recommendations for improvement:

- Paediatric Unit – environment of care, single point of entry and triage arrangements when the service is busy
- Cleanliness of the service corridor used by patients staff and visitors (to go to the wards from EU)
- Assessment and documentation of capacity

The inspection report has been reviewed by Medicine Clinical Board and an improvement plan has been developed in response to the findings. The report and improvement plan was published on the HIW web site on 9 June 2017.

Next Steps

A progress update on implementation of the improvement plans will be provided to the Committee at the October 2017 meeting. In the meantime, the Mental Health and Medicine Clinical Boards will be providing progress reports to their individual Clinical Board Quality Safety and Experience Meetings.

CARERS INFORMATION AND CONSULTATION STRATEGY 2016-2017

Executive Lead : Executive Nurse Director
Author : Acting Assistant Director Of Patient Experience telephone 02921 46108
Caring for People, Keeping People Well: The Health and Care Standards underpin all elements of the Health Board's Strategy.
Financial impact: the Health Board has received 2 years non recurring funding to support this work. It is a collaborative piece of work with Local Authorities in Cardiff and the Vale. For 2105/16 the monies allocated was £124, 961 to date the expenditure has been £124, 788
Quality, Safety, Patient Experience impact: The report provides the opportunity to inform the public of action being taken as part of the Carer Consultation Strategy.
Health and Care Standard Number: applies to all standards **CRAF Reference Number:** 5.1
Equality Impact Assessment Completed: No.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided /demonstrated by the progress and actions highlighted within the report.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** and **APPROVE** the contents of the annual report

SITUATION

The attached, sets out the annual report for 2016/17 of the Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council and Glamorgan Voluntary Services and the progress made towards implementation of the Social Services and Well-Being (Wales) Act 2014. It will also set out how the transitional funding, provided by Welsh Government, has been utilised, in partnership, to begin implementation of the Social Services and Well-Being (Wales) Act 2014 and support carers within Cardiff and the Vale area.

BACKGROUND

The Social Services and Well-being (Wales) Act 2014 set out the obligations that each of the statutory organisations, in partnership with the third sector, should be working together to ensure that all carers are identified as early as possible, that they are able to participate in key decisions about the person they care for, and that they receive the support and information they need in a timely way.

ASSESSMENT

The attached report provides details of all the key projects and work being undertaken to progress the careers agenda. Highlighted within the report are :-

Carers Engagement project

Carers Trust Wales, working jointly with Carers Trust South East Wales, were commissioned to undertake a five month project looking into carer engagement within Cardiff and the Vale of Glamorgan. This will ensure that we capture, listen and act upon the voices of carers.

Carers Accreditation project, Young Carers in Schools – Carers Trust South East Wales:

The first phase of the project was to make initial contact with the twenty-six secondary schools across Cardiff and the Vale in order to identify key individuals and their contact details. Once contact had been established a bi-lingual questionnaire was sent to schools asking key questions around the identification and support of young carers in school. Schools were also asked to indicate if they would be interested in participating in the Young Carers in Schools Award.

During phase one Carers Trust South East Wales achieved 100% response rate from the questionnaire and identified seven schools from Cardiff and five from the Vale of Glamorgan for phase two.

The second phase focused on working with the twelve secondary schools across Cardiff and the Vale of Glamorgan who had expressed an interest in the Young Carers in Schools Award.

Schools were also provided with posters and tools to adapt and use to raise awareness of young carers, and help staff understand young carers.

Care and Repair Carers Casework Service

As part of the work a post was temporarily funded in care and repair to support a 6 month caseworker post.

The pilot began in March 2017 and has funding until the end of September 2017. It is envisaged that the caseworker will be able to help and visit between 75 –100 carers during this time.

The Quality and Safety Committee are asked to note the detailed annual report and the content and progress of the work in supporting carers. Phase two/ three of the projects highlighted above will be completed in 2017/18 and there will be additional focus upon embedding the principles of the John's campaign and some practical assistance for carers which will include trialling carer's packs and increasing awareness of the roles of befriending and activities volunteers.

IMPORTANT PEOPLE

Carers Information and Consultation Strategy

25

Annual Progress Report - May 2016/17

VALE of GLAMORGAN BRO MORGANNWG

CARDIFF CAERDYDD

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Introduction

This document sets out the report for 2016/17 of the Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council and Glamorgan Voluntary Services and the progress made towards implementation of the Social Services and Well-Being (Wales) Act 2014. It will also set out how the transitional funding, provided by Welsh Government, has been utilised, in partnership, to begin implementation of the Social Services and Well-Being (Wales) Act 2014 and support carers within Cardiff and the Vale.

The Social Services and Well-being (Wales) Act 2014 placed a duty on local authorities and Local Health Boards to develop and publish an assessment of the care and support needs of the population, and carers who need support. The Cardiff and Vale Public Health Team lead on the assessment which was undertaken during the period February 2016 – January 2017.

To ensure there was a balanced view of the main care and support needs in Cardiff and the Vale of Glamorgan a number of methods and sources were used. They included:

- public surveys, for adults and for young people
- twenty five focus group interviews with local residents
- a survey for local professionals and organisations providing care or support
- service and population data
- information from key documents and previous work
- a series of workshops for professional leads

The Social Services and Well-being (Wales) Act 2014 set out the obligations that each of the statutory organisations, in partnership with the third sector, should be working towards. Ensuring that all carers are identified as early as possible, that they are able to participate in key decisions about the person they care for, and that they receive the support and information they need in a timely way.

Background

The 2011 census recorded 50,580 carers in Cardiff and the Vale of Glamorgan which is a 12% rise in the last 10 years. The percentage of people in the population who identify as carers is above the Wales average in both Cardiff and the Vale of Glamorgan.

The figure for young carers was 11,555 for the whole of Wales. Approximately 1579 people identified themselves as young carers for Cardiff and the Vale of Glamorgan. However, the likelihood is that the figures for both adult and young carers are much higher. The populations needs assessment carried out for Cardiff and Vale highlighted that the percentage of people in the population who identify as carers is below the Wales average in both Cardiff and the Vale of Glamorgan. This was echoed in a study carried out by Carers UK, Missing Out: The identification challenge, which stated that 24% of adult carers in Wales took over 5 years to identify themselves as a carer.

The Carers Measure Working Group was stood down in December 2015, however carers leads from Cardiff and Vale University Health Board and Cardiff and Vale Local Authorities continue to meet and work in partnership with the Third Sector Health and Social Care facilitators in both Cardiff and the Vale of Glamorgan. The partnership working is used to drive forward and oversee progress of the implementation of the Social Services and Well-being (Wales) Act 2014, in relation to Carers and their needs. Within the Cardiff and Vale University Health Board, work is currently being undertaken to identify the support given to carers whilst in our care, also looking at how we can improve the support given to ensure a seamless service.

Transitional funding has been provided by Welsh Government to facilitate partnership working in the implementation of the Social Services and Well-being (Wales) Act 2014. In Cardiff and the Vale the main investment to date has been used to commission the Third Sector to undertake three projects. The projects are looking into raise awareness of carers and improve information and support via schemes to develop support for young carers in schools, support for carers in health and social care and looking at models of engagement to allow us to better communicate with our carers.

The Strategic Carers Advisory Group (SCAG) and the Carers officers Learning and Improvement Network (COLIN) identified four distinct areas of delivery for the transitional funding in 2016/17 which are illustrated below.

- Strengthening partnership approach at regional level.
- Creating opportunities for Third Sector to fully participate in delivery.
- Planning and delivery of additional requirements for carers as set out in the Social Services and Well-being (Wales) Act 2014.
- Ensuring good practice is mainstreamed and becomes common practice.

The following report sets out the work that has been undertaken, in partnership, between Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council and Glamorgan Voluntary Services.

Progress

Strengthening Partnership Approach at Regional Level

The aim for this area of work is to ensure the cross organisational, cross sector, collaboration in the planning and delivery of support for carers of all ages. Partnership working at a strategic level across public and third sector bodies has continued after the standing down of the Carers Measure Working Group. This has ensured that work has progressed towards implementation of the support needed for carers under the Social Services and Well-bring (Wales) Act 2014. All work moving forward is consulted on by representatives from the voluntary sector in Cardiff and the Vale of Glamorgan together with Carers Leads from the Health Board and Local Authorities. Where possible the views of carers are also sought and considered.

The following sets out the work being undertaken to strengthen partnership working at both a local and regional level.

2016/17 Progress

Carers Engagement Project _ Carers Trust Wales

In October 2016 Carers Trust Wales was awarded funding via a tendering exercise, to undertake this project. A steering group was established and included representatives from the Health Board, Cardiff and Vale Local Authorities, Third sector as well as Carers Trust Wales and Carer Trust South East Wales. The project and the outcomes are outlined in below

Cardiff and the Vale of Glamorgan University Health Board and Local Authorities have often attempted to develop a robust system of engaging with local carers. A variety of different engagement forums have been tried, such as meetings, online discussions or linking in with established support groups. Unfortunately due to a lack of staff and resources the forums were difficult to maintain along with competing priorities. Although carers are more actively involved in decisions affecting the care and support of the person they care for, it is clear there is a gap in engagement with the Health Board and Local Authorities, when it comes to decisions on service delivery.

Carers Trust Wales, working jointly with Carers Trust South East Wales, were commissioned to undertake a five month project looking into carer engagement within Cardiff and the Vale of Glamorgan. The project aimed to achieve the following outcomes:

- Co-ordinate and support the development of a Cardiff and Vale Carers Forum for carers aged 18 and over, caring for someone aged 18 or over.
- Carry out research to analyse potential carers forum models for Cardiff and the Vale of Glamorgan which are based on good practice.
- Compile a comprehensive picture of groups who support carers in Cardiff and the Vale of Glamorgan, across all service area.
- Engage with staff, carers, support groups and other stakeholders to identify the value and purpose of a carers forum and how to overcome any barriers to engagement
- Consult with carers and those who work with them to identify a model for carer engagement founded on principle of stability.

The project which ran between 1st November 2016 and 31st March 2017 provided insight in to best practice, for carers engagement, by consulting with established forums across the UK.

The work highlighted a number of benefits of and barriers to meaningful carer engagement. However, it clearly confirmed that this project was just the starting point and that further work would need to be undertaken in phase two. The final project report has been submitted from Carers Trust Wales, their recommendations will be taken into consideration and next steps agreed by the Steering Group.

Progress

Carers Accreditation project ,Young Carers in Schools – Carers Trust South East Wales:

In October 2016 Carers Trust South East Wales was awarded funding via a tendering exercise, to undertake this project. A steering group was established and included representatives from the Health Board, Cardiff and Vale Local Authorities, Third sector as well as Carers Trust South East Wales and Carer Trust Wales. The project and the outcomes are outlined in below

In 2011 the national census identified 1,579 young carers within the Cardiff and Vale of Glamorgan, however, it is recognised that this number is an underestimation of the numbers of young carers when compared with other surveys of school children across the UK.

In recent years Cardiff and the Vale of Glamorgan University Health Board and Local Authorities have identified gaps in support for young carers living in Cardiff and the Vale of Glamorgan. In February 2016 the Young Carers: Speak Out report highlighted that that young carers felt there was a lack of awareness of their role as well as a lack of support both with practical issues and issues regarding their health and emotional well-being. Many young carers reported having experienced bullying, social isolation and increased emotional and physical demands being placed on them. All of these issues alongside their role as a young carer have huge impacts on education and future opportunities. It was identified that engaging with school settings was an ideal place to begin to tackle some of the concerns that young carers had, such as awareness raising and supporting young carers with information and signposting to relevant services. With this in mind the Young Carers in Schools Award project was commissioned.

The Young Carers in Schools Award, developed by Carers Trust and the Children's Society for implementation in England, consists of five standards which schools need to achieve and evidence in order to gain the award:

1. **Understand** - Assigned members of staff who will take responsibility for understanding and addressing carers needs.
2. **Inform** - Awareness raising amongst colleagues, sharing knowledge about carers
3. **Identify** - Carers to be identified
4. **Listen** - carers are listened to a, consulted and given time and space to talk.
5. **Support** - Carers are supported and signposted to resources and services.

The project was undertaken in two phases,

Phase One:
The first phase of the project was to make initial contact with the twenty-six secondary schools across Cardiff and the Vale in order to identify key individuals and their contact details. Once contact had been established a bi-lingual questionnaire was sent to schools asking key questions around the identification and support of young carers in school. Schools were also asked to indicate if they would be interested in participating in the Young Carers in Schools Award.

During phase one Carers Trust South East Wales achieved 100% response rate from the questionnaire and identified seven schools from Cardiff and five from the Vale of Glamorgan for phase two.

Phase Two:
The second phase focused on working with the twelve secondary schools across Cardiff and the Vale of Glamorgan who had expressed and interest in the Young Carers in Schools Award. Initial meetings were set up with the schools and through this process two schools completely disengaged and made no further contact and two schools felt, after conversations, that due to time constraints they would no longer be able to be involved in the project. Therefore eight schools moved forward to undertake the Young Carers in Schools Award pilot.

During this phase discussions took place with the schools in regards to the Young Carers in Schools Award, including framework, evidence and requirements to achieve the award. The current support the schools were offering young carers was also discussed along with any support there was currently available to schools. Baseline information was gathered from the eight schools which highlighted that the majority of schools involved already worked with support agencies, such as YMCA and they have a designated member of staff who works with young carers. Due to the short timescales of the project it was decided that the eight schools would be asked to focus on the basic award. The basic award includes the following key actions:

- Assigning a lead member of staff to understand young carers and their needs as the young carers operational lead.
- Develop and maintain a pupil notice board and online information highlighting young carer's issues.
- Develop a whole school commitment regarding the identification and support of pupils who are young carers.

Schools were also provided with posters and tools to adapt and use to raise awareness of young carers, and help staff understand young carers and how to identify them. One school in particular highlighted that since displaying carer information throughout the school and having presentations during form time and assemblies, the number of identified young carers had risen from seven to twenty-five.

Since the beginning of the project, with further support from the Schools Development Worker, two schools are close to completing the basics. It was clear from the results of the survey, discussions with schools and baseline assessments that schools had very little carers information on display and staff awareness of young carers and their issues needed to be developed. Moving forward the Steering Group will be considering the findings of the report and considering the sustainability of the Young Carers in Schools Award.

Carers Accreditation project, Health and Social Care – Carers Trust South East Wales:

In February 2016, in partnership with Carers Wales, the Pollen Shop and both Local Authorities, the Cardiff and Vale University Health Board developed the 'Supporting Carers Survey' for staff. The aim on the survey was to find out whether Health Board staff had the right level of knowledge to support carers. It was identified from the survey that more carer awareness raising was needed and well as knowledge of services that were able to help carers.

Using the results of this survey the decision was made to look at the feasibility and sustainability of developing a Carers Accreditation Framework across Cardiff and the Vale Health and Social Care settings. A steering group was established and included representatives from the Health Board, Cardiff and Vale Local Authorities, Third sector as well as Carers Trust Wales and Carer Trust South East Wales.

Carers Trust South East Wales consulted with six teams across Cardiff and the Vale of Glamorgan.

- Trauma and Orthopaedics, Ward B6, University Hospital of Wales
- Mental Health, Pine Ward, Hafen y Coed, University Hospital Llandough
- Haematology, Ward B4 University Hospital of Wales
- Rondell House, Barry
- Vale Community Resource Service
- Mental Health, Vale of Glamorgan

Progress

Year 3 Awareness Raising Progress

- During Carers Week 2015 two events were organised in partnership between Cardiff and Vale University Health Board, Cardiff Council and the Vale of Glamorgan Council.

The events were split into two themes;

The Carers Development Worker engaged with the six teams highlighted to explore the concept of adapting the Young Carers in Schools Award to create an adequate accreditation to be used within the Health and Social Care sector. These consultations also allowed for reflection of current practice. The consultations took place between January and March 2017 and it was highlighted that there was genuine interest and enthusiasm in an accreditation. However, concerns were raised about the 'required evidence' with most teams feeling it may be difficult to demonstrate and could become onerous.

All of the teams felt that if an award scheme was to be implemented that there would need to be corporate sign up and that training would need to be offered so that staff knew what was expected of them. The teams consulted felt that the Young Carers in Schools award was not directly transferable to Health and Social Care settings. In order for an accreditation to be implemented it was felt that we needed to ensure the right model is adopted. The findings of this pilot have been submitted to the Steering Group for discussion. The Group will consider the options and models presented and decide on a way to move forward.

Each of the three projects outlined above were developed and informed by consultations which have taken place with carers and those who work directly with them.

Young Carers Action Plan

In February 2016 young carers across Cardiff and the Vale were surveyed with regards to the services and support they receive. The questions for the survey were developed in partnership with Vale of Glamorgan Council, Cardiff and Vale Youth Services and young carers from the Cardiff and Vale area. As previously stated the results of the survey highlighted that young carers felt there was a lack of awareness of their role as well as a lack of support both with practical issues and issues regarding their health and emotional well-being.

From the findings of the report and feedback from young carers a Young Carers Working Group was established. The Group has representatives from Cardiff and Vale University Health Board and Local Authorities, Cardiff and Vale Social Services and Education, Youth Workers from across Cardiff and Vale and members of the YMCA Cardiff team. The Working Group has developed the Young Carers Action Plan to address some of the issues raised by young carers. The plan was then taken consulted on by young carers to ensure that the actions included were relevant to their needs they had identified. Included in the Action Plan is the need for a co-ordinated training package for staff in schools and health and a review made of policies regarding safeguarding to include young carers, for example. A task and finish group was also set up to look at the feasibility of a young carers ID card, what it would mean and how it would be implemented.

Care and Repair Carers Casework Service

Feedback from carers in recent years has often identified issues around discharge and the delays which can cause frustration. In order to try and address some of the concerns that carers have in regards to discharge, the Health Board and Local authorities have funded a post with Care and Repair. The Carers Casework Service is a pilot which will be citizen-centred and as such, will be tailored according to the person's needs.

A Caseworker will visit a person at their home and listen to what they want and need and will then put together a package with support to make it happen. The Caseworker is able to organise a variety of direct interventions and make referrals to existing voluntary and statutory agencies. Through partnership working with other voluntary and statutory agencies they can provide the right assistance for the individual at the right time and place.

The Carers Casework Service will be able to offer services such as:

Healthy Homes Checks to identify any areas of concern in the home, arranging and oversee practical repairs, safety and maintenance works.

Home fire safety checks to ensure the home is safe and has all relevant smoke alarms and fire safety equipment.

A falls assessment to identify areas of risk and get rails and other safety equipment installed to improve safety. Welfare benefits check to identify and apply for any unclaimed benefits or potential annuities carers may be eligible for to raise the household income.

The pilot began in March 2017 and has funding until the end of September 2017. It is envisaged that the caseworker will be able to help and visit between 75 – 100 carers during this time.

Information and Support Centres

In November 2016 the Barry Information Centre was officially opened by, Ruth Walker, Executive Nurse Director, Margaret McLaughlin, Independent Member of Cardiff and Vale University Health Board and Jane Hutt, Assembly Member for the Vale of Glamorgan.

Jane Hutt, Assembly Member for Vale of Glamorgan, Margaret McLaughlin, Independent Member, Volunteers and Patient Experience Team at the official opening of Barry Information and Support Centre

The three information and Support Centres across Cardiff and Vale University Health Board sites continue to be a great source of information for patients, carers and staff. As part of the development of services provided from the centres the new Macmillan Information and Support Facilitator has been strengthening partnership working with third sector and statutory organisations. Since April 2017, as well as providing welfare and benefits advice in University Hospital of Wales, Citizens Advice now provides a service in University Hospital Llandough, available to patients, carers and staff.

Patient Experience Team Members with Julian Osborne Citizens' Advice Advisor at the opening of the new advice service in University Hospital Llandough

Discussions with the Credit Union and NEST are also taking place to introduce their services, into the Information and Support Centres, where they would provide energy and financial advice to patients, carers, visitors and staff.

In addition to benefits and financial advice, plans are underway to develop a knit and natter session for patients and carers to come along and socialise away from the ward environment.

Creating Opportunities for Third Sector to fully participate in delivery

When undertaking the Cardiff and Vale Population Needs assessment it was clear that our Third Sector partners are a trusted asset, when delivering services for carers in our area. Carers who engaged in the population needs assessment expressed that third sector organisations were often more respectful and less judgemental than statutory organisations. It is for these reasons it is important to ensure that Third Sector organisations are able to participate fully in the development and delivery of services for carers.

Through our partnerships with Glamorgan Voluntary Services, Cardiff Third Sector Council and directly with third sector organisations ensuring that our carers have a voice. The following highlights out the ways in which opportunities have been created at both a local and regional level.

2016/17 Progress

Cardiff and the Vale Carers Support and Information Network Group (CSING)

Cardiff and Vale Carers Support and Information Network Group (CSING) brings together staff from the third sector, local authority and health board who plan and deliver services for carers in the region. CSING is a good opportunity to share information, highlight current and new services, identify gaps and issues which affect carers and support partnership working across sectors. Issues raised can be highlighted via regional partnerships and planning groups. CSING was also instrumental in ensuring that members were aware of the Cardiff and Vale population needs assessment that was undertaken as part of the implementation of the Social Services and Well-being (Wales) Act, allowing carers forums to feed directly into the assessment, ensuring the carers voice was heard. CSING, facilitated by Glamorgan Voluntary Services (GVS), in liaison with Cardiff Third Sector Council (C3SC) has been meeting for over 10 years and began as a Vale group before expanding to Cardiff. It now has over 30 members.

Over the last year there have been presentations from the Vale of Glamorgan Carers' Development Officer on the new carers' assessments under the Social Services and Wellbeing (Wales) Act, the Disability Advice Project on their Skills for a Better Life project and United Welsh on their Wellbeing 4U service.

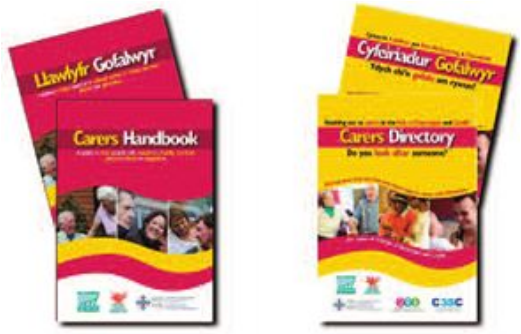
Long Term Conditions Alliance

Since its inception in 2013 the Cardiff and Vale University Health Board worked closely with the Long Terms Conditions Alliance Co-ordinater. The alliance which came to an end in December 2016 was a mechanism which allowed the Health Board to engage with patients, carers and representatives from third sector organisations in the development of policies and services. In 2016 the Health Board engaged with the Alliance on items such as the development of well-being hubs in Cardiff and the Health Boards Equalities framework.

The Long Term Conditions Alliance Co-ordiantor also ensured that the members of the Alliance were involved in the consultations on the Social Services and Well-being (Wales) Act as well as Local Authority policy.

Carers Handbook and Carers Directory

The Carers Handbook has been developed in partnership between the Cardiff and Vale Health Board, Cardiff and Vale of Glamorgan Local Authorities, Cardiff Third Sector Council and Glamorgan Voluntary Services. The handbook is currently being updated to encompass the changes under the Social Services and Well-being (Wales) Act. Discussions are also taking place as to changing the format of the handbook to make it easier to read and more relevant for carers.



The Directory of Services for Carers contains information about a range of third sector local authority and health services for carers in the region. The Directory was produced by Glamorgan Voluntary Services (GVS) in liaison with statutory partners and has proved popular with carers and front line staff who support carers. GVS continues to update the Directory online and all organisations which are listed have been encouraged to include their services on the Dewis Cymru information portal.

Case Study

During a public engagement event held in Cardiff County Hall a carer came over to speak to the Patient Experience Support Advisor, as she wanted to express her gratitude for the Carers Directory. The Carer had been given the directory at a previous event and had found it very useful, especially as the carer had been in the armed forces and was unaware that the type of help that British Legion provided. Since receiving the directory she had been able to utilise the handy man service that the British Legion provided, and said that the directory was the most useful document she had received to date.

Carers Week and Carers Rights Day 2016

During Carers week in June 2016 the Patient Experience Team held a number of information events across Cardiff and the Vale of Glamorgan. The events included infmoration stands in partnership with third sector colleagues from Bipolar UK, and Marie Curie, as well as a Carers drop in session held at the Age Connects Cafe in Barry. The aim of all the sessions was to raise awareness of Carers and the caring rols and to provide information, sign posting and advice to carers.

Carers Week Stand with Bi-Polar UK

A number of Local Events for Carers' Week 2016 also took place in partnership with the Vale of Glamorgan Council including a Marie Curie Caring for Carers Café (open for carers caring for someone with a terminal illness) offering advice: a Marie Curie Nurse, a legal representative and a benefits advisor. An Information Stand was held at Western Vale Family Practice where the Vale's Carers Development Officer was available, in Reception area, to provide carers' information. Carer's information was also available in Cowbridge Library, as well as a manual handling drop-in session at Business Service Centre in Barry, hosted by the Vale's manual handling co-ordinator. Mobility equipment and living adaptation/aids were on display.

Carers Rights Day Partnership Event

Both Velindre Hospital and Barry Library had Information displays with carers' information over the whole of Carers' Week.

In November 2016, to celebrate Carers Rights Day, the Patient Experience Team joined the Carers Lead from Cardiff Local Authority and a variety of third sector partners for an event at the Central Library in Cardiff. During the events carers and staff were signposted to sources of information and support as well as being offered practical advice.

Carers' Rights Day was marked in the Vale by having an Information Stand at Barry Hospital Reception area. A press release was used to promote the event, and this feature appeared in the Barry and District News: http://www.barryanddistrictnews.co.uk/news/14926751.

Intermediate Care Fund

Since the Intermediate Care Fund was introduced GVS and C3SC have put in place small grant schemes, working closely with statutory partners, so that third sector organisations are able to access Intermediate Care Funding to run small scale projects or try out new ideas. Three grant schemes have been facilitated since 2014 and a diverse range of third sector organisations have received funding. Services funded include a meal delivery service, an arts project for people with dementia, housing adaptations, an intergenerational lunch club and a project to increase the uptake of the annual health check for people with a learning disability.

Citizen's Advice and Tenuous Cancer Care

Both Cardiff and Vale Citizens Advice and Tenovus Cancer Care continue to provide a service at University Hospital of Wales and University Hospital Llandough. Citizens Advice provide a mixture drop-in and appointment based sessions and Tenvous Cancer Care take referrals from staff and visit wards and out-patient clinics where requested. Both services provide welfare and benefit advice.

Case Study

The client was a 17 year who was having treatment for lymphoma. He was in full time education, but was having to take a break as he was unwell. The Tenovus Cancer Care Advisor assisted the client in applying for personal independence payments and her was awarded the higher rates. His mother was unable to work due to health problems, but was not eligible for any sickness benefits herself. However, as she was now caring for her son the Tenovus Cancer Care Advisor was able to assist her with an application for Carers Allowance. The Carer was also referred for financial advice in relation to a critical illness insurance policy.

Planning and delivery of Additional Requirements for Carers

As part of the implementation of the Social Services and Well-being Act (Wales) 2014, we have to ensure that we are putting patients and carers at the centre of our services. It is important that we are providing information to support them in achieving and maintaining their own well-being. As part of this work it is important that our staff are provided with the tools to offer that support. This can be done through Staff awareness sessions and formal training as well as projects and initiatives that look at ways to help staff, help carers, such as the Read About Me Scheme.

The following looks at the work that is ongoing within Social Care and Health settings to ensure we are meeting the requirement of the Social Services and Well-being Act (Wales) 2014, in relation to carers.

2016/17 Progress

Health Board Staff Training and Awareness Sessions

The Health Board currently provides a carer awareness session to all newly appointed staff and an hour long training session to qualified members of staff who undertake the Skills to Manage and Leadership and Mentoring Programmes. Bespoke training sessions are also available to teams and areas who have an interest in carers issues.

Carer Awareness Session:
This session is aimed at staff of all bands in the Cardiff and Vale Health Board, and is part of the corporate induction programme for all newly appointed staff. Outcomes of the programme are to enable staff to:

- Define what a carer is
- Understand some of the issues young and adult carers may face
- Signpost to information and support where needed

During the period of this report 581 newly appointed Health Board staff, including Senior Medical staff, have undertaken the carer awareness session. To date since 2012, 2365 Health Board staff members have taken part in the awareness sessions.

Skills to Manage Programme and Leadership and Mentoring Programme:
The hour long training session given on the Skills to Manage and Leadership and Mentoring Programmes is aimed at qualified staff from all disciplines within Cardiff and the Vale Health Board. The aim of the programme is to:

Define what a carer is
- Understand some of the issues young and adult carers may face
- Understand carers rights under the new Social Services and Well-being (Wales) Act 2014 (ie carers assessments)
- Signpost to information and support where needed
- Involve carers in relation to ongoing carer/discharge planning care issues

These training sessions are run twice a year and give us the opportunity to discuss with senior managers, nursing and therapy staff who often need to engage with and support carers. From April 2106 to May 2017 53 staff have taken part in the full training. To date since 2012, 622 of staff have undertaken the hour long session.

Young Carers Training Slides Update and ID Cards

Training Slide:
As part of the work being undertaken with young carers the young carers working group noted that young carers issues are not always included in general carers training and where it was it may not always be up to date. Therefore, it was decided that the current training packages would be looked at updated, ensuring that all organisations were using the correct and relevant information. A couple of slides will be developed which can be inserted into organisations existing carer presentations, to ensure young carers and their needs are recognised.

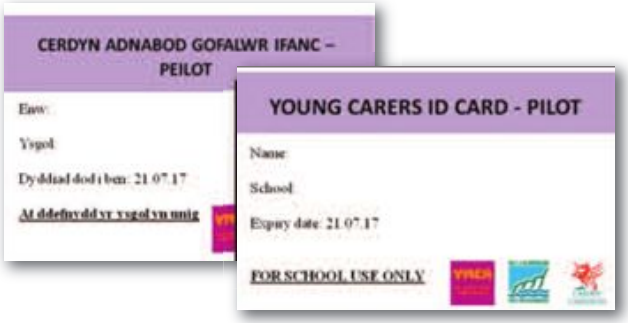
ID Cards:
In addition to the training slides, after consultation with young carers, it was highlighted that they would like young carers ID cards. In response to this suggestion from young carers the working group has established a task and finish group to undertake an ID card pilot scheme in two schools in the Cardiff and Vale of Glamorgan. The aim of the pilot will include:

- Design of ID Card
- Criteria for issuing of ID cards
- ID Card Guidance for Schools – what will the card mean for the young carer?

  For example, please consider that the Young Carer:

  - o May arrive late into school on occasions.
  - o May need to leave school early on occasions.
  - o May need to maintain mobile phone contact in line with caring responsibilities.
  - o May not on occasions have completed homework/projects to deadline, which may need to be extended.
  - o May need other or additional support.

Progress



Young Carers ID Cards for Schools

The pilot is set to run for one school term, this will help to inform the feasibility and sustainability of such an ID card. Any learning from the pilot will be taken to the young carers working group for discussion and possible roll out to all schools. If the ID cards are successful further work will be undertaken to understand how they would translate into other areas such as Health and Transport Services.

Read About Me Scheme

The Social Services and Well-being (Wales) Act 2014 puts the well-being of citizens, including carers, at its heart. Ensuring carers have a voice and are included in the care of the person they care for helps to ensure that we are considering our carers well-being. Public Health Wales is currently leading on a work stream which has pulled together teams across the Health Board who work with patients with dementia or cognitive impairment. The Public Health Wales Lead has established a working group who are looking at the documentation Wards are using with carers, for example, This is Me document and the accompanying documentation for the Butterfly Scheme. New documentation 'Read about Me' has been developed and is being trailed in Wards across the Health Board. The aim of the new documentation is to achieve a standardised approach that will hopefully improve its usage. A task and finish group has been set up to trial the documentation and will fed back into the larger working group once the trial period has come to an end.

Information and Support Centres

The Information and Support Centres across the Health Boards sites provide an ongoing opportunity to communicate with patients and carers. Under the Social Services and Well-being (Wales) Act 2014 we have a duty to provide our citizens, including carers, with up to date relevant information at the point they require it. Each of our Information and Support Centres has an area dedicated to carers which includes information such as Carers Directory, Carers Handbook and Carers Wales information.

Carers information in Barry Information and Support Centre

We use the opportunities in the Information and Support Centres to engage with carers listening to their issues and discussing their information needs.

Case Study

While in the Information and Support Centre in University Hospital Llandough the Volunteer Manager was approached asking if we provided information on Care Homes, specifically a copy of the Vale of Glamorgan Care Directory. The patient needed to be discharge to a care home and their carers wanted information to make and informed decision about the patient's future care. As we did not stock the Vale of Glamorgan Care Directory the Volunteer Manager sourced and printed a copy form the internet. The Information and Support Centre Manager is now sourcing hard copies of the Care Directory, and in the interim printed copies are available.

Engagement Events and Awareness Raising

Public Health Wales Community Activities Event, City Hall

In order to provide the right level of support and information to carers it is important that staff in Health and Social Care settings, as well as carers themselves, are aware of who carers are and what they do, their rights, needs and how they can be supported. Importantly we need to ensure that the information they are provided is up to date and relevant to them and their caring role. As with the Information Centres the Community Engagement events allow us to offer carers practical advice and signpost to sources of information and support.

Between May 2016 and April 2017 the Patient Experience Team have attended and provided information at Fourteen community events across Cardiff and the Vale and hosted eight across the Cardiff and Vale University Health Board sites. This is in addition to the events run by both the Cardiff and Vale of Glamorgan Local Authorities.

Information has been provided to carers and staff from various organisations on carers rights as well as the support that is available to carers financially, practically and emotionally. The events allow us to reach carers who may ordinarily not attend the Hospitals and see our Information and Support Centres. It allows us to provide relevant information to carers where they are, making it much more accessible to all.

Care and Repair Event, Penarth

Diverse Cymru Event, County Hall

Case Study

A lady who attended the Diverse Cymru event mentioned that she was lonely and feeling a little isolated, and wanted to know of any befriending services. After speaking to the lady further the Patient Experience Support Advisor determined that the lady was in an area which had a Friends and Neighbours (FAN) Group so provided her with the number to contact them. At the lunch break the lady returned to the stall to offer her thanks as she had called the FAN Group on her mobile and they were coming out to see her the following week to meet her and see what they could offer.

Progress

Ensuring good practice is mainstreamed and becomes common practice

Within Cardiff and the Vale of Glamorgan and across Wales and the rest of the UK there are lots of examples of good practice on how to engage with carers, raise carer awareness and in regards to information sharing. Within Cardiff and the Vale of Glamorgan, in partnership with both local authorities and third sector organisations, we identify examples of good practice, take the learning and adapt to suit our carers needs. We also ensure that we showcase any of our own examples of good practice and share our learning with partners and other organisations across Wales.

This section highlights the work being undertaken to identify and share good practice within Cardiff and the Vale of Glamorgan from across Wales and the UK.

2016/17 Progress

GP Carer Accreditation Scheme

The GP Accreditation Scheme is in the second year of roll out and we currently have twenty-two surgeries across the Cardiff and Vale who have achieved the bronze level accreditation. We have met with a further seven surgeries who are in the process of gathering evidence for the accreditation assessment. Draft Criteria are being developed for Silver Level and some of the Practices that have achieved Bronze Level and keen to progress towards this.

As part of the GP Accreditation Scheme Practices are asked to nominate a carers champion who work closely with the Patient Experience Support Advisor, in Cardiff and the Carer Development Officer in the Vale of Glamorgan. GP carer champion meetings are held throughout the year and offer the opportunity to share good practice, influence practices to take replicate exemplars, and to develop a relationship between both areas of care and local authorities. Existing champions have become an expert resource within their practices and are supported to be able to identify, support and signpost carers appropriately.

GP Carers Accreditation

Due to the success of the GP Carers Accreditation Scheme there is now work underway to develop a similar scheme for Community Pharmacists. The bronze criteria, used for GP Surgeries, has been amended to suit the Pharmacy environment which is currently being signed off by Community Pharmacy and roll out of the scheme will hopefully being in the near future.

Johns Campaign

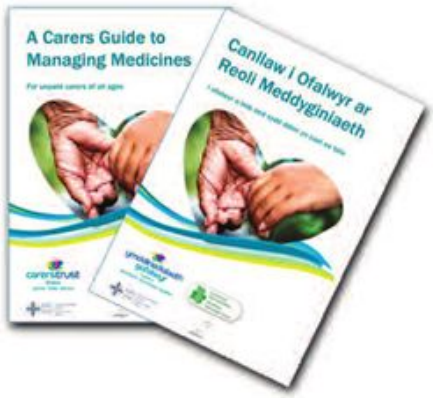
In November 2014 Nicci Gerrard and Julia Jones founded John's Campaign. The campaign's simple statement of purpose lays the belief that carers should not just be allowed but should be welcomed in the involvement of the care of the person they care for. John's Campaign has been adopted, to various degrees, by all Health Boards across. In Cardiff and the Vale of Glamorgan Health Board we have signed up to the principles of John's Campaign and are developing our own priorities principles and promises, which will include all our carers. As part of the development of our carers priorities, principles and promises a John's Campaign working group has been established, which includes Patient Experience and the Lead Nurses from all health board Clinical Boards. The working group are in the process of developing a questionnaire for both carers and staff, which will be used to establish a baseline of how we are performing against our priorities, principles and promises.

Carers Trust Projects

As mentioned previously in the report, Carers Trust Wales jointly with Carers Trust South East Wales, have been commissioned to undertake three projects. Each of the projects is drawing from good practice not only from Cardiff and the Vale, but also from Wales and the UK as a whole. The findings from each of the projects will be used to inform and improve our current practice allowing us to ensure that this good practice becomes the norm within our Health and Social Care Settings.

Medicines Management Information

In 2015 the Carers Trust Wales, in partnership with Public Health Wales and Community Pharmacy Wales, developed a Carers Guide to Managing Medicine, which was distributed to Pharmacies and Health and Social Care settings. The guide was very informative and proved very popular with carers. Due to the demand for the information a decision was made jointly, between Cardiff and Vale Local Health Board, both Local Authorities and Third Sector partners, to fund a reprint of the leaflets. However, it was also decided that some of the information could be more relevant to the local Cardiff and Vale area so the template was provided by Carers Trust Wales and amended to include contact numbers and websites for services delivered in the area. The leaflet is currently in the printing process and will be become a source of information we regularly provide carers.



A Carers Guide to Managing Medicines Leaflet

Showcasing and Carer Information and Raising Awareness

Jane Penny, Senior Nurse and Jo Gill, Specialist Nurse with Carers Board on Ward B4

After attending a Carers Event in Cardiff Central Library, staff on Ward B4 wanted to provide the carers who come onto their ward with relevant information on the support available in their area. The staff on B4 recognised that many of the carers they come into contacted do not even realise they are a carer. They hope that by displaying information on the carer's board that they will help to raise awareness of carers and their roles. The carer's information display was put onto the Health Boards social media sites to highlight the good practice to other areas.

Values into Action Project

In September 2016 the Cardiff and Vale University Health Board undertook a series of engagement workshops, over a two week period, with patients, carers and staff. The aim of the engagement workshops was to understand what it's like to be a patient, carer and staff member within Cardiff and the Vale Health Board. We understand that evidence shows that by improving the experience our patients and carers have in our care ensures patients have a better experience of care, patient care is also safer and of a higher quality. In addition when healthcare teams work better together they deliver better outcomes, more productively.

Progress

Values into Action, In Your Shoes Workshop

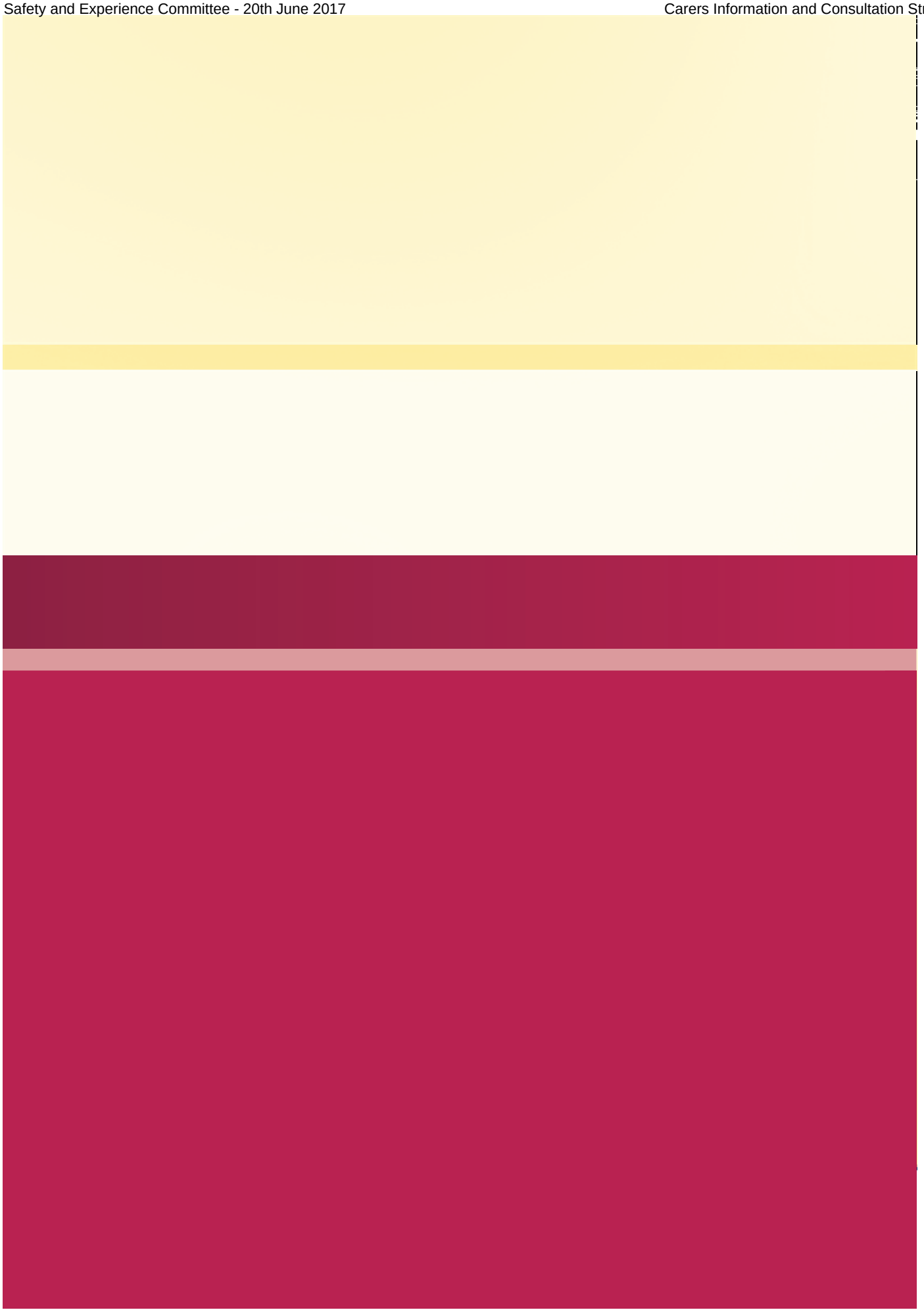
Six hundred and eighty five patients and carers contributed to the Values into Action projected either by attending an 'In Your Shoes' workshop or completing the online questionnaire. Patients and Carers shared their experiences of the Health Board and their comments were themed into what we did well and what we as a Health Board could improve upon. The findings from this feedback are being used to develop the Health Boards staff values and improvement priorities for patients. This work will include any areas of good practice being shared across the Health Board

Conclusion

This report gives and account of the progress of work overseen by the Cardiff and Vale working group in the implementation of the Social Services and Well-being Act (Wales) 2014.

Expenditure and Financial Projection

The Cardiff and Vale partnership was allocated a total of 108,935.97 for 2016 - 2017.The table below outlines the account expenditure for each work stream to date



MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 20 June 2017

Executive Lead : Chief Operating Officer
Author : Assistant Chief Operating Officer – Tel: 02920 744120
Caring for People, Keeping People Well : Timely follow up care underpins the care and sustainability elements of the Health Board's strategy
Financial impact : The cost of the plan to reduce endoscopy waits and elements of the Outpatient Follow-Up Improvement Plan form an integral part of the Health Board's Planned Care Plan
Quality, Safety, Patient Experience impact: Timely follow up is integral to the delivery of safe clinical care and good patient experience. The potential consequences of a follow up appointment past the clinically agreed dates are a poor patient experience and adverse patient outcomes.
Health and Care Standard Number: 5.1 and 3
CRAF Reference Number: 5.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress made against the UHB's Outpatient Follow Up Improvement Strategy and the re-focus of actions to increase the pace of improvement
- Outpatient Transformation is one of the Health Board's priorities for 2017/18 and is a key element of the National Planned Care Programme
- Reduced volume of patients waiting greater than 8 weeks and an improved risk profile for endoscopy surveillance patients

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the current position and work ongoing in relation to the management of outpatient follow up care and endoscopy surveillance

SITUATION

Timely access to follow up care is integral to delivering the Health Board's strategy "Caring for people, keeping people well". The purpose of this paper is to provide an update on progress over the last year in relation to the management of outpatient follow ups and endoscopy surveillance.

BACKGROUND

The Quality, Safety and Patient Experience Committee received a report at its meeting on 18th October 2016 on the management of outpatient follow ups and endoscopy surveillance. This, along with previous reports to the Board and also the People, Planning and Performance Committee, had been submitted against the backdrop of general concerns that patients are waiting too long and governance concerns arising from reported Serious Incidents in Endoscopy.

ASSESSMENT AND ASSURANCE

Outpatient Follow up care

As reported previously the UHB's has an approved Follow up Care Strategy comprising of a number of components. Key to the successful implementation of the strategy is identifying specialties and clinical conditions of higher risk; improving the quality of our data and transforming outpatients.

Clinical Risk Assessment: The UHB has identified clinical conditions across all specialties where there is a potential for harm through delays in follow up appointments. This is being used to direct limited resource to the areas with the greatest potential risk of harm.

Improving data quality: Key to the success of this component is to:

- Reduce and eliminate both patients being recorded on the system without a follow up date and those that are recorded requiring a follow up appointment when it has been clinically determined they do not require one
- Clarify the correct status of the backlog of patients recorded on the system without a follow up date

The approach remains twofold: firstly validation of the current follows up waiting list and secondly implementation of actions to ensure the data is entered correctly at the point of entry. Manual and automated validation continues and, since the last report to the Committee, an additional member of staff has commenced in the central validation team to focus on follow up validation. In addition, some IT solutions have been implemented to help ensure the target date is captured.

Whilst the work undertaken has realised a continued reduction in the overall volumes, the pace of reduction needs to increase. The numbers at the end of March 2017 are as follows:

Category	March 2017	April 2016	(Reduction) / Increase
No target date	191,527	217,461	(25,934)
Delayed OPFUs	104,767	81,362	23,405
Total	**296,294**	**298,823**	**(2,529)**

It is worth noting that 37K of the 105K patients waiting for a follow up who are delayed past their target date could not attend or did not attend their last appointment.

To speed up data quality improvement, there has been a recent re-focus on the work that needs to be done and a number of new actions have been agreed. These include:

- A review of Clinical Outcome codes e.g. changing the 'Discharge back to GP' outcome code so that it does not add the patient onto the follow up list without a target date but instead correctly closes down the pathway
- Identifying opportunities, through data mining, for further automated off-listing patients who should not be on the outpatient follow up waiting list
- Developing a 'live' alert to relevant members of staff to alert them to clinics not being 'cashed up' so immediate remedial action can be taken

In addition, reporting and monitoring of Outpatient Follow up volumes have become a key performance measure in the Executive Performance Reviews with Clinical Boards. Through this mechanism, the Chief Operating Officer has requested specific plans to address Outpatient Follow Ups from each Clinical Board with each being asked to expedite remedial actions and set trajectories for improvement.

Outpatient Transformation: Outpatient Transformation is being driven at both a National and Local level.

At a National level, this is being driven through the National Planned Care Board, both through Specialty Specific Boards and also the Outpatient Transformation steering Group. A key piece of work has been developing a Shared Outpatient Vision for Wales. The UHB held the launch engagement event in November 2017 – Working together to design Outpatients – and following a series of similar events across Wales, the vision for Wales was agreed in January 2017.

Locally, Outpatient Transformation is being driven through the UHB's Transformation programme and will form part of the remit of the new Planned Care Board. Work on the initial two BIG3 pathfinder projects - Eye Care and Musculoskeletal continues.

Endoscopy Surveillance

As reported previously, reducing waiting times for endoscopy surveillance forms part of the wider Health Board plan to improve patient experience and access to endoscopy services for all categories of patients – urgent, routine and surveillance. The UHB has refreshed its endoscopy plan for 2017/18, in light of the unsuccessful recruitment of an additional consultant and operator gaps from maternity leave and retirement. The plan has been altered to both continue to 'grow' skills in other disciplines e.g. nurse endoscopists and to commission external activity. As at the end of April 2017, the UHB's actual position of waits greater than 8 weeks for all categories of patients was on plan.

In addition, there has been progress in reducing the volume and risk profile of endoscopy surveillance patients. As previously reported, recognizing the 8 week target is a crude measure, a clinically agreed risk scoring methodology was implemented in July 2016 based on the planned interval date and the amount of time the patient is delayed beyond the planned date e.g. a patient who is planned for an endoscopy in one year's time and is one year overdue is higher risk than a patient who was planned at a two year interval and is one year overdue. The volume and risk rating profile is as follows:

Risk rating	Volume April 2017	Volume July 2016	Change – Volume	Change - %
300% or more	13	62	(49)	(79%)
200% - 300%	4	54	(50)	(92%)
100% - 200%	32	140	(108)	(77%)
75% - 100%	52	86	(34)	(39%)
50% to 75%	145	169	(24)	(14%)
25% to 50%	259	258	1	0%
0% to 25%	333	251	82	33%
Total > 8 weeks overdue	**838**	**1020**	**(182)**	**(18%)**

As can be seen from the table above, both the overall volume of endoscopy surveillance patients waiting > 8 weeks have reduced (18%) and volume of higher risk patients has reduced i.e. there has been a 81% reduction in the volume of patients classified with a risk rating of 100% to 300% or more.

TRAUMA AND ORTHOPAEDIC JOINT (KNEE AND HIP) REVISION RATES
Name of Meeting Quality, Safety and Patient Experience **Date of Meeting** 20th June 2017

Executive Lead : Medical Director
Author : Medical Director and Clinical Director Trauma and Orthopaedics Tel: 029 2074 2130
Caring for People, Keeping People Well : This report underpins the strategy as the as it is key to delivering outcomes that matter to people.
Financial impact : The majority of costs for the revision of joints (hips) has been recovered from the manufacturing company.
Quality, Safety, Patient Experience impact : Improved outcomes are essential an improved Quality, Safety and Patient Experience.
Health and Care Standard Number : Standard 2.9 (Safe Care) and Standard 3.1 (Effective Care)
CRAF Reference Number: 5.1 Deliver safe, effective and efficient care.
Equality and Health Impact Assessment Completed: N/A

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by:

- A National UK Programme of monitoring hip replacement products has been introduced to better predict failure rates and reduce the likelihood of a further largescale product failure.
- Strict choice of local implants to produce better outcomes
- Established programme of audit and clinical review, including NJR
- Results over the last five years (NJR) confirm revision ratio's within normal outcome limits.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the ongoing programme of audit and product selection to ensure improving patient outcomes.

SITUATION

At the November 2016 Audit meeting of Cardiff and Vale UHB concern was raised about Orthopaedic outcomes where Cardiff and Vale UHB had the highest joint revision rates. The Trauma and Orthopaedic department takes part in the National Joint Registry and has been submitting data to National Joint Registry (NJR) since its inception in 2003-4.
Compliance with data submission is one of the best in the UK.

There is a known issue with quality of data reported to the NJR with some institutions under-reporting revision rates. Cardiff and Vale UHB for 2015-16 has very high rates of data completion. This affects the overall results (funnel plots) and penalises departments who are correctly reporting revisions. This issue is slowly being addressed by the NJR.

Annual reports are issued for department level data and for surgeon level data detailing implantations of hip and knee replacements and revision rates. Funnel plots are produced that identify outlier units and surgeons based on comparison with national results. The aim is to compare brands and classes of implants to help monitor outcomes of new and existing products and aid decision making in choice of implant for surgeons.

It has been reported that the department revision rate for hip and knee replacement is above average for Cardiff and Vale UHB. This first occurred in approximately 2011. The Chief Executive received communication of this from HQIP/ NJR. As a result the Trauma and Orthopaedic department conducted an internal investigation into the reasons for this and put into place mechanisms to address this going forwards. The Medical Director has been in regular discussion with the Clinical Director Trauma and Orthopaedics and the Clinical Board Director for Surgery with regard to the processes being put in place.

BACKGROUND

HIP REPLACEMENT SURGERY

From 2006-2008, a high volume of metal on metal hip replacements (approximately 1500) were implanted at University Hospital Llandough. This selection of this implant was based on laboratory and company provided data suggesting lower wear rates, improved functional outcomes and therefore improved lifespan of replacements over more traditional implants for this class of implant. Cardiff, like other centres, made a group decision to use this class of implant. However there were many centres that decided not to use this implant.
The short-term results were excellent and as promised with improved functional outcomes and patient satisfaction. This class of implant would ultimately have a poor medium term outcome.
Approximately three years after implantation it became apparent that there were international reports of early failure attributed to a metal-on-metal articulation reaction. Patients started to return with pain, and swelling around the hip, or loosening of implant. This was known as adverse reaction to metal debris (ARMD), sometimes referred to as pseudo-tumours. Once the issue had been reported, many centres started seeing patients with these reactions. The result of delaying surgery once identified was potentially muscle damage, pain and disability.
One of the implants chosen for use in Cardiff, the Depuy ASR demonstrated significantly higher failure rate compared to other products but the reaction was also seen in other brands to a lesser degree.

As a result Cardiff and Vale instituted a review programme for all brands of this class of implant. Depuy issued a recall of the ASR type of implant and funded follow-up and monitoring for this brand. MHRA issued guidelines for long-term follow-up of all classes of metal on metal implant. Patients were invited to follow-up clinics, many of which were funded by Depuy as part of the recall. Blood investigations, x-rays, functional outcomes and MRI scans were performed where appropriate. With funding from Depuy. Patients identified with features of ARMD or pseudotumours were advised to have revision surgery before irreversible complications such as muscle damage, dislocation, bone destruction occurred.
The revision rate for hip replacement has been much higher than expected, which has pushed the unit and individual consultants (four to date) into outlier status on analysis of results (funnel plots). Because there is a time-lag to revision, these cases are ongoing although diminishing, but it will take several years for results to improve after selection of successful implants. The ASR implant has had over a 50% revision rate. The normal would be about 1-2% at this timeframe.
The data for the Annual Clinical Report (2016) which reflects the lifetime of the Registry (April 2003-february 2016) shows the Standardised Mortality rate to be equal to the National UK mean, for both Llandough and the University Hospital of Wales.

KNEES REPLACEMENT SURGERY

Cardiff and Vale UHB were identified as having a higher unit revision rate approximately three years ago, with two outlier surgeons. An investigation was completed by the lead surgeon and a colleague reviewing several years of revision cases to look for themes for the reason.

Conclusions from the investigation are as follows:

1. Higher revision rate in operations performed by Senior Trainee (Fellow). The Senior Fellow (post CCT) was felt by the trainer to be competent to perform unsupervised surgery but a few years later cases were being revised for technical issues.
2. Reoperation on the patella which occurs in approximately 1-5% of cases was classed as revision by NJR. Some centres were not reporting this to NJR but Cardiff were, so this falsely increased the revision rate compared to centres not reporting it.
3. A small number of cases on review indicated that there were only marginal benefits and a marginal indication for patients who were revised.
4. Failure of knee replacement (Deuce) implanted in 15 patients with unacceptable revision rate (almost 50%). Product withdrawn from market now.

The data for the Annual Clinical Report (2016) which reflects the lifetime of the Registry (April 2003-february 2016) shows the Standardised Mortality rate to be equal to the National UK mean, for both Llandough and the University Hospital of Wales.

ASSESSMENT

HIP REPLACEMENT SURGERY

For hip surgery we have been unfortunate in the selection of a class of implant several years ago that has had a considerably higher than average failure rate at approximately three years onwards. As a result this has rated us considerably worse than many units in the UK who did not select this implant. This will take several years of implanting hundreds of cases with low complication rate to correct the as the results of the NJR relates to performance covering the lifetime of the Registry (2003-2016). Results over the last five years (NJR) confirm revision ratio's is now falling within normal outcome limits.

As a result of the failure of the hip replacement a number of processes were put in place.

1. The Department works to use the Orthopaedic Data Evaluation Panel (ODEP) approved products in all cases unless it is necessary for anatomical reasons to use unrated implants. The ODEP provides the NHS with an approved list of prostheses that meet the revision rate standard at 10 years set out in NICE Guidance and which are suitable for use in primary hip and knee replacement.
2. Any new proposed implant to the department will be part of the Beyond Compliance scheme which has been set up nationally for closer monitoring or early results, with controlled roll-out based on risk assessment of implant. This was set up as a result of the ASR poor outcomes to closely monitor implants new to the market protecting patients and surgeons. Two members of the department in Cardiff, are on the National committee for Beyond Compliance and ODEP.
3. Weekly hip meeting to discuss preoperative plan for difficult cases, to review all x-rays from all surgeons from the previous week to ensure high standard of output from department.
4. Annual half day meeting to review overall departmental results, NJR figures, ODEP ratings and identify any early signs of poorer outcomes.

KNEE REPLACEMENT SURGERY

Outcomes of investigation:

1. All knee implantations to be supervised by Consultant surgeon rather than any lists run by Senior Fellows.
2. Weekly knee meeting to discuss preoperative cases, review all x-rays from previous week, ensure quality control of output from department, group discussion of any return to theatre cases, group discussion of planned revisions to ensure indications likely to have good success rate and unanimous decision on whether surgery to proceed.

3. Use of ODEP rated implants to continue. Any new implants part of a research trial and registered with Beyond Compliance scheme to monitor results closely.
4. Annual half day meeting to discuss department results, NJR plots, identify any deviation from improvement on funnel plots to identify early.

Results over the last five years (NJR) confirm revision ratio's within normal outcome limits.

UPDATE ON THE PROVISION OF SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20th June 2017

Executive Lead : Director Strategy & Planning
Author: Head of Compliance & Discretionary Capital. Tel 029 2074 6593
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact:
Health and Care Standard Number: 2.4
CRAF Reference Number: 5.2 & 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- NWSSP – Specialist Estate Services Isolation Room Ventilation Inspection Report March 2017
- Capital Investment agreed to improve the existing ward environment on B6

The QSE Committee is asked to:

- **NOTE** the position in relation to the identification of a decant ward area that would enable a rolling proactive ward refurbishment programme to be implemented.

- **NOTE** the plans for an estates strategic plan which will set out the programme for development of our estates – both our hospitals and our community facilities in order to deliver our strategy and ensure facilities are fit for purpose and sustainable

SITUATION

At its meeting in April 2017, the QSE Committee expressed concern about impact of the lack of facilities at UHW to isolate patients in relation to the prevention and control of infection. An update was requested for the June QSE meeting

BACKGROUND

The UHB has identified the condition of the estate as one of the highest risks facing the organisation, and there are plans to mitigate the risk as much as possible (which does mean tolerating conditions which are not as we would like them) whilst the longer term plans for the development of facilities that are fit for purpose are developed and implemented[1].

The recent Wales Audit Office review of the estates function recommended rebasing the estates budget and enabling a more proactive estates maintenance programme to be implemented. This will be challenging with the scale of remedial works being identified through the statutory compliance inspections.

The UHB receives a discretionary capital allocation of just under £15m per year (increased in 2016/17 from nearly £10m). This allocation funds all of the smaller UHB capital schemes including all of the estates compliance issues & backlog maintenance, IT infrastructure and backlog and medical equipment replacement.

The UHB completed an assessment in 2014 which indicated that in the order of £1.2b would be required over the next 10 – 15 years to make all of our facilities fit for purpose and that the current level of investment was not keeping pace with the upkeep of our existing buildings which were continuing to deteriorate. The discretionary capital programme is approved by the Board each year and reflects the most pressing priorities.

The isolation of an infectious patient resulting from an outbreak such as Acinetorbacter, does not require the use of a negative pressure facility but to contain the spread of the infection, it is essential that single rooms with en-suite facilities are available.

In relation to negative pressure isolation rooms, these are only used in the most severe cases, where a patient has, for example, multi drug resistant TB.

The UHB have a number of fully compliant negative pressure rooms in the following areas:

Emergency Unit
Ward A7 (Medical Ward)
Children's Hospital
Ward A3 (Critical Care)

The above facilities meet the requirement of the WG directive on the provision of negative pressure isolation rooms on acute sites.

ASSESSMENT AND ASSURANCE

The general wards at UHW have a small number of single rooms but these do not have en-suite facilities, which results in the patient having to leave the room to use the bathroom facilities shared by the other patients, increasing risk of spreading the infection.

Health Building Note 04-01, Isolation facilities for infectious patients in acute setting, acknowledges that *'A single-bed room with en-suite facilities is a simple way to provide isolation and will meet the needs of most patients on general wards.'*

To increase the number of single rooms with en-suite facilities on the ward would require a re-modelling of the ward and result in a reduction in bed capacity.

The alternative is to identify a ward area that could be converted to 100% single rooms to deal with any individual(s) in the event of then contracting an infection. Additionally the area could be used to decant into to undertake a planned refurbishment of a ward or in the event of an outbreak patients could be relocated to allow any urgent works or HPV cleaning to be undertaken.

As a result of an infection outbreak, B6 south ward (trauma) is currently undergoing refurbishment and there is agreement that once this work is completed. B6 north will be refurbished, and medical ward will be refurbished following this, on the same model. This means that around 19 beds will be out of commission during the period of the refurbishment programme. The beds would become available prior to the winter.

In order to create additional surge capacity this winter, the redevelopment of the Duthie Library area (which forms part of the neonatal business case and will become a colorectal ward eventually) is being brought forward.

As described previously to increase the number of single rooms available is not possible without significantly reducing bed numbers and incurring significant capital costs. Work has commenced to start to scope the replacement of the existing main building on the UHW site. This will involve detailed work on the service model so that the facility meets our requirements and reflects the principles set out in Shaping Our Future Wellbeing. New hospitals are required to provide many more single rooms. The planning assumptions include 50% of the beds being single room. This assumption will need to be tested as part of the detailed planning.

The inpatient haematology ward has been identified as a priority for re-provision as the environment is not appropriate for the care provided. Due to the treatment provided, some patients are required to spend extended periods in single rooms which currently do not have en-suite facilities. A medium term plan has been developed to address all of the service needs, but this would require the development of a full business case in order to secure capital funding from Welsh Government, and the national capital programme is under

pressure over the next few years so it is not guaranteed that the funding will be available. Therefore alternative solutions are being considered which will require freeing up a ward by another service area. The plans will be firmed up in the next two months.

COMMUNITY MENTAL HEALTH TEAM ACCOMMODATION UPDATE ON PLANS
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 20th June 2017

Executive Lead : Director Strategy & Planning
Author: Director of Capital, Estates & Facilities. Tel 029 2074 4335
Caring for People, Keeping People Well: This report underpins the Health Board's "Our Service Priorities" and "Sustainability" elements of the Health Board's Strategy.
Financial impact : Not Applicable
Quality, Safety, Patient Experience impact:
Health and Care Standard Number: 2.4
CRAF Reference Number: 5.2 & 6.4.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Long term solution identified as part of Shaping Our Future Wellbeing in the Community Programme.
- Short term solution being considered at joint meetings with Local Authorities from Cardiff and The Vale.

The QSE Committee is asked to:

- Note the situation in relation to the current CMHT accommodation.
- Note to potential outcome of the review of CMHTs and the implications for accommodation.

29

SITUATION

At its meeting in April 2017, the QSE Committee expressed concern regarding the poor condition of some of the CHMT accommodation. This paper sets out the outline plans for the development of the CHMTs and the consequences for the facilities required.

BACKGROUND

The UHB has identified the condition of the estate one of the highest risks facing the organisation, and there are plans to mitigate the risk as much as possible (which does mean tolerating conditions which are not as we would like them) whilst the longer term plans for the development of facilities that are fit for purpose are developed and implemented.

The recent Wales Audit Office review of the estates function recommended rebasing the estates budget and enabling a more proactive estates maintenance programme to be implemented. This will be challenging with the scale of remedial works being identified through the Estate compliance surveys.

The UHB receives a discretionary capital allocation of just under £15m per year (increased in 2016/17 from nearly £10m). This allocation funds all of the smaller UHB capital schemes including all of the estates compliance issues & backlog maintenance, IT infrastructure and backlog and medical equipment replacement.

The UHB completed an assessment in 2014 which indicated that in the order of £1.2b would be required over the next 10 – 15 years to make all of our facilities fit for purpose and that the current level of investment was not keeping pace with the upkeep of our existing buildings which were continuing to deteriorate. The discretionary capital programme is approved by the Board each year and reflects the most pressing priorities.

The UHB currently has eight community mental health teams that are made up of health and social care staff. The team's locations are as follows:

- Llantwit Major/Cowbridge NEEDS TO BE CONFIRMED (rented accommodation)
- Barry (Amy Evans)
- Penarth (rented accommodation)
- Ely Pendine Centre
- Grangetown Royal Hamadryad
- Gabalfa health centre
- CRI
- Pentwyn Health Centre

ASSESSMENT AND ASSURANCE

The CMHT's are generally based in poor quality facilities which do not support the delivery of modern mental health services. An update survey is currently being undertaken to determine, the Physical condition, functional suitability and utilisation of our Estate.

The Mental Health Clinical Board has completed a review of the CMHT service model in light of increasing difficulties in meeting rising demand and the providing the full range of community services. This review has involved key stakeholders including the two local authorities and patients.

The outcome of the review is a recommendation to reduce the number of CHMTs from eight to three so that each team (one per locality) has a critical mass to provide crisis services, on-call rota and more specialist services, in line with our strategic plan for mental health services. The Integrating Health and Social Care Strategic Leadership Team (directors from each of the Statutory partners and the third sector) will formally consider the outcome of the review at its meeting in July. The CHC has also been briefed on the outcome of the review and this will be discussed at the next Service Planning Committee. If it is agreed to proceed with merging the CHMTs to form three, new bases will need to be identified. It is unlikely that the existing bases will be suitable to house any of the CMHTs due to the size. Patients would continue to receive most of their care in a range of locations in the community including GP practices, community hubs and health centres. Discussions have commenced with the two local authorities to identify accommodation options, recognising that if it was agreed that we needed to form the new teams quickly due to the pressures facing the service, interim accommodation solutions may need to be identified whilst permanent solutions are identified.

The Shaping Our Future Wellbeing in the Community is developing the model for our community infrastructure that will need to be in place in order to deliver the objectives of our strategy. The detailed service specifications for the health and wellbeing and cluster hubs is being finalised and it is likely that this will the location of the CMHTs in the health and wellbeing hubs. The development of the hubs will be the subject of a programme business and a number of individual business cases in order to secure the capital required to deliver the service model.

HER MAJESTY'S CORONER REGULATION 28 PREVENTION OF FUTURE DEATHS REPORTS
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting :** 20th June 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 investigation in conjunction with the response 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 investigation and Coroner's recommendations.

30

SITUATION

In April 2017 the University Health Board received a Regulation 28 Prevention of Future Deaths Reports, from Her Majesty's Coroner. It related to issues regarding the use of Point of Care Ultrasound in the Emergency Medicine setting.

BACKGROUND

The Coroner has a legal duty following an inquest to consider 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 April 2017 the Coroner returned a narrative conclusion that a patient had sadly died as a result of complications following a ruptured thoraco-abdominal aneurysm.

The patient had attended the Emergency Unit in January 2017 with severe abdominal pain. He underwent an ultrasound scan of the abdominal aorta in the department. This revealed an aneurysm with a diameter of 40 mm. Following medical review, the patient was discharged for outpatient follow up. The patient attended his GP during that week to discuss the abdominal pain and outcome of his ultrasound scan. His abdominal pain persisted and he re-presented to hospital several days later. Examination revealed a ruptured aortic aneurysm. The patient underwent emergency surgery but sadly died later that day.

The Coroner raised the following issues of concern with the UHB:-

- Consideration should be given to reviewing the procedures related to the training and supervision of those undergoing training in conducting FAST (Focused Assessment with Sonography in Trauma) Ultrasound examinations.

- Consideration should be given to reviewing your procedures for recording the outcome of FAST Ultrasound examinations.
- Consideration should be given to reviewing your procedures surrounding the management of symptomatic patients where an AAA has been identified by a FAST Ultrasound examination.

The UHB is in the process of responding to the Coroner.

The Emergency Medicine Directorate follows Royal College of Emergency Medicine guidance in relation to the training and competencies for Point of Care Ultrasound (PoCUS).

Procedures relating to PoCUS have been revisited to strengthen them. To that end, the Ultrasound Governance group is supporting the embedding of revised procedures through the Ultrasound Governance Framework. A Medical Ultrasound Risk Management Policy and Procedure is in place.

Additionally, all patients who present to Emergency Medicine with a new diagnosis of an abdominal aortic aneurysm diagnosed in this manner, will be referred to the Radiology Department for consideration of further investigations and for surgical review.

The Regulation 28 and response will be shared with all Clinical Boards for their learning.

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

MINUTES OF THE MEETING HELD ON 12TH APRIL 2017

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Mike Bourne	Clinical Board Director
Lisa Griffiths	Quality Manager, Laboratory Medicine
Hattie Cox	Graduate Management Trainee
Rebecca Pettit	Medical Physics Quality and Safety Lead
Suzie Cheesman	Patient Safety Facilitator
Maria Jones	Senior Nurse, Outpatients
Bolette Jones	Acting Head of Media Resources
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration

Apologies:

David Lewis	Head of Finance
Matthew Temby	Clinical Board Director of Operations
Ceri-Ann Hughes	Head of Workforce and OD
Rhodri John	Assistant Head of Workforce and OD
Ian McMullin	Business Manager, Therapies
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sarah Jones	Pharmacy Quality and Safety Lead
Darrell Baker	Clinical Director, Pharmacy and Medicines Management
Rachael Daniel	Health and Safety Adviser

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

31.1

CDTQSE 17/113 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 17/114 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 17/115 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 22nd March 2017 were **APPROVED.**

CDTQSE 17/116 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 16/318 Purple Syringes

Due to a change to N-fit type syringes which are an international standard, connectors are being used until all old stock is depleted. A small batch will be provided to Radiology.

CDTQSE 16/340 Non Medical Prescribers

Alun Morgan will provide Maria Jones with the names of the individuals in Therapies.

Action: Alun Morgan

CDTQSE 17/080 Medical Examiner Role

Lisa Griffiths to consider the implications for Laboratory Medicine following changes to the Medical Examiner role.

Action: Lisa Griffiths

CDTQSE 17/082 Incidents

Sue Bailey has reviewed the open incidents for the Clinical Board that are greater than 30 days old. There are 393 incidents in total and 25% of these sit in other Clinical Boards, particularly in PCIC Clinical Board and mainly around labelling. She will escalate to Brendan Boylan and Sue Morgan that there are open incidents requiring action from PCIC Clinical Board.

Action: Sue Bailey

It was also noted that there is work to be undertaken in directorates to close the incidents that are being managed in this Clinical Board.

It was reported that a LIPs project is being undertaken in Laboratory Medicine to look at the scale of the problem of incomplete request forms/mislabelling of samples.

CDTQSE 17/086 Communicating Dignity and Respect Training

Ceri-Ann Hughes has enquired if any training is being provided in-house and is awaiting a response from LED.

CDTQSE 17/098 Professional Conduct Issues

It has been clarified that professional conduct issues are reported in the UHB but not through the safeguarding route.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 17/117 Patient Story

Hattie Cox presented a story involving a deceased patient admitted to the Mortuary. On 21st February, the patient was admitted to the mortuary by a nurse and a porter. When patients are admitted they are transferred to storage areas using an automated hydraulic tray hoist. It was noted by the attending nurse that the patient was placed in storage area R4 in the walking unit, however the patient was actually placed in M5 (also in the walking unit).

A daily body check was carried out on 22nd February which showed no record of injury to the forehead. The incorrect location was noticed and the register was corrected. No record of the error was raised with nursing staff or porters. The annotation was not signed/dated and an incident form was not raised on E-Datix.

A week later the patient was being released to the care of a Funeral Director. Routine checks were carried out during which the APT noticed an injury on the patient's face. A laceration across the forehead in a v-shape, approximately 5cm long was noticed. The APT informed the Funeral Director the patient could not be released at that time. The Head of Service for the Mortuary was informed and he attended the department to view the injury. The Head of Service informed the next of kin. The next of kin submitted a formal concern. The Head of Service was in contact with the next of kin on several occasions and has sent a formal written apology.

It was suspected that the laceration was caused by the trolley and a new trolley was ordered and the current trolley taken out of use. A repair of the laceration was completed following consent from the next of kin. A full review was undertaken of all patients in the mortuary and it was confirmed that no other patients had received injuries.

An RCA was carried out and it was identified that the trolley was used following manufacturer's instructions and weight limits. The staff operating the trolley had received appropriate training and competency assessments. When the hoist is in use it initially jolts forward to engage the tray. It has a v-shaped piece of metal underneath. As the APTs were releasing the patient, this jolted forward and the v-shape metal bar cut the forehead of the patient. The rollers within the fridge area upon which the trays move had become misaligned. It was also noted that there was no physical barrier to prevent the trolley from entering the tray area.

There are no checks or maintenance schedules in place for tray rollers and the mortuary team do not have copies of the procedure for identifying and escalating damage to equipment. t was identified that maintenance schedules need to be put into practice and the culture for incident reporting needs to be improved.

A full audit of the mortuary is being undertaken against HTA, CPA and ISO 15189:2012 Standards. It was noted that the incident is reportable to the HTA. It was suggested that a review of processes around the training for nurses should be considered as part of the audit.

At the next meeting, the patient story will be based on the report being submitted to the Coroner.

CDTQSE 17/118 Revision of Terms of Reference

The revised Terms of Reference for the Sub-Committee were **RECEIVED**. It was noted that changes to job titles are required. It was suggested that the terms of reference should state the core members that need to be present in order for the Group to be quorate. Alun Morgan will seek advice on this from Carol Evans.

Action: Alun Morgan

Mike Bourne raised concerns that in the absence of representatives, delegates from directorates are not attending. Sue Bailey will send out a reminder to directorates.

Action: Sue Bailey

Sue Bailey will make the amendments to the terms of reference and submit the document to the Clinical Diagnostics and Therapeutics Clinical Board Meeting.

Action: Sue Bailey

CDTQSE 17/119 Feedback from UHB QSE Committee 21st February 2017

The minutes of the meeting held on 21st February 2017 are not yet available.

CDTQSE 17/120 Health and Care Standards

An update of the self assessment for the Clinical Board against the Health and Care Standards was **RECEIVED**. The deadline for submission is end of April.

CDTQSE 17/121 Risk Register

There are no new risks or updates for the Clinical Board risk register. An Extraordinary Meeting will be held to focus on the risk register in July.

Action: Helen Jenkins

CDTQSE 17/122 Exception Reports

Nothing to report.

CDTQSE 17/123 Clinical Board QSE Scorecard

To be updated for the next meeting.

Action: Sue Bailey

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/124 Initiatives to promote Health and Wellbeing

A briefing on changes to Lucozade Energy, Ribena and Orangina was **RECEIVED.** It was noted that Lucozade Ribena Suntory is reducing the sugars and carbohydrate levels of their drinks by approximately 50%.

CDTQSE 17/125 Falls Prevention

Alun Morgan and Tim Banner will be undertaking work around supporting falls prevention on an inpatient basis. It was also noted that Judyth Jenkins is leading on a piece of work around nutrition and hydration that will have a positive impact on patient falls.

SAFE CARE

CDTQSE 17/126 Concerns and Compliments Report

The Clinical Board received 3 formal concerns in March. There was 1 breach in response times in the Outpatient/Patient Administration directorate. The Clinical Board has received 56 concerns between 1st April 2016 and 31st March 2017.

1 AM concern was received in March for the PET service which is not a service that sits within this Clinical Board and the PET service has responded to the AM directly. The Clinical Board received 9 AM Concerns between 1st April 2016 and 31st March 2017.

7 compliments were received in March. The Clinical Board has received 110 compliments between 1st April 2016 and 31st March 2017.

The key theme of formal concerns is communication issues between staff and patients; 31 of the 56 formal concerns related to this issue. It was noted that difficulties in arranging and cancelling appointments falls within this category.

Helen Jenkins and Sue Bailey will review the concerns relating to communication issues to identify if there are any trends/communalities.

Action: Helen Jenkins/Sue Bailey

CDTQSE 17/127 Ombudsman Reports

Nothing to report.

CDTQSE 17/128 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/129 Patient Safety Incidents

The Serious Incident report was **RECEIVED.** Sue Bailey reported that IRMER incidents no longer reported to Welsh Government and are reported to Health Inspectorate Wales (HIW). New guidelines have been issued relating to thresholds of greater than intended doses, therefore 2 incidents were not reportable to HIW. However all incidents are still being reported on Datix and are being investigated.

In terms of outstanding Serious Incidents:

In34781 IRMER right shoulder – the incident closure form has been completed.

In33308 Unintentional IA injection of Noradrenaline – closure form has been submitted.

In38935 CT colon incident

In38916 Physiotherapy patient who sustained a fracture – closure form to be submitted.

CDTQSE 17/130 New SI's

Nothing to report.

CDTQSE 17/131 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/132 WG Closure Forms – Sign Off

The following closure forms were received for sign off:

In38916: Physiotherapy patient who sustained a pathological fracture through a bony metastasis during an assisted transfer. The investigation has not identified that unreasonable force was used. It is recommended that the RCA is shared with Surgery Clinical Board for learning purposes.

In34781: Patient attended CRI for a plain film x-ray of the right shoulder. A review of outstanding studies without a report on the Radiology Information System indicated that no image had been archived on the PACS system against the patient. A further appointment was made the patient however the patient failed to attend and further contact with the patient was not successful. As the examination was not completed the radiation dose he received is considered to be unintended. An investigation was undertaken and it was recommended that a system should be put into place to prompt the user that x-ray review of archived images has been undertaken in a timely manner. This procedural step should be documented in a training procedure.

31.1

CDTQSE 17/133 Regulation 28 Reports

Nothing to report.

CDTQSE 17/134 Patient Safety Alerts

MDA 2017 003 Alaris Syringe Pumps

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

WHC 2017 014 – Putting Things Right Leaflet

The WHC has been circulated to directorates to advise that updated leaflets are available for patients who wish to raise a concern.

WHC 2017 017 – HCAIs – targets

There are reduction expectations for Wales for healthcare associated infections. The notice has been circulated across directorates.

Piperacillin/Tazobactam SBAR

Notification has been received around the availability of the antibiotic which is anticipated to be severely constrained from April to the beginning of July.

CDTQSE 17/134 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/135 IP&C Issues

The Clinical Board raised issues with the Learning and Education Department that focus and resources for Aseptic Non Touch Technique (ANTT) was being placed on nurses. This was acknowledged and a Clinical Board ANTT Group has been set up to work through the procedures and identify trainers. Places have been allocated for appropriate Clinical Board staff on the UHB training. There are issues relating to Phlebotomy which will be discussed with the Head of Service.

CDTQSE 17/136 Key Patient Safety Risks

Safeguarding

There has been no further meeting of the Safeguarding Group since the last meeting of this Group.

It was noted that there are new mandatory training modules to complete for domestic violence, Dementia and the Mental Capacity Act.

Mental Capacity Issues

Maria Jones and Sue Bailey have been tasked to produce a Clinical Board update report to the UHB Mental Health and Capacity Legislation Committee.

CDTQSE 17/137 Health and Safety Issues

The Clinical Board Health and Safety Report was **RECEIVED**. The report notes the ongoing work to meet the requirements of the Clinical Board action plan. The following issues are being reported as a Red status on the action plan:

- The status of the storage of liquid nitrogen in the stem cell processing unit has escalated from Amber to Red due to a delay in implementing the capital scheme.
- DSEAR compliance to regulations requires areas of potential explosives to be assessed. Radiology and Media Resources are undertaking an investigation of any old celluloid film that may be in storage.
- Risks have been identified around emergency evacuation of bariatric patients that are in care higher than the first floor.
- Fallen patients – Hover Jacks are being procured for the UHB to safely move fallen patients with risk of spinal injuries.

The Clinical Board Health and Safety Group was held last week. Fire training compliance has fallen to 69% and directorates are to encourage staff to complete their fire training. There is a new method of accessing mandatory training through ESR via a new icon on the desktop.

It was reported that obsolete manual handling equipment will be replaced.

Concerns were raised around the breakdown of lifts.

CDTQSE 17/138 Regulatory Compliance and Accreditation

Nothing to report.

CDTQSE 17/139 Policies and Procedures

A Blood Glucose Monitoring Practice Update was received from the Learning and Education Department to ensure that clinical staff are undertaking safe practice.

EFFECTIVE CARE

CDTQSE 17/140 Clinical Audit

Nothing to report.

CDTQSE 17/141 Research and Development

A document on how to manage the process for the Clinical Board's allocation of R&D funding is out to consultation with directorates and the R&D Group. The paper proposes 3 options:

- Do Nothing,
- A Clinical Board managed approach,

- A tender process where directorates evidence where R&D activities are taking place.

The preferred option is a Clinical Board managed approach. Following consultation with directorates, the document will be presented to the next Clinical Diagnostics and Therapeutics Clinical Board meeting for discussion.

CDTQSE 17/142 Service Improvement Initiatives

It was noted that there are numerous schemes relating to service improvements within the Clinical board IMTP process.

The new LIPs cohort has commenced this week. There are a number of participants from within this Clinical Board.

CDTQSE 17/143 NICE Guidance

Alun Morgan and Sue Bailey will review the process for managing NICE guidance within this Clinical Board.

Action: Alun Morgan/ Sue Bailey

CDTQSE 17/144 Information Governance

The ICO are auditing the UHB next week. The latest guidance from the ICO has been circulated to directorates.

DIGNIFIED CARE

CDTQSE 17/145 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

A CHC visit to CRI X-ray department is scheduled for 12th June 2017.

CDTQSE 17/146 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

The new radiology reception area is almost completed. The design meets the RNIB's 'Visibly Better' Standard. Learning from the design will be replicated in other areas.

Patient pagers are being trialled in Outpatient clinics and feedback has been positive. Going forward the department is looking to use the pagers for sensory loss patients to avoid calling out patient names.

TIMELY CARE

CDTQSE 17/147 Initiatives to Improve Access to Services

The Outpatients Department is also due to pilot text reminders for outpatient appointments which will benefit patients with sensory loss.

CDTQSE 17/148 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The Clinical Board acknowledged the high performance it has achieved against tier 1 targets this year.

INDIVIDUAL CARE

CDTQSE 17/149 National User Experience Framework

Sue Bailey is in discussions with the Patient Experience Team of what other methods can be used to obtain patient feedback aside from the User Surveys. The Clinical Board is particularly interested in capturing patient outcomes.

It has been agreed that the Outpatients department will pilot patient experience kiosks.

STAFF AND RESOURCES

CDTQSE 17/150 Monitoring of Mandatory Training and PADRs

The Clinical Board's compliance against the key workforce targets were noted:

- PADRS 70% compliant
- Medical appraisals 94.29% compliant
- Mandatory training 81% compliant

The Staff Recognition Awards were held on 24th March and it was pleasing that there were many nominations for staff within this Clinical Board.

Work is being held in the Workforce and OD department to triangulate the staff survey data, the medical engagement score and the UHB values work.

Work will also be undertaken to reinvigorate the Clinical Board's engagement plan and for individual directorates to develop their own engagement plans.

31.1

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The Outpatient/Patient Administration Directorate QSE Minutes 20th March 2017 were **RECEIVED.**

ANY OTHER BUSINESS

Mike Bourne formally thanked Sue Bailey and Matt Temby for all their efforts around the planning and design of the radiology reception area which will make a huge difference to patients, particularly those with sensory loss. Sue Bailey thanked Jonathan Avers for his support with the project.

DATE AND TIME OF NEXT MEETING

10th May 2017 at 2pm in Room 2.8. 2nd Floor, Ty Dewi Sant UHW

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

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
16th March 2017
Seminar Room, Hafan y Coed, Llandough Hospital

Present:
Jayne Tottle, Director of Nursing Mental Health (Chair)
Simon Amphlett, Senior Nurse Crisis & Liaison Services
Philip Ball, Deputy Senior Nurse Manager, CMHTs
Miranda Barber, Service Lead Cynnwys
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Alison Edmunds, Concerns Co-ordinator
Ceri Evans, Consultant Psychiatrist MHSOP
Heather Hancock, Deputy Directorate Manager Adult MH
Emily Hill, Psychologist
John Hyde, Lecturer, School of Healthcare, Cardiff University
Robert Kidd, Consultant Psychologist
Neol Martinez-Walsh, Integrated Manager Pentwyn CMHT
Peter Murray, Integrated Manager, Gabalfa CMHT
Bala Oruganti, Consultant Psychiatrist Crisis Team
Rakesh Pankajakshan, Consultant Psychiatrist Amy Evans CMHT
Tara Robinson, Team Lead Assertive Outreach Service
Rob Stamatakis, Consultant Forensic Psychiatrist
Somashekara Shiva, Consultant Psychiatrist Links CMHT
Jayne Strong, Interim Senior Nurse Manager Rehab & Recovery
Andrea Sullivan, Concerns Co-ordinator
Kim Tallett, Lead CPN Amy Evans CMHT

Apologies:
Jayne Bell, Lead Nurse Adult Mental Health
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director of Patient Safety & Quality
Catherine Evans, Patient Safety Facilitator
Nicola Evans, Professional Head MH Nursing, Cardiff University
Louise Flynn, Senior Nurse MHSOP In-patients
Martin Ford, Directorate Manager PMHSS/Psychology/Veterans
Lisa Lane, Senior Nurse MHSOP Community/Neuro
Sabari Muthukrishnan, Clinical Director MHSOP
Annie Procter, Director Mental Health
Ian Wile, Head of Operations & Delivery Mental Health
Paul Williams, ANP Adult Acute
Lowri Wyn, Ward Manager, Cedar Ward

31.2

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 SI

SI was a complex case. SI had a very intense and robust package of clinical and non-clinical support in the community, which was backed by a detailed risk management plan. Her mother wanted to support her at home, rather than her be hospitalised.

SI was using self-harming behaviours that were of very high risk to her life. It is evidenced throughout the records that the risks associated to the behaviours were discussed and explored with her regularly, and that she was aware and understood them.

Very sadly, SI was found hanging at her home. Her cause of death was:

1a) pressure on the neck consistent with hanging.

The Assistant Coroner returned a narrative conclusion as follows:
SI was found hanged at her home address. She had placed a cord around her neck which she tied to a banister. Her intentions at the time remain unclear.

SI attended DBT group a few days before her death and had a discussion around self harming thoughts, coping skills and options to manage her thoughts to keep her safe.

It was emphasised to SI that when staff are not available on-line forums could be accessed.

SI did not want information shared. There was a discussion about patient confidentiality and if a breach of confidentiality could be considered at times to protect the patient.

Lesson Learned:

Dilemma about whether to share information when the patient does not give consent to share.

The process of contacting the family after an incident was looked at.

Share the MCR/RCA with the family before the Coroner so that there are no more surprises; be open and transparent with the family.

TO CLOSE.

3.2 ND

ND's psychiatric history dates back to 1999. ND was diagnosed with Schizophrenia and substance misuse.

ND was referred for additional support with the Assertive Outreach Service in 2015 and there was regular contact, initially at least 3 times a week, as well as support from the Community Psychiatric Nurse.

A Mental Health Act assessment was carried out in 2016 following concerns that ND's mental health had deteriorated. ND agreed to continue with his prescribed depot medication and engage with Mental Health Community Services and it was agreed by the assessing team that ND was not to be detained under the Mental Health Act.

A couple of months later, hospital admission was discussed with ND due to concerns that he was showing signs of relapse, however, ND refused admission. A referral was made to the Approved Mental Health Manager for a Mental Health Act Assessment as ND voiced some delusional ideas, with increased agitation and hostility and had refused hospital admission. ND was assessed but the Assertive Outreach Service and the Community Psychiatric Nurse were unaware of the outcome of the assessment until the following day, when ND's mum contacted them to voice her concern that ND had not been not detained. During the assessment ND stated that he would engage with community services and remain compliant with depot; outcome of the assessment was that he was therefore not detained.

A few weeks later, ND overdosed and was taken to A&E. All contact details and information including history and concerns about ND's current presentation was handed over to A&E staff. The Assertive Outreach Service did not contact ND's mother at this stage as they believed that the A&E staff would contact ND's mother with further details when known. A& E staff referred ND for review with Liaison Psychiatry due to concerns about his presentation. ND was assessed and no evidence of delusional beliefs were present and there were no intent or plans to harm himself or others. ND showed little insight into how substances had a detrimental effect on his mental state. However, it was acknowledged that ND had been impulsive and reckless over the past few weeks and it was strongly felt that ND needed an informal admission for a period of assessment to see how his mental state was without substance use. The Crisis Team offered ND informal admission as recommended but ND refused informal admission. The assessing staff did not feel that the presentation warranted further assessment under the Mental Health Act.

The next day ND was found unresponsive in his room and transferred to A&E. The Assertive Outreach Service contacted ND's mother to inform her. Assessment of ND's physical wellbeing was undertaken by A&E staff and ND's family were advised that there was significant swelling to ND's brain, and medical intervention would be removed later that day when ND's family were present, and that ND's prognosis was poor. ND sadly died later that evening.

Lesson Learned:

ND had a long standing history of poly substance abuse, and support was offered to help him address this. ND refused this support on a number of occasions. ND had not disclosed that he had considered using or had injected insulin.

ND's mother was not informed about the first overdose by the Emergency Department. It is standard practice by A&E for all patients to be asked whether they would like nearest relative/family member to be informed of admission. If the patient refuses and the patient is deemed to have capacity, then their wishes are respected and family are therefore not informed. If the person is considered to be seriously unwell, and the situation is considered life threatening, then consent is overridden.

The family felt that the first overdose was a suicide attempt and that if ND had been discharged with family support the second overdose would have been prevented.

The Hostel that ND lived in felt that Mental Health Services did not respond appropriately to their concerns. There was a lot of communication but they felt that ND should have been hospitalised.

Issues identified:

The assessing doctor was a Locum and did not know the patient's long term history.

No contact with mother regarding any concerns and no contact with mother at time of Mental Health Act Assessment.

Contributory Factors:

- Lifestyle
- Engaging in high risk behaviour
- Motivation issues- lack of motivation to change lifestyle/address drug use.

Recommendations:

Consideration to be given to whether the Crisis Service Assessment referral form could include a prompt for assessing staff to ask the Service User if they would like their Nearest Relative or family member to be informed of the assessment and include the details of who to contact following assessment with the outcome.

The PARIS User Group to consider adding “share information with”.

TO CLOSE.

3.3 PC

PC was found deceased at a Quarry in Rhoose, Vale of Glamorgan. PC had written a suicide note and made funeral arrangements

PC who was 64 years of age had been known to the Community Mental Health Team since May 2012 and had attended Out-Patient Clinic from June 2012 to September 2015. In September 2015 PC was discharged back to the care of his GP.

PC had a long history of treatment resistant depression with on-going suicidal thoughts. The Community Mental Health Team had tried to produce change with 1 to 1 appointments, psychological interventions to address negative thoughts and advice on life style changes but there was very little change in presentation. PC was offered a trial of CBT which PC declined.

PC had long standing thoughts of suicide but was not detainable under the Mental Health Act as he had capacity.

Conclusion:

PC turned up for out-patient appointments but he was passive and did not get any better.

PC did not have any money problems. PC was not neglecting himself. PC was seeing his grandchildren.

PC had treatment resistant depression and maybe could have been discharged earlier.

TO CLOSE.

3.4 DS

DS was assessed under Section 136 by staff in the Emergency assessment suite. Following assessment DS was told that he did not need to be in hospital. When he realised that he was not being offered hospital admission he reacted by getting up and trying to leave the room; he kicked the exit door as he could not get out. He was shouting and swearing. The Police tried to restrain him but DS assaulted the police.

A violent situation erupted which resulted in the police having to use batons and CS spray to restrain him. Members of staff who had responded to the emergency call were caught up in this and were affected by the CS gas.

DS was arrested following the above incident and released following a caution

A risk alert was placed on DS's PARIS notes.

The Police have updated markers on the Police database.

Lessons Learned:

The locks on the doors have been changed from buttons to a card.

If there is a risk of the patient running out, the door should be left open.

A Guidance for the Care of Patients subjected to Incapacitant Spray Procedure has been approved at Mental Health Clinical Board Quality, Safety & Experience Committee.

TO CLOSE.

4.0 DATE OF NEXT MEETING

18th May 2017 at 9.30am in the Seminar Room, Hafan y Coed.

MENTAL HEALTH CLINICAL BOARD QUALITY & SAFETY CLOSURE AND LESSONS LEARNED MEETING
18th May 2017
Seminar Room, Hafan y Coed, Llandough Hospital

Present:
Jayne Bell, Lead Nurse Adult Mental Health (Chair)
Philip Ball, Deputy Senior Nurse Manager, CMHTs
Owen Baglow, Clinical Lead for Quality, Safety & Governance
Kay Challoner, CPN Links CMHT
Des Collins, Ward Manager, Pine Ward
Martin Connolly, CPN Gabalfa CMHT
Alison Edmunds, Concerns Co-ordinator
Catherine Evans, Patient Safety Facilitator
Ruth Evans, Lead CPN Links CMHT
Sarah Fitch, CT3 Psychiatry
Cathy Ford, Clozapine Co-ordinator
Michelle Griffiths, ANP MHSOP In-patients
Emily Hill, Psychologist
Peter Murray, Integrated Manager, Gabalfa CMHT
Bala Oruganti, Consultant Psychiatrist Crisis Team
Dr Radhika Oruganti, MHSOP liaison consultant
Tara Robinson, Interim Senior Nurse Manager Rehab & Recovery
Nicol Smith, Trainee Forensic Psychologist
Victoria Sobkowski, Third Year Student MH Nurse
Kim Tallett, Lead CPN Amy Evans CMHT
Natalie Williams, Lead CPN Gabalfa CMHT

Apologies:
Jayne Tottle, Director of Nursing Mental Health
Dan Crossland, Occupational Therapy Clinical Lead
Adeline Cutinha, Consultant Psychiatrist, Gabalfa CMHT
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director of Patient Safety & Quality
Martin Ford, Directorate Manager PMHSS/Psychology/Veterans
Jayne Jennings, Ward Manager, Willow Ward
Najeeb Khalid, Consultant Psychiatrist, Hafan Dawel CMHT
Robert Kidd, Consultant Psychologist
Sarah Lloyd, Directorate Manager Adult MH
Sabari Muthukrishnan, Clinical Director MHSOP
Annie Procter, Director Mental Health
Suchitra Sabari, Clinical Director Adult MH
Ian Wile, Head of Operations & Delivery Mental Health
Jo Wilson, Directorate Manager MHSOP

31.2

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 GD

GD had been receiving services from secondary mental health, including the Clozapine Clinic, from the mid 1990s. GD experienced voice hearing but this improved with Clozapine. GD was referred to the "Hearing Voices" Group and attended the Clozapine Clinic monthly. GD was very sadly found deceased at home.

GD was due to attend Clozapine Clinic on 5th January but did not attend. This was not thought to be unusual due to the Christmas holiday period when GD usually visited family members out of the area.

GD did not attend on 12th January either so attempts were made to contact him but the house phone did not work and his mobile went straight to answer phone. Pharmacy confirmed that GD last collected his medication on 22nd December, which meant that he was not due a further prescription until 19th January. Contact made with GP and unfortunately was informed that GD had been found deceased on 3rd January. The cause of death was misadventure.

There was much discussion on non attendance of clients at Clozapine clinic. It was noted that clients attending clinic 4 weekly were more stable; clients attending weekly or two weekly, who do not attend, have to be contacted quickly. It was emphasised that Clinic staff know the clients and know when they have to contact them quickly.

There is a Protocol for non attendance at Clozapine clinic which is being updated to include infections. The Protocol is on the Mental Health Policy Group agenda and the discussions from today will be incorporated into the review.

There was a discussion on physical health monitoring of Clozapine patients. Blood tests are carried out and the patient is advised to contact their GP if they have any physical health problems.

Issues identified:

Risk assessment of long term Clozapine patients; how can it be assured that the suicide risk has not changed? Community Mental Health Teams assess clients once a year formally.

Some clients collect their monthly Clozapine late. It was considered that if they collect it two days late they should only receive 26 days not 28 days' supply as they could stock pile the excess. However, pharmacy still provides the whole 28 days medication. Pharmacy does not inform the Clinic if the client has not collected their medication; this issue is currently forming part of the current LIPS project.

Lesson Learned:

More discussions needed with pharmacy regarding supply and contact when the client has not collected their medication.

31.2

To link up with doctors to assure suicide risk of Clozapine clients is covered.

TO CLOSE.

3.2 PG

PG had a history of alcohol and substance misuse.

PG was referred to Entry to Drug and Alcohol Assessment Service (EDAS) for assessment and was referred to Newlands Alcohol Team. PG very sadly died whilst on the Newlands waiting list.

PG had been on the waiting list for 11 weeks at the time of death. It was noted that at the time there was only one administrator which meant that clinical staff had to cover administration during the absence of the administrator.

Lesson Learned:

Extra administrator cover has now been identified from former EDAS resources and the waiting list has improved.

At the time some Cardiff & Vale Services believed that patients could only be referred to EDAS after they had been discharged but now understand that referrals can be made before discharge.

The criteria for urgent and non urgent referrals was reviewed as part of the changes to EDAS.

The EDAS service has set a maximum waiting time target and the service has been re-configured to achieve this.

TO CLOSE.

PART 3 : GOOD PRACTICE

3.3 LP

LP self referred to Entry to Drug and Alcohol Assessment Service (EDAS) and had attended the Community Addictions Unit (CAU) since July 2015.

Throughout 2015 and 2016, with a 2 month break when in custody, LP was supported by Addictions Services

At LP's last attendance he stated that he had split up from his partner and needed alternative accommodation. An appointment was made for him to see the Independent Living Advisor to help him in finding accommodation. There were no concerns regarding his mental health at that time.

Shortly after LP's last appointment he was found deceased at home. Cause of death was pressure to neck/self suspension. There was no prior history of deliberate self harm or suicide.

Good Practice

It was noted that the team did everything in a timely fashion and gave every possible support to LP.

3.4 MB

MB was a long standing patient of the Community Mental Health Team (CMHT) and the Community Addictions Unit (CAU). Diagnosis of Psychotic Disorder with Poly Substance Misuse and multiple physical health issues. Very sadly MB was found dead at her flat.

Good Practice:

Good evidence of proactive recovery focussed engagement with the Assertive Outreach Service (AOS).

Good evidence of clear communication and management of physical health monitoring between the CMHT and the GP.

Documentation was helpful and recorded very well.

Annual Multi Disciplinary Team reviews were carried out.

Lesson Learned:

It was identified that a month before MB died her depot medication was given to her one week early. MB was given a very thorough examination of her mental health and physical functioning and there were no adverse effects. Advice and guidance is being sought from Pharmacy to clarify time frame of medication. An addendum will be added to the Depot Administration Policy. Louise Williams, Nurse Advisor in Medicines Management has completed training and guidance in the CMHT.

Louise Poley and Conrad Eydmann had developed a Dual Diagnosis plan but it is not specific so Adult Directorate is looking at the plan. Clinical Director, Suchitra Sabari, is going to nominate a Lead.

It was clarified that Section 117 review does not need Local Authority representation. Having a Local Authority representative is not statutory but the review must have appropriate attendance.

3.5 CP

CP was well known to the Cardiff Alcohol and Drug Team (CADT), the Community Addictions Unit (CAU) and Pine/Adfer Substance Misuse Ward. CP had several admissions to the in-patient detox unit. CP had a history of Bulimia, Alcohol related liver disease, recurrent alcoholic hepatitis, variceal bleeds, banding of oesophageal varicies, low mood, social anxiety, suicidal thoughts and dependent personality. CP also had involvement with the Eating Disorders Team and Pentwyn Community Mental Health Team. Very sadly CP was found dead at home. Cause of death was severe steatosis and cirrhosis, alcohol dependence.

CP was a complex case. It was noted that the Consultant Nurse for Substance Misuse had spent a lot of time supporting CP.

Good Practice

Support given was above and beyond.

Excellent team working which included CAU, Pine Ward, nursing staff and CADT staff.

Lesson Learned:

Pine Ward has now established a clear bed for urgent admission, time frames for admission and routes to admission and this is working well.

3.6 BD

BD had a long history of alcohol misuse/dependence. BD failed to attend appointments with the Community Addictions Unit (CAU); he had a history of poor engagement with services. Very sadly BD passed away. The initial suspected cause of death is carbon monoxide poisoning caused by a lit cigarette fire.

Good Practice:

Always seen very quickly at GP's request.

Risk assessments were carried out.

Family were contacted to encourage BD to attend appointments.

Issues Identified:

BD had a history of poor engagement with services.

BD posed a fire risk with lit cigarettes whilst under the influence of alcohol. He had previously had a house fire caused by a lit cigarette.

Lesson Learned:

At the time of BD's involvement, the Re-engagement service was not available to clients with alcohol problems. The service has since extended its remit.

A Fire Service assessment of his home may have been helpful.

BD did not give consent to share information therefore does this extend to sending condolences to family members? Advice to be taken from the Corporate team.

4.0 DATE OF NEXT MEETING

13th July 2017 at 9.30am in the Seminar Room, Hafan y Coed.

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 1pm ON TUESDAY 14th March 2017 IN ROOM 1, CRI

Present :	Dr Gareth Hayes	Clinical Director for Clinical Governance (Chair)
	Brendan Boylan	Clinical Board Director
	Kay Jeynes	Director of Nursing PCIC
	Nicola Evans	Head of Workforce and OD
	Rhian Bond	Head of Primary Care
	Helen O'Sullivan	Quality and Safety Manager
	Carol Evans	Assistant Director of Patient Safety
	Matt McCarthy	Patient Safety Facilitator
	Karen May	Divisional Pharmacist
	Anna Mogie	Lead Nurse, North and West Cardiff
	Ceinwen Frost	Lead Nurse, Vale Locality
	Nicky Hughes	Lead Nurse, South and East Cardiff
	Helen Earland	Senior Nurse Primary Care
	Dr Georgina Forbes	Department of Sexual Health – Presentation

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.	
	Apologises for absence S Morgan, Dr M Dyban,Lynne Topham, Denise Shanahan, Lance Carver.	
	Declarations of Interest Gareth Hayes asked for any declarations of interest – none noted.	
	Minutes of the previous meeting held 10th January 2017 The committee accepted the minutes as an accurate account.	

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	Carol Evans – Presented on Quality, Safety and Improvement Agenda In final stages of developing a Quality, Safety and Improvement framework which has been influenced by internal audits, national guidelines etc.... The focus is on broad cross-cutting issues rather than individual Clinical Boards so the key objectives focus on UHB strategies. Key priorities have been identified for each aim. CE provided an overview of these priorities and stated the focus would be on ensuring standard approaches to a number of areas. Discussions with Welsh Government are ongoing to ensure there is a holistic overview of the whole system to ensure both Primary and Secondary care are considered. CE stated the framework is going to the April Quality and Safety meeting for approval so invited any comments to be sent within the next 2/3 weeks. Once approved online and paper resources will be developed to ensure this is being understood and embedded. Questions were raised over whether a focus on statutory and regulatory compliance was included at an appropriate level in this framework. CE advised that this would be developed further but stated the document available for the meeting to view and comment on is part of a larger document which will include information on this.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
	Patient Story CF presented information on emergency admissions from nursing homes in the Vale. It was noted that data for April to December 2016 showed a higher rate of deaths than previous years, especially between July and September (13). This data was analysed and investigated in order to ascertain any commonalities. An analysis was also done on total deaths within each Nursing Home to identify if any outliers existed. One Nursing Home was identified as having a higher level of deaths per bed than others in the area but the causes of death did not indicate any areas of concern. The deaths between July and September were also analysed by individual patient data. CF noted that whilst there has been an increase in deaths the data does not indicate anything suspicious but that further discussions with the Nursing Home identified as an outlier may be needed to ensure there are no other issues locally. It was noted that none of the patients had an Advanced Care Plan in place and the group agreed that if these were further embedded throughout the system this may help address any issues, particularly if any of the deaths were linked to HCAI's rather than the original reason for admission.	
	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 :	

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	316 Learning Disability – Enhanced Service uptake in practices RB advised this is awaiting further information from the national negotiations and will be brought back once the information is available. **Updated Concerns Report (No item ref number registered)** KJ advised there is a revised process and we should now be receiving regular updates. This piece of work is concluded and will be removed from the action log. **Risk escalation Western Vale (No item ref number registered)** KJ advised this has now been logged as completed. **313 Review Progress Against S4H Key Improvements 2014-15** KJ advised this is due to be updated for 15 /16 within the next few days. **Vale of Glamorgan Network Coverage** CF stated she will look to contact Nigel Lewis (Head of IT) as has had difficulty in getting appropriate engagement with IT previously and has not yet escalated. **DOSH Unannounced Visits by CHC (No item ref number registered)** No further CHC unannounced visits but we have met with the CHC in the last few weeks to clarify the planned changes in DOSH. It has been noted it will be important to keep robust audit data and this can then be revisited after the pilot of Roath. **Audit Plan** KJ advised this has been completed. **Risk Escalation re: TVN Waiting List** CF advised this has been completed. **Use of Digital Cameras** CF advised that staff to be trained have been identified and are awaiting training to be organised. **Pressure Ulcer Report** To be discussed later on agenda	
	Risk Register KJ advised that the risk register folder was accidently deleted by an unknown person and could not be recovered so has been rebuilt using the register that had been sent corporately. KJ advised Chris Darling has raised this with IT but there is no way to audit how this happened. A review has been carried out with IT. AM queried why the data could not be recovered as servers should be backed up every 24 hours. BB and GH asked an update on where this has been escalated to and to be brought back to the next meeting.	**KJ / CD**

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Review Risk Log using 4 Ts
Risks highlighted at the meeting for further discussion were :

QS&E 000214 OOH'S
KJ advised we are not looking to reduce this risk due to the current escalation levels.

QS&E 0000113 Independent Sector
AM stated we have included this in the IMTP and completed a business case regarding additional nurse resource. We have gone out to recruitment but are aware that we are unlikely to have an increase in establishment for this. Unlikely to reduce at present due to increasing number of concerns around certain care homes.

QS&E 020714 – CHAP
NH advised a meeting with Ruth Walker and Graham Shortland took place last week and although the service is fairly robust on a day-to-day basis until June, the majority of staff are not permanent staff so the service remains a risk.

QS&E 160714 – Patient Flow
KJ advised there is unlikely to be any update on this but noted that last week there was an issue regarding DN capacity to support palliative patients and some hospice beds were closed due to IP&C issues. DN teams are increasingly needing to support palliative patients and can normally accomodate but can not always meet demand so patients may not receive optimum levels of care. There are ongoing discussions among a number of areas regarding this but demand cannot be easily foreseen due to speed at which palliative patients can decline.

QS&E 160714 – Equipment/JES
KJ advised no change in risk score. SLA document is progressing and risk register now in place. Financial arrangements are also being reviewed.

QS&E 110914 – Complex packages of care
AM stated a number of packages are still very fragile and one patient still remains in hospital. One of the care agencies we use is now on contract which has helped somewhat. Discussions are ongoing regarding procurement issues and we are looking to develop SLA's with independent agencies to help develop more robust and sustainable arrangements.

Patient initials to be removed from risk register.

PICC 160614 – Primary Care Estates and PCIC 0814 – Local Development Plans
Meetings are ongoing around this and the risk remains the same.

PCIC 051114 – DN Risk
AM advised this has been covered and a further risk is to be raised later in the agenda.

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PCIC - GMS Services/Primary Care Capacity and Sustainability.
RB stated that we are awaiting the outcome of contract negotiations and we are aware that the Sustainability Framework is being discussed nationally and this may make the service more attractive and increase use. This could result in the risk of us needing to provide support increasing.

PCIC – Pressure Ulcer Prevalence
KJ noted there is a revised draft process for pressure ulcer root cause analysis investigations being considered and links with shared safeguarding need further consideration as this is a health document so may not have agreement for other partners such as the Local Authority and police.

PCIC – Domicillary Care Provision
It was noted that there is not much additional capacity available but demand is not stable so can be difficult to predict. GH noted this is the only risk noted as having inadequate existing controls on the risk register but KJ advised it is difficult to change this as it is dependent on Local Authority. Senior level discussions are ongoing to look at how we work with local authorities through the formal commissioning group and how we commission the services but there has been difficulty in getting engagement regarding building capacity for the future.

VL - Wound healing Teams delay for assessment
CF advised Band 6 in post since December 2016 but is still in a shadowing phase so cannot link this post with reductions in waiting times. However this role has provided capacity for other staff to work with care homes, such as a Band 7 delivering regular teaching sessions around reducing pressure ulcer damage. Risk score has been reduced from 16 to 12 due to this but the full benefits of the additional role are not yet being realised.

SI - Vaccine Efficacy (Cold Chain Breach)
KJ advised this will be closed shortly once actions around communication have been agreed.

HMP Cardiff – Prescribing, Staff Stress, Environment
NH advised the service is nationally at a heightened level. We have met with the new Governor and are working together to look at ways of managing patient health better considering the environmental constraints caused by staffing within the prison itself. Work ongoing with Medicines Management group regarding night-time sedation and allowing prisoners to hold their own medication but this is not suitable for all prisoners.

HMP Cardiff – OOH's Provision
Tender for the OOH service has gone out and we have received interest from 4 organisations. NH advised was unaware of the timescale but robust interim arrangements are in place. It was noted the risk could not be reduced due to fragility of the service.

HMP Cardiff – MH Provision
BB queried whether the issues around HMP Cardiff could be described differently on the Risk Register as a governance review has taken place and has an action plan developed. At present risks to this service are discussed as one issue but the risk register has them split into three areas and does not

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	discuss the governance report or the related action plan. KJ will bring the report to the next meeting to discuss. **Cardiff CRT Medication Administration Procedure** AM advised the policy is still being drafted and should help resolve the issue around the thickening of fluids being administered by home carers. This will remain a risk until the policy is completed and signed off. **Continence Service Pressures** CF stated there was a risk escalation at the last meeting due to a reduction in administration staff and some changes in clinical staff which has resulted in an increase in waiting lists. The generic waiting list has increased from under 7 days to 4 weeks. Recruitment is ongoing and the situation should improve by July dependent on recruitment. GH noted that many of the risks do not seem to be updated from meeting to meeting and risks are remaining at the same level. KJ stated the narrative is continually being updated but GH stressed the need to review risk scores possibly decreasing based on actions being taken.	
	SI Log **<u>Current SI's</u>** **Incident re: Cold Chain Process** Already covered during Risk Register review **Incident re: Paediatric - GP Surgery/Ambulance Response** RCA is being carried out with WAST in order for learning to be cascaded out to practices. The SI was raised by WAST but is on PCIC log due to our involvement in the RCA. There is also an OOH's SI to be added to the log. HOS will do so. KJ advised a root cause analysis had taken place which flagged the need for an SI to be considered by the Executive Nurse Director. **<u>Closure Forms</u>** GH noted three closure forms submitted (IN31038, IN37294 and IN40602). MM stated there is useful learning to take from each of these. **<u>Medication Errors</u>** KJ advised this is new to the agenda and is reported through Executive Performance Review. KJ advised there is an issue over the timeliness of managers reviewing incidents raised on Datix and so wanted to ensure that team managers are reminded to check their incidents for any significant issues. At present no themes are being identified regarding medications errors and appropriate action and management of the incidents is taking place but there needs to be an increased effort to deal with incidents and log	

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	progress on Datix. AM advised there are difficulties when awaiting investigations from other Clinical Boards, but KJ stated the greatest concern is that some incidents do not appear to being viewed at all so either managers are not checking them, or they are not updating them so the data does not reflect an accurate status. KJ advised the Medication Error Log will be bought to this meeting in the future. GH asked if patient details could be redacted for future meetings. MM advised he would see if we could add the date incident raised on E-Datix for reference.	
	Risk Escalation Reports **<u>District Nursing Workload Allocation Spreadsheets</u>** AM described an issue regarding IT compatibility which is corrupting the various DN Allocations Spreadsheets and could result in a risk to patients if files are lost. Advised there is a need to involve IT in supporting solutions but there have been difficulties in engaging them. KJ advised this risk will be added to the Risk Register. HE advised she has two Risk Escalation Reports to be bought forward which have not yet been submitted. One is concerning the use of Trac as band 7 bank roles have been approved but are not going live on the system and so staff cannot begin employment. BB asked what actions are being taken due to OOH's being our highest risk. NE stated there have been discussions ongoing but needs to be escalated further with WOD. BB asked for this to be taken to SMT. Other OOH issue is regarding IT support for OOH's concerning connectivity between IT and Adastra. KJ advised we would look to escalate this to IT for a response as there have been difficulties in engaging IT so far.	**KJ/CD**
	Information Governance Group Minutes 12.01.2017 KJ advised this was included for information.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
	Nothing covered under this section.	
SAFE CARE		**Action**
	Patient Safety Incidents **<u>Interface Incidence Update</u>** HOS advised an SBAR was recently developed looking at the interface incident process and it was identified that there were almost 200 incidents	

	reported between April 2016 and February 2017. Progress is continuing regarding developing some of the issues around the interface and MM is involved in this work. Policies/processes regarding communication between primary and secondary care are being developed and GH noted the GMC have published information regarding responsibilities around communication. KJ advised we are still looking to roll out Datix to GP practices to allow better reporting and links between primary and secondary care. MM and HOS commented that a number of system issues are reported on Datix as incidents so it is important to clarify what should be reported through Datix in order for issues to be dealt with appropriately.	
	Audit On Gonorrhoea Dr Georgina Forbes stated that Public Health Wales data had shown a reduction in gonorrhoea rates in Cardiff and Vale, so an audit was carried out internally to validate this and check compliance levels with BASHH outcomes and previous audit recommendations. Recommendations from the recent audit include a focus on documentation, coding, and standardisation. New documents have been developed which should improve future consistency in compliance with the BASHH outcomes. BB asked if some of the learning could be shared more widely amongst the community and GF advised she would arrange for this to be done.	**GF**
	PPV Audit KM advised that a report went to the Audit Committee and so had been asked to provide comments on this. It was noted that there was a high level of administration errors and this was due to information having to be transcribed from the clinical system to a claim system. Guidance has been sent out to pharmacies on how to prevent these errors but it was noted that if claims are entered on the claim system on a different day to being entered on the clinical system then this may show as an error, but is necessary due to workload demands. The Choose Pharmacy platform is being rolled out across Wales and this should incorporate both the clinical and claim systems so will reduce transcription errors.	
	HCAI Report KJ advised this is produced by IP&C team and the c.diff cases are reviewed by Dr Avkash Jain and then relevant communication is sent to the practices. We are looking into whether a root cause analysis can be carried out on the reported MSSA Bacteraemia cases. AJ working with IP&C team to draft a pro-forma which can then be bought back to this meeting for comments. It was noted that infection rates are increasing across the Health Board.	
	Outbreak of Influenza in Nursing Homes KJ advised that she will look to send out further information on this. It was a fairly serious outbreak, affecting 20 patients within a 39-bedded home. There were no hospital admissions as a result so it was noted that the home managed the situation well.	

	GH asked for vaccination uptake rate as felt this may have influenced the outbreak. KJ to bring this information back to next meeting.	**KJ**
	Locality Pressure Ulcer Reports NH stated it seems like there are increasing numbers of people being discharged from hospital with pressure ulcers. GH noted capacity in MASH appears to be impacting on strategy discussions. AM noted the need for POVA referrals to be raised for all Grade 3 and 4 may be overwhelming MASH and could result in genuine cases of neglect or abuse being missed. KJ advised meetings are planned to discuss how to improve communication between us and MASH. NH stated some cases are being closed before Locality Senior Nurses are informed. A concern was raised over how the MASH representatives are deciding to close concerns as themes or recurring instances in one area are not being identified. BB advised this situation is likely to get worse as the L3 Safeguarding training is now directing GP's to refer directly to MASH rather than having wider conversations with other involved health professionals first. NH stated the previous system allowed background information to be gathered through discussions between nurses in different areas. GH stated the formal reporting system is useful in ensuring standardisation but may not be the most effective system in its current guise. HOS suggested inviting safeguarding back to this meeting as they were involved when MASH was being set up.	
	C Diff / MRSA RCA Report KJ stated that quarterly information is included within the document pack. Discussions are ongoing regarding the recording process and this will be brought back to the next meeting. BB stated we have been asked to share this with the rest of Wales as other UHB's are not currently gathering data in this format.	**KJ**
	Concerns Report Any concerns already raised earlier in the meeting.	
	EFFECTIVE CARE	**Action**
	Implementation of key NICE Guidance: **NG61- Advance Care Planning :** **NG60 – HIV Testing in Different Settings :** **NG59 – Neuropathic Pain in Adults :**	

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	NG58 – First Contact With Services : **NG57 – Mental Health of Adults in Contact with the Criminal Justice System :** **TA418 – Dapagliflozin in Combination Therapy for Treating Type 2 Diabetes** **Outcomes from the CAVUHB Cluster Cancer Significant Event Audits 2015** GH stated the results of the audit were available to the meeting and that none of the findings should be new to the group. BB stated this was discussed at last CD forum and an action plan will be created for clusters to work with various directorates in secondary care. Suggested bringing this back to next meeting for update. GH noted that new software is also being developed to help with early diagnosis and BB advised this is currently being piloted. **Clinical Audit Project Proposal** KJ noted the work going on in the Vale around auditing which can be bought back to this meeting for any leaning to be shared.	**BB**
DIGNIFIED CARE		**Action**
	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans RB noted there have been no HIW reports in Dental or GP since the last meeting. **HIW Patient Discharge Thematic Review Letter to CVUHB** KJ referred to a letter from Sharon Hopkins concerning the review ofdischarge of patients from hospital care. The first phase has started and we are included in the second phase so will be asked for comments. **Adult Safeguarding QOF** KJ advised we will be undertaking the safeguarding QOF audit again across general practice. She stated that previous audits have found that we are not documenting evidence and processes well enough to be able to meet some standards although we are doing okay overall.	
TIMELY CARE		**Action**
	No items to discuss.	
INDIVIDUAL CARE		**Action**

	OPOID Switching Letter KJ stated this switch was raised at the last meeting and there have been no issues reported.	
STAFF AND RESOURCES		**Action**
SUB-GROUP REPORTS		**Action**
	• **Cardiff North and West Locality** AM advised no issues to raise except for DoLS. A number of urgent court applications are needing to be raised and there are costs associated with this in term of legal support and court fees. All other risks are included on the report in the documents pack. • **Cardiff South and East Locality** NH advised DN staffing levels still remain a concern, particularly in Butetown. Investigation into security issue at CHAP in January have been undertaken and we are finalising the actions in response to this. Roath clinic DOSH service has ceased and a large number of patients are now attending CRI. Levels of patients attending CRI will be reviewed in 4 weeks. A Whole Home Inquiry was due last week in response to complaints from student nurses and families – this was cancelled on the day and we are now looking to re-schedule. • **Vale Locality** Western Vale Mobile Phone - Some months ago we received a letter concerning a patient experience which encapsulates a number of the issues being experienced in the Vale so will bring it to the next meeting to share as a patient story. ART have moved to St Davids and the Wound and Continence team will also be moving shortly. A new DN treatment room will be opening in Penarth shortly. • **Out of Hours** HE raised the issue of DoLS with OOH's as we are being challenged by care home managers when we need to call the police GH queried the existing DoLS process with OOH's so AM clarified. It was noted that calling the police can be distressing for the residents and their families. Some homes have requested if a more pragmatic process could be established and AM stated the Sherard LeMaitre has discussed this with the coroner.	**CF**

	BB stated the existing process is a legal requirement. KJ advised that the response of the partner organisation may not be managed correctly and this is then making the process more distressing for patients and family members. HOS stated that Dr Sherard LeMaitre has discussed whether a more pragmatic process could exist for expected deaths but needs to get agreement for this in writing from the coroner. HOS confirmed that at the moment OOH are following Guidance issued by the Chief Coroner in 2015 and BB stated we would need to explain our rationale for changing the process fully in any further discussions. KJ stated Medical Examiners will be introduced from next year and this will affect how deaths are certified. Only other issues to note are the risk escalation reports raised earlier. • **Medicines Management** KM advised that the matrix management of the cluster pharmacists has been agreed throughout all localities. The prescribing team is now at establishment. Trac system seems to be picking up at the front end but there are still issues at the end in ensuring previous NHS service is picked up.	**SLM**
PART 2: Items to be recorded as Received and Noted for Information by the Committee		**Action**
	The Committee Received and Noted the following :- • Public Health Alert : CEM CPhA 2017 002 'Bayer PLC, Mirena 20Mcg/24 Hours Intrauterine Delivery System' • Patient Safety Alert : PSA006/January 2017 – Risk of death and severe harm from error with injectable phenytoin • Welsh Health Circular – HPV vaccination for men who have sex with men : WHC (2017) 03 • Patient Safety Alert : Fentanyl information leaflets and counseling checklists • NHS Alert : The reporting of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) • Patient Safety Alert : PSA007/January 2017 – Restricted use of open systems for injectable medication • Patient Safety Alert : PSA004/July 2016 – Ensuring the safe administration of Insulin • Welsh Health Circular – Ordering flu vaccine for the 2017-18 season : WHC (2017) 004 • Public Health Alert : CEM CPha 2017 003 Recall of Alka-Seltzer • NHS Alert : Metronidazole Change of Dose – January 2017 • NHS Alert : CDO letter on Private Dentistry (Wales) Regulations • Welsh Health Circular – Good practice guidance on the provision of	

	mental health support for asylum seekers and refugees dispersed to Wales : WHC (2017) 009 • Public Health Alert : CEM CPha 2017 004 Recall - UCB Pharma Limited Viridal Duo Powder and Solvent for injection 10 mcg/ml and 40 mcg/ml	
	ANY OTHER BUSINESS	
	KJ reiterated that the revised concerns process has been agreed. KJ will sign off the majority of concerns while the Executives will sign off the 4's and 5's. This will hopefully reduce some delays in the system. The complaints team will continue to provide support in drafting responses. AM stated that the Older People's Commissioner on Care Homes raised the issue of reporting on antipsychotic use in care home and queried if we were doing this. KM advised we would only know this if we went into care homes and audited this or utilized GP records. KJ confirmed this is not part of our standard reporting.	
DATE OF NEXT MEETING		**Action**
Date and time of next meeting : Tuesday 9th May at 1pm		

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Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 20th April 17 14:00 – 16:30
Venue: Classroom 2 UHW

Attendees	Rebecca Aylward (Chair)	Helen Ronchetti
	David Pitchforth	Fay Moorelock
	Jane Murphy	Gill Spinola
	Lisa Waters	Denise Shanahan
	Kath Prosser	Emma Mitchell
	Lisa Harwood	Alison Hayes (Minutes)

Apologies:	Jason Roberts	Sarah Follows
	Jeff Turner	Gareth Edgell
	James Coulson	Rebecca Owen-Pursell
	Barbara Davies	Sharon O'Brien
	Richard Evans	

		Actions
A1	Welcome & Introductions	R A welcomed everyone to the meeting, apologies had been received from R E
A2	Apologies for absence	**Apologies were noted above.**
A3	To receive the Minutes of the previous meeting Matters Arising	
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY		
1.1	Patient Story Internal Medicine (David Pitchforth)	Patient discharged from B7 – 38 year old known asthmatic on steroids with a borderline personality disorder. He was discharged from B7 with a new diagnosis of steroid induced diabetes and sent home with Insulin and subsequently overdosed which resulted in a respiratory arrest in the community. As a result of the overdose the patient has been left with a brain injury. The impact on the family has been massive. Learning points – better communication around the clarity of diagnosis when patients are sent home with insulin. There was no structured discharge process on B7 and it was identified that earlier referral to the Diabetic Specialist Team may have supported the patient not being discharged home on Insulin. . A new "ticket home for discharge" has been introduced for this ward which supports the ward staff to ensure clear and safe discharge processes..
1.2	Feedback from UHB QSE Committee	http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-
1.3	Directorate Risk Register's	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	SBAR DKA pathway	Colour copies of the SBAR are to be used, they are not to be photocopied.
2.2	Mouth Care Assessment and Care plan (Emma Mitchell)	EM updated the group on the All Wales Mouth Assessment Tool final version which includes a care plan on the back. Hopefully this will help create better oral care throughout the hospital. Lynda Jenkins is organising the roll-out.
2.3	Blood Glucose Monitoring Practice	(LH) All aware of the new training. This will be

	update Blood Glucose Training and Assessment SBAR	launched when the new practice development nurse starts.
SAFE CARE		
3.1	New SIs WG closure forms for discussion and shared learning • In41940 • In41997 • In40799 • In41231 • In42884 • In39694 • In41859 • In28716 • In31510	Open SI – 27. 9 are being presented today. Unfortunately to date this month we have already had 7 falls, a couple in the same area. **In41940** - Patient fall with a sustained fracture. The Hover jack was not used, Neurological observations were completed but not in line with NICE guidelines. The patient had a known history of dementia and was originally 1:1 specialled but following reassessment this was deemed not necessary. There is work ongoing to reduce the number of falls, increased observation with nurse stationing, bay tagging, increased staffing and ongoing education. Night visits will be undertaken to establish areas such as adequate lighting, and that visual checks are being completed. Additional measures include checks every hour to ensure patients are comfortable and safely within their bed. (LH) – bay tagging has gone pretty well in Clinical Gerontology. **(LH) to email to (JM) information on bay tagging. Action**. **In41997** – Un-witnessed patient fall in the bathroom with sustained hip fracture. Patient had a past history of falls but the patient requested to be left alone whilst using the bathroom. Neurological observations were completed but there was a gap in the frequency of completion not in line with NICE guidelines. All risks assessments were completed in line with UHB best practice. **In 40799** – An un-witnessed fall while patient was emptying their catheter they slipped on urine. Previous history of falls noted. Risk assessments were completed in line with best practice with the exception of the bed rails assessment. All staff have been reminded of their professional responsibility to ensure that individual patient risk assessments are acted upon or reassessed where necessary. **In41231** – An un-witnessed fall which led to a fracture of the Acetabulum. Previous history of falls. The risk assessments were completed in line with best practice, and the patient was on low rise bed and behaviour chart. It was noted that it was extremely unusual for the patient to attempt to mobilize unaided. Following the fall and completion of an x-ray no fracture was initially identified, however when the x-ray was formally reported two days later a fracture was identified. If staff are not sure whether a fracture has been sustained they have been advised to contact Trauma & Orthopaedics to review the x-ray. **In42884** – A witnessed fall on West 3. Patient was going to the bathroom carrying a towel over their Zimmer frame. All actions in line with NICE 2015 guidelines were completed identifying good practice. **Learning points** – The appropriate management of falls is about the whole care of the patient – 179 falls for the Clinical Board were reported in March and 7 have resulted in fracture. All measures that should be in place are in place. It has been agreed to set up a falls improvement group with representation from Bands 2 and Bands 5. LH will

31.5

		lead on this across all ward teams. **In39694** – MRSA and C *difficile* – likely cause was the arm wounds pre-admission. The MRSA investigation screen was not completed on admission as the patient had a previous history of MRSA. The C *difficile investigation* noted that antibiotics were prescribed with antibiotic stewardship evident, the patient also required NG feeding which may have also contributed to the development of C *difficile*. Hand hygiene and bare below the elbow was noted to be 100%. All staff have been reminded about the UHB procedure to screen all patients with a known history of MRSA or if they sit within the screening remit. **In41859** – Grade 3/4 pressure damage to the ankle hospital acquired. Patient was diabetic all risk assessment bundles were completed. The correct mattress was being used but the patient deteriorated. Initial discussions thought that the tissue damage may be a diabetic ulcer. As part of the learning identified wound study days are being arranged for new starters. **In28716** – Gentlemen admitted via WAST. He was admitted in MEAU following seizures in the community which were believed to be related to a history of excessive alcohol intake. The patient was triaged appropriately on arrival and moved to the trolley area of the department. The investigation found that the patient walked independently from the trolley and was found having a seizure on the floor. Following the completion of a CT head scan a significant head injury was sustained. It was difficult to ascertain if the fall in the department was the main contributory factor to the injury sustained, or if this could have occurred whilst in the community. Secondary to UHL having no on site neurology/neurosurgery input there was a delay in obtaining a clear management plan for the patient before being transferred to UHW. The investigation also found that whilst neurological observations were being undertaken as advised by the neurosurgeons, these were not undertaken in line with NICE 2015 guidelines post fall. All staff have also been reminded that they can escalate any speciality referral delay/decision making via the HUB in hours or Site Manager out of hours. **In31510** – GP referral with epigastric pain who requested own transport into UHW AU. For whatever reason the family flagged down a passing ambulance instead who conveyed the patient to the Assessment Unit. The handover from the WAST crew reported that the patient was fine. Secondary to this and a busy assessment unit lounge the patient was not triaged in line with best practice. Following the completion of an ECG nursing staff attempted to show this to a clinician, in line with best practice, however secondary to the pressures within the unit at that time there was a delay in this being reviewed. Following a review of the ECG the patient began to deteriorate and was admitted to CCU for the treatment of an MI. Learning point - handover triage has been reviewed, all staff have attended Manchester Triage training, importance of documentation has been highlighted – all ECGs must be seen by a clinician, and the staff member involved has received additional ECG training. The RCA will be shared with WAST as a means of sharing learning.

3.2	Patient Safety Alerts	**Welsh Health Circular: Updated information on 'Putting Things Right'** – All to note. **Field Safety Notice: V1647 Endoscope Decontamination** – GS to follow up on this to ensure it has been circulated to all the relevant staff. **MDA Alaris Syringe Pumps –** This will be recirculated.
3.3	Health Care Associated Infections (Helen Ronchetti) HCAI rates CDiff/MRSA RCA reports Progress with relevant improvement plans Hand Hygiene Awareness Day/competition Peripheral Cannulae audit tool KP CAN WE HAVE FURTHER VOLUNTEERS	**C *difficile*** – Still on downward trend but we have missed the expected reduction target by two. In April we had 3 cases but to achieve our target we need to have less than 2 cases a month reported for the Clinical Board. MRSA 0 last case in March MSSA - 1 case E-coli – To be reported as a Tier 1 performance indicator, no monthly target has been agreed to date. 11 days since last C *difficile* 26 days since last MRSA Clinical Board IP&C group is now up and running. A reminder to staff that on 05th May – Hygiene Awareness Away
3.4	Datix top ten trend review	Patient falls remain the highest e –datix incidents being submitted. Pressure ulcers – There continues to be disparity between the number of patient pressure damage being reported via e – Datix and the Health & Care standards dashboard. KP reiterated the importance of the difference between a moisture lesion and pressure damage. A moisture lesion should not be reported as a hospital acquired pressure damage on Datix but actions should be undertaken to promote learning. Also if a patient is admitted to the UHB with pressure damage, whilst staff should be encouraged to report these via Datix they should be clearly actioned not within their control by the Dif 2 user and either reallocated to Primary Care or rejected.
EFFECTIVE CARE		
4.1	Director of Nursing Quality & Safety Report February and dashboard (RA)	We received very good feedback with some of the Boards performance in green, well done to everyone. There was praise around closing patient safety incidents, this reduced from 212 in Feb to 87 in March. All staff encouraged to keep up the good work. Falls were a concern but it was identified that the Board have plans in place. 16% response time within 30 days in January in March 65%. We only 1 concern over 100 days. 25 concerns current at moment. Informal response is 63% this is increasing. All good news well done to all staff and thanks for all the hard work.
4.2	VTE/Hospital Acquired Thrombosis RCA feedback (KP)	-VTE –An RCA is completed by the VTE Lead for every patient with a hospital acquired thrombosis and the reoccurring themes are around the risk assessments are not being done. Nursing staff should be encouraged to raise this with the clinical teams in their areas as a means of improving compliance.
DIGNIFIED CARE		
5.0	HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans (JM)	JM update sent to JR. All updated, mouth care was outstanding but everything else signed off. Formal report awaited from HIW visit to the emergency unit.

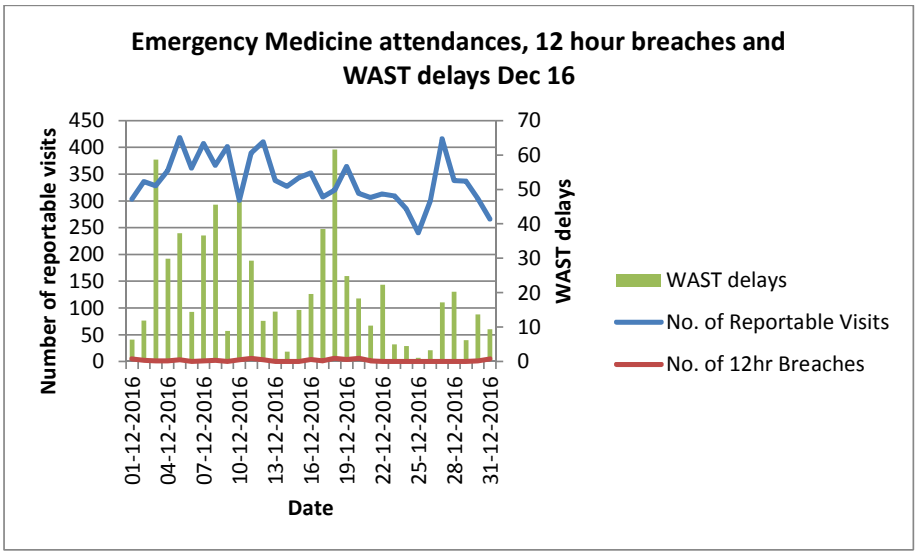
5.1	Sensory Loss (LH)	Dental hospital sent questionnaires to what people knew about this and from this an action plan was developed with champions identified. It was identified that we would require an additional champions within the Medicine Clinical Board, LH to send out questionnaires in Gerontology. Champions were needed at floor level to pass the information down. Learning resources are out there. As well as general care it links in with falls. LH requested a follow up meeting to go through the feedback/results of the questionnaire in order for relevant actions to be identified. Ruth Rhydarch to be invited to the next QSE meeting.
TIMELY CARE		
6.1	Waits within Emergency/Acute Medicine	Discussed that currently there has been no significant change in the number of patients waiting for more than 24 hours with the assessment units and continued periods of pressure within the departments.
INDIVIDUAL CARE		
7.1	National User Experience Framework Feedback from 2 minutes of your time survey – relevant improvement plans	Shared for information
7.2	Complaints and trends (KP) Compliments	Compliments were received for Emergency Medicine, Paeds, East 8 Staff below received a Recognition Award Jane Green from the Research Team and Dementia Ward C7 Liz Vaughan Lynda Edwards Deputy Ward Sister Sam Davies
Staff and Resources		
8.1	Staffing levels	
8.2	Winter pressure wards	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	AOB – Nutrition & Hydration Leaflets (RA)	Nutrition and hydration leaflets to be added to next month's agenda and leaflets to be circulated. There is lots useful learning that can be done from these leaflets.

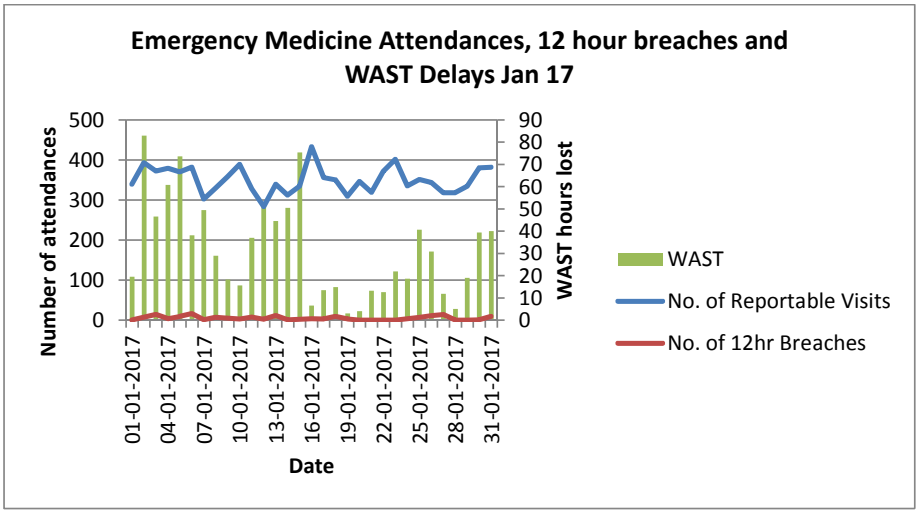
Date and time of next meeting: 18th May 2017 Classroom 2

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

Medicine Clinical Board QSE Dec-16/Jan-17

UHW/UHL Acute and Emergency waits





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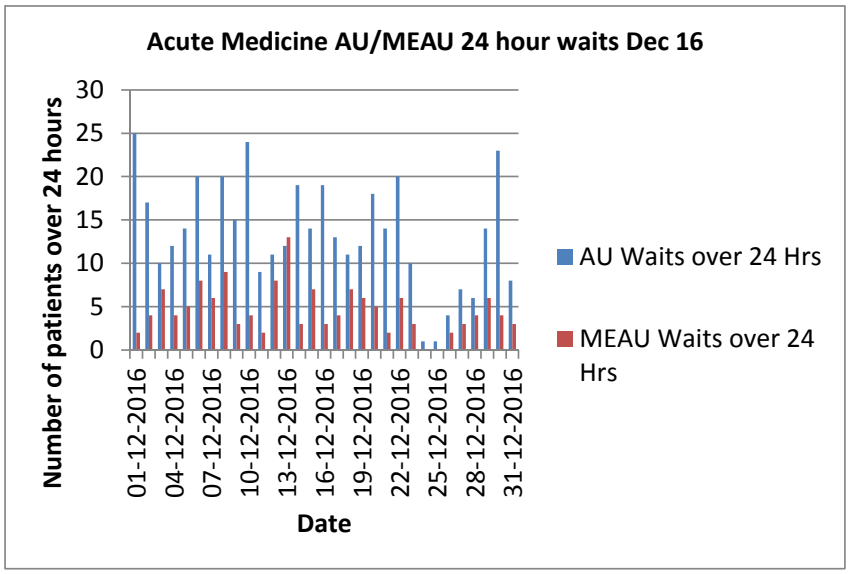
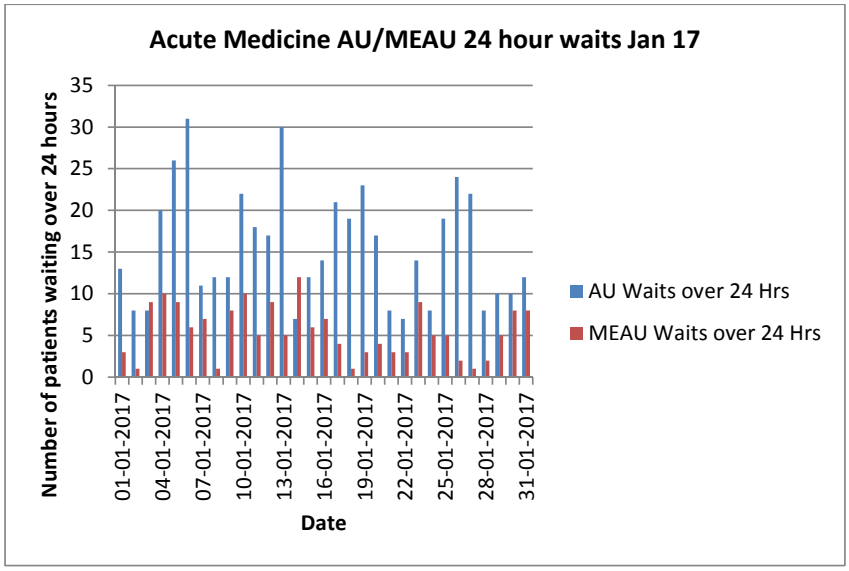

Acute Medicine AU/MEAU 24 hour waits Dec 16
Number of patients over 24 hours
30
25
20
15
10
5
0
01-12-2016
04-12-2016
07-12-2016
10-12-2016
13-12-2016
16-12-2016
19-12-2016
22-12-2016
25-12-2016
28-12-2016
31-12-2016
Date
AU Waits over 24 Hrs
MEAU Waits over 24 Hrs


Acute Medicine AU/MEAU 24 hour waits Jan 17
Number of patients waiting over 24 hours
35
30
25
20
15
10
5
0
01-01-2017
04-01-2017
07-01-2017
10-01-2017
13-01-2017
16-01-2017
19-01-2017
22-01-2017
25-01-2017
28-01-2017
31-01-2017
Date
AU Waits over 24 Hrs
MEAU Waits over 24 Hrs

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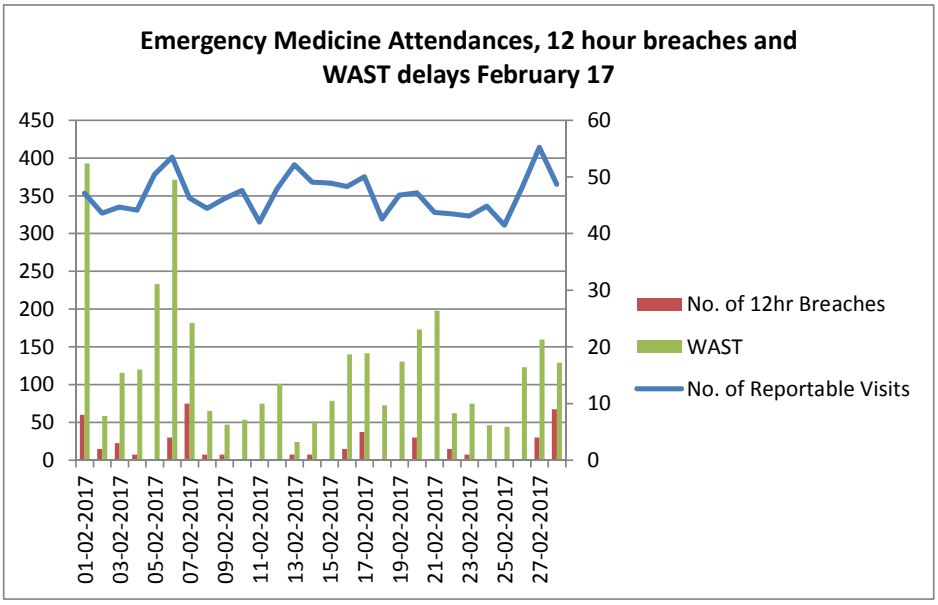
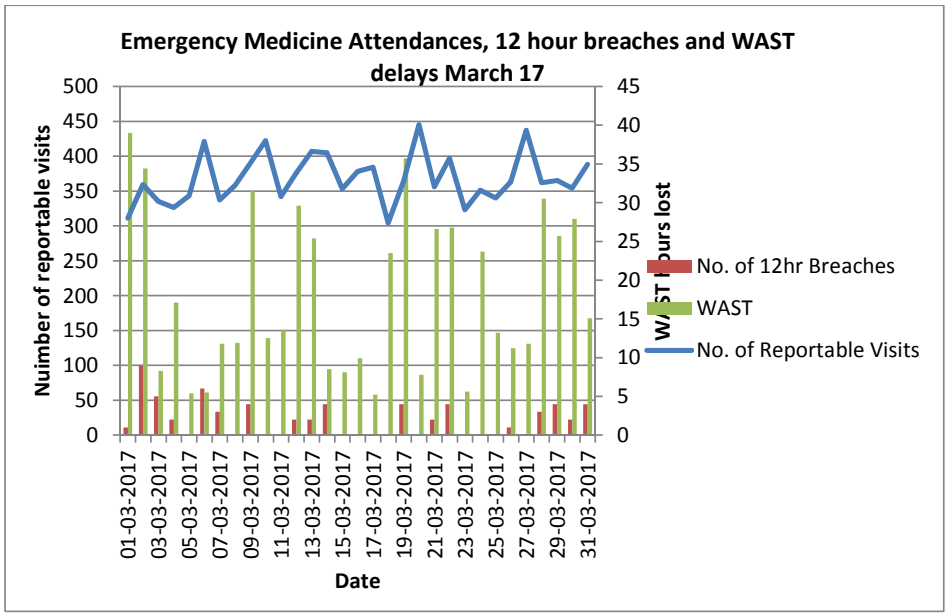
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Medicine Clinical Board QSE April 2017

UHW/UHL Acute and Emergency waits Feb – March 2017





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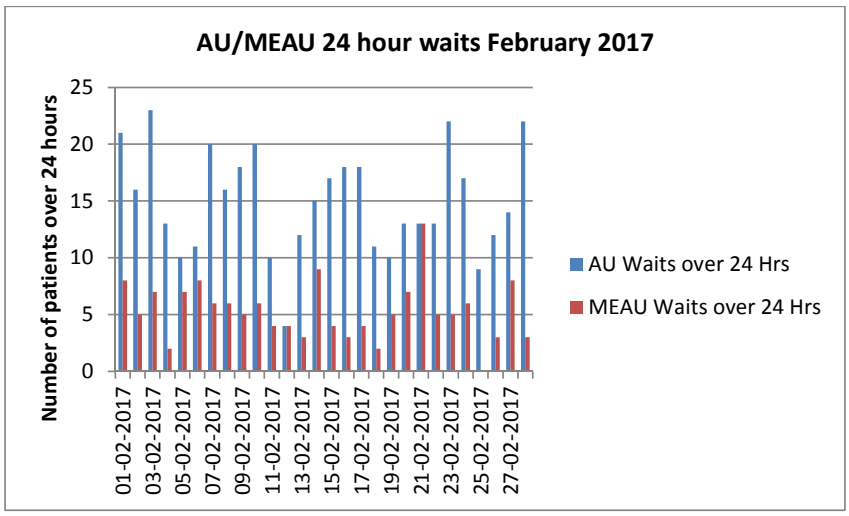
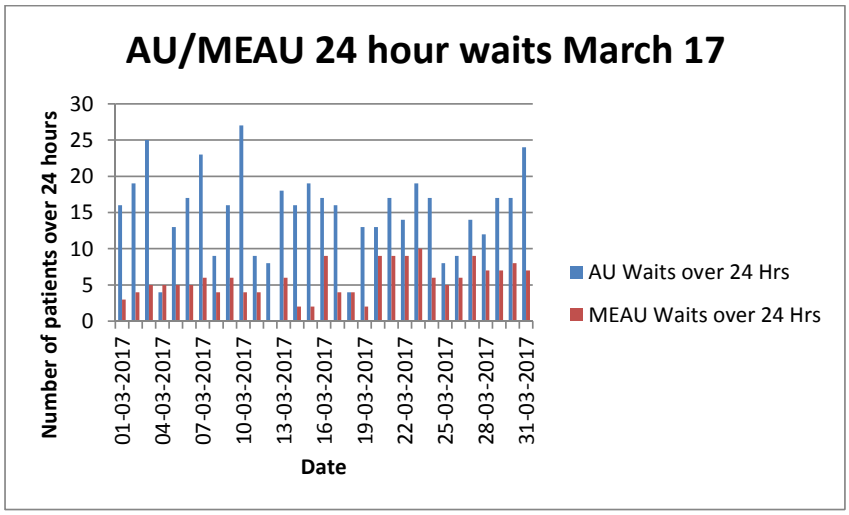

AU/MEAU 24 hour waits February 2017
Number of patients over 24 hours
25
20
15
10
5
0
01-02-2017
03-02-2017
05-02-2017
07-02-2017
09-02-2017
11-02-2017
13-02-2017
15-02-2017
17-02-2017
19-02-2017
21-02-2017
23-02-2017
25-02-2017
27-02-2017
AU Waits over 24 Hrs
MEAU Waits over 24 Hrs


AU/MEAU 24 hour waits March 17
Number of patients over 24 hours
30
25
20
15
10
5
0
01-03-2017
04-03-2017
07-03-2017
10-03-2017
13-03-2017
16-03-2017
19-03-2017
22-03-2017
25-03-2017
28-03-2017
31-03-2017
Date
AU Waits over 24 Hrs
MEAU Waits over 24 Hrs

31.5

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 14th March 2017, 08:00-10:30 hours
Council Room, UHW

CONFIRMED MINUTES

Present:

Richard Hughes	Chair, Consultant Anaesthetist	RH
Linda Walker	Co-Chair, Clinical Board Director of Nursing	LW
Andy Jones	Lead Nurse, General Surgery, Urology, ENT, Ophthalmology	AJ
Judith Smith	Lead Nurse, Perioperative Care	JS
Angela Jones	Senior Nurse, Resuscitation Service	AngJ
Chris Williams	Consultant Ophthalmologist	CW
Mark Bennion	Clinical Governance Facilitator, Perioperative Services	MB
Gillian Edwards	Lead Nurse, T&O	GE
Susan Mogford	Senior Nurse, Pain Service	SM
Rafal Baraz	Consultant Anaesthetist & CG Lead	RB
Leanne Saddler	DM, Trauma & Orthopaedics	LS
Claire Mahoney	CNS, IP&C	CM
Simon White	CD, T&O	SW
Adrian Turk	Pharmacy	AT
Kambiz Baber	T&O (shadowing Gillian Edwards)	KB
Clare Wade	Lead Nurse, Surgery Clinical Board	ClW
In attendance:		
Edwina Shackell	PA, Surgery Clinical Board	ES

PART 1: PRELIMINARIES *(Chair)*		**Actions**
16/185	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
16/186	**Apologies for Absence** Received from Oleg Tatarov and Catherine Evans.	
16/187	**Declarations of Interest** Nil declared.	
16/188	**Health and Safety Committee – Essential Update.** Mr Andrew Hynes extended his apologies following the meeting. The presentation would be rescheduled.	**ES**
16/189	**Approval of the minutes of meeting held 17th January 2017** Corrections: Attendees: Judith Smith had been in attendance. Page 2: "Three negative screenings are needed to confirm a patient is clear of infection". Inaccurate, to be deleted. Page 8: Item 9 – Montgomery. 'RB advised that from the anaesthetic audit on 15th February it was agreed that the anaesthetists verbally consenting the patient on the day of surgery goes against Montgomery principles' to be deleted, and amended to read:"RB advised that this will be discussed at Audit on 15th February" **Action: ES**	**ES actioned 24/3/17**

	Subject to these amendments the Minutes were accepted as an accurate record.	
16/190	**Matters Arising:** To receive Action Log from the above meeting 2.1.3 17/5/2011 – NPSA/2020/2011 - Checking pregnancy before surgery Remains with Children & Women CB. **Action: LW to chase again.** 16/175: Assurance Report GS, URol, Opht, ENT, T&O to be provided to ES. **Actioned and Closed.** 16/176: Exception Report Perioperative – list of items to JS. **Actioned and CLOSED.** 16/178: PSA006 Jan 17 Risk of death and severe harm from error with injectable phenytoin. RB had presented at Anaesthetics Q&S. In consultation with Sarah Plummer, the decision had been made to keep this in Theatre 12 & 14, Neuro, Main Recovery, CEPOD (i.e. Theatre 5 & additional CEPOD), UHL main recovery and CAVOC. **CLOSED.** 16/179: Covert administration of medicine – LW asked all to ensure that patient care is properly planned. **CLOSED.** 16/182: Consent audit, Perioperative. Print 'Right' 'Left', no abbreviations, print for legibility. RH urged colleagues to maintain focus. Chris Williams highlighted recent issues in theatres where nurses had expressed concern that the exact wording on the form did not describe the actual operation. An example was cited whereby working as a team to do the best for the patient had been affected due to concern re Montgomery and consent. Was this happening in other specialties? JS had been advised of the issues referred to. Mr Williams explained that colleagues were being challenged regarding variation in treatment when it was deemed to be in the best interest of the patient. LW noted recent wrong site surgery incidents in Ophthalmology and the heightened anxiety of this small team. However, the consent form is clear that consent is given for whatever is appropriate at that time. RH referred to time out and sign out at end, when any variance to consented surgery should be documented with the reason, i.e. for legitimate clinical reasons. **Action**: JS to feedback to team to ensure concerns are raised in an appropriate way, **Action:** Legibility of consent to be checked before patient anaesthetised. **Action:** Consent to be checked on clinic/ward, prior to transfer to theatre. **Action:** all of the above to be fed back to absent colleagues.	**LW** **JS** **ALL** **ALL** **ALL**
16/191	**Terms of Reference Annual Review** All to review membership. Comments to LW/ES asap.	**ALL**
16/192	**Patient Story** **LW** explained the background of this incident whereby a cancer patient was lost to follow up, following diagnosis in 2001. At the patient's last appointment in 2006, it was clear that annual flexi cystocopies were required. However, the last letter to the patient omitted this information, outpatient appointments were missed. The patient was admitted in 2014 and sadly died. Root causes: - Failure in 2006 to inform the patient regarding the importance of follow up cystoscopies - Outpatient DNAs not followed up - Annual letter for check cystoscopy not sent - Letter not sent to GP. - Patient not sent a follow up for May 2006, then lost to follow up. - IT systems at that time did not allow easy tracking of cancer patients.	

	Recommendations from the report were: - Automatic booking systems. Roll out now commenced. - RCA to be presented at this Board's Q&S - Ensure directorates have robust processes for patients lost to follow up, including MDT, medical secretaries and Radiology. This learning was relevant to all specialties, which must ensure that systems are in place to ensure patients are not lost to follow up.	
PART 2: PATIENT SAFETY AND QUALITY		
16/193	**NatSIPPS Progress Report – date of workshop Friday 12th May 2017, 13.00 – 16.00** Will Harrop-Griffiths, the author of English version of the document, will facilitate the UHB workshop that has been planned. The change of date was noted and all encouraged to attend. **Action:** All colleagues to submit nominations for the event; 40 places for Surgery CB. Perioperative Services had worked towards implementing NatSIPPS at a local level. A Health Board Group has been convened. All Health Boards have been called to present at the National 1000 lives event on 17th March.	
16/194	Consent process (for patients with capacity to consent) This had been circulated post Montgomery presentation after Grand Round. Alun Tomkinson had presented this at Clinical Board on 10/3/17. Simon W – described the mitigating actions undertaken by T&O. **To remain on agenda**	
16/195	**Directorate Assurance Reports:** 1. General Surgery, Urology, Ophthalmology, ENT – nil specific. 2. Perioperative Services – pressure sore B2 acquired prior to coming to theatre, and was discharged from the Health Board with Grade 3. Clare Wade is undertaking the RCA. – Ventilation Ortho 5 & 6. Engineers had passed fit for purpose, but there were other issues outstanding. It was acknowledged that this was potentially impacting on throughput. The agreement to write the OBC to build one new theatre had been given, but this is a medium term solution. - Theatre 11 UHW out of action a further 2 months minimum to allow for refurbishment works. - VRE – Claire Mahoney confirmed the last infected case 26/12/16. The decision had been taken at the last outbreak meeting to stop screening on admission. The team will continue to monitor for any new cases. Next meeting in 3 weeks. It was noted that some beds remain out of use, in particular side rooms. There is no discharge date for the patients isolated on Bethan Ward. 3. Anaesthetics - Injectable phenytoin – presented at Anaesthetic Q&S 15/2/17. Stocks will be limited to specific areas. - Restricted use of open systems for injectable medication. RB had met with LW and Barbara Jones. The aim is to ensure that no gallipots are used for antiseptics. In discussion with Dr Turley on 3/3/17, it was confirmed that there is no need to change current practice. The policy is to use Chlorhexidine 0.5% spray for spinal epidural and nerve block and Chlorhexadine 2.0% (Choroprep) for arterial and central lines. Dr Turley agreed that gallipots should not be used for antiseptics. - Reducing risk of oxygen tubing being connected to air flowmeters – this had been	

	presented at Q&DS 15/2/17. Angela Jones confirmed that there had been no incidents of connecting air instead of oxygen in this Health Board. 4. Trauma and Orthopaedics - Risk Register to be reviewed and new risks added. - Ward environments – poor state flagged up during IP&C and CHC visits. There are potholes in the corridor where patients are trying to mobilise. The general environment is poor. One ward has more than 100 maintenance requests outstanding.	
16/196	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing - nil ▪ Head & Neck, Maxillo Facial and Ophthalmology - nil ▪ Urology - nil ▪ Perioperative Care: Never Event, wrong route of administration of medication. ▪ Trauma and Orthopaedics - nil	
16/197	**Policies and Procedures** 1. WHC (2016) 049. All Wales Critical Care Escalation Guidance for the Management of Large Unplanned Increases in Demand Policy. **RECEIVED** for information 2. Multi Drug Resistant Organisms (MDRO) Procedure http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/MDRO%20Procedure%20FINAL%20Approved%20Dec%2016%20V1..pdf **RECEIVED and NOTED**	
16/198	**Alerts and other Safety Notices** NICE guidelines: 1. IPG572 – Irreversible electroporation for treating prostate cancer. Urology to complete and return to audit 2. CG65 – Hypothermia: prevention and management in adults having surgery, an update. It was noted that this should be redirected from Mr Geoff Clark to Dr Richard Hughes. The Guidance details two types of thermometer, direct, and indirect. The Guidance says that indirect thermometers should not be used for any adult undergoing surgery, as this is deemed unreliable. The UHB is non-compliant, as are the majority of other organisations. **Action: Guidance to be sent to Dr Hughes** **3.** NG63 – Antimicrobial stewardship: changing risk-related behaviours in the general population. All policies and procedures are in place within the UHB; this relates to Primary care, not applicable to Surgery CB. **Action: Alun Tomkinson to sign and return to audit.** **4.** CG174 – Intravenous fluid therapy in adults in hospital. **Action: Distribute to all clinicians and junior doctors. Liaise with Ben Hope-Gill to check where this is incorporated into trainee training.** NICE Audits 5. National Clinical Audit Assurance summary ..\..\Audit\National Audit assurance Clare Wade continues to update the database, and monitor overdue responses. Patient Safety Alerts 6. PSA004 July 2016: Administration of Insulin. BD Auto Shield Needles notice Ordering information **NOTED** 7. PSA007 January 2017: Restricted use of open systems for injectable medication Discussed above. Patient Safety Notices 8. PSN036 November 2016. Reducing the risk of oxygen tubing being connected to air flowmeters	**Actioned 24/3/17** **Actioned 13/4/2017**

31.6

	Action: LNs to check with wards. If the flowmeter is next to the oxygen line, as this can be an issue. **ASSURANCE RECEIVED** from Anaesthetics, Trauma & Orthopaedics, General Surgery, ENT, Ophthalmology, Urology, that this had been discussed at Q&S and PNF. Not relevant to Resuscitation. MDA 9. MDA/2017/001(Wales). 8th February 2017: Oxylog 3000 and Oxylog 3000 plus ventilator – risk of failure. ASSURANCE had been received that Theatres = 2000; UHL = 1000. **Action: To be discussed at next Perioperative Q&S.**	**Peri-op Directorate**
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
16/199	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Minutes 19th January 2017 & 16th February 2017 January: - New treatment fund – unclear where £80m is to be allocated. The UHB may be allocated £60m pump priming over 5 years. - Review of pts on PPIs in secondary care. There is wide acceptance that prescribing is excessive; there will be a review of the indication for prescribing. February: - Financial position: £1.6m overspend in Month 10 across Primary and Secondary care. RB will relay to Anaesthetic colleagues that when prescribing, a reason must be given for a patient being on PPI. 2. Medication Safety Executive Briefing for Clinical Boards, Issue 17, February 2017 RECEIVED for information 3. Surgery Clinical Board IPC Group. Meeting 23rd January 2017 non quorate, 3 members only. **Action: Directorates to send representation, particularly CDs or their representatives**. Next meeting: Monday 24th April 2017, reverting to 08.00. It was highlighted that C.difficile was at an all time high. LW emphasised that in future the relevant Ward Manager and Consultant will be called to meet with her and the Clinical Board Director to present their RCA. Status of Cepharoxime – Adrian Turk confirmed that one Perioperative dose is permitted. 4. Surgery Clinical Board H&S Sub Group. Approved Minutes 14th December 2016. - Legionella – assurance provided re flushing - Display Screen Equipment: there is an E- programme for users, via Zoe Brooks. - Neuraxial changeover non luer presentation. RB had provided an update on progress. There is a delay in implementation for C&V, originally due Oct 2017 - The Group is primary Nurse/ODP led. **Action: Directorates to provide representation, particularly CDs or their representatives**. 5. Decontamination Committee Minutes – December 2016 meeting cancelled 6. Water Safety Group Minutes 7th December 2016. Topics: Flushing. Heater/coolers in cardiothoracics. 7. Safeguarding Steering Group 26th January 2017 Training and compliance included in Mandatory Training. Packages added – Prevent and WRAP training re counterterrorism. A review of training is underway, in order to streamline the programme, to improve accessibility for clinicians. One-day training days are planned. **Action: AJ to circulate training**	**Action: Directorates** **Action: Directorates** **AJ**

31.6

	dates 8. Research Governance Group Minutes 24th January 2017 **RECEIVED and NOTED** for information 9. Transfusion Committee Minutes 21st October 2017. **RECEIVED and NOTED** for information 10. Information Management and Technology Bulletin – January 2017. **RECEIVED and NOTED** for information 11. NCEPOD "Treat as One" – Report of Study of Patients with Mental Health Problems in Acute Hospital Settings. **RECEIVED and NOTED** for information	
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
16/200	**Surgery Clinical Board Director of Nursing Quality & Safety Report February 2017 and dashboard** 1. The data was reviewed. Key issues: - Concerns process. Significant problems continue regarding turnaround times. 123 signed off by CB, 45 outside CB - Recruitment: 81 new starters scheduled to arrive by end of July 2017, although it is recognised that some will fall off. - C Difficile rates – discussed above. - Pressure damage prevalence. Appears high. A UHB Group has been convened and met 13/3/17 to look at this. - DTOCS & LOS – the UHB is undertaking a focussed piece of work, led by Alice Casey. 2. IP&C RCA database - For all to note - C.diff RCAs are well done where there is clinician engagement in the room. All the key points are on the spreadsheet.	
16/201	**Theatres Team Briefing: has practice improved** The Audit shows the benefits of team briefing. It was encouraging that this is gradually embedding into the process. **Action: Report authors to send updated presentation to LW.**	**RB**
16/202	**LIPS End of Year Progress Report** A formal update is awaited. There has been one individual nomination for Cohort 7; colleagues are asked to encourage teams to put their names forward. It was acknowledged that there were areas where staffing levels did not permit participation at this time. Cohort 6: 3 teams out of 6 fully attended.	
PART 5: GOVERNANCE		
16/203	Concerns (Clinical Incidents, Complaints, and Claims) 1. HIW Ophthalmology Thematic Report Improvement Plan. Chris Williams and Andy Jones provided a brief update. 2. Letter from Dr Chris Jones Ophthalmology Serious Incidents. **RECEIVED and NOTED**. Colleagues are reminded to report Incidents. 3. Open Sis, No Surprises: 16 open, 5/6 closed during the last month. No backlog of historical SIs. Grade 3-4 pressure sores reporting increased. All are reminded to close incidents as soon as possible.	

	4. Regulation 28 report & Open Inquests. One reported. 5. Closed SIs: Closure forms sent to WG since 1/2/17 (i) In31608 Fall B6 Learning points: GE is working through this in the directorate. o Neuro observations post fall o Reviewing times patients transferred o Effective communication. The directorate is following processes with staff involved in this incident. 6. Falls Report - 11 since April 2016, majority reported to WG. - Senior team not always informed in a timely manner. All colleagues to reinforce that falls need to be escalated immediately by the member of staff. - Post fall risk assessments and availability of low rise beds are an issue. - It was confirmed that non-injurious falls are reported on Datix. 7. Complaints, Claims and other Concerns (i) All New Clinical Negligence claims opened 9/1/17 to 2/3/17. 7 closed in this period. No trends. All Clinical Negligence Claims Settled 9/1/17 to 2/3/17 – noted. (iii) Personal Injuries Negligence Claims settled 9/1/17 – 2/3/17- nil (iv) New Personal Injuries Negligence Claims opened 9/1/17 – 2/3/17 - nil 8. New Process for Concerns – as above 9. Ombudsman's Reports received: nil	
16/204	**Internal Audits** 1. Oxygen Cylinder Audit 2016 – pharmacy in conjunction with theatres and wards. All to look at own audit findings. Action plan has been developed for directorates to follow. 2. QUAD Audit December 2016 – to follow	
16/205	**Welsh Risk Pool – Progress Report** This has now been superseded by NatSIPPS. Linked to this, WRP has moved to HIW. It has been agreed that the UHB will be a pilot site for HIW and testing standards in the Perioperative environment. Tools are being tested at present. Dr Kennedy leading the work for the HIW standards and is working in C&V to help him develop those standards.	
16/206	**Patient Surveys** National Survey Report for Surgery (January 2017). A disappointing and concerning report from both nursing and medical staff perspective. **Action: All to read and address issues in their own areas.**	**ALL**
16/207	Research & Development. Nil reported.	
PART 6: DATES OF NEXT MEETING **Tuesday 9th May 2017, 08.00 – 10.30, Council Room, UHW**		
PART 7: URGENT BUSINESS		
16/208	1. Medical Equipment Group. Surgery had been commended by the Chair for its management of risk assessments and prioritised equipment lists. Surgery had secured £700k of the current £2m spend. The Group has made the decision that if, as likely, further funds are made available prior to the end of the financial year, it will go to the Surgery prioritised list. RH thanked all for their robust work. The document would remain open for new additions/updated quotations to be included. 2. Single use laryngoscope handles. Now shelved due to prohibitive cost. There was a	

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	brief discussion on the most suitable decontamination machine. 3. Surgery CB Celebration event 6th April. Nominations to be sent to Ceri Chinn by close of play Friday 17th March.	
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
16/209	**Directorate Reports:** **Q&S meeting reports Received for information** 1. T&O 15/2/17 2. Anaesthetics December 2016 3. T&O M&M report 15/2/17	

SURGERY CLINICAL BOARD

BOARD MEETING

Friday 21st April 2017
14.30 – 16.00
Council Room, UHW

UNCONFIRMED MINUTES

Present:

Alun Tomkinson	Clinical Board Director (Chair)	AT
Linda Walker	Director of Nursing, Surgery CB	LW
Mike Bond	Director of Operations, Surgery CB	MB
Robert Parr	Deputy Head of Workforce & OD	RP
Steve Hill	Head of Finance	SH
Lee Evans	DM, Urology	LE
Daniel Jones	DDM, Trauma & Orthopaedics	DJ
Gillian Edwards	Lead Nurse, Trauma & Orthopaedics	GE
Howard Kynaston	CD, Urology	HK
Harriet Wilkinson	Graduate Management Trainee, General Surgery	HW
Sian Crowley	DM, Perioperative Services	SC
Tony Turley	CD, Perioperative Services	TT
Ceri Chinn	Interim Lead Nurse, Perioperative Services	CC
Andrea Sullivan	Senior Nurse, General Surgery	AS
Simon White	CD, Trauma & Orthopaedics	

PART 1: PRELIMINARIES		Actions
1.1	**Welcome and introductions** Colleagues were welcomed to the meeting and introductions were made around the table.	
1.2	**Apologies for absence** Received from Lianne Morse, Leanne Saddler, Helen Robertson. Tina Bayliss, Clare Wade, Alice Casey, David Owens and Andy Jones.	
1.3	**Declarations of interest** Nil	
1.4	**Minutes of Surgical Clinical Board Friday 10th March 2017** Accepted as an accurate record.	
1.5	Matters arising: Nil	
PART 2: GOVERNANCE , PERFORMANCE AND ASSURANCE		
2.1	**Performance Report** **Quality and Safety Report (based on March data)** ▪ Serious Incidents reported to WG: 5. ○ One misdiagnosis which was not notified until a concern was received from the patient's family. RCA is underway. There had been a breakdown in communication from Radiology	

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regarding an abnormal result. A paper is being submitted to Welsh Government regarding PACS.
- Never event in Recovery, UHL, when an oral drug was given intravenously. The RCA will be shared when completed.
- Two wrong site injections, which being given for pain, are not currently classed as never events. RCAs underway.
- Injurious fall, when the patient had sustained fractured femur and head injury. Neurological observations had not been carried out in a timely fashion. The patient sadly had subsequently died.

- No Surprises reported to WG in March: 0
- SIs which have breached WG time frame for closure is: 10
- Number of Closure forms submitted in March: 7

The Executive Nurse Director has mandated that 60% or above SIs are to be closed within the required timeframe. LW provided an overview of all SIs, relating to falls, infections, and pressure damage.

One death from Staphylococcus aureus had been recorded. Actions and learning points were summarised in the report.

- Datix open incidents:
  - Submitted awaiting review (7-30 days) = 31
  - Submitted awaiting >30 days = 28
  - In progress 30-60 days = 32
  - In progress > 60 days = 129.

Again, the Executive Nurse Director required 60% compliance by the end of June. The Clinical Board Lead Nurse continued to issue monthly reports, but received minimal responses from Directorates.

- Clinical Audit:

The CB is aware that improved work needs to be completed. Good audit work is taking place, but the number being registered with the audit department needs to improve.

Oesophageal cancer audit had been submitted.

- Medication errors - 10 for CB. No themes.

- POVAs involving staff – 0

- % of Nursing Shifts filled = 71%. Cause for concern. Work is continuing to address this. There are now 121 on contract agencies.

- Total number of falls in March = 47 (static).

- Pharmacy:
  - VTE risk assessments documented in drug chart = 69%. Areas to be checked for new drug charts, as this does not appear on the old chart.

- Patient Experience:
  Positive reports, an improvement on the previous month.
  Negative comments relate to poor communication.

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- Concerns (March): 72, a decrease from 129. The work behind this was acknowledged. Some issues remain around data accuracy which is being worked through with the Concerns team. The Executive Nurse Director requires 60% compliance in 30 days by June. 73% are managed via informal resolution, a much improved position.
  41% of formal concerns responded to within 30 days – static.

- Infection Prevention and Control

Very poor:

C.difficile – Total since April 2016 = 27 cases attributed to the CB (3 cases not for RCA as C Diff on admission). (6 above target)

MRSA - 3 above target since April 2016

MSSA – 3 new cases in March 2017. Total since April: 14 (of which 3 were transfers in)

A request to screen patients for MSSA before transferring in should be made to ensure the infection is attributed to the correct Health Board.

- Safeguarding – training to be maintained.

- Pressure Ulcer data (Feb) – of concern. LW is convening a UHW wide Group to look at this. All Grades 3 & 4's must be reported to WG, and are also taken via the POVA route.

- Hand Hygiene – patchy compliance. Attributable to medical staff non-compliance when moving from one bed to another.

- Flu vaccination – missed target.

- DTOCs – 7 for February

A brief discussion ensued regarding options to improve compliance for informal concerns. The volumes are such that it is a challenge for Directorates to respond within the 48 hour deadline. It was concluded that the optimum approach should be for the directorates to continue to lead this work, due to their ability to offer, e.g. an alternative appointment, which is not within the remit of the Concerns team.

RTT Performance

MB formally acknowledged on behalf of the Senior Team the amount of hard work, commitment and exceptional effort that had gone into delivering the Tier 1 target. The CB achieved the target, and had improved for the 9th consecutive quarter.
There was now a need to look at transformation and pathway changes. All from the Chief Executive down recognised the scale of the work achieved, with particular thanks to Perioperative Services for supporting this in what has been probably the most challenging of times. This had certainly been exceptional in terms of achievement.

A plan would be formulated for future meetings on how the agenda of

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this meeting would be managed going forward.

Workforce and OD March report

Sickness rate: 4.64%, target 4.28%, good progress. The CB is being challenged by the Executive Board to reduce this target for 2017/18.
Vacancies – 40 wte in Perioperative Services plus 40 wte on wards
Recruitment Events – numbers recruited January= 63, February=28.
Turnover = 9.62%- which offsets recruitment. Thanks were extended to all those who contributed to the success of the recruitment events.
Employee Relations – v good.

PADRs – The Executive Board requires realistic trajectories to achieve the target of 85% compliance. March compliance = 44%. Staff Engagement Group has been re-launched, the keystone being PADRs.
Statutory & Mandatory training: March = 59%. Data is being challenged. Gradually migrating to ESR.
Discussion:

- AT reinforced the Executive message regarding job planning and PADRs. Job planning has commenced with Ophthalmology and would be rolled out to other areas.
- It was acknowledged that e.g. Perioperative, relies on the role of the Service Manager to facilitate this; without this key person in post, it is a significant challenge to implement job planning.
- PADR trajectory – MB asked Directorates for an update on progress:
  - T&O – nursing well embedded via Confirm & Challenge meetings.
  - Nursing: for each of ward areas, trajectory is in place, monitored monthly via Confirm & Challenge and comprises part of Band 7s' performance reviews. Compliance 90 – 99% anticipated within 12 months. NMC registration and Pay Progression is being aligned to these.
  - Administration: T&O – similar process to Nursing. Dates for management team and secretaries secured.
- Financial governance: MB sought assurance that colleagues where financial governance was to be incorporated into their Objectives had actioned this.
- Staff engagement action plan: MB sought assurance on how this is being actioned in directorates. Measurable progress to date was required. The excellent work undertaken by T&O and HSDU was cited as an exemplar.
  - Perioperative: Communication planned regarding Pulse Survey.
    Band & and Band 6 Clinical Leaders Days planned.
  - General Surgery & Urology: Mirroring the T&O approach for Nursing
- Surgery CB Celebration Event. The success of this event was noted. Going forward, this nurse orientated event should focus on wider CB success, e.g. pathway change, quality improvement work (eg Urology on cancer). It was noted that the event had clashed with other clinical priorities. This would be taken into consideration when planning 2018.
- Structure of Perioperative Services. It was accepted that this work was a priority.
  ESR: the hierarchy was not yet robust.

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	Action: anomalies to be reported to Rob Parr. SC advised that the vast majority of Perioperative staff do not have logins. **Action: RP to address**. Formal training was not available. On line training had been found to be unsatisfactory. ESR2 was due for roll out shortly. A timeline for this from the Interim Director of Workforce & OD would be useful.	
2.2	**Financial Plan 2017/18 – verbal update** The Health Board had submitted a planned deficit of £69min March, which WG had rejected. There are significant concerns with regards to the financial situation across NHS Wales, which colleagues would have noted in the media. As a consequence WG had engaged Deloitte's to conduct a governance review; specifically to focus on the four Health Boards with the most significant deficits. Deloitte's had begun their review of C&V, which included reviewing the Surgery Board's arrangements in some detail. The meeting is to be held on 24th April. The Senior Team would feed back after that meeting. The HB had submitted a revised plan of a £45m deficit – no formal response yet. A number of actions had been taken to reduce the gap by £24m, to included increasing the CRP target by a further 0.5% (£0.6m), albeit on a non-recurrent basis. SH confirmed that this additional target would be held by the Clinical Board and not delegated to Directorates, to ensure the focus of delivering the recurrent 1.5% target was not deflected. Good initial progress against the recurrent CRP target was noted, but this had slowed down significantly in recent weeks. MB reminded colleagues that this target must be delivered, together with achieving financial balance. LW highlighted the need to be cognisant that events in clinical practice can have an unintended consequence, eg the financial cost of the VRE outbreak re capability on throughput, but the Board needed to improve its communication and messaging to the Executive Team in some instances **Financial outturn 2016/17** SH referred colleagues to the finance report and highlighted that the outturn deficit of £2.907m showed a small improvement against forecast of £0.084m. Whilst there were no new issues faced in month, the importance of ensuring sufficient grip on the position going forward was again emphasised by MB.	
PART 3: STRATEGY & DEVELOPMENT		
3.1	**New Appointments:** CD for General Surgery: Guy Blackshaw CD for Unscheduled Surgical Care: Geoff Clark CD for Urology: Howard Kynaston Clinical Lead for Breast: Helen Sweetland DM for Urology: Lee Evans **Themes:** The previous CB meeting had looked at planned themes.	

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	Unscheduled Care: GC explained that the aim was to enhance the surgical admissions profile, responding to NELA outcomes, which show poor performance time to critical care and theatre. GC explained that there were 2 surgeons during the week, daytime: 1 in SAU, 1 in house. Access time to theatre being driven, 2 CEPOD theatres. There needs to be a change of culture, where CEPOD is prioritised over elective surgery. The work is supported by Exec board, additional consultants facilitating 1 in 16 rotas. This had entailed changing the job plans of almost 16 consultants, changing the approach to on call, and that day time work is DCC. Confirmation had been received from the Deanery to run 2 SpRs on take, with a targeted start date of 1st September 2017, but will be delayed 2 – 4 weeks. A further colorectal surgeon and Perioperative care physician need to be appointed. It is a challenge to achieve the national targets for Critical Care post operative support. An audit is being undertaken. GC explained how patients were scored. Current practice is to review the patient in Recovery as to whether a Critical Care bed is needed, not prior to surgery. Whilst this is a practical approach, patients can be at optimum in Recovery, but can deteriorate subsequently. Significant work remains to be done, developing a protocol for SAU. The aim is to reduce admissions to SAU, admit patients promptly, and provide optimum post operative care. The goal is to improve 1% of every aspect of the pathway. Discussion: ▪ AT confirmed that the CB fully endorsed the approach that CEPOD is sacrosanct and has the full backing of the Executive Board. ▪ Over 50% of bed base is emergencies. ▪ MB reiterated support. The measure is about how patients are inappropriately admitted in the wrong bed and deteriorates in an acute setting. ▪ This approach had been successfully implemented in other NHS Trusts. ▪ It was noted that electives had never been prioritised over emergencies, but previous lack of CEPOD theatre had been a constraint. ▪ The priority is the clinical care of the emergency patient in the bed. ▪ GC gave assurance that 2 CEPOD theatres will be sufficient. If the model is correct at the beginning, there will be a measurable improvement. **Future presentations:** AT explained that other specialties, initially ENT, Urology, will be invited to present at future meetings. Pathway transformation work would aim to reduce variability around follow up systems, identifying potential reductions in OP clinics. Each directorate is asked to suggest 3 – 4 projects around follow ups and referrals, identifing any inefficiencies in use of resource. The Executive Board has provided a project manager and IT manager to support this work. **Action: Before the next meeting:** All to have 2-5 ideas each, high level with a name against it. A spreadsheet would be populated. If there are any constraints associated with other CBs, let the Senior Team know. **Action: Senior Team to send out a reminder** Discussion:	**Directorate Triumvirates** **MB**

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	▪ HK emphasised the importance of auditing the current position before making changes to ensure measurable outcome. ▪ AT suggested colleagues check for previous audits undertaken in areas under consideration. If not, an audit should be carried out. ▪ MB wished to see a standard approach, with shared learning and a shared repository. There would be discipline around governance. ▪ AT asked all teams to identify a person to run their project(s) ▪ LW referred to the recent Celebration Event when Mr Clark, Audiology and anaesthetists had presented. This event had been commended by the Executive team.	
PART 4: FINAL CLOSURE AND FUTURE MEETINGS		
4.1	**Any Other Business** **Clinical Board – future meetings** ▪ The Agenda will be revised ▪ A new Terms of Reference will be agreed ▪ Membership will be reviewed Agenda items will include: <u>Part One: 30 minutes (timed slots)</u> ▪ Briefing from the Clinical Board Director, feeding back from Executive level ▪ Briefing from each CD, one page ▪ Emergency Surgery ▪ Papers to ratify or for noting ▪ Performance framework ▪ Finance ▪ Quality & Safety ▪ Research ▪ IMTP update <u>Part Two – 1 hour</u> ▪ Service Improvement discussions to include, e.g. presentations. **Action: MB to send out draft agenda before next meeting** ▪ The New Chief Executive commences 19th June. ▪ Corporate Scrutiny Panel. The Executive team has put this in place. Exceptions are clinical Band 2s and Band 5s. All other posts are authorised via CB Deployment as per current process, then the Executives consider whether to approve. ▪ Directorate team changes: Ceri Chinn, Interim Lead Nurse, Perioperative Susan Mogford, Senior Nurse SSSU (in addition to her Pain Services portfolio) Helen Luton, Senior Nurse, T&O (replacing Jen Proctor) Andrea Sullivan, Senior Nurse, General Surgery Sharon Irving, Senior Nurse, Urology, ENT, Ophthalmology	**MB**
4.1	Review of the meeting and key messages for communication	

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4.2	To note the date, time and venue of the next meeting of the Board: **Friday 26th May 2017, 14.30 – 16.00 Pathology LHS Seminar Room**	

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 28 February 2017, 8.30 – 10.30am, Seminar Room A, PICU, 3rd Floor, CHFW

Preliminaries		ACTION
1.1	**Welcome & Introductions** Cath Heath (CH), Director of Nursing (Chair) Mary Glover (MG), Lead Nurse Acute Child Health Suzanne Hardacre (SH), Head of Midwifery Laura Bassett (LB), Risk Manager O&G Lois Mortimer (LM), Senior Midwife Rachael Sykes (RS), Health & Safety Advisor Anthony Lewis (AL), Clinical Board Pharmacist Heather Gater (HG), Head of Therapies, Acute Child Health Jane Maddison (JM), Head of Therapies, Community Child Health Matthew McCarthy (MM), Patient Safety Advisor Alicia Williams (AW), Deputy Directorate HOD, Acute Child Health Cheryl Evans (ChE), Directorate Head of Operations & Delivery, O&G Catherine Salter (CS), RCN Health & Safety Representative Michelle Abel (MA), Infection Prevention Control Nurse **In Attendance** Kirsty Hook (KH), Board Secretary Carol Evans(CaE), Assistant Director Patient Safety & Quality (Item 1.5 only) Katie McCormick (KM), Paediatric Dietician (Item 4.1)	
1.2	**Apologies for absence** Rachel Burton, Jenny Thomas, Angela Jones, Diane Rogers, Wendy Bridges, Sarah Spencer, Rim Alsamsam	
1.3	**To receive the Minutes of the previous meeting 24 January 2017** The minutes of the meeting held on 24 January 2017 were agreed to be an accurate record.	
1.4	**QSE bring forward action log from 24 January 2017 / Matters Arising** See updated action log from 24 January 2017.	
1.5	**QSI Framework** CaE provided some background to the framework that is being produced across the Health Board in order to triangulate the work that is being undertaken as part of the overall Q&S agenda. The key aim of the framework for delivery was noted and it was acknowledged that this fits into the overall Shaping our Future Wellbeing Framework. The aims are also aligned with the Health and Care Standards. It was noted that as part of framework a dashboard for Q&S has also been set up and this is just one of the measures that will be used to inform the focus for Q&S going forward. It was noted that resources will also be set up on the intranet for all to use. Discussion ensued as to the benefits and it was noted that there will be options for work	

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	and lessons learnt to be shared more easily across all areas within the Health Board. It is anticipated that the framework will be circulated for comment within the next few weeks prior to submission to the next Q&S Committee in April 2017.	
PART 1 : HEALTH & SAFETY FOCUS		
2.1	**Feedback from UHB Health & Safety Operational Group Meeting** The next meeting is scheduled to take place on 14 March 2017. **Enforcement Agencies Report** The report was noted for information and it was acknowledged that there are a number of areas that the HSE is monitoring which includes: • Legionella • Lift Inspections – It was noted that this is ongoing and the work to refurbish lifts is part of the refurbishment programme that is being taken forward by Estates. Discussion ensued and concerns were noted that further incidents have taken place within maternity. It was noted that these incidents continue to be reported to Estates. • Hydrotherapy Pools – It was acknowledged that an external review has been undertaken and an action plan is in place. There are regular meetings in order to take forward ongoing issues for resolution. • Contractor Fall – RS agreed to follow up on any update on this incident as was noted that this is still being reported as an open incident within Obstetrics & Gynaecology. As part of this incident, guidance has been produced outlining the requirements and responsibilities associated with any work undertaken by contractors.	
2.2	**Control of Contractors Guidance** Further to the update above, the guidance was noted for information and wide dissemination.	**ALL**
2.3	**Procedure for the Control of Legionella** The flushing guidance document was noted and the group were asked to ensure that this is widely disseminated in order to reiterate responsibilities for all. Discussion ensued and it was acknowledged that it is part of Directorate processes. Within the CHFW it was noted that this is undertaken on a daily basis by the Estates department, however in most areas this generally this is the responsibility of the ward manager/community managers for those areas.	**ALL**
2.4	**Health & Safety Report** The report was noted for information. It was acknowledged that since the report was produced, there has been a significant improvement across all areas of the Clinical Board. The types of incidents were noted and it was acknowledged that these figures relate to Tier 1 reporting. There were two incidents reported to the HSE as RIDDORS both of which all actions have now been completed and incidents are closed. **Medication Errors** The report for December – February was noted for information. It was acknowledged that this is regularly monitored by the Clinical Board Pharmacist and the current report focuses specifically on Acute Child Health due to the number of errors recently reported. However it was acknowledged that work continues as to how processes can be changed and developed in order to improve. Discussion ensued and it was noted that this information is collated by Patient Safety as part of the KPI's and Q&S dashboard. MM agreed to send through the data to AL for information as this will show the complete breakdown of the medication errors reported.	**MM/AL**
2.5	**COSSH Report for Noting**	

	Noted for information. It was acknowledged that there are a number of areas within community that need to be reviewed in order to update the current COSSH status.	
2.6	**Workplace Inspections Update** Catherine Salter was welcomed to the group and advised that she is the new RCN Health & Safety representative who will support the Clinical Board going forward. It was noted that work is ongoing in order to review the workplace inspection process, how this information is monitored and where this will be fed into in order to manage the process going forward. It was noted that there are no specific areas to raise from the Directorates. HG noted that a working group is also being set up within Acute Child Health which will monitor and actions and issues that arise from the workplace inspections.	
2.7	**Staff Side Health & Safety** • Rolling out Undermining behaviours training in conjunction with RCM. • Work continues in relation to the Caring for You Programme It was noted that further updates will be provided as this work progresses.	
2.8	**Exception Reports and Escalation of key H&S issues from Directorates** **Acute Child Health** • Working group has been set up within the Directorate in order to monitor health & safety actions going forward. Feedback will be provided as appropriately through these meetings • Mandatory training issues were noted and it was acknowledged that there have been a number of cancellations following staff booking on to the Paediatric V&A course and as a result staff are then out of date with training. Discussion ensued and it was noted that the training would be for inpatient staff only and due to numbers not being met, the trainers have been unable to run the training. It was agreed that any cancellations should go back to the manager for information. Further discussion ensued as to the suitability of the course for community staff. Concern was raised that the community staff were advised that this would meet the staff needs. CS advised of the levels of the training and the types of staff that would need to attend which level. Discussion ensued and it was noted that alternative training needs to be reviewed for community staff. PD agreed to review options for community staff. CS agreed to send through information on the description of the courses in order to provide clarity on the requirements for all. **Obstetrics & Gynaecology** • Work is progressing in relation to new Governance Framework for the Directorate • Action plan in place following KPI • WAST have requested some further amendments to the pathway and it was noted that a plan and implementation date is awaited. • Pressure area C1 – it was noted that the patient was nursed appropriately throughout • LIPS project to be presented at April meeting • Reclining chairs are now in place and very positive comments have been received • 92% compliance rate and 8.9% infection rate for caesarean section infection rates. Work is ongoing • Cystoscopes have been investigated for decontamination protocols and commendations were noted on excellent record keeping. Corporate capital is being reviewed to cover the cost of new cystoscopes to enable AER decontamination. • New theatres tables and lights have been order and hoped to be installed by April 1st 2017. • Hello My Name is badges are being ordered in order for the campaign to be introduced	**PD** **CS**

	within the Directorate. • Parent education classes are being offered in Welsh and this has been very positively received. • Caring for You programme is progressing well **Community Child Health** • Datix incidents have been reviewed and work is progressing to close down. • Cadoxton Clinic staff lone working issues and an OCP is being progressed to relocate the staff • Concerns were raised in relation to parking issues associated with the move to Global Link and work is ongoing to look to resolutions. • Recruitment event scheduled for this weekend and it is hoped that this will follow the success of the recent event held within Acute Child Health.	
PART 2: QUALITY, SAFETY & PATIENT EXPERIENCE		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Risk Registers – Exception Reporting / New Risks to be considered** • MLU Heating following recent incidents being reported. The Directorate agreed to undertake a risk assessment. • Recording of telephone calls – as a result of a number of themes with incidents. LB agreed to discuss further with Telephony Services Manager to explore options. MM noted that there have been similar issues within PCIC also.	**LB** **LB**
3.2	**Exception reports and escalation of key QSE issues from Directorate QSE groups** Noted as part of item 2.8.	
SAFE CARE		
4.1	**Update on Blended Diet** The presentation was shared with the group in order to provide an update on the progression of Blended Diet for children with gastrostomy tubes. It was noted that this work was initially taken forward as a LIPS project with input from Ty Hafan. This work has been taken forward as a result of increasing requests from families and carers. To date, there are 10 children that have blended diets and requests are now being received for this to be administered by nursing staff within Cardiff & Vale, however it was acknowledged that the volume of requests are increasing. There are a number of other Health Boards that are considering taking this forward and therefore there is a need to ensure that there are appropriate guidelines and support in place. Concerns were raised with regards to legal liability and it was noted that a rigorous risk assessment process would need to be in place to support this and this is being carried out on an individual patient basis. Although this is not currently being advocated through the Health Board, where families have chosen to go ahead with this, support is being provided by health professionals and in partnership with Special Schools to support the patients and their families. Staff competence is being monitored regularly through a specific competency tool. A robust process mapping process is followed and this is regularly monitored and audited. Work continues to monitor the pilot settings (within Special School setting) in order to review if there are options for this to be replicated within other settings; however it was acknowledged that this would be more difficult within an acute setting, specifically with regards to food preparation and food hygiene etc. Discussion ensued with regards to the costs associated with blended diet versus prescribed feeds, and whilst it was acknowledged that there would be possible savings for GP prescribing costs, there are a lot of other costs associated with providing this.	

	Further updates will be provided as this work progresses. It was agreed that further discussions will be needed with Communications Team in order to agree how the position statement can be widely disseminated to parents and families providing a consistent message to all.	**PD**
4.2	**Captopril investigation and RCA** MG provided an overview of the case. The patient was incorrectly prescribed an incorrect dose of the captopril (1000 fold error of the prescription). It was noted that there was no harm to the patient who has now recovered well. It was acknowledged that this was a misread of the BNF prescription by the prescribing doctor. RCA Findings were noted as: • Unfamiliarity of drug and dose • Extremely busy period on the Unit Another area highlighted was that of shared care between teams and the requirement to ensure that documentation is robust and that both teams are clear as to what is being prescribed. As part of lessons learnt, work is now being undertaken within pharmacy to provide information for new pharmacists and those without paediatric experience, on the basics of clinically checking paediatric prescriptions. This has been shared through the Pharmacy Q&S Meetings and will also be discussed and shared at the next Directorate Q&S Meeting.	
4.3	**Concerns Update** CH provided an update on changes to the concerns process going forward. It was noted that any concern graded as a level 3 concern will be signed off by the Clinical Board, with all level 4 and 5 concerns being reviewed by the Executive Team. The pathway for the concerns will be shared with the Directorates once received. It was also acknowledged that for cases that are reported through the Stillbirth review forum there will be a change in timescales in order to take into account the timeline of such cases.	
4.4	**WG Closure form for sign off** **In38525** Community midwife had notes stolen from her car. This was reported as an Information Governance concern. The investigation was very robust with a number of recommendations noted. All actions have been completed and the closure form was agreed for submission to Welsh Government. **In40736** Initially reported as a Never Event as a result of a Hickman Line being left in situ. Further investigation noted that this was well documented and it was known to be insitu. This was subsequently stood down and the closure form will now be submitted for closure.	
4.5	**Patient Safety Alerts (Internal/External)** **Welsh Health Circular 2017 049 – All Wales Critical Care Escalation Guidance for the Management of Large Unplanned Increases in Demand** The alert was noted for information. Reassurance was provided that there is appropriate escalation guidance for paediatrics which is in place. There is also a designated procedure for Neonates.	
4.6	**Infection Prevention Control Update** It was noted that a C Diff case had been reported in January and MA agreed to provide a	**MA**

	further update following the meeting.	
4.7	**Safeguarding** **Information Leaflet – Safeguarding Children Medical** Noted for information. This has also been shared with the Maternity Services Liaison Committee (MSLC).	
DIGNIFIED CARE		
5.1	**Latest Cleaning Scores Report – for information** Noted for information.	
TIMELY CARE		
6.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** It was agreed that the scorecard will be shared for information once received.	
ANY OTHER BUSINESS		
	Date and Time of Next Meeting Tuesday 28 March, 8.30am Council Room, Upper Ground Floor, UHW	
	Protocol for Care of Children & Young People under 18 Discussion ensued in relation to the responsibility of staff caring for patients across Clinical Boards. It was noted that documentation needs to be completed in order to demonstrate that there is a named paediatric surgeon that the patient remains under and is responsible for the care of the patient. This will be shared in order to raise awareness for the responsibility for all.	**CH**
	Statutory & Mandatory Training Information This has been shared for information and requests were made for improvements to be made across all staff groups. The group were asked to feedback any issues on reporting.	**ALL**
	VTE Assessment of Drug Charts This is now recorded as part of the Q&S dashboard. It was noted that overall compliance is high however the compliance on risk assessments is low. Discussion ensued where it was noted that this is likely to be as result of the implementation of the new drug charts, however it was acknowledged that the new treatment chart will cover all aspects of the risk assessments.	

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 28 March 2017
8.30am, Council Room, UHW
MINUTES

Preliminaries		**ACTION**
1.1	**Welcome & Introductions** Cath Heath (CH), Director of Nursing (Chair) Rachel Burton (RB), Director of Operations Paula Davies (PD), Lead Nurse Community Child Health Jane Maddison (JM), Head of Therapies Community Child Health Anthony Lewis (AL), Clinical Board Pharmacist Suzanne Hardacre (SH), Head of Midwifery, Obstetrics & Gynaecology Eirlys Ferris (EF), Senior Midwife, Obstetrics & Gynaecology Laura Bassett (LB), Risk Manager, Obstetrics & Gynaecology Mary Glover (MG), Lead Nurse, Acute Child Health Cheryl Evans (CE), Directorate Head of Operations & Delivery, Obstetrics & Gynaecology Rim Al-samsam (RAS), Interim Clinical Director, Acute Child Health Michelle Abel (MA), Infection Prevention Control Nurse Nigel Davies (ND), Clinical Director, Obstetrics & Gynaecology Sarah Evans (SME), Head of Workforce & OD **In Attendance** Kirsty Hookn (KH), Board Secretary (minute taker) Louise Williams (LW), Pharmacist (Item 2.1 only)	
1.2	**Apologies for absence** Diane Rogers, Matthew McCarthy, Angela Jones, Heather Gater, Jenny Thomas	
1.3	**To receive the Minutes of the previous meeting 28 February 2017** The minutes of the meeting held on 28 February 2017 were agreed to be an accurate record. Rim Alsamsam – apologies were provided and the minutes will be updated to accurately reflect this.	**KH**
1.4	**QSE bring forward action log / Matters Arising** See updated action log from the meeting.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Medication Management & Medicines Errors** LW was invited to the group following an increase in reporting over previous months, however it was acknowledged that there has been significant work undertaken and the number of errors have now decreased. LW advised that medicines metrics are being collated across the UHB and it was noted that there is an excellent compliance in a number of areas. With regards to VTE, it was noted that there is an issue with reporting within Obstetrics & Gynaecology however	

	this is due to the use of a different chart, which is now being recorded. Discussions ensued in relation to processes across the Board as there are some differences in practice across the Clinical Board. It was noted that a LIPS project has been undertaken where the medication practice guidelines have been produced. This includes a checklist which is an aid memoir for nurses. It was acknowledged that there has been further development of inclusion of a report from consultants where there is a prescriber issue identified. LW agreed to circulate this protocol electronically following the meeting for consideration of implementation if suitable. Concerns were raised with regards to reporting of any medication prescribing errors for medical staff and it was agreed that this should be reported. MG noted that within ACH, where this is identified the educational supervisor is contacted. It was agreed that there should be a pathway in place to ensure that this is followed for all staff (nursing and medical). It was agreed that the Clinical Board Pharmacist would review the options for producing a prescribing pathway for piloting and take to the safer medicines group and staff forum. Discussion ensued in relation to double checking and it was felt that in a number of cases, this will not always resolve a medication error. However it was acknowledged that the NMC professional body dictates that this should be undertaken. It was noted that within Community, further work is being undertaken to ensure that there is a robust process in place for special schools. **Insulin Safety Needles** It was noted that further to the device notice being received safety device needles should now be available for order if these are required for admission of insulin.	**LW** **AL** **ALL to note**
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)** **Acute Child Health** • RCA process is continuing. The never event is being managed and a meeting is being arranged with the family. With regards to RCA for JPS, further dates are awaited from the family to meet. • Falls Prevention Programme Pilot on Jungle Ward has been rolled out and will continue to be rolled out to Island Ward. • Problems identified in Pelican ward in relation to Hand Hygiene, daily audits will continue and it was noted that this is in relation to visiting staff. It was agreed that e-datix incident forms should be completed highlighting known offenders; the Medical Director has also requested to receive this information. • Collection and distribution of the pink health visiting forms for safeguarding is causing concern. It was noted that this form, once completed is usually forwarded to the health visiting team by the safeguarding team. This is no longer undertaken by safeguarding and there is an expectation for nursing staff to complete without any additional resource. CH agreed to discuss with Sheila Harrison with regards to withdrawal of services/change of practice provided from safeguarding and the impact of this. Queries were raised as to whether this could be provided by the GP to the Health Visitor. • Safeguarding Training for Domestic Violence has been added to the mandatory training list which needs to be completed. • Physiotherapy team undertaking a LIPS project looking at transition to adult physiotherapy service the aim is to promote independence in the young person.	**CH**

	• RTT – patient pathways are continuing to be validated and there have been a number that have been cancelled due to patients being unwell. DTOCS and repatriation for ACH is now being reported by Patient Flow co-ordinator as part of the main DTOCS report. • Paediatric Surgery concerns were noted and it was acknowledged that there have been 3 index cases identified with commonalities and RCA's were undertaken. Concerns were raised with regards to practice within ACH and an an action plan has been produced; however it was noted that since this further concerns have been identified. A significant piece of work is being undertaken to review all issues, the action plan has been shared with Executive colleagues and weekly meetings are undertaken with the Directorate for a regular review of actions. It was agreed that the action plan will be shared formally with the group as this work progresses.	**Clinical Board**
	Obstetrics & Gynaecology • Safer Pregnancy Campaign is being launched today • Gynae professional meetings have been re-established and main focus at present is ratification of all documents • In Obstetrics -there are currently 4 ongoing RCAs and 1 case review. There is 1 RCA ongoing in Gynaecology and 1 case review. • Security Tags for babies has been identified as a risk due to the number of tags. The system is no longer supported and now a review of all systems is being undertaken. • Gap and Grow Charts are in place however it was noted that there are still some instances where the customised charts are not being used by some Obstetrics colleagues. Concern was raised that the population charts are different from the customised charts which could then cause issues in management. Discussion ensued as to the reasons for the non use, with ND noting that there is a requirement that all clinics will require additional scanning and radiology support in order for the customised charts to be used. It was agreed that this will be reviewed in further detail following the meeting. • Mandatory Training and PADR database has been set up and it was noted that this has been successful. It was agreed that this would be shared with a view for implementation in other Directorates. • WAST Pathway for Pregnant Women under 17 weeks gestation has commenced and audits are scheduled for 6 weeks time. • Reclining Chairs are now in place to promote open visiting. • CSSI infection rate 8.9% and compliance has increased to 92%. • Non channelled cystoscopes. CH agreed to follow up with Clive Morgan on an update for outpatients. • Insufficient snack provision overnight has been highlighted with a view to increasing provision overnight. • Ongoing work to encourage the recording of weight and BMI on medication charts and completion of VTE assessment. • FGM pathway – midwife led service is being reviewed as an option. It was noted that there has been some over reporting of FGM issues and it was noted that a meeting is being arranged in order to raise awareness of the requirements for reporting. • Maternity Staff Facebook page has been developed which is a successful way of sharing options for training etc. • Information Governance – 4 cases are awaiting sign off. Immediate changes have been implemented in order to reduce the chance of reoccurrence and feedback is awaited from Information governance on the closure of the cases reported. • Funeral arrangements leaflets have been updated and parents are now being directed to the funeral directors.	**O&G DMT** **CH**

	• A specialised room is being created on delivery suite which is being funded by SANDS charity. Work continues. • CAV patient voices has been launched with over 40 members to date. • Caring for you campaign – coffee and cake mornings planned and resilience day is planned. Stress management course is also planned. **Community Child Health** • Consultation for School Nurse Framework has been responded to and further feedback is now awaited. • Immunisation uptake has been accepted and the cohort will commence in April 2017. • Information Governance breach has been reported and is being investigated prior to decision to report to ICO. • Move to Global Link has taken place. The security of the building has been escalated for a requirement for security at the end of the day. Further discussions are taking place regarding this. • Incidents at Rover Way have been discussed as there is no access to health visiting service on site. Health visiting services are still being provided in an alternative location although the uptake has declined. Further meetings have taken place however at present the service cannot be re provided on site due to risks to staff. An MDT meeting is being arranged to discuss the way forward with the required support from Children's Services. • Medicines management standards of practice and pathways are in development including possibilities of pharmacy support • Delivering joint safeguarding training is delayed and is being followed up • Increase in concerns reporting at present, increasing trend identified with regards to the safeguarding referrals • Inspections and unannounced visits in community are being reviewed • JW RCA has been signed off and an action plan is being produced. An offer of a meeting is being offered in order to share the investigation findings • CCNS access to PARIS in the home is causing concern. Meetings have taken place and different options are being reviewed. This will be added to the risk register. • Recruitment event was successful and it was noted that vacancies have been filled. CCNS and Flying Start have recruited.	
2.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** • **MS29 – Security Tags for Babies** • **CCNS access to PARIS**	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of:** **Patients** • ANNT – the work is being progressed and further updates will be provided as this continues **Staff** • Final Flu Figures – 58%, with the Clinical Board vaccinating the biggest numbers of staff. Well done to all for the hard work undertaken in achieving this target. • Caring for you Campaign & Resilience Days Update - Picked up as part of item 2.2	
SAFE CARE		

4.1	**Patient Safety Closure Forms:** **In24692** This case relates to a child who presented with septic shock secondary to Hickman line infection. It was noted that there were other contributing factors associated with ABMU as the child had also been cared for at Morriston Hospital. The root causes were identified as: No action taken from the receipt of the referral letter, no contact made with referring consultant and no written agreement to of follow up care plans. Incidental learning suggested the establishment of regular line insertion / removal lists in theatre that are open to non-oncology patients. It was noted that all actions have been completed and lessons learnt have been shared. It was agreed that this closure form could now be forwarded to Welsh Government for closure. **In19849** This case relates to a Child Death, where it was noted that the cause of death was been reported to be from overwhelming sepsis with an upper urinary tract infection being the source. The action following this was implementation and roll out of the sepsis guidelines within Acute Child Health. Learning from other Health Boards, now completed following implementation of Welsh Portal. All actions have been completed and lessons learnt have been shared. It was agreed this could now be forwarded to Welsh Government for closure. **In37810** Noted for information. It was agreed that the form would be circulated for information following the meeting. This case relates to a child death following admission to PCCU by the WATch team. There was a slight delay in transfer to PCCU however it was noted that the delay caused by the need to arrange a further bed was not considered to have contributed to the child's later deterioration. Further learning from this case was noted in relation to filing notes in date order for ease of review. This has been discussed at the morbidity and mortality meeting for cascade to medical and nursing staff. It was agreed this could now be forwarded to Welsh Government for closure.	**MM** **MM** **CH/KH** **MM**
	RCA Overviews **RCA – LJ (213653)** No recognised failings of care in delivery. Documentation guidelines are being reviewed as this has been identified as a theme. **Recommendations** • Further obstetric drills to include the multidisciplinary team with a focus on the tension used during manoeuvres and the documentation of events. • Following obstetric drills there should be an SBAR to highlight what was the dill, how it was managed, what went well and what can be improved.	

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	Lessons Learnt 1. Shoulder Dystocia drills to include discussion of and demonstration of force during manoeuvres and documentation of incident. 2. Shoulder Dystocia proforma to be advocated by team to aid clarity of documentation and ease of retrieval of information, particularly if multiple operators. 3. The importance of documentation that is clear and legible and includes a signature, printed name and designation to be shared within the directorate. **RCA – KL (229954 & 229956)** Follow up process was identified as the main issue identified. Root Cause, no suggestion of excess force. Family have been debriefed and this has been included as part of the RCA which will be shared with the family. It was noted that this was approved by the meeting. **Recommendations:** • Improvements needed for support for parents of baby's with a brachial plexus injury e.g. bathing, dressing and sensory stimulation. • A backup system required to ensure parents have a contact telephone number if appointments do not arrive. • Improvements in the system for referrals for physiotherapy. **Lessons Learnt:** 1. That every baby with a diagnosis of brachial plexus injury is seen by a physiotherapist who can teach exercises that can be done whilst waiting for the physiotherapy appointment. 2. Provide parents with an information sheet that details practical support for caring for a baby with a brachial plexus injury e.g. bathing, dressing and sensory stimulation. 3. To provide a contact telephone number for parents if appointments do not arrive. 4. Referrals for physiotherapy to be written and a copy of the referral given to parents prior to discharge.	
4.2	**Infection Prevention Control Update** • Learning video for staff has been produced • MSSA currently for 2016/17, 12 cases have been reported. Concern was raised that some of these cases have been attributed incorrectly • C Diff, 13 cases reported however it was acknowledged that inappropriate sampling has been noted and it was therefore noted that this is not a true reflection on the processes that are in place • MRSA – 1 case reported. It was noted that screening needs to be increased and work is being undertaken to review options for this. • It is likely that E Coli will be included in the reporting targets for next year, MA agreed to provide further updates when available.	
4.3	**Safeguarding** **Latest minutes from the Safeguarding Steering Group for information** The minutes from the last Safeguarding Steering Group were noted for information. It was advised that there was no exception reporting of note from the last meeting for the Clinical Board.	

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4.4	**Patient Safety Alerts (internal/external)** **WHC(2017)008: NHS Wales Policy for the Repatriation of Patients** It was noted that this is pertinent to this Clinical Board as it was noted that this can be an issue. It was agreed that it is important to ensure that this is highlighted. The group were asked to ensure that this is disseminated widely for information.	**ALL**
4.5	**UEFA – Preparation** Civil contingency planning department continue to prepare for UEFA. There are a series of events that will lead up to the final taking place on 03 June 2017. It was noted that plans need to be put in place in order to manage the impact on services and alternative arrangement that need to be put into place. The details are currently restricted; however as soon as this is received it will be shared. Risk assessments will need to be undertaken on the impact.	
4.6	**Mycobacterium infection post bypass surgery** Deferred to the next meeting. It was noted that the letter raised more questions and it was agreed that this will be discussed with Eleri Davies following the meeting.	**CH**
EFFECTIVE CARE		
5.1	**Sepsis Pathway Audit** Noted for information. This will commence shortly and once completed will be shared with a future meeting.	
DIGNIFIED CARE		
6.1	**Latest Cleaning Scores Report** The latest cleaning scores were noted for information.	
TIMELY CARE		
7.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** The scorecard was noted for information. • Medications Errors, although still high this is decreasing and significant work is being undertaken to ensure robust management. • VTE documentation compliance has decreased however it was noted that this is due to the implementation of new charts.	
INDIVIDUAL CARE		
8.1	**Update on latest 2 minutes of your Time feedback** No specific issues to note for this meeting.	
Staff and Resources		
9.1	**Latest Workforce Report for information** The latest report was noted for information.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
10.1	**South Wales Fetal Cardiology Service – Final Draft** Deferred to the next meeting.	

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ANY OTHER BUSINESS		
	Medication Error Report It was agreed that a summary report will be shared at future meetings. It was noted that there were no specific areas of focus identified and this will continue to be monitored.	**AL**
	Statutory Supervision of Midwifery This will cease from end of March 2017. It was agreed that the guidance would be shared with the group for information.	**SH**
	Falls Delivery Meeting Discussion ensued and it was agreed that the Babies don't Bounce project to be shared at the next meeting for information. It was noted that a request for midwifery representation at future meetings was noted and SH agreed to review representation. It was agreed that the minutes of the meetings would be shared for information and noting at future meetings for any sharing of lessons learnt etc.	**SH** **JM**

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 25 April, 8.30am, Meeting Room, Clinical Board Offices, lakeside UHW**

31.7

DENTAL CLINICAL BOARD

MINUTES OF QUALITY, SAFETY & PATIENT EXPERIENCE GROUP MEETING
13th April 2017 at 8.00 AM
Dental Boardroom

Present: Mr Andrew Cronin (Chair)(AC) S Bhatia (SB) **In attendance:** Jonathan Peck	Eira Yassien (EY) S Merrett (SM)	S Woolley (SW) Prof I Chestnutt (IC)
Apologies Received from: Prof M A O Lewis Dinah Jones N Drage Sharon Matthews	B Chadwick Catherine Evans R Griffiths J Gillespie	Dr G Bhamra Julia Charles

		ACTION
1.1	**Welcome & Introductions** AC welcomed everyone to the meeting of the Quality, Safety and Patient Experience Group.	
1.2	**Apologies for Absence** Received as above.	
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 12th January 2017 were accepted as an accurate record. **Matters Arising** AC noted that the trend of poorly attended audit sessions had been acknowledged at the last meeting. IC had previously requested that all staff should be made aware of the importance of attending audit meetings. ML was previously asked to send a letter to members of staff underlining the importance of undertaking and engaging in the audit process. The letter is yet to be sent.	ML
2.1	**Oral Surgery, Medicine and Pathology - Mr A Cronin** Minutes from the OSMP Audit Group meeting on the 15th February 2017 were received and noted. AC informed the group that this meeting had been well attended and the time set aside for audit had been well utilised. There was an update on the compliance of the LA form completion which had dramatically improved. This will be re-audited in the future.	

2.2	**Restorative Dentistry - Dr G Bhamra** Minutes from the Restorative Dentistry Audit Group meeting on the 22nd February 2017 were received and noted.	
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 15th February 2017 were received and noted. SB informed the group that the last meeting was well attended. Emma Stone had given a presentation which summarised the results of the latest Hand Hygiene audit. Rowena Griffiths gave a Never Event Presentation for an incident in the Oral and Maxillofacial Surgery department on the 25th July 2016. SM commented that the audit sessions were also being utilised for PAR scoring and noted how well the joint sessions were working with cases being discussed of interest to both Paediatric and Orthodontic specialities. AC noted the importance of reviewing the audit report. The Clinical Health Board would like progress reports on individual audits rather than audits being reported as simply 'ongoing'. Audits should be time limited with a date for the audit to be completed and results to be presented along with recommendations. EY commented that she had recently attended the OSMP Audit Group meeting where an interesting audit on tooth notation had been presented and had resulted in the HSQ being modified. EY inquired how these audits were shared as they were certainly of value to other specialities. AC confirmed that the Q&S meeting would be the place to disseminate audit results between specialities. AC at this time took the opportunity to mention a discussion at the last Clinical Leads meeting with regard to students / postgraduates / supervising consultants using mobile phones on clinic. IC acknowledged there was some confusion as to the use of mobile phones and had previously had a discussion with Prof. Gilmour. The group discussed.	
2.4	**Community Dental Service - Mr J Gillespie** Minutes from the CDS Quality & Safety Group meeting on the 9th February 2017 were received and noted.	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group - Prof I Chestnutt** IC commented on the recent hand washing audit and presentations by Emma Stone. Hand washing compliance appeared lower however it was noted that it was unclear as to whether the washing of hands was worse or the audit process was better.	
2.6	Medicine Management	
3.1	**Patient Story / Presentations** Steve Woolley presented to the group an overview of the summary of changes to the Sedation Standard Operating Procedure (Enclosure 19). SW informed the group that the SOP could be adapted for use in the Paediatric department. EY queried as to whether the SOP and associated documents could be put on the UHB website. SW commented that it would be useful for the information leaflets for patients to be placed on the website. AC thanked SW and acknowledged the amount of work that had been put into the document. AC requested patient stories be presented at this meeting in the future. Audit leads were requested to keep track of patient stories given at their respective audit meetings and to keep copies of the presentations.	
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. The concerns procedure was queried. IC suggested the process be checked to ensure incidents are closed when appropriate or escalated if required. EY informed the group that one of the biggest concerns raised at reception desks was the issue of parking on site. EY also noted that emails had been sent to Colin McMillan with regard to the raising of the road barrier to allow access for parents of children recovering from GA. No response had yet been received.	
5.2	**Patient Safety Incidents** The document was received and noted. AC acknowledged the number of sharps incidents. It was noted however that this was no better or worse than the rest of the UK.	
5.3	Medicines management issues/incidents/audit findings	
5.4	New Medical alerts Actions from previous alerts	
5.5	Medical devices/equipment issues	
5.6	Decontamination issues WHTM01-05	
6.1	Monitoring of CB Clinical Audit plan	
6.2	Research and development	
7.1	HIW/DSDU/WHTM 01-05 reports and improvement plans	
7.2	Ward inspection reports and improvement plans	
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	

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9.4	IMPAX - Generic screen saver time out	
Items to be recorded as Received and Noted for Information by the Committee		
	Ongoing Audits - The document was received and noted.	
	PSA006 Risk of death injectible phenytoin - The document was received and noted.	
	SI FLOWCHART FINAL - The document was received and noted.	
	UHB Communication - R Griffiths - The document was received and noted.	
	MDRO Procedure FINAL Approved Dec 16 V1 - The document was received and noted.	
	MASH referrals Flow Chart Dental issue 2 - The document was received and noted.	
	2017 UDH_Sedation_Procedures_v8 - The document was received and noted.	
	Hand Hygiene Observation Audit Tool draft - The document was received and noted. It was suggested that more posters were printed and laminated to display.	
	Regulation 28 response MI - The document was received and noted.	
	Summary of changes to SOP 2017 - The document was received and noted.	
	16-01-17 - (IR(ME)R) letter to NHS Wales from Deputy Chief Medical Officer et al - The document was received and noted.	
10	**Date of Next Meeting** TBA | TBA | TBA	

31.8

PRIVATE QUALITY SAFETY AND EXPERIENCE COMMITTEE

20th June 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 18th April 2017	*Chair*
5	Action Log – no outstanding action	*Chair*
6	Chair's Action Taken since the last Meeting	Oral-*Chair*
7	Safeguarding Update	*Executive Nurse Director*
8	Paediatric Surgery	*Executive Nurse & Medical Directors*
9	Liver Surgery Review Final Report	*Executive Nurse & Medical Directors*
10	Confidential Medical Staff Issues Update	Oral - *Medical Director*
11	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
12	Review of the Meeting	Oral – *Chair*
13	Date of next meeting Tuesday 12th September 2017	