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

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

9am on Tuesday 12th September 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 20th June	*Chair*
5	Action Log	*Chair*
6	Chair's Action Taken since the last meeting	Oral - *Chair*
Governance, Leadership and Accountability		
7	Patient Story	*Dental Clinical Board*
8	Dental Clinical Board Quality, Safety and Experience Assurance Report	*Dental Clinical Board*
9	Community Health Council Scrutiny Overview Report – July 2017	*CHC*
10	CHC - General Practice Branch Surgery Visits November - December 2016	
11	**Policies for Approval**	
11.1	All Wales Making Decisions on Individual Patient Funding Requests (IPFR) Policy	*Director of Public Health*
11.2	Point of Care Testing (POCT) Policy and Procedure	*Medical Director*
11.3	Nutrition and Catering Policy and Procedure for Inpatients	*Executive Director of Therapies and Health Sciences*
11.4	Venepuncture for Non Clinically Qualified Research Staff Policy	*Medical Director*
12	Update on the review of Outstanding Policies	*Asst. Director Patient Safety & Quality*
Theme 1: Staying Healthy (Health Promotion, Protection and Improvement)		
Theme 2: Safe Care		
13	Implementing the National Safety Standards for Invasive Procedures	*Executive Nurse Director*
14	Patient Safety Solutions – Alerts and Notices – Update on Outstanding Areas of Non-Compliance	*Executive Nurse Director*
15	Blood Products – Health and Care Standard 2.8	*Medical Director*
16	Nutrition and Hydration Report August 2017	*Director of Therapies and Health Sciences*
17	Point of Care Testing: Governance Review	*Medical Director*

18	Risk to Patients During the Changeover to the New Neuraxial Connector	*Medical Director*
19	Corporate Risk and Assurance Framework Update	*Director of Corporate Governance*
20	WRPS Themed Reviews of Emergency Departments & Composite Themed Review & Action Plans	*Executive Nurse Director*
21	Provision of a Decant Ward at UHW and UHL	*Director of Planning*
Theme 3: Effective Care		
22	Cancer Peer Review – Neuro Endocrine Tumours	*Medical Director*
23	LIPS Update	*Executive Nurse Director*
24	Annual Clinical Audit Plan	*Medical Director*
Theme 4: Dignified Care		
25	Carers Measure	*Executive Nurse Director*
26	Female Genital Mutilation (FGM) Safeguarding Update	*Executive Nurse Director*
Theme 5: Timely Care		
Theme 6: Individual Care		
Theme 7: Staff and Resources		
PART 2: Items to be recorded as Received and Noted for Information by the Committee Papers are available on the UHB website		
27	NICE Guidance	*Medical Director*
28	HIW Annual Report of the UHB	*Assistant Director of Patient Safety and Quality*
29	**Minutes from Clinical Board Quality Safety and Experience Sub Committees** 1. Clinical Diagnostics and Therapeutics – May, June & July 2. Mental Health – June 3. Primary, Community and Intermediate Care - May 4. Specialist Services – March, April x 2, May & June x 2 5. Medicine – May & June and A&E waits in March/April 6. Surgery – May 7. Children and Women – May 8. Dental - June	*Chief Operating Officer*
30	Agenda items for the Private QSE	*Chair*

31	Items to bring to the attention of the Board/other Committee	Oral – *Chair*
32	Review of the Meeting	Oral – *Chair*
33	Date of next meeting: Special meeting - 9am on Tuesday 17th October 2017	

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UNCONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9am ON 20 JUNE 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Maria Battle	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

In Attendance:

Abigail Harris (part)	Director of Planning
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Observer (Health and Safety Representative)
Daniel Price (part)	Deputy Chief Officer CHC
Fiona Jenkins (part)	Director of Therapies and Health Sciences
Fiona Salter (part)	Staff Representative
Dr Graham Shortland (part)	Medical Director
Helen Donovan (part)	Senior Nurse, PCIC
Jonathan Webb (part)	Observer, Legal and Risk
Kay Jeynes (part)	Director of Nursing, PCIC
Peter Welsh (part)	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Sue Morgan (part)	Director of Operations, PCIC
Steve Curry	Interim Chief Operating Officer
Stuart Egan	Staff Representative
Urvisha Perez	Observer – Performance Auditor, WAO

Apologies:

Angela Hughes	Acting Assistant Director Patient Experience
Dr Sharon Hopkins	Director of Public Health Medicine
Stephen Allen	Chief Officer CHC

Secretariat: Julia Harper

QSE 17/080 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, Urvisha Perez from Wales Audit Office who was attending the meeting as an observer, as part of Wales Audit Office Structured Assessment work.

QSE 17/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/082 DECLARATIONS OF INTEREST

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

QSE 17/083 MINUTES OF THE COMMITTEE HELD ON 18th APRIL 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 17/084 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 17/048 Ward Bathroom Refurbishment – The analysis of comparative data of 10 refurbished bathrooms did not demonstrate any significant decrease in the number of falls. However, one ward had seen a significant reduction, C1, and further work would be undertaken to identify the reason for this. The Chair asked for an analysis of the impact of colour to be undertaken at the same time. In addition, investigation into the use of transportable toilet bags (as per Manchester) would also be considered.
Action – Mrs Carol Evans

QSE 17/051 Mental Health QSE Sub Committee – In the absence of an update on identified action, the Chair asked that the individuals be invited to attend the next meeting.
Action – Mrs Julia Harper

QSE 16/192, 17/023, 17/048, Care of the Deteriorating Patient – There were systems in place, but this was not a single system. A report would be provided for the September meeting.
Action – Dr Graham Shortland

QSE 17/063 Healthy Restaurant and Retail Policy – In the absence of the Director of Planning, the Chair asked when healthy eating would be advertised in the UHB catering facilities.
Action – Mrs Abigail Harris

QSE 17/085 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/086 PATIENT STORY – PRIMARY, COMMUNITY & INTERMEDIATE CARE – SALLY'S STORY

Ms Helen Donovan, Interim Senior Nurse, Vale Locality, PCIC Clinical Board, presented Sally's story. Sally was 26 years old and severely disabled. Due to an eating disorder, and due to her poor physical health, she could not be actively treated when she was diagnosed with MS. This led to an extended period of rehabilitation at Rookwood Hospital, completely dependent on others to meet her daily living and care needs. Sally also had challenging behaviour, OCD, anxiety and depression.

On discharge, Sally remained at home for almost 3 years with a comprehensive package of care. This package broke down when she became non compliant with her treatment which resulted in her BMI falling to an unacceptable level and she developed a non healing pressure ulcer. As a result, Sally was admitted to UHL.

Although Sally requested a quick discharge home, there was a difference of opinion as to whether she had capacity to make a safe decision. The community staff felt unable to support her discharge at that point, involved the full MDT and agreed a specialist care home placement should be made in her best interest.

Sally continued to ask to go home and the DoLs team and an independent advocate were brought in to support her. Sally's physical and mental health improved as she continued to put weight on. As her capacity returned, and she understood the consequences of non compliance with treatment, a package of care was put in place for Sally to return home. Sally said "I am happier and in control of my life. I feel more confident and independent".

The Chair invited comments and questions:

- The cost of a specialist nursing home was £107k and the care package at home was £50k. More importantly, Sally was happier and where she wanted to be. It was noted that a saving was not always the case, and normally it was more expensive to provide a comprehensive care package at home.
- Sally's insight improved as she managed to put weight on and her physical health improved.
- Decisions on capacity were complex as acute consultants disagreed initially with the community team who were better acquainted with Sally. In addition, there was a lack of family support.
- The community team went above and beyond to meet Sally's wishes as soon as they thought she was safe to return home.
- Around 80 patients currently had home care packages at a cost of £4m.

The Chair thanked Ms Donovan for presenting. The Committee **NOTED** the excellent example of advocacy in this patient story.

QSE 17/087 PRIMARY COMMUNITY & INTERMEDIATE CARE CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Mrs Kay Jeynes advised that the Reviews undertaken in Prison Services and Asylum Seekers had been omitted from the report in error.

The Chair invited comments and questions on the report:

- Triangulation was not going well with commissioned services as the framework was outdated and awaiting Welsh Government review. UHB services were diverse but one theme was accessibility and waiting times for drop-in services. The Committee could expect to see reference to this in the Sub Committee Minutes.
- It was confirmed that sensory loss was included in engagement work.
- Guidance was awaited from Welsh Government on the uptake of GP enhanced service for adults with learning disability. In the meantime, this was being picked up by the contract monitoring team.
- Recruitment had improved. Workforce planning was being undertaken to map the need for staff over the next 5 years. There were currently 10 vacancies, a significant number for the Clinical Board. Efforts were being made to make jobs flexible and attractive and to retain staff. Exit feedback was being gathered in order to make improvements. However, recruitment was taking some time particularly when novice starters were appointed – this was the first time such staff were appointed. 40% of nursing staff were aged over 50 years.
- Specialist Nursing staff were key to supporting patients and reducing the need for clinic follow up appointments eg Diabetes reduced by 30%. This could be expanded to other specialties but required careful thought and modelling. It was agreed that the new Committee would be asked to consider this developmental work and connectivity with University syllabus.
  Action – Mr Peter Welsh
- It was agreed that the new Committees would be asked to scrutinise PCIC's top priorities and the impact of the Local Delivery Plan.
  Action – Mr Peter Welsh

ASSURANCE was provided by:

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

The Quality Safety and Experience Committee:

- **APPROVED** the contents of the brief report of the PCIC Clinical Board QSE Sub Committee
- **NOTED** the areas for further action:
  1) Increase the PPI activity across the breadth of the Clinical Board's provider and commissioned services

2) Ongoing work required to ensure that a comprehensive and responsive interface system of incident reporting was in place
3) The work required to treat and mitigate the Clinical Board's top 5 risks
4) The ongoing safeguarding work and monitoring of commissioned placements that was being undertaken across the commissioned nursing homes through the Locality Teams.

QSE 17/088 COMMUNITY HEALTH COUNCIL (CHC) REPORT

Mr Daniel Price, Deputy Chief Officer of the CHC corrected the dates in the report summary and highlighted commencement of follow up visits.

In terms of recommendations, the information requested on hand hygiene was available in the Infection Prevention and Control report. Repatriation information was not normally supplied to the CHC but the CHC had representation on other UHB Committees and Groups where this was discussed. Repatriation was discussed regularly and every Monday all Chief Executives considered such issues. This was another area that would benefit from system rules. It was noted that the Medical Director was discussing the production of a repatriation policy with a professor from Bristol in advance of the setting up of the Trauma network. Enforcement may require the introduction of charges for non compliance. The Committee requested that the CHC instigated a national debate on repatriation.
Action – Mr Daniel Price

It was agreed that, in addition to feedback to wards and departments, the CHC would, in future, provide feedback to the Equality Manager.
Action – Mr Daniel Price

The report was **RECEIVED** and **NOTED.**

QSE 17/089 CHARGES FOR LOST HEARING AIDS POLICY AND PROCEDURE

The Director of Therapies and Health Sciences, Ms Fiona Jenkins confirmed that patients would be supplied with a new hearing aid but that they would be followed up for payment if they did not meet the exemption criteria.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **APPROVED** the Charges for Replacement of Lost Hearing Aids Policy

- **APPROVED** the full publication of the Policy in accordance with the UHB Publication Scheme.
  Action – Mrs Julia Harper

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QSE 17/090 EXTERNAL REGULATORY AND ACCREDITATION VISITS TO CLINICAL DIAGNOSTICS AND THERAPEUTICS SERVICES

The Executive Nurse Director, Mrs Ruth Walker commented that the report was positive, demonstrated robust governance and showed lessons had been learned. The Chair agreed to write a letter of thanks and support to the Clinical Board.
Action – Ms Maria Battle

ASSURANCE was provided by:

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

The Quality Safety and Experience Committee:

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

QSE 17/091 ANNUAL QUALITY STATEMENT (AQS)

The Executive Nurse Director thanked Mrs Carol Evans, Assistant Director of Patient Safety and Quality and her Team for the depth and breadth of the work throughout the year that culminated in the production of the AQS. The timetable for production had been brought forward this year, but more engagement work had been undertaken. Mr Price confirmed the CHC section would be provided immediately.

The Chair invited comments and questions on the report:

- A sentence would be added linking the work to the Intermediate Medium Term Plan (page 94).
- Consideration would be given to making reference to improvements in the Emergency Unit and the current situation with Paediatric Surgery, although the dates were possibly not appropriate for inclusion until next year.
- In terms of engaging with young carers, details could be found in the Carer's Report.
- The author was asked to check pages 85, 125 to include behaviour and 128 to specify which disability awards this referred to. In addition,

the use of charitable funds to enhance patient experience would be included.
- It was noted that the template for the AQS had been set by Welsh Government as it was considered that this was easier for public digestion. Therefore, it may not be possible to reference benchmarking in the AQS.
- It was agreed to insert the traffic lights for clinical audit on page 106. **Action – Dr Graham Shortland**

ASSURANCE was provided by:
- The provision of the draft Annual Quality Statement 2016/2017.

The Quality, Safety and Experience Committee:

- **APPROVED** the Annual Quality Statement for 2016/2017 in draft; prior to full design work being undertaken in readiness for endorsement at the public Board meeting in July 2017.
- **AGREED** to include, where possible, comments made at the meeting. **Action – Mrs Carol Evans**

QSE 17/092 HEALTH AND CARE STANDARDS SELF ASSESSMENT 2016/17

The Executive Nurse Director, Mrs Ruth Walker, presented the annual assessment that was undertaken either by Clinical Boards or Committees. Links were available for Members to see the detail of each assessment. The final version for each assessment was signed off by an Executive Director and an Independent Member. The whole process had been given Reasonable Assurance by Internal Audit.

Concern was expressed about the verification process for the self assessments. It was noted that there was a tool for this and there would be a move away from self assessment in future years in favour of constant monitoring by Committees - progress would be clear in the QSE Sub Committees' minutes. The annual report would contain more detail on progress against key pieces of work so that areas of non-delivery would be identifiable.

ASSURANCE was provided by:
- The comprehensive assessments of each standard.
- Corporate validation of Self Assessments

The Quality, Safety and Experience Committee:

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

QSE 17/093 SAFEGUARDING REPORT UPDATE

The report was presented by the Executive Nurse Director, Mrs Ruth Walker. The agenda was growing in significance in terms of the work undertaken and the number of cases. This was challenging operationally and strategically with no resource increase to the Safeguarding Team.

One item raised was the deep distress caused to the local Somali community by the UHB's reporting of female genital mutilation (FGM). This was a Welsh Government requirement and the figures were significant. Whilst the UHB wanted to be respectful of this community's beliefs and culture, the message was unequivocal – FGM was a criminal offence and supporters of this practice could be charged with aiding and abetting. It was not clear whether the practice was taking place locally or abroad and this was being explored. Mr Hanuk commented that the Yemeni and Somali communities were some of the oldest in Wales and were now 4th/5th generation. It would be worth engaging with them and opening the debate. It was agreed to provide the Committee with details of the number of cases and the action being taken in response.
Action – Mrs Ruth Walker

Concern was expressed about safeguarding financial support to the Sexual Assault Referral Centre (SARC) as one Police force was not contributing. A joint meeting was about to be held. The UHB was clear that the model was working well and referrals were increasing.

The capacity of the Safeguarding Team was noted. An increase in resources would require a business case, although different ways of working, such as MASH, were proving supportive. In addition, it would be helpful to reference the Iris project and the bereavement work undertaken with charities.

Domestic homicide was an emerging agenda. Meetings had been held with Local Authorities to ensure a robust governance framework was in place.

ASSURANCE was 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:

- **NOTED** this report.

QSE 17/094 INFECTION PREVENTION AND CONTROL EXCEPTION REPORT

The Executive Nurse Director had nothing to add to the report. It was noted that half a ward was currently being refurbished but this did not include the provision of single rooms. Isolation rooms required specific criteria. With regard to the provision of single rooms, this required increased investment as well as a loss of capacity that depended on Welsh Government support. None of this work could be achieved without identification of a decant ward. It was also noted that UHW wards did not lend themselves easily to a new configuration. Given this, the UHB currently had no plans to create single rooms as no empty ward was available for decant purposes. The hospital was full and was in a catch-22 situation. However, one ward had flexed down to 19 beds and this would be used to refresh as many areas as possible over the summer months.

It was noted that significant capacity had been lost last year following outbreaks of D&V. Ideally, two wards needed to be identified – one for decant to enable a rolling programme of refurbishment and one to re-provide a ward of single rooms. To achieve this, demand had to be reduced. The Chair requested that this plan be brought to the July Board.
Action – Mrs Abigail Harris

The resource available in the IPC Team was raised frequently and also featured in the Neonatal Unit external report. If investment in this area provided payback financially, it was worth reconsidering. It was therefore agreed to revisit the resource risk assessment.
Action – Mrs Ruth Walker
The UHB was carrying a risk at senior nurse level but it was not clear if investment in this area would bring savings elsewhere. Additional staff may not result in reduced levels of infection because many of the issues were linked to the fabric of the estate and antimicrobial prescribing.

LIMITED ASSURANCE

The Quality, Safety and Experience Committee:

- **APPROVED** and **NOTED** the content of the paper.

QSE 17/095 CLEANING STANDARDS

The Director of Planning, Mrs Abigail Harris commented that this had been discussed at the Health Systems Management Board. Resources did not benchmark well in low risk areas and some of the public areas were not prioritised and were looking shabby. An internal audit would be carried out in the near future.

Reference was made to findings in the external report on the Neonatal Unit. This cited the use of the correct cleaning solution, but the wrong process (not

being left long enough before washing off) and the fact that the special cleaning machine could not be used when the operator was on holiday. This was a training issue which the department was addressing, along with attempts to stabilise the high turnover and vacancy rates.

It was hoped that the good practice of each ward having its own housekeeper managed by the ward Sister or Charge Nurse would be strengthened, avoiding the need to move staff around.

LIMITED ASSURANCE was provided by:

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

- **AGREED** the implementation of the Credits for Cleaning and Welsh Government Standards were being embedded and scores had improved to meet targets (or were being managed for immediate improvement) in the high priority areas (Very High and High Risk) given the current resource profile.
- **AGREED** that the Health and Safety Committee would receive a further report on clutter and cleaning at fire exits.
  Action – Mrs Abigail Harris

QSE 17/096 INDEPENDENT REVIEW OF THE MANAGEMENT AND RESPONSE TO ACINETOBACTER OUTBREAKS IN 2015

The report was presented by the Executive Nurse Director, Mrs Ruth Walker. It was noted that there was always an element of infection within hospitals, but where patients were placed affected its spread. On occasions, the UHB had reached the point where there was no physical space for this client group and admissions had been halted. However, a new environment was identified and made available very quickly.

The lesson was that the UHB knew it had a high risk (as identified in the CRAF), but failed to act. Fortunately no deaths had resulted from the infections. This had been a difficult agenda to balance, given the inertia whilst waiting for the outcome of the South Wales Plan that would have addressed the shortcomings.

Concern was expressed about the findings on hand hygiene. This was free and was within the UHB's control. The Policy was clear and had been

recently reiterated at the Health Systems Management Board and was also being reiterated at Clinical Board Performance Reviews.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report
- **APPROVED** the improvement plan
- **AGREED** to receive 6 monthly progress updates on improvements (December and June)
  Action – Mrs Ruth Walker

QSE 17/097 POINT OF CARE TESTING

The Medical Director, Dr Graham Shortland, gave a verbal update on the governance issues associated with POCT (point of care testing). It was important to have robust governance and accountability arrangements to ensure patients were not harmed. This was difficult without a national policy although the Committee would be asked to approve a local policy in September where POCT results would be sent directly to the clinical portal, providing a better audit trail.

The Committee **NOTED** the update.

QSE 17/098 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh reminded Committee of the complete review of risk management that was being undertaken.

ASSURANCE was provided by:

- Mitigation of risks being monitored by the appropriate Committees of the Board albeit the information provided via the CRAF required strengthening.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the CRAF Update Report and the high risks assigned to the Committee.
- **AGREED** to give further consideration to whether the risk descriptors and controls identified were adequate to provide assurance to the Committee. Comments would be provided to the Director of Corporate Governance by 20th July.
  Action – All Members and Attendees

QSE 17/099 CARE OF THE DETERIORATING PATIENT

The Chair had requested that the Committee debate this item as it had remained unresolved for a number of years and the previous Chair of the Committee had expressed her concern that no way forward had been agreed. This item had already been raised as part of the Action Log and it was agreed that a report with clear timelines would be presented in September.
Action – Dr Graham Shortland

QSE 17/100 PATIENT WRISTBANDS

The Executive Nurse Director, Mrs Ruth Walker, gave a verbal update to the Committee as the UHB was being criticised for not implementing the Safety Notice. The Board had previously placed this Safety Notice on hold as it was not considered a top priority. A business case for a solution would be presented in July to the BCAG and it was also agreed to include IT requirements in the IM&T Outline Plan.
Action – Mrs Ruth Walker

QSE 17/101 CANCER PEER REVIEWS - BRAIN

The Medical Director, Dr Graham Shortland, reminded Committee that peer review was a good process and as the second cycle was entered, comparison would be possible. The process was moving into specialty areas but the teams needed support across the cancer pathway and this would be highlighted to the cancer network.
Action – Dr Graham Shortland

Concern was expressed that WHSSC had not prioritised several areas that had been brought to their attention and the UHB Board was not cited on the detail of the decision making.

There was some confusion with the structure of the network. For example, doctors were locally accountable and not accountable to the network. It was agreed that the Medical Director would brief the Chair in order for her to raise all the issues with the Chair of the WHSSC QSE Committee.
Action – Dr Graham Shortland and Miss Maria Battle

Mr Curry reported that he had met with the commissioning team where he had discussed the risk impact on the UHB priority areas that were currently not being supported and flows from other Health Boards. All issues came back to the lack of system rules and how Health Boards collaborated generally. It was agreed to undertake work on rules in order to challenge WHSSC and the cancer network.
Action – Dr Graham Shortland

ASSURANCE was 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 were addressed via an action plan and were regularly reported within the required process; at the Clinical Board performance reviews and by Welsh Government and the South Wales Cancer Network.

The Quality, Safety and Experience Committee:

- **NOTED** the report and
- **DID NOT AGREE** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern. A report on "system rules" and collaboration would therefore be received at the September meeting. **Action – Dr Graham Shortland**

QSE 17/102 MORTALITY DATA AND MORTALITY REVIEW

The Medical Director, Dr Graham Shortland, presented the 6 monthly trend report and made specific reference to the number of patient deaths at weekends. Fortunately, this demonstrated there was no significant difference. Further observation and work demonstrated that the allegations of higher incidence of deaths at weekends had been overstated in the media, probably by the use of inappropriate data. It was noted, however, that a different population of patient was admitted at weekends which did impact the likelihood of death. Mortality would continue to be monitored and the UHB still had the lowest crude morality in Wales.

ASSURANCE was provided by:

- Monitoring of Mortality measures reviews
- Mortality Data

The Quality, Safety and Experience Committee:

- **AGREED** the ongoing proposed plans for mortality reviews.
- **NOTED** the planned introduction of the Medical Examiner Role.
- **NOTED** the discussion about weekend mortality.

QSE 17/103 UPDATE ON HEALTH INSPECTORATE WALES ACTIVITY

The Executive Nurse Director, Mrs Ruth Walker gave an overview of the very positive report. There were still some areas that required further work, in particular engagement with Mental Health staff.

The Chair requested that a progress report on the plans for a single point of entry for Paediatric Emergencies be brought to the next meeting in September.
Action – Mr Steve Curry

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **CONSIDERED** the inspections that have been undertaken
- **AGREED** that the appropriate processes were in place to address the recommendations
- **AGREED** that a future report, outlining progress should be presented at the October 2017 Committee.

QSE 17/104 CARERS INFORMATION AND CONSULTATION STRATEGY

ASSURANCE was provided/demonstrated by:

- The progress and actions highlighted within the report.

The Quality, Safety and Experience Committee:

- **NOTED** and **APPROVED** the contents of the annual report

QSE 17/105 MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE

Ms Caroline Bird attended the meeting to comment on the strategy for outpatient follow ups and its impact on the number of patients waiting and the improvement in the waiting times for endoscopy.

The Chair invited comments and questions:

- Asked why the UHB had the highest DNA rates in Wales, it was noted that the number varied by specialty and was part of the Transformation work. It was suspected that the figures may, in part, be due to data quality issues and “cashing up” at the end of clinic.
- Assurance was provided that there had been an 80% reduction in the number of highest risk patients waiting.
- It was noted that work was ongoing and that there was no quick fix option available.

ASSURANCE was 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 was one of the Health Board's priorities for 2017/18 and was 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:

- **NOTED** the current position and work ongoing in relation to the management of outpatient follow up care and endoscopy surveillance.
- **AGREED** to receive a further report in February 2018.
  Action – Mr Steve Curry

QSE 17/106 TRAUMA AND ORTHOPAEDIC JOINT REVISION RATES

The Medical Director, Dr Graham Shortland advised Committee that he had brought this report at the request of the Audit Committee where concern was expressed about the high number of joint revisions undertaken at the UHB. He confirmed that the reason for this was the UHB's use of an implant that was identified, by the manufacturer, as being substandard. All costs associated with the increased work had been reimbursed by the manufacturer. The Committee regretted the impact of this on patients.

ASSURANCE was provided by:

- A National UK Programme of monitoring hip replacement products had been introduced to better predict failure rates and reduce the likelihood of a further large scale 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) confirmed revision ratios within normal outcome limits.

The Quality, Safety and Experience Committee:

- **APPROVED** the ongoing programme of audit and product selection to ensure improved patient outcomes.

QSE 17/107 SINGLE ROOMS, DECANT FACILITIES AND ISOLATION ROOMS AT UHW

Given the earlier discussion, it was agreed that no further comment was required on this report and it would be referred to Health Systems Management Board.
Action – Mrs Abigail Harris

LIMITED ASSURANCE was 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 Committee:

- **NOTED** the position in relation to the identification of a decant ward area that would enable a rolling proactive ward refurbishment programme to be implemented.
- **NOTED** the plans for an estates strategic plan which would set out the programme for development of the estate – both hospital and community facilities in order to deliver the strategy and ensure facilities were fit for purpose and sustainable.

QSE 17/108 COMMUNITY MENTAL HEALTH TEAM (CMHT) ACCOMMODATION – UPDATE ON PLANS

The Director of Planning, Mrs Abigail Harris advised Committee of current thinking around the critical mass needed for larger community mental health teams. This would mean that 3 teams would need accommodation in the new Hubs.

The Chair requested a timescale for the delivery of BIG 2. This would be discussed with the Director of Corporate Governance as to where and when this should be received.
Action – Mrs Abigail Harris

LIMITED ASSURANCE was 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:

- **NOTED** the situation in relation to the current CMHT accommodation.
- **NOTED** the potential outcome of the review of CMHTs and the implications for accommodation.

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

QSE 17/109 HM CORONER REGULATION 28 PREVENTION OF FUTURE DEATHS

ASSURANCE was 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:

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

UHB 17/110 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – APRIL**
2. **MENTAL HEALTH – MARCH AND LESSONS LEARNED – MAY**
3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MARCH**
4. **SPECIALIST SERVICES – NO REPORT SINCE FEBRUARY**
5. **MEDICINE (AND ACUTE AND EMERGENCY WAITS) – APRIL**
6. **SURGERY – MARCH AND APRIL**
7. **CHILDREN AND WOMEN – FEBRUARY AND MARCH**
8. **DENTAL – MARCH**

QSE 17/111 AGENDA FOR THE PRIVATE QSE

The private agenda was published as part of the culture on openness..

QSE 17/112 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

Report to July Board on plans for decant facilities, single and isolation rooms.

QSE 17/113 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/114 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 12th September 2017.

ACTION LOG FOLLOWING QSE COMMITTEE JUNE 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/024 QSE 17/048 QSE 17/084	21.2.17 18.4.17 20.6.17	Ward Bathroom Refurbishment		Analysis of comparative data – new bathroom - effect on falls and infection rate. Further work on impact of use of colour on falls and use of transportable toilet bags.	C Evans	No significant decrease – except for C1 so further analysis to be undertaken.
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 QSE 17/084	18.4.17 20.6.17	Mental Health CB QSE Report		Refresh work on sensory loss and arrange walkround with representative of the deaf community.	I Wile	Chair requested Ian's attendance at next meeting to explain as no response had been received since April.
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		Discuss depth and	C Evans	Meeting arranged for 23rd June

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Clinical Board QSE Sub Committees		breadth of the Dental agenda with the CB.		
QSE 17/087	20.6.17	PCIC Quality and Safety Report Specialist Nursing staff were key to supporting patients and reducing the need for clinic follow up appointments eg Diabetes.		New Committee to be asked to consider this developmental work and connectivity with University syllabus Scrutinise PCIC's top priorities and the impact of the Local Delivery Plan at new Committee	P Welsh P Welsh	**New Committee** **New Committee**
QSE 17/088	20.6.17	CHC Report		To support the UHB, instigate national debate on repatriation. Visit findings and feedback to be regularly shared with the Equalities Manager	CHC D Price CHC D Price	
QSE 17/090	20.6.17	Regulatory and Accreditation Visits to CD&T		Letter of commendation to be sent to Clinical Board	M Battle	
QSE 17/098	20.6.17	CRAF		Comments to P Welsh on whether the risk descriptors and controls identified were adequate	ALL Members and Attendees P Welsh to	

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				to provide assurance to the Committee by 20th July.	correlate.	
QSE 17/101	20.6.17	Cancer Peer Review – Brain		Raise structure of the network with WHSSC Chair of Quality and Safety Committee (G Shortland to brief Chair). Undertake work on system rules on flows and collaboration	M Battle (Dr G Shortland) Dr G Shortland	
QSE 17/108	20.6.17	Plans for CMHT Accommodation		Timescale for the delivery of BIG 2 - discuss with P Welsh where and when this should be received.	A Harris	
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/192 QSE 17/048 QSE 17/099	18.10.16 18.4.17 20.6.17	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.	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) Report with action plan and timeline to be provided for **QSE in September**
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**.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						Business case now going to 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	**Reported to Board in July Complete**
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 17/009	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 and Retail Policy		Request PPP Committee to consider the comments and review value for money of all Wales food contract.	J Harper	**Referred to PPP Committee Secretariat (or its successor on 19/4/17)**

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MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/084	20.6.17			Chair requested confirmation of when healthy eating would be advertised in the restaurant.	A Harris	
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**
QSE 17/096	20.6.17	Independent Review – Acinetobacter NNU		6 monthly progress report to be received	R Walker	**QSE December 2017**
QSE 17/103	20.6.17	HIW Activity		Progress report on plans for a single point of entry for Paediatric Emergencies	S Curry	**QSE September 2017**
QSE 17/105	20.6.17	Management of Outpatient Follow Ups and Endoscopy		Receive update report early next year.	S Curry	**QSE February 2018**
QSE 17/107	20.6.17	Single Rooms, Isolation Rooms and Decant		To be discussed at HSMB	A Harris	**To HSMB**
COMPLETED ACTION SINCE LAST MEETING						
QSE 17/051 QSE 17/084	18.4.17 20.6.17	Mental Health CB QSE Report		Remind Other Clinical/Corporate Boards that staff in MH areas can access violence and aggression	J Tottle	Confirmed that Housekeeping staff do attend violence and aggression training provided by the MHCB and that Housekeeping Management had been reminded

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				training.		that this training was available. **COMPLETE**
QSE 17/095	20.6.17	Cleaning Standards		Further report on cleaning and clutter in relation to fire escapes to H&S Committee	A Harris	**July Health and Safety Committee. Complete**
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. Action was as resolved as could be. **CLOSED**
QSE 17/024 QSE 17/048 QSE 17/084	21.2.17 18.4.17 20.6.17	Ward Bathroom Refurbishment		Write to UHB Chair about the urgent need for a decant ward and single rooms.	I Grey	See Item 28 on June agenda. **Complete – discussed June**
QSE 17/089	20.6.17	Charges for Lost Hearing Aids Policy		Publish and Advertise	J Harper	**Complete**
QSE 17/091	20.6.17	AQS		Include clinical audit traffic light. Include comments made at meeting	G Shortland C Evans	GJS and CE discussed examples for how this can be incorporated in the next annual report. **Complete**
QSE 17/093	20.6.17	Safeguarding Report		FGM – report on number of cases and UHB's response	R Walker	**Complete on Agenda QSE September 2016**
QSE 17/094	20.6.17	IP&C Report		Bring plan to Board to identify 2 wards to enable decant and	A Harris	**Board July – postponed to September Board. Later agreed for September QSE. Complete**

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				provision of single rooms. Revisit IPC Team resource risk assessment	 R Walker	 Will be complete by September QSE Committee and progressed via normal process
QSE 17/100	20.6.17	Patient Wristbands		Present business case to BCAG in July. Include details in IM&T Outline Plan	R Walker R Walker	Both being processed via the BCAG process. **CLOSED**
QSE 17/101	20.6.17	Cancer Peer Review – Brain		Teams need support across the cancer pathway – highlight this to the cancer network.	Dr G Shortland	**Complete** – principle of support across whole pathway raised in last Cancer Peer Review – Upper GI
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 Complete**
QSE 17/022	21.2.17	Clinical Audit Plan		Update report to be received in September	Dr G Shortland	**QSE September 2017 Complete**

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DENTAL CLINICAL BOARD **QUALITY, SAFETY AND PATIENT EXPERIENCE**
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting**: 12th September 2017

Executive Lead: Executive Director of Nursing
Author: Director of Operations - Dental Clinical Board 02920 74 2607
Caring for People, Keeping People Well: The report summarises the quality and safety components for patients and staff within the Dental Clinical Board. It supports all aspects of the UHB's empowering the person, home first, outcomes that matter to people, avoiding waste variation and harm**.**
Financial impact: Not applicable
Quality, Safety, Patient Experience impact: This report provides assurance on the work of the Dental Clinical Board on quality, safety and patient experience issues. It is aligned to the NHS Outcomes Framework focusing on governance arrangements for the promotion of safe, effective and dignified care.
Health and Care Standard Number: All standards except 2.2 and 2.3
CRAF Reference Number: All, however this report predominately relates to Objective 5
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by audits carried out by internal audit to include:

- Medical Devices
- Medicine Management
- Patient access
- Quality Governance

These have provided reasonable and substantial assurances on the processes in place within the Dental Clinical Board

RECOMMENDATION

The Quality Safety and Experience Committee is asked to:

- **APPROVE** the content of this report and approach taken by the Dental Clinical board
- **NOTE** the progress made and the areas for further action

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SITUATION

This report provides information on the Quality, Safety and Patient Experience agenda over the past 12 months within the Dental Clinical Board. The report identifies the progress and achievements made and the planned actions.

BACKGROUND

The Clinical Board consists of 2 Directorates providing a varied range of dental services both locally and across areas of Wales. The Community Dental Services provides services for Paediatric, Personal Dental Adult Service, General Anaesthetic, Sedation, Special Care, Special Care Domiciliary visits and Orthodontic treatment. There are 21 clinics with a total of 38 dental chairs and treatment bays.

The prime remit of the University Dental Hospital Directorate is to provide student education at both undergraduate and postgraduate level and training of dental nurses, hygienists, therapists and dental technicians. There are 167 dental chairs and treatment bays within the University Dental Hospital plus an outreach facility within St David's and Mt Ash hospital consisting of 14 and 18 chairs and treatment bays. In addition, clinics are provided for specialist referrals.

ASSESSMENT AND ASSURANCE

An annual assessment of the Health and Care Standards has been completed and an action plan developed. This will be received by the QSPE Group in September.

The Clinical Board has an agreed QSPE and Board agenda which includes progress against action plans developed through internal audits and Health and Care Standards. It will be managing identified risks through the risk management process.

Assurance is provided through the processes that are in place within both Directorates, through the Internal Audit Department assurances and through the Clinical Boards QSPE and Board Committee.

ASSESSMENT

Governance, Leadership and Accountability

The Quality, Safety and Patient Experience Group is chaired by a Medical Lead; currently an Oral & Maxillofacial Surgeon. There is good attendance at these meetings with all specialties represented by Clinicians who provide minutes of local monthly audit meetings across both Directorates. Attendees include Governance Lead, Clinical Board Director, Directorate Managers, Clinical Directors, General Nurse Manager, Dental Nurse Manager, as well as IP&C and Health and Safety Lead.

The Clinical Board recognises the importance of the Infection Prevention Control agenda and has an Honorary Consultant in Oral Microbiology and a Senior Dental Nurse for IP&C in each Directorate who represent and report to the UHB's IP&C committee and team meetings. A work plan has been developed which will be discussed and agreed at the September QSPE group.

The Clinical Board holds separate quarterly Health & Safety meetings which has representatives from within and external to the Clinical Board. These meetings are held on a quarterly basis. Incidents trends and risks are reported, discussed and actions agreed. These groups have terms of reference which are reviewed on an annual basis. There is representation and reports provided to the Security & Personal Safety Strategy Group, Fire Safety Group and the Operational Health and Safety Group.

The Clinical Board has undertaken a review of its risk management process. Managers with responsibility for completing risk assessments attended a 'Working Safely in the NHS' course. The course was delivered within the Clinical Board by the UHB Health & Safety Advisors and focused on the top 3 risks. Departmental risk assessments and risk registers have been reviewed and updated.

The Clinical Board's Risk Register is currently under review and being updated. It will be based on risk assessments and departments risk registers. Actions plans set against identified risk and will be reviewed quarterly and progress will be monitored through the QSPE and H&S Groups.

Staying Healthy (Theme 1)

As of March 2017, 45.3% of staff members have received a flu vaccination. The Clinical Board has it's our own flu champions who will be running a proactive campaign to encourage staff to take up the seasonal flu vaccination this year. With both them on site and the service provided by the UHB it is hoped to improve our compliance rate for this winter. The overall leads for this Tier 1 target are the Director of Operations and Consultant in Dental Public Health who are in full consultation with the wider public health team.

All patients that are pre-assessed prior to undergoing a General Anaesthetic are provided with appropriate evidence based written and verbal information on weight management, smoking cessation and safe alcohol limits. Clinical outcome forms have been updated. It will now be recorded when smoking cessation has been offered to a patient and if accepted the referral will be automatic.

The Clinical Board is working closely with Public Health and will be running health Initiatives within our patient waiting areas. MECC training will continue to be rolled out across both Directorates.

The Clinical Board will be delivering the following health initiatives with the community setting: -

- Deliver the Designed to Smile programme in pre-and primary schools to reduce inequalities that exist in relation to dental caries.
- Work with Flying Start and other Health care professionals to provide consistent dietary messages to families.
- The Mobile Dental Unit provides preventative treatment for pupils in primary schools in areas of high need.
- Delivery of WHC2015 001-Improving Oral Health for Older people living in care homes
- Provide training for care home staff to support clients to care for and maintain good Oral Health
- Provide educational training for SONMS students to recognise and understand the importance of caring for patients mouths whilst in hospital
- Provide educational training in line with 1000 lives for trained hospital staff to be able to deliver mouth care for patients who are in hospital.

The Designed to Smile programme is a key element of the National Oral Health Improvement Plan; the programme covers all of Wales, the focus is on applying fluoride to children's teeth by means of supervised tooth brushing and/or the application of fluoride varnish and the application of fissure sealants. This year WG published the results of DFMT rates across Wales following an epidemiology screening survey which showed overall a decline by 13%, the lowest rates since records began.

The programme relates to NICE guidance recommendations 12 – 20, it is focused on targeting settings in areas of high need and is supplemented by raising awareness of the importance of oral health and encouraging a whole-school approach. The programme is delivered by the Community Dental Service in close liaison with pre-schools, schools and Local Education Authorities.

Safe Care (Theme 2)

The Clinical Board has improved the management of safety alerts by reviewing and implementing a flow chart outlining the process. Relevant safety alerts are discussed at the Clinical Boards QSPE Group before being closed out at Clinical Board meetings.

There were 2 Never Events which occurred in July 2016 and February 2017. Both have been reported to Welsh Government and were related to the wrong tooth being extracted. A full investigation was undertaken with findings and improvement plan shared with the QSPE group and Board. Progress will be monitored through the QSPE Group.

An IRMER Breach occurred in April 2017. This has been reported to HIW and is currently under investigation.

The Clinical Board has developed and implemented a flow chart outlining the process for dealing with Serious Incidents and Never Events. This has been discussed and agreed at the QSEP Group

Management of Incidents

All incidents are reported on the E-Datix system and closely monitored through the Clinical Board's Health & Safety and QSPE Group. It continues to be difficult establishing trends due to the coding system. Contact with sharps, and trips and falls is a theme which is being closely monitored. Safety devices for sharps have been implemented across both Directorates

Safeguarding

The Clinical Board has a Safeguarding Lead who is a Paediatric Consultant and Designated Lead Manager for Safeguarding. The Clinical Board has improved the management of referrals and has worked with the Lead Nurse for Safeguarding to implement a flow chart outlining the process for referrals across both Directorates.

Dental Undergraduates in Cardiff treat their own patients in the Hospital and Community Dental Services – the Importance of Safeguarding training is recognised by the inclusion of training to all dental undergraduates in the clinical programme. The training is delivered by C&V safeguarding teams and evaluated.

Infection, Prevention & Control

IPC Culture
The Dental Clinical Board supports delivery of IP&C programmes across undergraduate/postgraduate students, and clinical staff employed by the UHB and Cardiff University.
The Dental Clinical Board is represented and provides reports to both the IP&C Committee and team meetings and has strong links with the IP&C team within UHW.

Policies and Procedures
Infection Control Procedures and Uniform, Dress Code and PPE-

- Documents accessible in all Clinical Areas (audited biannually)
- Available on UDH and CU website
- Accessible via Staff Handbook (provided to all new staff on induction).
- Links to CAV UHB Infection Control Documents
- Reviewed every 3 years (and updated as required)
- New expanded section on water safety.

Education and Training

- Infection Control Team and Link Workers undertake regular training which is cascaded to all staff.
- IPC training on induction for all new staff and clinical postgraduates (includes prevention and management of inoculation injuries)
- Mandatory training online is completed
- Annual IPC training for all undergraduates.
- IPC poster reminders (hand hygiene and “Bare below the Elbow”) in clinical areas
- New “Gateway” to patient treatment competency assessment includes IPC theory and practical elements. IPC assessments embedded in every professional examination

Audit and Surveillance

- Monthly Hand Hygiene Audits-results reported on the Executive Performance dashboard. Feedback is given to Senior Dental Nurses, Clinical Leads and Leads of Audit groups.
- Engagement with WHO Hand Hygiene Day
- IP&C clinic inspections- results reported to Senior Dental Nurses for action
- Water testing programme carried in clinical areas of UDH - results reported to Senior Dental Nurses for action
- Audit of compliance with flushing of dental unit waterlines and results fed back to senior dental nurses

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The Clinical Board has carried out a full review of its local decontamination facilities within the Community Dental Clinics in line with WHTM 01-05. A report and action plan has been presented to a Board meeting and UHB Decontamination Committee. An action plan has been developed and progress will be monitored through the QSPE and UHB Decontamination Committee.

Medical Devices used within the Peripheral Hospital Dental Services will no longer be reprocessed locally and will be brought into the Dental Sterilisation and Disinfection Unit within the dental hospital. Work is currently underway to consider this as a better option for part- time Community Dental Clinics. Costs are being identified for the necessary improvements to facilities and additional decontamination equipment required.

Training has been provided for staff and an audit programme to monitor compliance developed which will commence in October 2017.

An issue arose with HIW not informing the UHB of planned inspections within the Personal Dental Service in CDS. This has been addressed by the Executive Nurse Director. The agreed actions to the Immediate and Improvement plan has been accepted by HIW and will be reported at the QSPE in September. Progress will be monitored through the QSPE Group.

Medical Devices/Equipment

The Dental Clinical Board is represented and provides reports to the Medical Equipment Group. There is a process for clinics to follow for the reporting of faults and repairs to medical devices.
An audit on the Management of Medical Devices was undertaken in November 2016 by the Internal Audit Department which reported Reasonable Assurance that appropriate arrangements were in place. The audit identified a problem where after attempting to run reports, some asset information was incomplete and test history missing. The equipment management software is not supported by Windows 7 and an updated software system is required. An action plan has been developed and progress monitored through the QSPE Group.

Medicines

An audit on the Management of Medicines was undertaken in January 2017 by the Internal Audit Department which reported Reasonable Assurance that appropriate arrangements were in place. An action plan has been developed and progress monitored through the QSPE Group. Medicines will be an agenda item at the QSPE Group with key issues escalated to the Board Meetings when deemed appropriate.

Effective Care (Theme 3)

The Dental Clinical Board has an active involvement in Clinical Audit. The activity is broad and spread across the Dental Hospital, Outreach and Community Dental service.

The Clinical Board's audit plan is being reviewed which will be aligned with the UHB Objectives. Audits are presented at the monthly audit groups and the audit activity is reviewed and discussed. The audit plan is monitored and discussed at the QSPE Group.

There are smaller work place inspections/audits in clinical areas. Actions identified are fed back to the Senior Dental Nurses and Dental Nurse Manager These are reported and discussed at the IP&C team meetings.

Dignified Care (Theme 4)

The Clinical Board has a Dementia Champion who represents and reports at the Dementia Champion Meetings and delivers training to staff. Staff are also required to complete the E-Learning training.

Enclosed rooms are available in clinical areas to provide a private area for conversations with clinicians and patients/family.

The Clinical Board has successfully implemented hearing loop systems across both Directorates; this includes way finding lines on the UDH main area floors. Our Equality and Diversity Lead has developed a sensory loss document which has been shared across the Board.

Posters have been put around our clinical areas regarding sensory loss to advise patients on what we are able to offer them, we also have hard of hearing stickers on patient notes.

The Clinical Board has a Mental Capacity Lead who is taking this forward to ensure training is being completed across both Directorates. A presentation was delivered at the November 2016 Board Meeting. This raised awareness of the importance and necessity of compliance with training. An audit is planned and will be undertaken in 2017. Progress will be discussed and monitored through the QSPE Group.

The Clinical Board is ensuring that the pathways and access to special care services are clearly defined for General Anaethetics, Sedation, Bariatric, Special Care and Domiciliary care and will continue to provide dental screening and dental treatment via the Mobile Dental Service in Special Care Schools in the highest need areas where access to GDS is difficult.

Timely Care (Theme 5)

The Dental Clinical Board continues to work hard to manage waiting lists and comply with RTT targets.

RTT position 2016/17

	<26 weeks	>36 weeks	>52 weeks	Delivery of 62-day target USC Head & Neck (shared)	Delivery of 31-day target NUSC Head & Neck (shared)
Target	**95%**	**0**	**0**	**95%**	**98%**
April	87%	0%	0%	100%	100%
May	85%	0%	0%	100%	100%
June	86%	0%	0%	100%	100%
July	87%	0%	0%	100%	100%
Aug	86%	0%	0%	100%	100%
Sept	84%	0%	0%	100%	100%
Oct	85%	0%	0%	100%	100%
Nov	86%	1%	0%	100%	100%
Dec	87%	0%	0%	100%	100%
Jan	84%	3%	0%	100%	100%
Feb	87%	2%	0%	100%	100%
March	87%	0%	0%	100%	100%

Following the completion of Lips Project 6, which reviewed waiting times for oral surgery treatment, the Clinical Board is further exploring the possibility of implementing a one stop oral surgery clinic for 50% of the extraction referrals to reduce the waiting list.

Staff and Resources (Theme 7)

Staff sickness

The tables below show the monthly sickness percentage between:

April 2016 – December 2017 against a target of 3.68%

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
3.96%	3.94%	3.96%	3.94%	3.98%	4.00%	3.96%	3.92%	3.86%

January 2017 – June 2017 against a target of 3.46%

Jan	Feb	Mar-17	Apr	May	Jun
3.98%	3.92%	3.88%	3.91%	3.92%	3.84%

Managers have completed sickness training and are working and supporting staff through the sickness process and signposting to relevant support service where appropriate.

Mandatory Training Compliance

	CDS	UDH	DCB Compliance
	% Compliance	% Compliance	% Compliance
Fire	90%	81%	83%
Health &Safety	96%	85%	88%
IP&C	95%	83%	86%
Equality & Diversity	98%	84%	86%
Information Governance	96%	85%	88%
Safeguarding Child	95%	84%	87%
Safeguarding Adult	95%	87%	89%
Violence & Aggression	93%	82%	85%
Manual Handling	90%	82%	84%
Resuscitation	78%	71%	73%
Dementia	90%	82%	85%
Mental Capacity Act	75%	64%	67%
VAW	63%	48%	52%
Total 10 modules	92%	82%	85%
Total 13 modules	88%	78%	81%

PADR Compliance

Both Directorates have worked hard to improve compliance with the PADR process. Compliance for the Clinical Board is currently 63%. A central database of all staff PADR dates has been developed. Managers are prompted monthly to ensure their teams are appraised annually.

The Clinical Board supports and encourages the UHB's core values and behavior's. These are embedded into the PADR process and included on all Job descriptions.

Staff successes are recognised by the Clinical board with the following initiatives:

- Employee of the month which is extremely successful, all nominated staff are invited to attend the Clinical Board Meeting for congratulations.

- UHB Staff Recognition Awards - The Mobile Dental Team was nominated and received runner up at the 2017 Awards.

- PULSE staff survey information provide valuable feedback; the result of which showed a positive result for the Dental workforce overall.

Staff members from the Dental Clinical Board have enrolled and participated in the LIPS programme and completed the Silver IQT training. The projects chosen are aimed at improving patient safety and avoiding harm, variation and waste.

Individual Care (Theme 6)

Patient/User feedback

The Clinical Board has a nominated lead that represents and reports at the Patient Experience Group. A work plan is being developed to ensure we are undertaking patient engagement in all four quadrants of the patient experience framework and ensure we are listening & learning from the feedback received.

The patient feedback kiosk was situated within the dental hospital which gave us real time feedback from our patients and staff. This feedback along with the work plan will be reviewed and discussed at the first patient & public involvement group meeting which is planned for October. Reports and progress will be discussed and monitored through the QSPE group

The Clinical Board has individual care plans in place which include MDT meetings to ensure full team engagement and agreement for best treatment options available to the patients.

The Clinical Board has a concerns lead that is proactive in contacting and meeting individuals who raise concerns at the informal stage to achieve a quick resolution. A review of the concerns process has been undertaken and rolled out across both Directorates. 'Putting Things Right' posters and leaflets are available in clinics and waiting areas in both English and Welsh.

There have been 66 informal and 19 formal concerns during April 2016 - March 2017.

Concerns are logged onto DATIX and reviewed and discussed monthly to identify trends and agree lessons learnt. These are shared and discussed by members of the audit and QSPE Groups.

Themes

The four key themes from informal and formal concerns are:

- Cancellation of out-patient's appointments
- Concerns about medical treatment
- Lack of communication
- Length of outpatient waiting times

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Compliments

Compliments have been received via letter, cards and email across both Directorates. These are logged and reviewed by members of the audit and QSPE Groups.

As soon as I enter the hospital I find every member of the staff extremely helpful and pleasant. I have also noted that the hospital is run very efficiently and am rarely kept waiting beyond my appointment time. I have been seeing Dr Atkin also Mr Addy and I cannot speak highly enough of the expert care and kindness they have given me, it has made these difficult times so much easier.

Just a quick note to acknowledge the excellent care I received from staff in your clinic this morning. I felt in very good hands!

We are very grateful and impressed by the care and attention our son is receiving at UDH. All the students he has come into contact with have shown a high standard of care. They have been reassuring and supportive. Many thanks to you and your students.

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

Scrutiny Overview Report

CHC Visiting Activity

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

July 2017

Index

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Summary of Scrutiny Activity

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

This report is a considered overview of the scrutiny visiting activity from all visits undertaken between the 4th March 2017 and 5th May 2017. In total 8 visits were planned to be undertaken, however, only 6 were completed. The following summarises to the 2 visits not completed and the reasons for this:

1. Neonatal Intensive Care Unit (NICU), University Hospital of Wales – Postponed until the service relocates in to its new environment.
2. Ward A2, University Hospital of Wales – Postponed due to member illness on the day of the visit.

Next Reporting Period – 06/05/17 to 07/07/17

The November Scrutiny Overview Report will incorporate all visit reports from the visits undertaken between the 6th May 2017 and 7th July 2017. In total 6 visits have been completed and are currently within the reporting process.

Looking Forward

The CHC has a schedule of visits planned until 31st December 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 (Rear)
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

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Visiting Overview

During this reporting period, the CHC only conducted visits to the Cardiff and Vale UHB. Therefore, there are no comments attributed to the Welsh Ambulance Service NHS Trust or Velindre NHS Trust.

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:

- **X-Ray Equipment** – In 2 of the 6 visit reports, both of which were linked to dental services, concerns were identified in relation to the limitations of equipment. In Paediatric Dentistry, it was found that there is no x-ray provision in the unit and that patients have to travel to another section of the Dental Hospital wearing a 'rubber dam' face mask. Furthermore, the Emergency Dental Service are prevented from using the digital x-ray apparatus and must use the less sophisticated self-developing x-ray sachets.
- **Support Services** – A number of reports identified either a lack of staffing and/or facilities for the provision of therapies. This has presented itself previously and has been a standing agenda item in other fora. It is noted that the high level of patient dependency has led to the reduction of Occupational Therapy activities in one area, however, this cohort of patients still require this support.
- **Repatriation** – This is the third Scrutiny Overview Report to have identified issues in relation to repatriation, whereby patients have to remain in a Cardiff and Vale facility as opposed to going back to their local hospital. This issue has been discussed at the Cardiff and Vale UHB Quality, Safety and Experience Committee where it was requested that the CHC instigate a national debate on repatriation.
- **Infection Prevention & Control** – Members commented on infection in 2 reports. However, only 1 of those related to previous concerns around lack of hand washing signs. More concerning was the cross-infection risk currently experienced in the Cystic Fibrosis Unit where all but 1 of 7 beds have a shared bathroom. It is also noted this risk is "extremely high with the possibility of a life-saving transplant being compromised".
- **Parking** – Both visit reports relating to services provided at the Dental Hospital identify patient/visitor issues with the parking arrangements. Whilst progress is being made on the UHW site in general, patients/visitors accessing the Dental Hospital predominantly attempt to park in the small car park behind the building, where, if full, they then have to leave the site in order to return to the small multi-storey car park. Furthermore, should parents have to park in the small multi-storey, they then have to walk or carry their child back to this car park following treatment which can include sedation.

Good Practice

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

- **Hospital Environment** – Predominantly the CHC raises concerns in regard to the hospital environment, with many areas in need of refurbishment. However, it is pleasing to note that in this reporting period, the standard of cleanliness and appearance was commended. Particularly noteworthy was the comment relating to the child centric decoration of the Paediatric Dentistry Unit
- **Patient Experience/Staff** – The majority of visit reports indicated a high level of patient satisfaction with the services being provided and in every case, this was extended to the care provided by staff members. The CHC would also like to draw specific attention to the recognition afforded to the Unit Manager of the Paediatric Critical Care Unit, within the Children's Hospital for Wales.

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 a minimum of 6 months after the original visits, purely to determine whether recommendations have been actioned or not.

This report is a summary of the follow-up activity undertaken prior to the drafting period for this document, that being 16th June 2017. In total 4 follow-up visits were planned to be undertaken and all were completed.

Cardiff & Vale UHB: St Barruc Ward, Barry Hospital (3rd April 2017)

Date of Previous Visit: **6th May 2016** Date of UHB Action Plan: **19th August 2016**

In total 4 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 4 recommendations, it was considered that zero were achieved in their entirety, with 3 being partly met. The action(s) considered not to have been met are provided below:

- New furniture was to be ordered for the ward and to be in place by January 2017

Cardiff & Vale UHB: Children's Assessment Unit, Children's Hospital for Wales (28th April 2017)

Date of Previous Visit: **19th May 2016** Date of UHB Action Plan: **12th July 2016**

In total 8 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 8 recommendations, it was considered that 4 were achieved in their entirety, with 1 being partly met. The action(s) considered not to have been met are provided below:

- A hearing loop has now been purchased.
- Explore opportunities for children's relatives, when attending Seahorse ward, have easy access to refreshments including out of hours. (*Recommendation as the action comments are no longer valid, the UHB will now be looking at the provision of a vending machine following feedback from a child-friendly questionnaire resulting from another CHC recommendation*)

- Proceed to engage more volunteers to enable the reception area to be manned during peak times.

Cardiff & Vale UHB: Ward West 4, University Hospital Llandough (5th June 2017)

Date of Previous Visit: **25th April 2016** Date of UHB Action Plan: **29th June 2016**

In total 9 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 9 recommendations, it was considered that 5 were achieved in their entirety, with zero being partly met. The action(s) considered not to have been met are provided below:

- High number of patients require assistance to mobilise – For access to toilet facilities
- To assess cost and whether they can be 2 way opening – Shower doors opening in the corridor
- Once estimate for enclosing nursing station received to be discussed with Directorate/ Clinical Board for approval of funding.
- Staff to ensure equipment is stored appropriately in areas and the areas are screened off

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Cardiff & Vale UHB: Ward East 12, University Hospital Llandough (9th June 2017)

Date of Previous Visit: **16th May 2016** Date of UHB Action Plan: **19th August 2016**

In total 4 recommendations were made during the original visit, all of which were provided an attributable action by the UHB, which was subsequently agreed by Council. Of these 4 recommendations, 3 were achieved in their entirety, with zero being partly met. The action(s) considered not to have been met are provided below:

- Staff shortages, as a result of vacancies, are supported by temporary staffing. It is the intention of the Directorate to close one ward and redistribute the staffing resource.

Summary of CHC Recommendation/Action Performance

Made	Achieved	Partly Achieved	Not Achieved	% Actioned
25	12	4	9	64%

* Please note, % actioned = sum of achieved + partly achieved

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, inclusive of the follow-up section.

Cardiff & Vale University Health Board (UHB) Visits

1. **UHB** – To improve access to x-ray equipment at the Dental Hospital and for the Emergency Dental Service.
2. **UHB** – To review the therapy provision on the Rhydlafar Unit, to ensure it meets the needs of the patient cohort.
   CHC – To consider a focussed activity in regard to Therapy provision across all UHB inpatient locations
3. **CHC** – To provide details of repatriation issues to the Board of CHC's, in order to instigate a national debate.
4. **UHB** – Provide the CHC with an update on progress against the urgently needed expansion of the All Wales Cycstic Fibrosis Centre.
5. **UHB** – Review access arrangements to the dental hospital and explore opportunities to make parking more accessible to those utilising services within this area, particularly those spaces at the rear of the building.

Follow-up visits:

The Cardiff and Vale University Health Board is asked to provide an urgent action plan, within 2 weeks of the CHC Council meeting on 10th July 2017, in regard to addressing agreed actions that have yet to be completed following previous CHC visit reports.

Visit Details

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

Type	Date	Service	Site	CHC Team	Appendix.
Announced	17/03/17	Cystic Fibrosis Centre	Llandough Hospital	Judy Simove (Lead) Paul Davies	01
Announced	20/03/17	Paediatric Dentistry	University Dental Hospital	Rob Henley (Lead) Gareth Williams	02
Announced	25/03/17	Emergency Dental Service	St Davids Hospital	Val Evans (Lead) Judy Simove	03
Unannounced	03/04/17	Minor Injuries Unit	Barry Hospital	Alison Walker (Lead) Gayna Morris	04
Unannounced	10/04/17	Neonatal Intensive Care Unit	University Hospital of Wales	Pat Mathews (Lead) Rob Henley	**Postponed**
Unannounced	25/04/17	Rhydlafar Unit	St Davids Hospital	Jill Shelton (Lead) Brenda Chamberlain	05
Announced	28/04/17	Paediatric Critical Care Unit	Childrens Hospital for Wales (CHfW)	Val Evans (Lead) Gareth Williams	06
Announced	03/05/17	Ward A2	University Hospital of Wales (UHW)	William Payne (Lead) Matthew Wedlake	**Postponed**
Type	**Date**	**Service**	**Site**	**CHC Team**	**Appendix.**
Follow-Up	03/04/17	St Barruc Ward	Barry Hospital	Alison Walker (Lead) Gayna Morris	07
Follow-Up	28/04/17	Children's Assessment Unit	Childrens Hospital for Wales (CHfW)	Gareth Williams (Lead) Val Evans	08
Follow-Up	05/06/17	Ward West 4	Llandough Hospital	Jane Jenkins (Lead) Brenda Chamberlain	09
Follow-Up	09/06/17	Ward East 2	Llandough Hospital	Eleri Jones (Lead) Bablin Molik	10

Next Reporting Period – 06/05/17 to 07/07/17

Type	Date	Service	Site	CHC Team	Stage
Announced	05/06/17	Ward East 1	Llandough Hospital (UHL)	Jane Jenkins (Lead) Brenda Chamberlain	UHB to Respond
Announced	09/06/17	Cardiff Breast Unit	Llandough Hospital (UHL)	Eleri Jones (Lead) Bablin Molik	Awaiting Report
Announced	12/06/17	X-Ray Department	Cardiff Royal Infirmary (CRI)	Steven Place (Lead) Eifion Pritchard	Awaiting Report
Announced	19/06/17	Bethan Ward	Llandough Hospital (UHL)	Judy Simove (Lead) Jane Jenkins	Awaiting Report
Announced	21/06/17	Ward A4	University Hospital of Wales (UHW)	Gareth Williams (Lead) Val Evans	Awaiting Report
Announced	27/06/17	Ward T4	University Hospital of Wales (UHW)	Julie Williams (Lead) Jane Jenkins	Awaiting Report

Forward Planning

Date	Service	Site	Date	Service	
05/07/17	Ward A2	University Hospital of Wales (UHW)	26/09/17	Rainbow Ward	Childrens Hospital for Wales (CHfW)
17/07/17	Physiotherapy Department	Cardiff South East	16/10/17	Community Dental Service (CDS)	Barry Hospital
18/07/17	Ward A5 South	University Hospital of Wales (UHW)	18/10/17	Ward East 6	Llandough Hospital (UHL)
24/07/17	Orthodontic Department	Dental Hospital @ UHW	27/10/17	Chemotherapy Inpatient Unit	Velindre Cancer Centre
31/07/17	Pelican Ward	Childrens Hospital for Wales (CHfW)	31/10/17	General Practice	To be Confirmed
01/08/17	Outpatients Department	Cardiff Royal Infirmary (CRI)	01/11/17	General Practice	To be Confirmed
07/08/17	Outpatients Department	St Davids Hospital	03/11/17	General Practice	To be Confirmed
11/08/17	Ward West 2	Llandough Hospital (UHL)	06/11/17	Ward East 2	Llandough Hospital (UHL)
14/08/17	Suite 19 Dialysis Unit	University Hospital of Wales (UHW)	07/12/17	General Practice	To be Confirmed
06/09/17	Ward A5 North	University Hospital of Wales (UHW)	12/12/17	General Practice	To be Confirmed
11/09/17	Endoscopy Unit	University Hospital of Wales (UHW)	15/12/17	Gwenwyn Ward	Llandough Hospital (UHL)
22/09/17	Radiology Department	Dental Hospital @ UHW	18/12/17	Ward T2 Colorectal	University Hospital of Wales (UHW)
25/09/17	Eye Clinic(s)	University Hospital of Wales (UHW)	20/12/17	General Practice	To be Confirmed

* Please note, unannounced visits are not publicised in advance

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Cardiff and Vale University Health Board

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University Hospital of Wales
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Eich cyf/Your ref:
Ein cyf/Our ref: LR-jb-08-6420
Welsh Health Telephone Network:
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Len Richards
Chief Executive

22 August 2017

Patricia Matthews
Chairperson
CHC PCIC OSPG
Cardiff and Vale CHC
Pro Copy Business Centre
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

Dear Ms Matthews

Thank you for your report on General Practice Branch Surgery Visits November to December 2016 (Thematic Report May 2017). We were pleased to see the overall high levels of satisfaction of patients accessing general medical services in branch surgeries across Cardiff and Vale.

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In terms of addressing the issues that your report has identified under the three main categories we would seek to respond as follows.

Patient Engagement

Through the annual contract review process, the Primary Care Team will seek to review all practice leaflets against the Regulatory requirements and ensure that these are updated accordingly. This will address a number of points made within this section of your report. We will also seek to do this to ensure that all appropriate opening times information as well as contact details for the Out of Hours service is displayed prominently within each practice.

With regard to appointment systems, I am sure that you fully appreciate that as independent contractors GP practices need to put systems in place that enable them to conduct their business in a safe and effective manner as well as meeting the reasonable needs of their patients. Whilst practices can be asked to review their systems, with more and more practices experiencing pressures from growing list sizes and recruitment and retention difficulties this is unlikely to improve in the short term.

The Primary Care Team would welcome any support that the CHC can offer to practices on an individual and potentially cluster level when considering Patient Participation Group establishment and development.

Accessibility and Assistance

As part of an annual programme of investment from Welsh Government, we have been seeking to support practices in making necessary changes to ensure they are accessible for all patient groups. Unfortunately some branch surgeries are difficult to reconfigure, however we will continue to work with practices where areas of concern are highlighted to identify the best and most appropriate solution.

Environment

Whilst recognising that there is some underutilisation of space within some branch surgeries the Health Board is very aware that there are growing sustainability pressures being faced by practices which could result in service consolidation and the closure of branch surgeries to enable the main sites to work functionally rather than expanding the remit of services provided from branch surgeries. The Health Board has recently agreed with the LMC and the CHC a branch surgery closure process which closely follows the previously agreed boundary change process and will be seeking to work proactively with practices through their clusters to review boundaries and branch surgeries to support the provision of sustainable general medical practice.

With regard to the other issues identified within the report we will be seeking to work with the relevant clinical boards to ensure that appropriate information is shared with colleagues in general practice to clarify the areas of concern raised.

In terms of updating you on progress against these three areas, I am aware that you have quarterly meetings with the senior team in the Primary, Community & Intermediate Care Clinical Board and they are keen to use this meeting as a means of providing updates.

Lastly, whilst fully recognising the value placed on branch surgeries by patients, as a Health Board we have recently started to experience some of the pressures that have been felt by General Practices in other parts of Wales. We need to find new ways of working going forward and we would welcome the support and assistance of the Community Health Council in consulting with patients when decisions need to be taken to support the ongoing sustainability of service provision to the wider practice population.

Yours sincerely



Len Richards
Chief Executive

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL



10.1

Cardiff and Vale of Glamorgan CHC

General Practice
Branch Surgery Visits
November - December 2016

Thematic Report: May 2017

Index

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10.1

1: Executive Summary

This report continues to build upon the excellent work relating to CHC visits to all main GP surgeries which concluded in 2013. From those results, it became evident that visits would be required to also focus on the GP Branch Surgery provision to gauge the entire Patients' Experience.

CHC voluntary members undertook visits to 22 Branch Surgeries and sought the views and experiences of patients who use these facilities. In total, the CHC received **1,476 patient experience surveys,** which equates to a **34%** response rate to our survey.

It is clear that Branch Surgeries are an invaluable facility to those patients who access them. However, due to the complexity of some services, patients do have to travel further, i.e. for some treatments. Patients acknowledge this and appear content to do so.

With the ever growing demand for GP services, the sustainability of Branch Surgeries has never been more important in empowering patients to access high quality GP services within their locality. It was somewhat disappointing to note that it appears the University Health Board's monitoring of Branch Surgery provision is in urgent need of reviewing, especially in relation to Branch Surgery opening / clinical times. It is recommended in this report that all GP Surgeries, which also have a Branch Surgery provision, should clearly provide details of the services and appointment times available to their patients.

This report, however, highlights significant issues with patients obtaining **appointments** at their Branch Surgery. Coincidentally, this issue was highlighted in our previous report in 2013. It is disappointing that progress to resolve this key issue has not been progressed by the NHS.

"Patient Satisfaction", once an appointment had been secured, was extremely high, with **97.3%** of patients rating their overall experience from Good to Excellent. In addition, both **GPs and Practice Nurses** received **high levels of satisfaction** from patients relating to the following areas; greeting the patient, understanding their concerns, treatment explanations and continuity of care. Patients also commented favourably on aspects of physical access to premises, cleanliness, and access to information.

I would wish to place on record my thanks to the patients who took time to either speak to our CHC members or complete our survey and Practice Staff for their assistance during this visiting process. In addition, I would wish to thank the voluntary CHC Members who gave up their time to undertake these visits on behalf of the wider public.

Patricia Matthews
Chairperson,
CHC Primary, Community & Intermediate Care Oversight, Scrutiny & Performance Group
(PCIC OSPG) May 2017

2: Preparation & Planning

Cardiff & Vale of Glamorgan Community Health Council (CAVOG CHC) is an independent statutory organisation with responsibility to scrutinise the operation of local health services. The CHC comprises of 24 appointed, voluntary Members, who are supported by 8 paid members of staff, together with additional co-opted Members.

Back in March 2011, the CHC's Primary Care Group; whose principle aim was to monitor and scrutinise the Primary Care elements of local NHS services, commenced a programme of scheduled monitoring visits to all main GP Practices within the Cardiff & Vale of Glamorgan area; having updated the CHC General Practice (GP) visiting model used previously by the Cardiff CHC, prior to the reorganisation of the CHC itself in 2010. At that time, the CHC received approval from the British Medical Association (BMA) and Local Medical Committee (LMC) indicating that this model represented good practice.

The premise for visits is to base the scrutiny reports around the views of the patients who use these services and then aim to construct a set of recommendations that are designed to assist each Practice improve its patient experience.

In order to gather the views of these patients, the CHC Primary Care Group also created a paper survey and guidance document containing questions that Members could reference during scrutiny visits. These included questions pertaining to the observations Members should make, in addition to the questions that could be asked of Practice staff.

CHC scrutiny visits are undertaken by a minimum of 2 Members and, as agreed during its development of the visiting model, Members would allow at least 2 hours on site, to incorporate brief discussions with patients, making observations on the environment and also the operation of the Practice. Once Members had completed their discussions, a meeting with the Practice representatives would be held to discuss the scrutiny visit and to also provide them with the results of the patient satisfaction survey for their Practice.

The visits undertaken to the Branch Surgeries during November / December 2016 mirrored the process previously carried out to the main Practices from 2011 and this has allowed the CHC to set a base-line benchmark for scrutiny visits that will be carried out by CHC Members moving forward.

There are 66 main GP Practices within the Cardiff and Vale of Glamorgan area, with an additional 22 Branch Surgeries serving patients. Prior to the scrutiny visits, the CHC provided 200 blank patient satisfaction surveys to each Branch Surgery for their patients to complete over a full two-week period.

In order to inform the general public of the planned CHC visits to these Branch Surgeries, the dates of the visits were promoted on social media. At the same time as delivering the patient surveys, the CHC supplied posters for display within each waiting area, supplying patients with details of the CHC survey being carried out and also the promotion of the actual scrutiny visit date.

A few different factors had to be taken into consideration with the results from the Branch Surgeries, i.e. the opening times varied from those provided by their respective main Practice; how many patients actually attended the Branch during the patient survey period and how actively the survey was promoted by each Surgery.

Upon completion of each visit, the lead CHC Member was tasked with producing a scrutiny report which incorporated both CHC Member and patient observations, their comments and recommendations to the Practice.

Each Practice was asked to respond within 20 working days on any matters of accuracy and to propose actions to address the issues raised in the recommendations. The report was then published in subsequent CHC Council papers with the formal letter-headed Practice response. Once agreed by Council, the visit report, Practice response and results of the patient satisfaction survey were made available on the CHC website under the Primary Care sub-heading.

Methodology

1) A provisional schedule of visits was drafted by the CHC at least 4 months in advance of the first planned visit date.

2) The CHC officer wrote to each Practice Manager, indicating the CHC's intention to carry out a scrutiny visit at their Branch Surgery, on a set date and requested briefing information which included list status, list size and any planned developments, at least 10 weeks ahead of the planned visit.

3) The patient surveys were delivered to the Practice, together with a survey returns box for completed forms. A number of stamped addressed envelopes (SAE's) were also provided, for patients to return their survey in a confidential manner, should they wish to do so. This was undertaken 5 weeks ahead of the planned visit, with the survey conducted over a full 2 week period.

4) The completed surveys were collected 3 weeks before the planned visit. This allowed the CHC time to manually enter the results and produce a brief analysis document to be included in the Members' briefing packs, together with the guidance document, which were then sent out a week prior to the visit.

5) Each visit was undertaken by at least 2 CHC Members and mainly took place between 10:00am and midday. However, due to the fluctuating opening times of some Branch Surgeries, a small number commenced at a different time.

6) Following the visit, the lead Member produced a report, noting comments from other CHC Members of the visiting team and then returned it to the CHC office within 2 weeks of the visit.

7) The CHC officer formatted the report using a standardised template and added any analysis graphs/comments that related to the contents of the report. The completed report was then sent to the Practice Manager upon completion.

8) The Practice was required to respond to the report, addressing any matters of inaccuracy and the recommendations made, within 20 working days of receipt of the report.

9) The report and subsequent response was then included in the next available CHC Council papers.

3: Practice Leaflet Analysis

As part of the Members' briefing pack, a copy of the Practice Leaflet was provided, together with a breakdown of any points that were missing from the Leaflet and what was required for inclusion.

Under the General Medical Services (GMS) Contract, the GP Practice should; 'compile a Practice Leaflet which shall include the information specified in Schedule 3 (a list of 30 particular details that must be included); review its Practice Leaflet at least once in every period of 12 months and make any amendments necessary to maintain its accuracy; and make available a copy of the Leaflet and any subsequent updates, to its patients and prospective patients. This schedule was updated in 2008, by way of "subordinate legislation" and now specifies a list of 23 particular details.

With the aim of encouraging Practices to keep their Leaflet up-to-date and to continue providing patients with relevant information, the CHC previously conducted an assessment of all Practice Leaflets within Cardiff and the Vale of Glamorgan on a 3 year cycle. The last assessment, at the time of writing, was undertaken in January 2014. In future, the CHC will undertake these assessments on a biennial basis.

For the purpose of this Branch Surgery scrutiny process, the CHC requested an up-to-date copy of the Practice Leaflet relevant to the Branch Surgeries in Cardiff & Vale of Glamorgan only.

Methodology

1) The CHC obtained a hard copy of the Practice Leaflet.
2) On receipt of the Leaflet, the CHC Officer reviewed its content against the updated 2008 Schedule 1 list of information; populating a spreadsheet specifically designed for this task.
3) The spreadsheet was formatted to automatically calculate a performance score, displayed as a percentage.
4) The CHC was then able to report on the performance of each Practice and highlight the missing information, as well as reporting on the average performance within the Cardiff & Vale University Health Board area.
5)

2016	
Total number of Branch Surgeries	**22**
Average performance	**55%**
100% performance attained	**3**
Performance under 50%	**6**
Practice Leaflet not provided	**3**

Out of the 22 Practices with an additional Branch Surgery, the following achieved 100% compliance:

- Four Elms Medical Centre
- Llwynbedw Medical Centre
- Minster Surgery.

With two Practices producing separate, stand-alone Leaflets for their Branch Surgery, the CHC questioned how Practices can best inform patients of the services it provides and, when reviewing this, the following options were considered:

1) ***Basic Leaflet***

This would involve the Practices providing no additional information on the Branch Surgery, other than what is specifically required under the 2008 schedule 1: Item 6 - "The address of each of the practice's premises".

2) ***Individual Leaflets***

The CHC commended those Practices that had taken the time to create separate leaflets for their Branch Surgeries. However, the Branch Leaflet would need to comply with Schedule 1 requirements and contain the majority of what is also provided within the main Practice Leaflet. The financial cost of producing two separate leaflets will also need to be considered.

3) ***Recommended Best Practice***

In order for those Practices with a Branch Surgery facility to be able to provide as much information as possible to its patients, it may be well worth providing one Practice Leaflet, with the addition of a separate, dedicated section on its Branch Surgery. By providing such additional information; such as opening days/times of the Branch, a list of the medical services provided at the Branch and any regular specific clinician availability if able to do so; this information would allow patients the choice and flexibility to choose which premises they attend for an appointment. This may well take the undue pressure off appointment availability at the main Practice and redistribute the balance between the other site(s).

Having engaged with the CHC, a number of Practice Managers were aware that their Practice Leaflets required updating. The CHC has undertaken to offer support to those Practices who have requested assistance in updating both their Practice Leaflets and their websites.

Conclusion

By combining the CHC assistance to General Practices with the suggested best practice above, it is envisaged that further Practice Leaflet improvements will be evidenced when the next assessment is completed, which is currently planned for January 2018.

The CHC expectation would be that every Practice will participate in this assessment and that none of these Practice Leaflets should fall below 50% performance compliance.

4: Patient Survey Overview

During October 2016, in order to obtain the patient's perspective of their Branch Surgery, which in turn would be incorporated within the CHC scrutiny reports that were planned for November/December, Branch Surgeries were supplied with 200 blank copies of the Patient Satisfaction Survey, for completion by its patients. The questions asked were identical to those used in the initial visits, which has allowed the CHC to combine the results to form a base-line assessment on which to expand and enhance future scrutiny visits to general practices.

As well as the surveys, a small supply of stamped addressed envelopes and a survey returns box were provided to each Branch Surgery. They were provided 5 weeks ahead of each visit and the Surgeries were allocated a full two week period to undertake the survey. Patients who attended these Branch Surgeries during this period were asked to complete a survey and leave it in the survey returns box or post it back to the CHC Office using one of the envelopes provided. It should be noted that many patients used the envelopes and survey box, which was more cost effective and retains anonymity.

The CHC distributed a total of 4,400 surveys across the 22 Branch Surgeries and the 1,476 responses received back represent a **34%** response rate.

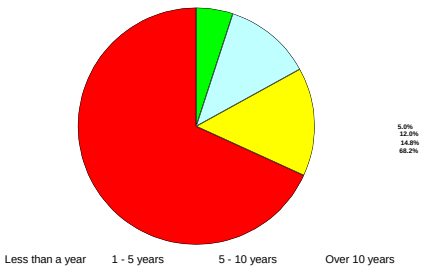
The results used to produce this report also include completed surveys that patients returned after the initial closing date for incorporation within the individual Branch Surgery reports.

The response rates can be broken down by locality as follows:

Branch Surgeries	Surveys Provided	Surveys Returned	Response Rate
Cardiff (15)	3,000	975	**33%**
Vale of Glamorgan (7)	1,400	501	**36%**

The returns from each Branch Surgery ranged significantly; the lowest return rate being 4 responses, up to an impressive 182 surveys being returned. However, there was one Practice that was recorded as nil. This was as a result of the CHC not being provided with any completed survey responses from their patients.

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The Vale Branch Surgeries show a lower figure of **17%** of patients registered for less than 5 y
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Whilst the results show that almost **80%** of respondents rated booking an appointment at their Branch Surgery as either "easy" or "very easy", a number of patients revealed in Question 15 they would like more appointment availability offered at their Branch Surgery.

Over **20%** of patients indicated that booking an appointment at their Branch Surgery was either "difficult" or "very difficult" and in order to understand why they have chosen these two options, we asked for comments.

Question 4: If "difficult" or "very difficult", please comment:

The following are a sample of the comments received from those patients who found booking an appointment difficult/very difficult:

- *Phone is rarely answered, often get told to phone back when I speak to someone.*
- *Phone is constantly engaged. By the time I get through, no appointments left.*
- *On the infrequent times I need an appointment, it can often be days or weeks before I can get an appointment.*
- *If you want an appointment for an emergency difficult to get through in the morning. Usually have to wait a few weeks to get an appointment even with any GP.*
- *I never fully understand the system & now have to drive to another branch for the open clinic.*
- *Attempting to get through on the phone at 8am is almost impossible.*
- *As I am in full time employment, you have to stay at home to phone from 8.30am for an appointment, then usually not seen anyway.*
- *For a same day appointment, we have to walk to surgery in all weathers and possibly walk back again. No appointment on the same day if made by phone.*
- *Impossible to book an appointment, always have to use open access, which makes it difficult for school times.*

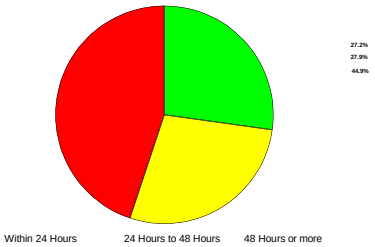
Word Cloud

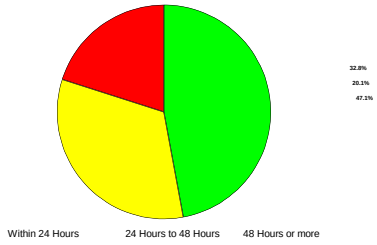
In addition to the examples above, the following Word Cloud has been produced to identify 50 of the most frequent words used in response to this question. The size of the words correlates with the frequency of use, with larger text being more frequent and smaller text less so.

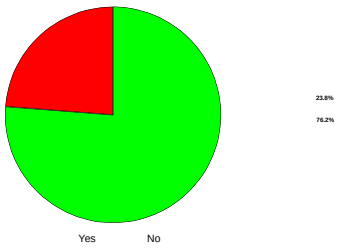


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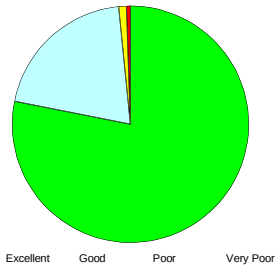
From the results provided above, patients appear to have very little concern regarding actual access to their branch surgery.

It is clear that the majority of Practices make every effort to ensure that consultation/treatment rooms are located on the ground floor of the Branch. If any Branches have consultation rooms on upper floors, the CHC were assured that arrangements were in place to make a ground floor room available, as and when necessary.

Whilst this is positive for accessibility to the Branch Surgery, it is disappointing to note the comments in Question 15, about the limited transport services to some main Practices, when a patient is unable to be seen at their Branch.



Whilst there was a very high satisfaction level for the seating arrangements within Practice waiting rooms, it was highlighted by CHC Members, who engaged with



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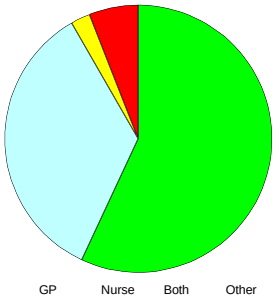
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Patients appear to be satisfied with the toilet facilities at their Branch Surgery, although a number of respondents did not answer this question, commenting they had never used them.

There was one Branch Surgery in particular that was singled out as having wholly inadequate toilet facilities available and that the Practice has been engaging with the University Health Board (UHB) on this matter as they operate within UHB premises. It is hoped that this will be addressed as soon as practicable for the benefit of all the patients concerned.



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It is interesting to see a shift between the GP and Nurse figures from those obtained in the initial report (**68.9%** and **21.74%** respectively). This leads on to questionning why this is happening; is it because the GP presence has reduced in comparison to the main Practice or are patients more willing to see the most appropriate clinician available?

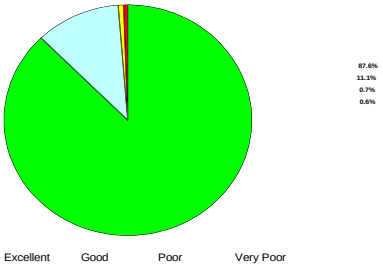
It is noted that if a GP is allocated to the Branch Surgery one day per week, i.e. Monday, a patient may have to wait considerably longer to see that GP at the Branch rather than at the main Practice where he/she operates Tuesday - Friday. Therefore, is it likely that patients are able to see their preferred GP at the main Practice, but less so at a Branch Surgery?

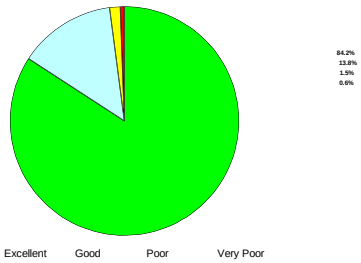
Under Clause 185 of the GMS Contract, “that a practice should notify the patient of their right to express a preference to receive services from a particular performer or class of performer, either generally or in relation to any particular condition”, the CHC understands that this means to include nurses as well as doctors, as they also provide General Medical Services under the contract. With this in mind, there does seem to be very little public/patient awareness of the full extent of this clause.

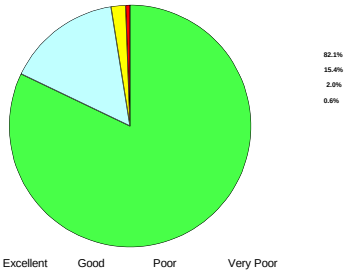
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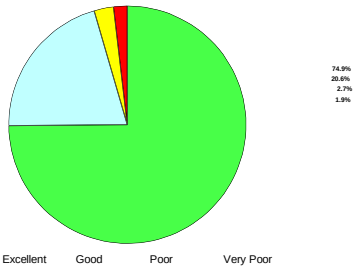
Question 11 - If other, which health care professional did you see?

- Phlebotomist
- Midwife
- Health Visitor
- Collect/drop off a (repeat) prescription.
- Receptionist.

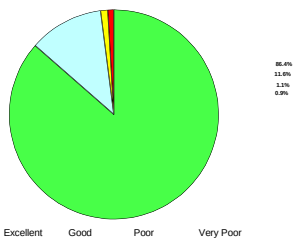


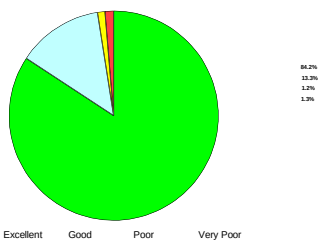






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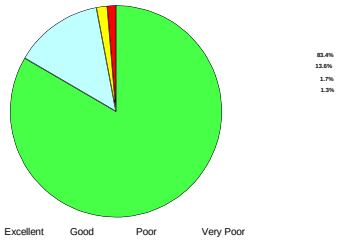


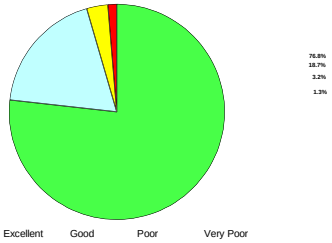


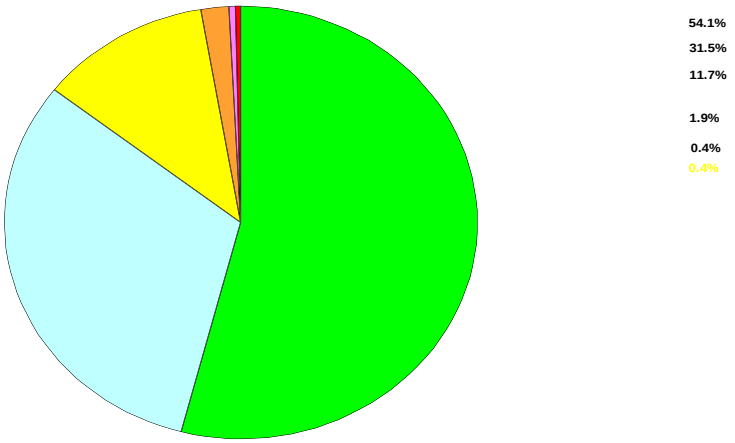
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achieved by 7 Practices, was 100%; compared with the lowest combined score of 84.3%. However, there was one Practice that was recorded as nil, due to the CHC not being provided with any completed survey responses from their patients.

- Upper Quartile: 25% of practices were at/above this score = **100%**
- Lower Quartile: 25% of practices were at/below this score = **90.4%**

Overall, **97.3%** (1,353) of patients gave their Branch Surgery a rating of good or better, with **54.1%** (752) of respondents providing a rating of 'excellent'.

It was pleasing to note that Branch Surgeries, from a patient perspective, received such a high level of satisfaction.

As General Practices are considered to be the 'gateway' to the NHS, the CHC would wish to see more of these Practices and Branches achieving an "excellent" rating from their patients in future surveys. This would evidence that patients have seen improvements having been made within their Practices, which would hope to, in turn, ease pressures experienced within other services, i.e. the GP Out-of-Hours Service and / or Accident & Emergency.

Question 15 - Do you have any additional comments you wish to make regarding your GP Practice or healthcare professional seen?

Out of a possible 1,476 returned, 428 respondents (**29**%) provided additional comments in the free text box at the end of the survey. The following comments are a small illustrative sample:

- *Delighted that this surgery is in the village.*
- *Much better than my last surgery.*
- *Yes! A better appointment system, being able to request registered surgery [name], as I live 10 minutes away. Take more time to listen to health concerns. I felt rushed out a few weeks ago. I didn't feel like I had a proper health assessment.*
- *We, as a family, have complete faith in the Doctors. I would never want to change. Thank you for all you do for us, we are grateful.*
- *Friendly, caring service and very understanding and efficient.*
- *Re: opening times. Would help as work full time to have appointments until 6:30 and Saturday am.*
- *I find the receptionist very understanding and very helpful. The GPs are very patient and understanding.*
- *I do not drive, therefore if I can't get an appointment here [Branch], I have to get a taxi to [the main surgery].*
- *Fed up with people moaning in the waiting room. They should see it's a great surgery. The point is this is a branch! The main surgery is great, doctors every morning – just walk in!*
- *On some occasions, the telephone manner of certain receptionists can often be rather curt, although this is the exceptions. Overall, very good.*
- *Always friendly, civil and understanding.*
- *Weekend opening would be of major benefit. Some GPs I have seen at the surgery have been fantastic, other rude and disinterested.*
- *Staff are pleasant and very helpful. Would like to see same doctor each time I have an appointment.*
- *All staff are welcoming and extremely professional.*
- *Disappointed that [Name] is the main surgery, because if needed to see Dr urgently, you would have to make your way there for Rhiwbina. There is not a bus service to this practice.*
- *Receptions staff always friendly and professional. It has become more difficult to make appointments. I see the doctor rarely; only when necessary. I have been given the option of an appointment the following week or to take part in the 8 o'clock phone battle.*
- *Have been registered with the practice for more than 20 years and am still full of praise for all staff at all times.*
- *The knowledge and friendliness is greatly appreciated.*
- *The midwife [name] is always running late. Every appointment I have been to have left me waiting between 30-50 minutes to see her.*
- *Once you get an appointment, GPs are excellent. However, the surgery's only open 1 evening a week for a short period and next appointments are booked well in advance. For an early morning appointment it is very difficult to get – difficult for those in full time employment to be seen.*

6: Summary of the Visit Recommendations

Following their scrutiny visits, recommendations were made in the individual scrutiny reports produced by the CHC Members. This provided each Practice with several constructive points to focus on, which Members believed would improve patient experience at their Branch Surgery.

These recommendations were prepared following information derived from the patient survey, work undertaken prior to the visit, Members' observations and/or discussions with patients on the day.

From the 22 visits completed by the CHC, Members made a total of 89 recommendations, which equates to an average of 4 recommendations per Practice. These recommendations, where possible, have been broken down into three categories: "Patient Engagement", "Accessibility and Assistance" and "Environment". Those that did not fit within these themes fall under "Other".

Patient Engagement

There were 32 recommendations made within the scrutiny report under this heading.

- It was found that information was missing from the majority of Practice Leaflets, details of which are indicated in the 2008 Schedule 1 of the GMS Contract documentation.

  Whilst not all Practice reports made a recommendation to update their Practice Leaflet, the CHC would encourage all Practices to consider the inclusion of a separate section on their Branch Surgery within their Practice Leaflet. This information would allow patients the choice and flexibility to choose which premises to attend an appointment, possibly taking the undue pressure off the main Practice and redistributing the balance between the other site(s).

- A number of Practices were recommended to review the appointment systems and the telephone arrangements currently in place. These recommendations were largely as a result of the patient feedback from the surveys and discussions during the visits.

- Recommendations were made to supply information on Practice opening times and contact details at the main point of entry; whether on the front door or front gates of the Branch Surgery. These recommendations also included the contact details for the Out-of-Hours Service, which would provide patient's seeking assistance, the information they require quickly and easily.

- A number of Practices consider carrying out engagement with patients, to establish if a Patient Participation Group would be practical.

- Practices should consider placing a suggestion box at reception, in order for patients to share their views/comments with the Branch Surgery.

- Whilst it was pleasing to observe that a large number of Branch Surgeries had an abundance of up-to-date information offering patients guidance on services available by both the Practice and third parties, it was noted that some do not give clear information on the complaints process within their Branch Surgery and were subsequently recommended to address this issue.

Accessibility and Assistance

There were 31 recommendations incorporated under this heading:

- A number of reports indicated that a hearing loop be considered for hearing impaired/deaf visitors or patients who attend the Surgery.

- A recommendation was made to consider the issue of gender appropriateness in the use of signers for hearing impaired patients.

- Having reviewed the toilet facilities available at Branch Surgeries, a number of recommendations were made to install an emergency pull cord for patients use.

- Recommendations were included in a number of visit reports on the lack of alternative seating available in waiting rooms.

- The recommendation of replacing the access doors to some Branch Surgeries were made for the for the benefit of wheelchair/pushchair users.

- A recommendation was put forward to consider the provision of a dedicated disabled parking spot in the car park.

Environment

There were 8 recommendations incorporated under this heading:

- A small number of Branch Surgeries were identified as having surplus space, currently unused. Recommendations were made to Practices to look at utilising these spaces to offer additional services for the benefit of patients. This should also be considered by the UHB.

- Redecoration to be carried out at some Branch Surgeries to make the surroundings more pleasant for patients.

- Members identified that some Branch Surgeries offered very basic medical facilities. Recommendations were made for Practice's to consider some refurbishment, to enable additional services to be offered to patients.

Other

There were 18 recommendations which could not be attributed to any of the above themes and the key points are summarised below for the UHB to consider:

- Members were made aware of Practice difficulties in obtaining Phlebotomy services, which are provided by Cardiff & Vale Health Board. Due to staffing issues within this service, a number of sessions had been cancelled, leading to Practices having to cancel and rearrange appointments that relied on this vital support service.

- To find out what the criteria for referral to the podiatry services at St Davids Hospital were.

- The process of contacting and referring patients to Mental Health services should be reviewed in light of a number of Practices identifying confusion over access arrangements.

- Providing staff training was recommended, in respect of dealing with a patient who is violent or abusive to a member of staff and also lone-person working Practices at Branch Surgeries.

7: Future Proposals

As referenced throughout this report, the CHC have undertaken these stand-alone Branch Surgery Scrutiny Visits in order to produce a baseline assessment of current provision and the subsequent patient experience. In addition to this scrutiny activity, the CHC also explored other avenues for specific information pertinent to Branch Surgeries but it is noted that there is nothing collected, and reported, on a national basis by Welsh Government. The CHC therefore believes that both the University Health Board and Welsh Government should consider the collection of information on GP Branch Surgeries, which will allow the monitoring of the data provided to ensure that sustainable services are being provided to patients.

The CHC will now look to review the full results of this activity, including the practice leaflet information, survey results, Members' observations/comments, recommendations and briefing information, together with the corresponding information collected during the main practice visiting programme 2011-2013.

It is envisaged that this exercise will lead the CHC to devise an enhanced visiting process that will scrutinise multiple aspects of General Medical Service provision.

The CHC will be looking to incorporate the following:

1) Holistic patient views

A new survey will be designed to explore the pre-established areas of concern/interest further and also to provide a holistic view to the operation/ performance of practices, across all sites from which they provide their services.

2) Branch Provision

In addition to collecting the holistic patient views of multiple site practices, the CHC plans to explore the operational link between main and branch sites and test how this, alongside appointment availability, impacts upon satisfaction and experience.

3) Links to Pharmacy

Pharmacies provide a key service to patients, which supplement GP services, and are best placed to provide initial advice before accessing a GP appointment. For this reason, the CHC intends to explore how general practices gather patient satisfaction levels in regard to routine pharmaceutical arrangements, such as medicine reviews and repeat prescriptions, and how 'patient choice' is supported in these arrangements.

4) Cluster Working

A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. The CHC will be looking at the involvement of practices in this group setting and how this benefits patients.

5) Quality Outcomes Framework

The Quality and Outcomes Framework (QOF) is part of the GMS contract and rewards practices for quality clinical practice. For 2015-17, Welsh Government agreed to retire a number of the indicators in order to allow GPs to spend more time caring for the most vulnerable patients with complex care needs, in particular, the frail elderly. The CHC will be looking to determine whether this aim has been realised.

6) Sustainability

There are concerns over the sustainability of General Practice, especially in Cardiff with the expected growth in population resulting from the Local Development Plan. The CHC will be engaging with colleagues in General Practice to ensure that the Health Board is supporting the sustainability agenda.

Within the Vale of Glamorgan area, sustaining branch surgeries in rural areas is also of vital importance and the CHC will continue to monitor the accessibility and provision provided within the branch surgeries, to ensure that residents are assured that they are being provided with equitable medical care within their locality.

In addition to the above, the CHC will continue to look at the environment and accessibility of the Practice, patient engagement and appointment access and provision.

8: Supporting Information

The supporting documents referenced within this report, include the individual Practice reports, responses and survey results, will be available to view on the CAVOG CHC website. Alternatively, in the absence of internet access, these documents can be provided upon request from the CHC Office. Contact details are located at the rear of this report.

List of supporting documents:

- Practice Leaflet Assessment Results and Information Pro forma.
- Protocol for General Practice and Branch Surgery Visiting.
- Patient satisfaction surveys - English & Welsh.
- Survey response rates.
- Individual Practice visit reports, responses and complete survey results.
- Combined survey results for Cardiff & Vale of Glamorgan.
- CHC Members' Visit Guidance Questions.
- Summary report of the visit recommendations.

9: Conclusion

The CHC has found that Branch Surgeries do experience similar difficulties as their main counterparts. However, it is thought that due to the nature of the branches, in supporting more rural areas, these issues take on extra significance. Additionally, there are a small number of areas where results differ between the main practice and the branch site and how the two working together could potentially address any inadequacies.

As a result of these findings, in addition to the future proposals referenced above, it is evident that the CHC should develop a new visiting model that embraces the 'whole Practice' in order to produce a true assessment of the services provided. It is also considered that this broad approach will allow the CHC to gain a better perception of the patients satisfaction with services offered, as opposed to a site-specific process, which is fraught with limitations.

Unlike the main Practice report in July 2014, no action plan has been produced, as the CHC intends to press ahead with its proposed next steps and, as such, have already commenced planning activities for this purpose.

Caroline Harris
Scrutiny Officer (Primary Care)
Cardiff & Vale of Glamorgan CHC

May 2017

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To view all of the results of the patient surveys, visit reports and/or practice responses, please visit the CHC website using the following address:

www.communityhealthcouncils.org.uk/cardiffandvale

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CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL



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CIC Caerdydd a Bro Morgannwg

Ymweliadau i Feddygfeydd Cangen y Practis Cyffredinol Tachwedd - Rhagfyr 2016

Adroddiad Thematig: Mai 2017

Mynegai

Adran	Teitl	Tudalen
1	Crynodeb Gweithredol	1
2	Paratoi a Chynllunio	3
3	Dadansoddi Taflenni'r Meddygfeydd	6
4	Trosolwg Arolygon Cleifion	9
5	Canlyniadau Arolygon Cleifion	10
6	Crynodeb o Argymhellion yr Ymweliadau	21
7	Cynigion i'r Dyfodol	24
8	Gwybodaeth Ategol	26
9	Casgliadau	26

1: Crynodeb Gweithredol

Mae'r adroddiad hwn yn parhau i adeiladu ar y gwaith rhagorol cysylltiedig ag ymweliadau CIC i holl brif feddygfeydd Meddygon Teulu (MT) a ddaeth i ben yn 2013. O'r canlyniadau hynny, daeth yn amlwg y byddai angen ymweliadau i ganolbwyntio ar Feddygfeydd Cangen MT hefyd er mwyn amcangyfrif Profiad y Claf yn ei gyfanrwydd.

Aeth aelodau gwirfoddol y CIC i ymweld â 22 Meddygfa Gangen gan geisio barn a phrofiadau cleifion sy'n defnyddio'r cyfleusterau hyn. Derbyniodd y CIC gyfanswm o **1,476 o arolygon profiadau cleifion,** sy'n cyfateb i gyfradd ymateb o **34%** i'n harolwg.

Mae'n amlwg bod Meddygfeydd Cangen yn gyfleuster amhrisiadwy i'r cleifion hynny sy'n eu defnyddio. Fodd bynnag, oherwydd cymhlethdod rhai gwasanaethau, mae rhai cleifion yn gorfod teithio ymhellach, h.y. ar gyfer rhai triniaethau penodol. Mae'r cleifion yn sylweddoli hyn ac yn ymddangos yn fodlon i wneud hynny.

Gyda'r galw cynyddol am wasanaethau Meddygon Teulu, ni fu cynaliadwyedd Meddygfeydd Cangen erioed yn bwysicach ar gyfer galluogi cleifion i gael mynediad at wasanaethau MT o safon uchel o fewn eu hardal. Braidd yn siomedig oedd nodi bod trefn Bwrdd Iechyd y Brifysgol o fonitro Meddygfeydd Cangen yn ymddangos fel pe bai angen ei hadolygu'n ddirfawr, yn enwedig o ran amserau agor / clinigol y Meddygfeydd Cangen. Yn yr adroddiad hwn argymhellir bod pob Meddygfa MT sydd hefyd â Meddygfa Gangen yn darparu manylion clir o'r gwasanaethau ac amserau apwyntiadau sydd ar gael i'w cleifion.

Mae'r adroddiad hwn, serch hynny, yn amlygu problemau sylweddol a ddaw i ran cleifion wrth geisio **apwyntiadau** yn eu Meddygfa Gangen. Trwy gyd-ddigwyddiad, cafodd y mater hwn gryn sylw yn ein hadroddiad blaenorol yn 2013. Siom yw canfod nad yw'r GIG wedi symud ymlaen o gwbl i ddatrys y mater allweddol hwn.

Wedi iddynt lwyddo i gael apwyntiad, roedd "Boddhad Cleifion" yn uchel dros ben, gyda **97.3%** o gleifion yn rhoi dyfarniad o 'Da' i 'Rhagorol' am eu profiadau'n gyffredinol. Yn ogystal, roedd **Meddygon Teulu** a **Nyrsys Practis**, fel ei gilydd, yn derbyn **lefelau uchel o fodlonrwydd** gan gleifion yng nghyswllt y meysydd canlynol: cyfarch y claf, deall eu pryderon, egluro triniaethau a pharhad gofal. Rhoddodd cleifion ymatebion ffafriol hefyd ar agweddau ar fynediad corfforol i adeiladau, glendid a mynediad at wybodaeth.

Hoffwn gofnodi fy niolchgarwch i'r cleifion a neilltuodd amser naill ai i siarad â'n haelodau CIC neu a lenwodd ein harolwg ac i Staff y Practis am eu cymorth yn ystod y broses ymweld. Hefyd, dymunaf ddiolch i Aelodau gwirfoddol y CIC a roddodd o'u hamser i ymgymryd â'r ymweliadau hyn ar ran y cyhoedd yn ehangach.

Patricia Matthews
Cadeirydd,
Grŵp Goruchwylio, Craffu a Chyflawni, Gofal Sylfaenol. Cymunedol a Chanolraddol, CIC
(PCIC OSPG) Mai 2017

2: Paratoi a Chynllunio

Mae Cyngor Iechyd Cymuned Caerdydd a Bro Morgannwg (CIC CaBM) yn sefydliad statudol annibynnol sy'n gyfrifol am graffu ar y modd y mae'r gwasanaethau iechyd lleol yn gweithredu. Mae gan y CIC 24 o Aelodau gwirfoddol, wedi'u penodi, ac maen nhw'n cael eu cefnogi gan 8 aelod staff cyflogedig ynghyd ag Aelodau cyfetholedig ychwanegol.

Yn ôl ym mis Mawrth 2011, cychwynnodd Grŵp Gofal Sylfaenol y CIC, oedd â'i brif nod i fonitro a chraffu ar elfennau Gofal Sylfaenol gwasanaethau lleol y GIG, ar raglen o ymweliadau monitro wedi'u trefnu ymlaen llaw i holl Brif Feddygfeydd MT yn ardal Caerdydd a Bro Morgannwg. Roedd hyn yn ddiweddariad ar fodel ymweld CIC o Feddygaeth Teulu (MT) a ddefnyddiwyd ynghynt gan CIC Caerdydd cyn i CIC ei hun gael ei ad-drefnu yn 2010. Ar yr adeg honno, derbyniodd y CIC gymeradwyaeth y Gymdeithas Feddygol Brydeinig (BMA) a'r Pwyllgor Meddygol Lleol (LMC) sy'n dangos bod y model hwn yn arfer da.

Cynsail yr ymweliadau yw seilio'r adroddiadau craffu ar farn y cleifion sy'n defnyddio'r gwasanaethau hyn ac yna anelu at lunio set o argymhellion wedi'u cynllunio i helpu pob Practis i wella profiad ei gleifion.

Er mwyn casglu barn y cleifion hyn, bu Grŵp Gofal Sylfaenol CIC hefyd yn llunio arolwg a chyfarwyddiadau ar bapur a oedd yn cynnwys cwestiynau y gallai Aelodau gyfeirio atynt yn ystod yr ymweliadau craffu. Roedd y rhain yn cynnwys cwestiynau'n ymwneud â sylwadau y dylai'r Aelodau eu gwneud, yn ychwanegol at y cwestiynau y gellid eu gofyn i staff y Practis.

Mae ymweliadau craffu'r CIC yn cael eu gwneud gan o leiaf 2 Aelod ac fel y cytunwyd yn ystod proses datblygu'r model ymweld, byddai Aelodau yn treulio o leiaf 2 awr ar y safle, i gynnal trafodaethau byr â chleifion, gwneud sylwadau ar yr amgylchedd a hefyd ar sut mae'r Practis yn gweithredu. Pan fyddai Aelodau wedi gorffen eu trafodaethau, byddai cyfarfod yn cael ei gynnal gyda chynrychiolwyr y Practis i drafod yr ymweliad craffu a hefyd i roi iddynt ganlyniadau arolwg boddhad cleifion ar gyfer eu Practis hwy.

Roedd yr ymweliadau a wnaed i'r Meddygfeydd Cangen yn ystod Tachwedd / Rhagfyr 2016 yn adlewyrchu'r broses a ddilynwyd ynghynt gyda'r prif Feddygfeydd oddi ar 2011 ac mae hyn wedi galluogi'r CIC i osod meincnod cychwynnol i ymweliadau craffu a wneir gan Aelodau CIC sy'n symud ymlaen.

Mae 66 Prif Bractis MT yn ardal Caerdydd a Bro Morgannwg, gyda 22 Meddygfa Gangen ychwanegol yn gwasanaethu cleifion. Cyn yr ymweliadau craffu, dosbarthodd y CIC 200 o arolygon boddhad cleifion ym mhob Meddygfa Gangen i'w llenwi gan gleifion dros gyfnod o bythefnos lawn.

I hysbysu'r cyhoedd o'r ymweliadau hyn a drefnwyd gan y CIC i'r Meddygfeydd Cangen, rhoddwyd dyddiadau'r ymweliadau ar y cyfryngau cymdeithasol. Wrth ddosbarthu'r arolygon cleifion, rhoddodd y CIC bosteri hefyd i'w harddangos ym mhob ardal aros. Ar y posteri roedd manylion i'r cleifion o arolwg y CIC oedd yn cael ei gynnal gan dynnu sylw hefyd at ddyddiad penodol yr ymweliad craffu.

Roedd rhaid ystyried rhai ffactorau gwahanol o ran canlyniadau'r Meddygfeydd Cangen, h.y. roedd yr amserau agor yn wahanol i'r rhai a roddwyd gan eu prif Bractis cyfatebol; faint yn union o gleifion a fynychodd y Gangen yn ystod cyfnod yr arolwg cleifion a pha mor rhagweithiol oedd pob Meddygfa wrth hyrwyddo'r arolwg.

Ar ôl cwblhau pob ymweliad, roedd Aelod arweiniol y CIC yn cael y dasg o greu adroddiad craffu. Roedd yr adroddiad hwn yn cynnwys arsylliadau'r Aelod CIC a'r claf fel ei gilydd, eu sylwadau a'u hargymhellion i'r Practis.

Gofynnwyd i bob Practis ymateb o fewn 20 diwrnod gwaith ar unrhyw fater o gywirdeb ac i gynnig camau gweithredu i fynd i'r afael â'r materion a godwyd yn yr argymhellion. Cafodd yr adroddiad ei gyhoeddi wedyn mewn papurau dilynol Cyngor y CIC gydag ymateb ar bapur ag iddo bennawd ffurfiol y Practis. Ar ôl i'r Cyngor gytuno, roedd yr adroddiad ymweld, ymateb y Practis a chanlyniadau arolwg boddhad cleifion i gyd ar gael ar wefan y CIC dan yr is-bennawd Gofal Sylfaenol.

Methodoleg

1) Cafodd copi drafft o amserlen interim yr ymweliadau ei lunio gan y CIC 4 mis o leiaf cyn dyddiad yr ymweliad cyntaf a drefnwyd.

2) Ysgrifennodd swyddog y CIC at bob Rheolwr Practis gan nodi bwriad y CIC i gynnal ymweliad craffu yn eu Meddygfa Gangen, ar ddyddiad penodol a gofynnodd am friff oedd yn cynnwys statws rhestrau, maint rhestrau ac unrhyw ddatblygiadau sydd wedi'u trefnu, a hynny o leiaf 10 wythnos cyn yr ymweliad arfaethedig.

3) Anfonwyd arolygon y cleifion i'r Practis, ynghyd â blwch dychwelyd arolygon ar gyfer ffurflenni wedi'u llenwi. Hefyd darparwyd nifer o amlenni â stamp a chyfeiriad parod arnynt i gleifion ddychwelyd eu harolwg ynddynt yn gyfrinachol, os oeddent yn dymuno gwneud hynny. Cafodd hyn ei wneud 5 wythnos cyn yr ymweliad cynlluniedig a chynhaliwyd yr arolwg dros gyfnod o 2 wythnos lawn.

4) Casglwyd yr arolygon gorffenedig 3 wythnos cyn yr ymweliad cynlluniedig. Roedd hyn yn rhoi amser i'r CIC fewngofnodi'r canlyniadau â llaw a llunio dogfen ddadansoddol fer i'w chynnwys ym mhecynnau briffio'r Aelodau ynghyd â'r ddogfen cyfarwyddiadau. Cafodd y rhain eu hanfon allan wedyn wythnos cyn yr ymweliad.

5) Cynhaliwyd pob ymweliad gan o leiaf 2 Aelod o'r CIC, a hynny gan mwyaf rhwng 10:00yb a chanol dydd. Serch hynny, oherwydd amserau cyfnewidiol rhai o'r Meddygfeydd Cangen, cychwynnodd nifer fechan ar amser gwahanol.

6) Yn dilyn yr ymweliad, lluniodd yr Aelod arweiniol adroddiad yn nodi sylwadau Aelodau eraill o dîm ymweld y CIC gan ei ddychwelyd wedyn i swyddfa'r CIC o fewn 2 wythnos ar ôl yr ymweliad.

7) Fformatiodd Swyddog y CIC yr adroddiad gan ddefnyddio templed safonedig ac ychwanegodd unrhyw graffau/sylwadau dadansoddi a oedd yn berthnasol i gynnwys yr adroddiad. Yna cafodd yr adroddiad gorffenedig ei anfon at y Rheolwr Practis.

8) Cafodd y Practis gais i ymateb i'r adroddiad gan ddelio ag unrhyw fater o anghywirdeb a'r argymhellion a wnaed, o fewn 20 diwrnod gwaith ar ôl derbyn yr adroddiad.

9) Wedyn, cafodd yr adroddiad a'r ymateb dilynol eu cynnwys ym mhapurau Cyngor y CIC oedd ar gael wedi hynny.

3: Dadansoddi Taflenni'r Practis

Fel rhan o becyn briffio'r Aelodau, cafwyd copi o Daflen Practis ynghyd â rhestr o unrhyw bwyntiau oedd ar goll o'r Daflen a beth oedd angen ei gynnwys.

O dan Gontract y Gwasanaethau Meddygol Cyffredinol (GMS), fe ddylai Practis MT: 'lunio Taflen Practis a fydd yn cynnwys yr wybodaeth a nodwyd yn Atodlen 3 (rhestr o 30 manylyn penodol sy'n rhaid eu cynnwys); adolygu ei Daflen Practis o leiaf unwaith ym mhob cyfnod o 12 mis a gwneud unrhyw newidiadau sydd eu hangen i sicrhau ei bod yn dal yn gywir; a sicrhau bod copi o'r Daflen ac unrhyw ddiweddariadau dilynol ar gael i'r cleifion sydd yno a chleifion i ddod. Diweddarwyd yr atodlen hon yn 2008, trwy 'is-ddeddfwriaeth' ac erbyn hyn mae'n nodi rhestr o 23 manylyn penodol.

Gyda'r nod o annog pob Practis i ddiweddaru eu Taflen yn gyson a pharhau i roi gwybodaeth berthnasol i gleifion, yn y gorffennol bu'r CIC yn cynnal asesiad o holl Daflenni Practis yng Nghaerdydd a Bro Morgannwg bob 3 blynedd. Cynhaliwyd yr asesiad diwethaf, wrth i hwn gael ei ysgrifennu, ym mis Ionawr 2014. Yn y dyfodol, bydd y CIC yn cynnal yr asesiadau hyn bob dwy flynedd.

At ddibenion y broses hon o graffu ar Feddygfeydd Cangen, gofynnodd y CIC am gopi diweddaraf y Daflen Practis perthnasol i Feddygfeydd Cangen yng Nghaerdydd a Bro Morgannwg yn unig.

Methodoleg

1) Cafodd y CIC gopi caled o'r Daflen Practis.
2) Ar ôl derbyn y Daflen, adolygodd Swyddog y CIC ei chynnwys yn erbyn rhestr wybodaeth Atodlen 1 2008 sydd wedi'i diweddaru, gan lenwi taenlen a gynlluniwyd yn benodol ar gyfer y dasg hon.
3) Roedd y daenlen wedi'i fformatio i gyfrifo sgôr perfformiad yn awtomatig, gan ei ddangos fel canran.
4) Roedd y CIC felly yn gallu rhoi adroddiad ar berfformiad pob Practis a thynnu sylw at yr wybodaeth goll, yn ogystal ag adrodd am y perfformiad cyfartalog yn ardal Bwrdd Iechyd Prifysgol Caerdydd a'r Fro.
5)

2016	
Cyfanswm y Meddygfeydd Cangen	**22**
Perfformiad Cyfartalog	**55%**
Perfformiad o 100% a gyrhaeddwyd	**3**
Perfformiad dan 50%	**6**
Taflen Practis nas darparwyd	**3**

Allan o'r 22 Practis, ac un Feddygfa Cangen ychwanegol, llwyddodd y canlynol i gydymffurfio 100%:

- Canolfan Feddygol Four Elms
- Canolfan Feddygol Llwynbedw
- Meddygfa Minster.

Gyda dau Bractis yn cynhyrchu Taflenni ar wahân ac annibynnol ar gyfer eu Meddygfa Cangen, gofynnodd y CIC beth yw'r ffordd orau y gall Practisau roi gwybod i gleifion am y gwasanaethau mae'n eu darparu ac wrth adolygu hyn cafodd yr opsiynau canlynol eu hystyried:

1) ***Taflen Syml***

Yn hon, ni fyddai'r Practis yn darparu unrhyw wybodaeth ychwanegol am y Feddygfa Gangen ar wahân i'r hyn a nodir yn angenrheidiol dan Atodlen 1 2008: eitem 6 - "Cyfeiriad safle pob practis".

2) ***Taflenni Unigol***

Canmolodd y CIC y Practisau hynny oedd wedi neilltuo amser i greu taflenni ar wahân ar gyfer eu Meddygfeydd Cangen. Serch hynny, byddai'n rhaid i Daflen y Gangen gydymffurfio â gofynion Atodlen 1 gan gynnwys y rhan fwyaf o'r hyn sydd hefyd ar gael yn y Nhaflen y Prif Bractis. Hefyd, byddai angen ystyried y gost ariannol o gynhyrchu dwy daflen ar wahân.

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3) ***Argymhellion ar gyfer Arfer Da***

Fel bod modd i Bractis sydd â chyfleuster Meddygfa Gangen fedru rhoi cymaint o wybodaeth ag sy'n bosibl i'w gleifion, gall fod yn fanteisiol darparu un Daflen Practis, gan ychwanegu adran benodedig ar wahân yn ymwneud â'i Feddygfa Gangen. Pe gellid cynnwys gwybodaeth ychwanegol fel hyn, e.e. dyddiau/amserau agor y Gangen, rhestr o'r gwasanaethau meddygol a gynigir yn y Gangen ac unrhyw glinigwyr penodol sydd ar gael yn rheolaidd, byddai hyn yn rhoi dewis a hyblygrwydd i gleifion benderfynu pa adeiladau y gallent fynd iddynt am apwyntiad. Mae'n siŵr y byddai hyn yn lleihau'r pwysau diangen o ran cael apwyntiadau yn y brif Practis ac ail-sefydlu cydbwysedd rhwng y safleoedd eraill.

Ar ôl bod mewn cyswllt â'r CIC, roedd sawl Rheolwr Practis yn ymwybodol bod angen diweddaru eu Taflenni Practis. Mae'r CIC wedi mynd ati i roi cefnogaeth i'r Practisau hynny sydd wedi gofyn am help i ddiweddaru eu Taflenni Practis a hefyd eu gwefannau.

Casgliad

Wrth gyplysu cymorth y CIC i'r Practisau Cyffredinol â'r arfer gorau a awgrymwyd uchod, rhagwelir tystiolaeth o welliannau pellach yn y Daflen Practis pan fydd yr asesiad nesaf wedi'i gwblhau. Mae hwn wedi'i drefnu ar hyn o bryd ar gyfer mis Ionawr 2018.

Mae'r CIC yn disgwyl y bydd pob Practis yn cymryd rhan yn yr asesiad hwn ac na ddylai unrhyw un o'r Taflenni Practis hyn ddisgyn yn is na 50% o ran cydymffurfiaeth perfformiad.

4: Trosolwg Arolwg Cleifion

Yn ystod mis Hydref 2016, er mwyn cael persbectif y claf ar eu Meddygfa Gangen, a fyddai yn ei dro yn cael ei gynnwys yn adroddiadau craffu'r CIC a drefnwyd ar gyfer Tachwedd/Rhagfyr, cafodd y Meddygfeydd Cangen 200 o gopïau gwag o Arolwg Boddhad Cleifion i'w llenwi gan eu cleifion. Roedd y cwestiynau a ofynnwyd yn union yr un fath â'r rhai a ddefnyddiwyd yn yr ymweliadau gwreiddiol, ac mae hyn wedi galluogi'r CIC i gyfuno'r canlyniadau i ffurfio asesiad sylfaenol ar gyfer ehangu a gwella ymweliadau craffu i bractisau cyffredinol yn y dyfodol.

Yn ogystal â'r arolygon, rhoddwyd cyflenwad bychan o amlenni â stamp a chyfeiriad parod arnynt a blwch dychwelyd arolygon ym mhob Meddygfa Gangen. Cawsant eu rhoi yno 5 wythnos cyn pob ymweliad a rhoddwyd cyfnod o bythefnos lawn i bob Meddygfa gynnal yr arolwg. Gofynnwyd i gleifion oedd yn mynychu'r Meddygfeydd Cangen hyn yn ystod y cyfnod hwn gwblhau'r arolwg a'i adael yn y blwch dychwelyd arolygon neu ei bostio yn ôl i Swyddfa'r CIC gan ddefnyddio un o'r amlenni a ddarparwyd. Dylid nodi bod llawer o gleifion wedi defnyddio'r amlenni a'r blwch arolygon - ac mae hyn yn fwy cost-effeithiol ac yn sicrhau anhysbysrwydd.

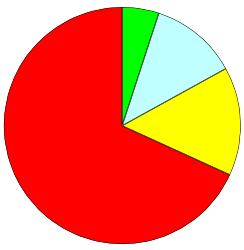
Dosbarthodd y CIC gyfanswm o 4,400 arolwg ar draws y 22 Meddygfa Gangen ac mae'r 1,476 ymateb a dderbyniwyd yn cyfateb i gyfradd ymateb o **34%**.

Roedd y canlyniadau a ddefnyddiwyd i gynhyrchu'r adroddiad hwn hefyd yn cynnwys arolygon cyflawn roedd cleifion wedi'u dychwelyd ar ôl y dyddiad cau gwreiddiol ar gyfer eu cynnwys o fewn adroddiadau unigol y Meddygfeydd Cangen. Gellir dadansoddi'r cyfraddau ymateb fesul ardal fel a ganlyn:

Meddygfeydd Cangen	Arolygon a Ddosbarthwyd	Arolygon a Ddychwelwyd	Cyfradd Ymateb
Caerdydd (15)	3,000	975	**33%**
Bro Morgannwg (7)	1,400	501	**36%**

Roedd yr arolygon a ddychwelwyd o bob Meddygfa Gangen yn amrywio'n sylweddol, gyda'r gyfradd dychwelyd isaf yn 4 ymateb, ac yn cyrraedd cyfanswm trawiadol o 182 arolwg yn cael eu dychwelyd. Fodd bynnag, cafodd un Practis ei gofnodi fel ''dim'. Y rheswm am hyn oedd bod y CIC heb dderbyn unrhyw arolwg wedi'i gwblhau gan y cleifion yno.

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ars

5 - 10 years

Over 10 years

Dengys Meddygfeydd Cangen y Fro ffigwr is o **17%** o gleifion wedi cofrestru am lai na 5 mlynedd yn eu Practis. Gellir priodoli sawl rheswm am hyn gan gynnwys

10.1

s

ars

Less than a year
1 - 5 years
5 - 10 years
Over 10 years

Er bod y canlyniadau'n dangos bod bron **80%** o ymatebwyr yn ystyried bod gwneud apwyntiad yn eu Meddygfa Gangen naill ai'n "hawdd" neu'n "hawdd iawn", datgelodd sawl claf yng Nghwestiwn 15 y buasent yn hoffi bod rhagor o apwyntiadau ar gael iddynt yn eu Meddygfa Gangen.

Nododd **20%** o gleifion bod gwneud apwyntiad yn eu Meddygfa Gangen naill ai'n "anodd" neu'n "anodd iawn", ac er mwyn deall pam wnaethon nhw ddewis y ddau opsiwn hyn, fe ofynnon ni am sylwadau.

Cwestiwn 4: Os yn "anodd" neu'n "anodd iawn", rhowch eich sylwadau:

Mae'r canlynol yn sampl o'r sylwadau a dderbyniwyd oddi wrth y cleifion hynny a deimlodd bod gwneud apwyntiad yn anodd neu'n anodd iawn:

- *Pur anaml mae'r ffôn yn cael ei ateb a phan fydda i'n siarad â rhywun, maen nhw'n aml yn gofyn i fi ffonio yn ôl.*
- *Mae'r llinell ffôn yn brysur byth a hefyd. Erbyn i mi lwyddo i fynd trwodd, does dim apwyntiadau ar ôl.*
- *Ar yr amserau prin hynny rwyf angen apwyntiad, yn aml gall fod yn ddyddiau neu wythnosau cyn i mi gael apwyntiad.*
- *Os ydych eisiau apwyntiad ar gyfer mater brys, mae'n anodd mynd drwodd yn y bore. Fel arfer, rhaid aros ychydig wythnosau i gael apwyntiad, hyd yn oed gydag unrhyw Feddyg Teulu.*
- *Dydw i erioed wedi deall y system yn llwyr a nawr rwy'n gorfod gyrru i gangen arall ar gyfer y clinig agored.*
- *Mae ceisio mynd drwodd ar y ffôn am 8yb bron yn amhosibl.*
- *Gan fy mod yn gweithio amser llawn, rhaid aros gartref i ffonio o 8.30yb am apwyntiad, ac fel arfer chewch chi mo'ch gweld wedyn.*
- *Os am apwyntiad ar yr un diwrnod, rhaid cerdded i'r feddygfa ym mhob tywydd ac o bosib cerdded yn ôl eto. Does dim apwyntiad ar yr un diwrnod os mai ffonio a wneir.*
- *Amhosibl trefnu apwyntiad, bob amser yn gorfod defnyddio mynediad agored sy'n gallu bod yn anodd adeg ysgol.*

10.1

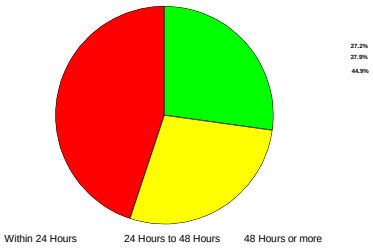
Cwmwl Geiriau

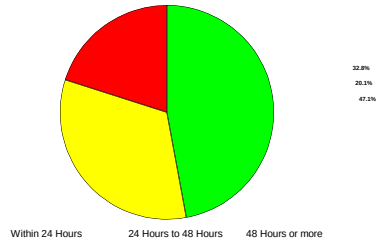
Yn ogystal â'r enghreifftiau uchod, mae'r Cwmwl Geiriau canlynol wedi'i lunio i ddangos 50 o'r geiriau a ddefnyddir amlaf wrth ymateb i'r cwestiwn hwn. Mae maint y gair yn cyfateb i ba mor aml caiff ei ddefnyddio, felly, y testun mwyaf - mwyaf aml a'r testun lleiaf - llai aml.

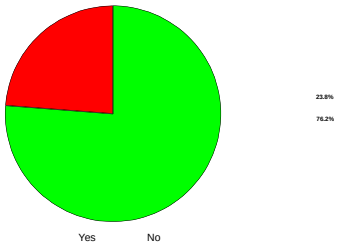
If "Difficult" or "Very Difficult", please comment:

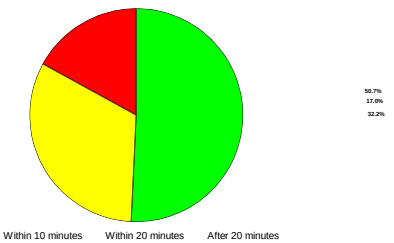


Wrth ddadansoddi'r canlyniadau hyn, y gair "appointment" neu "appointments" oedd yn digwydd amlaf, fel y disgwyliwyd. Serch hynny, roedd yn arwyddocaol mai'r 3 gair nesaf mwyaf aml oedd "phone", "difficult" ac "always", sy'n dangos bod yr









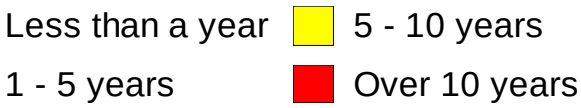
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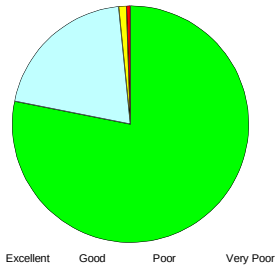
O'r canlyniadau uchod, mae'n ymddangos nad oes gan gleifion fawr ddim pryderon am y mynediad i'w meddygfa gangen.

Mae'n amlwg bod y rhan fwyaf o'r Practisau'n gwneud pob ymdrech i sicrhau bod ystafelloedd ymgynghori/triniaethau wedi'u lleoli ar lawr gwaelod pob Cangen. Os oes gan unrhyw Gangen ystafelloedd ymgynghori ar loriau uwch, cafodd y CIC eu sicrhau bod trefniadau mewn lle i gael ystafell ar y llawr gwaelod os a phan fyddai angen.

Tra bod mater mynediad i Feddygfeydd Cangen yn gadarnhaol, siomedig yw nodi'r sylwadau yng Nghwestiwn 15 am y gwasanaethau cludiant prin i ambell brif Practis pan nad yw'n bosibl i gleifion gael eu gweld yn eu Cangen.



Er bod lefel uchel iawn o foddhad o ran trefniadau eistedd mewn ystafelloedd aros Meddygfeydd, tanlinellodd Aelodau'r CIC a fu'n ymgysylltu â chleifion ar y dydd, bod



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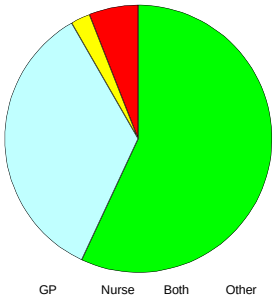
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Mae'n ymddangos bod cleifion yn fodlon â'r cyfleusterau yn nhoiledau eu Meddygfa Gangen, er bod nifer o ymatebwyr heb ateb y cwestiwn hwn gan ddweud nad oeddent wedi'u defnyddio erioed.

Tynnwyd sylw at un Feddygfa Gangen yn benodol am fod y cyfleusterau toiled yno yn gwbl annigonol a bod y Practis wedi bod mewn cysylltiad â'r Bwrdd Iechyd Prifysgol (BIP) ynghylch y mater gan eu bod yn gweithredu o fewn safle'r BIP. Y gobaith yw y caiff y mater hwn ei ddatrys mor fuan ag sy'n ymarferol bosibl er lles yr holl gleifion perthnasol.





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Mae'n ddiddorol sylwi ar y newid rhwng ffigyrau'r MT a'r Nyrs o'r rhai a gafwyd yn yr adroddiad cychwynnol (**68.9%** a **21.74%**, yn y drefn honno). Mae hyn yn arwain at gwestiynu pam fod hyn yn digwydd. Ai am fod presenoldeb Meddygon Teulu wedi lleihau o gymharu â'r prif Bractis neu a yw cleifion yn fwy parod i weld y clinigydd mwyaf addas sydd ar gael?

Nodwyd os yw MT wedi'i benodi i'r Feddygfa Gangen am un diwrnod yr wythnos, e.e. Dydd Llun, mae'n bosibl y byddai rhaid i glaf aros tipyn hirach i weld y MT hwnnw yn y Gangen yn hytrach nag yn y prif Bractis lle mae ef/hi yn gweithio o ddydd Mawrth i ddydd Gwener. Felly, ydy hi'n debygol bod cleifion yn gallu gweld yr MT o'u dewis hwy yn y prif Bractis, ond yn llai tebygol mewn Meddygfa Gangen?

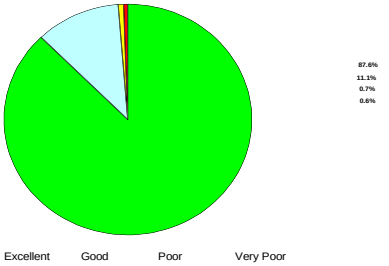
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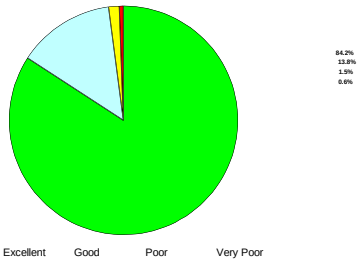
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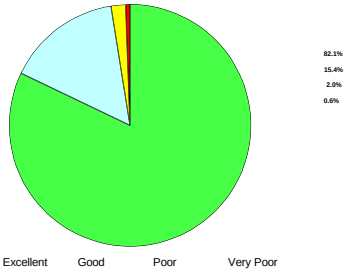
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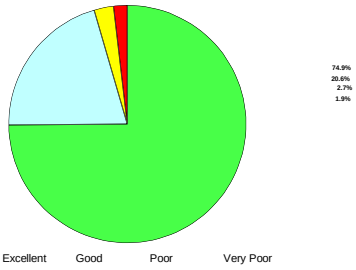
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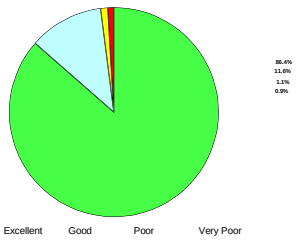
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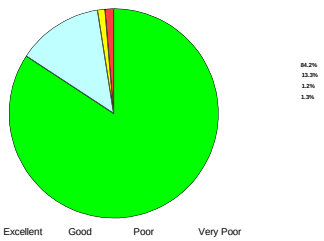








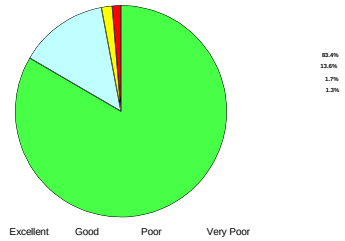


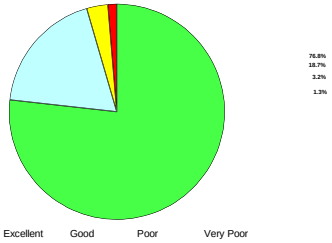


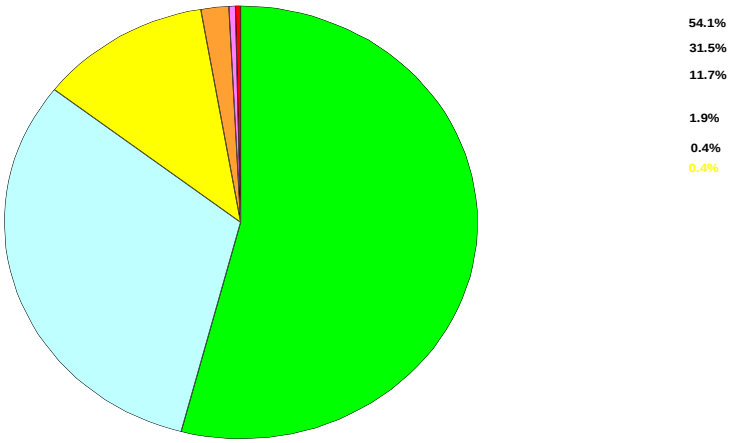
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gan 7 Practis, oedd 100% o gymharu â'r sgôr cyfunol isaf o 84.3%. Fodd bynnag, mewn un Practis 'dim' oedd y cofnod. Y rheswm am hyn oedd bod y CIC heb dderbyn un arolwg wedi'i gwblhau gan y cleifion yno.

- Chwartel Uchaf: roedd 25% o bractisau ar/uwchben y sgôr hwn = **100%**
- Chwartel Isaf: roedd 25% o bractisau ar/o dan y sgôr hwn = **90.4%**

Yn gyffredinol, rhoddodd **97.3%** (1,353) o gleifion ddyfarniad o 'da' neu well i'w Meddygfa Gangen, gyda **54.1%** (752) o ymatebwyr yn rhoi dyfarniad o 'rhagorol'.

Braf oedd nodi bod Meddygfeydd Cangen, o bersbectif y claf, wedi derbyn lefel mor uchel o foddhad.

Gan fod Practisau Cyffredinol yn cael eu hystyried yn 'borth' i'r GIG, hoffai'r CIC weld mwy o'r Practisau a'r Canghennau hyn yn cael graddfa 'rhagorol' gan eu cleifion yn arolygon y dyfodol. Byddai hyn yn dystiolaeth bod cleifion wedi gweld gwelliannau'n cael eu gwneud yn y Practisau, gyda'r gobaith y byddai hyn yn ei dro yn helpu i ysgafnhau'r pwysau a brofir yn y gwasanaethau eraill, h.y. Gwasanaeth MT Tu Allan i Oriau ac/neu Adrannau Damweiniau ac Achosion Brys.

Cwestiwn 15 - A oes gennych chi unrhyw sylwadau ychwanegol yr hoffech eu gwneud ynglŷn â Phractis eich Meddyg Teulu neu weithiwr proffesiynol gofal iechyd a welsoch?

Allan o 1,476 arolwg posibl a ddychwelwyd, rhoddodd 428 o ymatebwyr (**29**%) sylwadau ychwanegol yn y blwch testun rhydd ar ddiwedd yr arolwg. Mae'r sylwadau canlynol yn sampl enghreifftiol byr:

- *Mor hapus bod y syrjeri hon yn y pentref.*
- *Llawer gwell na fy syrjeri ddiwethaf.*
- *Hwre! Gwell system apwyntiadau, gan fy mod nawr yn gallu gofyn am y syrjeri gofrestredig [enw] gan fy mod yn byw 10 munud i ffwrdd. Mwy o amser i wrando ar fy mhryderon iechyd. Ychydig wythnosau yn ôl, roeddwn yn teimlo mod i ar ras gwyllt. Doeddwn i ddim yn teimlo mod i wedi cael asesiad iechyd iawn.*
- *Fel teulu, mae gennym ffydd lwyr yn y Doctoriaid. F'yswn i byth eisiau newid. Diolch i chi am bopeth rydych yn gwneud drosom ni, rydym yn gwerthfawrogi.*
- *Gwasanaeth cyfeillgar, gofalgar ac yn ystyriol ac effeithiol iawn.*
- *Amserau Agor: gan fy mod yn gweithio amser llawn, byddai o help cael apwyntiadau tan 6:30 yh ac ar fore Sadwrn.*
- *Rwy'n teimlo bod y derbynnydd yn llawn dealltwriaeth ac yn barod iawn i helpu. Mae'r Meddygon Teulu yn amyneddgar ac ystyriol iawn.*
- *Dydw i ddim yn gyrru, felly os na allaf gael apwyntiad yma [Cangen], rwy'n gorfod cael tacsi i'r [brif feddygfa]*
- *Rydw i wedi danto ar bobol yn cwyno yn yr ystafell aros. Dylent sylweddoli ei bod yn feddygfa wych. Cangen yw hon, wedi'r cyfan! Mae'r brif feddygfa yn grêt, doctoriaid mewn bob bore – cerddwch i mewn!*
- *Weithiau, mae rhai aelodau o staff y dderbynfa yn gallu bod braidd yn swrth ar y ffôn, er mai eithriad yw hyn. Ar y cyfan, da iawn.*
- *Bob amser yn gyfeillgar, cwrtais ac ystyriol.*
- *Byddai agor ar y penwythnosau yn fantais fawr. Mae rhai Meddygon Teulu rwyf wedi'u gweld yn y syrjeri yn ffantastig, eraill yn anghwrtais a dim diddordeb.*
- *Mae'r staff yn serchog ac yn barod iawn i helpu. F'yswn i'n hoffi gweld yr un meddyg bob tro mae gen i apwyntiad.*
- *Mae'r staff i gyd yn groesawgar ac yn broffesiynol iawn.*
- *Siomedig mai [Enw] yw'r brif feddygfa, oherwydd pe bai angen gweld meddyg ar frys, byddai rhaid i chi wneud eich ffordd yno i Riwbeina. Does dim gwasanaeth bysiau i'r practis hwn.*
- *Mae staff y dderbynfa bob amser yn gyfeillgar a phroffesiynol. Mae'n anoddach erbyn hyn i wneud apwyntiadau. Pur anaml rwy'n gweld y doctor, dim ond pan fo rhaid. Rwyf wedi cael yr opsiwn o apwyntiad yr wythnos ganlynol neu gymryd rhan ym mrwydr y ffonau am 8 o'r gloch.*
- *Rwyf wedi cofrestru gyda'r practis am dros 20 mlynedd ac rwy'n dal yn llawn canmoliaeth i'r holl staff bob amser.*
- *Mae'r wybodaeth a'r cyfeillgarwch yn cael ei werthfawrogi'n fawr.*
- *Mae'r fydwraig [enw] bob amser yn rhedeg yn hwyr. Pob apwyntiad rwyf wedi mynychu, rwyf wedi gorfod aros rhwng 30-50 munud i'w gweld hi.*
- *Unwaith y cewch chi apwyntiad, mae'r Meddygon Teulu yn ardderchog. Serch hynny, dim ond un noson yr wythnos am gyfnod byr y mae'r syrjeri ar agor, ac mae'r apwyntiadau nesaf wedi'u trefnu ymhell ymlaen llaw. Mae'n anodd iawn cael apwyntiad yn gynnar yn y bore – anodd i'r rhai mewn gwaith amser llawn gael eu gweld.*

6: Crynodeb o Argymhellion yr Ymweliadau

Yn dilyn eu hymweliadau, cafodd argymhellion eu gwneud yn yr adroddiadau craffu unigol a luniwyd gan Aelodau'r CIC. Felly, cafodd pob Practis nifer o bwyntiau adeiladol i ganolbwyntio arnynt, pwyntiau y credai'r Aelodau fyddai'n gwella profiad y claf yn eu Meddygfa Gangen

Cafodd yr argymhellion hyn eu paratoi yn dilyn gwybodaeth a ddeilliodd o arolwg y claf, gwaith a wnaed cyn yr ymweliad, arsylliadau Aelodau a/neu drafodaethau â chleifion ar y diwrnod.

O'r 22 ymweliad a gwblhawyd gan y CIC, rhoddodd yr Aelodau gyfanswm o 89 argymhelliad, sy'n cyfateb i gyfartaledd o 4 argymhelliad y Practis. Lle'r oedd yn bosibl, mae'r argymhellion hyn wedi'u rhannu'n dri chategori: "Ymgysylltu â'r Claf", "Hygyrchedd a Chymorth" a'r "Amgylchedd". Roedd yr argymhellion nad oedd yn cwympo o fewn y themâu hyn yn dod o dan "Arall".

Ymgysylltu â'r Claf

Gwnaed 32 argymhelliad yn yr adroddiad craffu dan y pennawd hwn.

- Gwelwyd bod gwybodaeth ar goll yn y rhan fwyaf o'r Taflenni Practis a cheir manylion am hyn yn Atodlen 1, 2008 dogfen Contract y GMS.

  Er nad oedd argymhelliad ym mhob adroddiad Practis i ddiweddaru eu Taflen Bractis, mae'r CIC yn annog pob Practis i ystyried cynnwys adran ar wahân ar eu Meddygfa Gangen o fewn eu Taflen Bractis. Byddai'r wybodaeth hon yn caniatáu i gleifion gael y dewis a'r hyblygrwydd i benderfynu pa adeilad i fynd iddo am eu hapwyntiad. Gallai hyn olygu ysgafnhau pwysau diangen oddi ar y prif Bractis a chreu gwell cydbwysedd o fewn y safleoedd eraill.

- Argymhellwyd sawl Practis i adolygu'r systemau apwyntiadau a'r trefniadau teleffon sydd ar waith ar hyn o bryd. Gwnaed yr argymhellion hyn yn bennaf o ganlyniad i adborth cleifion yn yr arolygon a thrafodaethau yn ystod yr ymweliadau.

- Cafodd argymhellion eu gwneud i ddangos gwybodaeth am amserau agor a manylion cyswllt y Practisau yn eu prif fynedfa, boed yn y drws ffrynt neu gatiau ffrynt y Feddygfa Gangen. Roedd yr argymhellion hyn hefyd yn cynnwys manylion cyswllt ar gyfer y Gwasanaeth y Tu allan i Oriau, a fyddai'n rhoi gwybodaeth i gleifion sy'n chwilio am gymorth yn gyflym a didrafferth.

- Mae sawl Practis yn ystyried ymgysylltu â chleifion i weld a fyddai sefydlu Grŵp Cyfranogiad Cleifion yn ymarferol.

- Dylai pob Practis ystyried gosod blwch awgrymiadau yn y dderbynfa, er mwyn i gleifion rannu eu barn/sylwadau gyda'r Feddygfa Gangen.

- Er mai braf oedd sylwi bod gan nifer fawr o Feddygfeydd Cangen ddigonedd o wybodaeth gyfredol oedd yn cynnig arweiniad i gleifion ar wasanaethau sydd ar gael yn y Practis a'r trydydd dosbarth, nodwyd nad pob un ohonynt oedd yn rhoi gwybodaeth glir am y broses gwyno o fewn eu Meddygfa Gangen ac felly cawsant eu hargymell i ddelio â'r mater hwn.

Hygyrchedd a Chymorth

Roedd 31 argymhelliad wedi'u cynnwys dan y pennawd hwn:

- Roedd sawl adroddiad yn argymell rhoi ystyriaeth i ddarparu dolenni clyw ar gyfer ymwelwyr neu gleifion â nam ar eu clyw/byddar sy'n mynychu'r Feddygfa.

- Cafwyd argymhelliad i ystyried y mater o briodoldeb rhywedd wrth ddefnyddio arwyddwyr ar gyfer cleifion â nam ar eu clyw.

- Ar ôl adolygu cyfleusterau'r toiledau ar gael yn y Meddygfeydd Cangen, gwnaed sawl argymhelliad i osod cortyn tynnu at ddefnydd cleifion mewn argyfwng.

- Cafodd argymhellion eu cynnwys mewn sawl adroddiad ymweliad ynghylch y diffyg amrywiaeth o seddau mewn ystafelloedd aros.

- Cafwyd argymhelliad i newid drysau mynediad i rai Meddygfeydd Cangen er budd defnyddwyr cadair olwyn/pram.

- Cafwyd argymhelliad i ystyried neilltuo lle parcio penodedig yn y maes parcio ar gyfer pobl ag anableddau.

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Amgylchedd

Cafwyd 8 argymhelliad dan y pennawd hwn:

- Nodwyd bod gofod dros ben mewn nifer fechan o Feddygfeydd Cangen a hwnnw ddim yn cael ei ddefnyddio ar hyn o bryd. Cafodd Practisau eu hargymell i geisio gwneud defnydd o'r lleoedd hyn er mwyn cynnig gwasanaethau ychwanegol er budd cleifion. Dylai'r BIP ystyried hyn hefyd.

- Gwaith addurno i'w wneud mewn rhai Meddygfeydd Cangen er mwyn gwneud y lle yn fwy pleserus i gleifion.

- Nododd Aelodau bod rhai Meddygfeydd Cangen yn cynnig cyfleusterau meddygol amrwd iawn. Rhoddwyd argymhellion i rai Practisau ystyried rhywfaint o waith adnewyddu fel y gellir cynnig gwasanaethau ychwanegol i gleifion.

Arall

Roedd 18 o argymhellion nad oedd yn bosibl eu priodoli i unrhyw un o'r themâu uchod ac mae'r pwyntiau allweddol wedi'u crynhoi isod i'w hystyried gan y BIP:

- Tynnwyd sylw'r Aelodau at anawsterau Practisau i sicrhau Gwasanaethau Tynnu Gwaed, a ddarperir gan Fwrdd Iechyd Caerdydd a'r Fro. Oherwydd problemau staffio o fewn y gwasanaeth hwn, cafodd sawl sesiwn ei ganslo. Felly, gorfodwyd Practisau i ganslo ac aildrefnu apwyntiadau oedd yn ddibynnol ar y gwasanaeth cymorth hanfodol hwn.

- Canfod beth oedd y meini prawf ar gyfer cyfeirio at wasanaethau podiatreg yn Ysbyty Dewi Sant.

- Dylid adolygu'r broses o gysylltu â chleifion i'w cyfeirio at wasanaethu Iechyd Meddwl am fod sawl Practis wedi nodi bod dryswch gyda'r trefniadau mynediad.

- Argymhellwyd darparu hyfforddiant i staff, o ran delio â chlaf sy'n dreisgar neu'n sarhaus i aelod o staff, a hefyd i Bractisau lle nad oes ond un person yn gweithio mewn Meddygfeydd Cangen.

7: Cynigion i'r Dyfodol

Fel y cyfeiriwyd trwy gydol yr adroddiad hwn, mae'r CIC wedi cynnal Ymweliadau Craffu i'r Meddygfeydd Cangen annibynnol hyn er mwyn llunio asesiad cychwynnol o'r ddarpariaeth gyfredol a'r profiad dilynol i gleifion. Yn ogystal â'r gweithgaredd craffu hwn, bu'r CIC hefyd yn ymchwilio i feysydd eraill am wybodaeth benodol yn ymwneud â Meddygfeydd Cangen, ond nodir nad oes dim wedi'i gasglu nac adrodd amdano ar lefel genedlaethol gan Lywodraeth Cymru. Mae'r CIC o'r farn felly y dylai Bwrdd Iechyd y Brifysgol a Llywodraeth Cymru, fel ei gilydd, ystyried casglu gwybodaeth am Feddygfeydd Cangen MT. Fel hyn, gellir monitro'r data a gyflwynir er mwyn sicrhau bod gwasanaethau cynaliadwy'n cael eu cynnig i gleifion.

Bydd y CIC yn mynd ati yn awr i adolygu canlyniadau cyflawn y gweithgaredd hwn gan gynnwys gwybodaeth am daflenni practis, canlyniadau'r arolwg, arsylliadau/sylwadau Aelodau, argymhellion a briffiau, ynghyd â'r wybodaeth gyfatebol a gasglwyd yn ystod rhaglen ymweliadau i'r Prif Bractisau 2011-2013.

Rhagwelir y bydd y gweithgaredd hwn yn arwain at y CIC yn llunio proses ymweld mwy effeithiol a fydd yn craffu ar sawl agwedd ar ddarpariaeth y Gwasanaeth Meddygol Cyffredinol.

Bydd y CIC yn anelu at gynnwys y canlynol:

10.1

1) <u>Barn Cleifion am yr Holistaidd</u>

Bydd arolwg newydd yn cael ei lunio i archwilio ymhellach y meysydd pryder/ diddordeb sydd eisoes yn bodoli, a hefyd i gynnig gogwydd holistaidd i'r modd mae practisau yn gweithredu/perfformio, ar draws pob safle sy'n darparu eu gwasanaethau.

2) <u>Darpariaeth Cangen</u>

Yn ogystal â chasglu barn cleifion ar arferion holistaidd practisau aml-safle, bwriad y CIC yw ymchwilio i'r cyswllt sydd ar waith rhwng y prif safleoedd a'r safleoedd cangen. Byddant yn asesu sut mae hyn, ochr yn ochr ag argaeledd apwyntiadau, yn dylanwadu ar foddhad a phrofiad.

3) <u>Cysylltiadau â Fferyllfeydd</u>

Mae fferyllfeydd yn cynnig gwasanaeth allweddol i gleifion, sy'n ychwanegol i wasanaethau Meddygon Teulu, ac maen nhw yn y sefyllfa orau i roi cyngor cychwynnol i gleifion cyn ceisio apwyntiad gan Feddyg Teulu. Am y rheswm hwn, mae'r CIC yn bwriadu canfod sut mae practisau cyffredinol yn crynhoi lefelau boddhad cleifion o ran trefniadau fferyllol arferol, megis adolygiadau ar

feddyginiaethau a phresgripsiynau a roddir yn rheolaidd, a sut mae 'dewis y claf' yn cael ei gefnogi o fewn y trefniadau hyn.

4) Gweithio mewn Clystyrau

Clwstwr yw grŵp o Feddygon Teulu sy'n cydweithio â gweithwyr proffesiynol eraill ym maes iechyd a gofal er mwyn cynllunio a darparu gwasanaethau yn lleol. Bydd y CIC yn edrych ar gyfranogiad practisau o fewn y trefniant grŵp hwn a sut mae hyn yn fanteisiol i gleifion.

5) Fframwaith Ansawdd a Chanlyniadau

Mae'r Fframwaith Ansawdd a Chanlyniadau (QOF) yn rhan o gontract y GMS ac mae'n gwobrwyo practisau am arfer clinigol safonol. Ar gyfer 2015-17, cytunodd Llywodraeth Cymru i gael gwared â nifer o ddangosyddion fel bod Meddygon Teulu yn gallu treulio mwy o amser yn gofalu am y cleifion sydd fwyaf agored i niwed ac sydd ag anghenion gofal cymhleth, yn enwedig yr henoed bregus. Bydd y CIC yn mynd ati i benderfynu a yw'r nod hwn wedi'i gyrraedd.

6) Cynaliadwyedd

Mae pryderon am gynaliadwyedd Practis Cyffredinol, yn enwedig yng Nghaerdydd gyda'r twf disgwyliedig mewn poblogaeth o ganlyniad i'r Cynllun Datblygu Lleol. Bydd y CIC yn ymgysylltu â chydweithwyr mewn Meddygaeth Gyffredinol i wneud yn siŵr bod y Bwrdd Iechyd yn gefnogol i agenda cynaliadwyedd.

10.1

Yn ardal Bro Morgannwg, mae cynnal meddygfeydd cangen yn yr ardaloedd gwledig hefyd yn fater hollbwysig a bydd y CIC yn dal i fonitro hygyrchedd a'r ddarpariaeth a gynigir mewn meddygfeydd cangen, er mwyn rhoi tawelwch meddwl i drigolion eu bod yn cael gofal meddygol teg yn eu hardal hwy.

Yn ogystal â'r uchod, bydd y CIC yn parhau i edrych ar amgylchedd a hygyrchedd y Practis, ymgysylltu â chleifion, a mynediad at apwyntiadau a'r ddarpariaeth.

8: Gwybodaeth Ategol

Bydd y dogfennau ategol y cyfeirir atynt yn yr adroddiad hwn, sy'n cynnwys adroddiadau unigol pob Practis, ymatebion a chanlyniadau arolygon, ar gael i'w gweld ar wefan CIC CaBM. Fel arall, os nad oes mynediad i ryngrwyd, gellir cael y dogfennau hyn ar gais o Swyddfa'r CIC. Mae'r manylion cyswllt yng nghefn yr adroddiad hwn.

Rhestr o Ddogfennau Ategol:

- Canlyniadau Asesiad Taflenni Practis a Dogfennau Gwybodaeth
- Protocol ar gyfer Ymweliadau Practis Cyffredinol a Meddygfeydd Cangen.
- Arolygon Boddhad Cleifion – Cymraeg a Saesneg.
- Cyfraddau ymateb i'r arolygon.
- Adroddiadau ar ymweliadau â phob Practis yn unigol, ymatebion a chanlyniadau cyflawn arolygon.
- Canlyniadau arolygon cyfunol ar gyfer Caerdydd a Bro Morgannwg.
- Cwestiynau Cyfarwyddiadau Ymweliadau gan Aelodau CIC.
- Crynodeb o argymhellion yr ymweliadau.

9: Casgliadau

Mae'r CIC wedi dod i'r casgliad bod Meddygfeydd Cangen yn profi anawsterau tebyg i'w cymheiriaid yn y prif feddygfeydd. Serch hynny y gred yw, am fod y canghennau oherwydd eu natur yn cynnal ardaloedd mwy gwledig, bod effaith y problemau hyn yn fwy arwyddocaol. Yn ogystal, mae nifer fechan o ardaloedd lle mae'r canlyniadau'n gwahaniaethu rhwng y prif bractis a'r gangen, ac mae'n bosibl y gallai'r ddau bractis wrth gydweithio â'i gilydd ddatrys unrhyw ddiffygion.

O ganlyniad i'r canfyddiadau hyn, yn ychwanegol at y cynigion i'r dyfodol y cyfeiriwyd atynt uchod, mae'n amlwg y dylai'r CIC ddatblygu model ymweld newydd sy'n cofleidio'r 'Practis Cyfan' er mwyn creu asesiad gwir o'r gwasanaethau a ddarperir. Credir hefyd y bydd yr agwedd eang hon yn galluogi'r CIC i gael gwell canfyddiad o foddhad cleifion gyda'r gwasanaethau a gynigir, mewn cyferbyniad i broses sy'n benodol ar safle ac sy'n llawn cyfyngiadau.

Yn wahanol i adroddiad y prif Bractisau ym mis Gorffennaf 2014, does dim cynllun gweithredu wedi'i lunio, gan fod y CIC yn bwriadu bwrw ati gyda'u camau nesaf arfaethedig ac felly maen nhw eisoes wedi cychwyn cynllunio gweithgareddau i'r perwyl hwn.

Caroline Harris
Swyddog Craffu (Gofal Sylfaenol)
CIC Caerdydd a Bro Morgannwg

Mai 2017

10.1

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www.communityhealthcouncils.org.uk/cardiffandvale

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APPROVAL OF NHS WALES POLICY MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)	
Name of Meeting: QSE Committee	**Date of Meeting**: 12th September 2017

Executive Lead: Director of Public Health
Author: Commissioning Officer, 02921 832101
Caring for People, Keeping People Well: This policy supports the sustainability of the Health Board in avoiding harm, waste and variation.
Financial impact:
Quality, Safety, Patient Experience impact: Clarification of the process for requesting individual funding for treatment.
Health and Care Standard Number: 3.1, 3.3, 3.5, 5.1, 7.
CRAF Reference Number: 2.1, 2.5, 3.1, 3.1.2, 4.3, 5.1, 5.1.5, 5.1.6, 5.3
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The implementation of the All Wales IPFR policy for requesting individual funding for treatment.

The Committee is asked to:

- **APPROVE** the UHBs adoption of the All-Wales IPFR Policy
- **SUPPORT** the full publication of the All-Wales IPFR Policy in accordance with the UHB Publication Scheme

11.1

SITUATION

This paper provides members with a summary of the key revisions to the All Wales Policy - Making decisions on Individual Patient Funding Requests (IPFR) 2016. Members are asked to approve the changes to the policy and support implementation of the policy.
This is an All Wales Policy and will be implemented to support decisions made by Cardiff and Vale IPFR Panel.

BACKGROUND

The NHS Wales IPFR policy is the mechanism used by all health boards across Wales and WHSSC to make a decision at an individual patient level to fund treatments not routinely available. This can include any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh

Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

Following the 2014 IPFR review and the implementation of its recommendations, Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport made an oral statement on the 26th September 2016 announcing a further independent review of the IPFR process.

The review group were asked to examine the evidence of good practice in Wales, the UK and other health systems in countries around the world, where comparable health system where in place. It was also asked to consider the advantages and disadvantages of retaining eight panels or moving to a smaller number, and make recommendations about what clinical criteria should be applied when determining eligibility and consider options for improving how decisions are communicated to patients.

Patients, their families and carers, health professionals and patient groups were invited to a number of workshops held in locations across Wales throughout November 2016. Individuals were also provided with the opportunity to express their views in writing. A total of 45 written contributions were received.

ASSESSMENT

The Independent Review Group made a total of 27 recommendations which are outlined in the report titled 'Independent Review of the Individual Patient Funding Request Process in Wales, January 2017'. These recommendations included changes to the All Wales IPFR policy and broader commissioning arrangements.

The Health Secretary, Vaughan Gething AM made an oral statement on the 21st March 2017 and said, "The report makes thoughtful and pragmatic recommendations that will help health boards deal with what are sensitive and very often complex decisions. Helpful recommendations to strengthen those aspects that are working well and improve upon other aspects of the process have been made".

The review group made recommendations to clarify when it is appropriate to use the IPFR process as well as recommendations to strengthen quality assurance. It concluded that the principle for making decisions at an individual patient level about access to treatment should be based upon the level of

expected clinical benefit and whether the treatment offers reasonable value for money. Given the costs and risks of changing the number of panels, and the review group's confidence that they have addressed the root cause of inconsistency, they did not recommend changing the number of panels.

The specific recommendations relating to All Wales the IPFR policy have been updated in the attached policy and are:

- **Replacing exceptionality** - The "exceptionality" principle is not well understood and has been applied in circumstances where it does not make sense. Whether the patient is given an intervention should depend on whether the patient will gain a significant clinical benefit from the intervention, and whether the intervention offers reasonable value for money. This is the fundamental change and the policy now reflects this.

- **Consistency of the IPFR process** - Many stakeholders had concerns about the consistency of the IPFR process. The review group encountered inconsistencies due to problems with commissioning and exceptionality and made recommendations to reduce those inconsistencies. A new national IPFR quality function is being created to monitor IPFR panels with a specific duty to report inconsistencies or any other concern through the NHS Wales quality process.

- **Improve Communication -** More can be done to improve communications between IPFR panels, clinicians and patients. A comprehensive process for communicating transparently the outcome of all IPFR decisions to the applying healthcare professional was recommended. New and improved training materials for clinicians and patients explaining in detail the IPFR process, how it is used and what to expect are being developed.

- **Outcomes –** The requirement for clinicians to provide outcome information for funded interventions is now clearly laid out in the policy. Cardiff and Vale has been routinely collecting outcome data for some time, so it is only the format that will be different as a result to the changes of the All Wales IPFR policy.

The IPFR team will ensure requests are dealt within in line with the updated NHS Wales IPFR policy for individual patient treatments, ensuring that IPFR Panel decisions are made based on the new criteria for significant clinical benefit and value for money.

The IPFR team will continue to work with the All Wales IPFR Policy Implementation Group to ensure communication mechanisms and training packages are updated and implemented as swiftly as possible.

The primary source for dissemination of this document within the UHB will be via the intranet. It will also be made available to the wider community and our partners via the UHB internet site.

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL June 2017
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales
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Welsh Health Specialised Services Committee (WHSSC)
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Author: Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR, Aneurin Bevan University Health Board

Development Group: All Wales IPFR Network

Consultation: Legal Advice from NHS Wales Shared Services Partnership – Legal and Risk Services, May 2017
NHS Wales Medical Directors
Clinical Networks
Patient Groups / Patient representatives
Stakeholder groups

Approved: Health Board IPFR Panel Chairs

Date of Publication: June 2017

Lead Health Board Contact: Contact details as per individual Health Board

Classification This document supersedes the previous IPFR policy document published in May 2016

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1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017. The recommendations made can be found at appendix 4.

11.1

1.2 Purpose of this Policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. In addition, the Welsh Health Specialised Services Committee (WHSSC), working on behalf of all the Health Boards in Wales, commissions a number of more specialist services at a national level. The use of the term 'Health Board' throughout this policy includes WHSSC unless specified otherwise. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.3 Each Health Board in Wales has a separate Policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because;

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG); and/or
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.4 The policy, called 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy on making decisions.

1.2.5 The challenge for all Health Boards is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board will have to make.

1.2.6 To ensure that we follow an open, transparent, fair, clearly understood and easily accessible process, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFR should not be confused with requests for packages of care for patients with complex healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.2 IPFR should also not be confused with treatments that have already been provided or administered. Requests **will not** be considered for retrospective funding.

1.3.3 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying;

i. why the patient is likely to gain a significant clinical benefit from the proposed intervention; and
ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.4 IPFR are defined as requests to a Health Board or WHSSC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories;

- a patient and NHS clinician have agreed together that they would like a treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments (for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition);

- a patient and NHS clinician have agreed together that they would like a treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone);

- a patient has a rare or specialist condition that falls within the service remit of the WHSSC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.5 The three categories of treatment will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have

substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained. In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE and AWMSG.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances this policy aims to establish a clear guide to making decisions on IPFR to determine whether evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable has been presented.

Please refer to the decision making guidance in section 6 to see how panel members determine the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 In accordance with their legal obligations, Local Health Boards must:

(a) Act within the terms of the statutory functions delegated to them by the Welsh Ministers under NHS legislation, in particular the NHS (Wales) Act 2006 and the secondary legislation that flows from that statute;
(b) be accountable to the Welsh Government for the decisions they make;
(c) meet the health needs of an individual free of charge, except where the legislation and/or regulations specifically permit charges;
(d) provide these comprehensive services within the resources delegated by the Welsh Government;
(e) operate within the governance structure created by the Welsh Government;
(f) act in accordance with the requirement to implement guidance published by the National Institute for Health and Care Excellence (NICE) and All Wales Medicines Strategy Group (AWMSG) within two months of the final guidance published.

(g) act in accordance with the requirements of the principles of Administrative Law and all legislation that may be enacted from time to time and which is relevant to the activities of the Health Board; and
(h) Comply with policies issued by Welsh Government such as Welsh Health Circulars.

2.2 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have taken into account all relevant issues in the decision making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive;
- when the issue is controversial and may not have the support of NICE or AWMSG;
- when life or death decisions are involved;
- when limiting access to specific services or treatments;
- when setting priorities;
- When other Health Boards may have used their discretion to make a different decision on a specific topic.

2.3 It is lawful for the Health Board to have policies about which treatments will, and which will not, be routinely funded. It is lawful for the Health Board to adopt an IPFR Policy for the exercise of its discretion and to allow for exceptions to it in specific clinical circumstances.

2.4 Decisions made by Health Boards may be subject to legal challenge in the High Court. Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to have to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 UNDERSTANDING LEGAL CHALLENGE

3.1 One of the grounds which a patient might include in any application they make to the court is the allegation that there has been interference in their rights in accordance with the Articles of the Human Rights Convention set out in the Human Rights Act 1998. The Act means that the Human Rights Convention is directly applied to the UK Courts and the Courts have to take account of the Convention and the decisions of the European Court in the interpretation of any legislation.

3.2 A public body is required to give reasons for its decisions. Since it is the decision making process which the courts may scrutinise, it is imperative that the process for Health Board decisions is transparent, that the patient is able to access and understand the process and to be aware of the reasons for any decision which has been made.

3.3 In addition, the Health Board should take into account that, in the light of the Human Rights Act, the concept of "proportionality" may come into play. The concept of proportionality means even if a particular policy or action which interferes with a Convention right is aimed at pursuing a legitimate aim (for example the prevention of crime) this will not justify the interference if the means used to achieve the aim are excessive in the circumstances. This involves striking a balance between the demands of the wider community and the need to protect an individual's fundamental rights. Any interference with a Convention right should be carefully designed to meet the objective in question and must not be arbitrary or unfair. Challenge may occur where the Health Board has balanced various interests and an individual alleges that the balancing was disproportionate to their rights. In this scenario, the Health Board would be called upon to explain why it considered the challenged action was necessary and suitable to reach the desired end and why the decision did not impose an excessive burden on the applicant. If an HB is not sure whether a particular approach would be proportionate, it should seek specialist legal advice before reaching a final decision.

3.4 Individuals have the right to bring an action alleging interference with their rights where decisions made by Health Boards may be shown to have contravened the individual Articles of the Human Rights Convention. Particularly, when life and death decisions are involved, the courts will submit the decision making processes of the Health Board to rigorous scrutiny. The more substantial the potential interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable.

3.5 Judicial Review is a process within administrative law which enables any individual to challenge the decision made by a public body. Greater levels of dissatisfaction may force some patients (who may be supported by a Registered Charity or Pressure Group) to seek redress for their complaints by way of Judicial Review.

3.6 The process of Judicial Review allows the Court to review decisions on the grounds that they are unlawful, irrational/unreasonable and/or procedurally unfair. The Courts will consider whether there has been an:

- error of law;
- excess exercise of powers/abuse of power;
- irrelevancy;
- irrationality;
- an unlawful limitation of discretion or fettering;
- improper delegation of decision making;
- procedural impropriety contrary to the rules of natural justice; and
- bias;
- Failure to follow its own policy.

Reviews have included decisions which unfairly discriminate between patients; 'blanket' policies not to treat particular conditions and decisions not to provide promised services.

3.7 The Court will want to consider whether the decision is beyond the range of responses open to a reasonable decision maker. They will examine the powers of the decision-maker, the requirements of the legislation and the

manner in which the decision was reached to determine if the decision-maker acted unlawfully.

3.8 In recent years, we have witnessed an increasing tendency for the Courts to use their powers to scrutinise the lawfulness of the decision making process of public bodies, including Health Boards. Previous examples include the Child B Case, challenges by transgender for the performance of cosmetic operations and a series of challenges by patients for funding for treatment with high cost cancer drugs not approved by NICE.

3.9 The Courts have shown an increased willingness to "second guess" decisions on expenditure/use of resources and substitute their own judgement for that of a public body, and even if the court does not go that far, it will scrutinise the way the decision has been reached to determine whether it is lawful. In a situation where the Courts consider that there has been a flaw in the decision making process, the Courts can declare the original decision was invalid and order a Health Board to make the decision again.

4 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

4.1 NHS Core Values are set out by the Welsh Government as;

- Putting quality and safety above all else: providing high value evidence based care for our patient's at all times;
- Integrating improvement into everyday working and eliminating harm, variation and waste;
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales;
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

4.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest needs first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do not harm;
- Reduce inappropriate variation using evidence based practices consistently and transparently.

4.3 Evidence-Based Considerations

4.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

4.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently. NICE issue Technology Appraisals and the All Wales Medicines Strategy Group issue guidance which Health Boards are required to follow.

4.3.3 Additionally, a central repository for evidence based appraisals will be available which will provide support for clinicians making an application. This will be located on the shared database. Users will be able to upload and access the information available which will develop over time as evidence /new reports are produced.

4.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

4.4 Ethical Considerations

4.4.1 Health Boards are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

4.4.2 Resources available for healthcare interventions are finite, so there is a limit to what LHB's can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

4.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect;
- minimising the harm that an illness or health condition could cause;
- fairness;
- working together;
- keeping things in proportion; and
- flexibility

4.5 Economic Considerations

4.5.1 It is a matter for the Health Board to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult balancing decisions have to be made. The Health Board has to prioritise the services that can be provided whilst delivering high quality, cost effective services that actively avoid ineffective, harmful or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e. the alternative uses to which resources could be put.

5 MAKING DECISIONS ON IPFR

5.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency;
- inclusiveness;
- accountability;
- reasonableness;
- effectiveness and efficiency;
- exercising duty of care;
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board has a clear and open mechanism for making decisions that are fair, open and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, given full consideration to the above factors, and has been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

5.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, the Health Board should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below;

- **evidence-based considerations** - clinical and cost effectiveness; service and policy implications;

- **economic considerations** - opportunity cost; resources available; and
- **ethical considerations** - population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Government's 'healthcare costs' website.

5.3 The following guide will be used by all Health Board IPFR Panels when making IPFR decisions.

It is the responsibility of the requesting clinician to demonstrate the clinical case for the individual patient, and of the IPFR panel to consider the wider implications for the NHS, such that the criteria in **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend not to use the intervention/drug; I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to the general population of patients for whom the recommendation is not to use the intervention, such that II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has not been appraised (e.g. in the case of medicines, by AWMSG or NICE); I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

11.1

6 DECISION MAKING GUIDE

IPFR Panel Decision-Making Factors	IPFR Panel Evidence for Consideration in Decision-Making
SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population? ***and*** Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Are there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be a comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? i.e. Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?
ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the costs for the treatment requested are there ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

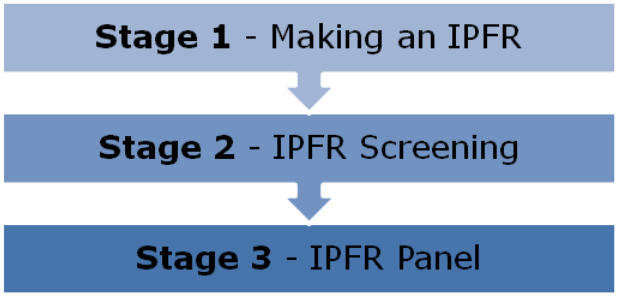
7 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

7.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These are available from the hospital consultant, GP surgery or via the Health Board website. Further information can be obtained from the IPFR Co-ordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Co-ordinator.

7.2 Summary of the IPFR Process



7.3 Stage 1 Making an IPFR

The patient and their NHS clinician (GP or local hospital consultant or out-of-area hospital consultant) agree together that a request should be made. The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provide to aid the decision making process.

11.1

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Co-ordinator in hard copy or electronically so that the authorised consent of the clinician is recorded.

Patients are able to access advocacy support at any stage during this process.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Co-ordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed and the requesting clinician notified accordingly.

7.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

(a) the request meets pre-agreed criteria for a service already commissioned/provided and can be automatically funded
(b) the request matches previous exceptions and precedent has been set
(c) an alternative and satisfactory clinical solution is found
(d) the request represents a service development which needs to be passed to the relevant Division or Director for their action.
(e) the request raises a policy issue where more detailed work is required

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

7.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Co-ordinator will ensure that the panel has all of the information needed to make a decision and will ensure that it is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the decision making criteria set out in this policy. The IPFR Co-ordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision. Where possible, they should set out their assessment of the likely incremental clinical benefit and their

broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

7.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise;

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of WHSSC – see Terms of Reference at Appendix 2).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director or Director of Planning.

Please refer to the Terms of Reference at Appendix 1 and 2 for details of the Health Board and WHSSC IPFR Panel.

7.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, taking into account the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours as per the application form.

7.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons is that it would make the process less fair, because it would draw to the attention of panel

members characteristics of the individual patient that should not influence their decision-making, such as age and gender. The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Community Health Councils are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

7.9 Holding IPFR Information

The IPFR Co-ordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file will also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

8 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, a review hearing can be requested in line with the following:

8.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period"). The letter from the Health Board that accompanies the original decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays and public holidays in Wales will not be counted.

8.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

8.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

The Health Board is committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluded relevant ones or gave unreasonable weight to particular factors.

Ground Three: *The Health Board has not exercised its powers correctly.*

The Health Board is a public body that carries out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board has acted outside its remit or has acted unlawfully in any other way.

Reviews which may require a significantly disproportionate resource relative to the health needs of the local population may be rejected at the Chief Executive's discretion.

8.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Co-ordinator of the Health Board within the review period. The review request form must include the following information;

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Co-ordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

8.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

8.6 What is the timescale for a review to be heard?

The review panel will endeavour to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

8.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 6 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)
- Chief Officer of the Community Health Council, or deputy
- Chair of the Local Medical Committee, or deputy
- WHSSC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavour to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

8.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

8.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be taken into account.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

8.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician.
The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to a further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

8.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

8.12 How will WHSSC undertake a review?

As the WHSSC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. WHSSC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A WHSSC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the WHSSC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

8.13 Nothing in this section shall limit or preclude an individual patient's right to bring Judicial Review proceedings if they are unhappy with a decision of the IPFR Panel.

11.1

9 REVIEW OF THIS POLICY

9.1 This Policy will be reviewed on an annual basis or as required to reflect changes in legislation or guidance.

9.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption to a treatment policy criteria has been agreed;
- new scientific evidence of effectiveness is published for all patients or sub-groups;
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect;
- evidence of increased cost effectiveness is produced;
- NHS treatment would be provided in all (or almost all) other parts of the UK;
- A National Service Framework recommends care.

10 MAKING A COMPLAINT

10.1 Making an IPFR does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

11.1

11 APPENDIX ONE

TERMS OF REFERENCE – IPFR PANEL (Health Board)

PURPOSE

To act as a Committee of the Health Board and hold delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support.

The Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy decisions for the Health Board. Any policy proposals arising from their considerations and decision will ultimately be reported to the Health Board Quality & Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director or Director of Planning. In Attendance: • IPFR Senior Officer • IPFR Co-ordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: At least once a month with additional meetings held as required and agreed with the Panel Chair.

Urgent Cases: It is recognised that provision must be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Co-ordinator will clerk the meetings to ensure proper record of the panel discussions and decisions are made. An electronic database of decisions will also be maintained.

12 APPENDIX TWO

TERMS OF REFERENCE – IPFR PANEL (WHSSC)

PURPOSE

To act as a Sub Committee of the Welsh Health Specialised Services Committee (the Joint Committee) and hold delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The Panel will act at all times in accordance with the all Wales IPFR Policy taking into account the appropriate funding policies agreed by WHSSC.

The Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support.

The Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel has delegated authority from the Joint Committee to consider requests and make decisions, limited to the purpose set out above. The IPFR Panel cannot make policy decisions for the Health Board. Any policy proposals arising from their considerations and decisions will be reported to the Management Group and/or Joint Committee for ratification. Financial authorisation is as follows: – The panel's authorisation limit is set at £300,000 for one-off packages and £1million for lifetime packages – Any decisions resulting in a financial cost in excess of these limits must be reported to the Director of Specialised and Tertiary Services and the relevant Health Board for authorisation	• Independent Chair (who will be from existing members of the NHS organisations Boards) • Two Lay representatives • Nomination at Director level from each of the LHBs A named representative from each of the seven Health Boards who should be a Director or Deputy/Assistant Director, or named deputies of appropriate seniority and experience who can operate in the capacity of the primary representative. The intention will be to secure an appropriate balance of processional disciplines to secure an informed multi-disciplinary decision. A further two panel members may be appointed at the discretion of the Chair of the panel, for example a member of the Ethics Committee or a Senior Pharmacist. These members should come from outside the 7 Health Boards and one of which would be nominated as the Vice Chair. The Chair of the panel will review the membership as necessary. In attendance from WHSSC • Medical Director or Deputy • Director of Nursing or Deputy • IPFR Co-ordinator • Finance Advisor (if required) • Other WHSSC staff as and when required.

PROCEDURAL ARRANGEMENTS

Quorum: The Chair or Vice-Chair and representation from five of the seven Health Boards, three of which must be clinical representatives.

Meetings: At least once a month with additional meetings held as required and agreed with the Panel Chair. Video conferencing facilities will be available for all meetings.

WHSSC will be responsible for organising the WHSSC Panel and will provide members with all relevant documentation.

Urgent Cases: It is recognised that provision must be made for occasions where decisions may need to be made urgently.

Where possible, a "virtual panel" will be held to consider urgent cases. If this is not possible due to the urgency of the request, then the Director of Specialised and Tertiary Services together with the WHSSC Medical Director or Director of Nursing and the Chair of the WHSSC Panel (or Vice Chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

WHSSC will provide an update of any urgent decisions to the subsequent meeting of the Panel.

Recording: The WHSSC IPFR Co-ordinator will clerk the meetings to ensure proper records of the panel discussions and decisions are made. An electronic database of decisions will also be maintained.

13 APPENDIX THREE

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

To act as a Committee of the Health Board and hold delegated Health Board authority to review (in line with the review process outlined in this policy) the decision making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Chief Officer, Community Health Council or deputy • Chairman, Local Medical Committee or deputy • WHSSC Representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • WHSSC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made. An electronic database of decisions will also be maintained.

See detail under section 8.12 of the policy on how WHSSC will undertake a review.

14 APPENDIX FOUR

INDEPENDENT REVIEW OF THE IPFR PROCESS IN WALES, January 2017 – LIST OF RECOMMENDATIONS

Recommendation 1
The 2007 ethical framework for commissioning healthcare in Wales should be updated in light of best practice, so that it is useful in making (and explaining) commissioning decisions.

Recommendation 2
Good commissioning practice should be shared between LHBs and WHSSC. A database of commissioning policies should be established, covering all interventions and used by WHSSC and LHBs to record their commissioning policies.

Recommendation 3
LHBs together with WHSSC should set up commissioning liaison meetings to coordinate their "out of area" and "out of county" services.

Recommendation 4
Ways to access interventions – commissioning and other pathways including IPFR – need to be explained more clearly to clinicians and patients. A guidebook should be developed that explains the entire process clearly and simply.

Recommendation 5
A clear and consistent national process for dealing with requests to access services outside LHBs local arrangements (including those of WHSSC) should be developed and communicated. The forms to request services that are routinely commissioned should be short and simple and consistent nationally.

Recommendation 6
The IPFR process should not be used to request services that are routinely commissioned. Different types of requests for interventions should be clearly and consistently differentiated. Information should be provided that helps clinicians to understand the distinction and the different criteria that apply.

Recommendation 7
It should be clearer to patients why they are not routinely allowed to choose their place of treatment and in which circumstances interventions are commissioned outside patients own LHB.

Recommendation 8
The services commissioned by WHSSC should be set out more clearly and accessibly. WHSSC should also explain what services it decides not to commission and why. It needs to be clear whether WHSSC is making an explicit decision that the service should not be provided or whether the LHBs have chosen not to delegate commissioning responsibility to WHSSC.

Recommendation 9
WHSSC and LHB's should review all their policies that refer to IPFRs and ensure that the policies taken together are up to date, consistent and coherent.

Recommendation 10
LHBs should set up a consistent national policy on the use of inexpensive interventions and introduce a consistent framework within which such decisions should be made, for example, either by making them available on request by clinicians or after suitable LHB approval (e.g. by a Multi-Disciplinary Team (MDT) or head of department).

Recommendation 11
The existing decision-making criteria based on "exceptionality" should be replaced substantially and in line with the proposed decision making criteria and the explanatory notes set out in this report.

Recommendation 12
So that the best evidence is available for future decisions, where possible, clinical outcomes from the IPFR decisions should continue to be tracked and recorded so that the effectiveness of decisions can be assessed over time.

Recommendation 13
The public should be reassured that affordability is not part of the decision criteria for individual patients.

Recommendation 14
Availability of interventions should not generally be part of the decision criteria for individual patients.

Recommendation 15
IPFR panel should record in their decisions a descriptor of their broad estimate of the likely incremental clinical benefit and the broad estimate of the likely incremental cost so their judgements on value for money are clear and transparent.

Recommendation 16
We recommend that non-clinical factors continue not to be taken into account in making intervention decisions.

Recommendation 17
IPFR panels should document the reasons for their decision clearly and in sufficient detail to enable the applying clinician to understand the reasoning and to check that the panel took into account all the relevant factors.

Recommendation 18
IPFR panel should continue to consider actively whether the panel has adequate advice and expertise on which to base its decision for each patient. When considering IPFR applications for specialist conditions, IPFR panels should ensure that they have the best available evidence on which to base their decision. Where necessary, panels should seek the advice of specialists, specialist groups or networks.

Recommendation 19
A national IPFR quality function should be established to support the IPFR panels to ensure quality and consistency. This quality function will provide quality assurance around the decision-making of panels and will promote consistency across Wales. It will include facilitation, advice, training and auditing of the IPFR process, and will have an obligation to report on the quality of the processes and to highlight any concerns through the existing quality and clinical governance processes in NHS Wales.

Recommendation 20
The current configuration of panels should continue.

Recommendation 21
It is vital that all pharmaceutical companies submit their medicines to AWMSG (if they are not already on the NICE work programme) as soon as possible after licensing to obtain a timely, fair and transparent appraisal of the medicines benefit to patients for the particular indication and to reduce the need for IPFR requests for individual patients.

Recommendation 22
Where AWMSG has issued a 'Statement of Advice' notice not endorsing the use of a medicine in NHS Wales, IPFR panels should approve requests for use of that medicine only if they are confident that there is clear evidence of likely clinical benefit to the particular patient which is sufficient to justify the cost of the medicine and associated treatment.

Recommendation 23
The IPFR quality function should create new or improved training materials (including a manual) for clinicians and separately for patients explaining in detail the IPFR process, how it is used, and what to expect.

Recommendation 24
Clinicians should enable patients to make informed decisions. Clinicians should enable their patients to understand all their treatment options and alternatives, the risks and benefits of those options and the likelihood of those risks and benefits, before seeking an IPFR on their behalf.

Recommendation 25
Clinicians should not make an IPFR application for interventions that have little or no realistic chance of clinical benefit solely in response to a patient request.

Recommendation 26
Clinicians should be supported (by training and advice) to understand the assessment process that the panel will follow for a specific request, so that the clinician can better assess the likelihood of an application's success before it is submitted.

Recommendation 27
The IPFR quality function, working with the IPFR coordinator network, should review the design of the forms in light of this report and make further improvements to streamline and simplify the process and to make it easier and quicker for clinicians to apply.

Equality & Health Impact Assessment for

NHS WALES POLICY MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR) Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Public Health Melanie Wilkey 02921 832100 Elinor Hammond 02921 832101
3.	Objectives of strategy/ policy/ plan/ procedure/ service	As stated in the individual policies
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment	• The procedure operates within the principles of the: • Cardiff and Vale University Health Board's 2015- 2025 ten year strategy, • 'Shaping Our Future Wellbeing', • 2010 Equality Act,

	• 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 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].	• Human Rights Act 1998, • Welsh Language Act 1993 and Welsh Language (Wales) Measure 2011, • Related policies such as Interventions Not Normally Undertaken, Top-Up Policy and European Economic Area funding. • Related UHB policies such as flexible working and Dignity at Work policies. • R v North West Lancashire Health Authority Ex Parte A(2000)1WLR 977CA NHS (Wales) Act 2006 • Colin Ross v West Sussex Primary Care Trust 2008 EWHC 2252 (admin) Health Commission Wales: A Review (2008), Professor Sir Mansel Aylward • Priority Setting: Managing Individual Funding Requests (2008), NHS Confederation Routledge Report 2009 • Improving the Availability of Medicines for Patients in Wales: Report of the Routledge Report Implementation Group 2011 R (on the Application of AC) v Berkshire West Primary Care Trust [2011] EWCA Civ 247. • Oxfordshire PCT Equality Impact Assessment on Individual Funding Request Policy (March 2011) During the review of IPFR and development of the policy views were sought from patients, carers, relatives, patient representatives, health charities, lobbying groups, clinicians, healthcare professionals, IPFR panel members in local health boards (LHBs) and the Welsh Health Specialised Services Committee (WHSSC), Assembly Members

		(drawing from their constituency correspondence), political parties and pharmaceutical industry representatives. The review group held a total of ten face-to-face engagement sessions in Wrexham, Aberystwyth and Cardiff during November 2016. In each location, there was a session specifically for patients, patient organisations, and healthcare professionals, as well as one in Cardiff for the pharmaceutical industry. The review group considered the published documents outlining the approach taken to IPFRs in England, Scotland and Northern Ireland. And looked at statistics on IPFRs in Wales and, where available, the equivalent processes elsewhere.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Clinicians submitting an IPFR request and their patients for whom the request is for, who are residents of the UHB will be affected by the Policy.

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	The IPFR application form requires patients to disclose their date of birth. This is collected to help:- • Establish the legal status of the patient and the need for an appropriate adult (parent or guardian) to act as an advocate on behalf of the patient. • To help locate the patient's hospital or general practice records as appropriate when required. The panel provides clinical	N/A	N/A

11.1

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
	based decision making and therefore social factors such as age, gender, etc. are redacted prior to review at the IPFR panel. Protected characteristics are not provided to the IPFR Panel for review and consideration therefore, this information is not taken into account during the decision making process. Since 2011 and April 2017 the UHB has received 390 applications under the procedure. The age of applicants has been:- • under 18 = 25 • between 18 and 65 = 275 • over 65 = 90		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	The Office of National Statistics, 2011 Census, Population and Household Estimates for Wales, states the median age of the population in Wales was 40 years for men and 42 years for women.		
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	The Policy would be made accessible to staff in alternative formats on request or via usual good management practice. The IPFR application form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the treatment	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	being sought in the IPFR request. Therefore this data is not routinely collected and cannot be measured.		
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	IPFRs referrals from clinicians of any gender, for patients of any gender are dealt with in the same way. All protected patient characteristics, including gender are redacted in the information provided to the IPFR Panel for review and consideration, therefore this information is not taken into account during the decision making process. However, where there is evidence that capacity to benefit from a treatment is related to gender, this may	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	affect the decision of the IPFR Panel. The IPFR application form requires patients to disclose their gender. Since 2011 to April 2017 Cardiff & Vale UHB has received 390 applications of which 41% (n=157) were in respect of male patients and 59% (n=233) were in respect of female patients. The Office of National Statistics, 2011 Census, Population and Household Estimates for Wales states there were 1.50 million men and 1.56 million women in Wales. The IPFR application form does not routinely require patients to disclose		

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
	information relating to gender reassignment. It is at the referrers discretion to disclose this information if it is relevant to the treatment being sought in the IPFR request. It has been noted that NHS England were legally challenged in the case of AC v Berkshire West PCT [2010] EWHC. The challenge itself related to the evidence for 'exceptional significance' for the IPFR commissioning decision rather than the collection or discrimination of the protected characteristic.		
6.4 People who are married or who have a civil partner.	The IPFR application form does not require patients to disclose their marriage or civil partnership status. Therefore this data is not collected and	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	cannot be measured.		
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.	The IPFR application form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the eligibility or treatment being sought in the IPFR request. Therefore this data is not routinely collected and cannot be measured.	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on patients regarding race, nationality, colour, culture or ethnic origin. The IPFR application form does not require patients to disclose this information. Therefore this data is not		

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
	collected and cannot be measured.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The IPFR application form does not require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the eligibility or treatment being sought in the IPFR request. Therefore this data is not collected and cannot be measured.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The IPFR application form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.		
6.9 People who communicate using the	The All Wales procedure, claim forms, website		

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
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	information and patient leaflets will all be made available in Welsh. Patients have the discretion to apply through the medium of the Welsh language in line with the UHB's Welsh language policy. Receipt of applications in the Welsh language will be measured accordingly.		
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	The IPFR application form does not require patients to disclose this information. Therefore this data is not collected and cannot be measured.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic	The IPFR application form requests the patient's address on the application	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
and/or health indicators, people unable to access services and facilities	form to ensure that the patient is a Cardiff and Vale resident and to allow for communication regarding requests. All protected patient characteristics, including address are redacted in the information provided to the IPFR Panel for review and consideration, therefore this information is not taken into account during the decision making process.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy. All patient identifiable information is redacted from		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	the request prior to being presented at the IPFR panel and is therefore not taken into account.		

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
health inequalities Well-being Goal - A more equal Wales			
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	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		
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	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
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			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity;	The All Wales IPFR policy enables the decision making process for patient funding requests and as such this is not applicable to this policy.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
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 part of the decision making process, the IPFR panel consider ethics of funding requests e.g. whether the allocation of funds for high cost drugs is a fair and equitable allocation of resource for a single patient.		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this All Wales IPFR Policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All non-clinical information will be redacted from the information provided to the IPFR panel during the decision making process.	IPFR Commissioning Officer	Ongoing	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identifi it it is unnecessary to undertake a more detailed assessme and formal consultation is not required.	N/A	N/A	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or servi 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	The Policy remains unchanged. It is due to consideration by the QSE Committee. When an IPFR policy is developed or reviewed, this EHIA will form part of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

APPROVAL OF POINT OF CARE TESTING (POCT) POLICY
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead : Medical Director
Author : POCT Head of Department Tel 02920 748332
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 : The procedure outlines detailed assessments required by the individual Clinical Directorates and they will include financial assessments**.**
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 3.1, 5.1, 2.9, 2.1, 3.4, 3.5 apply
CRAF Reference Number 5.1 applies
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

The POCT Policy and Procedures describes the governance and management procedures to minimize risk and assure that any POCT undertaken in the UHB is safe and clinically effective.

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Point of Care Testing Policy and Procedure

and

- **APPROVE** the full publication of the Point of Care Testing Policy and Procedure in accordance with the UHB Publication Scheme.

11.2

SITUATION

The POCT Policy and procedures supports the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
POCT is often more expensive than conventional laboratory testing, however, there is good evidence that optimization of pathways using well designed use of POCT can be both clinically effective and cost efficient. POCT is used in situations where the immediacy of the results can aid the clinical decision making and patient flow; it can facilitate early intervention reducing the risk of complications, reduce length of stay and ultimately reduce overall costs to the organisation. It can also help to improve the patient experience; with

convenient and local access to diagnostics, along with improve acceptability and motivation to manage long term conditions. As the focus shifts to managing patients in a primary care/ community-based setting, POCT will inevitably become more integral to both the needs of patients and clinicians. The Policy facilitates the requirement for shared decision making by adoption of POCT connectivity to the Wales Clinical Portal.

However, POCT is usually carried out in a busy environment with little or no 'thinking-time' before a change in patient management is instigated. Adequate checks and balances must therefore be in place to prevent medical errors and reduce risks. It is important, therefore, to ensure that POCT introduction in the pathway is well designed , evidence based, that the right equipment is used in the right clinical setting, it is managed appropriately and that its effectiveness in the clinical pathway is reviewed.

The POCT Policy and Procedures describes the governance and management procedures to minimize risk and assure that any POCT undertaken in the UHB is safe and clinically effective.

This is it a decision reserved for the Committee in accordance with the Written Control Documents Development and Approval Procedure

BACKGROUND

The Policy and Procedures is a revision of the Point of Care testing Policy (UHB062) March 2013. The revised documents takes into account more recent guidance from Welsh Government on the management of POCT. The Policy and procedures will ensure take The Health Board complies with the recent guidelines on POCT: the Welsh Government Policy on the Management of Point of Care Testing: What, when and how? (WSAC) 2017 and the relevant clauses relating to POCT (*Standard 3.1, 5.1, 2.9, 2.1, 3.4, 3.5*), Health and Care Standards for Wales, 2015.

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 03/08/2017 and 31/08/2017;
- The document was shared with the POCT Group and Bro Taf LMC.
- Comments were invited via individual e-mails from:
  Deputy Executive Nurse Director
  Clinical Director Clinical Governance
  Senior nurse Standards and professional regulation
  Senior Nurse for nurse education
  Patient safety manager

Chair, Medical equipment group
Laboratory Medicine Quality manager
Laboratory Director Medical Biochemistry and Immunology
Assistant Director IM& T.
Equality manager

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

The primary source for dissemination of the POCT Policy and procedures within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Compliance will be monitored by the POCT Group.

Reference Number: UHB 062 **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number: UHB71**

POINT-OF-CARE TESTING (POCT) POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently we will have an evidence based, consistent approach in the use and management of Point of Care Testing (POCT).

The Health Board will comply with the relevant guidelines on POCT: the Welsh Government Policy on the Management of Point of Care Testing: What, when and how? (WSAC) 2017 and the relevant clauses relating to POCT (*Standard 3.1, 5.1, 2.9, 2.1, 3.4, 3.5*), Health and Care Standards for Wales, 2015.

Policy Commitment

POCT is usually carried out in a busy environment with little or no 'thinking-time' before a change in patient management is instigated. Adequate checks and balances must therefore be in place to prevent medical errors and reduce risks. In considering the medico-legal status, under clinical governance and controls assurance directives and standards, NHS organisations are subject to both legal and statutory requirements relating to the "Duty of Care." This requires the UHB to ensure that staff and patients do not suffer any unreasonable harm or loss; that staff are competent, that the organisation provides safe working practices and that equipment, facilities and environmental conditions are safe. The UHB has a legal obligation under the Health and Safety at Work etc Act 1974 and under various regulations to provide training to its employees in the use of work equipment in cases where lack of training will increase the risk of harm to employees or other persons including patients. The Health and Safety Executive has stated that it would expect to be able to see evidence of the effectiveness of training, hence the need for training to be assessed and recorded.

We are committed to ensuring that there are appropriate arrangements in place to provide guidance on the selection and procurement of devices, that all staff undertaking POCT are trained and competent, that quality assurance procedures are in place and that there are systems in place to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.

- POCT devices must only be purchased after a case for clinical need and a detailed implementation plan has been approved by the POCT Group.

- The POCT Team will take responsibility for providing advice on the purchase of devices, training, maintaining and monitoring the quality of these services. Clinical Directors have a responsibility to ensure that there is a clinical requirement for POCT and the integration of POCT devices into care pathways is clinically effective. They

must also ensure that the infrastructure and working environment is appropriate to undertake diagnostic testing and that operators have the necessary skills and competence to undertake these tasks.

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- There must be close liaison between Directorates undertaking POCT and the POCT team on all issues relating to POCT. An agreement which satisfies the site requirement and defines the Directorate, Operator and POCT team obligations, is mandatory. This must be incorporated into a Service Level Agreement (SLA
- All staff who use POCT devices must complete the UHB approved training and competence assessment and have obtained a valid certificate of competence for that device before carrying out tests on patients.
- Where possible POCT devices that allow connectivity to the All Wales POCT Information System must be used.
- POCT which fails to meet the requirements of this policy will be suspended by the UHB until compliance can be demonstrated.

Supporting Procedures and Written Control Documents

This Policy and the supporting document Management of Point of care procedure describe the process in regards to Point of Care testing.

Other supporting documents are:

Legislation and guidance

1. Welsh Government, WHC (2017) 034 Policy on the Management of Point of Care Testing (POCT) : What, When and How? http://gov.wales/topics/health/nhswales/circulars/performance-delivery/?lang=en
2. Management and use of IVD point of care test devices - DB2010(02). MHRA http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON071082
3. Health and Care Standards for Wales, Welsh Assembly Government, Apr 2015. http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf
4. BS EN ISO 22870:2006 Point of Care Testing (POCT) – Requirement for quality and competence Available from BSI: http://www.bsigroup.co.uk
5. The Management of Health & Safety at Work Regulations 1999.
6. The Provision and Use of Work Equipment Regulations 1998.
7. The Workplace (Health, Safety and Welfare) Regulations 1992.
8. The Medical Devices Directive 93/42/EEC June 1993.
9. NCCLS Point-of-Care Connectivity; Approved Standard. NCCLS document POCT1-A (ISBN 1-56238-450-3). NCCLS, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania 19087-1898, USA 2001

References

1. Point of Care Testing: Needs opportunity and Innovation, 3rd Ed, Edited by C. P. Price, A. St. John and L.L Kricka.
2. Internal Quality Control in Point of Care Testing: Where's the Evidence?; J. Holt, D. Freedman ; Annals of Clinical Biochem 2015, Vol. 52(5)

Scope

This policy applies to all healthcare staff employed or contracted by the UHB to undertake diagnostic testing on patients. This includes those on honorary contracts, students working within the UHB, persons employed by Cardiff University, Public Health Wales, and independent contractors commissioned by the UHB to undertake testing.
The Policy also applies to primary care services such as - community dental services, community nursing services, family planning clinics and GP out of hours services.

GP contractors are not mandated to follow this policy as they are ultimately responsible for developing their own governance processes, policies and procedures for the quality and safety of POCT. However, it provides a framework for good practice with particular relevance to quality assurance and training, complementing existing guidance WHC (2017) 034, relevant within that setting.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. Key actions have been identified and incorporated within this policy and procedure.
Policy Approved by	Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Point of Care Testing Group
Accountable Executive or Clinical Board Director	Medical Director

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
2	Date approved by Board/Committee/Sub Committee	TBA *[To be*	*Revised document – Policy split into separate Policy and Procedure documents.* *1. Reviewed in line with* WHC (2017)

11.2

	dd/mm/yyyy	*inserted by the Gov. Dept]*	034 *POCT* 2. *Reviewed in line with Policy and Health and Care Standards 2015.*

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Management of Point of Care Testing (POCT) Procedure

Introduction and Aim

This document supports the Point of Care Testing Policy. This procedure describes how the Policy will be implemented across the Health Board

Objectives

.1 The procedure seeks to ensure that all patients subjected to POCT receive a high standard of care, and there is minimum risk to patients from inappropriate and misuse of POCT.

.2 The procedure seeks to ensure that all areas performing POCT:

- comply with all appropriate national standards
- follow evidence based best practice in all aspects of the procedures undertaken
- adhere to uniform standards across all UHB sites, reducing inappropriate variation
- ensure that all staff are trained and can demonstrate competence
- apply the principles of quality assurance and continuous improvement
- maintain high quality records of all results and procedures
- ensure the effective, collection, sharing and reporting of high quality data within a sound information governance framework
- demonstrate compliance with the policy

Scope

This procedure applies to all healthcare staff employed or contracted by the UHB to undertake diagnostic testing on patients. This includes those on honorary contracts, students working within the UHB, persons employed by Cardiff University, Public Health Wales, and independent contractors commissioned by the UHB to undertake testing .

The procedure also applies to primary care services such as - community dental services, community nursing services, family planning clinics and GP out of hours services.

GP contractors are not mandated to follow this policy as they are ultimately responsible for developing their own governance processes, policies and procedures for the quality and safety of POCT. However, it provides a framework for good practice with particular relevance to quality assurance and training, complementing existing guidance, WHC (2017) 034 relevant within that setting.

Equality and Health	*An Equality and Health Impact Assessment (EHIA) has been*

11.2

Document Title Point of care testing procedure	2 of 32	Approval Date: dd mmm yyyy
Reference Number: UHB		Next Review Date: dd mmm 2020
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By:		

Impact Assessment	*completed and this found there to be a no negative impact.*
Documents to read alongside this Procedure	Point of Care testing Policy Welsh Government, WHC (2017) 034 Policy on the Management of Point of Care Testing (POCT) : What, When and How? http://gov.wales/topics/health/nhswales/circulars/performance-delivery/?lang=en
Approved by	*Point of Care Testing Group* Quality Safety and Experience Committee

Accountable Executive or Clinical Board Director	*Medical Director*
Author(s)	*POCT Head of Department*

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
	Date of Committee or Group Approval	*TBA*	*New document – previous Policy* **UHB71** *has been split into separate Policy and Procedure documents*
			Main changes to UHB 71 1. *Reviewed in line with* WHC (2017) 034 *POCT Policy and Health and Care Standards 2015.* 2. *Section on information management added.* 3. *Amended training and competency assessment procedures.* 4. *Amended section on responsibility* 5. *Added information on WPOCT* 6. *Amended all Appendices* 7. *Added Estates , IM& T pre-installation checklist.*

11.2

Document Title: Point of care testing procedure	3 of 32	Approval Date: dd mmm yyyy
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1 INTRODUCTION

The Point of Care Testing (POCT) Policy and Procedure for Cardiff and Vale University Health Board is intended to promote evidence based practice and reduce the risk to patients from clinical errors in the use of these devices. An example of the devices is provided in Section 3 of this Procedure.

This procedure conforms to the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance: Management and Use of IVD Point of Care Test Devices**,** the Welsh Government Policy and procedure on the Management of Point of Care Testing: What, when and how? WHC (2017) 034 and the relevant clauses (*Standard 3.1, 5.1, 2.9, 2.1, 3.4, 3.5*), Health and Care Standards for Wales, 2015.

2 DEFINITIONS

POCT is defined as any diagnostic test undertaken by staff other than a laboratory healthcare scientist, which can include health care support workers, nurses, paramedics, pharmacists, podiatrists, dieticians, dentists and medical staff. This is usually carried out near the patient, and can be in the home, a clinic, in general practice, screening venue, at the hospital, or during transit.

In this document, the term “operator” refers to any Healthcare Professional undertaking a POCT procedure.

3 SCOPE OF DEVICES

The policy and procedure applies to all new and existing equipment used within the UHB irrespective of ownership.

Examples of devices include:
Blood glucose and ketone devices, Urinalysis test strips and devices , Pregnancy test kits and devices, Coagulation analysers, Blood gas and co-oximetry analysers, $HbA_{1C,}$ analysers, Haemoglobin and Haematology analysers, Pre-term labour marker analysers, D Dimer devices, Bilirubin analysers, CRP devices, Creatinine devices, Lactate devices, Rapid test kits for infectious disease markers, Procalcitonin analysers, electrolyte analysers, lipid analysers, drugs of abuse kits and devices, alcohol meters, cardiac marker analysers and BNP analysers.

This is not an exhaustive list.

4 ROLES AND RESPONSIBILITIES

4.1 POINT OF CARE TESTING GROUP

The POCT Group is responsible to the governing body of the organization and has responsibility for defining the scope of POCT, taking into consideration the clinical need for POCT, its financial implications, technical feasibility, and in ensuring that appropriate measures are in place to monitor the quality and clinical effectiveness of POCT.

4.2.1 Terms of Reference

The terms of reference will comply with National guidelines on POCT including, WHC (2017) 034, MHRA and ISO 22870.
Patient safety, clinical effectiveness and cost efficiency will be used as the guiding principal for the acquisition of devices.
The Group has the authority to require POCT activity to meet standards and take sanctions (including suspension or withdrawal of service), and the Chairperson has the authority to take executive action if necessary.

The Group will:

- Agree specification for proposed acquisition of POCT devices and their integration into care pathways (clinical effectiveness)
- Evaluate effectiveness of training (patient safety)
- Evaluate effectiveness of Quality Assurance Programme (patient safety)
- Have responsibility for harmonisation of equipment throughout the organization
- Have responsibility for approval of business cases for introduction of POCT devices (cost efficiency)
- Have responsibility for ensuring compliance with the organisational policy and procedure on the management of POCT
- Have responsibility for ensuring compliance with Healthcare Standards in relation to POCT
- Provide an annual report and a summary for the lead executive Director
- Along with the POCT Team work closely with clinical boards to determine how best to move forward with existing legacy devices and to implement new POCT within available resource limits.

The POCT Group is chaired by the Medical Director or his appointee and consists of core membership from clinical users, the POCT Team, Clinical Directors, representation from the Executive Nursing Director, and the Quality and Safety Department. Representatives from other Departments will be co-opted as and when required as detailed in Appendix B. The Group meets 4 times a year.

4.2 RESPONSIBILITY OF THE POCT TEAM

The UHB has a dedicated team of POCT professionals who can provide advice on how to implement and manage the POCT service.

The POCT team are responsible for:

- Providing advice on all aspects of POCT, including the selection and purchase of POCT devices, the suitability of devices, advice on connectivity requirement, infrastructure requirements and environmental factors.
- Evaluation of POCT devices in terms of trueness, precision, detection limits, interferences, ease of use and robustness to ensure that the device is appropriate for its intended clinical use, the results are compatible with the laboratory method (if indicated) and data integrity and security is maintained.
- Assisting in the completion of the proforma case for POCT.
- Organising and delivering appropriate training. For devices that are connected to all Wales POCT information Management System (WPOCT) a training register is held centrally by the POCT Team. The POCT team will monitor and inform the Clinical Director / Lead Nurse of any lapsed training.
- Developing and monitoring ongoing competency and re-validation of staff undertaking POCT.
- Managing the quality assurance (QA) process including monitoring internal quality control (IQC), registration, distribution and monitoring of external quality assessment (EQA) and audit of the service. See section 7
- Assisting in clinical incidence investigations.
- Monitoring, evaluating and auditing the clinical effectiveness of the service to the respective Clinical Boards including activity
- Reporting to the organization's Point of Care Testing Group.
- Escalating any clinical incidence issues, QA issues or concerns to the Clinical Director / Lead nurse.

4.3 RESPONSIBILITY OF THE CLINICAL BOARDS

4.2.2 Clinical Director (for the Directorate undertaking POCT)

The Clinical Director has a responsibility to:

- Ensure that there is a clinical requirement for POCT and the integration of POCT devices into care pathways is clinically effective. The Clinical Director will have ultimate responsibility for the patient result.
- Complete and ensure that the proforma case for POCT is authorised by the POCT Group before a POCT service is introduced.
- Identify arrangements for back-up services with the Pathology Laboratory (if appropriate) before a POCT service is introduced.
- Address any poor performance and non-compliance issues or failure to comply with the POCT Policy and Procedure.
- Report and investigate clinical incidences, with regards to POCT.
- Monitor clinical effectiveness.

- Ensure that staff have access to training.
- Ensure that IQC checks are carried out on the devices as advised.
- Ensure that EQA checks are carried out on the devices as advised and address any poor performance issues.
- Ensure awareness of regulations with regards to EQA poor performance
- Ensure that all operators have undertaken a training course approved by the POCT Team. A training register of staff authorised to perform POCT should be maintained by each Directorate. For devices that are connected to WPOCT the training register is held centrally and therefore there is no requirement to hold a local register.
- Ensure that all the operators have the necessary skills and competence to undertake these tasks.
- Ensure that the infrastructure and working environment is appropriate to undertake diagnostic testing.

4.2.3 POCT Operator

Operators must ensure that:

- They do not undertake POCT unless trained and signed off as competent
- Their training is kept up to date. For most devices this is a 2 year period with either e-learning or an approved training course. For devices that are connected to WPOCT the operators will be alerted 3 months prior to their expiration date. Refer to Section 9. However, the operator should also keep a copy in their training file.
- They have a valid ID badge to use the devices. They must contact the POCT Team if they have either lost or replaced their ID badge.
- They **do not** share ID Badges with other staff.
- Appropriate competencies are met.
- The ID of the patient is confirmed before commencing the test – please refer to the UHB policy on patient ID.
- All patients' results are recorded on approved Health Board documentation, stating date, time of test and operator undertaking test. For devices that are connected to WPOCT a permanent record will also be available in the Wales Clinical Portal (WCP).
- At the required frequency, IQC checks have been made and recorded. These must be documented and available for review. For devices that are connected to WPOCT an electronic record is sufficient.
- At the required frequency, EQA checks have been made and recorded. These must be documented and available for review. For devices that are connected to WPOCT an electronic record is sufficient.
- They comply with Health and Safety, UHB Waste Disposal, Decontamination and Infection, Prevention and Control Policies and Procedures.
- The equipment and the workstation are kept clean and in good working order, and consumables are correctly stored.
- They escalate problems with any aspect of the POCT procedure: these must also be reported to the POCT team. Any testing must cease until the problem is corrected and an incident form completed.

4.2.4 Independent Contractor

All independent contractors commissioned by the UHB to perform POCT must:

- Ensure that all operators have undertaken an approved training course. Maintain a training register of staff authorised to perform POCT.
- Ensure that all the operators have the necessary skills and competence to undertake these tasks.
- Ensure that all operators carry out IQC checks on the devices as advised.
- Carry out EQA checks and address any poor performance issues.

5 HOW TO IMPLEMENT A POCT SERVICE

5.1 IDENTIFY A CLINICAL NEED

Before deciding whether to implement POCT it is essential for Clinical Directors to establish a clinical need. This must be evidence based and clearly identify the risks and benefits of introducing a POCT service.

There is good evidence that optimization of pathways using well designed use of POCT can be both clinically effective and cost efficient. However, POCT can offer little or no benefit in a poorly designed pathway and can be more costly than traditional laboratory tests. Potential sites must discuss their requirements with the POCT team before purchasing POCT equipment or kits.

5.2 IDENTIFY THE RIGHT EQUIPMENT

Once a need has been established, the next step is to identify the most suitable device.

Accuracy and imprecision of results, robustness of device and traceability of results all need to be evaluated before acquisition; the POCT team will advise on the suitability of devices. Consideration will be given to ensuring comparability of results between POCT and those of the accredited pathology laboratory where patient management is shared.

The Clinical Director or designated deputy must identify and agree arrangements for back-up services with the pathology laboratory before a POCT service is introduced (if required). .

A business case must be produced to demonstrate the clinical and economic benefits (such as potential savings made in consulting, nursing, management and patient time) of POCT together with details of all financial costs of providing the service. They must include all capital costs, including infrastructure costs such as building, electrical and IT port installation costs, maintenance contracts, clinical risk assessment, EQA fees, consumable costs including IQC and professional costs including staff training, management of POCT programme, operator time and POCT Team and Pathology Laboratory support. All business cases must be sent to the POCT Group for approval, Appendix E - Proforma for introduction of a new POCT.

Within the organisation there is an approved list of equipment and consumables. Please contact the POCT team for further information. Only equipment and consumables approved by the Health Board must be used.

Once a device has been approved by the POCT Group the next step is to procure the device. Please follow the procurement process as detailed in the Standing financial instructions for Local Health Boards.

A Flow chart for the implementation of a new POCT service is provided in Appendix F. A new device must not be implemented until a minimum of 70% of staff have completed an approved training programme.

6 TRAINING AND COMPETENCE

6.1 TRAINING

All staff who use POCT devices must receive appropriate training and be in possession of a valid competence assessment certificate before carrying out tests on patients.
Training must be delivered by a member of the POCT team (or an approved cascade trainer). The POCT Manager has the responsibility to devolve training to an approved supplier. It is essential to agree training schedules for initial training, and establish retraining/refresher schedules.

For devices that are connected to WPOCT (see section 10) the training record is held electronically and operators are identified by their ID badge number. Operators must have a valid ID badge number to use the devices. **Please contact the POCT Team if you have either lost or replaced your ID badge.**

The knowledge/skill requirements include the ability to demonstrate an understanding of the appropriate use of the device, and appreciation of the pre-analytical aspects of the analysis, including:

- Intended purpose of the device
- Consequences of improper use
- Limitations of use
- Patient preparation, sample collection and application
- Health and Safety awareness
- Reporting & recording of results
- A practical demonstration
- How to deal with abnormal or unexpected results?
- What routine maintenance and (calibration) of the equipment is required?
- When and how to do IQC?
- What to do if the IQC fails?
- When and how to do EQA?
- What to do if the EQA fails?
- Competence assessment procedure

- How and when to undertake refresher training or e-learning?

6.2 COMPETENCE ASSESSMENT

Operators' competence must be objectively and independently assessed by an occupationally competent healthcare professional until the appropriate number of practical observations have been met.

Nursing competencies are approved by the Professional Practice Development Nurse Group. Healthcare staff wishing to obtain credits for these competencies can do so via Agored Cymru. A wide range of competences on POCT are available from Agored Cymru as part of the Credit and Qualification framework, Wales (CQFW) competence based units.

6.2.1 Ongoing competence

Following assessment, the individual operator is responsible for maintaining their continued competence in the use of the device. E-learning and performance monitoring can be used to maintain competence.

For most devices the certificate of competence is valid for a 2 year period. For devices that are connected to WPOCT the training record is held electronically and operators will be alerted 3 months prior to their expiration date. If the operator has failed to undertake refresher training in that period, they will be unable to use the device.

7 QUALITY ASSURANCE, AUDIT AND PERFORMANCE MONITORING

Operators of POCT should have a sound understanding of the principles of quality assurance (QA). This is a systematic process of verifying that a product, or service, is meeting the specific quality requirements for that product or service.

For POCT this includes the measures taken to ensure investigations are reliable and safe and includes the following:

- Having the right governance structure in place
- Correct identification of the patient
- Choosing the right test
- Obtaining the right sample (at the right time)
- Undertaking the right test procedure
- Undertaking IQC and EQA checks
- Recording results promptly and correctly
- Interpreting results accurately
- Taking appropriate action
- Documenting all procedures and actions
- Identifying and preventing errors
- Implementing quality improvements

The tools used to assure and monitor these processes include:

- IQC
- EQA
- Clinical audit
- Risk Management

The POCT team will advise and provide training on Quality Assurance procedures.

7.1 IQC

This is a means of checking that the results are safe before they are issued. The operator knows what value to expect and knows what range of values is acceptable for that control material.

If the value is within this range it provides reassurance that the system is working correctly. If the values are outside the range this alerts the operator that there is a potential problem with the test process.

IQC results will be automatically recorded on devices connected to WPOCT. This will include the time, date, operator details and any comments. Some devices will also alert the operator to perform the IQC test if it is outside the agreed frequency and prevent testing on the patient until this has been successfully completed. This process facilitates compliance with recommended IQC frequency and prevents the inadvertent use if the device fails.

7.2 EQA

This is when samples with unknown values are tested and reviewed by an external agency. They may compare results from operators within the UHB against those obtained from a number of other different organisations using the same device to determine the degree of variation and whether the results are within this acceptable variation. Alternatively, the results may be compared against a reference laboratory result, the “true” result. These agencies provide useful information on the degree of variation in diagnostic accuracy and reliability of POCT devices across the UK. The POCT Team will register the POCT service with the appropriate accredited agency (EQA provider), distribute the samples, report the results to the EQA provider and liaise with them and the respective Directorates on the performance of the UHB.

What happens if the individual operator or UHB site gets a poor report?
Non compliance (e.g. a no return) and poor performance reports (e.g. if the results were outside the acceptable limits) are monitored by the POCT Team in the first instance. However when the performance is outside the acceptable criteria on two out of three consecutive occasions, the EQA provider will contact the UHB. In the first instance they will work with the POCT team to provide assistance to resolve issues. Failure to improve performance over the next 3 months will lead to further contact by the EQA provider. In the UK persistent poor performance (i.e. no improvement after two contacts) will result in referral to the National Quality Assessment Advisory Panels (NQAAP). If no further improvement is made within a reasonable time period after NQAAP intervention, Health Inspectorate Wales is informed.

A flow chart on how poor compliance and performance is dealt with is indicated in Appendix G.

7.3 INCIDENT REPORTING

Any clinical incident involving POCT devices must be reported to the line manager and the incident recorded in eDatix. The POCT team must also be contacted to initiate an investigation. The POCT device must also be quarantined until further notification.

7.4 CLINICAL EFFECTIVENESS AND AUDIT

The POCT Team will periodically review the relative benefits of POCT, monitor the test ordering patterns, carry out audits to verify record keeping, review critical value reports and regularly review IQC and EQA reports and report their findings to the POCT Group.
However it is the responsibility of the Clinical Director to undertake regular clinical audit to monitor the clinical effectiveness of the service.
Compliance with the POCT Policy and Procedure will be monitored by the POCT Team as part of the Healthcare Standards Annual Review.

The following are examples of outcome based metrics.

Outcome	Metric
Has this intervention resulted in improved patient experience?	e.g. patient satisfaction surveys to identify whether more convenient, greater awareness or greater self motivation to manage condition.
Has this intervention resulted in improved disease outcome?	e.g. rate of secondary complications, improvement in symptoms, re-admission, urgent acute admissions, survival rate percentage of patients with improved diagnostic test .
Has this intervention resulted in improved treatment optimisation?	e.g. side effects, quality of life
Has this intervention resulted in a cost reduction?	e.g. reduction in staff resource, avoidance of transport cost, reduction of admission to secondary care, reduce length of stay.

8 ACCOMMODATION AND ENVIRONMENT

The working environment must be suitable to undertake POCT and the facilities allow for the correct performance of the test e.g. temperature and adequate lighting. There should be adequate facilities available for storage of kits and consumables and consideration given to patient privacy, comfort and needs during sample collection.

Work areas should be clean and well maintained and clinical samples and materials used in a manner to prevent cross infection. Appropriate decontamination procedures should be used in the event of clinical sample spillage and all devices and equipment should be decontaminated prior to moving to another area or returning to the manufacturer or to the POCT Team
.

Adequate power and network ports should be available and installed in a safe manner. Please refer to Appendix H - Pre-installation Checklist - IM&T & Estates

9 INFORMATION MANAGEMENT

Wherever possible, POCT devices that allow connectivity to WPOCT must be used. This ensures that the operator ID, patient ID, patient results including the date and time is recorded in the Laboratory Information System (LIMS) and the Wales Clinical Portal (WCP). This minimises subjectivity, transcription errors and loss of information, ensures positive patient verification on the device, facilitates sharing of information, eliminates duplication, and provides a full audit trail of the data.
The system prevents untrained operators using the POCT device, can alert users to undertake IQC, or undertake refresher training, facilitates quality assurance monitoring, operator and equipment performance, and non-compliance surveillance thus reducing clinical risk to the organisation

The system facilitates workload monitoring and test ordering patterns providing business intelligence on POCT activity for each Clinical Board.

The appropriate IT network ports or wireless access point must be in place to enable connectivity.

9.1 PATIENT RESULTS

There must be an agreed protocol to record all patient results, including date, time, operator, and device used so that a clear audit trail is established back to the patient.

10 SAFETY

Needle stick injuries and cross-infection can occur in POCT. Operators must be trained in safety procedures and know the correct procedure if a needle stick injury occurs in accordance with the Infection Control Protocol for Needlesticks and Other Injuries.

11.2

11 DOCUMENTATION

11.1 OPERATIONAL PROCEDURE

A copy of the Operational Procedure for the equipment must be readily available at the ward area. For most applications this is the “Red folder” provided by POCT Department.

Additional information for Cascade trainers should include:

- Guidance for assessors
- Training outline
- Cascade trainer certificate

11.2 RECORDS

Cascade trainers and Assessors must retain the following:
Record of staff training (Cascade trainers)

Records of staff assessment completed

Directorates must retain the following:
Warranty/ Service/ Maintenance records of equipment (including serial numbers).
For equipment > £5K a record should also be made in the asset register.
Reagent / strip lot number/ kit numbers (including expiry dates).
Patient results (Instrument printout / electronic report)
IQC records / EQA reports / Audit reports
Incident reports & action taken

For most devices connected to WPOCT, training records, patient results, IQC records, EQA records and reagent/ strip lot numbers are held electronically in the database and it may not be necessary for Directorates to retain full paper copies. Please check with the POCT Team.

11.2.1 Training Records

There are a small number of devices where connection to WPOCT is not available. For these devices, Directorates must maintain records of formal POCT training as follows:

Name and location details
Trainer's name
Date of training course POCT device on which trained and assessed
Date of assessment
Training content version
Expiry date of training

11.2.2 Competence Records

Competency records must be held with the end-operator. The records can also be incorporated into a Continuing Professional Development portfolio and act as evidence for the Knowledge and Skills Framework based practice.

11.2.3 Service / Maintenance Records

An inventory must be maintained of all POCT equipment including serial number and unique identification, manufacturer/supplier, date purchased, and service history, including dates out-of-service. Periodic and episodic maintenance of equipment shall be monitored and documented**.**
Equipment that is simple to use will still require maintenance. It is essential that the routine maintenance and calibration of equipment is carried out according to the manufacturer's instructions. Failure to properly maintain equipment may give misleading or dangerous results. The POCT team can advise in setting up maintenance schedules. A logbook must be provided to document service or maintenance schedules and outcomes.
For devices connected to WPOCT, details of all equipment are held electronically in the database and it may not be necessary for Directorates to retain full paper copies.

11.2.4 Reagent Log

Reagents, kits, and equipment shall be verified prior to routine use and records shall be kept of materials and reagents purchased for POCT that allows an audit trail with regard to any particular test performed. Records must be kept of the batch numbers of the test kits used, including date opened and expiry dates for all reagents.

11.2.5 Quality Control (QC) Records

A procedure must be in place to ensure that the results of EQA and IQC are readily accessible which includes: time, date, and operator details.

12 DOCUMENT CONTROL

All policies, procedures, protocols, record forms, etc must conform to the UHB Management of Policies, Procedures and Other Written Control Documents Policy and Procedure. All documents must be controlled, including POCT site generated documents. The document control system must comply with recognised Quality Systems, such as ISO 22870. All training manuals are controlled by the POCT Team in Q-Pulse document control system.

13 IMPLEMENTATION

The Point of Care Testing Group will implement the policy and procedure with due regard to the financial restraints on the UHB, and will endeavour to proceed so as to minimise the costs of implementation. Many areas performing POCT already work closely with the POCT team, and are compliant with the policy and procedure.

14 FURTHER INFORMATION

This Policy and Procedure will be made available on the UHB Intranet and Internet sites.
Further information on POCT is available under **POCT services** on the UHB Intranet.

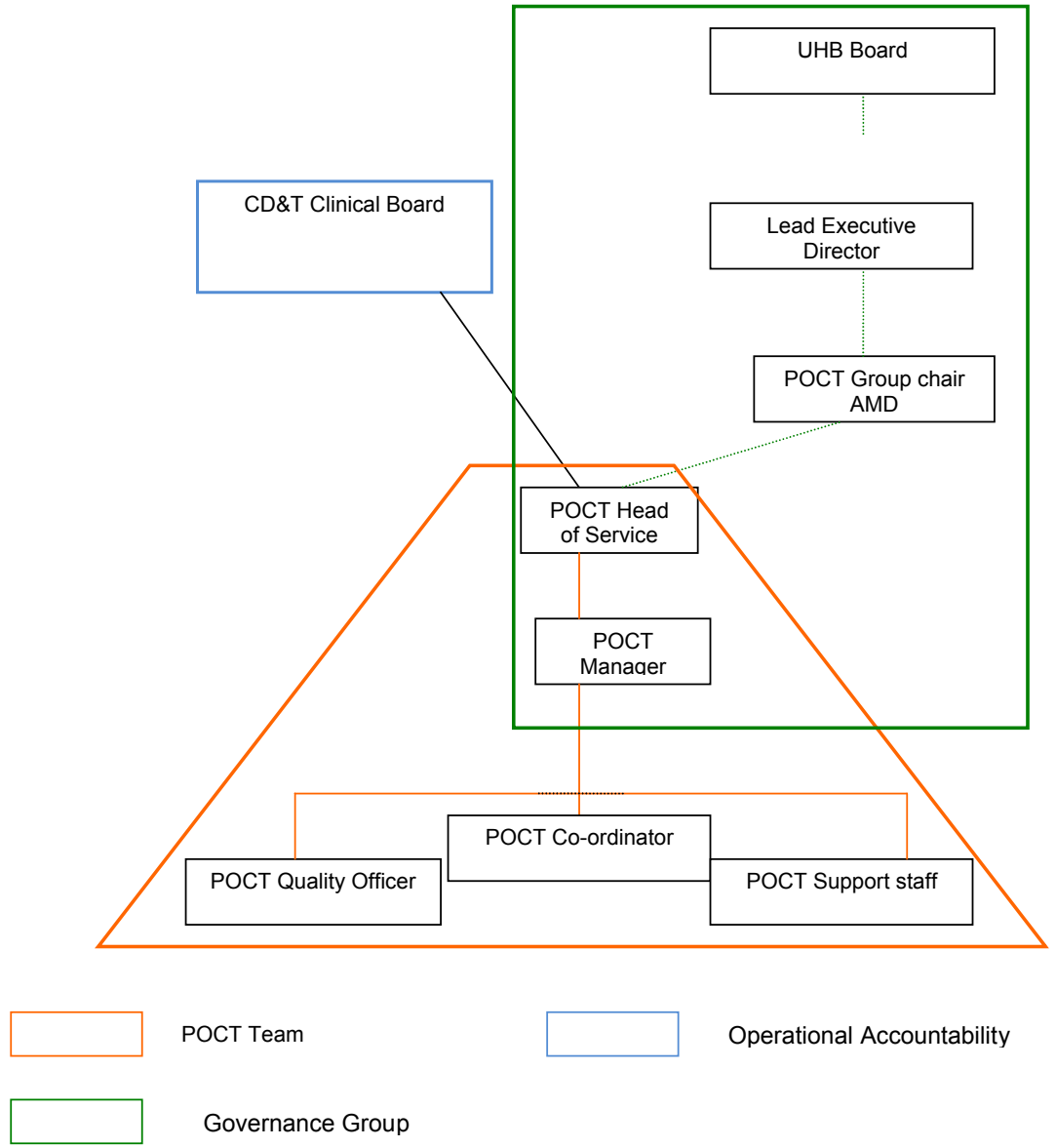
Any enquiries regarding this Policy and Procedure should be directed to:

POCT Head of Department	02920 748332	UHW ex 48332
POCT Manager	02920 745411	UHW ex 45411

15 APPENDICES

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APPENDIX A - POINT OF CARE TESTING SERVICE MANAGEMENT STRUCTURE



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APPENDIX B – MEMBERSHIP OF POCT GROUP

The POCT Group will consist of core membership of clinical users and the POCT team with representation from a wide variety of other departments co-opted as and when required.

Membership

The Medical Director or his appointee (Chairperson)	Core members
POCT Head of Department	
POCT Manager	
Clinical Directors – e.g. Director of Emergency Medicine, Director of Primary Care)	
POCT Nurse Lead (representing the Executive Nurse Director)	
Chair Medical Equipment Group	
Quality and Safety Manager	
Representative from:	Co-opted members
Learning and Education Department	
Information Management &Technology Department	
Clinical Engineering Department	
Pharmacy Department	
Laboratory Medicine Quality Manager	
Infection, Prevention & Control Department	

APPENDIX C – PRE-IMPLEMENTATION CHECKLIST

Question	Yes/No	Action/Date
Have you identified a clinical need which is evidence based?		
Have you contacted the POCT Team for advice and consultation?		
Have you undertaken a cost assessment? Examples of what to consider are in App E		
Have you undertaken a Risk assessment?		
Is the device on the UHB approved list of equipment?		
Have you addressed all Health and Safety requirements?		
Are you able to interface the device with WPOCT?		
Have you undertaken a site assessment – App H		
Have you discussed a “back up contingency” service with the Pathology Laboratory?		
Is there an agreed Service Level Agreement between you and the POCT Team?		
Do you have written operating and training procedures in place?		
Have you arranged for all users to receive appropriate training and competency assessment?		

APPENDIX D – EXAMPLE OF A SERVICE LEVEL AGREEMENT

This SLA requires for the planned and systematic approach for the implementation of POCT. Details to be agreed between the Directorate and the POCT team.

1. Specify the device, e.g. blood glucose, blood ketone, urinalysis, INR.
2. Specify the site, e.g. wards, accident and emergency, outpatient clinics.
3. Specify the staff group that will undertake the testing, e.g. HCSW, registered nurse, medical students, the proposed number of staff..
4. Specify the application of the device e.g. INR testing as part of stroke pathway in acute care, INR level 4 testing in general practice, HbA1c for diabetes diagnosis.
5. Specify the Directorate/ Site Contact person for POCT :
6. Specify the details of service provided by the POCT Team e.g.
   Agree number of staff per training session and number of training sessions per year
   Agree frequency of IQC and EQA
   Agree frequency of audits and format
   Agree troubleshooting support and turnaround time – telephone / face to face
   Agree workload reporting and frequency
   Agree any backup service (if appropriate).
7. Specify the responsibly of the Directorate e.g.
   Agree who is responsible for providing ongoing maintenance, calibration and repairs?
   Agree lines of communication and contacts
   Agree who organizes training rooms/ training consumables
   Agree whether cascade training can be used and how trained operators will be notified to the POCT Team
   Agree frequency of contract review.
8. Agree cost of provision of service provided by POCT team as specified in 6.

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APPENDIX E - PROFORMA FOR INTRODUCTION OF A NEW POCT

Proposer details:

Name: ……..

Position: ……..

Clinical Board: ……..

Directorate/ Site/Ward/: ……..

Cost Centre code: ……..

Date: ……..

POCT Scheme to be introduced: ……..

Name of POCT Lead person: ……..

Please answer the following questions and provide evidence where applicable.

Completed proposal forms should be forwarded to the POCT Manager for submission to the POCT Group for approval.

11.2

1. Proposed POCT Test

Is the proposed test to be used in a routine clinical or R&D setting?

Please give a brief overview of the proposed POCT scheme. Include information on which group of staff will be performing the testing, where the testing will be performed and which sites / Directorates will be using POCT under your responsibility as POCT lead.

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2. Proposed Benefits and Clinical Effectiveness

Please describe implementation of POCT into clinical pathway with proposed benefits to patient. Include any guideline /evidence/ audit information as deemed appropriate.
Identify the need for this POCT by answering the following questions:

a) Please describe the current and proposed changes in the patient pathway

b) What health care benefits will this POCT Scheme provide?

c) For which group of patients will this POCT Scheme be used and approximately how many patients will this benefit?

d) Is this investigation currently provided by a different mechanism? If so how? And why is this inadequate?

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3. Evaluation of Proposed Device

Has the POCT Team undertaken an evaluation on the proposed POCT test? Please provide data from either manufacturer or POCT Team.

Evaluation Checklist

Name of device and Supplier	
Details of method used by device	Type of assay e.g. immunoassay, HPLC etc. In house or kit (attach SOP or kit insert)
Source of reagents/analyser	(in-house/commercial)
Fluids that are valid	e.g. serum, urine, CSF, ascites, pleural
Relevant references	
Specimen requirements	Patient preparation Anticoagulant /preservative Minimum volume (include dead volume) Stability Sample handling
Comparison to laboratory method	Attach regression plot Attach difference (Bland-Altman) plot- *(usually provided by supplier or in-house evidence evaluation data inc. prepared and authorised by evaluation lead)*
Linearity	
Traceability Uncertainty	
Matrix effects	Lipaemia Hyperproteinaemia Icterus Haemolysis Ion suppression
Interferences / Cross-reactivity	
Precision	Intra and inter assay CV
Sensitivity / Technical limits of detection	state concentration and define method e.g. precision profile concentration relating to a CV of 20%, signal to noise ratio
Reference ranges Source of reference range	
Calibration and on-board reagent stability of automated assays	
Is the assay CE marked	
Internal Quality Control (IQC)	Source of material, Levels Please state clinical decision points
External Quality Assessment Scheme (EQA)	If no EQA details (numbers, frequency and centres participating). If none available please state.

4. POCT Equipment and Consumables and Costs

Give details of all equipment and reagents required for this POCT scheme

a) List equipment and reagents and state if they are to be purchased, or loan / trial / gift

b) What is the cost of the proposed POCT? Please provide a detailed breakdown including: Please refer to **Table 1** below to help calculate costs:

Total running costs	
Cost per patient	

c) How will this cost be met and has funding been agreed by the Finance Lead? Please submit confirmatory documentation

a) Please describe the current and proposed changes in the patient pathway

Table 1 Cost Considerations

Capital Costs		Revenue costs		Professional costs	
			Annual		**Annual**
Purchase/lease of POCT equipment/		Consumables: reagents / calibrators etc		Staff training	
Ancillary equipment: centrifuges, incubators, pipettes etc.		routine maintenance (including service contract/ Warranty agreement)		POCT Team support costs *: please refer to SLA*:	
Infrastructure - Network IT ports and connection costs. Power sockets / connector leads		Internal Quality Control material		Staff operator time	
Estates/ shelving/ construction work if required		EQA Subscription		Conforming to legal requirements	
New Interface for WPOCT		NWIS annual charge for WPOCT		Laboratory support (if appropriate)	
Depreciation		Waste disposal/ Decontamination/ IP&C possible costs			

11.2

5. POCT TEAM SUPPORT

If this is not being provided by the POCT Team, please provide details

Have you contacted the POCT Team?

Yes ☐ No ☐

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a) If yes, to whom have you spoken?
b) Was support from the POCT Team agreed?
c) If the Pathology laboratory presently provides this investigation, have you informed them of your intentions?
d) Has a Service Level Agreement (SLA) been agreed by all stakeholders?
e) Who will be providing ongoing maintenance, calibration and repairs? Details to be included in SLA agreement

6. QUALITY ASSURANCE

a) How will Internal Quality Control (IQC) be performed?
b) Which External Quality Assurance (EQA) scheme/s will you subscribe to?
c) Who will provide the training and competency assessment for operators of the POCT scheme?
d) Who will be undertaking audit of the service and how frequently?

7. CONTINGENCY PLANNING / BACK-UP PROCEDURES

a) How is the test to be provided if POCT is unavailable?
b) Have you agreed a back up service from the Pathology Laboratory?. Please provide details.

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8 RISK ASSESSMENT

Refer to UHB Risk Assessment Procedure for scoring matrix

Activity / Tasks	Potential Risk What could go wrong?	Impact	Likelihood	What procedures have I implemented to mitigate risk?
identifying the patient	wrong patient			positive patient identifiers. name, date of birth electronic ID via CRN/ NHS no.
taking the correct sample	sample contaminated: • by food / drink • by alcohol wipe • by interstitial fluid • by IV fluid • wrong anticoagulant inappropriate sample • blood stained urine • patient dehydrated or in peripheral shutdown			user understands pre-analytical effects competence assessed
undertaking the testing	• incorrect sample volume • incorrect filling • reagents / strips contaminated • stored at incorrect temperature or humidity • Device faulty			user trained and assessed as competent electronic operator lock out IQC check of reagent strips and device – QC lock out if outside limits temperature indicators on reagent boxes. electronic recording of strip information / errors
recording the result	• transcription or transposition of results – poor light/ busy			electronic transfer of data to clinical portal/ patient notes audit trail of date / time / operator
interpretation of the result	interferences • drugs • galactose / maltose • haematocrit effects dehydrated / shut down			user trained in limitations of procedure user aware of pre-analytical effects
acting on the result	Not acting on an abnormal result			user trained on critical ranges and alerts appropriate personnel.
Infection control	Not using lancing devices appropriately Devices not decontaminated Work area not clean			user trained and aware of decontamination, sharps and waste disposal policy and procedure
Assessors Name (s)		**Signature (s)**		
Position (s)		**Review Period**		

11.2

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If the risk is scoring 6 or above, using the Cardiff and Vale University Health Board Risk Assessment and Risk Register Procedure for a more in-depth assessment must be undertaken using the General Risk Assessment Form – Part 2 Please refer to UHB General Risk Assessment form Part 2

9. INFORMATION MANAGEMENT

Is the device interface available for connection to the All Wales POCT Platform (WPOCT)? If yes, has this been tested and approved by POCT Team?

If not, please describe how the operator details, patient results, IQC, maintenance and error logs will be recorded.

10. AUDIT

Once POCT has been implemented it will need to be audited against ISO standards for POCT and the Healthcare Standards. Please state nominated audit lead and describe any further audits demonstrating clinical effectiveness.

11.2

11. GOVERNANCE AND CLINICAL INCIDENT REPORTING

a) What governance procedures are in place to ensure that clinical incidents/ adverse incidents are monitored?
b) Nominated Quality and Safety Lead for incident investigation and Datix recording.
c) Nominated Lead for EQA non-compliance and reporting to NQAAP, if necessary.

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Checklist:-

Please attach the following documents with your proposal. Confirm inclusion by marking the appropriate box. Proposals will only be considered if all relevant documents are included and boxes are completed.

- Risk Assessment ☐
- Health and Safety Assessment ☐
- POCT Documentation ☐
- SLA with POCT Team ☐
- IT approval ☐
- Legal disclaimer for loan/trial/gift - N/A if not applicable ☐

Signature of Proposer: …… **Date:** ……

Signature of Directorate Manager: …… **Date:** ……

Signature of Directorate Finance Manager: …… **Date:** ……

Signature of Clinical Director: …….... **Date:** ……

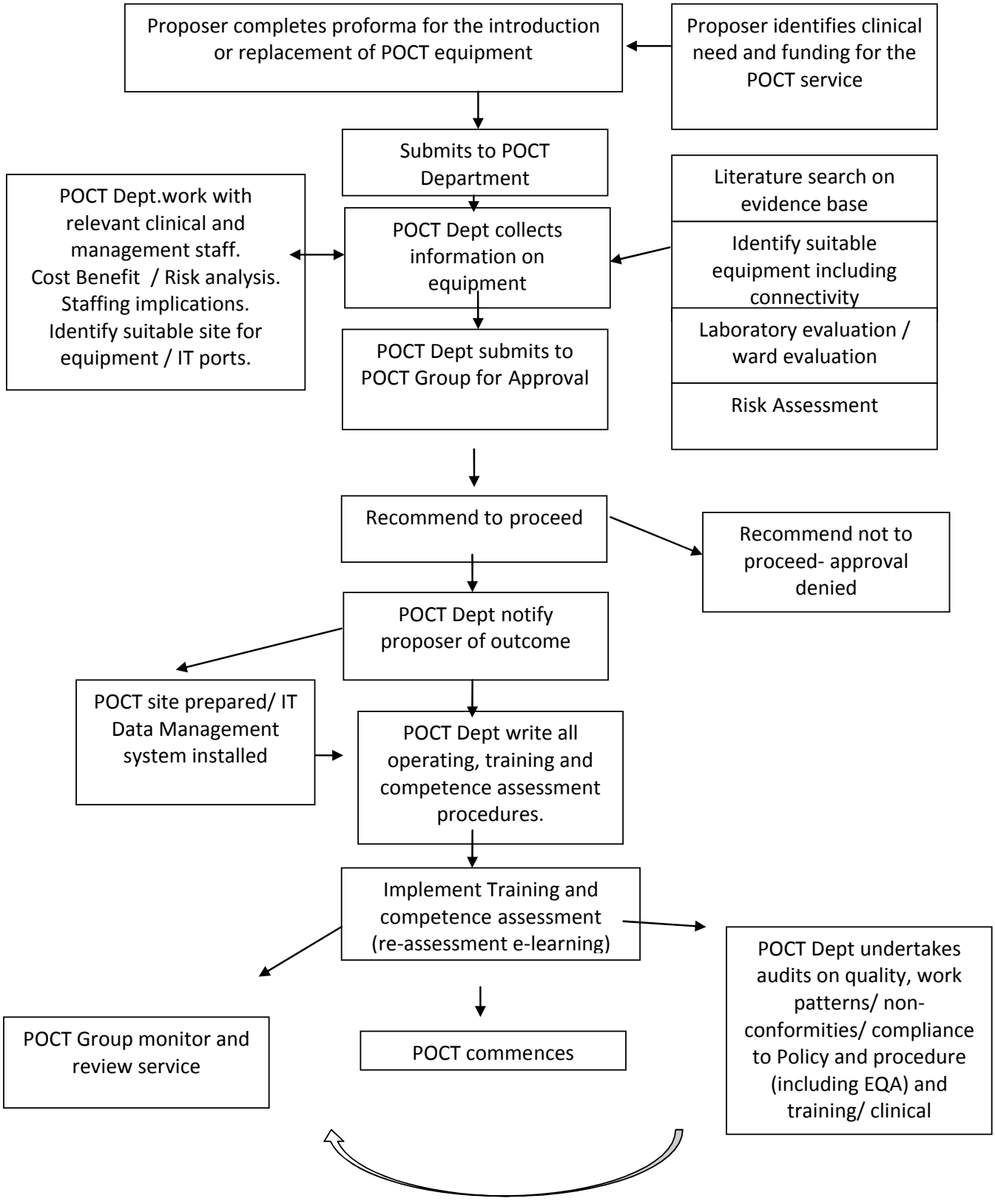
Signature of POCT Team Manager: …… **Date:** ……

'Electronic signatures' through receipt of e-mail confirmation by these individuals of their approval would be acceptable to the POCT Group as well as hard copy signed documents.

Feedback from POCT Group / Date:-
Feedback from Clinical Lead / Date:-

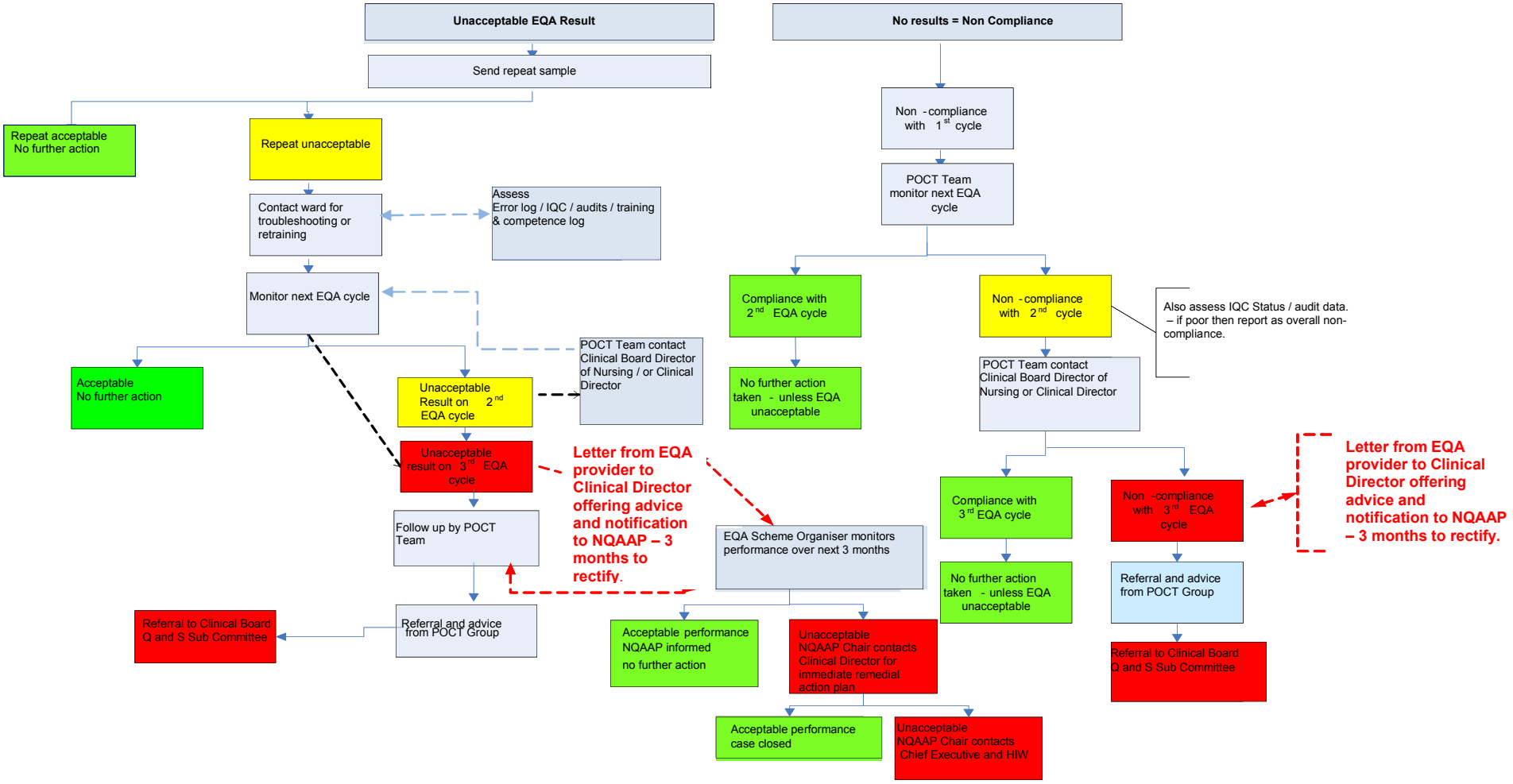
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APPENDIX F – FLOW CHART FOR IMPLEMENTATNG A NEW POCT SERVICE



11.2

APPENDIX G – NO RESULTS RETURNED AND POOR PERFORMANCE CHART



11.2

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APPENDIX H - POCT PRE-INSTALLATION CHECKLIST – IM&T AND ESTATES

ACCOMMODATION AND ENVIRONMENTAL CONDITIONS	Actioned / Date
Are storage space and conditions available and maintained to ensure the continuing integrity of sample materials, documents, equipment, reagents, consumables, records, results, and any other items that could affect the quality of interpretation of results?	
Does the POCT facility have adequate storage and handling facilities to maintain reagents and consumables in a manner that prevents damage or deterioration and in accordance with manufacturer's specifications? Is extra shelving required and does Estates/ Planning Dept. need to be contacted? Is there an associated cost?	
Is the environment suitable for the tasks to be undertaken? (e.g. access to areas affecting the quality of examinations should be controlled; medical information, patient samples and POCT resources are safeguarded from unauthorised access). Is consideration given to the accommodation of patient privacy, comfort and needs during sample collection?	
Do the facilities allow for the correct performance of the examination i.e. temperature and light sensitive and adequate lighting for visual sources? Also consider impact of:- energy sources, lighting, ventilation, noise, water, waste disposal and environmental conditions.	
Are clinical samples and materials used in examination processes stored in a manner to prevent cross contamination?	
Is the POCT facility maintained in a functional and reliable condition Are work areas clean and well maintained? e.g. housekeeping and cleaning	
Is there effective separation between incompatible activities i.e. multiple use of the room?	
IM&T / ESTATES / PLANNING REQUIREMENTS	
Are there adequate IT Network Points available? If so, are the ports live and functioning? *A walk through will identify if the area has sufficient outlets and if they are live, if not there is a charge. (see below)*	
If the port needs to be activated, is there an associated cost?	
If no ports available, is cabling required at extra cost? *If the work is carried out on a weekend there is an additional cost to cover weekend work, please contact IM&T*	
Is electrical power available? *If not please contact Estates*	.
Consider possible logistical difficulties if considering implementing POCT in sluice rooms with no existing power or network ports. *If new outlets are required, IT would need to survey the nearest Hub to make sure there is spare capacity. If there is no capacity in the local Hub then a different hub would need to be identified, however there is a limitation on the length of the data run of <100m from Hub to outlet.*	

APPENDIX I – ABBREVIATIONS

EQA	external quality assessment
IQC	internal quality control
ISO	international standards organisation
IVD	in vitro diagnostics
JWPQA	Joint Working Party on Quality Assurance
LED	Learning Education and Development
MHRA	Medicine and Healthcare Products Regulatory Agency
NMB	Nursing and Midwifery Board
NPT	near patient testing
POCT	point of care testing
QA	quality assurance
SLA	service level agreement
WHN	Welsh Hazard Notice
WSAC	Welsh Scientific Advisory Committee
WCP	Welsh Clinical Portal
LIMS	Laboratory Information Management System
WPOCT	all Wales POCT information Management System

Equality & Health Impact Assessment for

Point of Care Testing (POCT) Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Point of Care testing Policy Reference no. **UHB 062**
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics and Therapeutics (POCT Department) Annette Thomas Tel no: 48332
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objective of this is to provide a rational and practical framework on which to maximise patient safety during point of care testing (POCT).
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	• Over 5000 staff within the UHB undertake POCT. Staff groups include Healthcare Assistants, registerd nurses and medical staff. Over 1,000,000 tests are undertaken annually. There are over 400 devices and the repertoire of tests includes, glucose, ketones, urinalysis, pregnancy testing, anticoagulation, thromboelastography, thromoelastometry, haemoglobin, HbA1c, fetal fibronectin, blood gases, co-oximtery, basic haematology and HIV test. • Stakeholders consulted include the UHB POCT Group and all Laboratory Directors – comments were included in this document. • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet).

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	have engaged in the development stages • comments from those involved in the designing and development stages	• A part of good practice, other policies from different organisations were considered (1 HB in Wales 7 Trusts in England). No impact was reported in any of the policies and EHIA assessments relating to POCT. • National policies and standards considered included: Welsh Assembly Government (February 2017), Policy on the management of Point of Care Testing: What, When and How? WSAC 2017 Management and use of IVD point of care test devices - DB2010(02). MHRA BS EN ISO 22870:2006 Point of Care Testing (POCT) – Requirement for quality and competence • The National Institute of Economic and Social Research published a report which found LGB people were more likely to suffer with mental health problems. It outlined potential exposure to discrimination and harassment in relation to all aspects of life, including health service access, education, and employment. It can be found at https://www.gov.uk/government/publications/inequality-among-lgbt-groups-in-the-uk-a-review-of-evidence
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy applies to all healthcare staff employed or contracted by the UHB to undertake diagnostic testing on patients. This includes those on honorary contracts, students working within the UHB, persons employed by Cardiff University, Public Health Wales, and independent contractors commissioned by the UHB to undertake testing . The Policy also applies to primary care services such as - community dental services, community nursing services, family planning clinics and GP out of hours services.

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	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of age.		
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	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on		

11.2

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
conditions such as diabetes	request or via usual good management practice.		
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	No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of gender per se. However, a recent report at http://visual.ons.gov.uk/lesbian-gay-and-bisexual-people-say-they-experience-a-lower-quality-of-life/ says that more	Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans including those with non-binary identities (LGBT) patients in Wales report significant barriers to health and social care services[1] . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender	

[1] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

11.2

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
	LGB&T people than heterosexual people are dissatisfied with health services. Experiences of discrimination, heteronormativity, and a lack of information and/or staff knowledge on LGB&T people's health needs are identified as main sources of dissatisfaction. Mental health services are the most often perceived to be discriminatory. Research evidence in the area of health is lacking for transgender people. Heteronormative assumptions as well as experiences and/or fears of discrimination prevent LGB&T people from accessing mainstream services. Evidence suggests services do	identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services. However, Stonewall has commended work by healthcare employers around setting up LGBT staff networks, such as the UHB has, putting zero tolerance policies in place towards discrimination, and taking a more active	

11.2

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	not routinely monitor the sexual orientation and/or gender identity of their staff and/or service users, nor are LGB&T people routinely involved in consultative processes.	approach to LGBT community engagement as having improved the experiences of staff and their patients. Staff also have access to*:* It's Just Good Care – A guide for health staff caring for people who are trans *aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to*.	
6.4 People who are married or who have a civil partner.	There appears not to be any impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	There appears not to be any impact		

11.2

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
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There may be issues of language/communication and consent that will need to be considered.	The staff have access to the Wales Interpretation and Translation Services (WITS), should the need arise	To continue to use WITS when the occasion demands/requested /needed
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay);	http://visual.ons.gov.uk/lesbian-gay-and-bisexual-people-say-they-experience-a-lower-quality-of-life/ More LGB&T people than	Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay,	Clinical Boards will continue to support the UHB Rainbow LGBT+ FFlag Network and through its allies group, the Equality Champions.

11.2

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
• both sexes (bisexual)	heterosexual people are dissatisfied with health services. Experiences of discrimination, heteronormativity, and a lack of information and/or staff knowledge on LGB&T people's health needs are identified as main sources of dissatisfaction. Mental health services are the most often perceived to be discriminatory. Research evidence in the area of health is lacking for transgender people. Heteronormative assumptions as well as experiences and/or fears of discrimination prevent LGB&T people from accessing mainstream services.	Bisexual and Trans including those with non-binary identities (LGBT) patients in Wales report significant barriers to health and social care services[2] . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that	

[2] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

11.2

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
	Evidence suggests services do not routinely monitor the sexual orientation and/or gender identity of their staff and/or service users, nor are LGB&T people routinely involved in consultative processes.	patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services. However, Stonewall has commended work by healthcare employers around setting up LGBT staff networks, such as the UHB has, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients.	
6.9 People who communicate using the Welsh language in terms of	No documented evidence found.		

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
correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact		

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
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups including Carers or risk factors to take into account with regard to this Policy		

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	The aim of this policy is to enable POC testing to be undertaken safely, in particular to minimise the risk to patients from inappropriate testing or untrained operators. It is based on national guidelines and		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal - A more equal Wales	informed by local experience. Although section 7 is not applicable in terms of this Policy ,evidence suggest that POCT has positive impact in terms of patient satisfaction, convenience and improved equality of healthcare.		
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	As a policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	As a policy, there will be no impact.		
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	As a policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	As a policy, there will be no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
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	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Please see WITS, It's just Good Care, Rainbow network support	N/A	N/A	N/A
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially no impact identified, it it is unnecessary to undertake a more detailed assessment and formal consultation is not required.			

	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	Continue unchanged as there are no negative impacts. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

11.2

APPROVAL OF NUTRITION AND CATERING POLICY FOR INPATIENTS
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead : Executive Director of Therapies and Health Sciences
Author : Dietetic Catering Operational Lead Tel 029 2033 5232
Caring for People, Keeping People Well: To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will ensure that the nutrition and hydration standards set out in the document are the focus for all staff involved in the provision of food, fluid or nutrition services, ensuring the Health Board meet the diverse nutrition, hydration and dietary needs of all hospital inpatients.
Financial impact : Will need further assessment
Quality, Safety, Patient Experience impact: Nutrition and Hydration standards are met as per health care standard 2.5
Health and Care Standard Number 2.5, 3.5,4.1
CRAF Reference Number 5.1,5.18,5.7
Equality and Health Impact Assessment Completed: Yes An Equality and Health Impact Assessment (EHIA) has been completed and is found to have a positive impact. Key actions have been identified and these can be found in within this supporting EHIA document.

11.3

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Quarterly reviews of the associated Nutrition and Catering Action Plan as part of the Nutrition and Catering Steering Group

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Nutrition and Catering Policy for Inpatients

and

- **APPROVE** the full publication of the Nutrition and Catering Policy for Inpatients in accordance with the UHB Publication Scheme

SITUATION

Updated and reviewed policy in line with University Health Board changes, Welsh Government and professional standards. The Policy was updated in September 2016, but inadvertently was not passed to the Quality, Safety and

Experience Committee for approval. Once this error was identified, arrangements were made to bring the document to the first meeting of the Committee.

BACKGROUND

This policy will ensure that the nutrition and hydration standards set out in the document are the focus for all staff involved in the provision of food, fluid or nutrition services, ensuring the Health Board meet the diverse nutrition, hydration and dietary needs of all hospital inpatients.

ASSESSMENT

This Policy and the supporting policies and procedures describe how the Health Board can meet the diverse nutrition and hydration needs of its inpatients. The document will be subsequently split into a “policy on a page” and separate supporting procedures in line with the UHB’s guidelines.

Other supporting documents are:

- Enteral Feeding Policy
- Insertion of a nasogastric tube, confirmation of correct position and ongoing care in adults, children and infants(not neonates) policy
- Insertion, management and removal of the nasal bridle fixation device for naso-enteral tubes in adults procedure
- Catering policies and procedures
- Food hygiene policies
- Cardiff and Vale menu planning guidelines
- Protected mealtime tool kit
- Hydration tool kit

Consultation has taken place to ensure that the policy/procedure meets the needs of our stakeholder and the Health Board through the Nutrition and Catering Steering Group.

The primary source for dissemination of the Nutrition and Catering Policy for Inpatients 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: *Issued by Policy Manager* **Version Number:** 3	**Date of Next Review:** 01/09/16 **Previous Trust / LHB Reference Number:** 259

Nutrition and Catering Policy for Inpatients

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will ensure that the nutrition and hydration standards set out in the document are the focus for all staff involved in the provision of food, fluid or nutrition services, ensuring the Health Board meet the diverse nutrition, hydration and dietary needs of all hospital inpatients.

Policy Commitment

The policy will ensure that the diverse nutrition and hydration needs of its inpatients will be assessed, addressed and met.

Supporting Procedures and Written Control Documents

This Policy and the supporting policies and procedures describe how the Health Board can meet the diverse nutrition and hydration needs of its inpatients.

Other supporting documents are:

- Enteral Feeding Policy
- Insertion of a nasogastric tube, confirmation of correct position and ongoing care in adults, children and infants(not neonates) policy
- Insertion, management and removal of the nasal bridle fixation device for naso-enteral tubes in adults procedure
- Catering policies and procedures
- Food hygiene policies
- Cardiff and Vale menu planning guidelines
- Protected mealtime tool kit
- Hydration tool kit

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 (EHIA) has been completed and is found to have a positive impact. Key actions have been identified and these can be found in within this supporting EHIA document.

Document Title: *Insert document title*	2 of 50	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Policy Approved by	UHB Nutrition and Catering Steering Committee . This was an error and the Policy was subsequently presented to the QSE Committee in September 2017 for formal approval.
Group with authority to approve procedures written to explain how this policy will be implemented	UHB Nutrition and Catering Steering Committee
Accountable Executive or Clinical Board Director	Executive Director of Therapies and Health Sciences

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	01/03/2014	24/04/2014	New document to replace policy of Health Board. Policy revised in line with new Welsh Government Policy Guidance 2011 and National and Professional documents
2	01/09/2016		Updated and reviewed policy in line with University Health Board changes, Welsh Government and Professional standards
			Document split into separate Policy and Procedures

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Approved By:		

Nutrition and Catering Policy for Inpatients

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1.0 Introduction

Appropriate nutritional care is vital for all patients who are admitted to hospital as those that receive nutritious appetising food which is safe to eat and meets their therapeutic, religious or special nutritional needs may have shorter hospital stays, fewer post-operative complications and less need for drugs and other interventions This does present a challenge to caterers as the hospital population is varied and the food service will have to meet the needs of all patients from the very young to the very old with differing nutritional requirements due to their physical condition and/or illness.

The Welsh Government clearly recognises the importance of nutrition and catering as an essential component of the care patients receive in Welsh hospitals with the development of a number of initiatives and guidance documents providing the focus for us all. These include the Nutrition and Catering Framework 2002[9] 'Revised Health and Care Standards for Wales 2015, All Wales Nutrition Care Pathway and the 'All Wales Food/Fluid Record Charts' Nutritional awareness campaign, the web based 'Nutrition and Catering Framework for NHS Hospitals in Wales' and the 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'[29]

A major challenge facing caterers and dietitians is the number of patients entering healthcare facilities in a malnourished state. Many patients who are ill in hospital or will have poor appetites or a compromised ability to eat, thus potentially exacerbating a malnourished state. McWhirter and Pennington[1] found that 75% of hospital patients assessed to be undernourished on admission lost more weight during their stay. BAPEN[5] reported in 2008 that a number of studies have demonstrated a 20-75% increased length of stay in malnourished compared to non-malnourished patients6. Malnourished patients have a threefold greater complication rate during surgery, they require more medication, and their mortality risk is higher than well nourished patients7. BAPEN estimate that 33.6% of hospital inpatients will be malnourished at any single time during their stay5. The cost of malnutrition to both patients and the Health Service cannot be over stated.[7] Data from BAPEN[5] (2008 and 2009) showed that the risk of malnutrition increases significantly with age. Older people are more likely to remain undernourished during their admission, and are more likely to have longer hospital stays.[3,4,6]

Children are especially vulnerable to poor nutrition with their extra requirements for growth. Changes in their environment are also more likely to affect them than adults. The Department of Health (DOH) document "Better Hospital Food Catering Services for Children and Young People" (2003)[25] sets out what could be considered a "Gold Standard" in the provision of catering services to children and adolescents

So whilst there is this group to consider there are also patients who can be classified as 'healthy' individuals and may only be admitted for a short length of time. This will include patients who may be hospitalised due to a minor illness and are 'nutritionally well', maternity patients not experiencing complications, and previously fit healthy people whose illness does not/will not affect their food and fluid intake such as those having minor elective surgery. It would be appropriate for these patients to be provided with a diet that is based on general healthy eating principles. [17,18,]
While the NHS has a responsibility to promote education in healthy eating, it should be remembered that this will represent only a sub section of the hospital population for a relatively short period of time.

A healthy diet for people with diabetes, dyslipidaemia, hypertension or cardiovascular disease is considered an essential part of treatment and maybe beneficial in preventing further co-morbidities.

The healthier options on the patient menu must make provision that maintains a normal nutritional status and meets the target nutrient specification for the hospital menu.[19, 28]

In order to ensure the effective delivery of good nutrition in a hospital setting a team-based approach is absolutely essential. Caterers, kitchen staff, dietitians, nurses, doctors, speech and language therapists, ward housekeepers, porters and other healthcare staff all have an important role to play in achieving this policy.[8]

Cardiff and Vale University Health Board recognises and supports a multidisciplinary approach to the nutritional management of patients and strives to ensure that the nutrition and catering standards are met and maintained. This is achieved through the Cardiff and Vale Nutrition and Catering Steering Group which is led by the Executive Director of Therapies and Health Sciences and consists of a wide membership of Senior staff from the relevant disciplines (Refer to Appendix 2 Terms of reference). This group reports to the Board via the Executive Director of Therapies and Health Sciences and the Quality Safety and Experience Committee.

This policy is aimed at adults and children who are admitted to Cardiff and Vale hospitals, as inpatients, or those who attend day or unscheduled care units. This does not cover the needs of staff as these are covered under the Cardiff and Vale UHB Hospital Restaurants and Retail Catering outlets Policy. Our aim is to provide high quality equitable services that meet the needs of all patients who receive care in our hospitals.

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Approved By:		

2.0 Policy Statement

Cardiff and Vale University Health Board are committed to meeting patient nutrition and hydration standards by identifying departmental responsibilities from the Executive Board level to all departments involved in the food chain.

This policy document is an overarching document which must be considered in meeting the standards specified in the 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients', Health and Care Standards, Free to Lead Free to Care – All Wales Food Record Chart and Nutritional Care Pathway

This policy will be supported by other operational policies and protocols which have been ratified by the group. These policies and procedures include:

Enteral feeding policy,

- Insertion of a nasogastric tube, confirmation of correct position and ongoing care in adults, children and infants (not neonates) policy
- Insertion, management and removal of the nasal bridle fixation device for naso-enteral tubes in adults procedure
- Catering policies and procedures
- Food hygiene policies
- Cardiff and Vale Menu Planning Guidelines
- Protected Mealtimes Tool Kit
- Hydration Tool kit

This Nutrition policy applies to all hospitals within the Health Board where inpatient services are delivered.

3.0 Aim Of The Policy

Implementation of this policy will ensure that nutrition and hydration standards are the focus for all staff involved in the provision of food, fluid or nutritional services and to meet the diverse needs of all hospital patients.

4.0 Objectives

The objectives of this policy are:-

4.1 To identify a service in which nutritional screening, assessment of patient's dietary requirements, hospital food, patient hydration, nutritional support, monitoring, audit and informed redesign of food provision are seen as a vital component of patient care.

4.2 To consider how management, catering, financial and clinical services might work together to improve the nutritional care of patients by providing a more cost effective service targeted to patient needs.[16]

4.3 To consider the importance of monitoring and audit leading to modification of policies in the light of new evidence and experience.

5.0 Legislative and NHS Requirements

Cardiff and Vale University Health Board has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of age, race, gender or illness. The Wales Government and also the Healthcare Inspectorate Wales requires there to be auditable systems in place to ensure nutritional requirements of patients are met.

It is important to recognise the patients' rights within this policy and reinforce that:

- The feeding and hydration of patients at ward level is identified in the Code of Conduct of the NMC (Nursing and Midwifery Council) advice, as a nursing responsibility.
- All patients will have all aspects of their nutritional management explained, discussed and agreed with them.
- Patients have the right to expect to receive all the information they require to enable them to make informed choices about their nutritional care.
- A clear and understandable explanation of the patient's nutritional management will be provided to the patient, family and carers by the appropriate health care professional.
- Patients, family and carers will be appropriately advised and trained so as to feel secure in the use of any products or equipment.
- The views of the patient, family, carers and other relevant health care professionals will be considered when nutritional management is planned. Decisions should be multidisciplinary.
- Following discharge patients will have access to professional advice through attendance at community clinics and via domiciliary visits.
- Patients or their legally authorised representatives, have the right to accept or refuse nutritional support.

6.0 Accountability

The Chief Executive is responsible for ensuring delivery of a safe and nutritious catering service and for providing a nutritional support service.

7.0 Responsibility

7.1 Corporate

- The Executive Director of Therapies and Health Sciences is the nominated Board Level Director with lead responsibility for catering, nutrition and food hygiene whether provided in house, by external contractors or through voluntary services.
- The Nutrition and Catering Steering Group, a senior multidisciplinary team has responsibility for co-ordinating nutritional

care, and services, developing strategy, approving training programmes, monitoring performance against all nutrition related nursing, catering and dietetic standards and delivery of high standards of patient experience relating to nutrition and hydration The group will report to the Health Board at least annually via the Quality Safety and Experience Committee.

- For in-house catering the organisation must appoint Catering Managers with appropriate qualifications and experience in all matters relating to catering management, nutrition and therapeutic diets, food hygiene, contract management, cost control and budget management and food related legislation and good practice.
- Key indicators capable of showing improvements in catering services and food hygiene and the management of associated risk are used at all levels of the organisation including the board.
- The system in place for food safety is monitored and reviewed by the Health Board in order to make improvements to the system.
- The patient food budget should be valued as an essential clinical services and treatment.

7.2 Operational

Department of Nutrition and Dietetics

- Providing up to date advice and support for patients admitted to hospital requiring therapeutic diets and nutritional support
- A State Registered Dietician is responsible for providing a more in-depth nutritional assessment for patients identified as ‘at risk’ following initial nutritional screening.
- The department will work closely with senior catering and other professional colleagues to implement all nutritional standards and develop menus which contain a sufficient range of meals to meet individuals’ therapeutic, religious and cultural needs and to promote good health.

Speech and Language Therapy

- A nominated Speech and Language Therapist will provide guidance in relation to meeting the needs of patients identified with swallowing problems.
- The Department of Speech and Language therapy will advise on a universal system of terminology for texture and consistency of fluid and food items for patients requiring texture modified diets. Written information will be provided to all relevant staff involved in the production and service of patient meals.

Occupational Therapy

- The Occupational therapy department will provide guidance in relation to patients requiring feeding aids and adaptations to assist patients with independent feeding.

Nursing and Midwifery

- The Registered Nurse or Midwife, working to the Code, Standards of Conduct performance and Ethics for Nurses, Midwives (NMC2008) and Health Board policies, protocols and procedures are in the front line when it comes to identifying and addressing the nutritional needs of patients. It is the nurse's responsibility to ensure that patients in hospital receive the appropriate nutrition and fluids to aid their recovery.
- Nurses must complete a nutrition risk screening tool on every patient on admission to identify patients at risk of malnutrition through use of the nutrition screening tool Nurses identifying a patient who is malnourished or at risk of malnutrition can initiate an early referral to the dietetic team and can reduce morbidity rates.
- A senior nurse must lead on nursing policy and operational procedures which relate to nutrition.
- Ward Sisters and Charge nurses will be responsible for the implementation of protected mealtimes in their areas. Ward areas should have a clear procedure in place which is understood by all ward staff, clinical teams and visitors to the ward. Completion of the Nutrition and Hydration bedplan on clinical workstation is essential to identify patients dietary and hydration requirements on and throughout their period of admission should comply with the Protected Mealtime Standard as in Appendix 3.

Catering

- The Catering Manager is responsible for delivery of a safe quality assured catering service which meets agreed nutritional, food hygiene and operational service standards. Managers are responsible for identifying and monitoring staff training at induction and at agreed intervals.
- Procurement and Supplies officers must liaise with the relevant dietetic and catering colleagues to ensure procurement of foods and drinks are from sustainable and safe sources are of good nutritional value for money to ensure they meet the nutritional needs of the hospital population.

Audit

- At operational level, the organisation will routinely monitor compliance with all aspects of the system which includes nutritional standards, meal service quality, training standards and the required corrective actions taken where necessary. Where

appropriate, these will be carried out at different periods, including weekends and Bank holidays.

- As appropriate, routine continuous monitoring and/or periodic audit reviews will be co-ordinated by the Nutrition and catering steering Group ensure compliance through internal audits, nutritional assessments by Dietitians and routine unannounced checks.
- Healthcare Standard 2.5 will be assessed on an annual basis to continuously monitor performance, identify areas for development and provide internal assurance to the Health Board.

The Adult Nutrition Support Teams are responsible for:

- Preparing relevant nutritional support policies, protocols, procedures and / guidelines to address specific nutritional issues working closely with all relevant members of the multidisciplinary team and following guidance laid down by BAPEN and NICE.
- Ensuring such policies, protocols, procedures and / or guidelines are subjected to the UHB formal approval process.
- Identifying training needs and develop a training programme as required to meet standards and competencies compatible to their level of involvement.

Job descriptions should reflect the responsibilities and duties of all levels of executive, management, supervisory and other staff involved in the process of ensuring that appropriate nutrition is identified, prepared, delivered and presented to patients.

8.0 Standards

The following standards are taken from the document 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'[29] and other documents outlined in the list of references. (pages 17-18)

8.1 Nutritional Risk Screening Standards – Adults

All Wales Hospital Nutrition care Pathway protocol and UHB Nutritional Screening Compliance

- Within 24 hours of admission to hospital all patients should be weighed and screened for malnutrition of risk using a validated nutritional screening tool
- Patients identified with swallowing difficulties should be referred for formal assessment by a Speech and Language Therapist. A referral to a Dietitian should be made if advice on a textured modified diet or artificial nutritional support is required. In patients where enteral nutrition is contra-indicated total parenteral nutrition should be considered. When a nutrition risk score and weight has been established a multi-professional nutrition care plan should be implemented. The care plan developed will depend on the nutrition

risk. Any patient identified as at risk will be assessed regularly and appropriate action taken.

- Identification of a patient at nutritional risk should be followed by a thorough nutritional assessment, treatment plan including dietary goals, monitoring of food intake and body weight, and adjustment of treatment plan. The nutritional treatment plan should be reviewed on at least a weekly basis.
- Documentation in patients' notes will include screening/ re-screening assessment and actions taken.
- Weighing scales will be regularly checked for accuracy and maintenance requirements. Ward managers are responsible for ensuring appropriate weighing scales are available within their ward areas.
- The screening process (initial and ongoing) will be monitored by Ward Sisters /Charge or Senior Nurses. As a minimum compliance with nutritional screening will, be recorded on a monthly basis using the All Wales Nursing metrics system.
- Wards will identify nutritionally vulnerable patients and ensure they follow the nutritional care pathway, to meet the nutrition and hydration needs of all patients, with the necessary encouragement and assistance with eating.

In addition to the need for nutritional screening of all patients, an assessment of each patient's dietary needs should also form part of their individual nutrition care plan, such needs as:

- Eating and drinking, likes and dislikes
- Food Intolerances and allergies
- Need for therapeutic diets
- Cultural, ethnic and religious requirements
- Therapeutic dietary requirements
- Social, environmental mealtime requirements
- Physical and or sensory difficulties with eating and drinking
- Aids and adaptations e.g. adaptive cutlery or crockery requirements
- Ability to communicate
- The level of assistance and support required to eat and drink.

A plan of how these needs will be met should be developed, implemented and monitored. Relevant information for each patient must be added to the ward Nutrition & Hydration Bedplan to ensure good communication between disciplines.

It is important to remember that individuals' dietary needs can change with changes in their medical condition(s) and thus monitoring individuals' requirements is important to inform appropriate food provision.

8.2 Nutrition Risk Screening Standards for Children admitted to hospital

- All children admitted to hospital should be assessed on admission to hospital using the appropriate screening tool, with their height and weight measured with values plotted on appropriate growth charts.
- Every child should be weighed at timely intervals with the child's care plan during their admission. Weighing scales will be regularly checked for accuracy and maintenance requirements. Ward managers are responsible for ensuring appropriate weighing scales are available within their ward areas.
- Documentation in the nursing notes will include monitoring of dietary intake, physical ability to eat and drink and body weights.
- Consideration should be made to refer the child to the Dietitian if there are any concerns with the child's growth and/or there are concerns regarding the child's dietary intake.

8.3 Food Service Standards[23, 25, 28]

- All patient menus must meet the All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients[29] – Wales Government and contains a sufficient range of meals to meet individuals' therapeutic, religious and cultural needs. Further menu planning guidance is detailed in British Dietetic Association document entitled .The Nutrition and Hydration Digest: Improving Outcomes through Food and Beverage Services The British Dietetic Association[17]
- Patients are provided with sufficient information to enable them to make an informed choice as close to the meal service time as possible and written information is presented in an appropriate manner e.g. child friendly menus, large print menus, pictorial menus and menus in a range of languages.
- The dietary needs of all patients taking oral nutrition should be met, taking account of patients' preferences through meals that meet their nutritional requirements and these offered as a choice of dishes on a written menu.
- Patients are offered a choice of portion size. Nutritional enhancement is provided where the portion does not meet the determined minimum nutritional content. All meals should be presented in a way that facilitates and encourages independent feeding
- The Healthcare Food and Beverage Service Standards Good Practice Guide outlines the 'food chain' process from purchasing to methods of production, delivery and service at ward level.
- Nutritional information will be routinely obtained from the food commodity suppliers during the tendering process in order to

assess compliance with nutritional standards. The process for nutritional assessment of food commodities will be agreed with all the relevant parties.

- Ward provisions must be provided to ensure patients have access to a range of different snacks and beverages when the hospital kitchen may be closed. The list of items should be detailed in the Operational services Food Service Policy.
- Contingency arrangements are in place to ensure the delivery of safe nutritious food in the event of total or partial failure of normal arrangements.
- Services should be flexible with recognised procedures that provide for the dietary and nutritional needs of patients who cannot achieve their energy and protein requirements from the hospital menu or who miss a meal at normal service time.
- A missed meal service must be provided for all patients who did not have the opportunity to have a meal at the normal meal time and must provide a minimum 300 kcal and 18 g protein per main course.
- Main meals should be available every 4 to 6 hours during the day.
- The maximum period between the last main meal at night and the following breakfast should not exceed 14 hours.
- Assistance to eat must be given to all those who require it.
- A Food Safety policy will be available supported by appropriate procedures, which identifies how relevant food hygiene and food safety requirements are satisfied
- All staff involved in serving food to patients should be trained in how to do so properly which includes basic nutrition and food hygiene.

8.4 Nutrient and Food Based Standards-Adults[2,8]

Hospital menus must be able to meet the nutrient specifications, and provide foods that meet both food and nutrient based standards for the hospital population; these are detailed in the Appendix - Table 1.

- All menus must meet the nutritional requirements of patients of all ages i.e. Dietary Reference Values (DRV's) for Food Energy and Nutrients for the United Kingdom[18]. Where a menu must meet the needs of the 'nutritionally well' and the 'nutritionally at risk', then ensuring that both 'healthy choices' and 'higher energy and nutrient dense' choices are available at each eating occasion should enable all patients to choose a diet that meets their nutritional requirements.
- Menus should be nutritionally analysed to ensure that they have the capacity to meet the nutrient standards set for the 'nutritionally at risk' patient and enable individuals to choose a healthy balanced diet through selection of healthy choices. For more information refer to Chapter 4 Section 4.9 of the document The All Wales

Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Wales Government-[28]

- Menus must meet the needs of those patients with therapeutic dietary, cultural or religious needs. Patients must be given **choice** for all food and fluid options provided, including therapeutic and/or texture modified diets[26,27,28].
- Hospitals whose populations require certain therapeutic diets irregularly and in minimal numbers must include in their policy a formal contingency for the provision of these diets in the event they are required, for example by using an a la carte menu.
- All foods purchased for use within the patient meal service at either an All Wales or local level must be assessed by a dietitian against the nutritional specifications and standards to ensure the best nutritional value for money has been achieved[1715].

Chapter 6 of the document The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Welsh Government[29] There must be a hospital protocol for the provision of all therapeutic diets.

8.5 Nutrient and Food Based Standards- Children[24, 28]

Menu Planning Groups and hospitals should consider producing a specially designed menu for children and allow them to make their food choice as close to the point of service as possible.

For most children, the average length of hospital stay is two days. Most children and adolescent patients will benefit from eating a diet that follows healthy eating principles during their hospitalisation. However, attempting to impose a "healthy" diet upon a sick child can be counter-productive.

Guidance has been provided for hospital catering services for children and young adults[31]. However, a diet low in fat and high in fibre-rich carbohydrate may be too bulky and low in energy to satisfy a young child's (< 5 years) nutritional requirements.

- It is good practice to have a separate children's menu with child friendly familiar dishes as well as access to the main hospital menu for those who wish to have more choice (particularly for older children).
- Emphasis should be placed on the provision of popular and familiar if food is to have any nutritional value it must be eaten and children should be presented with a variety of foods and fluids that are tempting and familiar to them. In some cases this may mean foods such as fish fingers, chicken goujons, baked beans, burgers, fries or ice-cream. The main hospital menu may meet the needs of many children with traditional choices such as roast meats, vegetable and

potatoes and cottage pie as well as more 'modern' choices such as mild curry, pizza, pasta, jacket potato, and a filling.

- Menu planning groups should work closely with children, parents and carers in planning the menu for children taking into account likes and dislikes and making sure that suitable choices are available for the different ages and stages of development of the children being catered for.
- Diets must be tailored to suit young children's nutritional and energy needs and also their stage of development. Guidance has been produced for early years childcare settings that includes a variety of menus. It is best to provide young children with smaller, more frequent meals.
- Snacks such as bread, fruit, sandwiches, and yoghurts are preferred to those high in fat, sugar and salt. The provision of foods high in sugar should be kept to a minimum, especially between meals and the use of highly salted foods and addition of salt to foods should be discouraged.

For further information refer to Chapter 5 in document 'The All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients'-Welsh Government[29]

8.6 Standards for Fluid Provision[21, 22,28]

- There must be provision to ensure patients are able to access a minimum of 1.5 litres of fluid per day.
- Water must be available at all times throughout the 24 hours; preferably this should be chilled mains water.
- Water jugs should be changed three times per day.[29]
- 7-8 beverages should be offered in any 24 hour period.
- Where All Wales fluid charts are used to monitor patients fluid intakes these must be fully completed and signed in line with policy
- Ensure fluid is available in the appropriate drinking cups or utensils

8.7 Environmental Standards[23, 28]

- Meals and refreshments will be delivered in an environment conducive to their consumption, and at times that are flexible and sensitive to specific care group's needs and preferences. The food should be presentable and palatable, thus cold foods should be served as soon after removal from refrigerated storage and hot foods maintained above 63°C prior to serving, and with individuals' subsequent nutritional intake monitored.
- Interruption of patient meals by ward rounds and procedures should be minimised and each ward should have a clear protected meal-times policy in this respect. The environment at meal times should be made as conducive to eating as possible with any activity that

may cause anxiety in the period leading up to the meal time kept to a minimum. Refer to Appendix 3 for protected mealtimes standards

- Consideration should be given to washing hands, positioning, dental needs and any special aids required.

9.0 Training

All staff that influence the successful outcome of nutrition, safety and enjoyment of meals, are trained to carry out their duties and responsibilities effectively. Training commences at induction and is updated regularly. Managers are responsible for ensuring staff undertake relevant training and that appropriate records are kept and maintained. All nurses will be expected to complete the 'All Wales Food Record Chart Competence programme' e-learning training package
The Nutrition and Catering Steering Group will be informed of the nutrition education and training programmes that are carried out for all staff groups annually.

9.1 Training Implications

There will be training implications relating to this policy for many staff groups, some of which will be mandatory e.g. basic food hygiene training for all 'food handlers'. Individual line managers are responsible for identifying individual staff training needs within the member of staff's personal development plan. Training records will be kept and continuously updated. Training will be provided in house where possible. The training required will vary for various members of staff depending on their role profile.[15]

10.0 Equality Impact and Assessment

An Equality Impact Assessment will be undertaken to assess the relevance of this policy to equality and the potential impact on different groups, specifically in relation to the Equality Act 2010.

11.0 Implementation

This policy provides a framework to meet the core elements of the All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients – Welsh Government and the Health Care Standards for Wales 'Doing well Doing Better' Healthcare Standard 14[15]. It establishes the line of responsibility at both corporate and operational level that includes the Executive Health Board through to in-house catering management and members of the multidisciplinary team to achieve patients' optimal nutritional status.

The policy will provide an agreed basis for developing a Nutrition and Catering strategy with aims and objectives that will inform Directorate operational plans and reflect the key components of Clinical Governance.

12.0 Further Information

Several local guidelines, policies and procedures exist to support the Nutrition and Catering policy and may be accessed through relevant departments

These include:

- Nutrition and Catering Steering Group- Membership and Terms of Reference
- Nutritional Screening Policy and validated Nutritional Risk Screening Tool
- Food Service Policy
- Standards for Protected Mealtimes- Nursing
- Food Safety Policy
- Training Requirements for Staff Involved in the Food Chain

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Appendix 1: Table 1 - Nutrient and Food Based Standards – Adults

Menus need to aim for :-

- 1900-2625 Kcals and 55-90g protein to meet the needs of the nutritionally well and nutritionally vulnerable adult

Please note: - the majority of the hospital population are of a mixed age and nutritional need so will demand a menu which meets the higher level

- Fibre (NSP) 18g/day for nutritionally well adults and 12-18g Fibre /day for the nutritionally vulnerable

Menu should include :-

Breakfast: –

- A minimum of 380kcals and 8g Protein and a fortified High energy high protein option for nutritionally vulnerable e.g. cooked breakfast or fortified porridge

Mid Day and Evening meals that include:-

- A main course meal providing 300kcals and 18g protein (12g for vegetarian option). To achieve this the main protein part of the meal should contain 12-14g protein or 9-10g for vegetarian
- A fortified high protein high energy main course option to provide a minimum of 500kcals and a minimum of 18g protein
- 2 first course items
- 3 main courses as a minimum 2 of which should be hot
- 3 dessert course items 1 of which should be hot(custard alone is not adequate is not considered as a hot option

Desserts

- At least one fortified or high protein high energy dessert minimum of 300kcals and 5g protein at mid day and evening meals

Snacks

- within the standard menu to provide 100kcal energy and 1.5g protein
- an evening snack for patients
- snacks of higher energy and protein density to meet a minimum of 200kcal and 2.5g protein each must be offered to those patients identified as at moderate and high risk of malnutrition from Nutrition Risk Screening

Milk allowance

- 500ml milk per patient for cereals and drinks as ward allowance

Soup

- Soup where served of a minimum of 150cals and 4g protein in a 175ml serving and must be offered with bread and spread.
- If offered as a hot main meal choice the whole meal must meet 300-500kcals and 18g protein (dependent on patients nutritional needs)

Fruit Juice

- Should be offered as a first course item on 2 occasions in order to achieve the minimum vitamin C nutrient specification of 40mg
- Meal and snack items that meet healthy eating principles
- Vegetarian options at each meal
- A combination and balance of foods from all 5 food groups with a variety of cooking methods used to include Bread cereals, potatoes and other starchy foods, Fruit and vegetables, Milk and dairy foods, Meat, fish and alternatives, foods containing fat and sugar
- Codes to indicate healthier choices, fortified and high energy items and vegetarian items as a minimum. Too many codes can be confusing.

Fluid

- There should be 7-8 beverage periods throughout the day offering both hot and cold drinks. This will provide approximately 1500mls of fluid. Drinks should be served immediately after lunch and evening meal

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Appendix 2: Nutrition and Catering Steering Group - Terms of Reference

1. Introduction

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

2. Purpose

2.1 The purpose of the Nutrition and Catering Steering Group is to:

- To assure the Board that the nutritional care and needs of all patients is identified, managed and delivered in the context of Health Care Standard 14. This assurance will be demonstrated by the delivery of the requirements of "Improving Health in Wales", the Nutrition and Catering Framework Document, Free to Lead, Free to Care, and Fundamentals of Care plus all other policies and standards pertaining to nutrition and hydration.
- To consider and respond to the work to achieve the Corporate Health Standard
- To ensure the broader public health agenda is considered, including work to progress the UHB as a Practising Public Health Organisation and the implementation of the Healthy Weight Framework.
- To receive internal/external reports and form appropriate action plans.
- To review user feedback and outcomes of adverse events to enhance the patient experience.
- To inform the Board of any constraints or concerns regarding the above assurance.
- To provide strategic direction which enables the delivery of high standards of patient experience, relating to nutrition and hydration.

3. Delegated Powers and Authority

3.1 The Group will, in respect of its assurance role, seek confirmation that systems and processes are designed and operating effectively and effectively within all relevant Division's

to ensure the provision of high quality nutrition and catering services and care.

Further the group will ratify procedures and written control documents within the delegated authority from the Quality and Safety Committee.

To achieve this, the Group's work programme will be designed to ensure that, in relation to all aspects of nutrition and catering:

- Lead in the implementation of Healthcare Standard 14.
- To develop and implement a communication network to actively engage the wider workforce involved in the provision monitoring and quality of services provided to patients to meet their nutritional and dietetics requirements.
- To develop strategies to ensure catering, clinical services, management and finance work together to improve the nutritional and dietary support of patient by providing services targeted to patients' needs and expectations.
- To ensure Divisions take appropriate actions on the outcome of monitoring and auditing which will result in an ongoing evaluation of policies and delivery of procedures in the light of evidence based practice and other indicators.
- The development a framework in which screening, assessment of patients' requirements, hospital food, nutritional support, monitoring and audit are an integral part of patient care.
- To ensure the workforce is appropriately, trained, supported and responsive to the needs of the patients, ensuring that professional and legal standards are met.
- To receive the minutes/action plans of the Catering Steering Group, to ensure a system of assurance that standards policy etc are being met.
- To develop a set of key internal and external quality performance indicators which will be regularly monitored, assessed and reported on.

3.2 Access

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

3.3 Sub Groups

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

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4.0 Membership

4.1 Members

The group will comprise of:

- Chair: Assistant Director of Nursing
- Vice Chair: Lead Nurse Patient Experience
- Divisional Nurse representatives
- Head of Patient Environment
- Medical representative
- Member of Patient Quality and Safety team
- Head of Dietetics
- Head of Speech and Language Therapies (or representative)
- Staff Side representative
- Representative from Public Health
- Compliance Manager Operational Services
- Member of Cardiff and Vale Community Health Council

(each member to indentify one designated deputy)

4.2 Attendees

Other representatives may be requested to attend from time to time as required by the Group Chair.

4.3 Secretariat

The Secretariat function for the Group will be provided by the Patient Experience Division.

5. Steering Group Meetings

5.1 Quorum

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

5.2 Frequency of Meetings

Meetings shall be held no less than quarterly, and otherwise as the Chair of the Group deems necessary – consistent with the UHB's annual plan of Board Business.

6. Relationships and Accountabilities with the Board and its Committees/Groups

6.1 The Steering Group will report to the Quality and Safety Committee.

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7. Reporting And Assurance Arrangements

7.1 The Group Chair shall:

- Report formally, regularly and on a timely basis to the Nurse Director on the Group's activities. This includes verbal updates on activity, the submission of Group minutes and highlight reports (as required).
- Through the Quality and Safety Group bring to the attention of the Board any significant matters under consideration by the Group.

8. Applicability of Standing Orders to Committee Business

8.1 **Section A - Introduction**; sub section **Applying Standing Orders**, paragraph xx) states the following;

The Standing Orders of the LHB (together with the Standing Financial Instructions and the Values and Standards of Behaviour Framework) will as far as they are applicable, also apply to meetings of any formal committees established by the Board, including any Advisory Groups, sub committees, joint committees, and joint-sub committees.

9. Review

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Group.

11.3

Appendix 3: Standard for Protected Mealtimes and Red Tray Scheme (Applies to all mealtimes)

Protected mealtimes in Cardiff and Vale UHB are:-

"Mealtimes in which patients are prepared to eat appropriately. As a minimum expectation, this incorporates appropriate positioning, the offer of hand hygiene for patients, the environment is cleared and conducive to eating, non urgent clinical activity ceases, and in conjunction with the catering staff the nursing focus is to provide support to patients during the mealtime. Relatives and carers are encouraged and welcomed to participate in feeding should they so wish."

Activity	**Rationale**
Nursing staff works with catering staff to identify patients requirements for meals	Patients needs identified
Patients are offered toileting opportunities prior to meal service	To reduce the need for interruptions and ensure the patient is prepared to eat
Nursing staff prepare patients for eating, e.g. position appropriately	To enable patients to eat and drink safely
Hand hygiene is prompted or delivered prior to meal service	To reduce the risk of HCAI
The environment is made as conducive as possible prior to mealtimes (bed tables cleared etc)	To encourage the patient to eat well
All non urgent clinical activity ceases in the patient environment during the meal time	To reduce interruptions
The caterer and nursing staff work jointly to ensure patients needs/choices are met	To ensure a quick seamless food service is delivered meeting patients needs
The Nutrition & Hydration bedplan is the accepted tool which is used as a flagging mechanism and is understood across the ward area.	To ensure those at greatest risk receive optimum care and support
All nursing staff are available and help patients who require assistance to eat and drink and complete all appropriate documentation	To ensure patients are assisted as q quickly as possible and actions taken are documented
Nursing Staff encourage relatives and carers to feed their loved ones should they so wish	To encourage increased intake by patients
Protected mealtimes will be limited to no longer than 1 hour	To prevent delays to
Nursing staff need to adopt a flexible approach when implementing protected mealtimes. Consideration of the movement of the meal service around the ward and the ability to deliver care in the area not receiving a service at that time.	To ensure patient care is not compromised by the exclusion of other services (e.g. phlebotomy radiology and therefore lengths of stay increase)

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Appendix 4: Training Requirements for Staff Involved in the Patient Meal Service

Catering Staff

- Roles & Responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets
- Dysphagia /modified consistency
- Nutritional supplements and enteral feeds
- Basic / intermediate / advanced food hygiene training dependent on role
- Standard recipe production
- Menu planning
- Catering practices/processes/use of equipment

Ward Based Catering Staff

- Roles & Responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets
- Dysphagia /modified consistency
- Nutritional supplements and enteral feeds
- Basic / intermediate / advanced food hygiene and safety training dependent on role
- Ordering, serving and presenting meals
- The importance of time/temperature control / regeneration and record keeping
- Customer care and communication

Housekeeping Staff

- Roles and responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Therapeutic, religious and cultural diets
- Ward beverages and nutritional supplements
- Importance of modified consistency drinks/ meals
- Basic Food Hygiene/safety dependent on role

Nursing Staff including trained Nurses, Health Care Assistants

- Roles & Responsibilities of key staff
- Basic Nutrition and the importance of food and nutrition standards
- Using Nutrition pathway including food & fluid charts
- Therapeutic, religious and cultural diets
- Malnutrition and the hospital patient
- Nutritional screening
- Dysphagia /modified consistency
- Nutritional supplements and enteral feeds
- Basic food hygiene and safety

Equality & Health Impact Assessment for

Nutrition and Catering Policy for Inpatients

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Nutrition and Catering Policy for Inpatients
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Nutrition and Catering Steering Group chaired by the Executive Lead of Therapies and Health Sciences
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Implementation of this policy will ensure that the nutrition and hydration standards are the focus of all staff involved in the provision of food, fluid or nutritional services, and the diverse needs of all hospital patients are met.
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 designing and development stages	The population of Cardiff and Vale is growing and diversifying rapidly, higher than the average seen across Wales, with a consequence of higher demand for health and wellbeing services. People are living longer, with the over 65 years forming approximately 25% of the inpatient population. Over half of these will have one or more chronic conditions. The population of Cardiff and Vale is predicted to increase rapidly over the next 10 years, with the 85 years and over growing faster than any other part of the population. These over 85's are likely to become increasingly frailer with multiple co morbidities, cognition issues (inc dementia), with complex physical and social care needs, and subsequent increasing LOS (lengths of hospital stay) The ethnic diversity of Cardiff and Vale is also growing, with over 94 different languages spoken, inc English, Welsh, Arabic, Polish, Chinese and Bengali, all with diverse religious and cultural dietary needs and preferences.

	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].	1 in 10 people in Wales report long term health problems or disabilities, and with life expectancies increasing due to ongoing advances in medical science, it poses a greater challenge for the Health Board to meet patient's nutritional and dietary needs. In Wales the prevalence of malnutrition in hospitals in 1 in 4 adults (26%) Wales having the greater prevalence than England. The Risk of malnutrition increases significantly with age and patients have a 3 fold greater risk of complications following surgery, require more medications and a higher risk of mortality compared to the well nourished. Challenges are also faced by unhealthy life styles such as respiratory disorders from smoking, obesity and diabetes, alongside alcohol and drug, and social and economic deprivation. The public have been made aware that the care of older patients within care settings, have been suboptimal, through the Francis and Andrews reports, where the most basic elements of care was neglected such as nutrition and hydration, the Health Board has a duty of care to ensure the needs of all patients within Cardiff and Vale receive the best nutrition and hydration care that meets their specific needs. The policy document is an overarching document which must be considered in meeting the standards specified in the 'All Wales Nutrition and Catering Standards for Food and Fluid provision for Hospital Inpatients', the All Wales Nutritional Care Pathway and Health and Care standards 2.5 Nutrition and Hydration. The policy has been written with assistance and involvement from the above staff groups via the Nutrition and Catering Steering Group and/or work streams as appropriate. Patient feedback is sought via '2 minutes of your time', regular All Wales Patient Mealtime surveys, annual Health and Care monitoring, monthly MDT meal time service audits, Welsh Audit Office surveys, Community Health Council surveys and patient stories. Patient representatives from the community Health Council form part of the nutrition and catering working groups.

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

5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	In order to ensure the effective delivery of good nutrition and hydration in a hospital setting a team approach is absolutely essential. Procurement, Catering management, Production staff, Ward based catering staff, Dietitians, Medical and Nursing staff and Therapies such as Speech and Language therapy, Occupational Therapy and Physiotherapy all have an important role to play in achieving 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	All patients will be nutritional risk screened on admission to hospital, and their needs addressed. Suitable menu items are provided for all client groups from babies to the elderly. Specific or targeted menus include Texture modified menus, Children's menus, maternity menus. We recognize there may be a negative impact for those long stay younger and older patients due to the fact that the menu is largely aimed at the elderly who we know comprise 65% of the inpatient population. Within C & V there are sites specifically for particular age grouped patients e.g. Rookwood Hospital (long stay younger patients), Barry	Work is needed to develop specific menus suitable for the longer stay units to better meet the preferences and needs of these different age groups.	Work is currently being undertaken to develop specific menus suitable for the longer stay units to better meet the preferences and needs of these different age groups.

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
	Hospital, MHSOP wards, HYC.		
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	Menus are designed to meet the needs of patients with specific disabilities such as swallowing problems, diabetes, dexterity issues, and self feeding issues. Targeted menus are available e.g. texture modified menus, finger food buffet menus. There are some areas where social dining is encouraged to support the communication and nutritional needs of vulnerable patients. The Nutrition & Hydration bed plan is available to assist the identification of patients physical needs in relation to eating and drinking. Certain patients, such as	There needs to be consideration given to better meeting the needs of the older longer stay patient through special menus, buffet menus, finger food menus etc. Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	The health board dietitians are actively involved in the procurement of food items that can be used to increase the range and variety of foods/meals that meet patient's specific needs and meet the food and fluid standards. The health board is currently in the process of purchasing new crockery which will create greater independence to patients with eating. Patients with communication difficulties will need to have their menus in appropriate forms e.g. pictorial menus may be used so that they will be accessible to more people. There are plans to develop

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
	patients with mental health issues, patients with swallowing disabilities or dementia may be negatively affected due to their extended length of stay, and the limited number of menu choices can result in menu fatigue. Snack items are also limited for this category of patients. Availability of adapted cutlery and crockery is limited.		these. Ongoing patient feedback is used to provide information to make any relevant menu changes
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There is no evidence to suggest that the policy impacts adversely on patients who have or are undergoing gender reassignment. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes

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
	consider the nutritional well being of each patient regardless of background.		
6.4 People who are married or who have a civil partner.	There is no evidence to suggest that the policy impacts adversely on patients who are married or in a civil partnership. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes
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 is a maternity specific menu for patients who have very different needs compared to the main hospital population. The menu reflects the high ethnic diversity of the Cardiff and Vale	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to make any relevant menu changes

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
	population.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The menu reflects the high ethnic diversity of the Cardiff and Vale population. Halal , Kosher, vegetarian and vegan menus are available. The numbers of ethnic meal choices are limited for those patients especially those requiring texture modified diets We are aware that the needs of some smaller ethnic groups in Cardiff are not fully met within the UHB menus. We currently do not have menus available in the other languages of our diverse population. The Nutrition & Hydration bed plan is available to assist the identification of patient's cultural or religious needs in relation to eating and drinking.	There needs to be a long term plan to translate the new two week menu into different languages for those patients that request it. There needs to be consideration given to expanding the range of vegetarian, vegan and ethnic suitable meals especially for the various texture modified diets. Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Work is currently ongoing to increase the range of vegetarian and vegan meals. Pictorial menus may be used so that they will be accessible to more people. The UHB are able to source Kosher suitable meals in the texture modified diet range. For those patients with very specific needs and preferences currently not catered for with the UHB menus, staff are able to purchase specific meals or items to support their nutrition and hydration needs. Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
	Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The menu reflects the high ethnic diversity of the Cardiff and Vale population. Halal and Kosher, Vegetarian and Vegan menus are available. The Nutrition & Hydration bed plan is available to assist the identification of patients specific religious needs in relation to eating and drinking.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There is no evidence to suggest that the policy impacts adversely on patients who are attracted to people of the opposite or same sex. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is no evidence to suggest that the policy impacts adversely on patients who speak Welsh. The written menu is not available in Welsh	The written menu should be available in Welsh. Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of	There is a long term plan to translate the new two week menu into Welsh for those patients that request it. Ongoing patient feedback is used to provide information to make any relevant menu changes.

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
		patients.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is no evidence to suggest that the policy impacts adversely on patients of differing incomes. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There is no evidence to suggest that the policy impacts adversely on patients depending on where they live. Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

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 the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The menu does promote healthy choices where appropriate. A range of menu items including fruit, salads, jacket potatoes, desserts and other lower fat and salt items are included in the menu. We currently comply with the Food and Fluid Healthy eating guidance. The Nutrition & Hydration bed plan is available to assist the identification of patients with particular requirements in relation to eating and drinking. The main focus of the menus is to improve patient's nutrition and nutritional health in illness and therefore healthier options can	Consideration needs to be given to developing specific menus to meet the health and nutritional needs of client groups on these sites.	Specific menus may be developed to address Rookwood Hospital's particular problem. Ward based Caterer training includes healthy lifestyle, and how best to meet the needs of patients who are nutritionally well. Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
	appear to be limited. This may be a particular problem where patients are in hospital for longer stays where their medical condition impacts on their mobility e.g. Rookwood spinal rehabilitation unit, or Hafen Y Coed.		

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	There is no evidence to suggest that the policy impacts adversely on patients living in areas of deprivation and/or experiencing health inequalities.	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
Wales	Cardiff and Vale has a legal duty of care to all its patients as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient regardless of background.		
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	The menu does promote healthy choices where appropriate. A range of menu items including fruit, salads, jacket potatoes, desserts and other lower fat and salt items are included in the menu. We currently comply with the Food and Fluid Healthy eating guidance. The Nutrition & Hydration bed plan is available to assist the identification of patients with particular requirements in relation to eating and drinking.	Consideration needs to be given to developing specific menus to meet the health and nutritional needs of client groups on these sites.	Specific menus may be developed to address Rookwood Hospital's particular problem. Ward based Caterer training includes healthy lifestyle, and how best to meet the needs of patients who are nutritionally well. Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
Wales	The main focus of the menus is to improve patient's nutrition and nutritional health in illness and therefore healthier options can appear to be limited. This may be a particular problem where patients are in hospital for longer stays where their medical condition impacts on their mobility e.g. Rookwood spinal rehabilitation unit, or Hafen Y Coed. For those patients wanting additional lifestyle advice and support, the ward teams can refer the patient on to appropriate community advice and support groups.		
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	There is no evidence to suggest that the policy impacts adversely on patients with differing levels of income or employment status. Cardiff and Vale has a legal duty of care to all its patients, as does	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

11.3

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales	each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient, regardless of background.		
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	There is no evidence to suggest that the policy impacts adversely on patients in terms of their use of the physical environment. Cardiff and Vale has a legal duty of care to all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient, regardless of background etc. Cardiff and Vale UHB has a responsibility to improve health	Ongoing patient feedback must be used to provide information to support any relevant menu changes if needed for this group of patients.	Ongoing patient feedback is used to provide information to support any relevant menu changes.

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
	and prevent ill health in the local population, as well as providing patient care. Predominately healthier snack and meal options are available for purchase by visitors and staff at all of the restaurant and retail outlets across the HB. The health Board works in partnership with Shared Services regarding the procurement of food items/ingredients for use within staff, visitor and patient catering supports and promotes the use of sustainable foods where possible, with significant local and global environmental impact, with thought given to the amount of energy and water required to transport, and packaging.		
7.5 People in terms of social and community influences on their health: Consider the impact on family	There is no evidence to suggest that the policy impacts adversely	Ongoing patient feedback must be used to provide	Ongoing patient feedback is used to provide information to support

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
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	on patients in terms of their social and community influences. Cardiff and Vale has a legal duty of care to all its patients, as does each professional employed by them. Implicit in this duty of care is the necessity to comply with all relevant legislation and consider the nutritional well being of each patient, regardless of background.	information to support any relevant menu changes if needed for this group of patients.	any relevant menu changes.
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	The health Board works in partnership with Shared Services regarding the Procurement of food items/ingredients for use within staff, visitor and patient catering supports and promotes the use of sustainable foods where possible, with significant positive local and global environmental impact, with thought given to the amount of energy and water required to	Where possible consideration will be given to sourcing food products as locally as possible.	The health Board will continue to work with Shared Services for the procurement of food products that meet the 'sustainability policy'

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
	transport, and with packaging. The sustainability policy does have financial implications for the Health Board, and it is not always possible to source food items locally, within season, or in sufficient quantities.		

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	Cardiff and Vale University Health Board has a legal duty of care to all its patients, as does each profession employed by them. Implicit in this duty of care is the necessity to comply with all the relevant Welsh Government food and fluids standards and relevant legislation, as well as the Welsh Government Health and Care standards relating to nutrition and hydration. This policy takes into account that all patients admitted to hospital be treated in a consistent and dignified manner irrespective of their religion, age, gender, disability or beliefs. This policy is an overarching document which must be considered in ensuring the nutritional needs of **all** our patients regardless of age, race, gender, or illness, are met, and **all** patients receive the best possible nutritional care to aid recovery. The overall impact of this policy is positive in meeting the equality and diversity needs of all patients admitted to hospital. **Positive impacts** • All patients admitted to the HB are weighed and screened for the risk of malnutrition, with the patient's therapeutic and dietary needs documented (including cultural, ethnic and religious requirements) and communicated to appropriate staff via the nutrition and hydration bed plan. Nursing staff refer patients on for specific therapy input as appropriate. • Menus used within the HB meet the needs of all ages of patients from babies to the very elderly • Specific menus exist to meet patients specific therapeutic, dietary, religious and cultural needs • The menus used promote healthy choices and comply with food and fluid healthy eating guidelines. • Patient feedback is sought and used to drive menu changes as appropriate. • All staff involved in delivering nutritional care and meal services have access to appropriate training. **Areas for improvement** • Within longer stay areas patients can experience menu fatigue especially amongst the very elderly and the younger disabled adult.

	• There is a need for a menu that includes foods that can be eaten without cutlery for use within the MHSOP areas. • The range of texture modified suitable snacks is limited. • The range of vegetarian and especially vegan main meals and desserts are limited. • Written menus are available to patients but in English only. • The main focus of the menus is to meet the nutritional needs of the nutritionally vulnerable, healthier options can appear limited. • Staff uptake of available training relating to nutrition and hydration is poor.

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?	• Development of a new two week menu cycle is required to limit menu fatigue, with consideration for the very longer stay patients in areas such as mental health, MHSOP and neuro' and spinal rehabilitation. • Development of a 'finger food' menu to run alongside the main menu. • To procure an increased range of snacks suitable for the different texture modified diets. • Development of an increased range of main meals and desserts suitable for vegetarians and vegans. • Development of written menus in picture form and Welsh. • Continued compliance with the Food and Fluid Healthy eating guide lines. • Development and delivery of accredited training for ward based catering and nursing staff that includes basic nutrition, food hygiene and customer care.	ALL BY;- Dietetic and Catering working group and the HB's Nutrition and Catering Steering group	January 2018	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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 action required, other than the above development work.			

	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	The identified actions to be achieved in the next year.	Nutrition and Catering working group	January 2018	

APPROVAL OF VENEPUNCTURE FOR NON CLINICALLY QUALIFIED RESEARCH STAFF
Name of Meeting Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead : Medical Director
Author : Senior Manager(R&D) : 029 2074 8295
Caring for People, Keeping People Well : Research is a core function of the Health Board. Research has a direct impact on improving the efficiency and effectiveness of services, delivering better health and well being outcomes for people and improving the experience of care. Undertaking research allows patients to contribute towards taking responsibility for improving their health and wellbeing and provides access to novel treatments and new diagnostic tools. The Health Board can be seen as an organisation where staff can learn, work with partners to improve care and excel at research
Financial impact : N/A
Quality, Safety, Patient Experience impact : Research and Development impacts positively on patient experience. The research governance systems and controls in place in the Health Board ensure the research is of high quality and risk assessed and that research practitioners are appropriately trained and educated
Health and Care Standard Number 3.3 Quality Improvement, Research and Innovation
CRAF Reference Number 5.1.6, 5.7, 7.3
Equality and Health Impact Assessment Completed: Yes

11.4

ASSURANCE AND RECOMMENDATION

ASSURANCE / LIMITED ASSURANCE / NO ASSURANCE is provided by:

- This policy and related procedure which will ensure that non clinically qualified staff involved in research undertake the same rigorous training and education that is currently in place for clinically qualified staff and will ensure that standards of quality are being met

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Venepuncture for Non Clinically Qualified Research Staff Policy and related procedure

and

- **APPROVE** the full publication of the Venepuncture for Non Clinically Qualified Research Staff Policy and related procedure in accordance with the UHB Publication Scheme

SITUATION

Cardiff and Vale University Health Board has an expanding team of staff undertaking research delivery. Currently, clinically qualified staff undertake a programme of training to perform venepuncture. There is no policy available currently within the UHB to allow non clinically qualified staff working in research to undertake training in venepuncture.

BACKGROUND

In April 2017, thirty eight (38) Whole Time Equivalent (WTE) staff from Health Care Research Wales were transferred into the employment of the UHB from Health Care Research Wales under the "Transfer of Undertakings (Protection of Employment) Regulations 2006". All these employees are engaged in the delivery of research and with increasing difficulty in recruitment of nurses to undertake clinical research throughout the UK, the growth of 'research officer' post has risen nationally as a result. In order to fulfill the requirements of these roles, individuals require to undertake venepuncture. This policy and the related procedure ensures that the UHB has the same training and education available to clinically and non clinically qualified staff

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:-

- This policy and the supporting procedure were reviewed and recommended for approval by the UHB Research Governance Group on the 25 April 2017 and comments were taken on board and incorporated into the draft documents
- The documents were added to the Policy Consultation pages on the intranet and closed on the 16 June 2017. No comments were received as a result of this consultation.
- Compliance with this policy and supporting procedure will be monitored by the Research Governance Group

The primary source for dissemination of this policy and supporting procedure 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 unless document for review* **Version Number:** 1	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *N/A*

Venepuncture for Non Clinically Qualified Research Staff Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, this policy will identify the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board.

Policy Commitment

The purpose of this policy is to state the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture. To reduce this risk it is imperative to ensure that non clinically qualified research staff have received appropriate training and education, together with a period of supervised practice and assessment to ensure they are competent to undertake this invasive procedure autonomously.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedure describe the following with regard to Venepuncture for Non Clinically Qualified Research

- Staff Roles and Responsibilities
- Limitations
- Training

Other supporting documents are:

UHB Documents

1. Consent to Examination or Treatment Policy
2. Labelling of Specimens Submitted to Medical Laboratories Policy
3. Infection Control Procedure for Hand Decontamination
4. Patient Identification Policy
5. Blood Transfusion Policy
6. Mental Capacity Act and Tool Kit
7. Infection control procedure for Needle stick injury

National guidelines

1. Aseptic Non-Touch Technique (ANTT)
2. Royal Marsden Guidelines
3. Informed Consent in Research as part of Good Clinical Practice training

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Scope This policy is restricted to all unregistered practitioners working in research roles within the UHB, who are required to undertake venepuncture to support the delivery of research or drug trials. For the purposes of this policy, this includes permanent, temporary, bank and agency staff as well as holders of honorary contracts and letters of access. For the remainder of this document these staff will be referred to as 'Research Staff' This document serves to outline the conditions under which Research Staff working within research may be considered suitable to undertake venepuncture training and the limitations that apply.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a no impact

Policy Approved by	Quality, Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Research Governance Group
Accountable Executive or Clinical Board Director	Executive Medical Director

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.

11.4

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	New Document
2			

Reference Number: *TBA unless document for review* **Version Number:** 1 *unless document for review*	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Venepuncture for Non Clinically Qualified Research Staff Procedure

Introduction and Aim

This document supports the UHB Venepuncture for Non Clinically Qualified Research Staff Policy. The aim of this procedure is to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board (UHB).

Objectives

The objective of this procedure is to

- State the expected standards of care to minimise the associated risk of harm to patients and staff when undertaking venepuncture.
- To reduce this risk by ensuring that non clinically qualified research staff have received appropriate training and education, together with a period of supervised practice and assessment
- To ensure that all non clinically qualified research staff are competent to undertake this invasive procedure autonomously.
- Identify the roles and responsibilities of UHB staff and limitations on the scope of practice

Scope

This procedure is restricted to all unregistered practitioners working in research roles within the UHB, who are required to undertake venepuncture to support the delivery of research or drug trials. For the purposes of this procedure, this includes permanent, temporary, bank and agency staff as well as holders of honorary contracts and letters of access For the remainder of this document these staff will be referred to as 'Research Staff'
This document serves to outline the conditions under which Research Staff working within research may be considered suitable to undertake venepuncture training and the limitations that apply.

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed to support the Policy document implementation (the Venepuncture for Non Clinically Qualified Research Staff Policy). The Equality Impact Assessment completed for the policy found there to be no impact.
Documents to read alongside this	**UHB Documents** 1. Consent to Examination or Treatment Policy

11.4

Document Title: *Insert document title*	2 of 6	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Procedure	2. Labelling of Specimens Submitted to Medical Laboratories Policy 3. Infection Control Procedure for Hand Decontamination 4. Patient Identification Policy 5. Blood Transfusion Policy 6. Mental Capacity Act and Tool Kit 7. Infection control procedure for Needle stick injury **National guidelines** 1. Aseptic Non-Touch Technique (ANTT) 2. Royal Marsden Guidelines *3.* Informed Consent in Research as part of Good Clinical Practice training
Approved by	Research Governance Group recommended for Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Executive Medical Director
Author(s)	Senior Manager (R&D)

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.

11.4

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	New Policy and Procedure

Document Title: *Insert document title*	3 of 6	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Venepuncture for Non Clinically Qualified Research Staff Procedure

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1.0 Introduction

The aim of this procedure is to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board (UHB).

2.0 Roles and Responsibilities

2.1 The Senior Nurse (R&D) will ensure that

- Responsibility for the provision of training and the supervised component of the venepuncture competency procedure is delivered by the appropriate Registered Nurse Research Delivery Team members who are recognised trainers and assessors.
- Issues around the release of Research Staff to meet their training needs are escalated as appropriate.
- Issues around compliance of Research Staff in the completion of the All Wales ANTT e-learning programme as part of their venepuncture training and direct observation of Practice ANTT assessment are escalated as appropriate.
- Line managers are supported in monitoring compliance with the venepuncture policy.
- Investigation and action follow up in incidents involving this staff group and this competence that are reported using the UHB Incident Reporting System are undertaken.

2.2 The Learning Education and Development Department (LED) will ensure that:

- In house competency based training is current and evidence based in line with national guidelines and the training provided to nursing staff.
- The UHB venepuncture training resources are made available for use by the Registered Research Nurse trainers who will deliver venepuncture training to non-clinical research staff.
- All training and completed competency assessments will be recorded on the Electronic Staff Record.

2.3 Research Delivery Managers will ensure that

- The need for non clinically qualified members of research delivery teams to gain competence in venepuncture is identified in an individual or a team PADR.

- Compliance with this procedure is ensured with support from the Senior Nurse (R&D).
- All incidents involving this staff group and this competence are reported using the UHB Incident Reporting system and are escalated to the Senior Nurse (R&D) for review.

3.0 Limitations

- Requirement for an individual to gain competence in venepuncture must be made as part of an individual or team PADR by an appropriate Line Manager.
- Research Staff may only carry out a venepuncture procedure on a patient/client on the delegated instruction of a doctor/nurse practitioner or team leader/deputy where this delegated responsibility is listed and signed off on the Study Delegation Log by the Principal Investigator.
- Research Staff may only undertake venepuncture for research samples as outlined in the study protocol. If research participants require standard clinical blood samples to be taken during the same visit, this may be done by research staff to avoid the need for patients to have two procedures. Responsibility for the completion and review of these standard blood samples, including the completion of request forms must be undertaken by the clinical team.
- Research Staff may not take blood samples for any clinical indication where specialist training is required. This restriction includes but is not restricted to blood sampling for transfusion cross matching, blood sampling for blood cultures.
- Research Staff may only undertake venepuncture within staffed clinically designated areas of the UHB where immediate clinically qualified help is readily available.

4.0 Training

The existence of this Procedure and its implications for research staff will be covered during UHB R&D training events and during induction for all research delivery staff.

5.0 Implementation

All staff undertaking Research Delivery within the UHB together with those who have a specific responsibility within this procedure are responsible for its implementation.

6.0 Equality

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate

against individuals or groups. We have not undertaken an Equality and Health Impact Assessment on this procedure but undertook an EHIA as part of the Venepuncture for Non Clinically Qualified Research Staff Policy that underpins this procedure and received feedback on the policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment on the policy found that there was no impact to the equality groups mentioned.

7.0 Distribution

The document will be available via the UHB Inter and Intranet and on the R&D Internet pages.

8.0 Review

The Policy underpinning this procedure will be reviewed every 3 years, or more regularly if new legislation so requires.

Equality & Health Impact Assessment for

Venepuncture for Non Clinically Qualified Research Staff Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Medical Directors Office Learning, Education and Development Kate Craig 48295 Lisa Franklin 4XXXX
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Extend access to non clinically qualified staff to undertake venepuncture within research studies in the UHB
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	• Similar policies from other organisations within the UK were reviewed and advice was sought from similar research active Trusts within England via the UK wide Lead Nurse for Research Forum • Stakeholders were not engaged in the EHIA and/or policy development but were consulted in order to share views. • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet)

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	• comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	UHB Staff without a professional qualification working within research delivery will be affected by the Policy.

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

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	There does not appear to be any impact.	n/a	n/a
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	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to staff in alternative formats on request or via usual good		

11.4

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
	management practice.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff		
6.4 People who are married or who have a civil partner.	There appears not to be any impact on staff		

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
6.5 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 not to be any impact on staff		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on staff		

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
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact on staff		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact on staff		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design			

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
Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact on staff.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff.		

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
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups including Carers or risk factors to take into account with regard to this Policy.		

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	Not applicable		

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
and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
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	Not applicable		

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
management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Not applicable		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food,	Not applicable		

11.4

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
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			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging;	Not applicable		

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
social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
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	Not applicable		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of administrative type policies.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	None identified	N/A	N/A	N/A
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?	As there has been potentially no impact identified, it it is unnecessary to undertake a more detailed assessment and formal consultation is not required.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps?	This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

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UPDATE ON THE REVIEW OF OUTSTANDING POLICIES
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting 13th September 2017**

Executive Lead : Executive Nurse Director
Author : Quality and Safety Improvement Manager. Joy.whitlock@wales.nhs.uk 02920 745099
Caring for People, Keeping People Well : Delivering outcomes that matter to people; avoiding waste variation and harm
Financial impact : Failure to have updated and approved Policies in place that staff are aware of and working to can create a financial risk to the UHB
Quality, Safety, Patient Experience impact : Updated and approved Policies, known by staff and used by staff support the delivery of good quality and safe services to patients.
Health and Care Standard Number QSE Policies span many of the Standards for Health Services in Wales. However, having approved Policies in place are a key requirement of Standard 1, Governance and Accountability
CRAF Reference Number 5.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress that has been made since the last report to the Committee in February 2017
- The plan to address existing out of date policies

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the progress that has been made
- **APPROVE** the proposal to achieve a position where all clinical policies are in date.

12

SITUATION

The purpose of this report is to provide an update on progress since February 2017 with the review of outstanding clinical policies and procedures which have been assigned to the Quality, Safety and Experience Committee as the current designated approving committee.

BACKGROUND

The Board approved the Policy for the Management of Policies, Procedures and Other Written Control Documents in January 2010 (updated in June 2011). This policy delegated the responsibility for approval of a number of

policies, procedures and other written control documents to the Quality, Safety and Experience committee.

The Committee has previously received reports in June 2014 and February 2015 and 2017. These provided an update on the status of these policies at that time.

ASSESSMENT AND ASSURANCE

By February 2017 there were 23 former Trust policies and procedures and 34 UHB policies and procedures assigned to the Quality, Safety and Experience Committee that were out of date. This had been reduced from 57 former Trust policies and 39 UHB policies that were out of date in February 2015.

The Assistant Director of Patient Safety and Quality identified short term capacity to undertake a focused piece of work, to identify those policies that:

- are no longer current and can be removed from the intranet
- have been superceded by more current policies/strategies
- require review

In summary, since February 2017 paper to committee:

- 25 policies and procedures have been updated and approved and out of date versions replaced or removed
- 4 moved to Health and Safety and one to PPP Committee – registers updated
- 12 are currently being updated – at various stages
- 10 need assigning to a lead to undertake the review
- 6 are re-written and out for consultation

The remainder now need further investigation and discussion and timescales will be agreed to complete policy and procedure writing

This now means that the current position for policies that the Quality, Safety and Experience Committee is responsible for, is that 13 former Trust policies and 18 UHB policies and procedures remain out of date. Work will continue to review and revise these remaining policies and a further update will be provided to the committee in February 2018.

Appendix 1 provides a more detailed summary of the progress made with each policy and procedure.

APPENDIX 1 - REVIEW OF OUTSTANDING POLICIES . a) needing review, b) no longer relevant can be removed from intranet, c) superseded by another policy and can be removed from intranet or d) written and awaiting approval

Ref No	Version No	Title of Document	Type of Document	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
Ref 47		Isolation for Infectious Diseases Procedure	Policy	19.05.2019	No	Executive Nurse Director	c) Removed. Isolation is included in both the Standard Precautions (UHB 149 – exp 12.05.2019) and the Transmission Based Precautions (UHB 267 – exp 23.06.18) procedures
Ref 110	1	Breaking Bad News to Patients, Their Relative and/or Carers	Policy	01/02/06	Yes	Executive Nurse Director	a) Decision as to whether it is a policy. Recommend developing guidance. Lead and time frame to be agreed.
Ref 139	2	Patient Handover Policy	Policy	01/05/11	Yes	Medical Director	a) Medical lead and nursing support to be agreed + time frame.
Ref 143	1	Vancomycin Resistant Enterococcus Policy & Procedure	Policy & Procedure			Executive Nurse Director	c) Removed. Vancomycin Resistant Enterococcus is included in the MDRO procedure accepted at Healthcare Associated Infection Group therefore not required.
Ref 210	1	Tracheostomy Guidelines for the acute care in Cardiff and Vale NHS Trust	Guideline	01/10/10	Yes	Executive Nurse Director	d) Written and awaiting approval by the steering group then to be signed off through QSE
Ref 217	3	Trauma Team Protocol	Protocol	01/10/09	Yes	Chief Operating Officer	a) In progress. The trauma team are reviewing it and writing a number of policies which are required as part of the impending trauma network quality indicators and NatSSIPs framework.

Ref No	Version No	Title of Document	Type of Document	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
Ref 242	2	Writing prescriptions (previously ref DAG 1.1)	Policy			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 244	1	Telephone prescribing in an emergency (verbal order) Previously DAR 1.2 v2	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 246	1	Pre-printed prescription labels Previously DAG 1.5 v2	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 250	1	Faxing of prescriptions previously DAG 2.5 v2	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 268	1	Monitored dose systems previously DAB 3.7	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 270	1	Use of bed side medicine cabinets for wards without a POM service medicines management previously DAG 3.11	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 280	1	Disposal of medicines previously DAG 5.3	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.

Ref No	Version No	Title of Document	Type of Document	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
Ref 281	1	Handling linen contaminated with cytotoxic drugs – previously DAG 5.5	Procedure			Medical Director	c) Included in the new medicines code – waiting for publication.
Ref 288	1	Guidance in the event of unexpected death (Mental Health)	Procedure	01.07.10	Yes	Chief Operating Officer	a) Lead and timescales to be agreed
Ref 291		Being Open Policy	Policy	01.05.10	Yes	Medical Director	a) Work in progress. To be presented to the October 2017 QSE Committee
Ref 298	1	Covert administration of medicines	Policy	01.01.11	Yes	Medical Director	a) Included in the new medicines code – waiting for publication
Ref 302	1	Verification of expected death by qualified nursing staff (Mental Health and Medicine Rehabilitation Services)	Guidelines	01.11.08	Yes	Executive Nurse Director	a) Discussed at Nurse Director meeting. Lead appointed.
Ref 306	1	Clinical Supervision Policy	Policy	01.07.12	Yes	Medical Director	a) Lead and timescale need to be agreed by Medical Director.
Ref 328	1	Dealing with Visitors who are violent/abusive or vexatious procedure	Procedure	01.07.11	Yes	Executive Director of Planning	a) Discussed with Head of Corporate Governance and Health and Safety. To be moved to Health and Safety Committee. Register updated.

Ref 354	1	Preceptorship of newly qualified nurses	Policy	01.11.10	Yes	Executive Nurse Director	a) Currently being revised. Aiming to go to Nursing Midwifery Board in September 2017

UHB Ref No	Version No	Title of Document	Type of Document	Last Review Date	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
Ref 358	1	Managing Young People who a Sexually Active Protocol	Protocol	18.11.08	01.11.10	Yes	Executive Nurse Director	a) Lead and timescales to be agreed
Ref 377	1	Child Protection Supervision Protocol	Protocol	01.09.08	01.09.11	Yes	Executive Nurse Director	a) Lead and timescales to be agreed
UHB002	2	Data Protection Policy	Policy	10.12.13	10.12.16	Yes	Medical Director	b) Updated version has replaced old policy. This is PPP – not QSE committee. Register updated.
UHB003	2	Child Abduction Policy	Policy	21.02.12	21.05.15	Yes	Executive Nurse Director	a) Lead and timescales to be agreed
UHB016	1	Routine Enquiry Guidelines into Domestic Abuse for the Emergency Unit	Guidelines	17.08.10	17.08.13	Yes	Executive Nurse Director	a) Lead and timescales to be agreed
UHB017	3	Labelling of Specimen Policy	Policy	14.06.13	14.06.15	Yes	Chief Operating Officer	a) Work in progress. Timescales to be agreed
UHB030	1	Provision of Intra-Operative Cell Salvage Policy	Policy	22.02.11	01.02.14	Yes	Medical Director	a) Currently being reviewed. Lead appointed. Timescales to be agreed.

UHB032	1	Advanced Care & Emergency Pathway	Policy			No	Medical Director	b) Replaced by an all-Wales policy 334
UHB Ref No	**Version No**	**Title of Document**	**Type of Document**	**Last Review Date**	**New Review Date**	**Review Date Expired**	**Responsible UHB Director**	**Response a), b), c), d) & comments**
UHB062	1.1	Point of Care Testing Policy	Policy	14.06.12	14.06.15	Yes	Medical Director	a) All-Wales policy agreed. Out for consultation in the UHB
UHB068	2	Blood and Components Transfusion Policy	Policy	21.02.17	21.02.20	No	Medical Director	c) Approved QSE in Feb 2017
UHB068.1	3	Emergency Unit Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician	Procedure				Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020
UHB068.2	2	UHW Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician	Procedure				Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020
UHB068.3	4	Obstetric Massive Haemorrhage Protocol Cardiff and Vale UHB	Procedure				Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020

		Laboratory and Transfusion Response						

UHB Ref No	Version No	Title of Document	Type of Document	Last Review Date	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
UHB068.4	3	UHL Ward Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician					Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020
UHB068.5	3	Cardiac Theatre/ CITU Procedure for the Nurse Coordinator when the Massive Haemorrhage Protocol is requested by the Senior Clinician					Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020
UHB068.6	3	Theatre/ICU Procedure for the Nurse Coordinator when the Massive Haemorrhage					Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020

		Protocol is requested by the Senior Clinician						
UHB068.7	1	UHW Emergency Unit Portertrac Massive Haemorrhage Activation					Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020

UHB Ref No	Version No	Title of Document	Type of Document	Last Review Date	New Review Date	Review Date Expired	Responsible UHB Director	Response a), b), c), d) & comments
UHB068.8	2	UHW General Wards Portertrac Massive Haemorrhage Activation	Procedure				Medical Director	c) Approved QSE in Feb 2017 now in UHW 348 Blood and Components Transfusion Procedure. Exp 21.02.2020
UHB069	1	Safety Notices and Important Documents Management Policy	Policy	09.08.11	09.08.14	Yes	Director of Corporate Governance	c) Revised. Out for consultation.
UHB081	1	Parental Infusion Pumps Policy	Policy	18.10.11	18.10.14	Yes	Medical Director	a) Lead identified. Timescale for completion to be agreed.
UHB091	1.1	Control of Legionella Policy	Policy	13.12.14	13.12.17	No	Executive Director of Planning	V 1.1 published in 2015. This is a H&S policy and can be removed from QSE. Register updated.
UHB101	1	Patient Identification Policy	Policy	21.02.12	21.02.15	Yes	Medical Director	a) Lead identified. To be presented to the Dec 2017 QSE Committee
UHB104	1	Choice Protocol	Protocol	15.11.11	15.11.14	Yes	Executive Nurse Director	a) The choice protocol will sit as part of the new discharge policy

								which is currently out for consultation.
UHB110	3	Donation of Organs and Tissues following Death Policy	Policy	18.04.17	18.04.20	No	Medical Director	c) Approved and published
UHB113	1	Lasting Power of Attorney and Court Appointed Deputy Procedure	Procedure	17.04.12	17.04.15	Yes	Medical Director	a) Revised and out for consultation
UHB Ref No	**Version No**	**Title of Document**	**Type of Document**	**Last Review Date**	**New Review Date**	**Review Date Expired**	**Responsible UHB Director**	**Response a), b), c), d) & comments**
UHB116	1	Service Evaluation Guidelines	Guidelines	14.06.12	14.06.15	Yes	Medical Director	a) Lead and timescales to be agreed
UHB117	1.1	Patient Property	Policy	13.09.16	13.09.19	No	Executive Nurse Director	c) Approved and published
UHB119	1	Mental Health Clinical Risk Assessment & Risk Management Policy	Policy	14.06.12	14.06.15	Yes	Medical Director	a) Lead and timescales to be agreed
UHB125	1	Prescribing for Staff	Policy & Procedure	09.04.13	09.04.16	Yes	Medical Director	c) Included in the new medicines code – waiting for publication.
UHB155	1	Pressure Ulcer Risk Assessment Prevention and Treatment Policy and Procedure	Policy & Procedure	11.12.12	11.12.15	Yes	Executive Nurse Director	a) Being updated. Timescales required.
UHB156	1	Child Visiting Policy in a Mental Health Setting	Policy	11.12.12	11.12.15	Yes	Executive Nurse Director	a) Being updated. Timescales required.

UHB174	1	Search of Patients person and belongings	Policy & Procedure	05.03.13	05.03.16	Yes	Executive Nurse Director	a) Related to security – transfer to Health and Safety. Register updated.
UHB175	1	Management of patients/visitors in possession of alcohol or unprescribed/illegal substances policy & procedure	Policy & Procedure	05.03.13	05.03.16	Yes	Director of Corporate Governance	a) Related to security – transfer to Health and Safety. Register updated.
UHB186	1	Independent Mental Capacity Advocacy	Procedure	28.05.13	28.05.16	Yes	Medical Director	a) Written and ready for consultation
UHB Ref No	**Version No**	**Title of Document**	**Type of Document**	**Last Review Date**	**New Review Date**	**Review Date Expired**	**Responsible UHB Director**	**Response a), b), c), d) & comments**
UHB190	1	Antimicrobial Agents Policy	Policy	14.06.13	14.06.16	Yes	Medical Director	a) Being updated – expecting to go to consultation in September 2017.
UHB206	1	Top-Up Medicines Payment Policy and Procedure	Policy	15.10.13	15.10.16	Yes	Executive Director of Public Health	a) The top up policy needs to be reviewed on an All Wales basis and Velindre have been asked to lead on the development as a lot of the top up activity is around high cost cancer drugs. Expect this to be complete before the end of 2017.
UHB209	1	Safe Handling and Administration of Intrathecal Chemotherapy Procedure	Procedure	15.12.16	15.12.19	Yes	Medical Director	Updated Dec 2016 – uploaded on intranet

IMPLEMENTING THE NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES (NATSIPPS)
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 12th September 2017

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality; Carol.A.Evans2@wales.nhs.uk; 02921846117
Caring for People, Keeping People Well : This supports 'Delivering outcomes that matter for people' and 'avoiding waste, variation and harm'
Financial impact : N/A
Quality, Safety, Patient Experience impact : Implementation of NatSSIPs would be key to standardizing best practice across the organisation and reducing the likelihood of Never Events
Health and Care Standard Number … Standard 2.1 Managing Risk and Promoting Health and Safety; Standard 3.1 Safe and clinically effective care
CRAF Reference Number …… 5.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Work that has progressed to implement the Standards to date

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the progress that has been made to date and **AGREE to** receive an update report at the October 2017 meeting in order to decide whether the UHB is complaint or not with the Patient Safety Notice034

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SITUATION

The purpose of this report is to present the Committee with an update on the implementation of PSN034 - Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPPs)

The UHB is expected to declare compliance status by the end of September 2017 and while considerable work has been undertaken, the Committee should be advised that the UHB is likely to be able to declare compliance at the end of October 2017. By this time, the UHB wide scoping exercise will

have been fully completed in order to allow the development of a robust implementation plan for roll out of the standards, in a prioritised way, across the organisation.

BACKGROUND

The introduction of the WHO Surgical Safety Checklist in 2010 aimed to reduce the number of 'Never Events', such as wrong site surgery or retention of foreign objects. A marked decrease in 'Never Events' was not seen. Because of this, the Surgical Never Events Taskforce was set up in 2013 and the result of their work was the development of safety standards known as NatSSIPs. These were published for NHS England in 2015 and a slightly adapted version for NHS Wales in 2016. The Welsh NatSSIPs document can be found **here.**

NatSSIPs builds on the WHO safer surgery checklist and extends this to invasive procedures performed outside a general theatre environment. They consist of a nationally agreed set of 13 standards which gives a formal governance structure to support safety in invasive procedures. There is an emphasis on human factors and the team resource involved with invasive procedures. An important part of NatSSIPs is standardisation to ensure that procedures are as safe as possible regardless of where they are performed.

ASSESSMENT AND ASSURANCE

In order to implement the Standards across the orgniasation a Task and Finish group has been established. While this is currently chaired by the Assistant Director of Patient Safety and Quality, a medical lead is being sought.

The UHB is working closely with Dr Will Harrop-Griffths, Consultant Anaesthetist, Chair of the England NatSSIPs group, and author of the English Standards. He attended a workshop in the UHB in May 2017, which was led by Surgery Clinical Board. The UHB remains in contact with him for on-going support and advice. In addition to this, the Patient Safety Team has also developed a positive working relationship with Dr Anne Hunningher. Consultant Anaesthetist and NatSSIPs lead at Barts Health NHS Trust, London.

Directorates which undertake invasive procedures have been asked to appoint leads to join the UHB NatSSIPs task & finish group. To date there has been good engagement and enthusiasm for the project.

The Patient Safety team have established an excellent intranet site as a resource for staff and a member of the Patient Safety team has devised a flowchart (**Appendix 1**) to assist staff in identifying procedures/interventions that require application of the Standards in practice.

Currently the UHB is undertaking a gap analysis exercise to establish what types of invasive procedures are being performed in the UHB and how the current governance structures compare with the requirements of NatSSIPs. This has been an extensive undertaking across all Clinical Boards with the exception of Mental Health and Primary Community and Intermediate care (which were not considered to be the immediate priority compared to acute Clinical Boards in secondary care.. They will however be required to scope their working practices during the second phase of the roll out).

In order to declare compliance, the UHB is required to have completed a full self-assessment; to have identified all procedures which meet the NatSSIPs definitions and also to develop a plan to address any gaps identified in the gap analysis. The current position is as follows:

Clinical Board/Directorate	Self-assessment status	Lead appointed
Surgery		
Theatres and anaesthetics	completed	Yes
General Surgery	underway	
Urology	underway	
Ophthalmology	underway	
ENT	underway	
Trauma and orthopaedics	underway	Yes
Medicine		
Gastroenterology and Endoscopy	completed	Yes
Emergency medicine	underway	Yes
Internal medicine	underway	Yes
Gerontology	underway	Yes
Dermatology and rheumatology	lead to be appointed	
Specialist Services		
Haematology	completed	Yes
Critical care	underway	Yes
Cardio-thoracics	underway	Yes
Medical genetics	underway	
Neuro-sciences and ALAS	underway	Yes
Nephrology and Transplant	underway	Yes
Clinical Diagnostics and therapeutics		
Radiology	completed	Yes
Therapies	underway	Yes
Pharmacy	N/A	-
Therapeutics and toxicology	N/A	-
Laboratory medicine	N/A	-
Children and Women		
Obstetrics	completed	Yes
Gynaecology	completed	Yes
Acute Child Health	completed	Yes

Community Child Health	N/A	-
Dental		
Hospital dental	completed	Yes
Community dental	completed	Yes

Although a significant amount of work has already been undertaken, given the number of outstanding self-assessments, it is not possible to provide enough assurance at this stage to advise the Committee that we are compliant with the requirements of PSN034. However it is anticipated that this work will be achieved by the end of September and an update and full improvement plan will be presented at the special October 2017 Committee meeting, in order that the UHB can then declare compliance.

Cardiff and Vale UHB – NatSSIPs invasive procedure definition flowchart

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

Does the procedure:

Require the patient to undergo a general anaesthetic, receive conscious sedation or an epidural block? **YES**

NO

Involve insertion of any medical device that the patient will be discharged with?
(E.g. Stent, IUD, implant) **YES**

NO

Involve the removal of tissue from any internal organ for lab analysis or testing? **YES**

NO

Involve insertion of a drain or a nasogastric/jejunal tube?
(Excludes urinary catheters inserted via the urethra) **YES**

NO

Involve the insertion of any line which enters the central circulation or the circulation system of the pelvis? **YES**

NO

Involve direct visualisation and/or recording live images of any internal body part, other than the mouth, throat, nose, eyes or ears?
(Excludes non-interventional radiology) **YES**

NO

Involve the introduction of non-oral X-ray contrast into the body via a device that is not already in situ prior to the procedure?
(Excludes peripheral IV cannulation) **YES**

NO

Involve the closure/repair of an incision made during the procedure or a tear caused by childbirth? **YES**

NO

Involve the removal of an organ, tooth or other body structure? **YES**

NO

Procedure does not fall under the Cardiff and Vale UHB NatSSIPs definition

NatSSIPs

NatSSIPs proposes to address those procedures that have the potential to be associated with a Never Event if safety standards are not set and followed

'YES' to any question indicates that the procedure falls under the Cardiff and Vale UHB NatSSIPs definition

This flow chart is not exhaustive. It aims to provide guidance on the types of procedure that are classified as 'invasive' for the purposes of NatSSIPs.

Specific examples are given overleaf

13.1

v1.4 Aug 17

Cardiff and Vale UHB – NatSSIPs invasive procedure definition flowchart

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

Examples of procedures included in NatSSIPs:

Cardiac catheterisation

Angioplasty

Gastroscopy

Colonoscopy

Surgical repair of genital tract trauma associated with vaginal delivery

Bronchoscopy

Bone biopsy

Nephrostomy

Chest drain insertion

Central line insertion

Nasogastric or nasojejunal tube insertion

Examples of procedures NOT included in NatSSIPs:

Peripheral IV cannulation

Wound dressing

Plain diagnostic X-rays

Urinary catheter insertion (via the urethra)

DRAFT

For further advice or information about NatSSIPs, please contact the Patient Safety Team on UHW ext 46991

PATIENT SAFETY SOLUTIONS - ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON-COMPLIANCE
Name of Meeting: Quality Safety and Experience Committee **Date of Meeting : 12th September 2017**

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

RECOMMENDATION

Limited ASSURANCE is provided by:

- The UHB is currently 90% compliant with all current Patient Safety Solutions (PSS), and this will increase to 92% by October 2017, based on work underway to address the requirements of recently issued PSSs and declare compliance with historical alerts.
- The actions that are being undertaken to address the outstanding areas of non-compliance.
- Risk assessments that are in place to mitigate any outstanding risks.

The Committee is asked to:

- **CONSIDER** the update provided within the report.
- **CONSIDER** the risk assessments associated with outstanding areas of non-compliance.
- **AGREE** that we can now declare compliance with PSA002 – The prompt recognition and initiation of treatment for Sepsis for all patients.

SITUATION

This report has been written to provide the Committee with an update on the UHB's position relating to Patient Safety Solutions, which include alerts and notices from Welsh Government, as well as a number of outstanding notices from the now disbanded National Patient Safety Agency (NPSA). The report also includes associated risk assessments and the implementation plan to secure full compliance with **PSA002 –** The prompt recognition and initiation of treatment for sepsis for all patients.

BACKGROUND

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

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

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

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

ASSESSMENT

The Committee should be advised that there are several elements to each PSS. In all cases where the UHB is currently reporting non-compliance, the UHB has further work to undertake against one or two elements of the PSS i.e. there is partial compliance with elements of each PSS. In all cases there are other mitigating factors in place to address the patient safety risks.

Since the last report to Committee in July 2017, the UHB has declared compliance with:

- PSA007 – Restricted use of open systems for injectable medication.
- PSN025 – 'Risk of death or severe harm due to inadvertent injection of skin preparation solution'.
- PSN -036 - Reducing the risk of oxygen tubing being connected to airflow meters.
- Safer Practice Notice NPSA/2007/16 – 'Early identification of failure to act on radiological imaging reports'.

- NPSA/2009/SPN002 – 'Risk to patient safety of not using the NHS Number as the national identifier for all patients'.

This means that current UHB compliance overall has increased from 81% compliant to 90% with current Patient Safety Solutions (43/48).

The Board should be advised that one of these PSSs - Supporting the introduction of the National Safety Standards for Invasive Procedures – involves a year long, significant piece of work, across the whole of the UHB and will now roll over to a probable two year full implementation period.

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

The outstanding area of non-compliance relates to the roll out NEWS in community hospitals. Subsequent to the last report the Committee is advised that the following actions have taken or are taking place:

- NEWS training has been undertaken and rolled out in Clinical Gerontology Directorate in St David's and Barry Hospitals
- Escalation processes are in place at Rookwood Hospital and these are now being formalized into a written Standard Operating Procedure
- NEWS training will be implemented as part of the operational plan when Iorwerth Jones, Mental Health Services for Older People Directorate, is transferred to the University Hospital Llandough Site
- There is a plan to implement NEWS in Mental Health Services for Older People in Barry Hospital during 2017 and progress will be reviewed in December 2017

For this reason, the UHB is now able to declare compliance with this historical alert

Details of the PSSs where the UHB remains non-compliant are given below (Table 1). This includes our position in comparison with our peers across Wales.

Table 1

Patient Safety Solution	How do we compare with our peers
PSA003 – Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	Cardiff and Vale UHB is one of 3 Health Boards reporting non-compliance. The alert is not applicable to 3 Health Boards / Trusts and 4 have reported compliance.

PSN026 – Positive patient identification	Cardiff and Vale is the only Health Board reporting non-compliance.
PSN030 – The safe storage of medicines: Cupboard	The UHB is one of 7 Health Boards which has reported non-compliance with this notice. Only Velindre NHS Trust and Public Health Wales have reported compliance.
No 24 – Standardising wristbands improves patient safety	All other Health Boards in Wales to which the notice applies are already using electronically printed ID wristbands. Cardiff and Vale is the only Health Board that is non-compliant with this notice which was issued in 2007.

A summary of overall UHB compliance status is included at **Appendix 1.**

An improvement plan to secure compliance with outstanding notices is included at **Appendix 2.**

Risk assessments associated with remaining areas of non-compliance are included at **Appendix 3 a,b and c.**

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

Patient Safety Alerts				
PSA Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSA 008	May 2017	Nasogastric tube misplacement: continuing risk of death and severe harm	30/11/2017	(Not yet due for response – work underway)
PSA007	January 2017	Restricted use of open systems for injectable medication	01/08/2017	Compliant
PSA006	January 2017	Risk of death and severe harm from error with injectable phenytoin	10/03/2017	Compliant
PSA005	July 2016	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	14/10/2016	Compliant
PSA004	July 2016	Ensuring the Safe Administration of Insulin	28/10/2016	Compliant
PSA003	May 2016	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	01/07/2016	**Non-compliant**
PSA002	September 2014	The prompt recognition and initiation of treatment for sepsis for all patients	28/11/2014	**Compliance to be declared**
PSA001	June 2014	Legionella and heathed birthing pools filled in advance of labour in home settings	30/06/2014	Compliant

Patient Safety Notices				
PSN Ref.	**Date Issued**	**Title**	**Date for response to WG**	**Compliance Status**
PSN037	April 2017	Resources to support the safety of girls and women who are being treated with Valproate	06/10/2017	(Not yet due for response – work underway)

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PSN036	November 2017	Reducing the risk of oxygen tubing being connected to air flowmeters	04/08/2017	Compliant
PSN034	September 2016	Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPPs)	28/09/2017	(Not yet due for response – work underway)
PSN033	June 2016	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	27/07/2016	Compliant
PSN032	May 2016	Risk of patient harm from an interaction between miconazole and coumarin anticoagulants	09/06/2016	Compliant
PSN031	April 2016	Risk of Patient Safety Incidents Resulting from Errors in the British National Formulary for Children 2015-2016 and British National Formulary 70	31/05/2016	Compliant
PSN030	April 2016	The safe storage of medicines: Cupboards	26/08/2016	**Non-compliant**
PSN029	March 2016	Standardising the early identification of acute kidney care	04/04/2016	Compliant
PSN028	February 2016	Medicines Reconciliation - Reducing the risk of serious harm	30/03/2016	Compliant
PSN027	February 2016	Risk of severe harm or death when desmopressin is omitted ordelayed in patients with cranial diabetes insipidus	08/04/2016	Compliant
PSN026	April 2016	Positive Patient Identification	13/05/2016	**Non-compliant**
PSN025	February 2016	Risk of death or severe harm due to inadvertent injection of skin preparation solution	04/04/2016	Compliant
PSN024	January 2016	Risk of using different airway humidification devices simultaneously	01/03/2016	Compliant

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PSN023	January 2016	The importance of vital signs during and after restrictive interventions/manual restraint	12/02/2016	Compliant
PSN022	December 2015	The risk of harm from the inappropriate use and disposal of fentanyl patches	31/01/2016	Compliant
PSN021	December 2015	Risk of death and serious harm by falling from hoists	15/02/2016	Compliant
PSN020	October 2015	Minimising risks of omitted and delayed medicines for patients receiving homecare services	27/11/2015	Compliant
PSN019	August 2015	Harm from delayed updates to ambulance dispatch and satellite navigation systems	30/09/2015	Compliant
PSN018	August 2015	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	31/08/2015	Compliant
PSN017	July 2015	Risk of using vacuum and suction drains when not clinically indicated	31/08/2015	Compliant
PSN016	July 2015	Risk of inadvertently cutting in-line (or closed) suction catheters	31/08/2015	Compliant
PSN015	July 2015	The storage of medicines: Refrigerators	31/08/2015	Compliant
PSN014	July 2015	Patient Safety Notice: Residual anaesthetic drugs in cannulae and intravenous lines	31/08/2015	Compliant
PSN013	July 2015	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	13/08/2015	Compliant
PSN012	May 2015	Advice sheet: Adrenal insufficiency (Addison's disease) in adults - information for general practitioners	12/06/2015	Compliant
PSN011	May 2015	Patient Safety Notice: Risk of associating ECG records with wrong patients	18/06/2015	Compliant

PSN010	May 2015	Patient Safety Notice: Failure to act on known contraindications to Low Molecular Weight Heparins	25/06/2015	Compliant
PSN009	April 2015	Awareness of NICE Clinical Guidelines on head injuries	28/05/2015	Compliant
PSN008	April 2015	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	28/05/2015	Compliant
PSN007	April 2015	Risk of death or serious harm from accidental ingestion of potassium permanganate	31/05/2015	Compliant
PSN006	March 2015	Risk of hypothermia for patients on continuous renal replacement therapy	30/04/2015	Compliant
PSN005	December 2014	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	30/01/2015	Compliant
PSN004	December 2014	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	19/01/2015	Compliant
PSN003	December 2014	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	31/01/2015	Compliant
PSN002	July 2014	The Surgical Management of Urinary Incontinence and Pelvic Organ Prolapse	31/07/2014	Compliant
PSN001	July 2014	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women	31/07/2014	Compliant

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……Date of Meeting

Agenda Item… ??
Report title……

Outstanding NPSA Notices			
Date Issued	**Title**	**Date for response to WG**	**Compliance Status**
June 2009	Risk to patient safety of not using the NHS Number as the national identifier for all patients	18/09/2009	Compliant
July 2007	Early identification of failure to act on radiological imaging reports	28/02/2008	Compliant
July 2007	Standardising wristbands improves patient safety	18/07/2009	**Non-compliant**

Board Meeting
……Date of Meeting

Agenda Item… ??
Report title……

Appendix 2 - Action plan to address outstanding areas of non-compliance with Patient Safety Solutions

Reference	Title	Action required to secure compliance	By whom	By when
PSA 002	The prompt recognition and initiation of treatment for sepsis for all patients	The UHB must put in pace a documented plan for roll out of NEWS in to community hospitals, for approval at the September 2017 QSE committee	Resuscitation training team	To be approved at September 2017 QSE Committee
PSA003	Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	The UHB must agree a practical solution to that part of the Notice, which requires us to provide separate storage of epidural solutions that contain controlled drugs so that they are not stored alongside controlled drugs intended for intravenous use.	Medication Safety Executive group/Medicines management Group	End September 2017
PSN026	Positive Patient identification	Review and revise Positive Patient Identification Policy Secure investment and implement an electronic solution for the production of wristbands from the Patient Management System	Patient Safety team Patient Safety team	September 2017. Will now be presented to the December 2017 Committee The Clinical Boards are currently undertaking a scoping exercise of their requirements to inform a business case

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Report title……

		(see No.24 below)		to be represented to the October 2017 Business Case Approval Group.
PSN030	The safe storage of medicines cupboards	The UHB is awaiting the publication of revised guidance form WG which is being issued due to widespread non-compliance across Wales with the requirements of this Notice. NB –the UHB has robust mitigation in place for the safe and secure storage of medicines which is subject to annual audit across the UHB, and to regular scrutiny during pharmacy visits and unannounced internal and external inspections	WG	Keep under review until revised guidance is issued
No 24	Standardising wristbands improves patient safety	Secure investment and implement an electronic solution for the production of wristbands from the Patient Management System Establish a task and finish group to oversee	Patient Safety team Patient Safety team	October 2017 September 2017 March 2018

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……Date of Meeting

Agenda Item… ??
Report title……

		implementation of the electronic wristband system Implementation of the system across the UHB	Patient Safety team/ Information technology department	

QUALITY AND SAFETY RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
August 2017			
Originator:		**CRAF Ref:**	
Escalation date:	30-08-17	**Probability (Likelihood) Rating (1-5):**	3
Risk score change date:	N/A		
Risk:	Failure to comply with **PSN030** – The safe storage of medicines: Cupboard	**Impact Rating (1-5)**	4
		Risk Score (Max 25)	12
Executive Lead	END		
Lead Committee	QSE		

Controls - What are we doing about it (Mitigating Action Taken to Date):
(Detail the actions already undertaken to mitigate the risk impact)

UHB policy in relation to the Security and storage of medication is included within the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS)
All medicine is stored in secure, locked cupboards (even though these do not meet the specific specification of the PSN)
Security of drugs and medication is regularly audited as part of Clinical Board audit activity and as part of an annual audit of Medication Security overseen and monitored by the Medicines Management group
HIW will check storage and security of medication as part of their unannounced visits
Security and storage of drugs is also checked as part of regular observations of care visits to wards and departments

Assurances (How does the Board know if we are doing it)

HIW reports and reviews
Quality, Safety and Experience sub-committee reports
Reports to Medicines Management Group

Gaps in Assurance

None

Further Action being taken:
(What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)

Representatives from the UHB are due to attend an all Wales event hosted by Welsh Government in November 2017. The event will focus on medication related safety notices including PSN030.

Are there any existing controls that are not listed?

None

Is the Risk Rating /Score Accurate? If not what should it be?

N/A

Recommended Response:
(What action would you like to see or what action is the recommended response)

None

Risk Appetite - what will the Board do with this risk?

Terminate		Tolerate	√
Treat		Transfer	

14.1

QUALITY AND SAFETY RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
August 2017			
Originator:		**CRAF Ref:**	
Escalation date:	30-08-17	**Probability (Likelihood) Rating (1-5):**	2
Risk score change date:	N/A		
Risk:	Failure to comply with **PSA003** – Update to National Patient Safety Agency (NPSA) alert for safer spinal (intrathecal), epidural and regional devices	**Impact Rating (1-5)**	5
		Risk Score (Max 25)	10
Executive Lead	MD		
Lead Committee	QSE		

Controls - What are we doing about it (Mitigating Action Taken to Date):
(Detail the actions already undertaken to mitigate the risk impact)

- Full risk assessments are in place for safer delivery of spinal anaesthesia, epidural analgesia, regional anaesthesia and analgesia
- Local group in place to manage the replacement of Luer compatible devices used for all regional anaesthesia *infusions and bolus doses* with those which prevent cross-connection with other routes.
- Regional anaesthesia is only administered by trained and competent anaesthetists.
- Local anaesthetic (LA) infusion bags, although rarely used in Cardiff, are ready made and supplied by pharmacy. These bags are stored and locked in a separate cupboard away from IV bags or drugs.
- Vigilance among anaesthetists when drawing up bolus LA for peripheral nerve or plexus block, use of grey LA labels and placing syringes in a separate drug tray.
- LA bags and syringes are handled by trained staff only (anaesthetists and recovery nurses).
- Robust anaesthetic protocols and guidelines within Cardiff and Vale UHB.
- Incident reporting and investigation

Assurances (How does the Board know if we are doing it)

Reports to the QSE Committee

Gaps in Assurance

None

Further Action being taken:
(What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)

A solution needs to be identifed to address the one remaining area of non-complience which requires that such devices are stored seperately to other controlled drugs. This is an issue in non theatre areas where there is only one controlled drug cupboard available

Are there any existing controls that are not listed?

None

Is the Risk Rating /Score Accurate? If not what should it be?

Yes

Recommended Response:
(What action would you like to see or what action is the recommended response)

Continue with suggested action to address the current gaps in assurance

14.2

Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat	√	Transfer	

QUALITY AND SAFETY RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
August 2017			
Originator:	Patient Safety team	**CRAF Ref:**	
Escalation date:	30-07-17	**Probability (Likelihood) Rating (1-5):**	3
Risk score change date:	N/A		
Risk:	Failure to comply with **No 24** – Standardising wristbands improves patient safety; **PSN026** – Positive patient identification	**Impact Rating (1-5)**	4
		Risk Score (Max 25)	12
Executive Lead	END		
Lead Committee	QSE		

Controls - What are we doing about it (Mitigating Action Taken to Date):
(Detail the actions already undertaken to mitigate the risk impact)

Patient Identification Policy in place (awaiting review)
All in-patients wear wristbands which are completed using information from the Patient Management System
In Mental Health settings –photographic ID has been put in place to identify patients
There are local policies in place across the UHB for checking the identity of patients prior to interventions e.g medication polices, blood administration policies, radiology and theatre policies
HIW unannounced inspections check that patients have wristbands in place
This is regularly audited as part of observation of care visits to wards and departments
Incident reporting and investigation

Assurances (How does the Board know if we are doing it)

Regular updates on Patient Safety Solutions compliance to QSE

Gaps in Assurance

More regular audit of wristband compliance is required

Further Action being taken:
(What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)

- Develop business case for the introduction of an electronic wristband system
- Review and re-launch the Patient Identification Policy
- Complete LIPS project on Positive Patient identification

Are there any existing controls that are not listed?

None

Is the Risk Rating /Score Accurate? If not what should it be?

Yes

Recommended Response:
(What action would you like to see or what action is the recommended response)

Continue with suggested action to address the current gaps in assurance

Risk Appetite - what will the Board do with this risk?

Terminate		Tolerate	
Treat	√	Transfer	

14.3

UPDATE – HEALTH AND CARE STANDARD 2.8 - BLOOD PRODUCTS
Name of Meeting : Quality, Safety and Patient Experience Committee **Date of Meeting :** 12th September 2017

Executive Lead : Medical Director
Author : Consultant Haematologist and Blood Transfusion Lead
Caring for People, Keeping People Well : This underpins the UHB's principle of sustainability, making the best use of resources that we have and reducing waste , harm and variation.
Financial impact : Nil – with improving transfusion practices financial savings are potentially available to the organization.
Quality, Safety, Patient Experience impact : Ensuring the safe and appropriate delivery of blood products is central to high quality services and patient safety**.**
Health and Care Standard Number 2.8 Blood Products
CRAF Reference Number. 5.1 Deliver safe and effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current annual self-assessment for Health and Care Standard 2.8 is assessed as "Meeting the Standard".
- Evidence of continuing improvement is provided for 2017/2018

The Board (or name of Committee) is asked to:

- **AGREE** the report.

SITUATION

This report is submitted to update the Committee on progress with Health and Care Standard 2.8

BACKGROUND

In order to meet this standard people require timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

The full list of criteria can be found here in section 2.8 of the Health and Care Standards.

ASSESSMENT AND ASSURANCE

The Committee is asked the subsequent update on the annual assessment:

- The UHW transfusion laboratory successfully underwent an MHRA inspection on the 21st Feb 2017.
- The annual MHRA BSQR (Blood Safety and Quality Regulations) compliance report for UHW and UHL has been submitted. The MHRA response is awaited (expected Aug-Sept).
- The service improvements regarding massive haemorrhage and the E.U department have been agreed and staff are being trained out to go live on the 4th Sept 2017. The transfusion team continue to monitor the UHB responses to massive haemorrhage, including 'dry runs' within critical but low use areas such as neonatal.
- The transfusion group were satisfied that the UHB is Meeting the Standard with regard to Health and Care Standard 2.8 and agreed on the 14th July 2017 to ensure that more comprehensive information is gathered in subsequent years and to develop improvement plans with the clinical areas through the UHB transfusion team. The transfusion group is to review the definitions of response and engage with the clinical boards from Autumn 2017.

APPENDIX ONE

ANNUAL SELF ASSESSMENT
HEALTH AND CARE STANDARDS

<table>
<tr><td>S
Situation</td><td>Corporate Assessment

Standard: 2.8 Blood Products

People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.</td></tr>
<tr><td>B
Background</td><td>Please confirm the rating from the following definitions: Getting Started/ Getting There/ Meeting the Standard/ Leading the Way

Self assessments of standard 2.8 Blood products have been completed by all of the clinical boards other than Dental and Mental where blood transfusions do not occur.

<table>
<tr><td>Women and Children</td><td>Getting There</td></tr>
<tr><td>CD&T</td><td>Meeting the Standard</td></tr>
<tr><td>Dental</td><td>Not Applicable</td></tr>
<tr><td>Medicine</td><td>Getting There</td></tr>
<tr><td>Mental Health</td><td>Not Applicable</td></tr>
<tr><td>PCIC</td><td>Meeting the Standard</td></tr>
<tr><td>Specialist</td><td>Getting There</td></tr>
<tr><td>Surgery</td><td>Getting There</td></tr>
</table>

While areas of the standard were well evidenced the self assessments alone were not comprehensive enough to be able to offer assurance, however with corporate oversight as well as information from the blood transfusion group assurance can be given that the UHB is Meeting the Standard</td></tr>
<tr><td>A
Assessment</td><td>Provide 250 words (<u>maximum</u>) to give necessary contextual narrative
The self assessments have been reviewed by the UHB transfusion team. While the evidence provided was not

comprehensive the team were in agreement with the conclusion that the UHB is Meeting the Standard.</td></tr>
</table>

15

	There are several areas of excellent practice within the UHB. The transfusion laboratory has recently successfully undergone an MHRA inspection and as part of the haematology laboratories has been recommended ISO accreditation. The obstetric department has developed a revised blood product algorithm for post partum haemorrhage which is being adapted across Wales and certainly meets the criteria for 'leading the way' The transfusion team are also able to commend the active participation of the clinical areas with regards to the reporting and investigation of transfusion reactions and incidents, maintenance of the cold chain, traceability and transfusion competency assessments. The transfusion link nurses within the clinical areas are active in promoting good practice. The transfusion team are also able to commend the active participation of the portering staff in maintaining competency assessments. The UHB responses to massive haemorrhages are audited and service improvements are planned within the E.U department. The UHB transfusion group would be well placed to ensure more comprehensive information is gathered in subsequent years and develop improvement plans with the clinical areas to address any areas of service that may fall within 'getting started'.
R **Recommendation**	**The following improvement actions have been identified as key deliverables for 17/18** • Alignment of standard 2.8 with the Blood transfusion group agenda to allow ongoing monitoring of compliance • Clinical areas to agree improvement plans with the UHB transfusion group for any areas of service that fall into the getting started category.

NUTRITION AND HYDRATION REPORT August 2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 12 September 2017

Executive Lead : Executive Director of Therapies and Health Sciences
Author : Head of Nutrition and Dietetics
Caring for People, Keeping People Well This report underpins the Health Board's 'Sustainability' and 'Values' elements within it's strategy in relation to care, respect and dignity
Financial impact : This needs to be assessed following completion of the review
Quality, Safety, Patient Experience impact : Implementation of the management action plan will provide the necessary assurance
Health and Care Standard Number: 2.5,3.5,4.1
CRAF Reference Number :5.1,5.18,5.7
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The status report attached

The Quality, Safety and Experience Committee is asked to:

- **NOTE** progress on actions listed within the Patient Nutrition, Hydration and Catering experience management action plan particularly in relation to the model ward pilot and the pilot of the nutrition and dietetic service within the Emergency Unit.
- **BE ASSURED** that the Nutrition and Catering steering committee keep a regular review of the action plan to ensure and update on progress.

SITUATION

The Health Board is currently addressing the 10 key recommendations set out in the Public Accounts Committee report on Hospital Catering and Patient Nutrition ensuring that all elements of Nutrition and Hydration Standard 2.5 are being met. Good progress has been made in many areas notably staff catering and public health with reference to the delivery of the corporate health standard framework. The implementation of a pilot model ward if approved by the Health Board will enable more standardised nutrition and hydration practices across the inpatient setting.
A review of the actions outlined in the action plan document are monitored, reviewed and reported to the Nutrition and Catering Steering Group

BACKGROUND

The Patient Nutrition, Hydration and Catering Experience Management Action Plan has been developed to address issues highlighted within the Welsh Government key publications and pathways.

The Public accounts committee on hospital catering and patient nutrition published in March 2017 made 10 further key recommendations. An extensive action plan developed by the Nutrition and Catering Steering committee pulls together all standards resulting in twelve core themes. It encompasses ongoing Health Board wide audits on assistance to eat, meal service (adults and paediatrics) and nutrition screening. Nutrition related training logs are also being collated.

ASSESSMENT AND ASSURANCE

Timescales for implementation of the actions listed in the plan are continually reviewed. The actions to be taken are detailed in the implementation highlighted in the management action plan at Appendix 1.

The UHB's Nutrition and Catering Steering Group engaged in discussions towards the end of 2016 to agree that a pilot project should be set up to examine how best to deliver comprehensive and co-ordinated nutritional care practices to maximise patient outcomes and improve flow through the organisation. Food, fluid and nutritional care are crucial for the physical and mental health well-being of patients and are also fundamentals of care elements that can enhance the patient experience. The CNO for Wales Jean White was quoted in the Public Accounts Committee Report March 2017 stating 'Nutrition and hydration are one of those things that, to be frank, is almost as important as the medication that people receive'. This powerful statement needs to be adopted by healthcare organisations across Wales. A precursor to this work was the pilot of the nutrition and dietetic service in the Emergency dept within UHW. This work has been completed and the report attached at Appendix 2.

An inter-disciplinary group of Therapy, Nursing and Facilities colleagues collaborated to deliver the pilot project and identify and quantify what impact it could make on the patient's journey and UHB resource utilisation. The project has involved cross clinical board integrated working, and fits within the UHBs programme of transforming care and turning the curve. The project framework is based on service improvement methodology, which the UHB is driving forward with its 60 day cycle improvement work. The project is closely linked to and underpins the UHBs promoting independence and 'Get Me Home' campaign as assistance to improving patient flow.

The wards nominated to undertake the Model Ward pilot project were 2 acute medical wards, A4 in UHW and East 2 in UHL. The key aims of the project were:

Improve patient satisfaction and experience
Provide clarity in roles and responsibilities of nurses, facilities and therapies staff.
Remodel the workforce to meet the needs of the patients

- Increase snacks and beverage rounds, change timing of meals to reflect patient feedback from previous satisfaction surveys,
- Increase MDT engagement at mealtimes
- Re-invigorate Protected mealtimes which includes preparation of the environment and the patient, with social dining where possible
- Improved compliance and accuracy with nutritional screening and monitoring, and documentation of patients oral intake to facilitate informed nutritional assessments
- Ensure full use of the nutrition and hydration bedplan to maximise patient safety, and use of the safety briefings to identify patients needing cultural, therapeutic and religious diets and specific support and assistance.
- Ensure accurate menu ordering management systems
- Reduction in prescribed product costs e.g. Nutritional supplements, laxatives and IV fluids
- Launch new improved crockery to improve patients mealtime experience and aid independence

A scorecard was developed which captured data and outcomes from therapies, nursing, facilities and the Patient Experience Team. A draft report has been produced and is being circulated for comment from the teams involved in the pilot. The final report will be completed at the beginning of September and shared with the QSE.

Appendix 1

Cardiff and Vale University Health Board
Patient Nutrition, Hydration & Catering Experience Management Action Plan 2017
Review of progress August 2017

Surveys/Reports included:
Public Accounts Committee Report 'Hospital Catering and Patient Nutrition' March 2017
Community Health Council (CHC) Survey Report 2015 - 30 wards audited by CHC members and 168 patient surveys
Community Health Council (CHC) Visit Report 21/06/17 – A4 UHW
'Two minutes of your time' UHB patient satisfaction surveys -Feb, April, June, August October and December 2016
Annual Health and Care Monitoring Audit 2016 - includes ward self- assessment and patient user feedback
All Wales Patient Mealtime Survey 2013 746 patients surveyed including patients comments
Welsh Audit Office (WAO) survey 2015- 4 wards surveyed which included interviews with UHB staff ,patient representatives, Ward Managers, Dietetic and Catering managers and Executive Directors together with review of documentation
Summary of Meal Service Audits 2016 19 audits undertaken across all sites within the UHB
Nursing survey of nutrition/hydration issues for Ward Managers /Charge nurses -39 responses (MH 5, C & W 1, Surgery 7 Specialist 8 and Medicine 18)
Summary Nutritional Risk screening audits 2017
Summary Nil by Mouth audit 2017
Model Ward outcomes commenced June 2017
National Audit of Dementia Care in General Hospitals Report ,2016-2017

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
1. Menu Choice Need for improvement in patient menu choice especially for those patients who are longer stay, and those patients requiring therapeutic diets, vegetarian, Halal options and healthier choices to ensure all patients nutritional needs are	A UHB multidisciplinary Menu Review Group has been set up to address menu related issues with the aim of developing a new two week menu, increasing choices for patients on vegetarian,	New UHB 2 week Menus is on hold still due to delays in NPS awarding ambient grocery lines contracts. Work needs to be undertaken to evaluate the contract changes and implications for the new menu, likely date for launch of new menu October/November 2017. A new supplier has been awarded the All Wales Texture modified meal contract, C&V have	Oct /Nov 2017	**Judyth Jenkins (with Lee Wyatt)**	**On track awaiting contract award**

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
met.	vegan, Kosher and Halal diets, as well as provision for those patients with very specific therapeutic dietary needs, such as food allegens, and increasing the choice for patients needing healthier menu choices.	changed menus and supplier in line with the All Wales Menu Framework. A new supplier has been awarded the contract for patient sandwiches; C&V is due the alter menus and supplier in line with the All Wales Menu Framework. A new A La Carte menu has been developed to provide additional meal options to patients with very specific dietary needs (for example allergen free meals, Halal and Kosher suitable meals), this is due for implementation across the UHB in August/Sept 2017. A new Maternity menu has been developed in a response to patient feedback, and includes an enhanced range of vegan/ vegetarian and multicultural meals. This was implemented in April 2017. Work is currently in progress to address the specific dietary needs of longer stay patients within MHSOP and Mental Health. Following internal audit work and patient/staff feedback, and in response to the National Audit of Dementia Care, it has highlighted the need to develop a 'dementia friendly menu' for MHSOP areas that include familiar meals, foods that stimulate an appetite, foods that can be eaten without cutlery (maintaining patient independence with eating and drinking) and the inclusion of buffet meals, and that meet the All Wales Food and Fluid standards. It is hoped that this could be available to implement in October/November			

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
		2017 Within adult Mental Health there is a need to develop menus that include a predominance of healthier multicultural meal options, and include the ability for patients to choose their meal times, and be included in the meal preparation process. It is hoped that this could be available to implement in October/November 2017			
2. Provision of menus Menus need to be available at ward level to support patient menu choice, and to provide information on what they should expect from catering services	Menus will be printed and included in the new UHB Patient Bedside Information Folder for access by patients and carers.	This will be synchronised to coincide with new menus launch. Initially there will be bedding in time of 6 months for the new menus and temporary paper copies will be available. In the longer term menus will be available at ward level that will support patients to make informed meal choices and in the most appropriate format, for example in pictorial menus and in Welsh and English.	Oct/Nov 2017	**Lee Wyatt**	**On track**
3. Food service a) Better consistency in food quality and service of meals is required across all sites i.e. taste, temperature, appearance and presentation, portions sizes, and to include the offering of second helpings as routine.	Work is ongoing with Shared Services Lead Dietitian and the Catering Commodity Advisory Group to improve quality of food products procured for NHS. Continue to support the All Wales menu Framework in development of good	Awaiting new ambient grocery line contract information from Shared services /National procurement Services Wales, and the updating of the AWMF web site. Current the Lead Procurement Dietitian post is a vacant within Shared services which has delayed communication and updating of the website. Contractual agreements between C&V and Shared Services exist to support the work needed till the post is filled.	July 2017	**Peter Cockburn (CFPU) & Lee Wyatt (WBC service)**	**Some delay in appointment of shared services dietitian**

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
	quality recipes to meet the Welsh Government Food & Fluid standards. Review current equipment usage in relation to regeneration practices across all UHB sites and provide the necessary training to improve understanding of patients needs and quality and timing of menu items served.	There are outstanding food contracts yet to be evaluated and awarded. These include fresh and frozen meat, fish, fruit, vegetable, bread and diary. These are due to be awarded in 2017 Portion size training for production and ward based catering staff has been developed and is currently being delivered across the UHB Agored Cymru accredited training has been developed for ward based catering staff and a programme of delivery is being developed across the UHB. This training includes aspects of customer care such as presentation of meals, offering of seconds etc. Currently there is a 'model ward' project ongoing across 2 wards in the UHB where there has been a change in nutrition and hydration practices designed to increase opportunities for patients to eat and drink, with improved food choices, meal presentation and accurate meal ordering utilising a visual menu IT system. This has delivered an improved patient experience and significant positive clinical outcomes. The project has been extended whilst outcomes are fully evaluated and reported.		**Dietetics** **Dietetics** **Dietetics, Facilities, Nursing**	
	An All Wales patient nutrition and catering IT	Cardiff and Vale is represented and heavily involved in driving the All Wales Nutrition and	May 2017	**Lee Wyatt**	Model ward to

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
	solutions review will be scoped out to replace the variety of existing manual and IT systems, and provide efficient and effective patient catering services. To scope out the use and benefits of introducing dedicated ward hostesses and a hand held tablet ordering IT system.	Catering IT Solution business case. The introduction of the Menumark system to manage food production and the use of computer tablets to take patient meal orders has been piloted on the Model wards of Llandough Hospital and UHW alongside a new Ward hostess style, with improved customer care focus, and improved patient meal service. The Model Ward Project outcomes have been extremely positive and will shared.			pilot
	Revise WBC training to ensure service incorporates the offering of second helpings where applicable and embed in daily routine	Agored Cymru accredited training has been developed for ward based catering staff and a programme of delivery is being developed across the UHB. This training includes aspects of customer care such as presentation of meals, offering of seconds etc.	1/9/17	**Lee Wyatt/ Dietetics**	Model Ward to pilot
d) Provision of appropriate crockery and cutlery on all wards across the HB should be routinely available	Clinical Board needs to address this issue to ensure all necessary equipment is available across wards.	A review of crockery and cutlery used across the HB has been undertaken, with an initial acquisition of charitable funds to support the purchase of better quality cutlery and crockery, to improve the patient experience oral intake and independence, and meet patient safety needs. Availability of adaptive cutlery varies across wards This will form part of the funding **Phase 1** UHL, Barry, MHSOP(UHL) and A4 and B6 ward UHW - 20k Charitable funding sourced	April - Sept 2017	**Directors of Nursing/ Dietetic Catering Lead/Lee Wyatt**	For Phase 1 launched June 2017 Phase 2 commenced August 2017 Phase 3 to be

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
		and purchase made, and new crockery issued to wards. **Phase 2** Children's hospital submitted Noah's Arc bid for 5k (includes cutlery) purchase made, and new crockery issued for use. **Phase 3** UHW, Rookwood, Iowerth Jones- awaiting funding **Phase 4** Hafan Y Coed -awaiting funding Crockery going missing and being topped up regularly			considered Sept 17
f) The practice of leaving food within the reach of all patients and ensuring all patients are suitable positioned for eating and drinking needs to be reiterated to all staff	The importance of correct placement of trays etc. needs to be reiterated to all staff.	This is part of Model Ward mealtime procedures and is incorporated within protected meal times processes. The principles of protected meal times are reinforced as part of the Nutrition and hydration champion training. The 'principles poster' has also been refreshed and distributed so that the message is delivered to the widest audience.	June – Sept 17	**Directors of Nursing**	Consideration as part of model ward
4. Timing and access to meals, snacks and beverage rounds	Choice of drinks offered as a standard will need to be agreed to accommodate patient preferences.	This was reviewed as part of the Catering review' Model ward' project. Role out to be completed Oct 2017. *Update Aug 2017*	May 2017	**Lee Wyatt (with Directors of Nursing)**	

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
5. **Nurse engagement in mealtime process** a). Improvement is required in engagement of nurses at mealtime and beverage rounds to ensure patients are fully supported.	A review of engagement process of clinical nursing staff within patient mealtimes is required. Produce guidelines to embed in practice. Nutrition training for nurses which will include mealtime processes is currently being planned with LED and senior Nurses. Nurse champion's will become part of every ward establishment.	A Nutrition Champion training programme has been developed and are ongoing. 21 wards attended across UHB. 52 nursing and 1 catering supervisor have completed the level 2 'Improving Food and Nutrition care' accredited training. Health and Care standard 2.5 Nutrition and Hydration and All Wales Food and Fluid standards are included in the Nurse Foundation Training programme run x4 per year with approx. 30-40 nurses attending each time.			
b). Consideration needs to be given to employing dietetic /rehab assistants or staff with identified feeding support roles	A dedicated feeding and supporting role will be incorporated within the HCSW /Rehab assistant's role. Nutrition training for nurses will include all aspects of feeding and supporting patients	This would be incorporated into the role and responsibilities of all Health Care Support workers, and as part of the model ward pilot.	Dec 2017	**Dietetics/ LED** Directors of nursing	On track as part of model ward evaluation
6. Protected Mealtimes a) Ensure patient assistance is maximised and pre – mealtime preparation is undertaken	An assistance to eat audit is recommended to provide an accurate picture of the issues. Review of patient need and available staff to	As above, whilst not all staff are able to attend face to face training, the poster will act as a reminder of the principles of protected meal times			

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
	assist is required. Clear and defined nursing staff roles and responsibilities at mealtimes needs to be relayed to all staff. This will be included within the planned nurse training programme.				
b) Hand washing should be encouraged as a priority	Review hand washing procedures and efficient ways of providing the services.	The provision of hand wipes was discussed at the last Nutrition and Catering Steering group and a progress report has been requested for the next meeting on handwashing with soap and water. Hand wipes are available to order via Oracle but audits are showing hand hygiene remains and issue. Nurses need to ensure consistent approach.	Refresh during model ward evaluation	**Directors of Nursing/ Dietetics**	Feeding assistar Report.doc Assistance to e appendix.doc
d) Ensure that dining room areas in wards are promoted	Use of dining rooms should be maximised where this is possible and all nursing staff should encourage patients to leave their bedsides when appropriate.	Where possible, dining room is used. This is constrained by either case mix/ staffing and / or available environments. Dining rooms are used for lunch clubs across some areas of Medicine Clinical Board. dining rooms are used across Mental Health in patient's services. Patient satisfaction feedback is very good. The CHC have published a document on loneliness in hospital, available on CHC website detailing areas of good practice across the NHS and where mealtimes which include social dining patient satisfaction is high.	01/07/17	**Directors of Nursing**	

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
7. Nutritional screening /weighing of patients a) Further improve compliance to nutritional risk screening policy and completion of nursing documentation relating to nutrition and hydration needs to aid communication between all members of the multidisciplinary team.	Introduction of integrated nursing documentation and training planned will assist in meeting this recommendation. Assessment of patient risk screening and weights will form part of the revised tool. UHB wide Nutritional Risk screening audits will provide information to assist in targeting areas that do not meet the standards required. This will be relayed to Directors of Nursing	The audit of compliance with undertaking nutrition risk screening assessments and appropriate action is an all Wales requirement for in-patient areas and the results are reported to Welsh Government on a monthly basis. Audit results are discussed at clinical Board performance reviews as well as at Director of nursing Performance reviews undertaking by the Executive Director of Nursing. Audit compliance for the UHB for December 2016 was reported as 93.74% Comprehensive auditing across UHB due in the month of April with report back to the Nutrition and Catering steering group shortly after. Eating and drinking forms part of the proportionate nursing assessment completed on patient admission to hospital			
b) Mandate use of Nutrition & Hydration Bedplan as the means of providing the necessary information on patients' nutrition & hydration needs at admission which includes allergies, therapeutic diets, religious and cultural dietary information and recording changes as a daily process	An SBAR has been produced which will be submitted to the Nursing Clinical Standards and Innovation Group	The SBAR was presented to the CSIG in July 2016 and will now go forward to the Nursing and Midwifery Board for approval in September 2016. This needs implementation The bed plan will be required to be put forward for the June 2017 agenda	01/5/17	**Directors of Nursing**	

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
c) Ensure appropriate weighing scales are available in all ward areas accurate and regularly calibrated.	A bid for funding initiated by Dietetic team for new weighing scales for all areas to meet the new weighing scale standards has been partly secured and clinical areas have been prioritised. New scales have been delivered to all wards across the UHB. A maintenance programme has been agreed. Need to secure the remaining funding to ensure 100% compliance to current legislation.	New weighing scales have now been issued to all wards where appropriate, yet still weighing patients is an issue. The nutrition risk screening audit in April will provide further information on the situation. Request made to deputy director of Finance for slippage funding at year end to fund hoist scales. Waiting for a response	01/4/17 Incompl ete	**Directors of Nursing**	
8. Safe storage of supplements and drinks Review safe storage of drinks /thickener on patient bedside tables and wards to ensure sufficient and appropriate storage	Review guidelines on storage of drinks and apply guidelines.	A review of guidance available is currently being carried out and a process will be agreed.			
	Communicate procedure for safe storage of supplements and milky drinks to all ward staff.	Agreed at NMB in March 2016 and reported to the Nutrition and Catering Steering group at that time that thickener will be stored on the patient's locker.	30/6/16	**Directors of Nursing**	
	Continue to enforce safety advice on use of	Guidelines on safe storage of milky drinks	Complet ed		

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Current status / update
	thickeners for patients		March 2016		
10. Assessment of Oral health and the ability to communicate Assessment of oral health and ability to communicate assessment needs to be improved and prioritised.	Nursing staff to prioritise and complete oral health assessments. The All Wales Mouth care assessment document is referenced within the Integrated care assessment document to improve compliance.	The 1000 lives lead for mouth care came to the UHB on the 11th May 2016 to explain the reviewed assessment tool and care plan and to provide support with testing as the tool is currently in the testing phase. Initially testing on a medical ward at UHL. The pilot identified that further revisions were required, and following revisions to the All Wales tool, testing recommenced on the 5th August . Feedback on implementation is positive. The roll out will now progress to another 2 wards by 24th August 2016 A new tool has since been produced by the all Wales group and is currently being revised by the UHB to ensure that it guides nurses to the appropriate level of care.	March 2017	**Directors of Nursing**	

Completed Actions

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Completion date
6a) Review and improve compliance to protected mealtimes policy.	Protected mealtime training is required for all ward staff to ensure that staff have clear understanding of this policy. Clear signage will need to be instigated to clarify relatives/carers are welcomed at mealtimes. Discussion needs to take place with any staff groups who are noncompliant to the policy.	This work is being progressing through the Nutrition Champions training programme. In the meantime, a poster providing information on the key principles of Protected Mealtimes will be re-launched in the Clinical Standards and innovation group meeting on 14 September 2016.	Completed	**Directors of Nursing**	**April 2017**
Availability of healthier choices for staff across staff restaurants, catering outlets	All areas to comply with Hospital Restaurants and Catering Outlet Food Standards.	Working in close collaboration with Public Health team to implement the Hospital Restaurant and Retail Catering Outlets Food Standards. Gold award for healthy eating achieved in Y Gegin and Aroma outlets.	1/6/16	**Peter Cockburn**	**April 2017**
3b) Staff serving food need to wear gloves during every mealtime service	Guidance is required on the use of gloves during meal service.	Guidance once issued will be incorporated into training		**Lee Wyatt**	July 2017
3c) Temperature probing practices need to be consistent across wards	Communication and further training is required on use and timing of when temperature probes are to be used.	Agored Cymru accredited training has been developed for ward based catering staff and a programme of delivery is being developed across the UHB. This training includes aspects of food safety such as temperature probing of food. Food temps are audited by supervisors as part of the		**Lee Wyatt/ Dietetics**	July 2017

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Completion date
		"Need Service" audit			
3e) Trolley placement within wards needs to be reviewed	A review of where trolleys are sited during the meal service is required to ensure they are used appropriately within a particular ward area.	This was reviewed as part of the Model Ward based catering Nutrition & Hydration review. Hydration Trolley in Kitchen and on "Service" be made available in ward where possible or Day room may be a recommendation. However every ward is different on patient type, size and space available. Review therefore complete. *Update Aug 2017*	May 2017	**Lee Wyatt**	As per model ward Completed.
4. Timing and access to meals, snacks and beverage rounds a) Timing of meals and beverage service need to be reviewed to ensure no more than a 14 hrs maximum gap between supper and breakfast to meet standard set. 7-8 drink rounds per day must be provided as recommended in the All Wales Food and Fluid Standards	The mealtimes and beverage round timings need to be reviewed and implemented to meet the overriding evidence that supports change. Assessment of staffing levels needs to form part of this work with a full review of ward based caterers and housekeeper's role in relation to patient's nutrition & hydration. A pilot will be completed at UHW and UHL to support best practice.	'Model' ward was piloted on UHL and UHW sites. A project group which will include Senior nursing, Facilities, Dietetics and other relevant staff was set up and a trial (proof of concept) happened in May 2017 for 6 weeks. It included relevant senior staff to take this work forward. Outcomes proved we met all drink rounds collectively. This is however unachievable without additional staff in facilities, paper written and business case being drafted for Exec teams. This will involve a review of timings of meals and beverage rounds, improving other aspects of patient experience e.g. patient meal ordering processes, crockery, ensuring ward nursing processes focus on mealtimes, protected mealtimes and assistance required. So review taken place and complete. *Update Aug 2017*	May 2017	**Lee Wyatt**	July 2017
b) Improvement in access to **a variety** of hot drinks at	Clarity for role responsibility is required	This reviewed as part of the Catering review / Model Ward project.	May 2017	**Lee Wyatt**	July 2017

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Completion date
mealtimes and in-between meals needs addressing	on the roles of nurses and WBC in provision of drink rounds.	Model Ward ensured standards met for hydration by combination of the teams. Hydration improved by 2-% overall. Currently though for clarity and completion of this action: Water Jugs cleaned and changed by Facilities at 7am and 2pm. Nursing to do post 9pm. *Update Aug 2017*			
c) Times water jugs are cleaned and water changed needs to be reviewed to comply with the Food & Fluid Standards of 3 times a day	Clarify timing of existing water jug changes and review this as part of the beverage service with clarity of where responsibility lies for each round of drinks provided.	For Clarity and completion of this action: Water Jugs cleaned and changed by Facilities at 7am and 2pm. Nursing to do post 9pm. *Update Aug 2017*	May 2017	**Lee Wyatt**	July 2017
d) Access to snacks	The provision of snacks will need to form part of the beverage service review with clarity of where responsibility lies for each snack round.	This was reviewed as part of the Model Ward Trial. Additional costs involved for a wider choice and increased take up of snacks on wards. *Update Aug 2017*	May 2017	**Lee Wyatt**	July 2017
e) Review provision of snacks particularly at bedtime and if meals have been missed	As above Provision of healthier choice of snacks needs to be included in review.	This was reviewed as part of the Model Ward Trial. Additional costs involved for a wider choice and increased take up of snacks on wards. *Update Aug 2017*	May 2017	**Lee Wyatt**	July 2017
f) Review the provision of desserts being offered	As part of the review of mealtimes the impact of	This was reviewed as part of the Model Ward Trial project. It takes additional resource to do	May 2017	**Lee Wyatt**	July 2017

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Completion date
following main meals and not at the same time to ensure food is served at correct temperature.	the current change to serving of desserts following main meals needs to be assessed and appropriate changes made.	this and value vs practicality vs meeting standard need to be further discussed agreed and budgets adjusted if this is moved forward. Temp checks introduced as standard way forward. *Update Aug 2017*			
9. Patient Catering Costs Review patient catering costs to ensure accuracy and to be assured quality of meals and patient needs are not compromised, in relation to comparison costs quoted in EFPMS against other Health Boards	Review current patient catering cost mechanisms with consideration to linking this costing to all aspects of ward based catering. Consider best practice and benchmarking data available.	In order to manage performance we have introduced performance management within the Catering Services with an agreed set of Key Performance Indicators which are monitored and measured weekly and monthly which include cost controls, use of standard costed recipes, agreeing food and beverage allowances for patients, standardising local catering contracts and reducing food waste. EFPMS data is a great tool to monitor and benchmark catering and services however this information is now being used more effectively to manage and deliver a cost effective and improved standard of service in the form of KPIs. Complete	30/10/16	**Lee Wyatt**	
12. Finance	Full cost analysis required to identify all future capital replacement and maintenance costs	Facilities have implemented new process and procedures ensuring that Catering managers and Supervisors have full financial accountability and responsibility and is a key element of their training and development which is also supported with a commercial standard of catering IT management systems. The facilities commercial outlets have undergone significant financial review that involves all menu items being costed and where applicable, menu tariffs have been adjusted.		**Lee Wyatt/ Peter Cockburn**	August 2017

Recommendation	Planned actions/actions taken	Progress	Time Scale	Lead	Completion date
		Portion control guidelines have been implemented in line with healthy eating guidelines. The Model Ward has also provided insight from an IT system POV and we await the All Wales System. Some large benefits are thought to be gained from our trials within the Model Ward Concept. Catering cost per patient has also been benchmarked against other NHS authorities and used to introduce improvement. C&V sits however on the lower quartile in its spend per patient. Update Aug 2017			

Appendix 2

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Provision of a Nutrition and Dietetic Service to the Emergency Unit

Clinical Board Lead : Clinical Diagnostics and Therapeutics Board Director of Operations
Author : Head of Nutrition & Dietetics and Medicine Lead Dietitian
Caring for People, Keeping People Well : This report underpins the Health Board's 'home first', 'avoiding harm and variation', 'empowering people' and 'delivering outcomes that matter' elements of the Health Board's Strategy.
Financial impact : £ 152.5K
Quality, Safety, Patient Experience impact: This report demonstrates that a seven day nutrition and dietetic service to the EU ensures consistent, timely and equitable assessment of nutritional and hydration needs for all patients. A dietetic care plan is put in place at the front door for patients needing intervention to support nutrition and hydration requirements. To improve patient safety on admission the need for therapeutic and texture modified diets is highlighted by dietetic staff to the team, thus reducing the risk of adverse events. Drinks rounds and feeding assistance provided by dietetic support workers positively impacts on quality, safety and patient experience further supported by staff and patient stories. Data collected demonstrates that dietetic intervention improves measurable outcomes including nutritional parameters and there is a robust evidence base demonstrating the relationship between malnutrition and reducing number of hospital admissions and length of hospital stay.
Health and Care Standard Number 2.5, 3.5, and 4.1 **CRAF Reference Number** 5.1.5.18.4.1
Equality Impact Assessment Completed: Yes / No / **Not Applicable**

RECOMMENDATION

- The Board is asked to **to secure the funding for a permanent 1.6 WTE Band 7 Dietitian and 2.4 WTE Band 3 Dietetic Support Workers to deliver a 7 day nutrition and dietetic service to the emergency unit at a cost of £152.5k.**

Gaps in nutritional care identified in the EU require a nutrition and dietetic service to be present at the front door seven days a week to address the nutrition and hydration needs of all patients at the point of entry into the organisation. A nutritional care plan is put in place for their return to community or where admitted to the organisation ensure the care plan is adhered to throughout their admission and to mitigate risk, improve communication between the multidisciplinary team , develop education programmes and improve quality of patient care and patient experience .

There is a fundamental and underpinning role for nutrition and hydration in maintaining and improving an individual's nutritional and hydration status which impacts on health and well being and functional ability, contributing to reduced length of hospital stay, readmission prevention and reduced dependency on health and social care resources .

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

SITUATION

In January 2017 the Dietetic service received short term ICF monies to initiate a nutrition and dietetic service model in the UHW Emergency Unit (EU). Appendix 1. The service was delivered over an 11 week period with data collected for 8 weeks. The vision was for a fully integrated multi-disciplinary service, working closely with therapy colleagues to maximise efficiency in information gathering, assessment, referral and treatment planning. Data collection aimed to explore and measure the quantitative and qualitative benefits to patients through a service delivery model of targeted interventions to maximise patients physical and mental health status, patient safety, enhanced quality of care patient outcomes, and signposted patients and their carers to appropriate community services to reduce potential for future admissions and reliance on health and social care resources.

BACKGROUND

UHW EU has been under unprecedented winter pressures, with 9,832 patients being admitted to Majors in February 2017, compared with the national average of 4,449 attendances per month.[1]

From a national perspective there is a wealth of evidence demonstrating that nutritional intervention saves money. Malnutrition is both a cause and consequence of disease in adults and children. It affects over 3 million people in the UK with associated health costs exceeding £13 billion annually.[2] Better nutrition and hydration care for individuals at risk can result in substantial cost savings to the NHS[3]; with even a saving of only 1% of the annual health care cost of malnutrition, amounting to £130 million annually.[2]

The benefits of improving nutritional care and providing adequate and appropriate hydration are immense, especially for those with long term conditions and problems such as stroke, pressure ulcers or falls. The evidence shows clearly that if nutritional needs are ignored health outcomes are worse. Meta-analyses of trials suggest that provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%[4]. Additionally appropriate use of oral nutritional supplements in hospitals has been found to save £849 per patient based on length of hospital stay.[5] Dietitians have a unique skill set that enables them to assess and identify who would benefit from prescription of these products.

Locally we have demonstrated the value of dietetic input early in a patient's admission via our 2006 MAU project, suggesting a 14 day reduction in length of hospital stay (LOHS) for patients seen by a Dietitian at point of admission. Subsequently our UHW wide service evaluation 2013 demonstrated improvement in 1 or more nutritional parameters in 92% of 'at risk' patients.

Across unscheduled care services only AAU has a funded nutrition and dietetic service. Baseline audit data illustrated patients' nutrition and hydration needs and Healthcare standard 2.5 and the All Wales Standards for food and fluid are not consistently met across emergency medicine. This inequity of care prompted the development of a LIPS working group with Nutrition and Hydration identified as a priority across unscheduled care. A quality care model should include the consideration of patients' individual nutrition and hydration needs in the

context of improving care and maximising recovery potential. It is a mark of quality as identified by staff, patients and relatives in the 3 key external reports Francis, Berwick and Andrews.

As a result of the short term funding the following dietetic service model was introduced to the EU in January 2017 until 31st March 2017:

- All patients admitted through EU majors and streaming screened for risk of malnutrition and dehydration between 8am and 6pm each day by a dietetic support worker (DSW). DSWs are based on the unit throughout the day and are able to provide prompt intervention, often being the first person to see the patient after the medical team.
- Patients identified by the DSW as requiring dietetic input are referred to the Dietitian for individualised assessment, treatment and discharge planning.
- The Dietitian formulates an individualised treatment plan, signposts patients and family members to appropriate community services to optimise care following discharge and help prevent re-admissions.
- Feeding assistance is provided by DSWs to patients requiring support at mealtimes.
- Patient safety regarding special diets including allergies and texture modification is addressed via the dietetic team identifying those with dietary needs and communicating this to the nursing and catering teams.
- At every patient contact a suitable drink is offered and feeding assistance given where necessary. In addition a high energy and protein milkshake and drinks round is provided by a DSW twice a day. This is particularly for the frail elderly population presenting to the EU.
- Multidisciplinary team working includes advising nursing staff on appropriate fluid thickening techniques, supporting the medical team with managing re-feeding syndrome and the appropriate monitoring to reduce risk, and sharing of information with other therapists to avoid duplication. It also includes identification of patients placed NBM, challenging inappropriate nutritional decisions, prompting early referral for swallowing assessment and initiating artificial feeding if appropriate.
- Particular focus on patients presenting with falls due to the associations between recurrent falls and worsening degree of malnutrition and dehydration.

ASSESSMENT

Outcome data is still being analyzed and we are currently able to report the following outcomes.

- 28% of the 787 patients nutritionally risk screened in EU were referred to a Dietitian for nutritional intervention (Appendix 2). This figure is comparative with the national picture which demonstrates an average 25% of patients are at risk of malnutrition on admission to hospital across the UK (BAPEN). It is notably less than the 45% referral rate experienced by our service in the assessment unit. This is explained by the more vulnerable position of patients in AAU, given that they are unable to discharge straight from EU either as too acutely unwell or failing to cope at home; both of which are associated with higher nutritional risk.

- 37% of patients referred to the Dietitians were clinically malnourished. This is not unique to winter, with previous national BAPEN research indicating the prevalence of malnutrition on admission to be higher in the summer months. The relationship between malnutrition and other co-morbidities, number of hospital admissions, LOHS is well recognised.

- 17% of patients were screened as high risk of dehydration, with a further 49% at moderate risk of dehydration. All patients in these categories received dietetic advice aimed at improving their fluid intake and in turn preventing recognized side effects of dehydration. Of the patients admitted with

a fall seen by a Dietitian 97% were at moderate / high risk of dehydration, suggesting a strong relationship between dehydration and falls risk. Optimal hydration management has a fundamental role to play in falls prevention and reducing future repeat hospital admissions.

- Staff and patient stories have been undertaken and mapped. Feedback from staff and patients has been overwhelmingly positive (Appendix 3) and show a very different picture from the themes that emerged undertaken prior to the dietetic service commencing (Appendix 4).

- 20% of patients were randomized to follow up of which 87% achieved a positive improvement in a measurable outcome (weight or body measurement) between point of first contact and at 1 month follow up. All measurements taken were verified by a health care professional (Appendix 5).

- On 43 occasions adverse events were potentially avoided by dietetic staff identifying patients requiring modified diet or fluids at point of entry. These requirements had not previously been identified by nursing staff. Dietetic staff then arranged the appropriate diets for these patients and support nursing staff in thickening drinks accurately. This has huge implications for patient safety and future avoidance of adverse events related to choking / aspiration.

- 89% of patients offered a drink by the dietetic staff accepted one. An additional 125kcals, 5g protein per day were delivered via nourishing drinks round alone, equivalent to a 20% improvement in energy intake for a patient with a reduced dietary intake of 600kcals/day.

- Access to food and drink 'out of hours' doubled with the initiation of the dietetic service, with 100% of patients in EU being offered food or drink.

- On 41 occasions Dietitians made indirect nutritional recommendations to the MDT to enhance the holistic treatment plan, for example, advising on the management of refeeding syndrome, use of pancreatic enzyme replacement therapy or optimising glycaemic control.

We have not looked at readmission rates in this piece of work. However, research published in 2009 demonstrated a 30% reduction in hospital readmission with appropriately prescribed nutritional products.[6] The signposting to community services, for example Community Resource Teams (CRTs), domiciliary services, third sector services, weight management programmes, Diabetes Xpert programme is designed to support patients and lead to prevention of future admissions.

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CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Appendix 1
Emergency Unit Dietetic Service Jan – March 2017

To introduce a nutrition and dietetic service to the Emergency Unit (EU) to support patient flow by identifying and treating patients nutritional and hydration needs and meet the requirements of health and care standard 2.5 equitably across EU and AAU.
The aim is for a fully integrated multi disciplinary service, working with all MDT colleagues and working very closely with Occupational Therapy (OT) and Physiotherapy to maximise efficiency in information gathering, assessment and treatment planning.

Core Activities

The Dietetic team will focus on:-

- Identifying patients with poor nutrition and hydration status.
- Initiating care plans to meet needs either for those going home or for ongoing admission with the aim of reducing the likelihood of readmission / clinical deterioration.
- Making connections with community services to support safe return to the home environment, minimising loss of function and social care needs.
- Provide a bridging service to patients waiting for community interventions following discharge
- Reducing harm by ensuring correct prescription of therapeutic diets e.g. modified consistency and thickened fluids; allergies; diabetes education.
- Troubleshooting issues associated with the management of home artificial feeding devices / equipment to prevent admission and interruption to nutrition and hydration. If long term funding secured, this would extend to swallow screening for stroke patients.
- Facilitate access to food and drinks, and hot meals in the EU environment and support patients in eating and drinking.
- Education and empowerment of the EU healthcare team in Nutrition and Hydration needs.

Hours of work

7 Day a week Service
8am to 6pm Monday to Thursday
8am to 5.30pm Friday, Saturday and Sunday

Staff Cover

2 Band 7 dietitians Monday to Friday
2 Dietetic support workers Monday to Friday

1 Band 7 Dietitian Saturday and Sunday
1 Dietetic support worker Saturday and Sunday

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Key Outcomes Measured

Measuring the Nutritional and Hydration risk presenting at the front door:

- Screening for Malnutrition risk and identifying absolute malnutrition
- Screening for dehydration risk and identifying dehydration
- Identification of food Intolerances and food allergies
- Identification of Dysphagia

Capturing referrals and signposting to Community Services

- Quantify brief dietary interventions i.e. first line falls advice, smoking, iron, healthy eating
- Quantify referrals and signposting of EU patients to community services

Food and drink service at the front door

- Quantify impact of time spent delivering targeted nutrition / hydration care
- LIPS fluid campaign 'Think Drink'
- Improvement in drinks provided
- Patient experience: Patient stories and mini-survey
- Twice daily high energy and protein milkshake round – quantify intake, outcomes previously measured

Actions taken to discharge from EU and prevent readmission

- Measurement of impact on patient nutrition and hydration status post discharge >20% sample of patients
- Expedite discharges : Simple count with estimated bed days saved
- Prevent admission for nutrition / nutrition support related clinical presentations
- Referrals to CRT/ Community services; follow up outcomes for frail elderly.

Interdisciplinary working

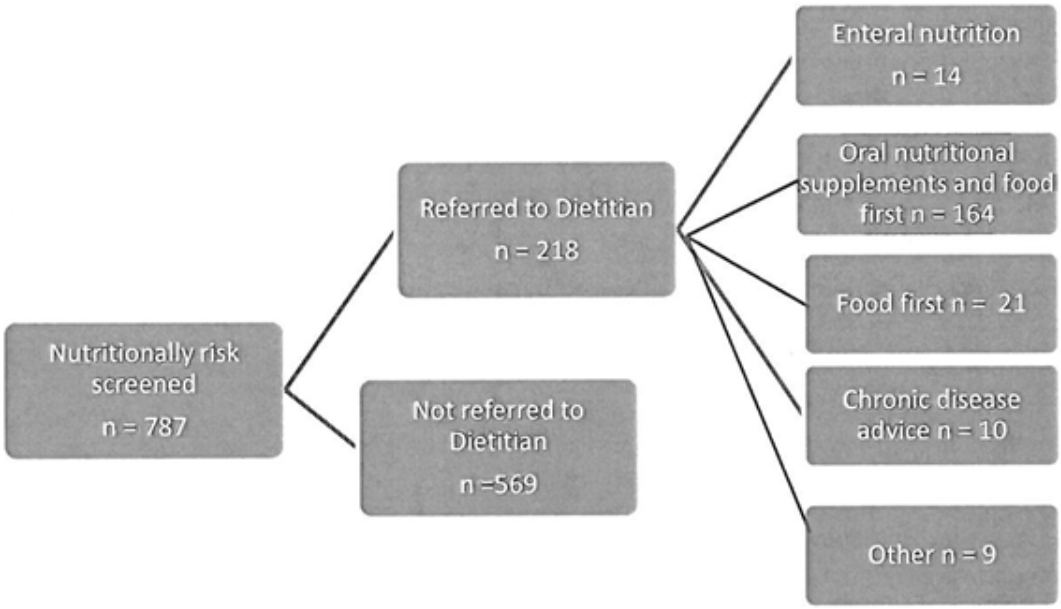
- EU Nursing staff feedback and discovery interviews
- Staff surveys: OT, Physiotherapy, Consultants, Catering
- Quantifying non-nutrition related dietetic support to patient care i.e. requesting investigations, medications, monitoring and biochemistry.

Nutrition and Dietetic Department **Jan 2017**

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Appendix 2: EU Dietetic Activity Data 8 weeks Jan-March 2017



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CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Appendix 3: Patient / Staff Quotes from Discovery Interviews

'What a difference to the last time we were here. Thank you very much for taking the time to give my Dad a drink'.

'Audits will show vast improvement and I think that will drop again especially assistance and assessment of needs'

'I know that in the time that the service has been running this has had a real positive impact (on)our patients, both when they are in the Unit and when they have gone home. I know the staff on the ground will be sorry that this excellent service for patients will be stopping ..... Please thank your staff they have been amazing.'

'Patients family don't notice life saving treatment or how often you do observations but do notice if given a cup of tea. Makes all the difference from their perspective'.

'When I first started here there was nothing for patients not even a water dispensers in the area and there might be a left over sandwich in the assessment unit if you were lucky but caterers didn't come through here to offer meals... so its 100 times better since then. Having Dietitians around to feed your patients is brilliant'.

'Helps with dietetic support workers (DSW) putting on the board who is eating and drinking'.

'Much easier with eating and drinking and diets, they (DSW's) are phoning and letting us know'.

'They come around in the morning... (DSW) go through notes and they highlight people who are eating and drinking, NBM, how they normally eat and drink, whether they have supplements, need assistance'.

'The assistants (DSW) have been really good in helping in the breakfasts and at lunch time and its just been amazing as there are not enough staff to help the patients... and if 3 or 4 patients need assistance with eating and drinking you are just physically not going to get around them, there porridge is going to be cold by the time you get to third person, its just not fair'.

'Vast improvement in our nutrition and hydration needs in the EU since the dietetic involvement'.

'The assessments of their (patients) nutritional needs early on in their admission to hospital is obviously going to improve patient outcomes.. and just their general patient morale, they're getting more food and drink'.

'Difficult because of physical space..... but the help that they are giving with basic nursing care that we are supposed to do... food and water... for them (DSW) being around to help with that is great'.

'Increased therapy has been fantastic for timely discharges... dietetics input which is great'.

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Appendix 4: Patient / Staff Discovery Interviews PRE dietetic service in EU

Core themes identified and corroborated by using these 2 methodologies.
These were Communication, Education and Provision of food and drink to meet the wide ranging needs of this diverse patient cohort.

These direct quotes identified that patients are not always fed the correct consistency of diet or fluid:

'I had a problem with swallowing, they started to put crystals in my drink.....I've got it at home, not had it here'

Staff struggle to access the correct food and drink to manage patients needs and importantly avoid harm:

'Sometimes at night we have to go to 3 or 4 different wards to get a sandwich for a patient with hypoglycaemia'

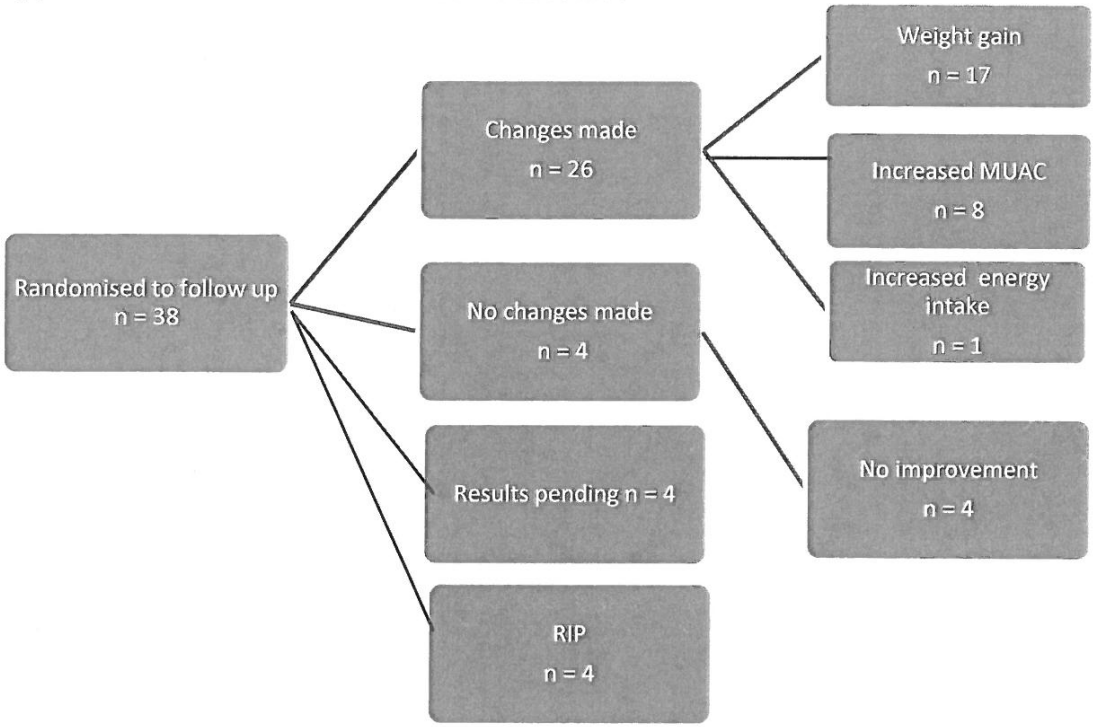
There is a lack of clarity about who is on what in terms of special diets and / or if patients are able to eat and drink:

'pureed meals...I wouldn't know how to go about getting that or ordering it'

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD MEETING

Date of Meeting:

Appendix 5: EU Dietetic Intervention Outcomes



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POINT OF CARE TESTING: GOVERNANCE REVIEW
Name of Meeting : Quality, Safety and Patient Experience Committee **Date of Meeting :** 12th September 2017

Executive Lead : Medical Director
Author : Consultant Clinical Biochemist and PoCT Lead for Cardiff and Vale UHB
Caring for People, Keeping People Well: The report underpins the UHBs strategy to provide sustainable services, including the reduction in waste, harm and variation.
Financial impact : The PoCT Department is under pressure to provide a robust service for its users. It recognises that investment is required to help sustain and expand the service to meet the demands from an expanding user population across all sectors of the UHB. In order to sustain and meet the demands of an expanding user population for PoCT across all sectors of the UHB, a designated funding stream must be identified. The proposed financial plan is to implement a cross-charging mechanism
Quality, Safety, Patient Experience impact : The provision of safe and effective methods of point of care testing is essential for the provision of safe and effective care for patients and the effective use of resources.
Health and Care Standard Number. Standard 2.9 – Medical devices, equipment and diagnostic services.
CRAF Reference Number. 5.1 Deliver safe, efficient and effective care.
Equality and Health Impact Assessment Completed: Not Applicable – Note EQUIA is included in accompanying Policy Document provided as a separate paper.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The Board (or name of Committee) is asked to:

- **AGREE** the continuation of the current Governance Structure for Point of Care Testing and **NOTE** the initiatives for service improvement that are being put in place to further strengthen governance.

SITUATION

Within the UHB, the Point of Care Testing (PoCT) Department is responsible for agreeing a specification for proposed acquisition of PoCT devices and their integration into patient care pathways, as part of clinical effectiveness. Its remit is extensive and covers procurement advice, equipment evaluation, training and competency assessment, device connectivity, quality assurance, performance surveillance, audit, governance surveillance and incident reporting within the UHB. Accuracy and imprecision of results, robustness of device and traceability of results all need to be evaluated before acquisition; the POCT Department will advise on the suitability of devices. Consideration will also need to be given to ensuring comparability of results between POCT and those of the accredited laboratory where patient management is shared. The POCT Department will work with the respective Departments in this process.The repertoire of devices managed by the PoCT Department includes, glucose, ketones, urinalysis, pregnancy testing, anticoagulation, thromboelastography, thromoelastometry, haemoglobin, HbA1c, fetal fibronectin, blood gases and co-oximtery devices. Additional training and maintenance of blood gas and co-oximetry analysers is undertaken by the Medical Biochemistry and Immunology Department.

This paper sets out to describe the current governance arrangements, which have not been reviewed recently, for this important service and the new initiatives currently underway to further strengthen the governance arrangements.

It is important to ensure that the right equipment is used in the right clinical setting, it is managed appropriately and the effectiveness of PoCT in the clinical pathway is reviewed. The governance and management of PoCT within the UHB is described in the PoCT Policy and PoCT Procedure which is being reviewed/agreed by the Quality Safety and Patient Experience Committee (September 2017).

The report highlights significant financial challenges going forward.

BACKGROUND

PoCT is defined as “any pathology test performed for a patient by a healthcare professional outside the traditional centralised laboratory”. Users of PoCT within Cardiff and Vale Health Board (UHB) include:- medical practitioners, nurses, midwives, healthcare assistants, pharmacists, podiatrists, medical students and other Healthcare professionals.

These tests may be carried out in a wide range of non-laboratory sites, PoCT is often more expensive than conventional laboratory testing, however it is used in situations where the immediacy of the results can aid the clinical decision making and patient flow; it can facilitate early intervention reducing the risk of complications, reduce length of stay and ultimately reduce overall costs to the organisation. It can also help to improve the patient experience;

with convenient and local access to diagnostics, along with improve acceptability and motivation to manage conditions.
As the focus shifts to managing patients in a primary care/ community-based setting, PoCT will inevitably become more integral to both the needs of patients and clinicians, thus helping to facilitate the reduction in acute admissions. It is important, therefore, to ensure that the right equipment is used in the right clinical setting it is managed appropriately and the effectiveness of PoCT in the clinical pathway is reviewed.

Organisational structure.

The PoCT Department is operationally managed within the Clinical Diagnostics and Therapeutics Clinical Board (see appendix one).

ASSESSMENT AND ASSURANCE

Governance of PoCT

This is addressed by the POCT Group. This group meets 4 times a year and is responsible for approving PoCT services, defining the scope of POCT, taking into consideration the clinical need for POCT, its financial implications, technical feasibility, and ensuring that appropriate measures are in place to monitor the accuracy and quality of POCT. All POCT devices must only be purchased after a case for clinical need has been approved by the POCT Group.
The Group has the authority to require POCT activity to meet standards and take sanctions (including suspension or withdrawal of service), and the Chairperson has the authority to take executive action if necessary. Patient safety, clinical effectiveness and cost efficiency is used as the guiding principal.
This group is chaired by the Assistant Medical Director and reports to the Quality and Safety Committee through the Medical Director by exception reporting.
In addition the Clinical Directors have a responsibility to ensure that integration of POCT into care pathways is clinically effective, and the use of the devices comply with the organization's POCT Policy and Procedure, clinical incidences are reported and poor performance issues are addressed in a timely manner.
The POCT Dept. conduct regular internal audits on the usage of POCT devices and operator performance surveillance reports which are made available to the Clinical Boards. Any quality and safety issue is escalated to the POCT Group and the Medical Director.

Service Improvement Initiatives

1. POCT Dept. has undertaken a number of IM&T initiatives:
    - Interface the POCT Data management middleware to the ADT feed (*Admission, Discharge, Transfer*), thus facilitating positive patient verification on the device. This work is currently being tested and will

be rolled out across the UHB as part of the “All Wales “ Poct connectivity solution (WPOCT).

- Interface the POCT Data management middleware into Laboratory Information Management system and ultimately into Clinical Portal. This is dependent on a successful outcome of the ADT project and WPOCT project. The latest “Go live” date is anticipated for October 2017.
- Interface the POCT data management middleware to the UHB Business Intelligence tool to facilitate POCT -dashboard reports for Clinical Boards to provide activity, test usage and operator test performance criteria.
- Interface the POCT data management middleware to the UHB Business Intelligence tool to facilitate patient alerts. This is an on going project and the Diabetes teams already have access to daily hypoglycaemic and hyperglycaemic patient alerts.
- Roll out automated fully connectable devices to replace manual testing procedures to facilitate data capture, audit and quality monitoring of uncontrolled manual procedures. 60 Urine Analysers and 15 Urine hCG Analysers have already been purchased by the UHB. The PoCT Department has successfully interfaced and tested devices in readiness for WPOCT (see appendix two):

2. POCT and LED to develop a planned approach to training and competency initiatives:
    - Improve awareness of POCT IT governance issues during HCSW initial training.This is now included in the Committed to Care training programme.
    - POCT Department and LED to monitor ongoing competency and re-validation of qualified staff. A new process has been developed for ward based on-going assessment of registered nurses and HCSW.
    - POCT Department to undertake spot audits to determine accuracy of the recording process for blood glucose monitoring of diabetic patients. The audit will analyse the data recorded on paper based nursing notes and the information held electronically in WPOCT. A period of amnesty for 3 months for lost (borrowed) ID badges will be implemented in the first instance to facilitate the process. Old style ID badges will be replaced with the current format.
    - POCT Department to undertake weekly audit of the emergency bar code and any misuse will be reported to the Clinical Board nurse.
    - POCT training for glucose monitoring for registered nurses working in a clinical environment will be mandatory. Any lapsed training will be reported to the respective Clinical Board nurse. A notice period of 21 days will be sent to the individual operator.
    - POCT and LED to develop and implement e-Learning packages. There is no funding stream available for the development of ongoing competency assessment tools. This needs to be identified.
3. Organization wide (outside scope of POCT Dept):

- On-going vigilance and re-enforcement of record keeping and awareness of IT Data Protection Policy. Prevention measures for POCT ID badge sharing by all stakeholders and notification of termination of employment linked to POCT ID badges.

Although the POCT Dept. is responsible for implementing training and competency on POCT devices, the mitigation of risks to the UHB can only be achieved with full stakeholder engagement across the organization, compliance to the POCT Policy, consolidating training and competency issues, with electronic capture of POCT data, thus facilitating full audit trail and improved compliance with the POCT Policy.

4. Improved governance of blood gas operators.

- The existing middleware used by Medical Biochemistry (Radiance) has limited functionality for the management of operators. To ensure that an equitable service is rolled out across the UHB for all POCT, the blood gas middleware will be upgraded to Aquire to allow full connectivity with WPOCT. Similarly, the Abbott iStat devices will require additional middleware (DE software) to enable full connectivity. Although these upgrades were provided free of charge, they will require an additional 2 servers and the ongoing support from the server team. This is an additional cost pressure for the POCT Department.

Financial Analysis/Governance

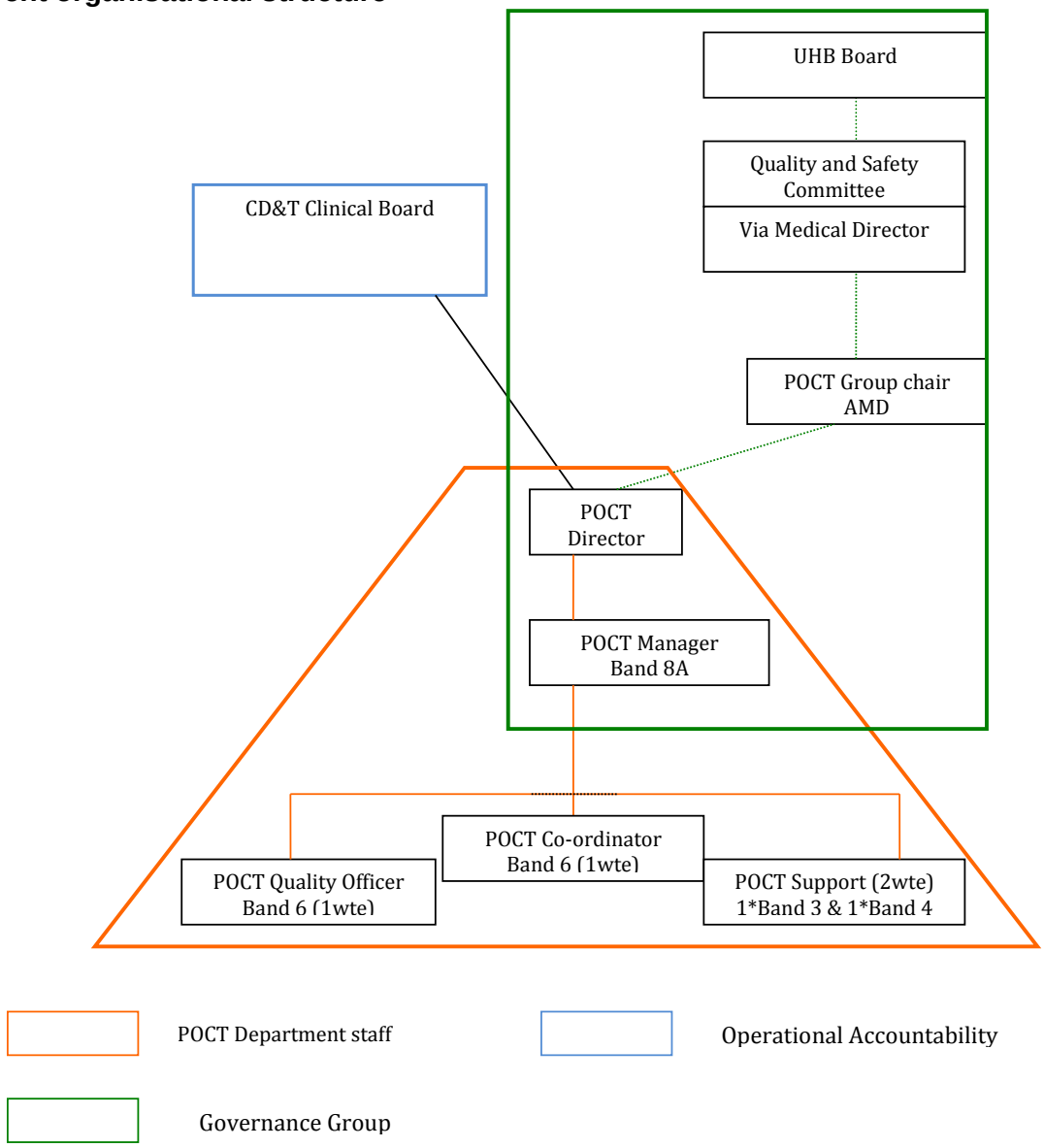
At present, the PoCT Department receives little funding from Cardiff and Vale UHB, a small cross charge of £115K to part cover salaries is made available from Weqas hosting charges, ad hoc charges to LED Department and from SLA with General Practitioners for EQA and support for anticoagulation monitoring. The SLA agreement with LED covers the provision of an agreed number of HealthCare Support Worker and Nurse Foundation Programme training sessions by the PoCT Department. However, this sum is negotiated year on year and is not guaranteed.

The PoCT Department is under pressure and struggling to provide a robust service for its users. It recognises that investment is required to help sustain and expand the service to meet the demands from an expanding user population across all sectors of the UHB. There is also a requirement to ensure that the quality of the service is fit for purpose and meets national guidelines. In order to sustain and meet the demands of an expanding user population for PoCT across all sectors of the UHB, a designated funding stream must be identified.

Abertawe Bro Morgannwg UHB, provides a similar level of service to C&V UHB PoCT Department with a larger staff structure of five staff. The Department is centrally funded with a cross-charging mechanism in place. The responsibility for PoCT strips and devices in Aneurin Bevan HB has been transferred from Pharmacy to Pathology Department with appropriate cross charging mechanisms in place.

The proposed financial plan is to implement a cross-charging mechanism, employing a similar charging mechanisms already in operation within the CD & T Clinical Board. In addition implementation of a fully Managed Service Contract for all PoCT devices across the UHB, will allow the organisation to make substantial cost savings. The effect of not supporting the proposal will ultimately result in a decline in the quality and safety of PoCT use across the UHB and the risks identified in the FMEA matrix.. The investment required to maintain the PoCT Department is small compared with the risks to the UHB of not providing this service. The benefits of providing a robust PoCT Department are clear and will ultimately enable efficiencies of resources and effectiveness of service delivery.

Appendix One
Current organisational structure



Appendix Two

Test Repertoire	Manufacturer and device
Blood Gas and Co-oximtery	Radiometer (various)
Multi-Test meter including Blood Gases	Abbott i-Stat
Blood Glucose meters / ketone meters	Nova StatStrip
Pregnancy testing	Siemens Clinitek Status
HbA1c	Siemens DCA Vantage
ACT	Elitech Hemochron Jr Signature Elite
Haemoglobin	Radiometer Hemocue
INR	Roche CoaguChek XS Plus
INR	Roche Coagucheck XS-Pro
Urinalysis	Sterilabs Urilyzer 100 Pro
TEM	Rotem Sigma
Foetal Fibronectin	Hologic Rapid fFn 10Q System
CRP	Alere Afinion
Glucose/Ketone	Nova Statstrip Wireless
DDimer	Roche Cobas H232
CRP	Orion Quick Read Go

RISK TO PATIENTS DURING THE CHANGEOVER TO THE NEW NEURAXIAL CONNECTOR
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead: Medical Director
Author: Neuraxial Implementation Lead and Consultant Paediatric Oncologist, 029 2074 3599 (UHW)
Caring for People, Keeping People Well: The Health Board's Strategy includes 'avoiding harm'. A neuraxial connector that cannot connect to intravenous products is an important improvement in patient safety. However, during introduction of the new connector, risks to patients could increase. This changeover needs to be planned for and managed appropriately to mitigate against any potential increased risk.
Financial impact: There may be additional, not quantifiable at present.
Quality, Safety, Patient Experience impact: Safety: to mitigate the risk to patients
Health and Care Standard Number 2.9
CRAF Reference Number 8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Quality, Safety and Experience Committee is asked to:

- **AGREE** the continued work of this group.
- **APPROVE** the initial risk assessment in Appendix 1.

SITUATION

Equipment relating to neuraxial (spinal) procedures is changing. The expected changeover date within the CVUHB is likely to be after March 2018. Because of the need to roll out equipment procurement and the roll-out across other Health Boards this date will be kept under review. This equipment change covers a number of critical areas including anaesthetics.

Neuraxial procedures involve introducing a needle into the spinal canal from the back, either as a diagnostic tap (where fluid is dripped into a bottle) or to inject a drug eg. for pain relief. All neuraxial procedures will be affected by the changeover as the needles will change for this procedure. The new needles will use the ISO standard non-Luer connector (NRfit) at the hub, requiring specific NRfit syringes to enable connection.

This is to minimize the risk of drugs intended for the intravenous route being given into the spinal canal (neuraxial route), which can cause devastating side effects. The change will affect more than 8,000 procedures per year within the CVUHB over several departments including anaesthetics, acute pain, chronic pain, emergency unit, general medicine, haematology, neurology, neurosurgery, oncology, paediatrics and neonates, pharmacy, radiology and spinal surgery.

Neuraxial procedures most significantly affected by the change are those which require a syringe, namely epidurals, spinal anaesthetics and the instillation of intrathecal drugs, including chemotherapy. However, diagnostic lumbar puncture needles will also change. This poses a different and wider-reaching logistical and training issue at changeover as these are performed across most clinical areas within the UHB.

BACKGROUND
In 2009 the NPSA (National Patient Safety Agency) issued an alert requiring neuraxial procedures (spinal, epidural and lumbar puncture) and regional nerve blocks to use a connector that could not connect to intravenous products. This alert was issued after an inquiry following the death of Wayne Jowett in 2001 when an intravenous drug was administered intrathecally in error. The updated alert in 2011 required Trusts in England to have dedicated neuraxial devices in place by April 2012 and April 2013.

The alerts and supporting information are available at:

- Safer spinal (intrathecal), epidural and regional devices - Part A update - 574 KB 1310 A | Safer spinal (intrathecal), epidural and regional devices - Part A update | 2011-01-27 | v1
- Safer spinal (intrathecal), epidural and regional devices - Part B - 201 KB 0927B | Safer spinal (intrathecal), epidural and regional devices - Part B | 2009-11-24 | v1
- Safer spinal (intrathecal), epidural and regional devices supporting information - 240 KB 1310 C | Safer spinal (intrathecal), epidural and regional devices supporting information | 2011-01-27 | v2

During this time Welsh Government set up a multidisciplinary group, the Welsh Non-Luer Connector Reference Group (WNCRG), whose function was to aid the NHS in Wales in publicising and implementing the alert safely. Following advice from the WNCRG, the alert was not implemented in Wales due to a delay of development of a suitable non-Luer connector. The relevant Public Health Link from the CMO in Wales in 2012 can be seen at: http://gov.wales/docs/phhs/publications/120404cmoletter19marchen.doc

The ISO standard for the new NRfit neuraxial connector has now been published. Once the connector is available in the UK and the whole product-range is available (estimated as the end of 2017), implementation will go ahead to make Wales compliant with the alert. This roll-out will be phased across Wales, with an earliest implementation date for this UHB of March 2018.

The ISO standard is available at
http://shop.bsigroup.com/ProductDetail?pid=000000000030288422

Concerns have been identified that changes to the new devices may have unexpected clinical consequences, therefore Welsh Government-funded surveillance is now in place across Wales, with baseline data being collected now. This has the added benefit of raising awareness of the imminent changeover. The risks to patient safety of the changeover itself are not inconsiderable and include:

- Failure of spinal or epidural anaesthesia, despite the needle being correctly positioned
- Failure of analgesia in labour
- Conversion of epidural to general anaesthetic
- Inability to give intrathecal drugs, including chemotherapy
- Exposing patients to a repeat procedure

ASSESSMENT AND ASSURANCE

Procurement are leading the changeover of neuraxial devices. However, in view of the complexity involved, a UHB Task and Finish Group has been set up to provide a link between Procurement and clinical teams, and a forum for detailed planning of the changeover. This group is led by Dr Rafal Baraz (Consultant Anaesthetist) and Dr Cathy Morley-Jacob (Consultant Paediatric Oncologist). The group (membership in Appendix 1) meets alternate months at present and reports to the Medical Director.

Procurement have compiled a list of neuraxial equipment used in different areas across the UHB. There are currently four entry routes for equipment into the UHB, with this being simplified as much as possible, so that most equipment will be ordered from the 'catalogue'. Off-label use is being identified and needles for these uses will be changed to 'long-Luer' needles in place of spinal needles ahead of the neuraxial changeover. The list will then inform where equipment will be changed, and in which areas equipment must remain (for those procedures continuing to be managed on the risk register ie. caudal epidurals). National Procurement Services and the WNCRG have identified which suppliers are or are not able to fulfil orders of the magnitude required across Wales, and this information sits with Procurement.

The structure of the changeover will follow that set out in the Implementation Document (Appendix 2) developed by Leicester Hospitals Trust when they recently implemented a changeover of neuraxial devices. There is a more detailed version of a month-by-month version available through the WNCRG. Each hospital site within the UHB will transition on a single day at a specified time (Monday morning), with approximately a week gap before the next site changes. Sealed boxes of the new equipment will be delivered to each clinical area a week prior to the changeover date and will remain sealed until the changeover time. The box will also contain a list of what should be removed from that clinical area, placed in the box and quarantined in the Central Sterile Services Department (CSSD). The quarantined equipment will be held centrally for a number of weeks.

This will also maintain equipment for any patient with an epidural *in situ* during the changeover.

The new NRfit syringes have a yellow plunger, giving a visual clue that they are for neuraxial use, but they will require labelling within clinical and storage areas, to avoid their unintended use with an intravenous needle (which will not connect). Sterile neuraxial syringes will only need to be available in Pharmacy, and to a lesser extent in Radiology and in areas where anaesthetics are given. As chemotherapy syringes are pre-filled in Pharmacy and syringes are not required for a lumbar puncture, Haematology and Oncology units, General Medicine and Paediatric departments will not require empty syringes to be available.

UHB Pharmacy and St Mary's Pharmaceutical Unit are writing new Standard Operating Procedures for the neuraxial drug products they manufacture. This includes intrathecal chemotherapy and antibiotics as well as pre-made epidural syringes. Once the new syringes are available to the NHS, they will be made available to both areas for Quality Control (QC) testing (both for sterility and drug stability in the new syringes). QC will be performed in strict isolation from the present systems, to prevent a NRfit syringe entering a clinical area prior to changeover (the syringe would not connect with the present needles and therefore the drug could not be administered). The Pharmacy units are the only areas of the UHB with a staggered changeover, as products for each site will have to be made in the correct syringes.

A Risk Assessment has been compiled for the changeover (Appendix 3). A further, more detailed, assessment is required for those higher risk entries, to be compiled with input from key colleagues. This includes the UHB's interaction with St Mary's Pharmaceutical Unit and areas that perform intrathecal chemotherapy. Specific, but predictable, issues include women in labour who have an epidural *in situ* from the Sunday night into Monday of the changeover. Equipment compatible with the old system will be available for those small numbers of patients. Emergency cases being performed during the changeover period and critical care cases may also require the old set of equipment for longer and this is being built into the process.

Training within the UHB needs to include doctors, nurses, midwives and other health care professionals. The Learning, Education and Development Department will be involved in rolling out a general awareness campaign across the UHB. Operating Department Practitioners (ODPs), in particular, will require significant training as they prepare trolleys of equipment for Anaesthetists (both Luer and non-Luer syringes will need to be used during anaesthetic procedures and will no longer be interchangeable). Surveillance has raised the awareness with doctors that this changeover is imminent. The regular, almost monthly, Safety and Quality sessions will be utilised to allow clinicians to familiarise themselves with the new needles and syringes, and new medical staff will be introduced to the new equipment during the UHB Induction. Nursing and midwife training is to be co-ordinated by the Senior Nursing Teams.

The changeover to the new NRfit connectors is a national process and roll-out of the new connectors will occur UHB by UHB across Wales, starting with Aneurin Bevan UHB, possibly in January 2018. Cardiff and Vale UHB is expected to be towards the end of the Welsh process in view of its size and complexity. The earliest date for implementation in the UHB is therefore likely to be after March 2018. Once the first UHB in Wales confirms the exact date for its implementation, then other UHB's can plan their exact dates of implementation.

Appendix 1: Members of Neuraxial Task and Finish Group

Name	Role and Department
Rafal Baraz	Consultant Anaesthetist/Obs and theatre
Cathy Morley-Jacob	Consultant Paeds Oncology
Terry Stephens	Procurement, Nurse advisor
Eurig Jenkins	Pharmacy
Awen Proctor	Pharmacy/Aseptic Services
Pam Saunders	Radiology, senior nurse
Rebecca Vaughn Roberts	Radiology Q&S
Michelle Beynon	Neurosurgery, nurse
Robin Corkill	Consultant Neurologist
Bethan Lever	Neuroscience, nurse
Natalie Ryan	Neuroscience, nurse
Anna deLloyd	Consultant, Medicine
Jonathan Kell	Consultant Haematologist
Victoria Duffin-Jones	Consultant Anaesthetist, Paeds
Mudit Kumar	Consultant Anaesthetist, Paeds
Catherine Twamley	Acute Pain, senior nurse
Rahul Guru	Consultant Anaesthetist and Chronic Pain
Lorraine Coultis	Anaesthetic practitioners lead
Dave Smalley	Anaesthetic practitioners lead
Janice Aspinall	Anaesthetic practitioners lead
Paul Morgan	Consultant Intensivist ICU (via emails)
Matt McCarthy	Patient safety
Rachael Daniel	Health + Safety (H+S)
Jayne Thain	Main theatres, Senior Nurse
Mark Bennion	Clinical Lead for Governance, Peri-Operative
Barbara Jones	Peri-Operative Education Lead
Rachel Gidman	LED (via emails)
Darren Cooke	Senior Nurse, ICU
(no name yet)	Communications

Last met 11.7.17; Next meeting 19.9.17

ISO 80369-6 Implementation of neuraxial / neural devices in the UK.

01/06/2016

This paper is a case study of local practice and was reviewed by the NHS Small Bore Connector Clinical Advisory Group, who agreed that the information would be useful for other Trust when implementing new neuraxial connectors.

Dr Paul Sharpe, Chairman of NHS England Small Bore Connector Advisory Group.
Consultant Anaesthetist University Hospitals of Leicester NHS Trust.

Dr Ian Shaw, Consultant Anaesthetist, Sheffield Teaching Hospitals NHS Trust.

Mr Pete Phillips, Director, Surgical Materials Testing Lab, Princess of Wales Hospital, Bridgend, South Wales

Headline messages

1) The change to an Internationally agreed (ISO) connector for neuraxial / neural devices is soon to be deployed.

2) The change is currently anticipated to commence at the end of the first quarter of 2017.

3) Most Luer and proprietary non-Luer connectors currently in use will cease to be produced.

4) The change affects a wide distribution of users within your organisations, many more than you may be aware of.

5) It is anticipated that the preparation to change in your organisation may take over 6 months to co-ordinate.

Guide to transition process:

Introduction

This document distils the experiences of two English teaching hospitals in converting from Luer neuraxial devices to non-Luer (Surety), with the aim of producing a HOWTO guide for others to access when ISO 80369-6 (a new standard for non-Luer neuraxial connectors) is deployed in Spring 2017.

Those of you who have already made the change to proprietary non-Luer (pn-L) devices may still find additional tips within this document to facilitate smooth transition to the new ISO system.

The switch from Luer to non-Luer connectors on neuraxial medical devices was initiated by the NPSA/2009/PSA004, a response of the National Health Service in the United Kingdom to a number of Serious Untoward Incidents, in particular the incorrect administration of Vincristine into the CSF which resulted in a number of fatalities.

ISO 80369-6 (also known as 'NRFit') details a neuraxial specific connector intended for use in spinal needles, epidural needles and catheter connectors and a range of other neuraxial devices, and has been ratified by ISO. Eventually neuraxial devices currently on the market using the Luer and pn-L connectors will cease to be manufactured.

April 2017 is the target date to start the introduction of ISO 80369-6 devices into the UK, but it is not a deadline. It is anticipated that this will take a number of months to complete.

The ISO 80369-6 standard will make the conversion much simpler than previously. It should be possible to simply replace your current product (Luer or pn-L) with the same device containing the new 80369-6 connector, as the connector is common across all manufacturers.

Alternatives to the IV bag-spike for local anaesthetic, epidural and regional infusions are presently being developed by ISO, but this is probably at least 2-3 years away.

Step 1: Identify the disciplines affected by the conversion.

Planning the conversion process requires a multidisciplinary team from the beginning. We found that a minimum of six months is required to fully prepare for the conversion. You should be aware that a number of specialties may be using current Luer and pn-L equipment “off-label”, you will also need to engage with these users as described below. Experience has shown the following groups will be affected and should be involved:

- Safety & Risk Management
- Supplies Management/Procurement
- Pharmacy
- Anaesthesia
- Oncology/Haematology services
- Neurology services (who may also represent General Medicine).
- Radiology services
- Paediatrics
- Pain Specialists
- Pain nurses
- Medical Director or a representative of their team

Step 2: Recruit staff to be involved in the changeover.

A local implementation group should be set up of users actually using the devices.

Ensure that this group includes a procurement representative. Procurement nurse specialists will be particularly useful for this exercise.

Identify a single point of contact (a 'Champion') who is responsible for coordinating the exercise for each site. This person needs to be identifiable within your organisation and be willing to devote sufficient time to the process.

Step 3: Identify what kit you currently use.

Construct a list of items ordered by each clinical area when planning the conversion. From this list, construct a master list (such as a spreadsheet) of each Luer or pn-L device which needs replacing by an ISO 80369-6 alternative.

We recommend asking your local procurement team to help with this, and then using clinicians to review the list. Clinical review is vital, as it is not always evident exactly what equipment is required. For example, 3 way taps and extension lines may be vital for procedures, but may not be immediately obvious as required devices just looking at a list of “neuraxial” products.

A report which helps identify the final delivery location for the affected products should be run, as this may highlight additional users of the items. This will be especially useful for off-label usage.

Step 4: Check with your supplier that they will provide ISO 80369-6 versions of these devices.

Contact manufacturers individually, or discuss with NHS Supply Chain, to discover if and when they are going to adopt the ISO 80369-6 connector, and whether all of the portfolio your hospital relies on will be covered.

There has been significant work to identify what are the "essential items" for successful adoption. The NHS England small bore connectors clinical advisory group has a spreadsheet of essential equipment that manufacturers are committed to producing, this will be a useful reference resource and is available from – https://goo.gl/KEkCxn .

Note that as we approach the introduction date, it is expected that some devices previously thought of as non-essential may be identified as essential, and individual hospitals may also have different requirements. This list is therefore fluid and should be adapted to local circumstances.

Step 5: Ensure that your expert advisors have early sight of the new devices.

The ISO process has involved a complex set of laboratory tests (to show the connectors do not leak for example), usability tests (to show that they are clinically acceptable) and CAD tests (to ensure that they do not easily connect to Luer devices, pn-L products or other connectors in the ISO 80369-6 series).

However, it is possible that manufacturers may take the opportunity of introducing the new connector to make changes to the current device design, so it is important to give key opinion leaders the opportunity to see samples of the new equipment, to ensure they are fit for purpose. Manufacturers will have had to satisfy their regulatory bodies regarding product usage when gaining CE marking for their product, this includes clinical testing if that regulator requests it, although this is not anticipated to be the case.

Step 6: Understand your off-label usage and ensure continued supply

Many clinicians use spinal needles for non-spinal/non-neuraxial procedures. For example, in orthopaedics it is common to use these needles to inject into joints. Obstetrics may use them for amniocentesis and ENT to inject drugs in to the ear.

List the areas where off-label usage is practiced and contact manufacturers to check whether a Luer version of the device will continue to be made available, as certain lengths and gauges may not be available after the introduction of the 80369-6 portfolios.

It is anticipated that some manufacturers will continue to make 'long Luer needles' for these procedures, which will no longer be labeled or sold as "spinal" needles, and a list of possible suppliers for these off-label uses should be developed.

If devices presently used 'off-label' are no longer available with a Luer connector, and the only alternative is to use neuraxial-specific devices, a risk assessment should be undertaken and if necessary an entry made in the organisation's risk register. Support from the organisation's Medical Director may be necessary in some circumstances.

Step 7: Ensure that the pharmacy aseptic service has appropriate device options;

Many pharmacy aseptic units prepare pre-filled syringes with medicines for the spinal route (such as spinal chemotherapy).

They should ensure that any of the bespoke equipment they require will be available with ISO 80369-6 connectors (e.g. syringes, drawing-up needles, filters, syringe caps (some units may require these to be tamper evident)), or undertake a risk analyses to assess whether they can continue compounding with their currently used devices. It is thought that because pharmacy compounding is well-controlled, the risks of continuing to use Luer filling devices **only** within the pharmacy department may be acceptable until a full range of devices becomes available. This may be the case with devices such as elastomeric and cassette pumps until full 80369-6 versions become available.

The NHS England Small Bore Connector Clinical Advisory Group, in conjunction with NHS pharmacy aseptic and quality assurance groups has produced advice for manufacturers on the evidence they will be required to provide to NHS customers for devices used for aseptically produced pre-filled syringes, most commonly associated with chemotherapy. This includes microbiological integrity testing. It is anticipated that this evidence will be made available to hospitals through an easily accessible website (for example, via the BAREMA or PASG websites).

Step 8: Obtain senior management approval

Once you have made decisions on the devices to be replaced and ensured that all *essential items* will be available, ask the Senior Management Team, or the Medical Director for approval to initiate the change. Do this early, as it is likely to need discussion at Board level quality and safety meetings.

Step 9: Plan the timetable

The time from approval to deployment is likely to be at least 12 weeks.

Decide how and when each hospital will change (all together, one per week etc). This will depend on the size of the institution and the geographical distribution of clinical areas involved.

Ensure that coordination with specialist departments (such as Pain clinics/ Acute pain teams) is undertaken to minimise disruption. For example, Monday can be a good day to convert as there will have been no elective patients over the weekend who need to be attended to on the Monday, ensuring availability of staff.

Create a checklist of all devices which need to be changed and in which wards or departments they will be found.

Step 10: Educate your staff

Awareness of the change is vital. Low level information can start early in the process. However, if undertaken too soon, staff will forget about the changeover. We recommend messaging starts in earnest about 6 weeks before the changeover date.

The cascade process may include the following:

- Presentation at Nurse Directors meeting.
    - Dissemination through ward managers.
    - Use of posters on wards and in theatre common rooms.
- Presentation at Clinical Directors meeting.
- Presentation at Directorate meetings by appointment.
    - In particular, Anaesthesia/ Oncology & Haematology, Neurology & Radiology.
- E-mail to all consultants, pharmacists & ward managers.
- Web-based learning packages can be created and reach large numbers of staff. This will need to be created in-house to meet your local needs.

Messages should include:

- date of the changeover;
- a FAQ on the changeover – for example, GEDSA have an FAQ[1] which could be adapted for local use;
- contact names and numbers for advice before, during and after the changeover;

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ISO 80369-6 Implementation of Neuraxial devices in the UK – Page 5 / 7

- lists of all devices and area affected by the changeover
- strategies for patients with a working epidural. For example, will they require continued access to Luer or pn-L devices for a short period? If so, ensure that sufficient Luer or pn-L devices are still available in an appropriate and convenient safe location. This is a potential risk and needs careful management and controlled access.

Step 11: Provide demonstration sets

Provide sets containing the full range of needles and syringes that will be supplied with the new connectors, and make available at meetings (such as audit meetings or training days) to allow staff to pick up and play with the needles.

Step 12: Coordinate with your suppliers

Once the fixed date for each site has been agreed, coordinate with your suppliers so that you can:

- quarantine or remove all the old Luer or pn-L equipment;
- introduce the new ISO equipment;

If your establishment consists of multiple hospital sites you could consider reducing waste. If you change one site at a time you can move Luer or pn-L stock to the other site/s until you change there too.

Ask suppliers to have staff available on the day of conversion, as there is likely to be a lot of equipment to be moved around, and this will require additional help.

Step 13: Produce an exchange box for each clinical area;

Using the original spreadsheet of affected devices, produce an 'Exchange Box' for each clinical area (ward by ward, theatre by theatre). This should contain every item used by that clinical area, at a level of stock that they normally carry, and should include information for a point of contact for clinical staff to go to if they encounter problems on changeover day. These boxes should be labeled for the target clinical area and sealed.

Around 1 week before changeover, deliver the exchange boxes to each area. They should be quarantined in that location to ensure the new devices are not introduced in to clinical practice too early, as combinations of Luer, pn-L and new ISO non-Luer devices on the same shelves will undoubtedly lead to misconnection errors.

A central storage area should be identified which can hold extra supplies of the entire range of ISO equipment that the hospital uses should any of the exchange boxes be found to have items missing.

Contingency stock of Luer or pn-L devices should be kept available in a centralised safe area for 1 month after the changeover in case problems are experienced with the new ISO non-Luer devices.

Step 14: Conversion Day.

Ensure sufficient numbers of procurement, supplier and clinical staff are available on the day.

Identify staff (such as ward managers/ ward stock controllers) who will be on wards to facilitate exchange. At the designated time it is their responsibility to ensure that unused Luer or pn-L supplies are removed from stock shelves, exchange boxes are unsealed and new ISO compliant equipment is put into place.

All Luer or pn-L equipment should then be placed into the exchange box which should be resealed and returned to the procurement team or quarantined until it can be collected.

Ensure that staff have an emergency contact telephone number, which is manned by procurement staff, to deliver extra kit to clinical areas if unexpected deficiencies are noted.

Note that at this point any ordering catalogues used by staff should be altered to have the new ISO order codes rather than the Luer or pn-L codes.

Step 15: Continue to provide support

Keep a team available as long as necessary (we suggest at least a week) to provide advice and extra supplies. We anticipate that after 3-4 days problems will be intermittent. Some patients with epidurals may straddle the changeover period, and it may be useful to continue to treat them with Luer or pn-L compliant devices as long as is necessary. Changing over on a Monday may minimise the number of epidurals affected.

The time taken to achieve conversion will depend on the size of the institution and the number of personnel you have available. It is likely to take up to a week to convert a single hospital to all non-Luer equipment. Remember that you will need to change all of the elements of each clinical procedure in one clinical area at the same time, to ensure you can proceed with the clinical service safely. If you have multiple hospital sites the conversion to non-Luer across all sites may be best managed in a staggered fashion, rather than all sites at once. It must be remembered though, that staff and indeed patients, may move across these clinical sites during the transition period. It is vital therefore, that staff are aware of this and plans are in place to minimize the risk of confusion and errors in clinical practice.

Useful Documents and Web Sites (accessed 1/6/2016)

- http://stayconnected.org/wp-content/uploads/2015/10/GEDSA-Neuraxial-FAQv1.4.pdf
- http://www.nrls.npsa.nhs.uk/resources/?entryid45=94529
- https://www.england.nhs.uk/patientsafety/medical-device-incidents/small-bore-connectors/

APPENDIX THREE - GENERAL RISK ASSESSMENT FORM – PART 1
LUER NEURAXIAL CONVERSION TO ISO 80369-6 NON LUER DEVICES

Location Cardiff and Vale UHB, all sites	**Clinical Board/ Directorate**	**Department**

Activity /Tasks (Brief Description)	**Potential Risk**	**Consequence X Likelihood = Current Risk Rating** (See Tables 1-3 – Risk Assessment Scoring & Matrix)			**Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above**
Usage A number of specialities use Luer spinal long-needles “off-label” for non-spinal procedures. For example, in Orthopaedics it is common to use these spinal needles to aspirate a joint. Radiology will use these spinal needles to inject a contrast agent / local anaesthetic and for MSK work.	Continued need to use Luer long-needles in these areas could lead to mismatching of equipment i.e. they may order / receive non-Luer needles which will prevent their syringes connecting. This could result in lengthening / cancellation of procedures and negative patient experience. Continued use of Luer long-needles in some specialities could result in them getting into wider circulation, again resulting in mismatching of equipment, but in those areas that have converted to non-Luer. Internet-purchased “off-label” use could result in an area being	3	2	6	More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • Listing the areas where “off-label” usage is practised; • Constructing a list of items ordered by each clinical area & a master list of each Luer device which needs replacing. • System to flag non-approvedequipment orders to Procurement. • A Champion (senior clinician) to oversee equipment issues.

	omitted from the changeover process.				

Continuation Sheet

Activity /Tasks (Brief Description)	**Potential Risk**	**Consequence X Likelihood = Current Risk Rating** See Tables 1-3 – Risk Assessment Scoring & Matrix	**Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above**

Usage cont Paediatric Anaesthetists will continue to use Luer spinal short-needles for caudal epidurals.	Luer spinal short-needles may be unavailable if removed in changeover process, and procedure not possible, or may get into wider circulation, leading to mis-connection.	2	2	4	Specific box to be set up for caudal epidural insertion in small children, keeping Luer spinal short-needles out of general circulation.
Procurement Obtaining stock in preparation for changeover.	If non-Luer devices are not readily available the changeover timetable may not be achieved. Areas may find themselves without either Luer or non-Luer devices.	2	1	2	No further action as: • An overarching action plan is being developed by the Neuraxial Task & Finish Group which includes Procurement colleagues. • There will be coordination with central supply stores to perfect planning. • A central storage area will hold extra supplies.
Maintaining non-Luer supply from Industry.	If supply of all components cannot be maintained, procedures may be cancelled.	4	1	4	No further action as: • A stock of Luer devices to be kept available in short term. • Luer stock will continue to be available on the world market.

Continuation Sheet

Activity /Tasks (Brief Description)	**Potential Risk**	**Consequence X Likelihood = Current Risk Rating** See Tables 1-3 – Risk Assessment Scoring & Matrix	**Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above**

Procurement cont. Managing procurement during changeover.	Individuals / departments may procure non-Luer in error before their area has changed over or Luer in error after they have changed.	3	4	12	More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • System to flag non-approved orders to Procurement. • A Champion (senior clinician) to address ordering of non-approved equipment.
Maintaining stock of Luer long-needles for those areas with continued usage.	Luer long-needles may become unavailable due to reduced usage after changeover, impacting upon the delivery of therapy in those areas still using them.	3	1	3	No further action as: • There is already a Luer long-needle available and it is properly labelled as such. • The changeover of Luer long-needles for non-spinal procedures will occur before the neuraxial changeover.
Transition Coordinated changeover from Luer to non-Luer within the UHB and across Wales.	As clinical sites within the UHB will be making the transition at different times, staff / patients may move between these clinical sites during the transition period leading to confusion / errors / incompatible equipment.	3	3	9	More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • Concurrent changeover of clinical areas. • Complete changeover of site to be achieved in 1 day and narrow time frame to next site.

Continuation Sheet

Activity /Tasks (Brief Description)	Potential Risk	Consequence X Likelihood = Current Risk Rating See Tables 1-3 – Risk Assessment Scoring & Matrix			Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above
Transition cont.	Pharmacy aseptic units prepare pre-filled syringes with medicines for the spinal route such as chemotherapy. Its changeover may result in confusion / errors / incompatible equipment within clinical areas for example medicines delivered from Pharmacy in non-Luer syringes to areas without non-Luer spinal needles. If neighbouring Health Boards changeover before / after C&V then we / they may not have compatible equipment to treat transferred patients which could result in unnecessary replacement of devices in patients.	4 3	2 2	8 6	More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • Completion of pharmacy audit that is already underway to establish routes of administration of neuraxial drugs (via needle or tubing). • Implement a new prescribing process and new SOPs. More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • WNCRG (Welsh Non-Luer Connectors Reference Group) will share a timetable of Health Board changeovers. • A flag system similar to that already present in ICU to identify patients with non-compatible epidurals.

					• Ability to send compatible equipment with the patient if one UHB has changed and the other not.
Activity /Tasks (Brief Description)	**Potential Risk**	**Consequence X Likelihood = Current Risk Rating** See Tables 1-3 – Risk Assessment Scoring & Matrix			**Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above**
Transition cont.	Combinations of Luer and non-Luer devices on shelves in clinical areas may lead to confusion and misconnection errors.	3	1	3	No further action as: • There will be a sealed "Exchange Box" for each clinical area. • Identified staff member on each ward to ensure unused Luer neuraxial supplies are removed from stock shelves, exchange boxes are unsealed & new equipment put in place. • Luer neuraxial equipment will be placed into the Exchange Box, resealed and collected by procurement.
	The existing storage in Procurement and theatre pack rooms may be inadequate and lead to cluttering/potential hazards.	2	2	4	
Education/Training Ensuring staff are fully aware of the changeover, recognise the new equipment and are appropriately trained to use it.	Staff from pre changeover areas or new / temporary staff may not be aware of the changeover, may not recognise the new equipment or be trained to use it which could result in confusion and misconnection errors.	3	4	12	More detailed Risk Assessment to be conducted via Neuraxial Task & Finish Group, control measures will include: • Use of posters on wards & in common rooms. • Teaching using Safety & Quality sessions to allow

					staff to become familiar with the full range of needles and syringes in practical demonstration. • Induction training for all new & temporary staff with information packs.
Activity /Tasks (Brief Description)	**Potential Risk**	**Consequence X Likelihood = Current Risk Rating** See Tables 1-3 – Risk Assessment Scoring & Matrix			**Further Action required e.g. Undertake more detailed Risk Assessment if score 6 or above**
Safety Awareness of potential for wrong route administration.	Staff may become complacent and not appreciate that the risk of wrong route administration still exists despite being diminished. This could result in incidents.	4	1	4	No further action as: • Chemotherapy protocols will continue to administer chemotherapy via different routes on different days. • Continued awareness via Nurse Directors, Clinical Directors and Ward Managers' meetings.
Debriefing Learning lessons during and following changeover.	If problems experienced are not shared then lessons will not be learned and the same problems repeated elsewhere.	4	1	4	No further action as: • There will be a meeting of the WNCRG after changeover of the first site in Wales for experience sharing.
Finance Budget appropriately for cost impact of changeover.	There will be a negative impact on our existing spend / financial targets if:	*	*	*	Complete assessment of this potential risk [* risk not yet evaluated as information of costs currently being collected, and will be

	- the price for non-Luer is higher than that for the existing equipment. - there is cost associated with drug-stability testing in the new syringes. - UHB incurs costs / sustains losses for disposal of unused items. - there is a cost for extra storage areas / containers in Procurement, Pharmacy and Theatres.				presented to the UHB Management Executive].

Continuation Sheet

Assessors Name (s)	**C Morley-Jacob S Rowlands**	**Signature (s)**		**Position (s)**	**Consultant Paediatric Oncologist Head of Corporate Governance**

Date	**24.8.17**	**Review Period**			**Dates of Review**	**24.5.17**	**4.7.17**	**11.7.17**	**24.8.17**

CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE REPORT
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 12 September 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.

As part of the risk review, meetings are being 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. Committee members have also been asked to provide comments as an integral part of this review. An update on this review will be presented to the Audit Committee in September 2017.

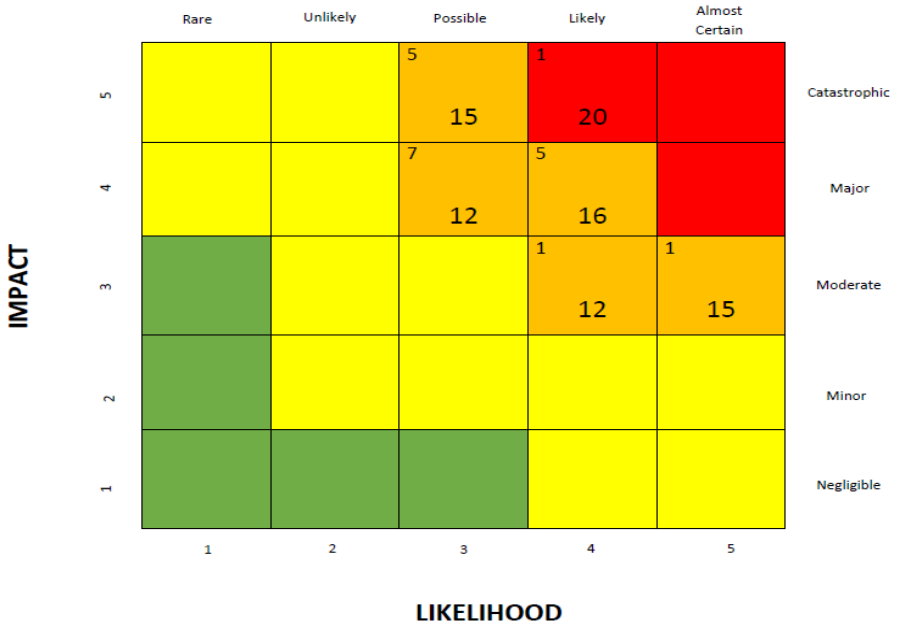
The Board agreed the production of more visual, less text based standardized reports that reflect all risks not only extreme ones. This report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 12 September 2017). As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF. The assignment of risks has not changed since this was reported to the last committee meeting.

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

			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.				

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**	

19

WELSH RISK POOL THEMED REPORT ON THE EMERGENCY DEPARTMENTS AND COMPOSITE ALL WALES REPORT
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** September 12th 2017

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality Action plan developed by Medicine Clinical Board
Caring for People, Keeping People Well : the report provides assurance on 'Outcomes that matter to people' and 'reducing waste variation and harm'
Financial impact : none
Quality, Safety, Patient Experience impact : Welsh Risk pool themed reviews provide assurance on safety and quality of services. These particular reviews focused on specialties considered to be at high risk of litigation
Health and Care Standard Number 3.1 Safe and Clinically Effective Care
CRAF Reference Number: 5.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Positive findings of the Cardiff and Vale UHB review
- Improvement plan developed to address the recommendations

The Quality, Safety and Experience Committee is asked to:

- **CONSIDER** the WRP composite report of the themed review of Emergency Departments across wales and the report of the review of the Emergency Department in Cardiff and Vale UHB**.**

SITUATION

The purpose of this report is to present the findings of the All Wales Welsh Risk Pool Services Themed review of Emergency Departments that was undertaken between October 2016 and April 2017. In addition there is also a report which reflects the findings of the specific review of the Emergency Department at University Hospital of Wales as well as the associated improvement plan.

BACKGROUND

The WRPS assessments have recently focused on specialities considered to be at high risk of litigation and these have confirmed that organisations are pro-active in developing procedures and protocols in relation to recognised good practice. However, the operational implementation is more challenging and the claims indicate that often there are weaknesses in the fundamentals of care provided. These include communication, record keeping, undertaking risk assessment and acting on observations. Furthermore, the clinical audit and performance management arrangements are not necessarily well developed to provide management and governance assurance or highlight deviations from expected practice.

The WRP approach for 2016/2017 focused on the essentials of care which are relevant to claims. This included a review within each Health Board's Emergency Departments of patient records and system and processes to ascertain compliance with good practice in relation to:

- Missed fractures management and scrutiny
- Management of infection and sepsis
- Patient monitoring and escalation
- Evidence that test results have been acted upon
- General record keeping
- Compliance with skin care bundles
- Availability and use of bariatric equipment
- Staffing levels and acuity
- Training provision to staff- including x-ray interpretation
- Compliance with incident reporting requirements and lessons learned
- Paediatric care

To this end the WRPS Assessors conducted a review of patient notes, departmental training records and systems and processes for managing diagnostic test results and incident reporting and feedback. Governance arrangements for Minor Injury Units were also evaluated.

ASSESSMENT AND ASSURANCE

Composite report of the themed review on Emergency Departments

The main findings across Wales, were as follows:

- Acuity, capacity and workload pressures were clearly evident at each emergency department visited. There are varying processes are in place

to manage situations when there is no space in the unit in which to offload the patient from ambulances.
- Corridor working in one department caused particular concern.
- Environment cleanliness, space and lack of clutter was notably improved in new or refurbished departments but these departments were also working at or beyond capacity on a regular basis.
- Triage systems are in place on a twenty four hour basis in most departments but one health board resource limitations inhibit this service being fully available.
- Staffing levels amongst nursing teams varies across Wales, with some areas successfully recruiting, others less so. Medical staffing at middle and senior levels is also problematic across the board.
- Sepsis recognition and management improvement projects have been introduced in most departments.
- Having Psychiatric liaison teams located in the emergency departments reportedly helps to improve safety and throughput for patients with mental health problems.
- Imaging reports and timescales vary. Departments have systems in place to check abnormal results against outcome and recall patients where necessary.
- Training in x-ray interpretation is provided to clinicians but this is variable across the organisations, some using external courses, others provided in house.
- Local feedback from lessons learned varies across departments.
- Governance arrangements are acceptable in the majority of Minor Injury Units but are in need of review within some health boards. Where this was noted the requirement for formal documented governance plans has been called for.
- The decision by GP's to no longer provide a wound dressing service within their surgeries has further impacted on already stretched resources and particularly in the Powys Minor Injury Units.

There were also findings in relation to record keeping which included:
- High acuity and workload can impact on clinicians' concentration and record keeping standards.
- Gaps in vital sign monitoring, risk assessment and confirmation that self care advice and how to manage worsening conditions had been provided.
- Recording of safeguarding prompts
- Consistent completion of records
- Patient identification stickers were not applied to all pages of the records booklets.

Themed review of the emergency Department at University Hospital of Wales

The report was very positive. Main findings included:

- Mandatory training levels have improved in the last year and plans made for achieving full compliance.
- New staff have a four week induction period and image interpretation training is also provided.
- a prompt and appropriate response to concerns was demonstrated.
- Staffing levels of nurses have been enhanced and skill mix improved. This has reportedly improved morale within the unit. Some concern was expressed about the ability of medical staffing numbers to manage the forthcoming increase in resuscitation room capacity.
- Emergency Nurse Practitioners rotate between the acute department and minor injury units
- The emergency unit was noted to be clean and uncluttered. Recent refurbishment has helped improve patient treatment areas.
- Protocols are in place to manage the unit when capacity limits are encroaching. Improvements to risk assessment to manage these situations are being progressed.
- Paediatric patients are nursed in an area separate from adult patients. Specific documentation for safeguarding is in place and was noted as completed in the patient records reviewed. However, rarely had previous attendances been checked.
- Incident reporting systems are in place and staff encouraged to report. Feedback is provided.
- Discharge communication arrangements need improvement.
- Processes to highlight developing infection are in place and training provided. However, it was identified during the records review that a patient with a potential infection had taken his own discharge and no imminent follow up provided. This was acted upon when the issue was highlighted.
- An assessment of the emergency unit in 2014 prior to a NATO convention resulted in a commendation.
- Risk assessments completed include those for manual handling needs. Assessments of risk and vital signs had been completed as appropriate. Pathways were used as appropriate and compliance with standards is monitored.
- Advice on care and action to be taken if the condition did not improve or worsen were not documented in the patient records, which leaves the organisation vulnerable in the event of any adverse outcomes.
- The records available for scrutiny were from the day before the site visit and no imaging reports had been received for the patients concerned. The Assessors were informed that in the main formal reports are received on image investigations within a few days.
- Pain scores were not documented in any of the records scrutinised although free text included comments on pain levels or the administration of analgesia.
- Patient records were signed but rarely was there printed confirmation of the name or designation
- There is a system in place to manage abnormal test results and ensure that patients can be recalled where necessary.
- Patients are not discharged from the unit without senior medical review.

- Cases with adverse outcomes are discussed at the regular mortality and morbidity meeting

The Composite Report of the Themed Review on Emergency Departments is included at **Appendix 1**; the review of the Emergency Department at University Hospital of Wales is included at **Appendix 2** and associated improvement plan at **Appendix 3**

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PROVISION OF A DECANT WARD AT UHW AND UHL
Name of Meeting : Quality and Safety Committee **Date of Meeting :** September 2017

Executive Lead : Director of Strategic Planning
Author : Director of Capital, Estates and facilities 029 2074 4335
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 : TBA
Quality, Safety, Patient Experience impact : Improving the environment and estate statutory compliance
Health and Care Standard Number 2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention Control (IPC) and Decontamination
CRAF Reference Number 5.2, 6.4
Equality and Health Impact Assessment Completed: Not applicable but individual EHIA' s are prepared on a project basis where required.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The agreement to develop a Business Case for the re-provision of Blood and Marrow Transplant inpatient facilities including Haematology Ward and Day Unit which will result in the availability of B4H at UHW becoming vacant
- The Surgical Clinical Board Business Case, 'Development of Emergency Surgery' which seeks to reduce bed capacity by 13 beds at UHW.
- The feasibility undertaken to develop a ward at UHL by extending into the car park adjacent to the Board Room.

The Committee is asked to:

- **NOTE:** the content of the report recognising that the options considered require the development of a number of Business Cases to secure Welsh Government funding.

SITUATION

The purpose of this report is to provide the Committee with the outcome of a review undertaken by the Capital, Estates and Facilities Service Board to identify potential areas/solutions for the provision of decant ward space on both the UHW and UHL sites.

The report will describe the options, deliverability and constraints associated with each of the proposals.

BACKGROUND

The UHB has a pressing need for inpatient decant facilities on both of its acute sites, UHW and UHL. Whilst this has been understood for a number of years, it has been difficult to identify additional areas for decant facilities. Over the last two years we have seen an increase in outbreaks on wards so the need to confirm plans for decant space has become more urgent.

The lack of decant space prevents:

- patients with an infection being relocated or segregated which would impacts on the ability to contain and infection
- wards being vacated to undertake refurbishment or urgent works

The need for decant space to enable patients to be isolated in an infection outbreak is often confused with the issue of isolation rooms. It should be noted that the UHB complies with WG guidance on the number of fully compliant isolation rooms.

Over the last 12 months there has been a requirement to undertake ward refurbishment works to a number of ward areas due to risks associated with infection outbreaks. It was fortunate that the works were able to be carried out during the spring and summer months when in patient numbers are reduced, which allowed the areas to be emptied.

During 2016/17, B4 North and South and B6 North and South have been fully refurbished and works to A4 North and A5 North are due for completion by mid-September.

The lack of a decant facility prevents a rolling refurbishment programme being developed and work has been completed on an ad hoc basis.

ASSESSMENT AND ASSURANCE

The Capital, Estates and Facilities team have considered the options to create decant space on the UHW and UHL sites.

UHW – This is by far the greatest challenge as the current building is fully occupied for the majority of the year, and unless the Clinical Boards agree to reduce capacity the options are both limited and lengthy to deliver.

All wards are currently occupied including what was the Paediatric decant ward, Heulwen, which currently provides a 13 bed facility for liver surgical patients. The surgical Clinical Board relocated to Heulwen to accommodate the expansion of Neonatal services.

As a longer term option the team have identified ward B4H as a potential option. However, this would only be possible when a new facility for BMT, Haematology and the Day Unit was developed. A Business case for this unit is being developed but is likely to be 2 -3 years away from completion and subject to WG funding.

The BMT ward and day unit is subject to an inspection in November 2018 by the accreditation body JACIE and in their last inspection report identified the need for a new facility and expected to 'see significant progress being made to address the situation'. We are working with WG to take the proposals forward as quickly as possible.

The team also considered an option for a modular ward facility but it is impossible to identify a location that will enable the physical link back into the hospital.

UHL – from a deliverability and cost perspective the preferred option would be to relocate the Board room and adjacent offices and expand out on the adjacent car parking area. This could be a single or double storey extension and either traditional or modular build.

A longer term option would be the redevelopment of area currently occupied by the modular theatres. This would require significantly more investment and take longer to deliver.

The Capital, Facilities and Estates Team will be finalising the options for Management Executive to consider, including an estimate of the costs involved, and the potential source for capital funding (either our discretionary capital or the all-Wales capital budget secured via business case to Welsh Government).

REPORT FOLLOWING NEURO ENDOCRINE TUMOURS (NETs) PEER REVIEW JANUARY 2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting:** 12 September 2017

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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 : There is an agreed business plan in place with WHSSC and funding has been identified to take forward the service initiatives. That is subject to joint monitoring of WHSSC (Commissioner) and Cardiff and Vale UHB (provider).
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: 3.1 Safe 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 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 Welsh Government and the South Wales Cancer Network

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report
- **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 Peer Review processes reported to Welsh Government and the South Wales Cancer Network following the review, re-review of each of the cancer tumour sites within the Health Board.

This review is the second one being undertaken of the rare cancer tumour sites.

BACKGROUND

Neuro-endocrine tumours (NETs) are a rare form of malignancy but due to distinct diagnostic and treatment pathways, and often-prolonged clinical course, they require a dedicated service, which has needed to grow to meet clinical demand and align with National and International service standards. The NET multi-disciplinary team offers care and support to patients and advice to the wider NHS for the population of South Wales (approximately 2.4 million people).

The South Wales NET service, as with many other cancer services, has grown rather organically, but the NET MDT and patients have in recent years become increasingly aware of deficiencies in the service being provided. Therefore, at the request of the Medical Director of Cardiff and Vale University Health Board, peer review of the service being provided in South Wales was brought forward to look at the quality of care currently being provided by the NET MDT for the population of South Wales and whether the Business Case developed by WHSSC in collaboration with clinical leads addressed the current service deficiencies i.e. whether service was safe and progressing in the right direction.

ASSESSMENT AND ASSURANCE: Summary of Peer Review Report for Neuroendocrine Tumours (NETs)

Good Practice/Significant Achievements:

- MDM video conferencing that was available to anyone throughout Wales was a major asset,
- Central pathology review taken on all cases was considered excellent
- Access to systemic therapies which are routinely funded was better than some other parts of the UK
- The clinical MDT demonstrated a commitment as a group to develop the Business case and move things forward.
- Good links with the upper gatsrointestinal nurses in different hospitals although it was acknowledged this could be more formalised in the form of named clinical leads in each HB
- Established good links with centres of excellence, Liverpool and Royal Free.
- There had been substantial and excellent patient engagement.
- The peer review panel thought it important to note that it considered the service that was being delivered to be safe, and it did not see or hear any evidence that patient had come harm through any service deficiencies.

Serious Concerns noted were:

- Database development required.
- Need for the development of Operational Policies, guidelines and Audit.

Concerns noted were:

- Lack of good Governance Arrangements - lack of clarity on ownership and responsibility of the service.
- Leads by specialty - need for local champions within each of the Health Boards to act as a point of contact for liaison and development
- Responsibility and clarity - further consideration of the details of the Business is required. In particular the distribution of clinical time between gastroenterology and oncology, dietetic input, MDT co-ordinator and secretarial time
- Delegation - lack of clarity on where Lung NET patient sit. Patients query who is looking after them therefore, there needs to be a clear remit on who is going to do this.
- Consistency of service for patients.

Given that it was acknowledged that the business case needed to be implemented and there were many service developments that could only be aspirational at this stage, it was felt that formal written reports in 6 and 12 months should detail actions that have actually been completed, and highlight any barriers to progress.

Where appropriate, overarching actions have been identified and an action plan has been formulated and implemented to address the concerns outlined above. Further detail is provided in the full action plan appendix 1.

Neuroendocrine Cancer Peer Re- Review Action Plan 2017

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
	SERIOUS CONCERNS					
	Database It was clear to the review panel that the papers that have been submitted as part of the pre review self - assessment that it has been challenging to provide the data that had been requested. Database development required.	A fit for purpose NET Database needs to be developed to better capture and record relevant information /evidence in the following areas: • Safety • Quality • Outcome measures • Key performance indicators as dictated by ENETS The data then needs to be looked at and, reflected upon on a regular basis to evaluate the service being delivered. In addition it provides a tool that will allow the service providers MDT to assure themselves, commissioners , Welsh Government, patients and public of the safety and quality of care being provided.	High	Cancer Lead Clinician/ Cancer Services Senior Manager/ MDT coordinator/ CNS/ NET clinical lead	March 2018 (6 months of phase one commencing)	Since Feb 2017, coding of each MDT case is reviewed by the lead to ensure all cases are recorded accurately in CANISC (inaccurate historic coding accounted for a significant proportion of challenge in data submission). This can be updated upon adoption of new coding/ registration systems. Whilst the functionality of CANISC is incorporated into WCP over the next few years, an option for an in-house database/CRM

Ref	Area for Improvement	Action Required	Priority	Lead	By When	Progress to Date
						tailored for NETs is being explored which will require funding to set up and maintain.
	There is a need for the development of Operational Policies, guidelines and Audit.	Standard Operating Procedures (SOPs) and guidelines specific to the NET population covered by the service need to be developed.	Medium	NET Lead Clinician/CNS/ MDT core members	During first year/ phase I (September 2018)	SOPs, guidelines and audit programmes will be developed as phase I of the NET service is established and following training of the NET CNS by the lead
	Lack of audit programme.	An audit programme specific for NETs needs to be implemented against which performance can be monitored.	Medium	NET Lead Clinician/CNS/ MDT colleagues with support from cancer services	1 year of phase I (September 2018)	
	Regular business meetings need to be set up.	Regular business meetings to be set up that have a focus on service improvement.	Medium	NET Lead clinician/ Directorate managers/ medicine clinical board/ HB representatives/ MDT colleagues with support from cancer services	January 2018	Following the WHSSC T&F group, implementation and stakeholder meetings have been established.

	CONCERNS					
	Lack of good Governance Arrangements. Lack of clarity on ownership and responsibility of the service.	Governance arrangements need to be clear and put in place across South Wales in order to develop and monitor sustainable and comprehensive services that provide equitable access for patients across South Wales. Discussion between Cardiff and Vale and WHSSC to determine accountability for each aspect of the service	Immediate	Medical director/Medicine Clinical Board director/ WHSSC		
	Need for local champions within each of the Health Boards to act as a point of contact for liaison and development.	Identify local champions within each of the Health Boards to act as a point of contact for liaison and development. There needs to be engagement with other Health Boards and organisations regarding the NETs Business Case (BC)	Medium Medium	NET Lead Clinician/ CNS/ MDT colleagues Medical director/ NET Lead Clinician/ Directorate manager/ Cancer services senior manager	1 year of phase I (September 2018) January 2018	Discussions with clinicians and CNSs within CAV, ABMU, HD, CT, VCC have taken place but will be dependent on the model in phase I. The next phase business case will be shared with all parties including referral centres (Liverpool RFH) once informed by data from phase I
	Further consideration of the details of the Business is required. In particular the	For the phase II WHSSC business case, dietetic input, balance of secretarial and MDT coordinator time, MDT demands	Medium	Medical director/ medicine clinical board/ Cancer Services Senior	January 2018	The next phase business case will be informed by data collected during

	distribution of clinical time between gastroenterology and oncology, dietetic input, MDT co-ordinator and secretarial time	will be considered. Distribution of clinical time for phase II will be considered. The existing case was based on a detalied analysis of the cohort of NET patients and their needs after the WHSSC T&F group with patient engagement.		Manager/ NET Lead Clinician/		phase I and the complex pathways, accounting for the differences in speciality distribution between SE and SW.
	Lack of clarity on where Lung NET patient sit. Patients query who is looking after them therefore, there needs to be a clear remit on who is going to do this.	During establishment of phase I, engagement with lung cancer teams will identify appropriate lung NET cases requiring input from the NET team and data will be captured to explore the demand of this subgroup.	Medium	CNS/ MDT members/ NET Lead Clinician	1 year of phase I (September 2018)	Lung cancers currently requiring input from the NET MDT are referred into the MDT and discussed
	Patient Consistency	Work with patients to help redesign services.	High	WHSSC/ NET Lead Clinician. MDT members/ Medicine clinical board	September 2017	A stakeholders group has been established with patients who have already provided and will continue to input into the next business case
	Very limited junior staff engagement, important thoughts be given to succession plans. It is quite a lot of	Encourage engagement from junior staff and education. Cover needs to be identified for members of the MDT. Identify areas for the senior /more	Medium	MDT members/ NET Lead Clincian/ Medicine clinical board	6 months of phase I (March 2018)	NET training in national training days to gastroenterology, surgery, pathology

	responsibility for any one individual	experienced members of the team to provide education/ training.				palliative care have been planned. Junior staffing will be considered in the next phase.
	Consistent sign posting for patients along their cancer pathway is needed. Patients need to know what is going to happen to them, why they are being referred to a different Centre, how the service works.. It was felt important for patients to understand this from the outset and have a point of contact.	During phase I and II, processes ensuring all NET patients receive consistent care across the partially centralised/hub/spoke model. Ensure all patients are provided with appropriate information and a point of contact from the outset.	High	CNSs/ NET Lead Clinician/ MDT members/ Patient groups	3 months of phase I (December 2017)	Education of other HB CNSs and clinicians on this has been commenced. Signposting for patients in CAV and ABMU has been commenced which will be rolled out to patients from other HBs/ organisations.

LEADING IMPROVEMENT IN PATIENT SAFETY (LIPS)
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 13th September 2017

Executive Lead : Executive Nurse Director
Author : Quality and Safety Improvement Manager. Joy.whitlock@wales.nhs.uk 02920 745099
Caring for People, Keeping People Well: This report underpins the Health Board's "Outcomes that Matter to People, Sustainability" and "Culture" elements of the Health Board's Strategy.
Financial impact : £50,000
Quality, Safety, Patient Experience impact: The LIPS programme enables up to 200 people per year working in teams on projects to improve quality, safety and patient experience by reducing waste, harm and variation in the system.
Health and Care Standard Number Standard 6, Participate in quality improvement activities. Standard 7, Safe and Clinically Effective Care.
CRAF Reference Number 5 - Operational and Clinical Excellence - High quality services will be delivered sustainably through a committed and engaged workforce which meets targets within available resources. 10 - Benefits Realisation - To realise benefit in everything that is done through a culture that drives delivery and improvement at the required pace.
Equality and Health Impact Assessment Completed: Not Applicable**.**

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The number of individuals and number of improvement projects being undertaken through the LIPS programs in Cardiff and Vale University Health Board
- Unprecedented demand for places on LIPS
- Ideas for future improvement projects to be undertaken next year already being generated by Clinical Boards
- International interest in our LIPS programme

The Quality, Safety and Experience Committee is asked to:

- **NOTE** progress of the LIPS programs
- **APPROVE** future plans

SITUATION

Two cohorts of LIPS per year have run since April 2014 equating to 655 people working on 113 projects. Cohort 8 commences on 6th September 2017 with another 80 people working on 16 improvement projects.

Each cohort finishes with a celebration event where teams present their project progress and next steps. These events are strongly supported by Executive Directors, Independent Members and Clinical Boards as well as other colleagues in Welsh Government and visitors from other Health Boards and Trusts. Results have supported a growing confidence in the LIPS programme to provide high quality training and deliver improvements amongst Clinical Boards and corporate departments. They are being more judicious in the selection of teams and projects to maximize return on their investment and deliver organisational priorities. Increasingly there are multi-professional, whole pathway projects being proposed and led by very senior leaders.

Recurrent funding of £50,000 per year was agreed in April 2017. This is less than previous years. Demand far exceeded the number of places for this cohort. With support from procurement we will work with event providers to try and get even better value for money and increase the number of people who can attend LIPS without compromising the quality of the programme.

In 2016 and 2017 LIPS received international recognition when it was presented at the Institute for Healthcare Improvement (IHI)/BMJ International Forums on Quality and Safety. Each forum is attended by healthcare leaders from over 70 countries across the world. The presentation in April this year was broadcast live from the main auditorium with capacity for 3000 people. The recording can be viewed here.

BACKGROUND

Previous papers to committee describe the evidence based structure and content of the LIPS programme – the last one being February 2017 LIPS Update. Of note LIPS includes the all-Wales Improving Quality Together silver level training which is measured by Welsh Government. Also included are leadership skills and behavioral human factors that impact on safety and half a day on the science of happiness. The scientific evidence tells us that this increases wellbeing, team working and productivity – essential components to create capacity to undertake improvement activity.

ASSESSMENT AND ASSURANCE

- Two cohorts per year have run and all places have been filled
- Each team has at least one senior leader to increase the probability of success of the project and some teams are made entirely of senior leaders
- LIPS provides the resources for whole pathway/cross directorate/clinical board projects to be undertaken

- The alignment with strategic priorities is strengthened by Clinical Boards and corporate departments who now approve the improvement projects and team members for each cohort
- There is currently greater demand than places for LIPS enabling the clinical boards and corporate departments to be judicious in their project and team selections
- Some projects deliver a measurable financial saving while others measurably reduce waste, harm and variation which enhances patient experience and provides more cost effective care
- The celebration events are well supported by Clinical Boards, Executive Directors and Independent Members and other colleagues who listen to presentations on the improvement projects. Cohort 7 projects are described in appendix 1 and pictures of the event can be viewed on Twitter by searching #cavlips
- A small survey was done to find out how people had applied the learning from the science of happiness – see appendix 2
- Written feedback from delegates at every session continues to be good or excellent
- We are reviewing options to get best value for money and increase the number of people who can attend LIPS
- The committee will continue to receive 6 monthly updates

Appendix 1

Cohort 7 Projects

Projects presented at the Celebration event on 20th July

Children & Women –

- **Health Visiting** – Improving immunisation uptake in children – Flying Start
- **Midwifery** - Implementing the principles of Welsh Government's Prudent Maternity Care, specifically around women with a raised BMI

Clinical Diagnostics and Therapeutics

- **Pharmacy –** Improving the governance of unlicensed medicines
- **Physio team** – Creating a Walking Aids pathway to access aids in a timely manner –increases safety and mobility and reduces unnecessary time in hospital
- **Laboratory Medicine** – Improving the labeling of specimens to reduce the amount of re-work and improve reporting mechanisms.
- **Therapies - I**nvestigating an Outreach prolonged disorders of consciousness (PDOC) team.

Medicine CB

- **Rehabilitation** - Reducing inpatient falls with establishment of strength and balance classes on a rehab ward.
- **Emergency Medicine -** Implementing evidence based guidance

Mental Health

- **Adult** – Reducing waste and potential harm by increasing the use of patients own medicines (POMS) on admission to hospital by developing a protocol within MH services. Achieved a 38% increase by the celebration event.
- **MHSOP and Adult** – Meeting patient needs appropriately by developing a needs-based service instead of the traditional an age-based service.

Primary Community and Intermediate Care

- **Vale Community Resource Team** – Improving multidisciplinary support to for patients who reside in Vale residential homes.

Surgery

- **Ophthalmology -** improving attendance in the diabetic retinopathy clinic.

Dental

- Developing a pathway for bariatric patients requiring dental care.

Specialist Services

- **Artificial Limb and Appliance Service –** improving specialist wheelchair maintenance and repair service.

Corporate Services

- **Workforce and Organisational Development –** Improving the timeliness of the disciplinary processes.
- **Referal To Treatment team** – Improving referral to treatment in cardiology.
- **Operational Services –** Improving cleaning and maintenance and saving a significant amount of money.

Appendix 2

Feedback on the Applied Positive Psychology – the Science of Happiness sessions

Staff said they would aim to take two actions each. A sample included the following:

Actions to improve personal positivity and influence team culture and patient experience

- Increase personal positivity – (n=26)
- Improve team positivity – (n=12)
- Write down 3 positive things daily – (n=16)
- Smile more /mirror neurones – (n=5)
- Do random acts of kindness – (n=1)
- Mindfulness/stress management - (n=13)

Actions to increase team safety and productivity

- Compliment/ give constructive feedback - (n=21)
- Improve patient care/ systems – (n=12)
- Other human factors – (n=3)
- Reward/praise effort (as opposed to achievement) –(n=3)
- Prioritise /limit the number of objectives set – (n=3)
- Leadership/training - (n=3)
- Increase positive to negative comments to at least 3:1– (n=8)

30 staff were sent a copy of their feedback forms with their promises they made 11 months previously and invited to tell us about how they have applied the learning and what effect it had/continues to have.

Responses so far:

'I am still making more effort to be more positive. Always think twice before rushing to conclusions, being negative. Although this was not a new message as I had already done the Clinical Leadership program, transforming care etc.. BUT I think updates on positive psychology should be mandatory. It is very easy to get stuck in a negative cycle again when times get tough. I know I am a better leader when I am happy.'

'At the start of our weekly team meetings we always start with a 'positive of the week' from each of the team members – it adds 10 minutes to the meeting but I feel that the benefits outweigh this as everyone starts the meeting engaged and in a positive mind frame. I find it sets a positive state at the

beginning of the meeting and helps to stop it turning into everyone just moaning about things! We also have a treat rota attached to the meeting so that we take it in turns to bring a treat of some kind – cake, biscuits etc.'

'I created a positivity board which is about a meter square in our office on the wall which everyone is encouraged to contribute too. It has pictures, thank you cards, upcoming events, print out of quotes and positive thoughts. Very colourful and bright. Everyone always comments on it when they walk in. I have also made bunting for all year use and also specific Christmas bunting! Again just to try to lift spirits and make the environment a little more appealing.'

'Also did team building quiz during the same meeting. We started doing 3 positives a day but I have to say this isn't as regular as daily anymore. I have encouraged random acts of kindness and this does continue in our office.'

'I think being able to recognise what drives people and focusing on their strengths in the team has also helped when we have been working on service development. While I have been leading this area of work, certain tasks have been delegated and being able to recognise who is the best person to complete the task is paramount. Recognising success and praising during supervision sessions is also something that I try to do.'

'It is very hard for me to quantify any impact however I have been making a conscious effort to look for positives both at work and home. During conversations with team members I endeavor to be fully engaged and even when there are difficult situations look for positivity that we can build on to problem solve.'

'At the start of the full team meeting we now get one of the teams from the MDT to provide a 'thought of the day' at the start of every meeting. Again it helps to get the teams involved on a more personal level as they have a responsibility to contribute to the meeting rather than me just talking at them. Also, the rest of the team listen to hear what their colleagues have chosen to talk about.'

Feedback from the learning sessions:
'Mindful and positive thinking should become useful tools to bring changes I can use easily' (Consultant Paediatric Oncologist).

The LIPS project taught me so many skills and approaches to implement changes and feel very fortunate to have had the opportunity to be part of it.' Advanced Nurse Practitioner.

"Thank you for putting on an excellent programme. Enjoyed the science of happiness session. Inspired by Mark and the human factors workshop. We have really asked some difficult questions of ourselves, and others, in an attempt to make headway with our project. In regard of the LIPS celebration event – really looking forward to this". (Consultant Physician & Clinical Director).

‘Introspective look at my management/leadership skills. Good discussions during partner led learning.’ (Specialty doctor).

‘They were an unlikely duo but both speakers kept me engaged totally throughout the day. I also think the additional knowledge received today (human factors) is the most relevant so far to my professional role’ (Corporate Manager).

‘Information taught is very much applicable to daily work; effective team work, authority gradient etc. I will be a more effective team player and know when to use social/professional/crisis language’ (Registrar).

‘Speaking in general terms, these topics have made me more aware of the language and approach that I use within my team – to motivate, to challenge, to improve. I think it helped me understand more how to motivate, how to approach challenges (perhaps when things don’t go so well), how to understand people and I guess ‘be more human.’ Sometimes in the workplace we are so busy looking after the ‘task’ that we forget the importance of these things.

ANNUAL CLINICAL AUDIT PLAN
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead : Medical Director
Author : Patient Safety and Quality Assurance Manager 029 20744018
Caring for People, Keeping People Well : Offer services that deliver the improvements in population health that our citizens are entitled to expect
Financial impact : There are no financial implications associated with the actions currently being taken as identified within this report.
Quality, Safety, Patient Experience impact : Clinical audit seeks to improve patient care and outcomes through systematic review of care against explicit criteria. A prudent clinical audit programme requires a focused and directed approach to address clinical priorities.
Health and Care Standard Number 3.1 Safe and Clinically Effective Care
CRAF Reference Number 5.1 Deliver Safe Effective and Efficient Care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development of a Clinical Audit Plan
- The development of the Clinical Audit Strategy

The Quality, Safety and Experience Committee is asked to:

- **APPROVE** the Clinical Audit Plan and
- **NOTE** the Clinical Audit Strategy

SITUATION

The purpose of this paper is to present the UHB 2017/2018 Clinical Audit Plan and Clinical Audit Strategy.

BACKGROUND

The National Institute for Health and Clinical Excellence 2002, defines clinical audit as: "A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."

The National Clinical Audit and Outcome Review Advisory Committee (NCAORAC) was established to provide leadership, ensure clinical audit is appropriate to Wales

and promote action and learning. It agrees the content of the annual National Clinical Audit Outcome Review Plan (NCAORP) which is published by Welsh Government and requests timely feedback about the processes by which the Health Boards ensures the findings and recommendations from the National Clinical Audit reports and outcome reviews are fully considered and acted upon. Full participation is mandatory.

As well as mandated national clinical audits there is significant local clinical audit activity undertaken within the Clinical Boards.

ASSESSMENT

A Clinical Audit Strategy **(Appendix 1)** has been developed and circulated to Clinical Boards along with a Quality and Safety Summary that detailed:

- Patient safety themes
- Results and recommendations of 2016/2017 local clinical audits
- Mandated National clinical audits for 2017/2018
- Complaints and Claims themes
- Infection prevention and Control information

It is anticipated that these resources will offer direction and support in developing a rolling clinical audit programme thereby increasing the impact of clinical audit on clinical services.

To support the planning, development and reporting of clinical audits that address clinical priorities, and to comply with information governance requirements, clinical audits are required to be approved and registered and the results reported though the agreed governance structure. To embed this process Clinical Boards have been asked to identify one audit per directorate to include in their annual Clinical Audit Plan **(Appendix 2).** This will not preclude additional clinical audit activity, however, it is expected that this will take priority.

An electronic audit management tool is under consideration and will allow Clinical Boards to track the progress, results and associated improvement plans of their clinical audits. It is anticipated that all clinical audit activity will be registered and recorded through this process thereby supersede the current format of the Clinical Audit Plans.

Appendix 1

Clinical Audit Strategy 2017/2018

Situation

The UHB is committed to delivering effective clinical audit in all of the clinical services that it provides. The UHB sees clinical audit as essential to continually evolve, develop and maintain high quality, patient centered services.
An effective clinical audit programme will:

- provide assurance around the quality of the care we are delivering
- Identify and thereby reduce unwarranted clinical variation
- Improve quality of care

Background

Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes (HQIP 2011).

The aim of the strategy is to support the use of clinical audit as a process (Appendix 1), to embed clinical quality and to deliver improvements in patient care over the next year. It is anticipated that clinical audit will be used to underpin the Quality, Safety and Improvement (QSI) Framework (Appendix 2), with particular focus on the Effective Care and Safe Care elements. The strategy focuses on creating a culture that is committed to learning as well as continuous organisational development through measurements of evidence based practice to deliver demonstrable improvements in care.

Assessment

The overall objective of the strategy is:

- To ensure compliance with the National Clinical Audit and Outcome Review Programme and other national audits.
- To develop and maintain an audit forward plan that reflects the clinical priorities of each of the Clinical Boards.
- To support a robust and timely system for reporting outcomes including results, improvement plans and plans to re- audit.
- To ensure organisational compliance with regulatory standards.
- To ensure appropriate escalation of risks identified by clinical audit
- To develop an effective and visible reporting mechanism to prevent duplication and to share learning.
- To ensure that staff have the necessary competency and support to participate in clinical audit.

- To support the development requirements of clinicians and medical students while ensuring that the clinical audit activity remains prudent and aligned to clinical priorities

Clinical Audit forward plans should reflect clinical priorities including:

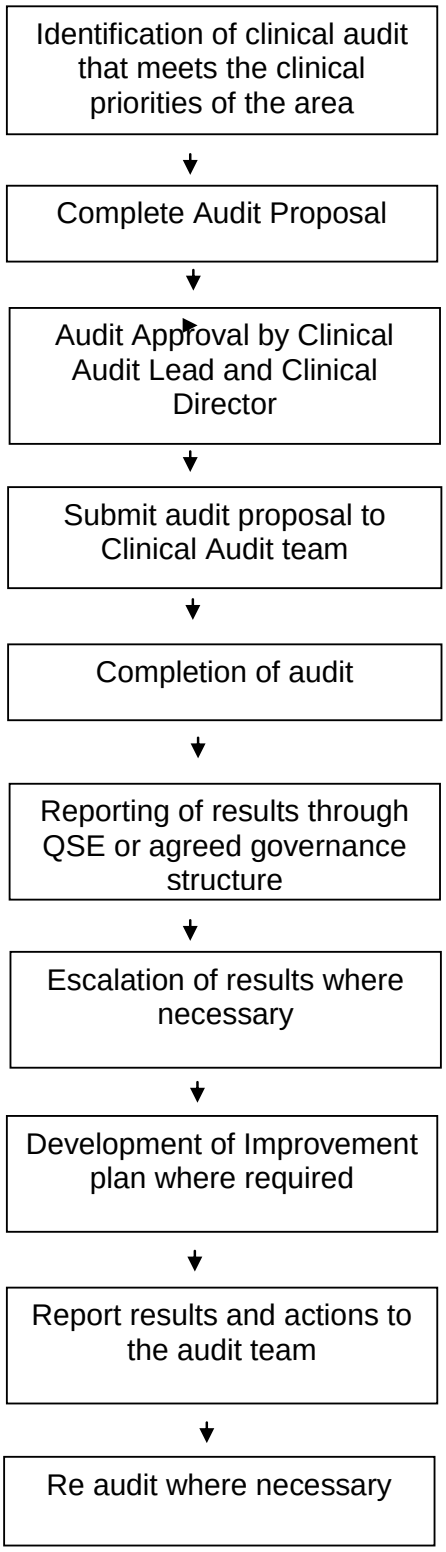
- Clinical effectiveness
- Reducing unwarranted variation
- Management of clinical risk
- Management of complaints and clinical negligence claims
- Ensuring the fundamentals standards laid out in the Health and Care Standards

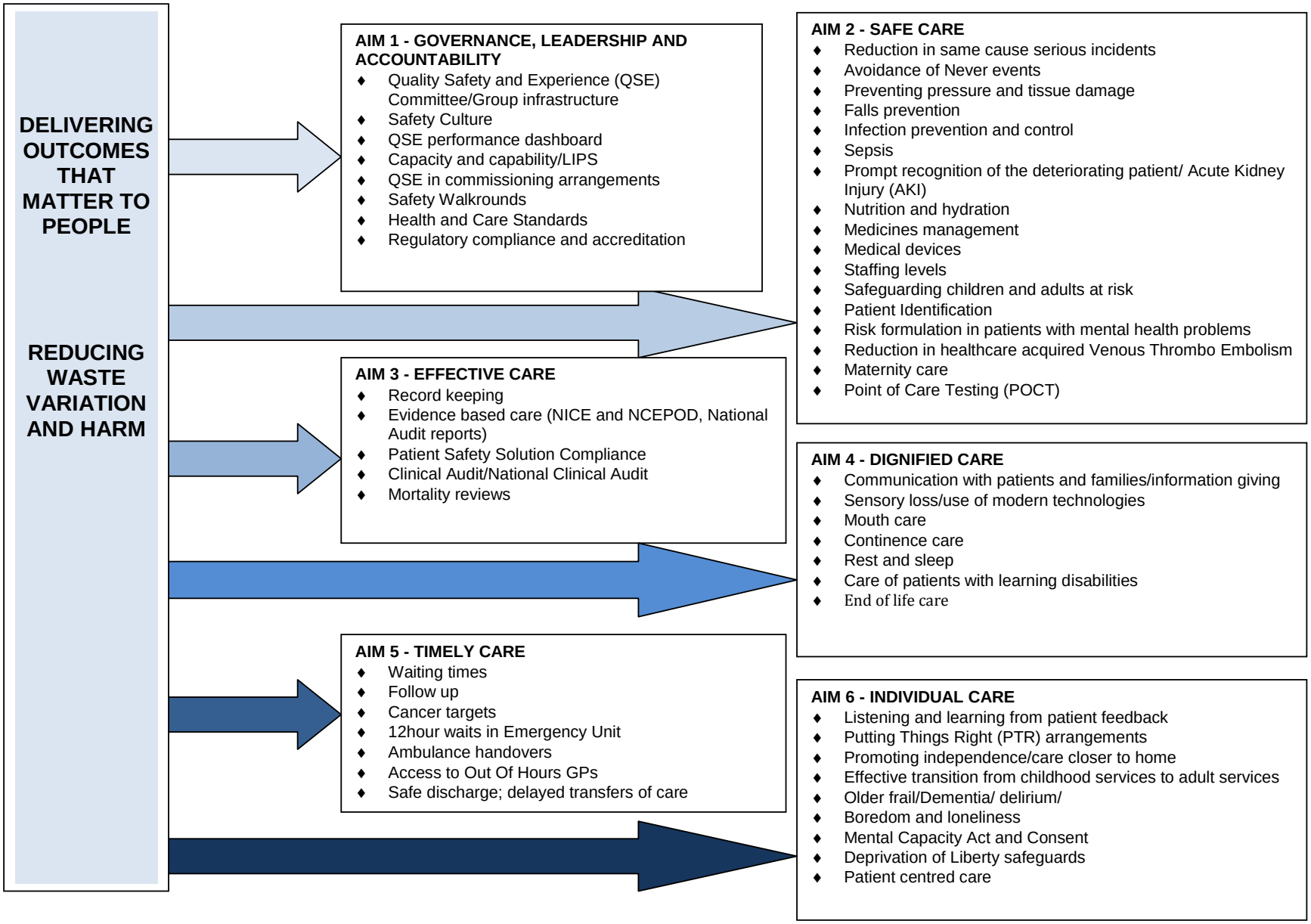
To support the development of these plans each Clinical Board has been provided with a summary of their quality and safety performance for 2016 /17. It is recognised that there will be fluidity around these plans and that there will be additional audit requirements identified throughout the year to reflect changing priorities. In recognition of these Clinical Boards are asked identify a single audit per directorate that is identified as a priority. Progress against these audits will be reported to HSMB on a quarterly basis.

To comply with information governance requirements each clinical audit must be registered with the Clinical Audit team using the proposal form (Appendix 3).

(Appendix 1)

Audit Process




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
♦ Safe discharge; delayed transfers of care
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

(Appendix 3)

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

CLINICAL AUDIT PROJECT PROPOSAL FORM

SECTION 1

Clinical Board:	**Audit Ref:** **(For office use only)**
Directorate:	**Sub Speciality (if applic.):**
Clinical Director:	**Directorate Audit Lead:**
Audit Title:	

Personnel Undertaking Audit:

Surname	Initials	Grade/Job Title	Mobile/Bleep/ Extn	E-mail Address (please print clearly)

Clinical reason(s) for undertaking the audit and background information:

Objectives: (*specific* details of what you are planning to investigate)
N.B. Forms with insufficient detail will be returned.

Please provide specific references below for the standards/guidelines/literature to be used. ***Details should include the name of the relevant organisation/body, the title and information regarding which sections are to be included for comparison with local practice.***

PLEASE NOTE: ONLY PROJECTS WHICH AIM TO MEASURE ACTUAL CLINICAL

Proposed date of project commencement:
Proposed date of audit presentation and forum:
Data to be collected: Prospectively ☐ Retrospectively ☐
Period to be reviewed:…….. to ……
Sample size to be reviewed:……..……
A maximum of 50 casenotes can be retrieved per project from the UHB filing libraries only.

Do you require casenote retrieval by the Clinical Audit Department?
Yes ☐ No ☐
***If yes*, do you have a list of relevant cases (quoting hospital number/ patient name/DOB)?**
Yes ☐ No ☐
***If yes*, please forward a copy to the Clinical Audit Department with this proposal form.**
***If no*, please contact the Clinical Audit Department for assistance with obtaining a patient list.**

Please specify the location of the room where casenotes can be delivered (with details of keypad numbers/key locations etc):

PRACTICE AGAINST GUIDANCE/PUBLISHED EVIDENCE/STANDARDS WILL BE REGISTERED.

Casenotes will be supplied in batches according to availability. ***Please note – Casualty Cards are not retrieved by the Clinical Audit Department, these are available from the EU reception area.***

Names of Consultants whose practice is to be reviewed: NB: Please ensure that they are aware of the audit prior to commencement.	
1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

To enable Directorate awareness/support of projects undertaken this audit proposal form must be signed by both the Directorate Clinical Director and Directorate Clinical Audit lead clinician before submission to the Clinical Audit Department for final approval.

Clinical Director signature:		**Date:**
Directorate Clinical Audit Lead signature:		**Date:**

PLEASE PROCEED TO SECTION 2 - WHICH MUST ALSO BE SIGNED AND RETURNED BEFORE THE AUDIT CAN COMMENCE – INCOMPLETE FORMS WILL BE RETURNED TO PROPOSER.

SECTION 2

Before signing this section please ensure that all people involved are collecting data specific to this project only. If there is any variation in the data collected a separate proposal form must be completed.

DECLARATION OF USE OF PATIENT IDENTIFIABLE INFORMATION

I/we acknowledge the following conditions under which patient identifiable information (PID) will be disclosed to me/us.

- **The project data, once anonymised, will not be re-attributed or used in conjunction with other data that could result in any patient being identified.**
- **Any reports, papers or statistical tables that are published or released to other organisations will fully protect the identity of individuals.**
- **PID will be stored for transfer purposes only on encrypted data sticks and then deleted once the transfer has taken place.**

- **All information supplied by Cardiff and Vale University Health Board and any copies will be destroyed when it is no longer required for the purpose for which it was supplied.**
- **PID must only be saved to 'H' or 'S' drives or the UHB Network Clinical Application and should *not* be saved to the hard drive of a privately owned PC, Laptop or PDA.**
- **PID must not be e-mailed to an address that is not on the Digital All Wales Network, i.e. allowable e-mail address must end with 'wales.nhs.uk'.**
- **Non UHB staff are not allowed to access PID unless they have Honorary Contracts or Confidentiality Agreements which allow access to the Trust patient identifiable resources with an approved Trust network/system account**
- **All project information, whether electronic or otherwise, will be used, held and processed in compliance with the Data Protection Act 1998 and current legislation. Full details of the act are available on the Cardiff and Vale UHB intranet site.**

Names and signatures of personnel who will be collecting the project data.

Name (block capitals)	Signature	Date

ONCE COMPLETED AND SIGNED, PLEASE FORWARD THIS FORM TO THE RELEVANT CLINICAL AUDIT CO-ORDINATOR (SEE OVER).

- ***This project is subject to approval by the Clinical Audit Department – confirmation will be sent to you (please provide an e-mail address).***
- ***When approved, details of this project will be entered onto the Clinical Audit project database where progress will be monitored until completion.***
- ***Once your project is complete please submit a report of the findings to the Clinical Audit Department for inclusion in the UHB Annual Report/Speciality Reports.***
- ***Please contact the relevant Clinical Audit Co-ordinator for any help/further information (details on page 4).***

CLINICAL AUDIT DEPARTMENT PERSONNEL

Name	Telephone Number and Base	Responsibility
Susannah Coles Senior Clinical Audit Co-ordinator susannah.coles@wales.nhs.uk ext: 46380	UHW Spur N PSA Building Fax: 029 207 42128	General Surgery, Urology, Theatres/Day Surgery/Endoscopy, Emergency Unit.
Alena Ball Senior Clinical Audit Co-ordinator alena.ball@wales.nhs.uk ext: 46997		Integrated Medicine, Unscheduled Care, Haematology, OPAIC, Neurosciences, Nephrology.

Kathy Morris Senior Clinical Audit Co-ordinator kathleen.morris@wales.nhs.uk ext: 46977		Dermatology, Rheumatology, Integrated Medicine, Cardiac Services.
Alison Short Senior Clinical Audit Co-ordinator alison.short@wales.nhs.uk ext: 46827		Critical Care, Head and Neck, Ophthalmology, Anaesthetics, Trauma and Orthopaedics.
Daniele Richards Clinical Audit Co-ordinator danielle.richards@wales.nhs.uk ext: 25511	UHL On Call Landing Room 26 Room 24	Children and Women's Division, Primary and Community.
Mick McGeoch Clinical Audit Co-ordinator mick.mcgeoch@wales.nhs.uk ext: 25639		Mental Health Services, Clinical Diagnostics and Therapeutics, Pharmacy.

Appendix 2

Clinical Audit Plan

Directorate	Name of Audit	Audit Lead
Women and Children		
Acute Child Health	National Diabetes Paediatric Audit (NPDA)	Justin Warner
Acute Child Health	Paediatric Intensive care (PICaNet)	Allan Wardaugh
Acute Child Health	National Neonatal Audit Programme Audit	Roshan Adappa
Acute Child Health	Epilepsy in Children and Young People National Clinical Audit	Frances Gibbon
Acute Child Health	Cystic Fibrosis Registry	Iolo Doull
Community Child Health	TBC	
Obstetrics and Gynaecology	National Maternity and Perinatal Audit	Suzanne Hardacre
PCIC		
Primary Care	National Core Diabetes Audit	Rhian Bond
North and West Locality	TBC	
South and East Locality	TBC	
Vale Locality	TBC	
Mental Health		
Adult Mental health	National Audit of Psychosis	
Mental Health for Older people	TBC	
Dental		
Dental Hospital	Audit on the compliance with completing the medical history form to include the evacuation question	Rowena Griffiths
Dental Community	Audit of the consent process for the paediatric GA extraction service	Nicola Forrester
Clinical Diagnostic and Therapeutics		
Therapies	National Diabetes Foot Care Audit	Scott Cawley
Pharmacy	TBC	
Radiology	TBC	
Therapeutics and Toxicology	TBC	

Laboratory Medicine	TBC	

Surgery		
General Surgery	National Oesophageal Gastric Cancer Audit	Wynn Lewis
General Surgery	National Vascular Surgery Audit	Richard Whiston
General Surgery	National Audit of Breast Cancer in Older people	
General Surgery	National Emergency Laparotomy Audit	Chris Morris
Ophthalmology	National Ophthalmology Audit	Chris Williams
Trauma and Orthopaedics	National Joint Registry	Alun John
Urology	National prostate Cancer Audit	Owen Hughes
ENT	National Audiology Audit	Clare Wilson
Theatres and Anaesthetics	TBC	
Specialist		
Nephrology and Transplants	Renal registry	Aled Phillips
Cardiothoracics	Cardiac Rhythm management	Peter o Callaghan
Cardiothoracics	National Adult Cardiac Surgery Audit	Indu Deglurkar
Cardiothoracics	National Audit Of Percutaneous Coronary Interventions (PCI)(Coronary Angioplasty	Tim Kinnaird
Cardiothoracics	MINAP	Tim Kinnaird John Thompson
Cardiothoracics	National Congenital Heart Disease Audit	Dirk Wilson
Cardiothoracics	Cardiac Rehabilitation Audit	Rachel Owen
Neurosciences and ALAS	Epilepsy in Children and Young People National Clinical Audit	Frances Gibbon
Critical Care	Case Mix Programme (CMP)	Martyn Reed
Haematology	TBC	
Medical genetics	TBC	

Medicine		
Emergency medicine	Major Trauma Audit	Melissa Rossiter
Gastroenterology and Endoscopy	Inflammatory Bowel Disease register	John Green / Helen Ludlow
Gerontology	Falls and Fragility Audit Programme	Anthony Johanssen
Gerontology	National Dementia Audit	Swana Fernandez
Internal Medicine	Pregnancy in Diabetes Audit	Lindsay George / Aled Roberts
Internal Medicine	National Diabetes Inpatient Audit	Lindsay George / Aled Roberts
Internal Medicine	National COPD audit	Ramsey Sabit
Internal Medicine	Sentinel Stroke Audit	Shakeel Ahmed
Internal Medicine	National Heart Failure Audit	Zahir Yousef and Victor Sim
Internal Medicine	MINAP	Tim Kinnaird and John Thompson
Internal Medicine	National Lung Cancer Audit	Diane Parry

CARERS UPDATE

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.	
Quality, Safety, Patient Experience impact: The report provides the opportunity to update the committee with the ongoing progress.	
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 paper

SITUATION

Cardiff and Vale University Health Board, Cardiff and the Vale of Glamorgan Local Authorities, Cardiff Third Sector Council and Glamorgan Voluntary Services continue to work together towards implementation of the Social Services and Well-Being (Wales) Act 2014. The aim of this paper is to inform the committee how the transitional funding, provided by Welsh Government, has been utilised, in partnership, to continue the 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 (SSWB) 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 report provides details of all the key projects and work being undertaken to progress the careers agenda in the final year 2 of the transitional funding.

We are working in partnership to ensure that we have strategic direction and governance arrangements in place across the region. To support this work a Vale Carers lead has started work from 4th September

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. We held a consultation event with carers and agreed with them the sustainable model to support the carers' forum moving forward.

Carers Accreditation project, Young Carers in Schools – Carers Trust South East Wales:

Schools were also provided with posters and tools to adapt and use to raise awareness of young carers, and help staff understand young carers

The project continues to identify a significant number of young carers, who once identified we can offer them appropriate support and guidance,

Schools are able to record young carer status and awareness has been built into safeguarding practice and procedure. They have drafted a young carer policy; a young carer card pilot is underway. In addition the assessment forms and referral process has been developed,

We are working with GP practices to ensure that they recognise carers and share this information. We are currently agreeing the Silver Criteria for accreditation

Information for carers

The carer's handbook and Managing Medicines booklet have been updated. These have been made more indexed so that people can refer to the relevant section and customised to provide local information.

Internal work of the Carers group

We are committed to adopting the principles of the John's campaign but rather than use the term carers we are asking **Do you look after someone?**

We recognise that many families see themselves as partners; children etc but actually are carers

We are committed to supporting carers and creating carer friendly environments through adoption of priorities, principles and promises

Our priority is to identify carers early

Our principles are to care for the carers and their wellbeing and to ensure they always;

- have a carer's voice
- are communicated with
- are informed

Our promises are that if a carers wishes to continue their caring role in hospital we will always welcome and support their involvement where possible in

- times
- personal care
- giving medicines

Whilst we will always try to hour our promises we would ask that carers

•respect other patient's privacy
• respect any issues on the ward that might impact on us supporting you to stay
• tell us if you need our help and support

Please see attached draft posters and leaflets currently under consultation.

Recommendations

The committee is asked to NOTE and APPROVE the contents of the paper

Do you look after someone?

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

At Cardiff and Vale University Health Board

'We care for those who care'

Our PRIORITY is to identify carers early

Our PRINCIPLES are to care for you and your wellbeing and to ensure you always;

- have a carer voice
- are communicated with
- are informed

Our PROMISES are if you wish to continue your caring role in hospital we will always welcome you and support your involvement where possible in;

- meal times
- personal care
- giving medicines

We will always try to honour our promises – however sometimes this might not be possible
All we ask of you is that you PLEASE;

- respect other patient's privacy
- respect any issues on the ward that might impact on us supporting you to stay
- tell us if you need our help and support

At Cardiff and Vale we are adopting the principles of Johns Campaign

26.1

If you need any further help or support please speak to a member of staff or contact the **Patient Experience Team on 02920 745692**

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

Do you look after someone?



At Cardiff and Vale University Health Board

'We care for those who care'

At Cardiff and Vale University Health Board our **PRIORITY** is to identify carers early.

A carer is someone, of any age, who provides unpaid care to a relative, friend or neighbour who needs care and support.

At Cardiff and Vale we are adopting the principles of Johns Campaign

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

At Cardiff and Vale University Health Board

'We care for those who care'

As a Health Board we recognise that carers are important and that they have valuable information about the patients we are caring for.

Our **PRINCIPLES** are to ensure carers have a voice, are communicated with and are fully informed about what is happening with the person they care for.

Once identified, carers will be involved in discussions about the care and treatment of the patient. Treatment plans and medications will be fully explained to the carer and they will be involved in the discharge planning process.

Carer's will be listened to and their views and concerns will be taken into account by hospital staff.

Some carers wish to continue their caring role while the person they care for is in hospital. Once the main carer has been identified a Nurse on the ward will discuss with the carer what involvement in caring for the patient, if any, they may wish to have during the hospital stay. We would not expect carers to carry out elements of care that are normally undertaken by hospital staff unless they so wish to.

As a Health Board we welcome this and **PROMISE** to help and support carers in their involvement of the following aspects of care:

Meal Times
It is essential for the well-being of patients that their nutrition and hydration needs are met. We understand that some patients, when they are ill, have difficulties in feeding themselves or don't want to eat. Therefore we support carers who wish to help at meal times, helping to feed the patient and encouraging them to eat.

Personal Care
You might wish to continue to assist with personal care, however before you undertake this we would be grateful if you please discuss with a member of staff. This will ensure that the staff can document correctly any changes that might occur.

Giving Medication
Staff on the wards will support carers who wish to help with giving medication. We understand that some patients may become agitated while in hospital, due to a change in routine, and not always take their medicine from members of staff.

However, if you wish to help giving medication this must be discussed with the Nurse in Charge so that a medication plan can be put in place.

The hospital staff will always try and honour our promises, but there are times when this might not be possible. All we ask is that at these times you **PLEASE** understand and work with us.

Respect other patients
As a carer you could have agreed with ward staff more flexible visiting, but please respect the other patients on the ward by keeping the noise at a respectable level. There might also be the odd occasion when we would ask you to leave the ward /unit if the dignity and privacy of our patients was being compromised.

Issues on the Ward
There may be times when due to issues such as infections etc you will not be able to visit the person you care for. Please understand that during these time restrictions are put in place to protect you as well as our patients. If you are unable to physically visit the ward you will be able to ring staff for updates on the patient's condition.

Tell us if you need our help
There are lots of organisations and services that can support carers while the patient is in hospital and when at home. The support can include emotional, physical and financial elements. Please ask a member of staff if you feel you need support and help in your caring role.

FEMALE GENITAL MUTILATION (FGM) SAFEGUARDING UPDATE
Name of Meeting: Quality, Safety and Experience Committee **Date of Meeting:** 12th September 2017

Executive Lead: Executive Nurse Director, Cardiff and Vale UHB
Author: Head of Safeguarding - 029 218 32001 Acting Deputy Executive 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
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The provision of a detailed Safeguarding report on the current UHB situation
- Safeguarding Female Genital Mutilation training and raising awareness across the Health Board
- The number of appropriate mandatory referrals and child protection 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

All Health Boards and Trusts across Wales are requested by Welsh Government (WG) since October 2016, to provide data relating to all identified adult cases of Female Genital Mutilation (FGM) each quarter. 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.

Identification is shared with the National Safeguarding Team on behalf of WG, whilst the All Wales Clinical Pathway for FGM is completed by practitioners and copied to the Safeguarding Team for collation of data.

Due to the diverse population within the Health Board population we experience a higher proportion of contacts, far greater than any other UHB/ Trust within Wales. The service areas most affected by the process are Midwifery, Department of Sexual Health (DOSH), Sexual Abuse Referral Centre (SARC) and Community Health Access Team (CHAT). This is reflected in the completed FGM Pathways and is where additional training has been targeted.

The strategic lead for FGM is the Head of Safeguarding while the Maternity lead for FGM has a shared role between FGM and the Specialist Asylum Seeker role. There is currently no clear pathway for paediatric cases for FGM prior to the child arriving in the UK.

There appears to be a poor wider cultural understanding of FGM, which lacks consistency with, identification, reporting, on-going signposting and management. In addition there is requirement to develop a referral process to meet the needs of psycho-sexual/ psycho-social aspects of care. A community FGM clinic plan has been proposed by the midwifery service to provide a facility within an existing out-patient provision. Once implemented the clinic will provide a weekly midwifery led service that will have a Consultant Obstetrician/ Gynaecologist available fortnightly and a psycho-sexual counselling service provision.

BACKGROUND

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. This means that a person who is a UK national or resident within the UK who commits an act be that in or outside the UK can still be prosecuted. A further change namely, section 70 (1) was also amended section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia). Therefore this has extended the Act to acts of FGM performed on a UK national or a person who is resident in the UK. This revision has also 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 World Health Organisation has classified FGM into four types:

Type 1 – Clitoridectomy: partial or total removal of the clitoris

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

Type 4 – All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising of the genital area.

The All Wales Clinical Pathway for FGM was ratified in July 2016 and is used by practitioners within the UHB. The Clinical Pathway should be completed every time a new case of FGM is identified or suspected in women or girls of any age, however not all of these instances will meet the statutory mandatory reporting threshold.

ASSESSMENT AND ASSURANCE

The table below identifies the increase in identification since data collection for WG has been commenced.

Quarter during 2016-2017	Number of Women Identified	Child Protection Referral Made
Q3	40	17
Q4	55	25
Quarter during 2017-2018	**Number of Women Identified**	**Child Protection Referral Made**
Q1	71	34

This increased identification is likely to be due to the increase in awareness through training within the UHB. Online FGM training endorsed by the Home Office is available and accessible to UHB staff. The UHB has provided specific training for Midwives since 2015, delivered as a rolling programme and provided on a monthly basis. Bespoke additional training is provided to targeted areas within the UHB by safeguarding team members. In addition a

trainer within Health Visiting Services has recently been identified to introduce a regular programme within the service.

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 for practitioner information and guidance, which has included the FGM pathway, procedures, training information and referral documentation along with useful links for further reading.

An FGM working group led by the Head of Safeguarding continues to develop the service provided to practitioners across the UHB, ensuring that training opportunities and advice are available.

Midwifery services have developed a FGM clinic. There has now been an appropriate venue identified with suitable equipment, and the staffing resources eg administration support and midwifery specialist support to deliver the service at no additional costs. Consultant Gynaecologist support has been included into a new Job Description and it is hoped to be functional in the next month. Once the clinic is opened, an evaluation of outcomes of psycho-sexual support will be completed by Black & Asian Women Step Out (BAWSO)/ National Society for the Prevention of Cruelty to Children (NSPCC) at no additional cost.

Work is underway to introduce clear referral guidelines for children subjected to FGM prior to arriving in the UK. The current referral process for children only includes those whose cases are progressing through criminal investigations or other child protection concerns. The introduction of a revised pathway will ensure that girls as well as female adults will receive equity of services.

NICE GUIDANCE
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** 12th September 2017

Executive Lead : Medical Director
Author : Patient Safety and Quality Assurance Manager 02920744018
Caring for People, Keeping People Well : This report underpins the Health Board's "Deliver the Outcomes that Matter and offers services that deliver the improvements in population health that our citizens are entitled to.
Financial impact : There are no financial implications associated with the actions currently being taken as identified within this report
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 3.1 Safe and Clinically Effective Care
CRAF Reference Number 5.1 Deliver Safe Effective and Efficient Care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The process of disseminating NICE guidance and recording levels of implementation

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the compliance with the current process and the intention to disseminate NICE Quality Standards

SITUATION

The National Institute for Health and Care Excellence is an independent arm of the NHS that is responsible for providing guidance on treatments and care for people in the NHS in England and Wales.

BACKGROUND

NICE guidance other than Technology Appraisals and Quality Standards are currently disseminated by the Patient Safety and Quality Team to identified Clinical Leads and Clinical Board directors on a monthly basis.

Clinical Guidelines make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions to planning broader services and interventions to improve the health of communities.

Interventional Procedure Guidance recommends whether interventional procedures - such as laser treatments for eye problems or deep brain stimulation for chronic pain - are effective and safe enough for use in the NHS.

Medical Technologies Guidance address specific technologies notified to NICE by manufacturers. The 'case for adoption' recommendations are based on the claimed advantages of introducing the specific technology compared with current management of the condition.

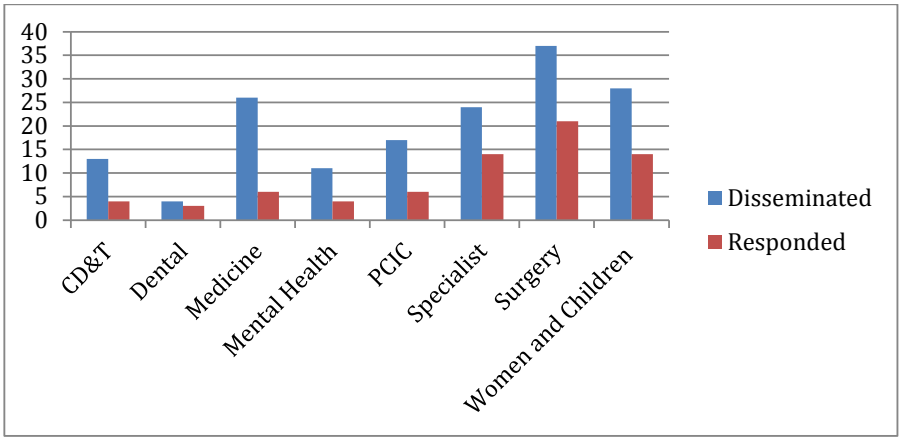
Diagnostic Guidance focuses on the evaluation of innovative medical diagnostic technologies in order to ensure that the NHS is able to adopt clinically and cost-effective technologies rapidly and consistently.
Highly Specialised technologies guidance are evaluations and recommendations on the use of new and existing highly specialised medicines and treatments within the NHS in England.

ASSESSMENT
Between April 2016 and March 2017 175 elements of NICE guidance (excluding Technology Appraisals) were disseminated to one or more Clinical Boards and of these 94 were for consideration of implementation and the remaining 81 elements were circulated for information only.

NICE guidance disseminated for "information only" is sent directly to the Clinical Board Director to circulate as appropriate. NICE guidance circulated "for action" is sent to the Clinical Board Director and the Clinical Lead to consider implementing. Clinical Boards are asked to respond detailing their levels of implementation using the pro forma (**appendix 1**). Partial or non implementation should be discussed in Clinical Board Quality Safety and Experience (QSE) meeting to mitigate any risk associated with non implementation.

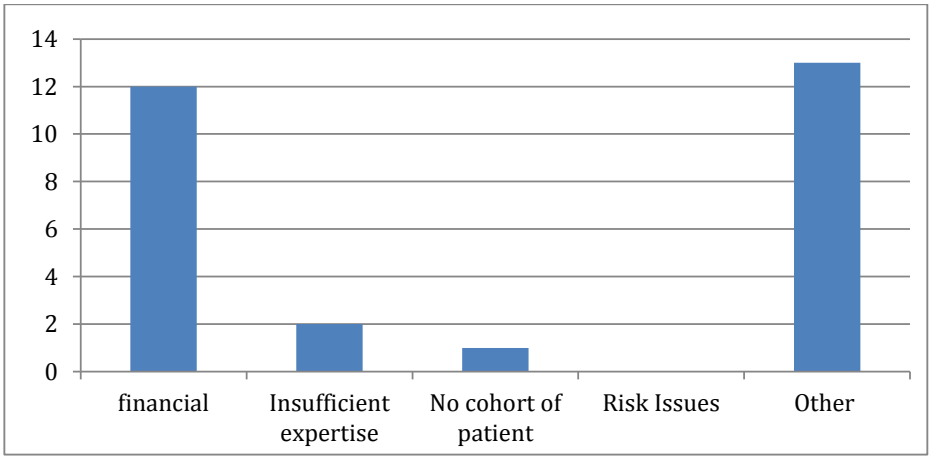
In 2015 / 2016 responses were received for 26% of guidance disseminated for action. To improve compliance, quarterly summary reports were circulated to Clinical Boards. In 2016 /2107 responses detailing the levels of implementation were received for 42% of guidance circulated for action. This continues to be monitored.

Implementation Response 2016 / 2017



Of the responses received it was confirmed that 53% of guidance had been implemented in full. The reasons given for non or partial implementation were complex and often multifaceted with financial restriction being the most common specified reason.

Reasons for non or partial Implementation 2016 / 2017



Quality standards are developed in collaboration with health and social care professionals, practitioners and service users. Implementation is not mandated but can be used to plan and deliver services. It is the intention to start to disseminate Quality Standards to the Clinical Boards for information only with guidance included in quarterly summary to prompt discussion at Clinical Board QSE where necessary.

Appendix 1

Title of Guidance:

Date issued by NICE:

CLINICAL BOARD Director

Lead clinician nominated
To be returned by/**/**** to** Clinical.audit.cav@wales.nhs.uk

Please answer the following questions:

Q.1 Has your clinical area/speciality fully implemented this guidance*? Yes ☐ **No** ☐
*(Please be aware that NICE may recommend that the treatment **should not be** undertaken).

If the answer to Q1 is **'Yes'** (the Guidance has been fully implemented), please:

- distribute the guidance to relevant colleagues;
- tick the 'Yes' box above and sign below;
- email this form to Clinical.audit.cav@wales.nhs.uk

No further action is now required.
If the answer is **'No'** (the guidance has not been fully implemented), please tick the 'No' box above and go to Q2.

Q2. What are the reasons for not fully implementing the Guidance? Please use the template below to record reasons. This should then be progressed through future QSE meetings – see process on next page.

Reasons for not fully implementing		Comments
A – Financial	☐	
B – Insufficient expertise to implement the guidance	☐	
C - No cohort of patients group	☐	
D - Risk issues	☐	
E - Other reasons (e.g. weak evidence/don't agree with the evidence)	☐	

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If this NICE Guidance has not been fully implemented the following process is advised:

1. The nominated clinical lead should make this an agenda item for discussion and to agree actions at the next directorate QSE meeting.

   If actions are agreed to fully implement the guidance at this level, no further escalation is necessary. Please provide a copy of the minutes of the appropriate QSE meeting and forward them to: Clinical.audit.cav@wales.nhs.uk

   If unresolved at directorate level, please progress to stage 2.

2. The Clinical Director should make this an agenda item for discussion and to agree actions at the next CLINICAL BOARD QSE meeting.

   If guidance implementation issues have been resolved or there is a decision to accept the risk of not fully implementing at this level, no further escalation is necessary however this should be appropriately recorded on the relevant risk register. Please provide a copy of the minutes of the appropriate QSE meeting and forward them to: Clinical.audit.cav@wales.nhs.uk

3. If the decisions affect more than your CLINICAL BOARD then escalate to Health Systems Management Board.

   Please provide a copy of the minutes of the appropriate HSMB meeting and forward them to: Clinical.audit.cav@wales.nhs.uk

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Signature _____ **Date** _____

Please print full name and title_____

HEALTHCARE INSPECTORATE WALES (HIW) – CARDIFF AND VALE UHB ANNUAL REPORT 2016-2017
Name of Meeting : Quality, Safety and Experience Committee **Date of Meeting** : September 12th 2020

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and quality – Carol.A.Evans2@wales.nhs.uk; 02921846117
Caring for People, Keeping People Well : Supports delivery of 'Outcomes that matter to people' and 'reduction in waste, variation and harm'
Financial impact : None
Quality, Safety, Patient Experience impact: HIW assess the quality and safety of services as well as the patient experience. The report provides a summary of the UHB performance as a result of a number of inspections and reviews**.**
Health and Care Standard Number: relevant against all Health and Care Standards
CRAF Reference Number …… 5.1
Equality and Health Impact Assessment Completed: Not applicable.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- A reduction in the number of immediate assurance issues to one, compared to the previous year
- HIW statement that the UHB has demonstrated itself to be a learning orgnaisation
- HIW statement that it enjoys a positive working relationship with the UHB

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the contents of the Cardiff and Vale UHB Healthcare Inspectorate Wales Annual report for 2017- 2020

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SITUATION

The purpose of this paper is to present the HIW Annual Report for Cardiff and vale UHB for 2016-2017

BACKGROUND

ASSESSMENT AND ASSURANCE

During the year, HIW conducted 34 inspections or visits at Cardiff and Vale University Health Board settings, these included:

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 10 dental practice inspections
- 6 learning disability inspections
- 4 Mental Health Act visits
- 1 mental health unit inspection
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 5 Death in Custody investigations

The UHB is required to co-operate with and respond to the outcome of each visit, inspection or review and to put in place the necessary learning and monitoring based on the findings.

The report is very positive stating that 'The inspections conducted within Cardiff and Vale University Health Board generally indicate that the care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff.' In addition the report confirms the view that Cardiff and Vale has demonstrated on a number of occasions the fact that it is a learning organization, enjoying positive working relationships with HIW.

HIW have requested that the UHB concentrates on:

- The quality of documentation which was cited as requiring improvement in a range of inspection types during the 2016-17 inspection year including hospital and dental inspections
- Issues with maintenance and improvement of some clinical environments.

The quality of documentation has been identified as a priority within the Quality, Safety and Improvement Framework and is subject to regular scrutiny through Clinical Board audit mechanisms and as an integral part of unannounced observation of care visits.

Maintenance and the poor condition of some of the UHB working environments remains a risk and the Estates department work closely with

Clinical Boards and the Planning team to prioritise areas for investment, refurbishment and on-going maintenance of the Estate. Both feature on the UHB Corporate Risk and Assurance Framework

The report can be viewed via the following link



Cardiff and Vale University Health Board

Annual Report

2016 - 2017

29.1

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

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1. Purpose

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. Our purpose is to check that people in Wales are receiving good care.

This annual report has been produced as a summary of the activity that HIW carried out between 1 April 2016 and 31 March 2017 within Cardiff and Vale University Health Board.

Through our work we aim to:

- **Provide assurance:** Provide an independent view on the quality of care.
- **Promote improvement:** Encourage improvement through reporting and sharing of good practice.
- **Influence policy and standards:** Use what we find to influence policy, standards and practice.

2. Overview

During the year, HIW conducted 34 inspections or visits at Cardiff and Vale University Health Board settings, these included:

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 10 dental practice inspections
- 6 learning disability inspections
- 4 Mental Health Act visits
- 1 mental health unit inspection
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 5 Death in Custody investigations

3. Key Messages

The inspections conducted within Cardiff and Vale University Health Board generally indicate that the care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff. Our work highlighted the following issues which may require further attention.

- The quality of documentation was cited as requiring improvement in a range of inspection types during the 2016-17 inspection year including hospital and dental inspections
- Issues with maintenance and improvement of some clinical environments.

4. Inspection Findings

During 2016-17 HIW conducted a variety of work within Cardiff and Vale University Health Board. There are a number of key themes that have emerged through the work this year. These are summarised below.

Hospital Inspections

Key findings from hospital inspections during 2016-17 are as follows:

- HIW inspected wards C6 and C7 at University Hospital of Wales (UHW) in October 2016. We found effective systems in place for the sustainable delivery of safe, effective, person centred care and patients were happy with the service being provided. All documentation was completed to a good standard and in sufficient detail. Risk assessments and plans were seen to be reviewed regularly and were up-to-date. We made recommendations in relation to health and safety, building maintenance and repair, medicines management, infection prevention and control and the recording of patients' weight.

- HIW carried out a follow up inspection at University Hospital Llandough in March 2017. We found that appropriate action had been taken in relation to our previous inspection in February 2016. We found evidence that care was safe and effective across the four wards inspected. We made recommendations in relation to a maintenance issue, correct use of door observation panels, delivery of unified care between mental health and medical services, and staff engagement on the future health board provision of Mental Health Services for Older People. (Full report due for publication on 31 May 2017.)

- An inspection of the Emergency Unit (EU) at UHW was completed in March 2017. Overall, we found evidence that the EU provided a good standard of care and treatment to patients. This was evidenced as we received positive feedback from patients and family with staff demonstrating enthusiasm and compassion in providing safe and dignified care. We observed senior members of nursing and medical staff providing guidance and support to junior members of staff in a timely manner. There was evidence of different staff groups working well together throughout the EU and clinical environments were clean and tidy. We made recommendations in relation to the condition of the paediatric unit environment as well as the environment leading to wards, which could pose a health and safety risk to patients and staff. There was also scope for improvement in adherence to infection control practices and principles. (Full report due for publication on 9 June 2017.)

Mental Health

Our inspection of the Hafan y Coed mental health unit concluded that on the whole, effective care was being provided to patients. We commented positively on the respectful manner in which care was being delivered in a safe environment and the fact that patients were provided with up-to-date information in written form or through speaking to staff. We did however have some concerns relating to the management of medication and environmental design which could impact on patient safety. (Full report due for publication on 31 May 2017)

29.1

Ionising Radiation (Medical Exposure) Regulations

Whilst the HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services, it did discover systemic failings in relation to staff entitlement as required within the Regulations. This meant that staff in general across nuclear medicine services may not have been clear about who was entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could have potentially led to an error and unnecessary harm to patients. As a result, it was necessary for HIW to issue a non-compliance letter to the health board

General Practice

We found that services were operating very well, and were providing safe and effective care, despite the challenges faced in terms of trying to provide patients with timely appointments in response to their needs. Overall we found evidence of good management and leadership, with two practices in particular having developed very good systems of audit and governance. Areas for improvement were identified in two practices, as follows:

- The need to ensure that sharps containers were securely stored in consultation rooms
- Staff training in relation to chaperone duties
- The need for display screen equipment (DSE) staff risk assessments
- The need to amend/strengthen Putting Things Right arrangements

Dental

We completed ten inspections of dental practices providing NHS treatment. These inspections highlighted the following themes:

- Patients told us they were happy with the service provided (all inspections)
- We found the majority of practices to be well equipped, clean and tidy
- In most cases, documentation and information was available to show that x-ray equipment was being used safely
- Staff felt supported or well managed in five practices
- HIW found that record keeping needed to improve at all ten inspections
- Decontamination and sterilisation issues were noted in nine inspections
- The need for further staff training, or for staff training needs to be assessed was an issue at five practices
- Poor state of repair or unsatisfactory nature of the environment was highlighted in four inspections

Learning disabilities

Community health learning disability services in the Cardiff and the Vale of Glamorgan area are the responsibility of Cardiff and Vale University Health Board. However, these, and residential services are provided by Abertawe Bro Morgannwg University Health Board (ABMUHB). During 2016-17 HIW undertook six inspections of residential settings and one community learning disability team inspection.

Our inspection of the community learning disability team (CLDT) revealed a passionate and committed staff team with a strong values base and we found evidence that the CLDT was effective in delivering a range of multidisciplinary assessments and interventions.

Health staff were proactive in preventative work which they undertook alongside clinical roles. However, we found that the health board needed to take a more strategic approach to raising awareness and implementing best practice for people with learning disabilities receiving primary and secondary care.

Overall, we found a lack of appropriate service provision available, particularly where specialist services were required, and a lack of effective joint planning

with ABMU around future service provision. There was a need for both health boards to work together to map and understand the current needs of the Cardiff and Vale of Glamorgan learning disability population in order to effectively plan future services.

We found that improvement was needed to the overall governance of learning disability service provision so that there was clarity about population needs, ABMU's service specification and systems of oversight.

5. HIW Special Reviews, Investigations and Thematic Work

We did not undertake any special reviews or investigations within Cardiff and Vale University Health Board during 2016-17. HIW undertook five clinical reviews to support the work of the Prison and Probation Ombudsman in relation to death in custody incidents.

Death in custody clinical reviews – HMP Cardiff

During 2016-17 HIW contributed to five (four natural and one suicide) death in custody reviews relating to HMP Cardiff. Of the five, two reviews are still ongoing.

From the three clinical reviews that have been completed, it was evident that the standard of healthcare provided to the individual during their time in custody was of a satisfactory standard and similar or better than would have been available in the community.

One case saw the individual die of an uncommon complication of a pre-existing condition which was not foreseeable before his operation. This complication was very unlikely to have been present before he was admitted to Hospital prior to his death. The prison service dealt with him appropriately and promptly.

One case saw the individual diagnosed with prostate cancer. He was seen regularly by the palliative care team and detailed care plans were created. He did not want to be admitted to hospital and he received full palliative care at HMP Cardiff. The care he received from the prison service was excellent.

One case saw the individual die due to self inflicted death. The care given to him was generally of a high standard, although some shortcomings and omissions were highlighted that needed addressing. However, there was nothing to suggest that had these been in place, the death of the individual would have been avoided.

HIW made recommendations in relation to record keeping, transfers to secondary care appointments and the quality and completeness of discharge information.

Learning Disability Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[1] of NHS health services for people with learning disabilities in Wales. The review set out to identify common strengths and areas for improvement, and makes recommendations for health boards. It also highlights good practice, to support improvement in the services provided to people with a learning disability in Wales. The key findings from our review were:

- Our findings were mostly positive about the services provided by community learning disability health teams.
- We found that NHS residential services for people with learning disabilities required significant improvement in many areas.
- We found that people usually received good individual care from staff who tried their best to care for patients.
- Care for patients was often not underpinned by good management and staffing arrangements.

All health boards need to consider the purpose of their learning disability NHS residential settings and whether the care being provided at these establishments is purely healthcare. If not, health boards should consider whether a social model of care is more appropriate.

Ophthalmology Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[2] of Ophthalmology Services. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services. The review focussed on 'wet' Age Related Macular Degeneration (AMD), due to risks associated with any delay in treatment for patients. The key findings from our review were:

[1] http://hiw.org.uk/docs/hiw/reports/161208ldreviewen.pdf

[2] http://hiw.org.uk/docs/hiw/reports/170131opreviewen.pdf

- Eye care services across Wales have insufficient capacity in secondary care to meet current demands.
- The absence of key personnel can cause parts of the care pathway to stop working effectively increasing the risk of potential avoidable harm to patients.
- Health boards need better information about the demand capacity gap to enable informed workforce planning decision.
- We heard that poor working relationships between primary and secondary care in some health board areas have hindered efforts to improve joint working.
- We saw some new initiatives across Wales relating to delivery of 'wet' AMD services, including the introduction of non-medical injectors, however progress in development and delivery of these initiatives has not been consistent across health boards.

All health boards need to understand that further development of services is required to fully utilise available resources to strengthen infrastructure and sustainability of eye care services.

6. Follow Up and Immediate Assurance

Follow Up

Following each of our inspections we issued an inspection report with our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan on how they were going to make the improvements. For some inspections, we will undertake a follow up inspection to ensure improvement plans have been actioned.

- University Hospital Llandough – During an unannounced inspection in February 2016, HIW highlighted significant failings within medical and mental health services for older people areas of the hospital. In order to assess progress following this inspection, HIW undertook a follow up inspection in February 2017. Whilst we made a number of recommendations, we found that appropriate action had been taken in relation to the February 2016 inspection.

Immediate Assurance

Where we identified a risk to patient safety that required immediate improvement action, we issued letters to the health board and practices in accordance with HIW's immediate assurance process.

Of the inspections conducted across Cardiff and Vale University Health board only one inspection resulted in an immediate assurance letter. In this instance the letter was in the form of a non compliance letter associated with a breach in relation to the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R). The HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services. However, the discovery of the systemic failure in respect of 'Entitlement' means that staff in general across nuclear medicine services may not be clear about who is entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could potentially lead to an error and unnecessary harm to patients.

Following each of our inspections we issued an inspection report with our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan on how they were going to make the improvements.

7. Governance

During 2016-17 the health board had a number of opportunities to demonstrate that it is a learning organisation. As issues arose, the health board responded soundly, seeking clarification where necessary and engaging with HIW to ensure that it could improve services where necessary.

It is clear that the health board ensures that inspection reports are discussed at its Quality, Safety and Experience Committee in order to extract any learning from these inspections and to monitor the implementation of any actions required. The Committee also appears firmly focused on exploring and addressing some of the major challenges to patient safety not covered in HIW's reports.

8. Engagement

During 2016-17 the HIW Relationship Manager attended a number of meetings with health board staff including presenting the 2015-16 Health Board report to the Public Board.

HIW's Relationship Manager also meets regularly with the Director of Nursing in order to exchange information and, where necessary, discuss any further

assurance required following inspection activity or issues raised with the health board.

During the year the health board was very welcoming to any approaches from HIW. This positive working relationship enabled HIW to contribute to the health board's 'when the inspector calls' workshops aimed at providing staff with a sense of what it is like to be inspected and how to engage positively with the process

Correspondence between HIW and the health board was dealt within a timely and satisfactory way.

The Chief Executive of HIW met with the Chief Executive and Chair of the health board during July 2016.

9. Inspection Activity

Hospital Inspections

1. University Hospital of Wales	18 October 2016
2. University Hospital of Llandough (Follow-up inspection)	27 February 2017
3. University Hospital of Wales	6 March 2017

GP Inspections

4. Four Elms Medical Centre, Stirling Close, Pengam Green, Cardiff. CF24 2HB	18 January 2017
5. The City Surgery, 187 City Road, Roath Cardiff. CF24 3WD	24 January 2017
6. Cloughmore Medical Centre, 19 South Park Rd, Splott, Cardiff. CF24 2LU	31 January 2017
7. Meddygfa Albany Surgery, 219 - 221 City Rd, Roath, Cardiff. CF24 3JD	23 February 2017

Dental Inspections

8. Nicola Taaffe@West Grove, Roath, Cardiff. CF24 3AN	26 September 2016
9. Ellen Davies Dental Practice, 4a Barons Close House, East Street, Llantwit Major, Vale of Glamorgan. CF61 1XY	27 October 2016
10. Dental Surgery, 57 High Street, Cowbridge, Vale of Glamorgan. CF71 7AF (Follow-up inspection)	14 November 2016
11. Cardiff Smile Centre, 113 Clare Road, Grangetown, Cardiff. CF11 6QR	15 November 2016
12. Wilson Road, Dental Surgery, 29 Wilson Road, Ely, Cardiff. CF5 4LL	18 November 2016
13. Smiles Dental, 68a Cowbridge Rd East, Cardiff, Canton. CF11 9DU	24 November 2016
14. Cathedral Orthodontics, 80 Cathedral Road, Pontcanna Cardiff. CF11 9LN	5 December 2016
15. The Orthodontic Centre, Beck Court, Cardiff Gate Business Park, Pontprennau, Cardiff. CF23 8RP	5 January 2017
16. Wilton House Dental Practice, 49 Station Road, Llandaff North, Cardiff. CF14 2FB	28 February 2017
17. My Dentist practice, 17 Quay Street, Cardiff. CF10 1EA	21 March 2017

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection

18. University Hospital of Wales, Nuclear Medicine Services	5 October 2016

29.1

Learning Disability Inspections

19. ABMU managed residential service	2 June 2016
20. ABMU managed residential service	14 June 2016
21. Rowan House, Ely, Cardiff	27 June 2016
22. Hafod Y Wennol, Hensol, Nr Pontyclun	28 June 2016
23. Cardiff and Vale Learning Disability Community Team	4 July 2016
24. ABMU managed residential service	5 July 2016

Mental Health Act

25. Hafan Y Coed, University Hospital of Llandough (4 visits)	27 February 2017

Mental Health Unit

29. Hafan Y Coed, University Hospital of Llandough	27 February 2017

Investigation - Death in Custody

30. Cardiff HMP	May 2016
31. Cardiff HMP	November 2016
32. Cardiff HMP	February 2017

29.1

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

MINUTES OF THE MEETING HELD ON 10TH MAY 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
Ian McMullin	Business Manager, Therapies
Rachael Daniel	Health and Safety Adviser
Sarah Jones	Pharmacy Quality and Safety Lead
Rebecca Pettit	Medical Physics Quality and Safety Lead
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Lisa Griffiths	Quality Manager, Laboratory Medicine
Hattie Cox	Graduate Management Trainee
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Suzie Cheesman	Patient Safety Facilitator
Maria Jones	Senior Nurse, Outpatients
Bolette Jones	Acting Head of Media Resources
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
Stuart Egan	Independent Member Trade Union
Andrew Wood	Clinical Director, Radiology and Medical Physics/Clinical Engineering Directorate
Kathy Ikin	Directorate Manager, Radiology and Medical Physics/Clinical Engineering Directorate
Darrell Baker	Clinical Director, Pharmacy and Medicines Management

Secretariat:

Helen Jenkins	Clinical Board Secretary

30.1

PRELMINARIES

CDTQSE 17/151 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 17/152 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 17/153 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 12th April 2017 were **APPROVED.**

CDTQSE 17/154 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 17/080 Implications for Laboratory Medicine Following Changes to Medical Examiner Role

Lisa Griffiths reported that early implementer sites have seen an increase in coroners' cases. This work is being taken forward in the UHB by Joy Whitlock. Sue Bailey will liaise with her for an update.

Action: Sue Bailey

CDTQSE 17/118 Terms of Reference

Alun Morgan to clarify with Carol Evans on the core members that need to be present for the Sub-Committee to be quorate.

When this has been clarified Sue Bailey will update the terms of reference document and submit to the Clinical Board meeting for ratification.

Action: Alun Morgan/Sue Bailey

CDTQSE 17/121 Review of Concerns Relating to Communication Issues

30.1

A review was undertaken of concerns that were specifically related to communication issues. There were 16 concerns but no trends were identified. There were 3 complaints relating to the Patient Booking Team during 2016-17, however given the nature of their work and the large numbers of patients they deal with on a daily basis this is not of concern for the Clinical Board.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 17/155 Patient Story

A 57 year old gentleman, Mr E attended EU at 4am complaining of abdominal pain which had worsened overnight. He was seen by an EU SHO. The pain was constant and he had vomited. He was feeling well prior to the onset of this pain. He had a past medical history of heart disease and was taking a number of medications. He was an ex smoker but had no alcohol history.

Mr E had a set of observations taken at triage which demonstrated a respiratory rate of 16, oxygen saturations of 98% on room air, a heart rate of 95 and a blood pressure of 143/98 in the left arm (with right arm blood pressure measuring 146/62). He denied having symptoms of any fevers, constipation, diarrhoea, cough, dyspnoea, rectal bleeding, trauma or lower urinary tract symptoms and was feeling well prior to the onset of this pain. He reported he was continuing to eat and drink, pass urine, and had opened his bowels.

The SHO was working on a diagnosis at this time which included urinary tract infection, diverticulitis or gastroenteritis, and the SHO also aimed to rule out significant aortic pathology or a bowel perforation.

Blood test results demonstrated an elevated white cell count, with a C-reactive protein of 6. Results for urea, electrolytes and liver function tests did not demonstrate any abnormalities**.** A chest x-ray demonstrated no evident change since 2014 and a urine dipstick demonstrated no evidence of urinary tract infection.

Mr E was reviewed by a Clinical Fellow in the Emergency department and was asked to see Mr E in order to perform a bedside ultrasound scan. A focussed ultrasound scan of the abdominal aorta was performed in the Emergency Unit with the maximum diameter of the aneurysm measured being 40mm. A plan was made to request a CT aortogram for the patient and if this was declined or was normal, to discharge this gentleman with a course of antibiotics if remaining investigations were unremarkable.

The SHO telephoned the Radiology Registrar to ask what the next form of imaging would be in this scenario. He explained that an incidental 4cm aneurysm requires surveillance and being a weekend the safest way to ensure he goes into the correct surveillance program would be to request an outpatient ultrasound to confirm and document the aneurysm. The Clinical fellow discussed with the SHO that if everything was normal then the patient could be discharged**.** Mr E was discharged home with antibiotics.

3 days later Mr E attended his GP to discuss the results. He was still complaining of pain. He was advised to finish his antibiotics and was started on a laxative. He was advised to seek further medical attention if the situation worsened or if not resolved. Mr E and his GP discussed the aortic aneurysm and the need for referral to the out-patient team for further follow-up and monitoring.

4 days later an emergency ambulance called to Mr E's home. Earlier that day Mr E had been in pain which he described as 'trapped wind'. He had passed a small bowel motion which had eased his pain but it returned later that evening. Mr E was found crawling on the floor having possibly had a grand mal seizure. He had been incontinent. Mr E was transferred to the Emergency Unit at UHW.

The impression was his aneurysm had ruptured and Mr E required a massive transfusion of blood. He was unable to maintain his blood pressure. He was taken straight to Theatre.

Mr. E was admitted to the ICU at UHW. Further blood and blood products were transfused but Mr E remained shocked and did not improve with further intensive care treatment.

Throughout the morning and day Mr E was passing urine however he needed a number of blood products to maintain his blood pressure and at 18.25hrs hours the Consultant Intensivist was concerned that he was unable to maintain the blood pressure despite continuing to transfuse large units of blood. At this point Mr E then developed a large amount of blood from the left chest drain. It was decided to take Mr E back to theatre due to the fact that he may be bleeding.

The surgeon reopened the whole incision and found there was no bleeding in the chest. There was a small vessel bleeding on the posterior aspect of the back wall which was sutured despite this there was a significant amount of blood in the retroperitoneal space. Due to the fact also that despite the lactate being 10 prior to the surgery the lactate had continued to rise during the afternoon and it was then decided to incise the abdominal cavity and have a look at the bowel. It was clear that the colon and much of the small bowel was ischemic. This was something which had clearly been going on for a number of hours if not days and therefore at this point it was deemed highly unlikely that Mr E would survive.

The surgeon therefore reclosed the wound and Mr E was returned to intensive care. On return from theatre the surgical and intensive care consultants discussed the operative findings with the family of Mr. E and the fact that he would not be expected to survive. Treatment was changed to include comfort measures only and Mr E died at 23.35hrs on 22 January 2017.

An investigation was undertaken into the incident and key learning was around the use of ultrasound in EU. It is operator dependent and should only be used by appropriately trained personnel. Whilst the Clinical Fellow had been trained she was not signed off as competent and was unsupervised when she undertook the ultrasound.

There is a possibility that the aneurysm was incorrectly measured, but the aorta varied in size all the way down its length.

There are unfortunately no images of the scan taken in the EU available and therefore an evaluation of the PoCUS scan performed on 15th January could not be undertaken. As with all imaging, a report on the scan should be documented and the designation of the operator recorded. The outcome of the bedside ultrasound scan was not well documented. There is no formal record of the imaging performed with no captured images or written, signed and dated report in the clinical record.

Recommendations from the investigation:

- EU looking at pathway for patients who present with aorta aneurism.
- Need to ensure staff are competent to scan.
- There was a failure to meet standards for recording outcome of ultrasound. Need to consider electronic storage of these images.

The Coroner recorded the cause of death as a result of complications following a ruptured thoraco-abdominal aneurysm. A Regulation 28 Report was issued with the following actions:

- Consideration should be given to reviewing procedures related to the training and the supervision of those undergoing training in conducting FAST Ultrasound examinations

- Consideration should be given to reviewing procedures for recording the outcome of FAST ultrasound examinations.

- Consideration should be given to reviewing procedures surrounding the management of symptomatic patients where an AAA has been identified by FASt ultrasound examination.

It was noted that the EU are taking the recommendations on board. Learning from the case will be discussed at the UHB Ultrasound Group being held tomorrow.

CDTQSE 17/156 Feedback from UHB QSE Committee 21st February 2017

The minutes of the UHB QSE Meeting held on 21st February 2017 were **RECEIVED.** It was noted that the Clinical Board presented its report at that meeting which was well received.

CDTQSE 17/157 Health and Care Standards

Self assessments have now been submitted and the corporate leads will bring together responses.

It was noted that this Clinical Board has been commended around the quality of its submission.

CDTQSE 17/158 Draft Internal Audit Follow Up Review - Quality and Safety Governance Arrangements

30.1

Sue Bailey reported that an internal audit follow up review of quality and safety governance arrangements will be undertaken. The aim is to provide assurance around quality arrangements in Clinical Boards and directorates.

CDTQSE 17/159 Risk Register

Sue Bailey and Rachael Daniel attended a risk management workshop which has led to worthy consideration on what should be included on a risk register. Sue Bailey will bring some of the points discussed to the Clinical Board risk register workshop in July.

CDTQSE 17/160 Exception Reports

SBAR for the Recommendation for the Investigation Management of Unconfirmed Transfusions

The SBAR document was **RECEIVED**. The document represents the corrective action agreed with the MHRA inspector to be escalated to the Clinical Board Quality and Safety and Experience Group for dissemination to the wider clinical areas on the requirements of traceability investigations.

In the event that a unit remains as an unconfirmed transfusion then a clinical incident will be generated. The ward manager will be assigned as investigator lead in conjunction with the transfusion practitioner team. Together the investigators will be required to conduct a root cause analysis, produce a summary of their findings and agree the actions to be taken to prevent a reoccurrence.

Non compliance data will be circulated to Clinical Leads on a monthly basis for dissemination in their areas.

There is a requirement that all Health Boards will maintain the data needed for full traceability of blood or blood components for 30 years. Sue Bailey will check with the Datix Team that there is 100% compliance with incident forms.

Action: Sue Bailey

CDTQSE 17/161 Clinical Board QSE Scorecard

The key issue relates to the numbers of open incidents. Managers should close incidents when there is no further action that can be taken.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/162 Initiatives to promote Health and Wellbeing

Nothing to report.

CDTQSE 17/163 Falls Prevention

Alun Morgan reported that the next meeting of the Falls Delivery Group is next week. He requested that a story relating to a patient fall is presented to this group. This was **AGREED.** Alun Morgan to confirm if this will be presented to the next meeting.

Action: Alun Morgan

SAFE CARE

CDTQSE 17/164 Concerns and Compliments Report

The Clinical Board received 8 formal concerns in April. There was a breach in response times by Physiotherapy.

0 AM concerns were received.

The Clinical Board received 4 compliments and is therefore starting the new financial year with a greater number of concerns than compliments.

The main theme of the formal concerns received relates to clinical diagnosis and treatment.

CDTQSE 17/165 Ombudsman Reports

Nothing to report.

CDTQSE 17/166 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/167 Patient Safety Incidents

The Serious Incident report was **RECEIVED.** The following SI's are outstanding:

In34781 - CRI IRMER incident; currently with Health Inspectorate Wales (HIW) for closure.
In33308 – IA Noradrenaline incident; closure form submitted for sign off.
In38935 – CT Colon incident; report submitted to HIW
In38916 – Physiotherapy patient who sustained a fractured humerus. Closure form submitted for sign off.

The lupus incident is currently outstanding.

CDTQSE 17/168 New SI's

There are no new SIs to report.

CDTQSE 17/169 RCA/Improvement Plans

Nothing to report.

30.1

CDTQSE 17/170 WG Closure Forms – Sign Off

Nothing to present.

CDTQSE 17/171 Regulation 28 Reports

Nothing to report.

CDTQSE 17/172 Patient Safety Alerts

PSN037 Resources to support the safety of girls and women who are being treated with Valproate

This item was received for noting but is not applicable to the Clinical Board.

Pharmacy will be advising prescribers.

An alert was received in Laboratory Medicine relating to vacutainers expiring in October 2017. Rachael Daniel will follow up with Procurement.

Action: Rachael Daniel

CDTQSE 17/173 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/174 IP&C Issues

Meetings have been held around the implementation of Aseptic Non Touch Technique (ANTT). Alun Morgan reported that all directorates have an implementation plan. A meeting is being held to discuss a training programme in Phlebotomy.

The main issue will be around developing and maintaining a database to report compliance. The Clinical Board will be required to report on a monthly basis to the UHB IP&C Group on compliance.

The Clinical Board will also need assurance around training for medics. This will involve a one off assessment for clinicians repeated every 3 years. This will affect Radiologists, Biochemists and Haematologists.

CDTQSE 17/175 Key Patient Safety Risks

Safeguarding

Sarah Richards was welcomed to the meeting. She is the Health Independent Domestic and Sexual Violence Adviser and is based in the UHB. She offers support if a patient or member of staff discloses domestic abuse from a partner, ex-partner or family member. She will assist in completing assessments and support with safety measures, the criminal justice process and referrals to community services. She is available to meet individuals on site.

She noted that since October the majority of her work has been based in EU and Maternity but she is available for referrals from anywhere within the Health Board. She circulated her details and further information is also available on the intranet.

Alun Morgan reiterated that directorates should still link in with himself and Maria Jones with any safeguarding issues.

It was noted that there are currently no open safeguarding cases within the Clinical Board.

Mental Capacity Issues

Sue Bailey and Maria Jones attended the Mental Health and Capacity Legislation Committee on 9th May 2017 to present the Clinical Board report.

In 2016/17 there were 49 incidents of aggressive behaviour. Of these 49 incidents, there were 5 identified that involved patients who were deemed as lacking in capacity. 3 involved Phlebotomy and 2 involved OT. These will be brought to a future meeting as a patient story.

Action: Sue Bailey

It was noted that MCA training is now a mandatory training module. There is a UHB wide IT issue that staff cannot access e-learning modules online. Sue Bailey will discuss with Ceri-Ann Hughes.

Action: Sue Bailey

CDTQSE 17/176 Health and Safety Issues

New manual handling equipment is due to come into the UHB during the first 2 weeks of June. Departments are expected to decontaminate equipment before it is exchanged.

Changes to E-Datix forms are imminent. Patient details will now be required if a patient is involved or a reason will need to be provided as to why patient details are not being included.

CDTQSE 17/177 Regulatory Compliance and Accreditation

It was reported that Blood Transfusion and Haematology, subject to a number of actions to be closed off, have achieved accreditation.

CDTQSE 17/178 Policies and Procedures

The following policies are out to consultation:

Lost Hearing Aid Policy
Management of Foetal Remains Policy
Policy of Research and Sponsorship
Lone Worker Policy

EFFECTIVE CARE

CDTQSE 17/179 Clinical Audit

Nothing to report.

CDTQSE 17/180 Research and Development

Following a presentation at the last meeting of the Clinical Board proposal paper relating to R&D allocations, Option 2 has now been approved by the Clinical Board.

CDTQSE 17/181 Service Improvement Initiatives

Nothing to report.

CDTQSE 17/182 NICE Guidance

The proforma and process for NICE guidance was **RECEIVED.** Whilst the process is clear the issue was raised of how the Clinical Board can be made aware of guidance circulated within directorates of the Clinical Board.

CDTQSE 17/183 Information Governance

Sion O'Keefe reported that the ICO completed its audit last week. Findings have not yet been shared across the Health Board however 70 recommendations have been made.

An internal audit on information governance has been undertaken in Cellular Pathology and Health Records. The report is currently in draft and substantial assurance has been provided. An area of low assurance applied to lack of IAO training.

Discussions are being held around corporate risk clarification from information asset registers.

CDTQSE 17/184 Data Quality

The UHB Data Quality Group was held last week. Issues were raised around duplicate records and overlayers as an information governance risk.

DIGNIFIED CARE

CDTQSE 17/185 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 17/186 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

TIMELY CARE

CDTQSE 17/187 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 17/188 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

The excellent work undertaken in directorates to achieve the end of year performance targets has been acknowledged by the Clinical Board. The UHB also held a Thank You Event for directorates across the UHB.

INDIVIDUAL CARE

CDTQSE 17/189 National User Experience Framework

The report for April 2017 reported a 35% response rate. 87% of visitors rated their experience as 8 out of 10 or above.

A patient experience kiosk is being piloted in Outpatients. The initial aim is to identify the frequency that this is being used.

STAFF AND RESOURCES

CDTQSE 17/190 Staff Awards and Recognition

Sue Bailey acknowledged members of the Dietetics team who were awarded a Five Star Award from the Wales Council for Deaf People and Wales Council of the Blind for the support they provided to a patient with sensory loss. Patients across Wales nominated health professionals who had provided exceptional service to patients with sensory loss.

CDTQSE 17/191 Monitoring of Mandatory Training and PADRs

No data is currently available for compliance against mandatory training however the Clinical Board is reporting:

A sickness rate of 2.6%

71% compliance against PADRs

87.3% compliance against medical appraisals.

The Workforce and OD function is currently analysing data from the staff survey. Ceri-Ann Hughes will use this information to update the Clinical Board engagement plan and look at producing directorate level engagement plans.

CDTQSE 17/192 New Employee Assistance Programme

From 1st May a new Employee Assistance Programme is available for all staff provided by Care First. This will involve a free telephone service and also online services.

There is a lifestyle website including articles on health, issues at home, issues at

work, management support tools, stress questionnaires and online counselling in real-time.

There is also a zest website which is an online personal and interactive wellbeing portal which helps identify which areas of an individual's wellbeing may need some focus, and provides all the tools, information and support needed to make positive changes.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

No items were received.

ANY OTHER BUSINESS

Lisa Griffiths reported that there are 14 outstanding SABRE incidents. There is a new SABRE incident relating to an incident on a ward involving a mix up of sets of bloods. Patients are being followed up to get them re-bled.

A transgender awareness session was held on Friday. Excellent feedback was received. Learning will be taken from the session and put into practice in Outpatients.

DATE AND TIME OF NEXT MEETING

7th June 2017 at 2pm in Room 4.2. 4th Floor, Ty Dewi Sant UHW

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

MINUTES OF THE MEETING HELD ON 7TH JUNE 2017

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Mike Bourne	Clinical Board Director
Scott Gable	Head of Service, Cellular Pathology
Ian McMullin	Business Manager, Therapies
Rachael Daniel	Health and Safety Adviser
Sarah Jones	Pharmacy Quality and Safety Lead
Rebecca Pettit	Medical Physics Quality and Safety Lead
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Suzie Cheesman	Patient Safety Facilitator
Maria Jones	Senior Nurse, Outpatients
Bolette Jones	Acting Head of Media Resources
Ceri-Ann Hughes	Head of Workforce and OD

Apologies:

David Lewis	Head of Finance
Matthew Temby	Clinical Board Director of Operations
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Lisa Griffiths	Quality Manager, Laboratory Medicine
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Stuart Egan	Independent Member Trade Union

Secretariat:

Helen Jenkins	Clinical Board Secretary

30.1

PRELMINARIES

CDTQSE 17/193 Welcome and Introductions

Sue Bailey welcomed everyone to the meeting.

CDTQSE 17/194 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 17/195 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 10th May 2017 were **APPROVED.**

CDTQSE 17/196 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 17/080 Medical Examiner Role

Scott Gable advised that the pilot site is still running and has noted an increase in coroner's cases.

CDTQSE 17/118 Terms of Reference

Alun Morgan has been advised that it is for Clinical Boards to determine the numbers required to be in attendance for the Sub-Committee to be quorate. Sue Bailey will therefore consider appropriate representation.

Action: Sue Bailey

CDTQSE 17/175 Records Compliance with Blood Regulations

Traceability records need to be retained but Sue Bailey will need to check if incident forms are required to be retained. If this is the case, the intention is to retain data for 30 years as long as Datix database still exists in 30 years. Mike Bourne suggested that the issue is raised with the Caldicott Guardian at the Medical Records Management Group.

Action: Sue Bailey

CDTQSE 17/175 E-learning

Sue Bailey has written a guide to access the e-learning modules. Volunteers to test to the guide will provide feedback to Sue Bailey.

30.1

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 17/197 Patient Story

A serious incident was reported following receipt of a concern from a gentleman on behalf of his wife relating to the management of her chest x-ray findings. The patient presented to the Emergency department at the UHW on 26th August 2016 after calling an ambulance for symptoms of central and lower abdominal pain. A chest x-ray was requested and was noted to show a circular mass in the right lung. The patient was referred to the on-call surgical team with a suspected diagnosis of gallstones and urinary tract infection, however the patient discharged herself against medical advice prior to review by the surgical team due to the waiting time to be seen.

On 5th September the chest and abdominal x-rays were formally reported and validated and 6th September a paper copy of the x-ray report was filed in the Emergency Unit records.

A CT scan was subsequently requested from a surgical outpatient clinical appointment on 4th November 2016 due to the patient's abdominal symptoms and the chest x-ray report from August was noted to have been reported as abnormal.

On 24th November the CT scan was performed. On 2nd December 2016 the CT was reported and validated and it was concluded that a lung cancer should be considered.

On 6th December the GP sent an urgent suspected cancer priority referral form to the Respiratory Department following review of the CT report. On 13th December the patient was reviewed in a rapid access chest clinic and a CT guided biopsy was requested. This was performed on 14th December.

On 22nd December, the patient was discussed at the lung cancer multi-disciplinary team meeting. Provisional biopsy results reported as a poorly differentiated non-small cell carcinoma. And a referral was made to the Oncology team the following day. The full biopsy results were reported on 28th December and the patient was reviewed in the Oncology Outpatient Clinic the following day. The patient later passed away on 11th February 2017.

In terms of lessons learned, there is a need to ensure that additional processes and safeguards are put n place to ensure that unexpected radiological findings are highlighted to referring clinicians/departments and cancer MDTs where relevant to facilitate the timely assessment and management of patients.

It is also important to ensure that potentially abnormal investigations are communicated to patients at the point that they are identified. Discharge advice letters available to primary care should also be completed with all relevant clinical information, highlight any potentially abnormal investigations that require follow up, even in cases where a patient may discharge against advice.

Since this incident, the Emergency Department Consultants now annotate all radiology reports once reviewed with any action taken.

2 patient stories will be presented next month relating to a patient fall and a story from Podiatry.

CDTQSE 17/198 Feedback from UHB QSE Committee

The minutes of the UHB QSE Meeting held on 18th April are not yet available.

CDTQSE 17/199 Health and Care Standards

No update to report.

CDTQSE 17/200 Risk Register

An update has been made to the Clinical Board risk register relating to the entry around Neuro- interventional Radiology whereby 2 consultants have left the UHB. The risk rating score has been increased.

An Extraordinary meeting is being held in July to review risk registers.

CDTQSE 17/201 Exception Reports

Nothing to report.

CDTQSE 17/202 Clinical Board QSE Scorecard

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/203 Initiatives to promote Health and Wellbeing

There are no initiatives to report this month.

CDTQSE 17/204 Falls Prevention

Nothing to report.

SAFE CARE

CDTQSE 17/205 Concerns and Compliments Report

The Clinical Board received 5 formal concerns and 3 compliments in May. 1 AM concern was received relating to Podiatry. The key theme of formal concerns relates to concerns with medical treatment.

From April 2017 the Clinical Board is reporting a greater number of concerns than compliments. Directorates were reminded to submit copies of their compliments to the Clinical Board Secretary for logging.

Action: Directorates

CDTQSE 17/206 Ombudsman Reports

Nothing to report.

CDTQSE 17/207 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/208 Patient Safety Incidents

The Serious Incident report was **RECEIVED.**

The Clinical Board is currently reporting 1 open SI relating to the lupus incident. A meeting is scheduled with the Nurse Director in July to bring this incident to closure.

CDTQSE 17/209 New SI's

There are no new SIs to report.

CDTQSE 17/210 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/211 WG Closure Forms – Sign Off

Incident Number In38935 relating to an unnecessary CT examination has been submitted to Welsh Government.

CDTQSE 17/212 Regulation 28 Reports

An incident involving an ultrasound scan in EU was presented as a patient story last month. The Coroner has issued a Regulation 28 Report and the UHB has responded to the recommendations.

CDTQSE 17/213 Patient Safety Alerts

No new patient safety alerts have been received.

CDTQSE 17/214 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 17/215 IP&C Issues

Other Clinical Boards are conducting hand washing and bare below the elbow audits on wards and have reported that a number of staff within this Clinical Board working on the wards have not shown compliance. Directorates were requested to reinforce to their staff working on the wards that bare below and hand washing also applies to them.

Action: Directorates

CDTQSE 17/216 Key Patient Safety Risks

Safeguarding

Nothing to report.

Mental Capacity Issues

The Clinical Board attended the Mental Health and Capacity Legislation Committee and was asked to produce a report. The report to the Committee was **RECEIVED.**

Mental Capacity Act training is now a mandatory training module to be undertaken every 3 years.

A baseline assessment of MCA compliance was undertaken by the Clinical Board in August 2016 and an SBAR document has been produced. A repeat audit is planned for August 2017.

Capacity is only captured on Datix incidents related to violence and aggression incidents by patients towards staff. A report was generated from Datix for 1st April 2016 to 1st March 2017. Within this period there were 49 incidents identified, 5 of which involved patients who were deemed to lack capacity. 3 involved Phlebotomy and 2 in Occupational Therapy. 4 were in Mental Health inpatient areas and 1 on a ward at UHW.

There is a concern that professionals appear to be of the understanding that if a person who is deemed to lack capacity consents to treatment, that this consent is valid. There is also concern that professionals perceive that as a patient is not objecting but is compliant with a decision, that the patient has capacity. This Clinical Board provides support services that receive referrals from other clinicians. The time spent with the patient can be very short. There is an assumption that assessment has been undertaken at the time of referral that the patient has capacity to consent to the intervention. If the patient lacks capacity this should clearly be identified on the referral form. The Clinical Board will need to review ongoing issues of DNAR status where patients lack capacity.

It was noted that the Clinical Board will need to report its compliance with training to the Committee in September.

30.1

CDTQSE 17/217 Health and Safety Issues

There were no issues to escalate from Clinical Board Health and Safety Group held earlier this week.

CDTQSE 17/218 Regulatory Compliance and Accreditation

Nothing to report.

CDTQSE 17/219 Policies and Procedures

There are 4 policies currently out to consultation:

Incident Reporting Policy
Sharps Management Policy
First Aid at Work Policy
Venepuncture Non Clinically Qualified Research Staff Policy

EFFECTIVE CARE

CDTQSE 17/220 Clinical Audit

Nothing to report.

CDTQSE 17/221 Research and Development

The Clinical Board R&D Group minutes were **RECEIVED.**

CDTQSE 17/222 Service Improvement Initiatives

Nothing to report.

CDTQSE 17/223 NICE Guidance

Nothing to report.

CDTQSE 17/224 Information Governance

Nothing to report.

CDTQSE 17/225 Data Quality

Nothing to report.

DIGNIFIED CARE

CDTQSE 17/226 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

The CHC will visit the STAR Leisure Centre 17th July 2017. Therapies staff are moving into the premises next week. Longcross House will then be vacated.

30.1

CDTQSE 17/227 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

Nothing to report.

TIMELY CARE

CDTQSE 17/228 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 17/229 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

There are 590 incidents in progress, 333 are more than 60 days old and 240 of these sit within Laboratory Medicine. Of the 590 incidents, 137 are for other Clinical Boards to manage. 48 of these are over 2 months old. Positive action is being planned in relation to long standing incidents to enable them to be closed.

INDIVIDUAL CARE

CDTQSE 17/230 National User Experience Framework

The return rate for May was 31%. A number of surveys are not being submitted in a timely manner to be counted. It was noted that overall patient responses received provided very good feedback. Car parking is still being raised as an issue.

STAFF AND RESOURCES

CDTQSE 17/231 Staff Awards and Recognition

Nothing to report.

CDTQSE 17/232 Monitoring of Mandatory Training and PADRs

The Clinical Board is reporting a sickness rate of 2.8% against a target of 3.5%.

The Clinical Board is reporting an increase in short term sickness cases and as a result will be revisiting the hotspot areas. Work related stress as a reason for sick leave is increasing. The Workforce and OD function need to understand what the underlying issues are and requested that any directorates with staff on long term sick leave due to work related stress issues to notify the Head of Workforce and OD.

30.1

Action: Directorates

In terms of PADRs/Statutory training, there is no information available yet on compliance rates.

It was noted that the Workforce and OD function are actively involved with flu planning for next winter and a first strategy meeting was held today.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

Minutes from the following Groups were **RECEIVED:**

Clinical Board R&D Group Minutes 19th May 2017
Clinical Board IP&C Group Minutes 15th May 2017

ANY OTHER BUSINESS

Work is being held in the UHB looking at local safety standards in relation to invasive procedures. The Clinical Board has been asked to complete a template in readiness.

It was noted that requests have been received for drinking water to be provided at CRI and Maria Jones is trying to progress this.

DATE AND TIME OF NEXT MEETING

12th July 2017 at 2pm in Room 4.2. 4th Floor, Ty Dewi Sant UHW

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

MINUTES OF THE MEETING HELD ON 12TH JULY 2017

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Matthew Temby	Clinical Board Director of Operations
Mike Bourne	Clinical Board Director
Stuart Egan	Independent Member
Sarah Jones	Pharmacy Quality and Safety Lead
Lisa Griffiths	Quality Manager, Laboratory Medicine
Robert Bracchi	Consultant, Toxicology and Therapeutics Directorate
Rebecca Vaughan-Roberts	Quality and Safety Lead, Radiology Department
Maria Jones	Senior Nurse, Outpatients
Bolette Jones	Acting Head of Media Resources
Sue Dayananda	Head of Podiatry
Kevin Hogan	Safeguarding Trainer

Apologies:

David Lewis	Head of Finance
Rachael Daniel	Health and Safety Adviser
Alun Morgan	Professional Lead for Quality, Safety and Experience/ Assistant Director of Therapies and Health Sciences
Ceri-Ann Hughes	Head of Workforce and OD
Rhodri John	Assistant Head of Workforce and OD
Rebecca Pettit	Medical Physics Quality and Safety Lead
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Scott Gable	Head of Service, Cellular Pathology
Ian McMullin	Business Manager, Therapies
Suzie Cheesman	Patient Safety Facilitator

Secretariat:

Helen Jenkins	Clinical Board Secretary

30.1

PRELMINARIES

CDTQSE 17/233 Welcome and Introductions

Sue Bailey welcomed Kevin Hogan, Safeguarding Team link for this Clinical Board to the meeting and introductions were made.

CDTQSE 17/234 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 17/235 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 7th June 2017 were **APPROVED.**

CDTQSE 17/236 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 17/118 Terms of Reference

It has been **AGREED** as per the previous terms of reference that 7 members are required to be in attendance for this Group to be quorate. The terms of reference document will be presented to the next Clinical Board Meeting for ratification.

Action: Sue Bailey

CDTQSE 17/160 Record Keeping Compliance with Blood Regulations

It has been confirmed that incident forms will be retained on E-Datix for the required duration to meet record keeping compliance with Blood Regulations.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 17/237 Patient Story

Vanessa Goulding, Highly Specialist Podiatrist presented the diabetic foot assessment service improvement project she has undertaken.

Healthcare acquired pressure ulcers remain a problem despite strategies such as skin bundles, waterlow score, body mapping etc. Grade 3 and 4 healthcare acquired pressure ulcers are reportable to Welsh Government.

In accordance with NICE Guidance, all patients with diabetes on admission to hospital should have a foot assessment within 24 hours and those with a moderate or high risk of developing a diabetic foot problem should be given a pressure redistribution device to offload heel pressure.

Since 2011 the UHB has participated in the National Diabetes Inpatient audit data. In 2016 16.1% of patients in UHL and 10.4% of patients in UHW received a foot assessment.

There have been poor outcomes for patients resulting in below knee amputations. A case study was presented of a 61 year old patient, with type 2 diabetes, registered blind, renal failure/dialysis, peripheral neuropathy, use of wheelchair, history of toe amputation. The patient was admitted to UHW for insertion of line for

dialysis treatment. Waterlow score equalled 18 which should have been 29 and was identified as not on correct mattress. The patient developed problem with heel which was identified by the Community Podiatry Team late as the patient had cancelled several appointments post discharge from hospital. The patient lives in assisted living accommodation and receives 4 care calls daily. There was deterioration of the heel pressure ulcer and the patient became unwell and in low mood. The outcome resulted in a below knee amputation.

In discussions with nurses on wards, it was noted that they are unsure how to assess a foot and unclear if this is part of their role. It is the role of nurses to assess feet and links directly with the waterlow assessment that is completed within 6 hours of admission. A foot assessment involves an assessment of circulation – pulse palpation and assessment of sensation i.e. a touch the toes test.

There are several diabetic foot assessment projects across the UK all showing mixed results and Vanessa Goulding therefore decided to undertake a service improvement project using action research methodology and evidenced based behavioural change. The project covered 2 wards (2 sites) Ward 1 FOPAL and Frame and Ward 2 Diabetes. The service improvement project ran for 18 weeks duration. The project included:

- educational intervention – ward based presentation, practical demonstrations, e-learning, pocket card guide and 1:1 support.
- An audit process based on NaDIA audit at week 0, 4, 12 and 16 weeks.
- Use of the foot protection tool
- Regular visits to the wards, written reminders and newsletters to encourage completion of assessment.

The results identified that more assessments were completed on Ward 2. This was due in part to a full team response and involvement of a medical team. The results were presented to the Clinical Standards and Innovation Group (CSIG) meeting in November 2016 and the foot protection tool was revised.

30.1

A further PDSA cycle was repeated at East 2 and A4. A recent audit reported that 70% of patients received a foot assessment and 70% of those patients were identified as high risk. The project was rolled out to West 4 and B2. Questionnaires were sent out to ward staff. All qualified staff who responded stated that the foot assessment is important and part of their job. Staff identified time and lack of training as a barrier to completion of the foot assessment. Staff felt that the tool was easy to use and would be used if available in the assessment booklet.

Discussions were held around the possibility of the inclusion of the foot assessment tool within the integrated assessment proforma documentation and this is awaiting review by the Nursing and Midwifery Board.

Challenges highlighted from the project:

- 20 new referrals to Podiatry from UHW/UHL were received for patients with heel pressure damage. 50% of these had either PAD or neuropathy highlighting the need for correct assessment.

- There is an issue around time for nursing staff to complete the foot assessment tool. Foot assessments need to be undertaken within 24 hours of admission.

- Inclusion of the foot assessment tool within the assessment documentation rather than being used as a stand-alone document.

- Ensuring nurses link the foot assessment with waterlow risk assessment.

- Embedding into practice and sustaining the improvements.

- Rolling out to other areas requires adoption from other Clinical Boards.

- Ensuring an increase in completed foot assessments correlates with reducing in hospital acquired foot lesions.

Recommendations:

- Introduction of the foot assessment tool in the integrated assessment proforma.

- Roll out to other areas and resources to support roll out. Evidence has demonstrated that the foot assessment tool results in an increase in referrals to Podiatry and need to ensure appropriateness of referrals.

- Continued staff training to highlight the importance of the foot assessment. This is currently provided within UHB study days.

Maria Jones attends CSIG and will enquire when this proposal will be submitted to the Nursing and Midwifery Board.

Action: Maria Jones

CDTQSE 17/238 Feedback from UHB QSE Committee

30.1

Sue Bailey referred to the item around the Healthy Restaurant and Retail Policy, noting that whilst the policy is welcomed she acknowledged and shared the concerns raised at the cost of food at the restaurant. A suggestion was made whether the costs of healthy meal options could be reduced compared to the less healthy menu options.

It was noted that the new UHB coffee shop outside the Radiology department is proving very popular with patients and staff.

CDTQSE 17/239 Health and Care Standards

There is no update since the standards were submitted.

CDTQSE 17/240 Risk Register

It was noted that the Risk Register Review Workshop for the Clinical Board is being held on 27th July.

CDTQSE 17/241 Exception Reports

The new Chief Executive visited Radiology last week and concern was raised around the length of time taken from scanning to reporting. It was identified that 90% of reports are actioned within 10 days. The Clinical Board has been asked to provide a report to Management Executive at the end of the month on the real position on the backlog for reporting, over and above the agreed reporting time. This will lead to an improvement trajectory being put in place. It was highlighted that technology systems will be a constraint in managing this.

Matt Temby was able to provide assurance around the process for inpatients and known cancer pathway patients.

CDTQSE 17/242 Clinical Board QSE Scorecard

Nothing to report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 17/243 Initiatives to promote Health and Wellbeing

A Clinical Board Meeting was held around a strategy for the flu campaign for the coming winter. The Clinical Board will be looking for more of its staff to provide the vaccination this year. The UHB has not yet been officially advised of the target for this year but it is anticipated that it will be 75% of frontline staff to receive the flu vaccination.

Thought needs to be given of how to capture staff who decline to receive the vaccination and to record the staff who have received the vaccination elsewhere.

It was also noted that there is an identify issue, particularly where staff are working in clinical areas, not understanding that they work within the Clinical Diagnostics and Therapeutics Clinical Board. Matt Temby will request that the Clinical Board Workforce and OD team consider how this issue can be taken forward.

Action: Ceri-Ann Hughes/ Rhodri John

CDTQSE 17/244 Falls Prevention

No update to report.

SAFE CARE

CDTQSE 17/245 Concerns and Compliments Report

In June 2017, the Clinical Board reported 5 formal concerns, 3 in Radiology and 2 in Physiotherapy.

18 formal concerns have been received since 1st April 2017.

For June 2017, there were 4 breaches against response times and a total of 6 breaches in response times since 1st April 2017.

1 AM concern was received in June with a concern relating to Physiotherapy and this has been responded to. The Clinical Board has received 2 AM concerns since 1st April.

11 compliments were received in June and 19 compliments have been received since 1st April.

The key theme for formal concerns relates to concerns with clinical diagnosis and treatment. This is a change in trend from last year where communication between staff and patients was highlighted as the key theme.

Mike Bourne was concerned with the level of breaches in response times and asked for the reasons for the breaches. The reasons relate to complex cases where the Clinical Board has asked for the complainant to be sent a holding letter to allow more time to investigate. There are incidences of concern letters arriving late in the Clinical Board and cases where part of a concern relates to other Clinical Boards and these comments are outstanding.

Mike Bourne requested that Sue Bailey provides a breakdown of the breaches and a report on the reasons for the breaches for the next Executive Performance Review.

Action: Sue Bailey

It was reported that members of the Radiology team received a lovely compliment letter from an 11 year old patient and it was remarkable that the patient remembered the staff by name. Matt Temby would like the compliment to be shared in the next edition of the Clinical Board newsletter and asked Rebecca Vaughan-Roberts to seek permission from the parents.

Action: Rebecca Vaughan-Roberts

30.1

CDTQSE 17/246 Ombudsman Reports

The Ombudsman was very critical of case 13055 which involved a patient some years ago who was referred as urgent for a scan which was downgraded to routine. An update has been submitted to the Ombudsman which also noted the progress that has been made since that time to reduce Radiology waiting times. The Ombudsman responded that sufficient steps have now been taken and closed the incident.

Case no 15433 involved a discrepancy of a wrongly reported image in Radiology. The UHB have accepted the recommendation to undertake a review of the imaging, which is underway.

Case no 14087 involved a deceased patient who sustained an injury in the mortuary. The department referred to the injury as ‘small’ which the family disagreed with and felt that it did not reflect the extent of the injury. The

department accepted the recommendations of the Ombudsman to clarify the extent of the injury to the family and apologise for any confusion or distress.

CDTQSE 17/247 RCA/Improvement plans for Serious Complaints

Nothing to report.

CDTQSE 17/248 Patient Safety Incidents

Serious Incident Report

The Clinical Board is reporting 1 outstanding SI, the LUPUS incident.

A meeting to close this incident down was cancelled. It was reported that Cardiff patients have all been reviewed and closed. The UHB is awaiting information from Cwm Taf Health Board.

It was reported that IRMER Incidents are no longer reported to Welsh Government. A new IRMER incident has been reported relating to a patient who received an unnecessary scan when it was perceived that a pacemaker had been fitted.

CDTQSE 17/249 Management of Datix Incidents Report

Sue Bailey presented a report which proposes for the Clinical Board to take proactive action to close incidents which occurred in other Clinical Boards that were reported by Laboratory Medicine directorate and actions are still outstanding.

These incidents are being reported against this Clinical Board and a meeting is being arranged with the Datix Team to discuss how the KPI is reported.

CDTQSE 17/250 Datix Newsletter

The Datix Newsletter has been circulated across the Clinical Board. The newsletter highlights changes to DIF forms to make the flow of the forms more logical.

30.1

CDTQSE 17/251 New SI's

There are no new SI's to report.

CDTQSE 17/252 RCA/Improvement Plans

Nothing to report.

CDTQSE 17/253 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 17/254 Regulation 28 Reports

Nothing to report.

CDTQSE 17/255 Patient Safety Alerts

MDA 2017/015 Solus Flexible Wire Reinforced Laryngeal Mask Airway

The alert was **RECEIVED.** There are no actions required from this Clinical Board.

MDA 2017/017 BVM (Bag Valve Mask) Manual Resuscitation Systems

The alert was **RECEIVED.** There are no actions required from this Clinical Board.

WHC 2017 026 Prescribing of Co-Proxamol

The alert was **RECEIVED.** There are no actions required from this Clinical Board.

CDTQSE 17/256 Addressing Compliance Issues with Historical Alerts

There are two historical alerts where there have been issues around compliance:

- The alert relating to Radiology imaging and notification of critical urgent and unsuspected findings. The Radiology department have now proposed a scheme to provide limited assurance.

- National Safety Standards for Invasive Procedures (NATSSIPS) - the set of standards to standardise safe care for interventional procedures affects the Radiology team and the Clinical Board is establishing any other service areas where this may have implications. There has been debate around whether cannulation is included and it has been agreed that it should not be included.

CDTQSE 17/257 IP&C Issues

An issue has arisen whereby an image intensifier from Radiology for trauma theatre was used for a highly infectious patient and the theatre was decontaminated with a vaporised cleaning agent. This is against the manufacturer's instructions. There will be costs attached to an engineer attending and servicing the unit and the unit will be out of action for several days. Manufacturers are unwilling to send out engineers until they have received advice that there is nothing infectious in the vents of the unit.

The image intensifiers should only be cleaned with Clinell wipes and the Radiology department is working with the IPC team to look at covering the units with sterile plastic during theatre cases if necessary.

An Aseptic Non Touch Technique (ANTT) meeting was held with the Phlebotomy team to undertake an initial assessment against compliance. It was identified that if the Phlebotomy team comply with ANNTT this will add 3 minutes to each patient contact, the equivalent of 9 wtes. Work is now underway to consider current practice in terms of safety and a decision will need to be taken as to whether it is viable to implement ANTT.

Matt Temby advised that a request was issued at Big Room today of whether there are any elements of good practice around IP&C that could be demonstrated in Big Room.

All directorates are requested to look at their data and identify whether there are opportunities to share good practice around IPC.

Action: Directorates

CDTQSE 17/258 Key Patient Safety Risks

Safeguarding

Kevin Hogan was in attendance as safeguarding Team link for this Clinical Board. His role is to offer advice, training, support and supervision to staff for safeguarding issues relating to both adults and children.

In terms of the safeguarding training programme available, level 1 is the mandatory training available via ESR. Level 2 is generic training for patient facing staff and it was noted that attendance on this programme has significantly increased. There is also Level 3 face to face training available including Human Trafficking, Female Genital Mutilation Training and training around the legal aspects of safeguarding. It was noted that support is provided to staff from the team around legal aspects of safeguarding.

The Safeguarding Team use the PARIS system on a regular basis and are tasked to raise awareness for managers to ensure that PARIS is checked on a regular basis for notifications and alerts in relation to safeguarding of patients.

He noted that the he multi-agency safeguarding hub was launched in Cardiff for both adults and children in the Cardiff area. The Vale is not currently included in this.

In terms of referrals, the quality of forms varies and managers are asked to ensure that referrals are completed robustly. It was requested that safeguarding referrals are emailed to the safeguarding team generic email address.

Maria Jones enquired whether Safeguarding level 2 training is applicable to administrative staff within Health Records. Kevin Hogan advised that level 1 should be sufficient. Level 2 could be applicable to reception staff.

Mental Capacity Issues

Nothing to report.

CDTQSE 17/259 Health and Safety Issues

Nothing to report.

CDTQSE 17/260 Regulatory Compliance and Accreditation

It was reported that the MHRA are re-visiting SMPU on 17th and 18th August.

The HTA are visiting 9th and 10th August.

CDTQSE 17/261 Policies and Procedures

Cardiff and Vale UHB Recommendations for Lung Nodule Follow Up

The Recommendations were **RECEIVED.** It is anticipated that the frequency for CT for Nodules will increase. Mike Bourne stated that the recommendations will need to be distributed throughout the UHB.

Action: Sue Bailey

The recommendations should also be presented to the LMC and Mike Bourne agreed to do this. Sue Bailey will ask Sue Morgan how this can be placed as an agenda item.

Action: Mike Bourne/Sue Bailey

EFFECTIVE CARE

CDTQSE 17/262 Clinical Audit

Nothing to report.

CDTQSE 17/263 Research and Development

Nothing to report.

30.1

CDTQSE 17/264 Service Improvement Initiatives

The Clinical Board 60 Day Improvement Group commenced as of 20th June. There have been two meetings held with subsequent meetings to be held fortnightly. There are currently 5 improvement projects of work covering improving patient flow through excellent hydration, nutrition and resultantly optimal mobility. Timeliness and appropriateness of diagnostics in clinical pathways and reducing DNA through improving patient bookings and communications.

The Clinical Board is using the CSI 60 day cycle approach methodology promoted by the UHB and are linking in closely to cross cutting initiatives where possible, primarily Turning the Curve. Over time there are plans to build the number of workstreams and use the Clinical Board Operational Delivery Group as a knowledge sharing forum.

CDTQSE 17/265 NICE Guidance

NG69 – Eating Disorders: Recognition and Treatment

The notification of the latest guidance was **RECEIVED** and **NOTED.**

CDTQSE 17/266 Information Governance

WHC 2017/025 Cyber Security – Third Party Guidance

The WHC was **RECEIVED**. Services need to be aware of the document and consider how to respond it. The Clinical Board has discussed with the Corporate Information Governance Team and a more coordinated assessment will be required. The principal advice is that it needs to be ensured that all third party arrangements are linked accordingly to departmental Information Asset Registers with an assessment as to which level of cyber security control each would fit. It is then intended to assess these at a Clinical Board or Corporate level to determine an order for a more detailed review process of third party agreements.

CDTQSE 17/267 Data Quality

The next Data Quality Group is being held tomorrow. A risk register has recently been shared. Of particular issue is the importance of good record keeping, particularly medical records.

As part of the Subject Access Request process, patients or 3rd parties acting on their behalf are entitled to request all personal data and as such services need to be mindful of how information is stored and retrieved. This can also include information where the data subject is named i.e. emails, concerns information incident reporting etc.

It is also vital that clinical documentation always has correct and full demographic details provided in order to identify the individual and that full care and attention is made to ensure only information relevant to that patient is retained within their casenotes. The Legal Services Department are identifying that records will have information relating to another patient within them. Incident forms will be raised for each occurrence.

30.1

DIGNIFIED CARE

CDTQSE 17/268 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

A CHC Visit to Physiotherapy STAR Leisure Centre will take place on 17th July 2017.

A CHC visit to Outpatients will be held at the CRI on 1st August.

A CHC Visit to Outpatients at St Davids will be held 7th August. Concern has been raised that St Davids is not managed by this Clinical Board and it is therefore inappropriate for the Outpatient Department to provide the briefing to the CHC. Matt Temby has raised the issue with PCIC Clinical Board and is awaiting a response.

CDTQSE 17/269 Initiatives to Improve Services for People with:

Dementia/Sensory Loss

The second trial of patient pagers has commenced, this time using the current bleep system, which is intended to ease the process for staff and patients. Feedback so far supports this as a better approach.

The main demographic screen on the PMS system is being reviewed to ensure it can be updated to include information on sensory impairment and dementia. The intention is also to link to communication preference and where feasible appropriately flag patients' sensory loss status in relevant PMS screens in order to act as a prompt for staff when dealing with patients.

TIMELY CARE

CDTQSE 17/270 Initiatives to Improve Access to Services

Directory of Services

A letter has been received from Welsh Government providing notification that there is an intention to have 1single health related directory of services and work is taking place at a national level to support this.

CDTQSE 17/271 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

Quarter 1 is showing very good performance levels. Radiology has maintained levels as per end of the last financial year and Therapies has reduced this. There will be challenges to continue this particularly in Physiotherapy and Radiology, given the impact of the MRI vans. A management plan has been produced and shared with the Executive Directors.

INDIVIDUAL CARE

CDTQSE 17/272 National User Experience Framework

The Clinical Board is reporting a 53% return rate.

Comments were made around parking at CRI and non patients taking advantage of the parking.

References were made to the period of hot weather and the need for access to water. Maria Jones to explore plumbed water options that could fit in the small space available in the outpatients department at CRI and will look at costs. She will feedback to the Group.

Action: Maria Jones

A Paediatric Radiology patient satisfaction survey was undertaken and reported excellent patient experience outcomes which have been shared with the UHB Board.

STAFF AND RESOURCES

CDTQSE 17/273 Staff Awards and Recognition

Sion O'Keefe was delighted to receive the award for Equality/ Welsh Language and thanked Outpatient and Health Record staff who have been instrumental in taking forward the service improvements for patients with protected characteristics.

CDTQSE 17/274 Monitoring of Mandatory Training and PADRs

All directorates should now have received a spreadsheet from LED to validate the PADR information for their staff following the merger and transfer of data from the old ESR system. Spreadsheets need to be validated and returned to LED by Friday.

Matt Temby stated that he expects managers to ensure ESR is kept up to date.

Sarah Jones and Rebecca Pettit tested the guide produced by Sue Bailey for undertaking e-learning modules and following positive feedback she will circulate this to the group.

Action: Sue Bailey

Work is being undertaken by the Clinical Board Workforce and OD team to target hotspot areas for completion of PADRs and develop a project plan.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

30.1

Nothing to report.

ANY OTHER BUSINESS

Rebecca Vaughan-Roberts reported that Radiology is awaiting for assistance from IT to assist the Project Team to support the implementation of the Q-Pulse system.

Lisa Griffiths reported an issue around the management of incidents assigned to NWIS relating to the LIMS system and receiving feedback. Matt Temby suggested writing to NWIS. Sue Bailey and Lisa Griffiths will discuss how to approach this with Clive Morgan.

Action: Sue Bailey/Lisa Griffiths

It was noted that NWIS have requested that Laboratory Medicine log all performance issues with LIMS so they can identify the scale of the issue.

Stuart Egan reported that a workplace inspection has been undertaken for Medical Records UHW. There are problems with the storage of casenotes particularly within the filing libraries that raises concerns around the safety of staff. Matt Temby requested that he discusses this in further detail with Stuart Egan outside of the meeting.

Action: Matt Temby/Stuart Egan

DATE AND TIME OF NEXT MEETING

9th August 2017 at 2pm in Room 4.2. 4th Floor, Ty Dewi Sant UHW

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
14th June 2017
SEMINAR ROOM, LLANDOUGH HOSPITAL

Present: Annie Procter, Clinical Board Director, Mental Health (Chair)
Simon Amphlett, Senior Nurse (representing Jayne Bell)
Owen Baglow, Quality, Safety & Governance Lead
Daniel Crossland, Clinical Lead Occupational Therapist
Mark Doherty, Lead Nurse MHSOP/Neuro
Catherine Evans, Patient Safety Facilitator
Claire Humphries, Nurse Adviser Safeguarding
Mollie Kearns, Graduate Management Trainee
Robert Kidd, Consultant Psychologist
Mick McGeogh, Clinical Audit Co-ordinator
Natalie Wraith, Head of Workforce &Organisational Development
Sadie Williams, Assistant Head of Workforce & Organisational Development

Apologies: Jayne Tottle, Director of Nursing Mental Health
Jayne Bell, Lead Nurse Adult Mental Health
Wendy Davies, MHCB Pharmacist
Carol Evans, Assistant Director of Patient Safety & Quality
Sarah Lloyd, Directorate Manager Adult Mental Health
Faye Mortlock, CNS, Infection Prevention & Control for MH
Sabari Muthukrishnan, Clinical Director MHSOP & Neuro
Suchitra Sabari, Clinical Director Adult Mental Health
Rachael Sykes, Health & Safety Adviser
Ian Wile, Head of Operations & Delivery Mental Health

30.2

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting and stated that the meetings had been changed to a Wednesday (from a Thursday) in order to avoid clashing with HSMB meetings. Chair thanked members for tolerating this change.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on16th February 2017 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

The Committee received the Action Log and noted the actions that had been completed, these would be removed from the Log.

Risk Register

The electronic medication transcribing and discharge system (MTed) does not contain information from PARIS.

No update from Wendy Davies on the action required regarding Electronic Discharge/Prescribing. An update will be requested for the next MHCB Quality & Safety meeting. **Action Wendy Davies**

Hospital at Night Plan

This is on-going and an update will be given at the next meeting. **Action: Annie Procter**

Managing Risk and Promoting Health & Safety

Roll out of suicide risk assessment package across in-patient services and develop further for use in community services. It was noted that Robert Kidd, Consultant Psychologist, had rolled out the package to Adult in-patient services and would liaise with Mark Doherty regarding MHSOP. Dan Crossland has helped to develop the package for community services; Dan is interviewing for a Band 5 Occupational Therapist at Hamadryad Community Mental Health Team. The plan is to transfer cases from the Band 6 Occupational Therapist at Hamadryad to the new Band 5 with a view to a pilot over a 4 month period to look at improving the general assessment pathway. The 3 session suicide-pathway as recommended by NICE is something that we plan to address within this pilot.

MHSOP Community Base

"Unsuitable MSHOP Community base" has been deleted from the risk register as services have now moved to suitable accommodation in Llanfair Unit. Annie Procter wished to record her thanks to MHSOP for soldering on under difficult circumstances whilst waiting for the move.

30.2

Risk Assessment/Risk Management Plan

There has been a LIPS project looking at the link between risk assessment and risk management plans, the work on this project concluded that the design of Form 4 plays a significant part in the failure to link the assessment to the management plan. Therefore, the form needs to be re-evaluated or re-designed.

Simon Amphlett said that this was on-going and an update will be provided for the next meeting.
Action: Jayne Bell/Suchitra Sabari

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

The Chair noted the Minutes of the UHB Quality, Safety and Experience Committee dated 18th April 2017:

Patient Story

Jayne Tottle presented Sally's story to the UHB Quality, Safety and Experience Committee. 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. Sally would not give consent to allow health professionals to share information about her use of ligatures with her mother. Sadly, 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 therefore the information regarding her ligaturing behaviour that emerged at the Inquest came as a complete surprise and understandably upset and angered the family. Reassuringly, the Coroner was of the opinion that health staff had acted appropriately. A lesson learnt from this sad story was to share the Review with the family before Coroner's Court so that there are no surprises.

The UHB Quality, Safety and Experience Committee often discussed suicides but did not usually receive this level of detail. This story highlighted that, however hard staff tried, it was sometimes impossible to prevent a death by self-harm.

Annie Procter remarked that the UHB Quality, Safety and Experience Committee expressed the view that they had benefited from the opportunity to discuss staff experience and balancing risk.

Mental Health Clinical Board Report

- 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 portering or housekeeping, who were working in mental health areas, could access the training provided to mental health staff - this would be reiterated to Facilities Management.

- 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.

  Robert Kidd stated that there was a risk of re-traumatising staff by having debriefing meetings as some may not want to meet and the debrief will not help them and might re-open stressful issues for others. Also the label 'debriefing' might not be the best name for the meeting although an alternative label has been difficult to identify. Rob said the debriefing meeting should be factual not emotional. Annie Procter emphasised that the Clinical Board did not want to ignore incidents as staff might feel unsupported as a consequence. It was agreed to look at the clarity of process for all Directorates – Jayne Tottle will be invited to consider possible modifications or changes to the process. ***Action: Jayne Tottle***

2.2 Health and Care Standards

No report as awaiting feedback on our self assessment.

2.5 Regulatory compliance and external accreditation - No report.

2.6 Risk Register

*Service User Smoking***:** It was noted that a service user no smoking pilot in Hafan y Coed is being planned by the Clinical Board.

Psychological Therapies: Dan Crossland, Clinical Lead Occupational Therapist, requested that waiting lists for Psychological Therapies be added to the risk register. Chair said that she would liaise with Jayne Tottle; this may be on the Directorate risk register.

Action: Annie Procter/Jayne Tottle

Externally influenced risks: Chair said she would discuss including externally influenced risks, e.g. the UEFA Champions League Final, with the Director of Nursing.

Action: Annie Procter/Jayne Tottle

2.7 Directorate QSE Groups

The **Adult Directorate Quality & Safety** Minutes dated 25th May 2017 were noted:

The Court Liaison post is being advertised.

The **MHSOP/Neuropsychiatry Quality & Safety** Minutes dated 8th May 2017 were noted:

HIW Update - East 10 and East 18

Mark confirmed a draft report had been received and is available to read on line; a final report to be published. There were only a few minor negatives including mop and buckets being left out and observation panels left open. A memo has been sent to all wards to rectify these issues.

Ward East 14 Pilot for six months relocating patients efficiently to other wards.

Relocate Iorwerth Jones Wards to UHL, hopefully in October 2017.

Psychology & Counselling Quality & Safety – Minutes dated 7th June 2017 were noted:

There was a long discussion regarding honorary contracts and training.

30.2

Timely Care – discussion on waiting lists. Waiting times for some services that do not clearly fit in Part 1 or Part 2 therefore the Clinical Board is considering this.

In the Therapies Hub there was a two year waiting list for the Emotion Regulation Group. Martin Ford, Directorate Manager, is attending a meeting with the Welsh Government that gives more detail on what data we should be providing about waiting times.

There is an issue with referrals into MHSOP due to gaps in psychology provision in physical health e.g. Cardiac care. This is being monitored.

Service evaluation proposals - Annie Procter suggested the R&D Committee would be ideal for service evaluations.

Safeguarding – Claire Humphries, Nurse Adviser Safeguarding

Head of Safeguarding is Linda Hughes-Jones and Gareth Edgell has just been appointed as Deputy and he is commencing in August 2017.

Claire said that the Safeguarding team is now an integrated team that covers safeguarding for adults and children.

The Safeguarding agenda covers domestic abuse, parental mental health illness and substance misuse, human trafficking and child sexual exploitation, female genital mutilation, Honour based violence and terrorism/PREVENT.

Claire provides Safeguarding supervision for the department of Sexual Health, Sexual Assault Referral Centre (SARC), LAC Nurses, Neuro Development Team CAU and from now on the Peri-Natal Mental Health team.

Cardiff Multi Agency Safeguarding Hub (MASH) commenced July 2016 and is based at Cardiff Bay Police Station and two of the Safeguarding Team are based there 9-5 Monday to Friday. Claire reminded mental health staff that mental health notes are routinely being read at the MASH for information sharing and risk assessment.

The Safeguarding Team attends the Multi Agency Risk Assessment Conference (MARAC) twice a month at Cardiff MARAC and at the Vale MARAC. They also attend the Human Trafficking MARAC once a month.

Claire informed the Committee that information on the Safeguarding team and its members is on the CAVWeb Safeguarding page. It also has information on how to make a referral. All referrals for children and adults are sent to Safeguarding who then e mail them to MASH or Vale SS

Claire extended an invitation to visit the Safeguarding Team and observe their work.

<u>Training</u>

Level 1 Training: All staff working in health care settings - This level is equivalent to basic safeguarding children/child protection training across all partner organisations working with children and young people.

30.2

Level 2 Training: All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers.

Level 3 Training: All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Claire said that her training programme includes Consultants and Psychiatrists.

Claire said that staff should be aware of the safeguarding events box on PARIS. All mental health staff can access safeguarding information saved in the Safeguarding Events Box.

Sarah Richards is the Independent Domestic Violence Advisor (IDVA) based in UHW. Sarah intends to raise her profile in Mental Health Services.

Pharmacy

Fundamentals of Care (FoC) audit is carried out by pharmacy staff every month (audit tabled).

The intention is that the findings of the audit will be fed back to the nurse in charge on the day. There is still an issue with the VTE assessment but there is work going on with the medical staff to address this issue.

Training nursing staff – Wendy Davies is working with Natalie Prosser, Professional Practice Development Nurse, to provide training to nursing staff on both psychopharmacology and other more practical issues such as CD ordering etc.

Paul Howells, Senior Nurse, looked into recent and longstanding issues with mental health services users receiving prescribed mental health medications whilst an in-patient on physical health wards. Issues are mental health medications not being administered, as well as duplicate administration of antipsychotic medication including long acting depots. It has been identified that physical health pharmacists have no access to mental health prescribed medications through any systems including GP records. Wendy Davies will follow this up with Louise Williams to look into solutions. **Action: Wendy Davies**

Annie Procter referred to the "Treat as One" Poster which gives information on medication to mental health patients going into a general hospital.
http://www.ncepod.org.uk/2017report1/downloads/MHPatientLeaflet.pdf

Primary Mental Health Support Service (PMHSS) – No report.

Mental Health Act Report –

Invalid Mental Health Act Detentions - There are no exceptions for this period.

Discussion on patients detained on an informal basis and escorted leave. Patient safety and the vulnerability of nursing staff were paramount. Simon Amphlett will take this to Directorate for consideration.

30.2

Infection, Prevention & Control

No Report.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing

Smoking

Ian Wile, Director of Operations, has arranged a Mental Health Smoking Exemption meeting in July which includes stakeholders. The meeting will consider a no smoking implementation plan in a pilot area in Hafan y Coed and the availability of nicotine replacement and disposable e-cigarettes.

SAFE CARE

4.4 Patient Safety Incidents

Regulation 28

A regulation 28 had been received in Medicine Board regarding risk of falls assessment. In this incident, no clear plan was introduced until after the fourth fall and the 1:1 care was not consistent. The Medicine Board have ensured that all patients identified as at risk have a falls care plan commenced and staff providing 1:1 are not to participate in care that would take them away from their role.

EFFECTIVE CARE

5.1 Monitoring of MHCB Clinical Audit Plan

The MHCB Audit Lead, Dr Martin Andrew has retired.

The directorates are currently looking to support audit at directorate level and are looking at how audit plans can reflect the IMTP and strategy priorities of the MHCB and the wider UHB.

Annie Procter said that she would be happy to be the Lead temporarily. This should be discussed in the Performance meetings. **Action: CDs and Ian Wile**

5.3 Research and Development

Annie Procter reported that Cardiff and Vale UHB had taken part in a successful Research and Development (R&D) Conference on 13 June which celebrated the valuable work of the R&D Directorate. The conference recognised partnership and the opportunity for patients to participate in research.

5.4 Improvement Plan

Annie referred to the “Turning the Curve to Transformation Programme” that aims to deliver improved and cost effective services.

DIGNIFIED CARE

6.1 Internal Inspections

No report.

TIMELY CARE

No report.

INDIVIDUAL CARE

8.1 Carer and Patient Feedback Survey

It was noted that the forms could be modified for individual requirements.

8.2 Compliments

Compliments received for:

Willow Ward – Thank you letter from the mother of a patient.

South Crisis Team - Thank you letter from a patient.

ECT Team - Thank you letter from a patient.

Mental Health Concerns Co-ordinators – Thank you from a patient and his wife.

Forensic Community Team "Best Mentor" was Sharon Henry – positive experience by a student nurse.

Complaints

The Sentinels Group Terms of Reference dated February 2015 was reviewed. No updates.

RCA/Trends

Robert Kidd tabled a "Framework for the Measurement and Monitoring of Safety". This framework could be useful in the patient suicide work.

STAFF AND RESOURCES

9.1 Disciplinary Trends

Sadie Williams, Assistant Head of Workforce and Organisational Development presented the Mental Health Clinical Board Disciplinary Trends:

In Spring 2017 the closed investigations and disciplinary cases with the Mental Health Clinical Board since 2013 were reviewed in order to make improvements.

Of 77 cases:
14 closed at investigation stage
8 progressed via the Fast Track Procedure
55 went to a Full Disciplinary Hearing

30.2

Inappropriate behaviour towards a patient and Medication errors are the two most frequently disciplined examples of misconduct.

The biggest delay in completing disciplinaries was completing the investigation; factors were not receiving responses and time management. Need to reduce the time taken to complete investigations. Recommendations:

- Agreed deadline for investigations at point of commissioning
- Bespoke in-house training
- Admin support when acting as Investigating Officer
- Creation of templates for e mail/letters
- Expand the pool of Investigating Officers, Professional Advisors & Disciplining Officers

Sadie said a package for Investigation officers will be available in the Mental Health HR folder.

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

Policies and Procedures

The Group were asked to receive and ratify the following:

10.0 Procedure for the Prevention, Control & Management of Multi Drug Resistant Organisms (MDRO) including Carbapenemase Resistant Organisms (CRO), Meticillin Resistant Staphylococcus Aureus (MRSA) and Glycopeptide Resistant Enterococci (GRE)

This Procedure describes the infection prevention and control management to be applied when a patient is identified with a Multi Drug Resistant Organism (MDRO) in all UHB locations.

THE PROCEDURE WAS APPROVED

10.1 Drug Testing in Adult Mental Health Settings Operating Procedure

This Procedure is to describe the procedure for the safe administration of drug testing within adult mental health settings. Drug testing can be undertaken by analysis of hair, blood, breath, saliva and urine. These guidelines can be applied and followed for all methods of drug testing. The processes detailed here will specifically focus on urine testing with single use disposable drug testing kits.

THE PROCEDURE WAS APPROVED

10.2 Guideline for Nurses concerning their role in offering advice about medication

This Procedure is to support Nurses in offering advice to GP's or General ward Doctor's regarding medication when a psychiatrist is not available to discuss this with, prior to advice being provided.

This guideline is to ensure that Nurses offering advice to Doctor’s regarding medication when a Psychiatrist is not available is in line with good practice and legislation and adheres to the NMC Standards for Medicines Management and Cardiff and Vale UHB guidance.

30.2

THE GUIDELINE WAS APPROVED

10.3 Staff Accessing a Mental Health Assessment Protocol

This protocol is to provide guidance to Cardiff and Vale UHB staff regarding employees of Cardiff and Vale UHB accessing a mental Health Assessment. The aim is to ensure that any staff requiring a mental health assessment can access this via a GP, the A&E department or Police.

THE PROTOCOL WAS APPROVED

10.4 Adult In-patient Discharge Flowchart

Discharge from Crisis Assessment Ward or on transfer to a Treatment Ward.

THE FLOWCHART WAS APPROVED

10.5 Protocol for Crisis Resolution & Home Treatment Teams and the Interface with Welsh Ambulance Service Trust

This protocol is intended to provide guidance to staff regarding the management of patients who are assessed by the Welsh Ambulance Service as an emergency (999) who have no evidence of physical complications that require attendance at the Emergency Unit (EU), but present with apparent mental health needs.

THE PROTOCOL WAS APPROVED

10.6 Environmental Ligature Point Audit and Assessment Procedure for Inpatient Mental Health Services

This procedure aims to ensure that an appropriate level of operational management of ligature risk is maintained for the safety of inpatients and the prevention of suicide. The procedure provides guidance for identifying potential ligature points and ligature risks and recording the findings.

THE PROCEDURE WAS APPROVED

10.7 Improving In-patient Processes and Discharge Arrangements

This is the Red to Green Bed day visual management system.

THE SYSTEM WAS APPROVED

10.8 Procedure for the Care of Pregnant Women within Cardiff & Vale UHB Substance Misuse Services

To ensure pregnant women with a substance misuse problem are provided with information regarding drug and alcohol misuse and information as to how to reduce risks associated with these substances

Claire Humphries, Nurse Adviser Safeguarding, said she would contact the Author with her comments.

30.2

THE PROCEDURE WAS APPROVED

10.9 Mental Health Assessments when there is a known risk of violence Protocol

The objective of this protocol is to offer a comprehensive guidance of risk management when Adult Mental Health staff are required to assess clients with known risk of violence.

THE PROTOCOL WAS APPROVED

10.10 Mental Health Clinical Board Lone Worker Protocol

To support the Cardiff and Vale UHB Lone Worker Policy and provide managers and staff with instructions on minimum information regarding staff contact details. It will provide clarity on what actions to follow in the event of a staff member going missing.

THE PROTOCOL WAS APPROVED

10.11 Safe Working Procedure for Access to the Hafan Y Coed Gymnasium for Mental Health Service Users within Core Working Hours and Out of Hours

This procedure has been devised to ensure safe access for patients to the gymnasium within Secondary Mental Health Services in Hafan- Y -Coed. The purpose of access to the gym for service users is to enable recovery focused therapy and enhancing health and wellbeing.

THE PROCEDURE WAS APPROVED

DATE OF NEXT MEETING

9th August 2017 at 9.30am in The Seminar Room, Hafan y Coed.

(next Clinical Board Q&S Lessons Learned Meeting is on 13th July 2017 in the Seminar Room)

MINUTES OF A MEETING OF THE PCIC CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 1pm TUESDAY 09th May 2017 IN ROOM 1, CRI

Present :	Dr Gareth Hayes	Clinical Director for Clinical Governance (Chair)
	Brendan Boylan	Clinical Board Director
	Sue Morgan	Director of Operations
	Kay Jeynes	Director of Nursing PCIC
	Maria Dyban	Community Director QS&E
	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
	Carol Preece	Senior Nurse, South and East Cardiff
	Helen Earland	Senior Nurse Primary Care

Preliminaries		Action
	Welcome and Introductions All present introduced themselves and were welcomed by Gareth Hayes.	
	Apologises for absence Lynne Topham, Lance Carver, Ceinwen Frost, K Elcock, N Hughes	
	Declarations of Interest Gareth Hayes asked for any declarations of interest – none noted.	
	Minutes of the previous meeting held 14th March 2016 Date of meeting recorded was incorrect is incorrect and apologies were not noted for S Morgan and M Dyban, following these amendments the committee accepted the minutes as an accurate account.	

30.3

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		**Action**
	Patient Story This item has been bf'd for the July meeting due to C Frosts unexpected leave	
	QSE bring forward action log **<u>PCIC CB Quality and Safety Group Action Log</u>** The Clinical Board Quality and Safety group action log was reviewed. Members noted the content. Actions requiring further work : **316 Learning Disability – Enhanced Service uptake in practices** RB asked if this item could be removed and will be brought back once the national negociations have been confirmed and are available. **Updated Concerns Report (No item ref number registered)** The high level report was shared with the committee and will be avilbale for the future meetings. **Vale of Glamorgan Network Coverage** No update availbale due to the unexpected leave of Vale Locality Lead Nurse **Risk Escalation re: TVN Waiting List** Report to be provided for the July meeting **Use of Digital Cameras** CF advised that staff to be trained have been identified and are awaiting training to be organised. No update availbale due to the unexpected leave of Vale Locality Lead Nurse **Loss of the PCIC Risk Register** C Darling to provide a brief for the next QS&E Committee **STI Information circulated to GP's** K Jeynes to check that this information has been distriuted **Patient safety team to check if Medication error data can include the date of the incident actually taking place** M MCcarthy advised that Datix can provide this information **Influenza outbreak in N&W Locality** A Mogie advised that Immunisation rates within the Residential home were high, therefore the outbreak was not down to poor immunisation rates	

30.3

	PCIC NICE process K Jeynes commented on the agreed process and that it has been shared with the Clinical audit team. K Jeynes to work through timescales for reporting with the R&D CD and Clinical audit dept **Cancer Action plan** K Jeynes advised that the action plan would hopefully be availbale for the July meeting **ANTT Action plan** All Business units to ensure that action plans have been agreed and are available for discussion at the next QS&E committee in July	
	Risk Register **<u>Review Risk Log using 4 Ts</u>** 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. Business case has been agreed by the Exec team. Escalation levels during the week are generally reasonable level of 1 or 2 however on weekends it is generally 3 or4 **QS&E 0000113 Independent Sector** Additional Nurse assessor resource has been agreed and aligned to the apporopriate Locality. Safeguarding issues have reduced slightly reducing the impact on the availbale nurse assessor resource **QS&E 020714 – CHAP** Awaiting the outcome of the tender exercise in June 2017 to agree next steps, senior staff within the service have been made aware and staff Communication will be availbale once a clear plan is in place **QS&E 160714 – Patient Flow** DN teams are increasingly needing to support palliative patients and can normally accomodate but can not always meet demand despite the additional HAH resources so patients may not receive optimum levels of care or the choice to die at home. D2A model in Ty Llandaff has been extended. GP OOH pressures remain as described above. **QS&E 160714 – Equipment/JES** KJ advised no change in risk score. SLA document is progressing and risk register now in place. Internal audit review has provide reasonale assuance for the Clinical board. Repose products being reviewed in terms of access. 2 issues of delays in equipment provision leading to possible pressure damage (S&E Locality) **QS&E 110914 – Complex packages of care** Exec decision on future POC for patient X has been made and communicated to the patinets and his NOK. Legal challenge received re the decision.	**KJ / CD**

30.3

	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 (May 2017) and the risk remains the same. **PCIC 051114 – DN Risk** AM advised this has been covered under patient flow , the clinical biorad had a very succesful recruitmnet event and most of the vacancies with District Nursing have been appointed to (some novice recruits with start dates in July/Feb 2018). Further adverts to go out on TRACS. Priosn vacanices were not all recuited to and additional adverts have been placed. **PCIC - GMS Services/Primary Care Capacity and Sustainability.** 3 fragile practices have been flagged in the last few weeks 92 S&E, 1 in Central Vale), one practice is considering an application under the sustainablity policy , deciosn to be made by the end of May 2017. Risk to the local population is significant. Option appriasal is being undertaken to ensure servuce sustainability. Risk score to increase to 25. **PCIC – Pressure Ulcer Prevalence** KJ noted there is a revised draft process for pressure ulcer root cause analysis investigations being considered at All Wales level. **PCIC – Domicillary Care Provision** Capacity within the market is still an issue, the Joint Commissioning group is considering sustainable options for the future, this risk has been transferred to the Partnership manager. **VL - Wound healing Teams delay for assessment** Evaluation report to be brought to the July QS&E meeting **SI - Vaccine Efficacy (Cold Chain Breach)** Closure form received at the QS&E committee. Lessons learnt to be communicated out to GP's and wider all Wales workforce re cold chain learning. **HMP Cardiff – Prescribing, Staff Stress, Environment** Issues remain the same at the facility in terms of the challenges, K Jeynes advised that the CD had resigned; an action plan is in place to support the recommendations from the QS&E review. **HMP Cardiff – OOH's Provision** Tender has been awarded risk to be reviewed **HMP Cardiff – MH Provision** QS&E review shared with the committee, Locality team have engaged with MH to review MH provision in the prison, agreed actions to be brought back to a future meeting with the updated action plan(July).	

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	Cardiff CRT Medication Administration Procedure The policy is still being drafted awaiting the agreed position **Continence Service Pressures** Recruitment is ongoing and the situation should improve by July dependent on recruitment, base has changed and staff morale improved. .	

30.3

	SI Log **<u>Current SI's</u>** **Incident re: Cold Chain Process** Closure form received, actions noted, Toolkit to be finalised by July 2017 and compliance with the cold chain to be re-audited in July 2017 **WAST incident re: Child death in GP Surgery/Ambulance Response** The SI was raised by WAST but is on PCIC log due to our involvement in the RCA. The report has been finalised, I am not sure if it has been shared with the family. As soon as Kay Jeynes has received a copy of the report she will share with the practice and relevant stakeholders. 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 two closure forms submitted (IN39710, IN36249). No surprises form – Datix In43854 noted for an unexpected prison death **<u>Medication Errors</u>** K Jeynes advised that there were 6 Medication errors reported within District Nursing N&W x 4, S&E x 2, Vale x1, Two involving insulin administration linked to poor discharge arrangements, both of these incidents had been followed up with the discharging wards. K Jeynes reminded business units of the need to ensure they are managing the Datix incidents in a prompt manner. Interface incidents review of process is in place with the support of the patient safety team to try and improve the system in place, CD rep and LMC are involved, once the process has been reviewed it will be shared with the Executive team and other relevant stakeholders	**RB** **KJ** **HO'S**
	Risk Escalation Reports **<u>Patient Safety officer post</u>** GH advised that the above post had been vacant from February 2016 through no individuals fault; the gap in the post has had a significant effect on the smooth operation of QS&E processes within the clinical board. The post will be appointed to from June 2017, G H wanted stakeholders to be aware of the undue pressure this has had on his role, the DON role and the patient safety	

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	manager role.	
	Information Governance Group K Jeynes advised that the IG Commissioners office has fed back on the loss of a diary in the Vale Locality- they viewed this as a serious breach and due to weak controls in place. They expect the action plan recommendations to all be in place. They wish any updates if a serious incidents or complaints occur as a result of the loss of this information. Diary compliance audit is planned for July; K Jeynes will recommend that the CRT staff undertake similar exercises. C Darling to provide the audit template	**CD/ LN's/ CRT Leads**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		**Action**
	Quality Dashboard KJ agreed to link in with C Darling and review the proposed dashboard and explore whether a template from SDG can be agreed that feeds the dashboard	**CD/KJ**
SAFE CARE		**Action**
	HCAI K Jeynes stated that the Cdiff incidence within PCIC is reasonably high and above the agreed levels. RCA's are being undertaken and being reviewed by IPC CD, chasing completion of the reports is challenging without the Patient safety officer. A similar process for MSSA bacteraemia is being considered and that of Ecoli. **Locality Pressure Ulcer Reports** Reports were received from S&E Locality and Vale Locality. The group was advised that there is an ongoing requirement for the Localities to provide a review of their pressure ulcer prevalence at the bimonthly QS&E committee to provide assurance to the board on what actions are being taken from prevention- to treatment and safeguarding issues. S&E reported 2 incidents that may be related to equipment delays. C Preece to look into this and feedback to the next meeting. B Boylan asked what the learning was from the reviews of the pressure damage, A Mogie advised that there were themes linked to non compliance, carer lack of knowledge, K Jeynes advised that District Nursing HCSW have received training to enable them to support prevention of pressure damage within patients own homes or residential homes. B Boylan suggested that it may be useful to use a shared decision making risk assessment to document decision. D Shanahan is exploring the use of this within practice. **Concerns report** K Jeynes advised that the clinical board had received 12 concerns since April, Primary care (6), N&W (2), Vale Locality (4). Themes were varied, compliance with the targets has been variable due to a number of issues relating to consent and difficulty accessing clinicians due to the part time nature of their	**CP** **KJ/LN/ LM's**

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	roles(specifically within GPOOH). K Jeynes asked everyone to try and work within the timescales and for all depts. to review their processes to improve compliance. Everyone was thanked for their support with informal concerns and resolution. **Point of care testing policies** K Jeynes brought the All Wales and C&V policies to the attention of the committee. Some discussion was held regarding the requirement of the policies to ensure full compliance, such as training records for existing staff POCT trained and ongoing training evidence, equipment register and a template for all new requests for POCT devices. K Jeynes advised that she would write out to the business units and ask them to agree a process within their services to ensure compliance. **GP Information letter-Mycobacterium chimaera** For information **PHW-Hepatitis A outbreak** For information	
	EFFECTIVE CARE	**Action**
	Implementation of Key Nice Guidance KJ advised that an agreed process had been agreed with the CD for R&D to share NICE recommendations in summary form to internal clinical board partners, UHB Clinical Audit Department and external stakeholders. The R&D CD has been been complemented externally regarding the quality of these summaries. .	
DIGNIFIED CARE		**Action**
	Prison action plan K Jeynes went through the action plan and the outstanding items that require	**NH**

30.3

	a further update at the July meeting. S&E Locality have been asked to bring a further update on progress of the actions to close down all identified actions in July 2017 **Ombudsman Report Clifton Surgery** A number of Lessons learnt were identified from this complaint relating to a late diagnosis of a patient with cancer who went on to die – acting on red flag symptoms, good documentation, update on constipation guidelines. These key messages will be circulated out to practices in the next newsletter **Public accounts committee (PAC) Report on Nutrition and catering** K Jeynes advised that Judyth Jenkins and Sheila Harrison had attended the DON meeting with Ruth Walker to advise that the PAC report on Nutrition and catering had been published with 12 recommendations, generally the PAC were unhappy at progress within health boards against the nationally agreed standards and want to see a measurable improvement. Judyth has advised that the UHB Nutrition and catering group is poorly attended and was attending the meeting to gain agreement for each clinical board to provide a representative. This was agreed. Two main recommendations that apply to PCIC are Nutritional screening and weighing and Oral Health assessment. K Jeynes to liaise with the CRT leads and ask for them to provide a rep for the clinical board.	**RB** **KJ**
TIMELY CARE		**Action**
	Letter to Vaughan Gethin re access for older people(Older peoples commissioner report Letter received from Vaughan Gethin re the above and how the clinical board is looking to improve access for older people. S Morgan advised that an action plan was being developed following a baseline scoping exercise, this would be shared at a later meeting**.**	**RB**
INDIVIDUAL CARE		**Action**
	DOLS (Deprivation of Liberty Safeguards) Guidance H O'Sullivan advised that correspondence had been received from the Coroner's office regarding revised guidance re DOL and care home residents relating to unexpected deaths and reporting to the coroner's office. This revised guidance was welcomed which generally advised that patients with a DOLs in place that experienced an expected death would not be required to be reported to the Coroner's office. **Mental Capacity Act updates** K Jeynes reiterated the importance of training for staff, e learning module is now mandatory so staff need to be encouraged to undertake the module and/or attend a face to face session through Julia Barrell. A future audit is	

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	being planned within the clinical board to review compliance with the MCA. K Jeynes advised that at the MHcLc it was suggested that GP's were not involving families in discussion regarding DNA CPR, K Jeynes advised she did not believe this to be the case, J Barrell advised she had undertaken a MCA training sessions with GP's where they advised they didn't routinely involve families. K Jeynes asked for the evidence and agreed to follow this up.	
STAFF AND RESOURCES		**Action**
	Physicians assistant N Evans advised there is an All Wales pilot in place to evaluate this role, there is no identified funding to support a local pilot. There is also concern regarding the governance framework and regulatory accountability of this new role. **Specific workforce issues** Demand capacity issues and recruitment and retention of band 5 staff within the clinical board were discussed within the risk register update. N Evans has agreed to provide a HR update for the QS&E committee as the other business units.	
SUB-GROUP REPORTS		**Action**
	• **Cardiff North and West Locality** A Mogie just wanted to bring the possible judicial review issue involving patient X to the attention of the committee. A Nursing home under PPM is still causing concern- closure notice in place by CSSIW, regular monitoring and liaison with the providers, LA and CSSIW are in place to mitigate risks. • **Cardiff South and East Locality** Nothing specific to highlight that is not already recorded or discussed • **Vale Locality** It was noted that a Vale rep was not available to attend as the Locality Lead nurse was off work and the senior nurse was not able to attend. N&W and S&E Locality LN & SN are supporting this leadership gap and the Vale Senior Nurse. • **Out of Hours** Staff Fill rates still remains a challenge on weekends, action plan is in progress, Bank band 7 is still not in place, KJ has escalated to Ruth Walker for a decision. Q&S review to be undertaken in the next few months . • **Medicines Management** K May advised that a prescribing team risk register is now in place, a n agreed process was in place for operational management of Pharmacists within the 3 Localities. A compliment has been received from a specific GP practice in relation to the positive work being undertaken in a care home. • **Palliative care** K Jeynes advised that the SLA procurement process was still a cause for concern, liaison with procurement is ongoing with little assurance or progress. One of the SPC providers has raised a specific concern regarding demand and capacity. A review of the SPC nursing ole and support for 7 day working is taking place and will be brought back to a future QS&E committee.	**CF**

30.3

PART 2: Items to be recorded as Received and Noted for Information by the Committee		**Action**
	The Committee Received and Noted the following :- MDA/2017/009 April 2017 MDA/2017/005 April 2017 MDA/2017/003 February 2017 MDA/2017/004 March 2017 PSA007/January 2017- Restricted use of open systems for injectable medication PSN037/April 2017- Resources to support the safety of girls and women who are being treated with Valproate WHC 2017-17 Changes to the shingles immunisation programme WHC/2017/005- The 2017 European Centre for Disease Control (ECDC) National Healthcare associated infection, device usage and antimicrobial usage point prevalence WHC/2017/011- HCAI reductions by March 2018: C difficile, S Aureus bacteraemias and E coli bacteraemias WHC (2017) 009- Good practice guidance on the provision of Mental Health Support for Asylum Seekers and Refugees disperse to Wales Strides pharma trading as co-pharma: Diclo-Sr 75 tablets: PI 13606/0145 Influenza season 2016-17- Cessation of use of antivirals now recommended Evidence of harm from Fentanyl contaminated heroin Universal credit- further guidance Important information regarding Lucozade drinks products •	
	ANY OTHER BUSINESS	

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DATE OF NEXT MEETING		**Action**
Date and time of next meeting : Tuesday 11th July at 1pm		

Specialist Services Clinical Board
Quality, Safety & Experience Committee
17th March 2017

PRELIMINARIES	ACTIONS
Welcome & Introductions In Attendance: Rachel Barry (RB), Lead Nurse, Neurosciences Suzie Cheezman (SC), Patient Safety Facilitator, Patient Safety Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board- *chair* Colin Gibson (CG), Clinical Engineer, Neurosciences & ALAS Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics Mark Jones (MJ), Directorate Manager, Nephrology & Transplant Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant Bev Oughton (BO), Senior Nurse, Critical Care Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services Sian Pring (SP), PA, Haematology, Clinical Immunology and Medical Genetics- *minutes* Hywel Pullen (HP), Director of Finance, Specialist Services Clinical Board Vinod Ravindran (VR), Consultant Nephrologist, Nephrology & Transplant Martyn Read (MR), Consultant Intensivist, Critical Care Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead, Critical Care Richard Wheeler (RW), Consultant Cardiologist, Cardiothoracic Services Sian Williams (SW), Senior Nurse, Cardiothoracic Services	
Apologies for absence Jessica Castle (JC), Director of Operations and Delivery, Specialist Services Clinical Board Lorraine Donovan (LD), Senior Nurse, Neurosciences Steve Gage (SG), Clinical Board Lead Pharmacist Nick Gidman (NG), Directorate Manager, Cardiothoracic Services Jonathan Kell (JK), Consultant Haematologist & Clinical Director, Haematology Noreen Lewis (NL), Lead Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics Claire Main (CM), Lead Nurse, Nephrology & Transplant Nav Masani (NM), Clinical Board Director Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care Orla Morgan (OM), Lead Nurse, Critical Care	
Minutes of the previous meeting The minutes were agreed to be an accurate record of the previous meeting. Actions No update is available on the gallipot situation. CF has drafted hand hygiene letter to be sent out to all Clinical Directors. Improvement plans have been implemented, the "GEL please" campaign is among them. Global hand hygiene	

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	day is 05/05/2017. Each Directorate is expected to hold a related event that day	**Directorate Q&S Leads**
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY		
	Patient Story RW presented the investigation into a concern regarding the death of patient on CCU during an acute admission. The patient, who had Down's syndrome, was known to the Adult Congenital Service for Eisenmenger's Syndrome and also had a history of polycythaemia. The primary reason for admission was right-sided chest pains, which had been worsening for several months. The patient was also experiencing worsening cyanosis and signs of heart failure on admission. The main issues raised in the complaint were- the antibiotics used (there was no indication for use of IV antibiotics), the competency of nursing staff using the CPAP machine (staff involved were found to be competent, there were no apparent failures) and the delays in transferring the patient to ITU. Communication issues were the main issue identified during the investigation; it was found that whilst the ITU consultant had been involved in decision making he did not liaise with the family at any point. As a result an allegation was made by the patient's relatives that the patient's co-morbidities influenced his treatment- there was absolutely no evidence of this. The family picked up on a lot of the language used by medical and nursing staff in relation to the patient and their management. RW suggested that staff should be mindful of what is being said in the clinical areas and in earshot of relatives; ie. appreciation of the sensitivity of the situation in light of the patient's Down syndrome. Division of labour between the referring speciality and ITU complicated matters. In this particular case there were assumptions made that the other team would do things. In shared-care cases a decision needs to be made about who will take charge. RW suggested that Adult Congenital Service should ensure patients and relatives are prepared for the inevitable deteriorations and that there needs to be more clarification for patients in regular follow- up so that they understand the severity of their condition and any life limiting factors. It is hoped that the appointment of nurses in the ACS service will help address these communication issues. This case has been presented at Cardiothoracics Q&S meeting. All other Directorates need to discuss the common factors, i.e. communication with families and communication between clinical teams.	**Q&S LEADS**
	Feedback from UHB QSE Committee None.	
	Health and Care Standards– sign of self- assessment/ ongoing review of implementation/ improvement plan Information has been gathered in the individual directorates. CF will recirculate the matrix.	CF
	Risk Register – review and revision Critical Care has been within SMR targets for the past 2 months. Based on this new information CF will review the risk and potentially drop the rating from 25 to 20. Directorate needs to confirm this. Amendments to the risk register are awaited from Haematology. JK has written to Ruth Walker and Abigail Harries regarding the new build. Haematology is to provide an update on how they are managing the risks. Haematology also needs to undertake a risk assessment in relation to the DVT service, add to risk register and forward to CF	MR/BO KW/JK/NL KW/JK/NL

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	Exception reports and escalation of key QSE issues from Directorate QSE groups CP provided an update on the Cardiac Heater/Cooler issue. There are approximately 4000 patients who will be notified, approximately 106 are paediatric. Letters are due to be sent out to patients on 20th March 2017 and PHW have set up a helpline. Cardiac are working closely with labs and are in the process of identifying a point of contact within the department. Dedicated clinics to deal with patient queries will also be held. Dirk Wilson will be reviewing paediatric patients. RB reported a case of ? CJD in a patient who had already undergone surgery in September 2016, patient testing suggests that a positive diagnosis is unlikely. Unfortunately the theatre equipment used on this patient had been used on a further 30- 40 patients before being quarantined. Definitive decision regarding risk needs to be agreed with IP&C and a decision made re other patients operates on using the same kit	RB/LD/TH
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
	Initiatives to promote health and wellbeing of: Staff The Clinical Board reported a 54% uptake on the flu vaccination. The overall Health Board uptake exceeded 50% for the first time this year. Many thanks to Orla Morgan for leading the campaign and for all the excellent champions undertaking the vaccinations	
SAFE CARE		
	Patient Safety Incidents Overall Trends CF has received the falls report from Rachel Sykes. There was a significant increase in reported falls in February (90 in total). No significant injurious falls in that number Each area is to check for patterns in the patients falling, ie. CF would like to know whether the increase in falls is related to the increase in specialling. Are the patients being specialled still falling but without serious injury. Therefore, is the specialling preventing serious injurious falls? To be reviewed by SNs and fed back at next meeting An injurious fall in renal on 16/03/2017 has been reported to CF by SM. New Sis 1 SI has been reported in renal following an MRSA related death in a patient with a permacath. The primary cause of death was identified as a stroke, but MRSA was listed in section 2. Microbiology SpR is undertaking RCA An action plan will be devised once the SI has been investigated for reporting to the WAG. The SI will also be discussed at a future QSE Committee meeting and lessons shared.	SNs SM/VR
	Key patient safety risks: Medicines management issues/incidents/audit findings There has been a decrease in the number of medication errors since the last report; a duplication discrepancy in Llandough Haematology and a lost bag of chemotherapy in UHW Haematology (the bag was actually never dispensed). Both issues belong with pharmacy. Tier 1 Targets All implementation plans have been received for the Tier 1 targets. These need to form part of every Directorate's Q&S to monitor improvements and refine plan as required. There will	

	be increased performance management re Tier 1 targets at Directorate performance reviews	
INDIVIDUAL CARE		
	National User Experience Framework Feedback from surveys – relevant improvement plans There was a decrease in responses to last month's survey, this was potentially the result of distribution and collation problems. There were lots of comments, patients are very sure of their care and are having good experiences. Comments to be discussed at Q&S meetings, Sister and Staff meetings	
Staff and Resources		
	Staff awards and recognition CF reported that there have been lots of nominations of this year's staff recognition awards. Haematology CNS Charlotte Bloodworth came 3rd at the BJA awards for her work on the Lymphoma Service.	
	Staff surveys The results of the recent staff survey in neurosciences (ward C4) were overwhelmingly positive. The survey will be rolled out to other clinical areas	
ANY OTHER BUSINESS		
	MR wished to commend Sonya Daniel on starting regular Quality Meetings in Critical Care. HR reported that the Mental Capacity audit tool is being piloted by Julie Barrell. CF reported that the late April QSE meeting would focus on audit plans.	

Date and time of next meeting 7th April 2017, 8am Critical Care

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Specialist Services Clinical Board
Quality, Safety & Experience Committee
7th April 2017

In Attendance:

Bev Oughton (BO), Senior Nurse, Critical Care
Bethan Lever (BL), Nurse Practitioner, Neurosurgery (in attendance for part of the meeting)
Elaine Saunders (ES), Renal Access Nurse Specialist, Nephrology & Transplant (in attendance for part of the meeting)
Hywel Pullen (HP), Head of Finance, Specialist Services
Martyn Read (MR), Consultant Intensivist, Critical Care
Maria Roberts (MMR), Patient Safety Manager, Patient Safety
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board, (Chair)
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Steve Gage (SG), Clinical Board Lead Pharmacist
Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics
Noreen Lewis (NL), Lead Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care
Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services
Martyn Read (MR), Consultant Intensivist, Critical Care
Vince Saunders (VS), IP&C
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Rachel Barry (RB), Lead Nurse, Neurosciences
Rafael Chavez (RC), Consultant Surgeon, Nephrology & Transplant
Nick Gidman (NG), Directorate Manager, Cardiothoracic Services
Mark Jones (MJ), Directorate Manager, Nephrology & Transplant
Keith Wilson (KW), Consultant Haematologist & QSE Lead, Haematology
Mathew Price (MP), Assistant Service Manager, Neurosciences

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Preliminaries		Actions
	Welcome & Introductions Welcome and introductions were made.	
	Apologies for absence Carys Fox, Director of Nursing Jessica Castle, Director of Operations	
	Minutes of the previous meeting The minutes from the 17th March 2017 (circulated via email 4/4/17) were approved. Matters Arising World Hand Hygiene Day is being held on 05.05.17. HR advised that CF would like to know	

	what activities the directorates have planned. Critical Care will be having a stall in concourse. Cardiothoracic are having an awareness day with various activities planned. Neuro and Nephrology & Transplant were planning an awareness day with activities on their link corridors. **Action**: HR reported that CF would like for Directorates to advise her of their plans by email. HR highlighted that Q&S Leads are required to present their audit plans for the next meeting as they should be refreshed annually. **Action**: Audit Leads to present audit plans.	**ALL** **AUDIT LEADS**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
	<u>Presentation from Neuro:</u> Beth Lever, Neuro Nurse Practitioner presented re: improving the intrathecal drug service which is an improvement project undertaken via the 'LIPS' programme. Historically, the service was medically led but also requires up to 50-80% of 1 WTE nurse time. The neuro nurse specialists are not pain specialists and the care of these patients is something that has developed in their roles over the course of time. Through the LIPS project, which involved a consultant and pharmacist as well as nursing staff, process mapping identified 40 different issues in need of improvement. There were some quick wins, for example, issues of unlicensed strength of associated medication in use has been resolved by use of licensed strengths of medication. The service has improved communications to GPs by ensuring that letters to GPs following therapy changes are in place which historically had proved to be problematic. A clinic code has been added to PMS so activity is recorded. Prescription improvements have also been made. MMR highlighted that we used to see lots of incident forms about issues related to this service but this is not the case now. This is testament to the improvements made which are addressing the patient and staff concerns. MR was positive about the service improvements which are aiding the governance arrangements. SG raised that MTeD developments may assist the ongoing improvement work intended as part of this project. <u>Presentation: Nephrology and Transplant:</u> Elaine Saunders, Renal Access Clinical Nurse Specialist presented an interesting overview of a service development on behalf of the Nephrology & Transplant Directorate. The presentation outlined positive developments for patients whereby nurse specialist roles in renal access services have improved timely care for patients with good outcomes following nurse interventions. HR thanked the presenters for two excellent presentations given today which demonstrate significant service developments and new ways of working. <u>Feedback from UHB QSE Committee:</u> MMR advised that a meeting is scheduled to take place shortly and so feedback can be provided at the next meeting. <u>Health and Care Standards:</u> Discussion took place about the requirements for this year's annual assessment. However, it	

	was identified that Clinical Board Leads would benefit from clarity as to the requirements. MMR is to ask Alex Scott if she can make contact so that staff can be advised.	MMR
	Risk Register Haematology: NL and KW advised the meeting about regulatory body compliance issues that are on the Haematology, Specialist Clinical Board and organisational risk registers but environmental concerns continue as an unresolved matter. Following the last inspection, many service improvements were completed but an issue beyond the directorate's direct control is the environment. They are due for a return visit from the regulatory body in 18 months time and are concerned about unresolved issues. For example, on the ward there is a lack of triage facilities and lack of en suite bathroom facilities. HR asked if there is a plan in place to address the issues. He was advised that there is no resolution further to the issue being raised with the Interim CEO and WG. HR suggested that an email summary of progress and the position with the action plan following the inspection be provided to CF as it is not possible for this meeting to resolve the matter for the directorate today. NL advised that CF has this information. MMR suggested that the Clinical Board could raise this in their Executive Performance Review for discussion. NL also added that the DVT Service has recently been added to their risk register as there are concerns about the volume of patients to nurses available; environment concerns relating to the suitability of their clinical space and succession planning as the nurses will retire in 2 years time. Cardiothoracics: NG reported that Theatre 10 and 11 are still closed and are likely to remain closed for 3 months so contingency arrangements continue. He also advised that the Patient Notification Exercise for the mycobacterium issue in the Sorin equipment is to be closed down. There are 33 patients to be followed up which is in line with what was expected. SG advised that there is a supply chain problem with Tazocin and further information will be circulated on this matter. New Serious Incidents: MMR highlighted that two SIs for Specialist Services Clinical Board have been reported since the last meeting. These are IN43319 which is unfortunately a Never Event in Critical Care. In this incident, a guidewire was inadvertently retained in a patient who required a Vascath. An investigation is underway and the Delivery Unit are having oversight of the process as usual following a Never Event. The guidewire was subsequently removed without harm. An incident reference IN43165 regarding an injurious fall on a B5 Nephrology patient occurred on concourse. CM is dealing with this matter. Inquests and Regulation 28 Prevention of Future Deaths reports: MMR provided an overview of a Coroner's inquest and Regulation 28 Prevention of Future Deaths report that had been received for Medicine Clinical Board advising that there were issues of note for the wider UHB. The gentleman concerned was very elderly and frail and cognitively impaired. He sustained a number of falls whilst he was an inpatient and the number of falls recorded in the notes/incident forms is contested by the family. On the final fall, the patient sustained a significant head injury following which he died. The investigation	Director ate Clinical Board

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	determined that the registered nurse inappropriately delegated neurological observations to a healthcare support worker. The incident occurred when the patient was receiving 1 nurse: 4 patients enhanced monitoring and the healthcare support worker attend the sluice having assisted another patient, believing that this patient was asleep. The group noted the Coroner's recommendations and that an outcome of a specialling review and pilot is due shortly. It was also noted that healthcare support workers are no longer doing neuro obs in Medicine Clinical Board but a UHB-wide approach is required. This will be considered by the Clinical Standards and Innovation Group, chaired by Lynda Jenkins. Directorates are encouraged to share the learning from this incident with their clinical staff. There are 2 forthcoming inquests of note for the Specialist Clinical Board. One involves a cardiothoracic patient but limited information is available to MMR who will liaise with NG about it. The second inquest is for Nephrology & Transplant. The consultant's statement is awaited which will help to advise on any potential concerns that need to be addressed. <u>Patient Safety Solutions:</u> MMR wished to draw attention to an <u>MDA (MDA/2017/003)</u> which has been circulated. It relates to a problem with a broken spring in the plunger assembly in an infusion device which could lead to an unintended bolus of medication being administered. Clinical Engineering have advised that they will check the infusion devices as they go through the Equipment Library. There is a replacement programme scheduled over next few months within the UHB. All areas are asked to ensure that the syringe drivers are being returned to the Equipment Libraries so they can be checked.	ALL ALL
SAFE CARE		
	<u>Health Care Associated Infections</u> <u>HCAI rates</u> – VS advised that the UHB C Diff reduction target was missed by 2 cases. UHB MSSA was 42 cases over the reduction expectation. There was some discussion regarding screening appropriateness and a view expressed that improved education and guidance on when samples are needed might be helpful for staff. VS agreed and advised this will be considered as IP&C related policies and procedures are scheduled for revision. WG has acknowledged the C Diff position. Other Health Boards have seen a similar picture on MSSA infections. New targets will soon be circulated from Dr Eleri Davies and will include an E Coli reduction expectation. Information on the position to date was tabled by VS. HR expressed views that it needs to be clarified on the data analysis reports when the infections are healthcare acquired or not and clinical staff present agreed that if patients come in to hospital with these infections, they should be removed from the data analysis reports. It was raised that there have been some discussions at the Wales Intensive Care Society who would be happy to contribute to this. VS added that a letter regarding IP&C related work plans will also be circulated soon. <u>Micro Survey:</u> SG advised that a Microbiology survey on antibiotic governance is being circulated. Participation was encouraged.	ALL
DIGNIFIED CARE and INDIVIDUAL CARE		

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	No related issues were raised at the meeting.	
STAFF and RESOURCES		
	Staff Recognition Awards There was excellent representation from across Specialist Services at the recent staff awards, which was very positive. Staff Survey LD reported that a Pulse Survey was undertaken on C4 Neurology previously and the positive nature of the experience has led them to roll this out to other wards in Neuro. Ward 7, Rookwood is currently having this survey undertaken.	
	ANY OTHER BUSINESS	
	SG advised that a medication safety bulletin would be in circulation shortly from the Medication Safety Executive Group. It would be raising awareness of thromboprophylaxis issues. MR advised that there was a campaign underway in Critical Care to improve prescribing. The campaign aimed to reinforce prescribing standards and for staff not to administer medication where there is poor prescribing that does not meet the necessary standards. Posters are in place about what constitutes appropriate prescribing standards. There is some concern regarding the application of this practice which the Directorate is working through. SC drew reference to an SBAR circulated via LED regarding blood glucose monitoring training requirements which was drawn up in consultation with Point of Care Testing department. Concern was raised that the frequency of training updates required on the SBAR are not in line with other frequencies of mandatory training. It was agreed that this would be fed back via the PoCT Group and Medical Equipment Group, which CG offered to assist with.	CG/SC

Date and time of next meeting Thursday 27th April 2017 at 8am in the Critical Care Resource Room

30.4

Specialist Services Clinical Board
Quality, Safety & Experience Committee
27th April 2017

In Attendance:

Carys Fox (CF), Director of Nursing, Specialist Services, (Chair)
Jessica Castle (JC), Director of Operations, Specialist Services
Navroz Masani (NM), Clinical Board Director, Specialist Services
Hywel Pullen (HP), Director of Finance, Specialist Services
Maria Roberts (MMR), Patient Safety Manager, Patient Safety
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board
Lorraine Donovan (LD), Senior Nurse, Neurosciences
Steve Gage (SG), Clinical Board Lead Pharmacist
Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics
Claire Main (CM), Lead Nurse, Nephrology & Transplant
Dale-Charlotte Moore (DCM), Directorate Manager, Critical Care
Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services & temporarily covering for Critical Care
Vince Saunders (VS), IP&C CNS
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Rachel Barry (RB), Lead Nurse, Neurosciences
Keith Wilson (KW), Consultant Haematologist & QSE Lead, Haematology
Colin Gibson (CG), Clinical Engineer, ALAS
Lisa Evans (LE), Clinical Nurse Leader, Critical Care
Kevin Nicholls (KN), Service Manager, Cardiothoracics and Critical Care
Vinod Ravindran (VR), Consultant & QSE Lead, Nephrology and Transplant
Jonathan Kell (JK), Clinical Director, Haematology

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Present: Gemma Williams, PA to the Specialist Services Clinical Board (Note taker)
Chris Loran, Nurse Manager, Haematology (Presenting)

Preliminaries		Actions
1.1	Welcome & Introductions Welcome and introductions were made. CF welcomed Gemma Williams, PA to the Clinical Board, back from maternity leave. CF thanked Sian Pring, PA for the Haematology Directorate, for her help with note taking whilst Gemma was away. CF noted that the Board was expecting Carole Bell from WHSSC to attend today's meeting but that she was no longer available.	
1.2	Apologies for absence Andrea Edwards, Fiona Kear and Noreen Lewis.	
1.3	Minutes of the previous meeting The minutes of the previous meeting held on 7th April 2017 were approved as accurate, subject to; the date of the minutes should read 7th April 2017 and not the	

	27th March 2017. Jessica Castle also gave apologies which were not noted. **Action:** Both to be amended.	**GW**
	Matters Arising Audit Plans CF requested that Directorates present their audit plans at this meeting – Directorates confirmed that they would be providing this information. CF noted that the World Hand Hygiene day is taking place on the 5th May 2017 with some events taking place. All Directorates confirmed that they were displaying posters/banners or had activities supporting the day. IP&C will have a display in Concourse. Health and Care Standards - Annual Assessment It was confirmed that MR had asked Alex Scott to make contact with staff to provide them with clarity on what the requirements were. Risk Register – Haematology JC confirmed that the Clinical Board discussed the summary of progress and position with the action plan following the JACIE inspection at the Executive Performance Review. CF noted that Carole Bell, WHSSC, had visited the Haematology Day Unit and Haematology Ward this week, the visit helped Carole to appreciate the issues that patients and staff have to deal with. Inquests and Regulation 28 Prevention of Future Deaths reports MR referred to a patient in another CB who had fallen several times even though they were being specialled. There are learning points for all CBs **Action:** CF informed the group that the next meeting would focus on falls **(GW).**	**GW**
	Patient Safety Solutions CF referred to MDA/2017/003 (re problem with a broken spring in the plunger assembly in an infusion device which could lead to an unintended bolus of medication being administered). CF noted that she had contacted Clinical Engineering. MR informed the group that the manufacturing update was in hand. They will be out of use by September. **Action:** All areas were asked to ensure that the syringe drivers are being returned to the Equipment Libraries so that they can be checked. Health Care Associated Infections IP&C Annual Work plan CF confirmed that she had received the draft UHB IP&C Annual Work plan. Once the Health Board plan is finalised, the Clinical Board will need to produce their work plan for the year, with help from VS. **Action**: CF and NM to meet with ED and VS to progress. GW to arrange. Micro Survey As per the previous meeting, participation was encouraged with regards to the Microbiology survey on antibiotic governance. Any Other Business SBAR re Blood Glucose monitoring training requirements CG confirmed that he had fed back the issue that the frequency of training updates required on the SBAR was not in line with other frequencies of mandatory training, to the PoCT Group and the Medical Equipment Group.	**ALL** **GW**

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	Reduced Sugar in Lucozade JK raised the issue of reduced level of sugar in Lucozade in relation to diabetic patients. Many diabetic patients rely on fizzy drinks to stabilise them – the reduced sugar content could put the patient at risk of becoming hypoglycaemic. **Action:** raise awareness within Directorates.	**Dirs**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	Patient Story: Presentation from Chris Loran, Haematology Chris Loran presented a video to the group, in relation to a gentleman with Haemophilia A. The video documented the difficulties experienced by the gentleman growing up with Haemophilia A. Issues such as; schools were apprehensive to have him due to the risks associated, he missed important exams due to health reasons, left school with no formal qualifications, and was also fired from his driving jobs due to his sickness. However, he noted that through an RAF scholarship and support/help from the Haematology Department, he was able to learn how to fly aircrafts and is about to get his pilot licence. The gentleman was keen to encourage others with the condition and to not be disheartened. Chris Loran informed the group that the gentleman contracted Hepatitis A through contaminated products and was now participating in trials. Chris also noted that it was great to help the gentleman achieve his dreams of learning to fly and that he was a role model to other patients. Chris was asked if schools were still reluctant to take children with haemophilia and noted that things have changed but still some experience of schools being reluctant to take such pupils. CF noted that it was a very positive story and thanked Chris for sharing it with the group.	
2.2	Feedback from UHB QSE Committee: MR informed the group that a meeting took place on the 18th April 2017 and noted the following was discussed: • Donation of Organs and Tissues After Death Policy was approved. This will be available on the intranet and should be noted by the directorates as a key policy for this Clinical Board. **Action**: Donation policy to be discussed at the N&T Q&S meeting. • Quality and Safety framework was presented by Carol Evans, Assistant Director of Patient Safety and Quality and a Patient Experience Framework was presented by Angela Hughes, Acting Assistant Director of Patient Experience; launch events will be scheduled in due course with presentation at the Clinical Board's QSE Group also planned. • Patient safety solutions and areas of non-compliance were discussed. There are several legacy solutions from the former NPSA that are a particular challenge and the UHB needs to address the outstanding issues, for example, patient identification wristbands, unexpected significant radiology findings amongst others. • Alun Morgan, Assistant Director of Therapies and Health Sciences presented a paper regarding patient falls. Work is ongoing to recruit a falls lead post but Agenda for Change banding issues need to be resolved. • A Regulation 28 paper was discussed – this included the fall which occurred with the Medicine Clinical Board which was discussed from the last meeting and chest drain issues which relates to Specialist Clinical Board. • An update regarding HIW was presented since they have been back to UHL (they visited 2 medical wards and MH wards last year). MR noted that last	**N&T**

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	year's report was particularly critical and urged the group to read it. The most recent visit was much more positive and obvious improvements have been made. • Welsh Risk Pool Report – £74m expenditure was incurred by the Welsh Risk Pool in 2015-2016 in NHS Wales in litigation costs. It is reported that our open claims activity for clinical negligence cases is just 10% of the total open across NHS Wales. This is a positive position to be in but we must not rest on our laurels.	
2.3	Health and Care Standards: CF confirmed that she had received some of the standards back from identified standard lead but not all. **Action:** Standards due back by the 28th April 2017. Returned to CF. Any queries to phone Alex Scott or Carys Fox. The standards will then be uploaded to the UHB site.	**Dirs**
2.4	Risk Register CF noted that there were no new updates for this month, apart from the Haematology risk as per recent discussions. CF informed the group that she had met with Carol Bell from WHSSC, who had requested a breakdown of risks related to WHSSC services. CF will circulate once completed.	
2.5	Directorate Exception Reports Nephrology & Transplant CM noted that the Portacabins placed in S19 protected parking spaces are causing access issues. This issue has also highlighted the number of illegal parking spaces. Liaising with Indigo and security and monitoring the situation. The Kidney Walk of Life will be taking place in May. Route still to be finalised but will visit all satellite dialysis units in Wales. Communications Department are helping as the walk will finish at S19. CF noted that the new Cleppa Park Dialysis unit was now officially open. CM noted that the next unit to open will be Pontypool in June/July. Vaughan Gething is due to officially open it. Haematology KW expressed concern that the computers in the clinics were too old to print PDF reports. KW has been in touch with IT about providing a new computer on the replacement programme but due to the current workload this will not be possible for some time. **Action:** JC will speak to Matt Temby to escalate the issue. Cardiothoracics CP noted that Mycobacteria Chimera Patient Notification Exercise was closing down. This was undertaken with support from PHW and the process was streamlined and worked well. CF said it had been raised at IP&C yesterday and Ruth Walker has requested final figures. Two more clinics to be run in May. Patient results to be monitored e.g. blood cultures. CP will continue to provide updates at this meeting. Critical Care DCM raised the LTV medical cover issue. Mark Smithies has been leading on this and he is due to retire. A meeting will be taking place in relation to extending the contract as Nick Stallard is currently still off sick. It was confirmed that this was included on the Directorate Risk Register. **Action:** Send to CF for consideration of the Clinical Board Risk Register.	**JC** **DCM**

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	Neurosciences RB noted that Fiona Kinghorn (Interim Director Public Health) and Maria Battle (Chair) had carried out a walk around of Rookwood and shared concerns around the environment which staff felt was supportive. Building work on old/main building and heating systems work underway. B4 refurbishment work has now commenced. RB noted that she had received communication yesterday that the whole ward will be refurbished and not just the bathrooms. 12-14 weeks work in total. The refurbishment is based on a new scheme which focuses on work that the UHB has carried out with RNIB regarding patients with sensory loss and using the correct colours. Working with capital planning so that the ward decoration meets RNIB standards but also meet the requirements of the low stimulation patients also. The work is currently quite disruptive. ALAS CG noted that they had not as yet heard from WHSSC regarding fleet of wheelchairs replacement. HP will pick this up with CG outside of the meeting. CG noted that it was a concern as the wheelchairs are past their manufacturing update. High on the ALAC and the Clinical Board Risk Registers. Pharmacy SG noted that in relation to MTED many Junior Doctors have been happy to sign off print outs without checking them first. SG noted the importance of reading/checking. **Action:** SG requested that this message is taken back to Directorates. Haematology JK noted that there were B1 OP issues in relation to the delays moving to T1 due to neonatal work. **Action:** To be raised with Abigail Harris, Executive Director of Planning, by JC for an update.	**Dirs** **JC**
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and well being of: Patients and staff CF noted that the B4 refurbishment had already been discussed under item 2.5. JC referred to an email from Claire Radley, Assistant Director of Organisational Development, regarding the Corporate Health Standard (CHS) assessments which expire this year. The Gold standard requires a full assessment and the Platinum needs to be revalidated. JC has asked Jonathan Pritchard for further detail on what we are required to provide as a CB and that will be circulated to the Directorates for submission of examples. **Action:** JC will circulate once received.	**JC**
3.2	Bring forward – progress on relevant improvement plans (previously approved/discussed) None.	
3.3	Audit Plans CF requested that Directorates present their audit plans to the group. The following people presented their plans: Haematology – Keith Wilson Medical Genetics – Gareth Jenkins Cardiothoracics – Kevin Nicholls Critical Care – Dale-Charlotte Moore N&T – Vinod Ravindran Neurosciences – Rachel Barry ALAS – Colin Gibson	

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	NM noted that it would be useful to have this information in a table format with standardised columns so that each Directorate can populate; i.e. National Audits/Local Audits/Sporadic Audits. **Action:** CF requested that Directorates send a summary of this information, along with their plans to Gemma Williams via the generic Pa.SpecialistServices@wales.nhs.uk email address. HR noted that it was useful to discuss the plans in order to provide the Board with the reassurance that there is a proper structure. MR noted that it is helpful in that it also links in with what information needs to be included in the Risk Register etc. KW requested the documentation audit template previously agreed upon in order to carry one out. **Action:** CF will circulate. MR keen to audit consent and NPSA Alerts in future.	**Dirs** **CF**
3.4	<u>National Safety Standards for Invasive Procedures (NatSSIPs)</u> CF referred to the report circulated when it first came out and ahead of the meeting noting that it came out last September; most of the work to date has been undertaken in Surgery CB, this has now been extended. A Task and Finish Group will be put together to involve these procedures in other areas. **Action:** CF requested a nomination for someone to attend this group on behalf of the Directorate and Clinical Board so that meeting information can be shared/fed back. HR suggested that Martyn Read may be interested in this role depending on his workload. **Action:** HR will contact him. An Awareness study day will be taking place on the 12th May 2017. 5 places available. Clare Wade from Surgery is organising this. **Action:** CF requested that all Directorates nominate someone to attend – medical and nursing nominations were encouraged.	**Dirs** **HR** **Dirs**
SAFE CARE		
4.1	<u>Closure Forms</u> CF presented 3 closure forms to the group. <u>NHS Ref: IN22230</u> Patient fell in the car park at Rookwood and sustained a fractured neck of femur. The patient was carrying out outdoor mobility exercises using his prosthesis with his physiotherapist and a student physiotherapist. This form was signed off at the meeting. Note that the falls procedures and policies do not take account of the ALAS service and are therefore not suitable to be used there. A separate flow chart has been developed for ALAS as part of this incident and closure. <u>NHS ref: IN43165</u> Recent SI in relation to a lady from B5 who left the ward without telling any staff and fell and fractured her femur whilst walking through the Concourse. The patient reports that she was attempting to lean against a wall but misjudged it and fell. The lady required surgery and she was healing well. Patient acknowledges that she shouldn't have left the ward without telling staff. This form was signed off. <u>NHS Ref: In12503</u> Date of incident was September 2015 – relates to a gentleman who absconded from T4 with a Deprivation of Liberty (DoLS) authorisation in place. He was returned to UHW by WAST but immediately absconded again from outside EU. The man was found in Treorchy by an off duty police officer and returned to UHW. It has taken time to get a robust action plan in place. DCM noted that access to and from the ward has been looked at. Work has also taken place between the police and the Welsh Ambulance Service. This closure form was signed off.	

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	MR noted that the C4 Legionella case was close to being signed off. CF informed the group that 5 closure forms have now been signed off for the month which was good. Inquests MR referred to the report circulated ahead of the meeting, detailing upcoming inquests. MR will pick these up with CF when she meets with her later on today.	
4.2	Patient Safety Alerts MR referred to patient safety notice PSN037/April 2017 – Resources to support the safety of girls and women who are being treated with Valproate. Action taken to be reported by no later than 6 October 2017. Medicines group are leading on this. Discussions with Neuro and Paediatrics required. A Task and Finish Group is likely to be set up. **Action:** RB will pick this up with colleagues in Neuro.	**RB**
4.3	Deprivation of Liberty Safeguards (DoLS) – 3rd April 2017 onwards **Action:** Document for information and discussion at Directorate Q&S and M&M meetings.	**Dirs**
4.4	Health Care Associated Infections VS provided an update to the group on new targets for 17/18. C.Difficile The target for the Health Board is no more than 10 cases within the month. In April there were 11 cases. 4 within the Clinical Board. MSSA The target for the Health Board is no more than 8 cases. 12 so far have been reported. Acintobacter Issues An investigation is taking place within Critical Care in relation to 3 patients who acquired Acinetobacter. An incident meeting has taken place, the patients are trauma and neuro. Waiting for typing. CF noted that this was also discussed in the UHB IP&C meeting. It was noted that this is a sensitive bacteria. It is not related to the incidents on A7 and currently B6 which is a resistant strain. UHB IP&C Committee The IP&C Annual Work Plan has been published and CF noted that the Clinical Boards have been requested to take their plans to the June UHB IP&C meeting to discuss. This is not just a nursing issue and the CBDs are required to attend. VS will work with the Clinical Board on this.	
4.5	Key Patient safety risks Blood Management MMR referred to the report Re: Traceability Non-Compliance for (March 2017). Within the Clinical Board there were two areas of non-compliance; one in Theatre 9 and one within the Transplant Unit. **Action:** MMR requested that Directorates look at the figures. MMR noted that the figures showed a significant improvement on previous results.	**Dirs**
4.6	Bring forward – progress on relevant improvement plans (previously approved/discussed) None.	
INDIVIDUAL CARE		

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5.1	National User Experience Framework CF referred to the National Survey Report circulated ahead of the meeting. **Action:** CF requested that attendees review the comments. CF noted that many of the comments relate to how busy the staff were, but that in the main the comments were positive. Communication between departments was also highlighted as an issue which is a theme in concerns as well. **Action:** Directorates to feedback to staff.	**ALL** **Dirs**
5.2	Complaints None discussed.	
5.3	Bring forward – progress on relevant improvement plans (previously approved/discussed) Not discussed.	
STAFF AND RESOURCES		
6.1	Staff awards and recognition JC fedback to the group on the runner ups and winners of the Staff Recognition Awards. Charlotte Bloodworth – Runner Up, Chair and Chief Executive Award Erica Cook – Winner, Dr Kate Grainger Award Compassionate Care Deborah Herbert – Runner Up, Dr Kate Grainger Award Compassionate Care Annette Blackmore – Runner Up, Equality, Diversity and Human Rights Tanya Burton – Winner, Going the Extra Mile Dorothea Reed – Runner Up, Volunteer of the Year Award Carys Fox – Chairs Commendation Project 95 and Switch Over Group JC noted that there was fantastic representation from the Clinical Board and that the Board was delighted with staff rewarded on the night. It was suggested that some of their work was shared at Q&S as patient stories. CNO Conference CF informed the group that the CNO Conference would be taking place in May. Quite a few posters have been accepted for this which is encouraging. RCN Awards CF noted that a large number of nominations had been sent. **Action:** Feedback from medics and what they have been nominated for should be celebrated to.	**Med Leads**
6.2	Monitoring of attendance at relevant training e.g. pressure damage, falls, MCA, DoLs HR is still working with Julia Barrell on this. It was noted that ESR is unreliable, has inaccurate information on it and some staff are unable to access it.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		
	No related issues were raised at the meeting.	
7.1	**ANY OTHER BUSINESS**	
	MCA Audit in Critical Care HR informed the group that an MCA Audit had been completed in Critical Care which other areas would need to consider. Julia Barrell and one of the SHO's have developed a pilot tool that they wish to present at the meeting. **Action:** GW to arrange a 20 minute slot.	**GW**

Date and time of next meeting **Friday 19th May 2017 at 8am** in the Critical Care Resource Room.

MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Falls Focused

Date and time: 8am, 19th May 2017
Venue: Critical Care Resource Room

In Attendance:

Carys Fox (CF), Chair, Director of Nursing
Jessica Castle (JC), Director of Operations
Navroz Masani (NM), Clinical Board Director
Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board
Bev Oughton (BO), Senior Nurse, Critical Care
Maria Roberts (MMR), Patient Safety Manager, Patient Safety
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
Gareth Jenkins (GJ), Service Manager, Haematology, Clinical Immunology and Medical Genetics
Jennifer Procter, Lead Nurse, Haematology, TCT, Clinical Immunology and Medical Genetics
Ceri Phillips (CP), Lead Nurse, Cardiothoracic Services
Vince Saunders (VS), IP&C
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Rachel Barry (RB), Lead Nurse, Neurosciences
Rafael Chavez (RC), Consultant Surgeon, Nephrology & Transplant
Colin Gibson, Clinical Engineer, Rehabilitation Engineering, ALAS
Kevin Nichols, Service Manager, Cardiothoracics and Critical Care
Chris Bimson, Principle Finance Manager
Vinod Ravindran, Consultant Nephrologist
Fiona Kear, Assistant Service Manager, Haematology, Immunology and Medical Genetics
Sarah Matthews, Senior Nurse, Nephrology & Transplant

Present: Gemma Williams, PA for the Specialist Services Clinical Board (Note taker)
Oliver Williams, Senior Physiotherapist
Sharon Parkhouse, Senior Nurse, Clinical Gerontology

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PART 1: Preliminaries		Actions
1.1	**Welcome & Introductions** The group introduced themselves one by one. CF thanked SW for arranging the fall related agenda items.	
1.2	**Apologies for absence** Received from; Jonathan Kell, Steve Gage, Carol Evans, Andrea Edwards, Dale-Charlotte Moore, Mark Jones and Martyn Read.	

1.3	**To review the Minutes of the previous meeting 27th April 2017** The minutes were agreed as an accurate record. **Matters Arising** CF noted that she expected all actions to be carried out and fed back to CF/GW.	
PART 2: GOVERNANCE LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – Regulation 28 response** Sharon Parkhouse introduced herself to the group as the Senior Nurse for Clinical Gerontology. Sharon presented an incident that occurred within the Medicine Clinical Board regarding a 98 year old man who had fallen in hospital and died. Before entering hospital the gentleman lived at home with his daughter and had been deteriorating mentally and physically and an end of life plan had been discussed. He had had 3 falls at home the week before being admitted to hospital and a review of care packages was being looked at. Whilst the gentleman was an Inpatient he experienced 8 falls in total - 4 of which did require an x-ray/head scan. He was a very private man so was cohorted with 3 other patients at risk and monitored at night. There was concern that 1:1 care would exacerbate his agitation. A falls care plan was completed specific to him. Once in place he experienced a further 4 falls. The last fall occurred during the night, when the HCSW had left another patient to go and empty a urine bottle in the sluice (the HCSW thought that this particular gentleman was fast asleep). The HCSW heard a bang and realised he had fallen. The patient was found lying at the bottom of the bed on his back. He was responding appropriately at that time so was helped back into bed. His neurosurgical observations were satisfactory at this point. As the night went on he deteriorated and started to act out of character and was complaining of a headache and was also holding his side. He was given Oxynorm for the pain. He continued to be agitated. When the patient was checked at 8.30am in the morning he was unresponsive. The Doctor was bleeped straight away but took 45 minutes to get there. The patient passed away 2 days later. Findings: - All risk assessments were completed and reviewed appropriately and recommendations were appropriate. However it was found that the risk assessments were not always carried out to a satisfactory standard. - The Care Plans could have been improved. The Care Plan regarding the gentleman's confusion was very generic and there was no Care Plan for frequent pain relief. - His high risk of falls was documented and 2 hourly intentional rounding was carried out. - The patient's daughter had open access to visit the ward as she was able to calm him down but there was no written evidence of this plan of care in conjunction with the patient's daughter. - The wards couldn't access sensor mats at this time. - The neurosurgical observations were a significant issue. Pupil size was missed as an important observation. Radiological imaging of the patient may have been undertaken if neurosurgical observations had been appropriately implemented. It would also have aided appropriate interventions to manage his pain. - Communication to the Doctor on call was an issue as the Doctor was told the patient's GCS was 14 however this was incorrect. The case went to the Coroner's court and received a Regulation 28. Work carried out since the incident: - A significant amount of teaching around falls for staff - it was found that not	

	all staff had been trained in falls and dementia. - The feeling was that the patient should have been 1-1 specialled so this process has been tightened up significantly. - The Work station has been changed and you can now add specific comments for that individual patient. - Documentation has been firmed up. Audits have been taking place to ensure care plans are in place. Patient specific information must now be on there. - Family visiting has been formalised. - Piloting patient passport on the ward. - Closer monitoring. - Can now access equipment, i.e. sensor mats but there are considerations to their use and must be reviewed on an individual basis. - The Clinical Board has carried out some bench marking with other Hospitals. - More activities to occupy and engage patients so less wandering on the wards and falling. - Trying to improve staffing levels by moving staff around and having recruitment events. - Reviewing HCSW role. The Medicine Clinical Board has stopped HCSW's carrying out neurosurgical observations since this incident occurred. Looking at a consistent approach across the Health Board. Looking at education around this as well. CF requested that any patients being specialled are done so by our own staff and Nurses booked from bank. A discussion took place on the usefulness of sensor mats – it was noted that they didn't work well for Neurosciences for faster moving patients. A discussion also took place on the use of Anti Embolic socks with grips for patients who pose a greater risk of falling. **Action:** CF requested that SW discusses with Lisa Franklin in LED who had previously undertaken work with the manufacturer of the AES when pressure damage was a concern. MR added that the Clinical Standards and Innovation Group is reviewing the UHB-wide approach to neuro-observations and HR commented that competence to undertake them is key.	**SW**
2.2	**Feedback from UHB QSE Committee** No meeting since our previous Clinical Board meeting.	
2.3	**Health and Care Standards** CF requested that the Health Care Standards are brought to this meeting to discuss what each Directorate is going to do with regards to improvement plans and what will be put in place. **Action:** GW to agenda for future meeting.	**GW**
2.4	**Risk Register – review and revision** CF noted that nothing new had been added to the Risk Register for the Clinical Board. CF informed the group that an Executive Performance Review had taken place on Wednesday where Bob Chadwick, Executive Director of Finance, had requested more detail around what the risks were in relation to Cost Reduction Programmes. **Action:** CF will send the risks that don't have sufficient recurrent savings in our plan to Hywel Pullen and Chris Bimson for further work.	**CF**
2.5	**Exception reports and escalation of key QSE issues from Directorate QSE groups** <u>Cardiac Surgery Heater Cooler</u>	

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	CP noted that every patient had been offered a follow up. CF noted that the process had been managed really well by the Directorate. <u>Incident logged with Surgery</u> RB informed the group of an incident which was logged with Surgery in relation to the malfunction of a drill perforator where the patient was left with a significant limb deficit. RB will provide an update at the next meeting.	
PART 3: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	**Initiatives to promote health and wellbeing of:** **Patients** **Staff** Oliver Williams, Senior Physiotherapist introduced himself to the group. Oliver provided a presentation on the "Community Resource Team provision of an Individualised Strength and Balance Programme (ISBP) for falls prevention in the Community – Performance Report for 01/11/2015 to 12/4/2017". The report was circulated prior to the meeting and details the method used and outcomes for patients who took part. Oliver focused on two main themes; raising awareness and intervention. Posters were displayed and talks took place regarding the ISBP. Falls awareness talks were carried out with carers and managers at care homes in 2016 and then sheltered accommodation in 2017. Oliver informed the group about the falls prevention "fuel tank" which is used as a way of encouraging the patient to seek help sooner – the person at risk of falling needs to monitor their fuel gage and not wait until the first fall. Oliver referred to the intervention process. The patient has an initial visit and then visits every two weeks after that. Then at week 8 they have a review. Then at 3, 4, and 5 months a telephone review and finally a 6 month review. The majority of patients completing an ISBP were female and the most common age group was 75+. Results showed over 2 falls less per patient for those who completed the programme. Public transport is an issue for the Vale with regards to getting people to attend the community based exercise classes whilst taking part in the programme. Only 11% attendance at the moment. CP requested copies of the posters. CP will check with Denise Shanahan first as advised by Oliver. If circulated the posters can be displayed to advertise the programme more and encourage participation. CF thanked Oliver for attending the meeting.	**CP**
3.2	**Bring forward –progress on relevant improvement plans (previously approved/discussed)** None discussed.	
PART 4: SAFE CARE		
4.1	**FFFAP Newsletter Feb 2017** **Lying and Standing Blood Pressure Guidance** SW referred to the Newsletter circulated ahead of the meeting entitled "Falls and	

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	Fragility Fracture Audit Programme (FFFAP) – newsletter February 2017". The newsletter notes that the Lying and standing blood pressure QI tool is now live. SW noted that she was not yet clear as to whether it was being advised that this tool is used as it is still being discussed. It is a guide and aid to assist clinical teams with lying and standing blood pressures and adopting a more standardised approach. SW will find out when it can be circulated to all areas for use. **Vision Assessment Tool** It was noted that since January 2017 the Vision Assessment Tool has been live. This is being piloted in some of the Medicine Clinical Board wards. The tool is fairly long which could be an issue. SW passed the documentation on the tool around to the group. **National Audit** The National Audit for Patient Falls will be taking place this week. It will mean people coming to areas to assess documentation and look at the assessments that staff are using. A discussion took place on taking a manual BP rather than electronic as this was one of the recommendations. More trialling possibly needed. The recommendation is to use the guidance ?	
4.2	**Patient Falls Data** CF informed the group that this was for information – noting that Neurosciences had the highest rate of falls, closely followed by Cardiology and Nephrology.	
4.3	**Patient Safety Incidents** <u>Inquests</u> The following Inquests were discussed with the group: - <u>INQ/IN35428</u> This one relates to N&T and a patient who was admitted for a kidney transplant. The inquest took place yesterday. Awaiting outcome. - <u>INQ/UHW/3126</u> Karen Lewis in Claims is leading on this. It relates to Cardiothoracics. The patient's mother has previously made a complaint. Karen has advised that it would be beneficial for a clinical person to review statements submitted to the Coroner and to identify if there are concerns. - <u>INQ/IN44394</u> This one relates to N&T and compliance with the News score protocol and coagulopathy issues in the patient. The Clinical Board is still seeking an Investigating Officer for this case. CF noted that she had contacted a medic asking him but had had no response as yet. **Action:** The Directorate were asked to follow this up. - <u>INQ/UHW/3078</u> Patient had an unwitnessed fall on B4 Neuro. This is subject to a Coronial investigation at the moment. All information has been produced and a report has been provided. <u>Open Serious Incidents (SIs)</u> Open SIs attachment for information.	**N&T**
4.4	**Patient Safety Alerts (internal/external)** <u>Alert For information:</u> - PSN034 Supporting the introduction of the National Safety Standards for Invasive Procedures. <u>National Safety Standards for Invasive Procedures (NatSSIPs) Task and Finish Group</u> MRR noted that a representative is still required for this group and highlighted that	

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	work is required as part of our assessment of compliance. **Action:** HR to speak to Martyn Read. CF noted that there was a NatSSIPs day on the 12th May which someone attended from one of the Directorates. **Action:** CF will find out who attended and share feedback with the group.	**HR** **CF**
4.5	**Health Care Associated Infections** CF asked SM how N&T were dealing with the increased C.Difficile incidents. SM noted that the cases were being closely monitored. BO noted that Critical Care had recently had 3 Aceintobacter Baumannii cases. 3 patients came in 2 days apart. The unit was explored and infection control was involved. Focus on Theatres and A&E. Follow up meeting being arranged. Completed our screening and it came back negative. Difficulty tracking batch numbers. It should be noted that this does not relate to the outbreak of Aceintobacter on B6. VS informed the group that there were 4 cases of C.Difficile within the Clinical Board. 2 cases in February and another case in May. For May so far, 1 on B5 and 1 on the Cardiff Transplant Unit.	
4.6	**Bring forward –progress on relevant improvement plans (previously approved/discussed)** None discussed.	
PART 5: INDIVIDUAL CARE		
5.1	**Bring forward – progress on relevant improvement plans (previously approved/discussed)** None discussed.	
PART 6: URGENT BUSINESS (missed off Agenda but discussed in meeting)		
6.1	**To consider any urgent issues** NM raised the following items with the group: <u>Hand Hygiene</u> NM noted that Hand Hygiene was discussed on Tuesday at the Annual Directorate Performance Reviews and as an IP&C item at HSMB yesterday, in relation to clarifying our approach. The Clinical Board will be producing a letter that will be circulated to all DMTs stating that from the 1st June 2017 there will be a zero tolerance approach to bare below the elbow and Hand Hygiene. The Clinical Board wants to empower all staff at all levels to challenge staff if not adhering to this. NM agreed to strengthen the section in the letter that notes the importance of empowering staff to challenge. <u>Cyber Security</u> Directorate teams need to collect a list of all medical and other devices that are based on Windows PC, e.g. Echocardiograms and ECG machines. Directorates need to make sure that lists are complete. **Action:** JC emailed Directorate Managers yesterday to collate lists. N&T had responded to say that they have none. Critical Care have 4 items. The list will then go to IT so that they can patch the machines to protect them from viruses. It was noted that the UHB recommends the use of encrypted memory sticks and that they may not be being used in all areas of the Board. **Action:** NM requested that Directorates start to think about how to address this. <u>National Audits</u> NM noted that there are a number of National audits that the Directorates take part in and that every so often the National Audit produce a report on these to Welsh Government who then send it to us for a response - Part A: How it affects us locally and Part B: What we'll do. National audit response proformas. CF to	**DMs** **ALL**

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	check as 2 outstanding.	

Date and time of next meeting: Thursday 8th June 2017, 8am, Critical Care Resource Room, A3/B3, UHW.

Specialist Services Clinical Board
Quality, Safety & Experience Committee
8th June 2017

PART 1: PRELIMINARIES		Actions
1.1	Welcome & Introductions CF welcomed the 3 guest speakers, Julia Barrell (JB)- MCA Manager, Patient Safety Team, Dr Jacqueline Jeffries (JJ)- F2 who had worked in Critical Care and Dr Peter O'Callaghan, Clinical Director, Cardiothoracics to the meeting. In Attendance Carys Fox (CF), Director of Nursing, Specialist Services Clinical Board- *chair* Rachel Barry (RB), Lead Nurse, Neurosciences & ALAS Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety Lisa Evans, Clinical Nurse Leader, Critical Care Colin Gibson (CG), Consultant Clinical Engineer, Rehabilitation Engineering, ALAS Nick Gidman (NG), Directorate Manager, Cardiothoracic Services Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant Sian Pring (SP), PA, Haematology, Clinical Immunology & Medical Genetics- *minutes* Jennifer Procter (JP), Lead Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics Hywel Pullen (HP), Director of Finance, Specialist Services Clinical Board Martyn Read (MR), Consultant Intensivist, Critical Care Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board Maria Roberts (MMR), Patient Safety Manager, Patient Safety Vince Saunders (VS), IP&C Sian Williams (SW), Senior Nurse, Cardiothoracic Services	
1.2	Apologies for absence Andrea Edwards (AE), Consultant, Medical Genetics Mark Jones (MJ), Directorate Manager, Nephrology & Transplant Claire Main (CM), Lead Nurse, Nephrology & Transplant Dale- Charlotte Moore (DCM), Directorate Manager, Critical Care Beverley Oughton (BO), Senior Nurse, Critical Care Jessica Castle (JC), Director of Operations Nav Masani (NM), Clinical Board Director Steve Gage, Pharmacy	
1.3	To review the Minutes of the previous meeting 19th May 2017 The minutes were agreed to be an accurate record of the previous meeting. Matter Arising A representative from the Mental Health team will be talking at the next NMB meeting to discuss the reduction of falls in the department. 2.1 Patient Story – Regulation 28 response RB reported that use of sensors had been discussed by neurosciences. CF asked that they identify ones that may be suitable and trial them. 4.4 National Safety Standards for Invasive Procedures (NatSSIPs) Task and Finish Group	**RB**

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	Martyn Read has agreed to be the NatSSIPs lead. Deb Powell from Haem attended the awareness day on 12th May. Maggie Hill and another cath lab staff member were unable to attend due to operational pressures. They will link in with Deb Powell.	**SW**
	6.1 Hand Hygiene Nav Masani has drafted the consultant's letter. It will be circulated upon his return from leave next week.	**NM**
PART 2: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	Patient Story – Peter O'Callaghan PO'C discussed case in cardiology that had led to a patient concern. The patient attended A&E 3 times within a week in June 2015 for chest pain (the first 2 instances for atypical chest pain, the 3rd for severe chest pain). During his first A&E attendance on 7th June, the patient was given a full assessment by a cardiology SpR and a plan put in place for future management as an outpatient. The patient presented to A&E again on 10th June with recurrence of the same chest pain symptoms and the patient was kept on MAU overnight. The cardiology SpR was informed, but only provided telephone advice. The medical team were advised to stick to their original plan and the patient was discharged. On 13th June, the patient presented at A&E with severe chest pain (totally different in character and severity to his previous attendances) via ambulance. ECG indicated an anterior STEMI, PPCI was performed with an excellent result. Following receipt of a formal complaint, initial investigation into the patient's concerns deemed cardiology management to be appropriate and that there was no indication for urgent treatment before the 3rd admission. However it was noticed that during his second admission the lead physician was not aware he had been discharged. The concern was subsequently sent to the Ombudsman, and at that point PO'C changed his view on the initial response. The PSOW stated that the cardiology SpR should assess all patients personally and avoid giving telephone advice, PO'C agreed with this action. PO'C also noted a culture of inappropriate requesting of troponin testing, something which is in operation across the country. Salient messages for all Directorates related to seeing every patient that is referred rather than providing advice by phone. All Directorates to discuss at DMT and QSPE PO'C to follow up Troponin testing with Jo Mower although it was recognised that there is an issue with in patients as well. HR reported that many patients in Critical Care have Troponin tests which are often unnecessary, which he will raise at the Critical Care Consultant meeting. MMR suggested that Laboratory Medicine would likely be keen to assist with ensuring appropriate testing.	**ALL** **HR**
2.2	Feedback from UHB QSE Committee There hasn't been a committee meeting since the last Specialist CB Q&S meeting.	
2.3	Risk Register – review and revision The Interventional Neuroradiology service cannot be provided at present. Patients are presently being sent to other hospitals for care (7- 8 patients in total have been transferred to	

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	Birmingham, Oxford and other centres). Advertising for substantive posts and locum staff is underway. The service is delivered by CD&T but this is a significant risk to neurosciences patients. The 2 Clinical Boards have been working together on resolution. Due to the impact on patients the risk assessment score has been reassessed at 25 and input has been sought from CD&T for the risk register. MMR advised that this matter has been reported to WG and WHSSC on behalf of CD&T CB. The cardiology risk assessment for the TAVI service is to be added to the CB risk register. **Action: NG to forward risk to CF.**	NG
PART 3: SAFE CARE		
3.1	Patient Safety Incidents An Open SI Report RB reported that the SI that occurred in neuro theatres is progressing and the patient is improving and doing well. The equipment in question has been sent to the manufacturer for analysis as part of the investigation. Closure Forms 2 closure forms have been sent to the WG. VS reported that the legionella case closure form was still outstanding from ED. **Action: VS to liaise with ED.** RB stated that there are a few issues to capture on a closure for a C4 incident that should all be signed off by the end of the week. MR is to review the "Never Event" investigation on Critical Care with MMR and SC after the meeting in order to progress it. An Open Inquest report The inquest for INQ/UHW/3126 took place on 07/06/2017 and the outcome is awaited (cardiology patient) An inquest date for case INQ/UHW/3078 has now been set for 24/08/2017; this relates to a neurology patient where a concern has also been received. No revised date has been set for INQ/IN44394 as yet, but an investigating officer has been appointed.	**VS**
3.3	Health Care Associated Infections HCAI rates VS reported that in May there were 4 cases of MSSA and 4 cases of *C. Diff* in Specialist Services. So far for June there have been 2 cases of *C. Dif in the CB*. C.Diff/ MRSA RCA reports Reports for the 2 June C. Diff cases are not out yet. RCA reports for the recent E. Coli cases also need to be distributed. Progress with relevant improvement plans CF, NM, ED and VS will be meeting on 12th June to devise the Annual Work Plan for HCAI for Specialist Services.	**VS**
PART 4: INDIVIDUAL CARE		

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4.1	<u>National Survey Report – May 2017</u> The May reports have been circulated. CF noted that the numbers of responses returned are highly variable month to month. Each Directorate is to review the process for return of completed questionnaires. CF to put in place a database for monthly collection of figures	**ALL** **GW**
PART 5: DIGNIFIED CARE		
5.1	<u>MCA Audit Pilot Results and Learning Points – Critical Care</u> JB and JJ presented the results of their MCA pilot audit conducted earlier this year on HDU. The results of the audit showed that of the 19 decisions assessed, 11 patients with good reason to doubt capacity had no documented capacity assessment or best interest decision for any aspect of their medical/nursing care. The remaining 8 decisions had a capacity assessment- 7 as part of consent form 4, 1 on a restraint proforma. Furthermore there was no mention of lack of capacity being permanent/temporary, the UHB capacity assessment or best interests decisions forms had not been used, only 2 people provided sufficient evidence of why they had come to the conclusions they had and nobody had outlined what steps they had taken to support the patient making the decision for themselves or if this was possible. The audit concluded that documentation of decision making around capacity issues was generally extremely poor across all professionals working on HDU. Documentation of patients' mental capacity was most likely to be included when considering invasive or risky procedures. UHB approved paperwork is not in use in critical care, despite its recommendation in departmental policy and documentation improves with the presence of forms and proformas. There was evidence of poor understanding of the MCA and responsibilities as healthcare professionals. This is now a mandatory requirement for staff to be trained. The audit tool is to be further developed. The form used for the pilot audit will be circulated for discussion at Directorate QSPE meetings and audit in all Directorates. Mental capacity with the audit results will be an agenda item again at Clinical Board QSPE in September 2017.	**ALL** **HR** **ALL**
PART 6: ANY URGENT BUSINESS		
6.1	MR shared a request from Alan Wardhaugh regarding the need for each Clinical Board to have an Informatics lead. He also requested that each Clinical Board send 4 representatives to the IMT committee. MR also stated that NWIS will be imposing access levels dependent on job roles on the Welsh Clinical Portal. Advice will be sought regarding what aspects of people's roles will determine their access level. VS reminded everyone that for the next few weeks the IP&C team will be conducting the point prevalent survey. As a result availability of staff will be severely limited. Nat SSIPs- all Directorates have to identify a lead. CF considered that the most affected Directorates will probably be Cardiac and N&T CF will forward documents for review and MMR offered assistance from Patient Safety Team to undertake the gap analysis required.	**ALL** **CF**
PART 8: DATE OF NEXT MEETING		
8.1	Friday 30th June 2017, 8am, in the Critical Care Resource room, UHW.	

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MINUTES
Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, 30th June 2017
Venue: Critical Care Resource Room

In Attendance: Jessica Castle (JC), Director of Operations (Chair)
Navroz Masani (NM), Clinical Board Director
Hywel Roberts (HR), Consultant Intensivist & Medical QSE Lead for Specialist Clinical Board
Rachel Barry (RB), Lead Nurse, Neurosciences & ALAS
Suzie Cheesman (SC), Patient Safety Facilitator, Patient Safety
Colin Gibson (CG), Consultant Clinical Engineer, Rehabilitation Engineering, ALAS
Mary Harness (MH), Senior Nurse, Haematology, TCT, Clinical Immunology & Medical Genetics
Fiona Kear (FK), Assistant Service Manager, Haematology, Immunology & Medical Genetics
Sarah Matthews (SM), Senior Nurse, Nephrology & Transplant
Sian Williams (SW), Senior Nurse, Cardiothoracic Services
Beverley Oughton (BO), Senior Nurse, Critical Care
Mathew Price (MP), Assistant Service Manager, Neurosciences
Gareth Jenkins, Service Manager, Haematology, Immunology and Medical Genetics
Claire Main, Lead Nurse, N&T
Steve Gage, Pharmacist Clinical Board Lead
Rachel Rayment, Consultant Haematologist
Ceri Phillips, Senior Nurse, Cardiothoracics
Rafael Chavez, Consultant, Nephrology & Transplant

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Present: Rachel Rayment, Consultant Haematologist (presenting)
Gemma Williams, PA Specialist Services Clinical Board (Note taker)

PART 1: PRELIMINARIES		ACTION
1.1	Welcome & Introductions	
1.2	Apologies for absence Received from; Carol Evans, Mark Jones, Jonathon Kell, Dale Charlotte-Moore, Vince Saunders, Jennifer Proctor, Andrea Edwards and Maria Roberts.	
1.3	To review the Minutes of the previous meeting 8th June 2017 The minutes were agreed as an accurate record, subject to adding Steve Gage's apologies. Matters Arising 1.3 Patient Story – Regulation 28 Response RB noted that they are trialling a few different types of sensor mats on B4 and will feed back to the group at a later date. They are trialling one that they have	

	purchased at the moment. <u>National Safety Standards for Invasive Procedures (NatSSIPs) Task and Finish Group</u> CP informed the group that a NatSSIPs meeting took place on Monday 26th June with Maria Roberts and Suzie Cheeseman (SC) from the Patient Safety Team and one representative from each Directorate attended. Hoping to get all of the relevant information required by next week. SC noted that the group will be getting together again in July to review further. CP noted that Maggie Hill, Unit Manager, Cardiac Cath Lab, and Deborah Powell, Senior Nurse, Haematology, were looking to benchmark with some other hospitals in England regarding the PCI Service - there are some links with centres in London. Theatres are also further on with this work so Maggie and Deborah have emailed Mark Bennion, Clinical Governance Facilitator for the Surgery Clinical Board, regarding joint working (meeting on the 14th July with CP, Mark Bennion and Maggie Hill). CP noted that it seemed like a large amount of work was required and that information sharing should help with the process. JC suggested that Cardiac share this information with other Directorates once received. <u>Hand Hygiene</u> NM confirmed that he had drafted and circulated the Consultants letter regarding the zero tolerance approach to not adhering to bare below the elbow in clinical areas. Directorates were asked to circulate widely. **Action:** NM requested that Directorates feed back to let him know how it's going and whether the requirements are being adhered to. NM noted that a mechanism is needed for Directorates to record any deviation. <u>2.1 Patient Story – Peter Callaghan</u> All Directorates confirmed that they had discussed in their areas the importance of seeing every patient that is referred rather than providing advice via the phone. JC noted that HR was not present at the meeting at this point to confirm whether he had raised the issue of some patients in Critical Care having Troponin tests which are often unnecessary in the Consultants meeting. **Action:** This will be picked up with HR outside of the meeting. <u>2.3 Risk Register – review and revision</u> It was confirmed that Nick Gidman had sent the cardiology risk assessment for the TAVI service to Carys Fox to add to the Clinical Board Risk register. <u>3.1 Closure Forms</u> SC confirmed that the Legionella case closure form was no longer outstanding and had been sent to Welsh Govenrment. <u>3.3 C.Diff/MRSA RCA Reports</u> Vince Saunders not present at this meeting – **Action:** GW to check whether he has circulated the reports for the two C.Difficile cases and the recent E.Coli cases. <u>4.1 National Survey Report</u> Directorates confirmed that they had reviewed their processes for returning the completed questionnaires. **Action:** GW to speak to Carys Fox, Director of Nursing, Specialist Services	**Dirs** **JC/HR** **GW/VS** **GW**

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	Clinical Board, regarding the setting up of the data base to collect monthly Directorate figures. 5.1 MCA Audit Pilot Results and Learning Points – Critical Care Directorates confirmed that they had informed staff in their areas that MCA was now a mandatory requirement for them to be trained and that mechanisms were now in place to ensure that this is completed. It was confirmed that Directorates had discussed the tool in their QSE meetings. 6.1 NatSIPPs Discussed above.	
PART 2: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	Patient Story No patient story at this meeting.	
2.2	Feedback from UHB QSE Committee SC confirmed that she had not yet received feedback on the recent UHB meeting. Maria Roberts, Patient Safety, will discuss with Carol Evans, Asst Director Pt Safety And Quality and feed back at the next meeting.	
2.3	Risk Register – review and revision JC noted that Carys Fox had asked Hywel Pullen, Director of Finance for the Clinical Board, to review the financial risks included on the Risk Register. JC noted that the Board is forecast to be under spent again this year – revised risk rating to 4. JC noted that the TAVI risk previously discussed was going to be added to the Clinical Board Risk Register and asked the group if there were any more that needed to be included. CP noted that she had sent an SBAR to Carys Fox re the Pacing Theatre C3/CCU staffing levels. RB noted that the Neurovascular risk was still ongoing. JC noted that they were currently revising the risk as it is changing on a day to day basis. **Action:** JC will send RB the latest version. **Action**: RB to review it re mitigating actions.	**JC/RB**
2.4	Exception reports and escalation of key QSE issues from Directorate QSE groups SG informed the group that supply chain problems are affecting enoxaparin (Clexane®) 20mg and 40mg pre-filled syringes, noting that it was a national problem. He noted that Pharmacy expect supplies to meet demand in July and August but beyond that is uncertain. SG noted that it is used across all areas. **Action:** JC requested that Directorates make sure staff are aware.	**ALL**
PART 3: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
3.1	Initiatives to promote health and wellbeing of: JC referred to the link included in the agenda relating to the Renal Nurse Study Day. CM noted that their clinical psychologist provides a lunchtime meeting for staff to discuss any patient or staff issues but that the Nurses were finding it hard to get to the meeting. Therefore this renal study day was arranged to include a number of sessions all in one day, to discuss stress coping techniques/issues for patients on dialysis long term, mindfulness etc. The session was thought to be very positive and recommended as a regular event.	
PART 4: SAFE CARE		
4.1	Patient Safety Incidents	

Regulation 28 response DE

SC noted that this case related to a gentleman in his 50's who died as a result of complications following a ruptured thoraco-abdominal aneurysm. The patient was presented at UHW A&E with severe abdominal pain. Whilst in hospital he underwent an ultrasound scan of the abdominal aorta that revealed a diameter of 40mm. The registrar had instructed a junior doctor to discuss the need for further imaging with a radiologist who decided; based on the information provided, that further imaging was not required., No further investigation of the aorta was conducted and he was discharged with a diagnosis of diverticulitis and given antibiotics. 7 days later he was admitted to UHW and an examination revealed a ruptured abdominal aortic aneurysm. The patient underwent surgery to repair the aneurysm. He deteriorated and was taken back to theatre soon after where a significant amount of ischemic bowel was identified from which he was unable to survive and died later that day.

Matters of concern raised by the coroner:

- The evidence revealed that the Dr that conducted the Focused Assessment with Sonography for Trauma (FAST) Ultrasound examination had not completed the necessary training and should have conducted the scan under supervision.
- The evidence revealed that records of FAST ultrasound examinations are not routinely stored preventing evaluation of scans to be undertaken after the event.
- Where an abdominal Aortic Aneurysm (AAA) is identified in the emergency unit by a FAST ultrasound examination and a patient is symptomatic there should always be an appropriate escalation of care.

Actions to be taken:

- Consideration should be given to reviewing procedures related to the training and supervision of those undergoing training in conducting FAST Ultrasound examinations.
- Consideration should be given to reviewing procedures for recording the outcome of FAST ultrasound examinations
- Consideration should be given to reviewing procedures surrounding the management of symptomatic pain ets where an AAA has been identified by a FAST ultrasound examination.

All actions are complete and arrangements are in place to share lessons from this incident.

NM noted that the Registrar should talk to the correct department and no-one else should be asked to pass on a message re the patient. **Action:** JC requested that Directorates take this message back to their areas. **Action:** CP to speak to Richard Wheeler in Cardiology re sharing this information.

Closure Forms

SC informed the group that the target each month was sign off of 4 closure forms. SC noted that since January the Board has signed off 15 which is good. Currently 17 open – 10 over due and 7 in date. SC to liaise with JC to attend the next Clinical Board Weekly Ops meeting to discuss in detail. It was noted that there were some valid reasons for the out of date ones.

IN21389

A lady under the care of the North West Locality Team developed a grade 4

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	pressure sore whilst at home. The lady has a wheelchair provided by ALAC. The lady has some physical disabilities and suffers from Multiple Sclerosis. It is believed that the ROHO cushion in use with the wheelchair may have been leaking, contributing to the deterioration in the patients pressure areas. However there were a number of contributing factors – such as the patient was not complaint with the correct use of the cushion and was sitting on lots of layers. The main issue with the case was that a referral to ALAC was made by sending a referral form electronically but unbeknown to the District Nurse, the referrals are only accepted on paper and the email address on the form was no longer monitored so the referral was not received. A district Nurse did then contact ALAC to enquire about the referral and was advised of the correct process which was then followed. It was noted that the referral email address has now been decommissioned and the new forms circulated. Information and training has taken place with patients on how to use the cushions. The closure form was signed off by the group. IN33844 A gentleman who was an in-patient on C4 Neurology contracted Legionella. Water samples were taken to test for Legionella from outlets on C4 Neurology adjacent to the patient's location. Several water outlets were positive for Legionella including, the shower in the en-suite of the telemetry cubicle, the hand wash basin in the cubicle and the hand wash basin in the 4-bedded area outside the cubicle. The patient is now fine and home. The shower was not routinely used by patients admitted in to the cubicle due to the nature of the investigations; for those reasons the shower was deemed to be a low usage outlet and as such should have been regularly flushed. This was not being carried out. The investigation revealed that regular flushing of taps was in place but the shower was overlooked. The shower has now been removed from the ensuite. Legionella team will be auditing records. The closure form was signed off. IN22038 A lady on Intensive Care underwent a surgical tracheotomy nursing staff reported difficultly ventilating the patient. When the patient was rolled the tracheotomy became dislodged. A larger tube was inserted which did result in ~~bring~~ being able to ventilate with difficulty but by now the patient was profoundly hypoxic and hyperbaric resulting in cardiac arrest. Cycles of CPR were unsuccessful and the patient died. All guidelines were followed correctly. Work undertaken to support the CEPOD session when repositioning a patient, the closure form was signed off. Serious Incident Report For information. Open Inquests For information.	
4.2	Patient Safety Alerts (internal/external) For information. MDA/2017/015 Solus Flexible Wire Reinforced Laryngeal Mask Airway – risk of hypoxia due	

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	to partial or total occlusion of the airway tube after inflating the cuff. MDA/2017/017 BVM (Bag-Valve-Mask) manual resuscitation systems – risk of delay to emergency treatment. SC noted that the feedback she has received is that we don't use bag valve resuscitation in Critical Care. SC requested that Directorates review the alerts and follow the guidance/advice.	
4.3	TTP Pathway Rachel Rayment, Consultant Haematologist, was introduced to the group. Rachel referred to the paper she had circulated ahead of the meeting "Diagnosis and management of thrombotic thrombocytopenic pupura (TTP)" and noted that she was hoping for sign off by the Clinical Board. Rachel informed the group that 18 months ago the TTP Service was suspended due to a patient death and they have been working on making the service more robust. Nurses have been trained to use the ? machines in ICU. The document provides guidance on the diagnosis and management of patients with TTP. Rachel discussed the pathway in detail with the group. Anyone suspected of TTP has to follow this pathway. BO noted that they had had 10 cases since August and that demand was higher than expected. Rachel was not aware of 10. Possibly counting different things. The group were happy with the clinical pathway. More thought needed as to how to put this into practice. JC suggested that this is discussed again at a future meeting. NM suggested that there must be some cost benefit analysis of testing patients for TTP rather than treating all suspected patients with plasma exchange. VTE – the results of the latest Audit SG presented to the group on Medicines Safety Metrics – Thromboprophylaxis prescribing Specialist Services Clinical Board. SG discussed the following: - Policy for the prevention of venous thromboembolism in adult and teenage inpatients - 2017 Audit records (5 compliance) Specialist Services CB by ward SG noted that the documentation on the chart can be improved and that the prescribing was better than the documentation showed. Appropriately prescribed mostly but feedback needed to change behaviour. **Action:** NM requested that the group take back to their Directorates the importance of ticking the box on the IP prescription chart in relation to "have you considered prescribing thromboprophylaxis - Yes/No". Rachel Rayment (who is the lead for the Health Board) noted that Rookwood isn't included as not an acute hospital. Need to look at how data can be captured from Rookwood.	**NM**
4.4	Health & Safety Group TOR MP noted that the Terms of Reference (TOR) need ratifying by this group. Health and Safety will be a subgroup of the Clinical Board QSE Committee. **Action:** JC felt a couple of amendments were required which she will make and then send back to MP. **Action:** JC requested that the group send any comments back to MP by next Friday (7th July) and then further discussion at the next QSE meeting.	**JC** **ALL**

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4.5	Health Care Associated Infections JC noted that Vince Saunders was not available to attend this meeting. HR noted that a lead for each Clinical Board for HCAI was required. It was agreed that this would be brought back to the next meeting.	
4.6	NICE Guidance Proforma NG67 (not discussed/noted at previous meeting) For information.	
4.7	Bring forward –progress on relevant improvement plans (previously approved/discussed) None.	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Mental Capacity Audit Template (circulated to the group 27/6/17) JC noted that the template had been circulated so that Directorates could complete their own audits. 3 months to complete these audits. Results to be brought back to a future meeting in the Autumn. SBAR re Pacing Theatre CP confirmed that she had sent the SBAR to Carys Fox, Director of Nursing for the Clinical Board, to review in the first instance. NM noted that intentional rounding would be useful.	
PART 6: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
6.1	Received and noted for information	
PART 7: DATE OF NEXT MEETING		
7.1	Thursday 20th July 2017, 8am, in the Critical Care Resource room, UHW.	

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Minutes
Medicine Clinical Board
Quality, Safety & Experience Committee
Held on 18th May 17 14:00 – 16:30
Venue: Classroom 2 UHW

Attendees:	Rebecca Aylward (Chair)	Jason Roberts
	Suzie Cheesman	Lisa Harwood
	Lisa Graham	Sharon Parkhouse
	Jane Morris	Andrea Datta
	Ruth Rhydyrch	Gemma Murray
	Wayne Parsons	Jane Murphy
	David Pitchforth	Gill Spinola
	Tara Cardew	Helen Ronchetti
	Sarah Dimond-Garcia	

Preliminaries		Action
A1	**Welcome & Introductions** Rebecca welcomed everyone to the meeting.	
A2	**Apologies for absence** – Richard Evans, Sarah Follows, James Coulson, Rebecca Owen-Pursell, Sarah Dix, John Green, Sian Brookes & Sharon O'Brien, Kath Prosser, J Turner	
A3	**To receive the Minutes of the previous meeting** Matters Arising – Minutes from the previous meeting were approved as a true record.	
GOVERNANCE, LEADERSHIP AND ACCOUTNABILITY		
1.1	**Patient Story (LH)** – LH didn't feel that this was a patient story but discussed the Dementia Champions meeting that she had attended where families were invited to share their experience. Two relatives attended this meeting of which one had been a concern which was formerly managed by LH. It was a difficult meeting and from a personal view point was quite challenging. They were making some quite professional strong comments. The environment was difficult and there are two sides to every story. LH felt compromised at this meeting and found it very uncomfortable. For future meetings staff should have the opportunity to prepare.	All to note
1.2	**Feedback from UHB QSE Committee** Link to all Q&S confirmed minutes has been sent out. http://www.cardiffandvaleuhb.wales.nhs.uk/quality-safety-and-experience-committee-	
1.3	**Directorate Risk Register's** Gastro – There were two new additions Treatment room on A7 in terms of the nurse led paracentesis service Elective admissions to A7 Alert from WAG relating to endoscope use not for licensed use	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
2.1	**Sepsis 6 Implementation up date** Hand-outs were given out by (Jane Morris) and group discussion held. 1 – **Quality improvement & skills teaching** – There was good representation and good feedback. Gerontology & Gastroenterology are planned to attend the next session. 2. **Sepsis steering group** led by Andrea Datta and Jane Morris.	

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	3. **Sepsis group meeting** next week to discuss roll-out 4. **Questionnaire to staff** – results were mixed but education is needed, a teaching programme will be rolled out to include HCSW on the ward. 5. **Sepsis Charts** haven't been printed yet – once printed there will be a launch day.	
2.2	**Health & Care standards action plan MCB** The plan has been sent out with the papers, over-arching action plan has been set up so we can evidence what has been completed by the Clinical Board following on from the recommendations submitted. To be discussed in the next Medicine Nursing Board forum.	
2.3	**Sensory Loss** Presentation on Sensory Loss was presented by R Rhydyrch	
SAFE CARE		
3.1	**New SIs** WG closure forms for discussion and shared learning • **In41386 (Gastro)** – injurious fall West 1 – Patient was admitted via MEAU. The risk assessments had been completed and the patient was confused (encephalopathic) with a high risk of falls, all bed rails were in place as per risk assessment but the fall mat wasn't assessed as needed. Patient shuffled to the end of the bed overnight and subsequently fell off. The patient sustained a fractured humerus. He was moved back to bed using a sling hoist rather than a hoverjack as the patient was uncomplaining of any other pain on examination. A couple of days later the patient was attempted to be mobilised by the physio and he complained of hip pain, an x-ray showed a fractured neck of femur. There was also a delay in advising the family of this fracture asradiology input was needed by T&O to confirm the fracture. (Patient sustained the initial fall on the Saturday but fracture NOFwasn't diagnosed until the Monday).There was a delay in the WAST transfer over to T&O UHW for surgery. The patient is still an inpatient. Learning from this incident involved reinforcing the need for post falls RAs, pre-falls were completed but post were not. We have also reinforced the need for to use the hoverjack. • **In31084 (Clinical Gerontology)** SRC – Patient A fell on to patient B. Patient A had moderate dementia and there was a delay in this patient receiving a CT head scan secondary to their cognitive impairment and the completion of neurological observations in line with NICE 2015 guidelines. The patient was monitored by nursing and medical staff whilst attempts were made to complete a CT head scan which confirmed a Sub Dural Haematoma. Sadly this patient died several days later. Unfortunately this incident was also linked to an IRMER where the incorrect patient was sent for a CT head secondary to incorrect patient identification labels being placed on the request form. • **In40929 (Clinical Gerontology)** – East 6 – Patient was admitted following a fall, all assessments had been completed in line with best practice, the patient's bed was set at the lowest and a mobility care plan was in place. The patient suffered an un-witnessed fall at the end of the bed sustaining a fracture. The patient was assessed and assisted to return to bed, the Hover jack wasn't utilised. It was noted that there were a high number of patients on the ward with potential risk of falls at the time of this incident. Learning points – All staff have been debriefed, staff continue to receive education and training in relation to NICE 2015 guidelines post falls, and the utilisatiion of the Hover jack. The established Ward Sister was acting up on a different ward at the time of the fall.	

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	• **In42980 (Clinical Gerontology)** – Sam Davies Ward – Un-witnessed fall sustaining a fracture. Transferred to UHW for surgery and was transferred back to Sam Davies for ongoing rehabilitation. Patient had past medical history of Alzheimer's and had a known history of falls. All assessments were completed in line with best practice and it was noted that the patient was non compliant using the nurse call bell. Unfortunately the Hover jack was not utilised in line with best practice following the provision of this equipment recently at Barry Hospital. Neurological observations were also not completed in line with best practice. All staff have been reminded of the NICE 2015 guidelines post falls procedure. • **In43010 (Clinical Gerontology)** –SRC – Grade 3 – 4 hospital acquired pressure damage – sadly the patient later died of bronchial pneumonia. The RCA noted that Skin Bundles had been completed in line with best practice and that patient was nursed on the appropriate mattress. - Learning identified audits of risk assessments are being regularly undertaken and are discussed at the Senior nurses' meetings. All staff within this area have been on pressure damage training days. SRC has had a change of nursing establishment as there have been deficits over the last year. Two Grade 2 pressure damage have been reported in April but the patients were identified as high risk secondary to diabetes, mobility and contracture. Improvements have been seen on the Ward. • **In41789 (Internal Medicine)** – Pressure damage reported on admission as being red but skin intact and to refer to the Tissue Viability Team. At this time the appropriate mattress selection was being used. The pressure damage was confirmed as Grade 3 by the Tissue Viability Team. The All Wales Pressure Damage RCA identified that the appropriate care had not been correctly carried out, skin bundles were not completed and there was a delay in the required air mattress being ordered/delivered. **Actions** – All staff have been reminded about the requirement to maintain accurate and timely documentation. Education and training for pressure damage management and prevention for the ward is currently 85% complete. Improvements have been noted in the completion of pressure damage care plans and intentional rounding documentation.	
3.2	**Patient Safety Alerts** All patient safety alerts have been discussed. **MDA -** Alaris Syringe Pumps **PSN0307** – Resources to support the safety of girls and women who are being treated with Valporate **WHC –** The new treatment fund: Access to medicines recommended by NICE and the All Wales Medicine Strategy Group **Gastroscopes** not being used for license purposes – WAG have issued an alert – this will be added to the Gastroenterology, Hepatology and Endoscopy Risk Register.	
3.3	**Health Care Associated Infections (Helen Ronchetti)** HCAI rates HCAI rates CDiff/ - 4 in April and 1 in May so far (at the time of meeting) MRSA Bacteraemia – 0 for April	

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	E-Coli Bacteraemia – 0 MSSA Bacteraemia – 5 days since last case on A7 Weekly/Environmental Audits – All wards need to carry out their own weekly audits (Rebecca Aylward). **Hand hygiene** – Range from 69-93% across areas but this needs to be improved Bare Below the Elbow – this continues to be a problem. Staff need to challenge doctors/junior doctors or any staff that are not BBE and this can be escalated to Dr RE It was identified that there was a need to review the process and procedure around patient wash bowls as the water used cannot be disposed of down the sinks within all clinical areas and that they should only be disposed of down the Sluices. It was discussed if other options could be explored such as sterile wipes that could be used around the wash basins rather than having to provide trolleys to carry the washing bowls to the Sluice as staff are not permitted to carry them. Patients should be encouraged to use the bathrooms to undertake washing and dressing activities. JR to c/f for further discussion.	
3.4	**Decontamination Group up date** - (TC) A decontamination action plan relating to processing single use laryngoscopes will be released which will likely affect USC. — Hwel Dda – Have been using scopes which have been leaking and we are using similar scopes in Cardiff, these have all been checked and no leaks have been reported. Decontamination machines (AERs) – an alert was issued for wassenburg AERs which are used in UHW endoscopy, whereby on an intensive wash a leak may occur leading to scoped not being properly decontaminated. IN Cardiff and Vale we only use a full wash so time exposed to detergent is maximal and therefore this alert is not an issue for us. Decontamination work plan for 2017-18 includes a review of management out of hours and provide decon audit framework.	
EFFECTIVE CARE		
4.1	**Director of Nursing Quality & Safety Report February and dashboard SIs** - Nothing specific to report we have 21 open Sis with a further 8 currently being prepared for closure in June. Medication errors – on average we are reporting 20-25 but there are no common themes. **VTE issue** – 55% we were challenged on new medication chart but we are still running down old medication charts. **Concerns** – For April 35% of concerns have been issued within target, 4% issued that have breached target, 54% ongoing within target and 2% that are ongoing that have breached target. Any concerns that are waiting for responses by other Clinical Boards need to be escalated to JR. .	
4.2	**Clinical audits:** 'How are we managing pneumothoraxes' 'Diabetes Ketoacidosis' This wasn't discussed, JR to discuss with Dr Richard Evans.	JR to discuss with Richard Evans
4.3	**Model Ward – Nutrition & hydration** – There is a ward based caterer on the ward from 07.00am until 19.00 pm including a dietetic assistant. Protected mealtimes are in place, however, patients relatives and carers are encouraged to visit to assist with dietary/fluid intake if required. Patients are offered meals from a menu choice with additional milkshake rounds and hot/cold drinks made readily available for patients. New plates/dishes are also being used to assist	

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	patients in that they are a different colour and have a ridge around the outside. To date the feedback has been extremely positive from patients and relatives. Further feedback will be given at the next Clinical Board QSE meeting in June.	
DIGNIFIED CARE		
5.0	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** EU – HIW visit – action plan agreed and to be verbally up dated at each Clinical Board QSE meeting to share progress. **East 4/East 1** - This can be taken off all actions have been done.	East 4/East 1 to be taken off agenda as all actions have been done.
5.1	Sensory Loss/up – date questionnaire feed back - Sensory loss updates were discussed after the presentation above.	
TIMELY CARE		
6.1	**Waits within Emergency/Acute Medicine** – Overall numbers are slightly up but the acuity of patients are changing. Nothing else to report.	
INDIVIDUAL CARE		
7.1	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans	
7.2	**Complaints and trends (SDG)** Figures have dropped but we are still 49% ongoing in target Informal concerns 21 informal received and 16 have been dealt with 76% within time. There continues to be a drive by the Clinical Board to promote informal responses which is reflected in April's figures. No concerns over 100 days, this is really good result. Sarah Cornes-Payne is now Acting Head of Concerns. Invite her to the next meeting. Draft responses – Reminder for all staff - Can you email the draft responses to cavresponses@nhs.uk and NOT CavConcerns@nhs.uk . **Compliments** – A letter has been received from Vaughan Gethin praising the care on East 8.	Sarah Cornes-Payne to be invited to next meeting All to note
Staff and Resources		
8.1	**Staffing levels** We are £192,000 overspent, £135,000 of which is in 3 areas. We have held meetings with all the problem areas to get the message across. Vacancy, specialing and sickness are problems areas but we are expecting a reduction.	
PART 2: Items to be recorded as Received and Noted for Information by the Committee		

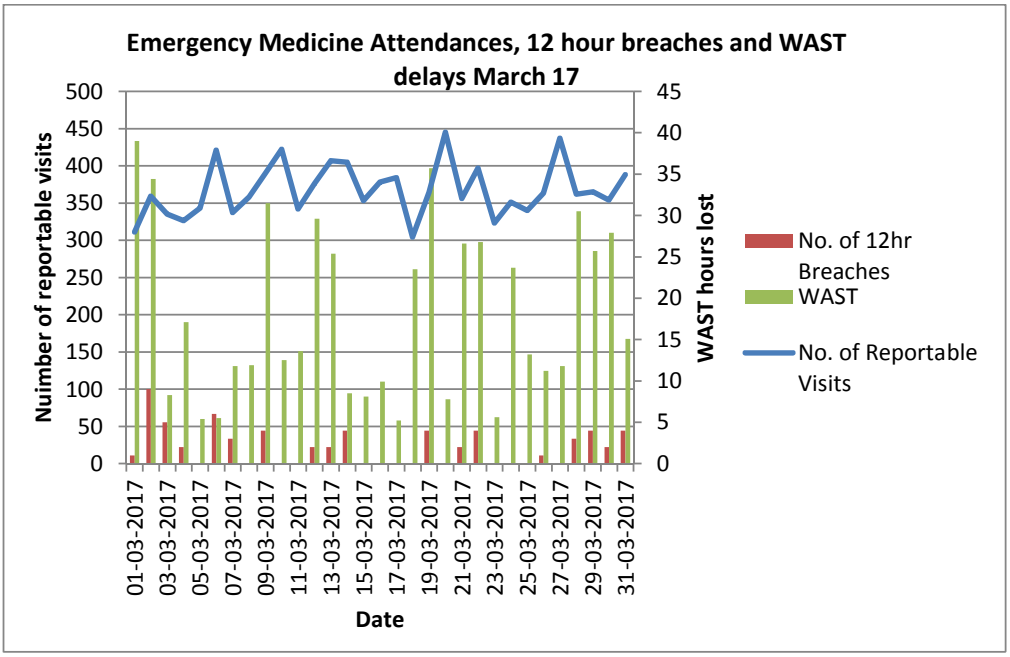
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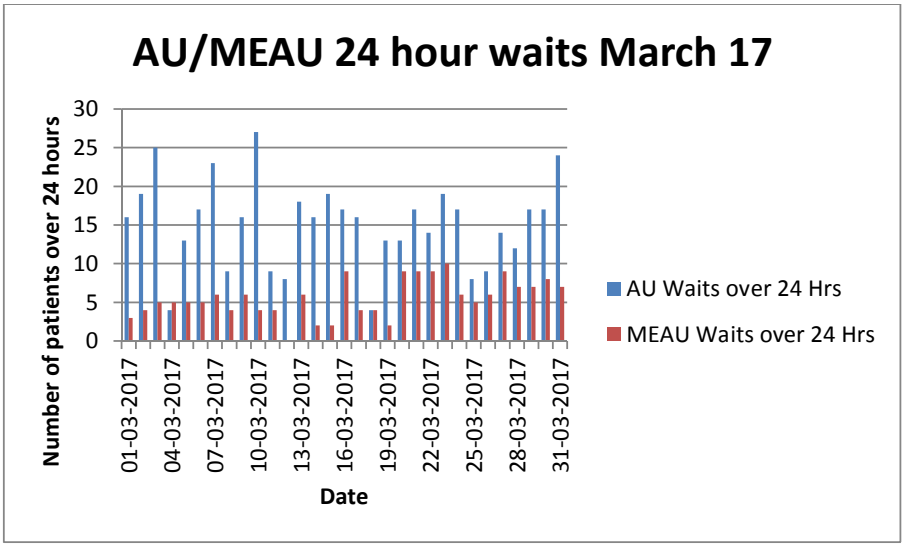
Date and time of next meeting: 15th June at 14.00 Classroom 2 UHW

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

Medicine Clinical Board QSE May 2017

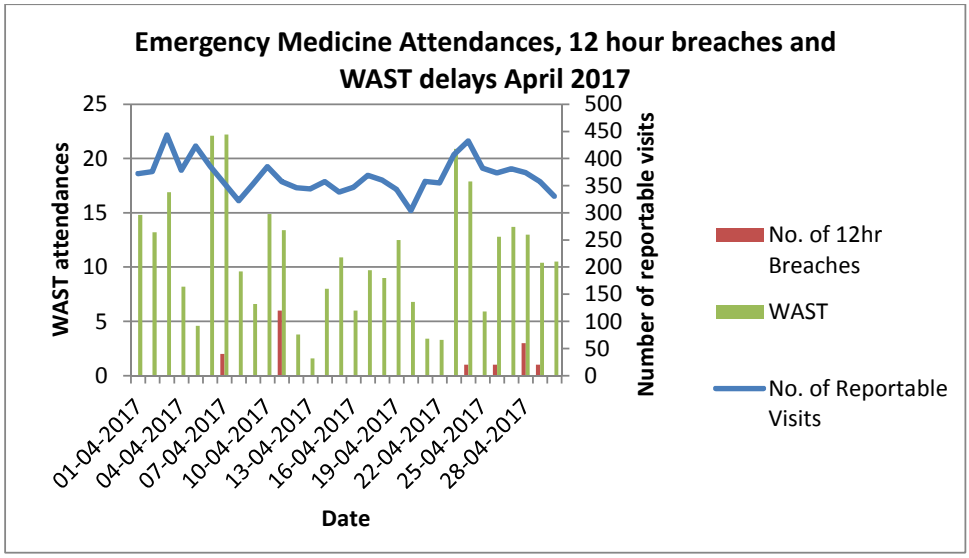
UHW/UHL Acute and Emergency waits March – April 2017

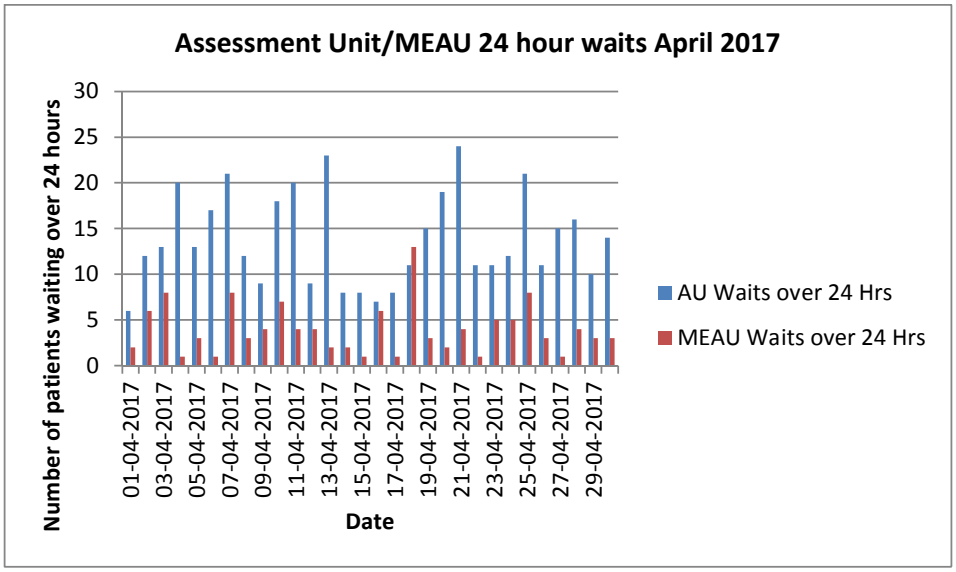




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MCB QSE May 17


Emergency Medicine Attendances, 12 hour breaches and WAST delays April 2017
WAST attendances
Number of reportable visits
Date
No. of 12hr Breaches
WAST
No. of Reportable Visits


Assessment Unit/MEAU 24 hour waits April 2017
Number of patients waiting over 24 hours
Date
AU Waits over 24 Hrs
MEAU Waits over 24 Hrs

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SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 9th May 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
Ceri Chinn	Interim Lead Nurse, Perioperative Care	CC
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
Tina Bayliss	Deputy Director of Operations	TB
Catherine Evans	Patient Safety Facilitator	CE
Lee Evans	DM, Urology	LE
Claire Mahoney	CNS, IP&C	CM
Simon White	CD, T&O	SW
Sally Finlay	Surgical Lead Dietician	SF
Graham Roblin	ENT Consultant	GR
Clare Wade	Lead Nurse, Surgery Clinical Board	ClW
Oleg Tatarov	Consultant Urologist	OT
Barbara Jones	Perioperative Care	BJ
In attendance:		
Andrew Hynes	Legal Services – for item 17/005	AH
Edwina Shackell	PA, Surgery Clinical Board	ES

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PART 1: PRELIMINARIES *(Chair)*		**Actions**
17/001	**Welcome and Introductions** Colleagues were welcomed to the meeting and introductions made around the table.	
17/002	**Apologies for Absence** Apologies were received from Mike Jones, Rafal Chavez, and Raf Baraz.	
17/003	**Declarations of Interest** Nil	
17/004	**Health and Safety Committee – Essential Update – Personal Injury** Andrew Hynes explained that this had been presented at a cross section of forums, to raise awareness of changes in Health and Safety (H&S) legislation and its implications for clinical practice. Andrew's role is to defend all of the personal injury actions for all of Wales related to the work environment. There is now enforcement of H&S regulations in the criminal court, fines for the organisation and potential for manslaughter charges to be brought either corporately or against the individual. Changes came into effect in January 2016, when tariffs for H&S offences massively increased. Eg Fine for one past case £6K, now would potentially be £600K.	

The Government had taken measures to restrict liability for various civil measures in order to address the 'compensation culture'. Therefore when organisations do get it wrong, it will be taken to the criminal courts.

Specific examples of historical cases were reviewed and key issues highlighted:
- No risk assessment, failure to follow own procedures
- Failure to act on previous concerns raised by workforce
- Lack of supervision
- Poor reaction when notified

The scale of fines relate to the size of company/organisation. the UHB is in the 'large' organisation category.

Culpability: there are 4 categories according to the scale of breach of standards – Very High, High, Medium and Low. It is recommended that colleagues network UK and worldwide to keep abreast of appropriate standards.
Medium, High and Very High categories are likely to result in criminal prosecution and fine.
The Health and Safety Executive (HSE) is now pursued by prosecutors.

Level of harm: 3 levels. A court will consider harm risked not actual harm caused and set the fine accordingly. Prosecutors will look at an organisations' own risk assessments to see if they can be used against the organisation.

An example was given of a corporate manslaughter charge against an NHS Trust. The case was only dismissed due to one co-defendant leaving the country. The prosecution had focused on trying to prove that management should have been aware that the doctors were not suitably qualified.

For a new clinical procedure, the law will judge the organisation against the standard it has set itself. When employing doctors from e.g. abroad, ensure a close look is taken to see that what they can do and what they claim they can do is true. There is an issue of due diligence for medical and nursing staff. Ensure qualifications are verified, skills assessed and recorded.

Focus of the example above was on the appropriate level of skill, qualifications, supervision and assessment of doctors, including locums.
Link;
http://www.kennedyslaw.com/casereview/dismissal-of-corporate-manslaughter-charges-against-nhs-trust/

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H&S Advisors can also be prosecuted, an example cited of inadequate site inspection.

Does an employer need to anticipate an employee's foolish act?
Yes they do, and consider this in their risk assessments, even for well trained, experienced staff. Ensure regular reviews of all staff.

H&S Prosecution of a public authority. This example resulted in a penalty of £500,000K. But the range was £800k to £1.3m.

Discussion
Risk Assessments: AH advised that ideally there should be a framework for risk assessments and the thought process behind it. Risk assessments are to guide the minds of staff, so that they think about the risks involved.

NICE national standards: RH noted that these are recommendations and advice, and are not mandatory; the UHB does not have the finances to implement them all so where does that leave staff? AH advised that Guidelines do not have same effect as legislation, they are not the law.

	Andrew was thanked for his thought provoking presentation. Feedback from colleagues would be requested following the meeting.	
17/005	**Patient Story: Perioperative Directorate** MB presented an overview of this incident when there had been a failure to process a histology sample correctly. The patient was scheduled for a morning list in SSSU, and consented for surgery and biopsy. Summary: - No WHO Surgical Safety Briefing had been held by the operating team prior to the list. The patient had been ambulatory and well; no preoperative checks were documented as completed at this stage to confirm e.g. patient details, allergy status. - The WHO Safety Checklist sign in section of the care document was not signed as completed. - During the procedure a specimen was taken, and a request made for a specialist medium for transport of the specimen, which was not available and which should have been booked beforehand. The specimen was therefore wrapped in a damp swab until clarity could be obtained. - The procedure was carried out under local anaesthetic. Had the WHO Safety Checklist Time Out been undertaken the confusion over the specialist medium may have been raised. The WHO Surgical Safety Sign Out was done correctly however, and no concerns were raised. - A labelled histology form was provided at the time of the procedure. - The Scrub Nurse intended to pursue the surgeon for clarity. The specimen was placed in the fridge and not noticed until 11 days later when the specimen was taken to Cell Pathology. - The following day a phone call from Pathology advised that the specimen was not labelled, and the form was not with the specimen. A 2nd form was sent with the patient demographics. - The specimen was found to have deteriorated too much which rendered it unsuitable for diagnosis. Root causes were: - Breakdown of communication in theatre between all staff regarding the processing of the specimen. - Failure of WHO sign in and sign out - Failure to follow procedure for checking the patient in to theatre - Failure in the Department to follow the procedure for labelling and management of specimens. Action plan: - The majority of actions had been completed. - LW had undertaken a team briefing. - Actions have led to changes in the procedure for specimens. - The Clinical Leader is continuing an audit of practice - The patient was contacted and had received the RCA report. No further patient outcome for the patient. Discussion: - It was noted that due to local anaesthetic being used, an anaesthetist was not present throughout. It was agreed that Anaesthetists generally do lead on checklists and sign out, but that it is everyone's responsibility to ensure that this happens. - The key failing was the lack of communication between the surgeon and the scrub nurse re the specialist medium at the time of the procedure. - The WHO checklist is not a tick box exercise. In this case the surgeon had been under time pressure to get to main theatre.	

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	- For clarity, the sign out for children cannot be done until the patient is extubated. With adults, it is possible to sign out prior to extubation. The anaesthetist and the surgeon need to be satisfied that the patient is safe at whichever stage it is done. - A previous serious incident was cited when the WHO sign out had been done too early before a throat pack had been removed. - According to the data, UHL and UHW are compliant with the WHO checklist. However from experience, it is estimated that approximately 50% are not completed fully. A recent audit had demonstrated a measurable increase in compliance. This does, however, need to be ingrained in the culture. - An SI the previous week was cited where the list order was changed and the checklist for the wrong patient was done. - Although ideally it would be the surgeon to call the stop for the time out, in practice it is the theatre sister - Reference was made to Andrew Hynes' presentation, and the potential for exposing the UHB to H&S prosecution. - Colleagues agreed that the WHO sign in and sign out need to be treated as a procedure not a tick list. - Comparison was made with trauma management, where a 'hands off' handover is done, and works well, with a clearly identified leader. - Theatre staff may not be confident, and feel they may be challenged or ignored. It was acknowledged that clarity is needed on who leads the WHO checklist, i.e. Nurse in Charge, ODP, Clinical Leader? **Action**: encourage clinicians to be involved in team briefing, and aim to empower ODPs/Nurse in Charge/Clinical Leader to lead on WHO	
17/006	**Approval of the minutes of meeting held 14th March 2017** The Minutes were accepted as an accurate record.	
17/007	**Matters Arising** To receive Action Log from the above meeting <u>Minute 2.1.3 17/5/2011. Pregnancy before surgery</u> – ongoing. No update. <u>16/182 Consent Audit Perioperative</u> Mark Bennion confirmed that all staff had been emailed to remind them how to raise their concerns regarding consent. Additional training on audit days had been arranged re MCA All staff had been reminded regarding legibility of consent. LW cited a recent RCA regarding the legibility of a consent form, where no clear Left or Right was written. There had been incidents in theatres where the anaesthetist has challenged the surgery regarding consent. RH reiterated that the Consent Policy must be adhered to. **Action: All to distribute Consent Policy to teams** **Action: A Patient Safety Alert Notice is currently being drafted on this topic and will be circulated once agreed.** <u>16/198 Item 4. CG174 – Intravenous fluid therapy in adults in hospital</u> RH had contacted Ben Hope Gill and John Dunn regarding improving the quality of doctors' training. **CLOSED.** <u>16/199 Item 4: Surgery CB IPC Group representation.</u> One consultant had attended the April meeting, however lack of clinical engagement from the surgeons remains an issue. Which is disappointing given several IP&S issues the Clinical Board has been dealing with over the past few months. The Terms of Reference had been circulated, and directorates asked to secure clinician engagement. **CLOSED**	**ALL** **LW/CW/MB**

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	16/199 Item 4: Surgery CB H&S Group CW had asked for Admin staff representation from directorates, which had improved at the last meeting. **CLOSED** 16/199 Item 7: Safeguarding Steering Group. Adult SG training dates were now on the Shared drive. AJ offered to arrange bespoke 2.5 hour sessions for colleagues if required. **Action: Directorates who wish to take this approach to contact AJ.** It was noted that Level 1 is mandatory for all staff. All staff who have any contact at all with children must be Level 2. E-learning packages are available for Level 2 and Level 3. 16/201: Theatre Team briefing: has practice improved. Authors to send an updated presentation to LW. **CLOSED** 16/206 Patient Surveys: National Survey Report for Surgery January 2017. LW had asked SNs/LNs to draw up action plans. Slight improvement in March. **CLOSED**	**ALL**
17/008	**Terms of Reference Annual Review – sign off** **AGREED** pending any outstanding comments to be sent to LW	
PART 2: PATIENT SAFETY AND QUALITY		
17/009	**NaTSIPPS Progress Report** Friday 12th May. Registrants: approx 50 in total, 30 of which are Surgery CB. RH explained the NaTSIPPS would be implemented in September 2017.	
17/010	**12 hour Breach report** There is a focus on patient waiting times in ambulances. Tina Bayliss is leading this piece of work. The expectation is that Directorates will need to do an investigation regarding referral time, decisions that were made, and clarity around admission if needed, transfer to receiving area, and if there is a delay, and why and what was done to mitigate them.	
17/011	**Directorate Assurance Reports:** General Surgery, Urology, Ophthalmology, ENT On shared drive. Incident reports had been circulated. Local rules are in place regarding laser work in Ophthalmology. Action log. Assurance was given that all reports had been circulated and that attendance at Surgery IPC and H&S Groups was being encouraged. SIs: Massive Haemorrhage Policy HAPU – significant volume, now closed down. Perioperative Services Never Event – wrong route administration of medication - investigation almost complete. Awareness under anaesthesia, RCA awaited, this week. Theatres: Th 11 UHW remains closed. Timeframe for repairs – likely end of August. RCAs – see action log PSAs, alerts have been shared Review of actions on log – assurance received that all reports had been circulated and all actions completed. Trauma & Orthopaedics SIs – outstanding SIs being worked through. SI, wrong level injection, spinal anaesthetic. Acinetobacter on B6 –ongoing, remains closed. Action log – Consultant had attended Surgery IPC Group. There are plans for	

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	directorate teams to attend this and H&S groups. Theatres Ortho 5 and Ortho 6 – update. SW had not seen a report on the ventilation. MB had received ventilation testing data of the 2 theatres, which had passed. LW advised that the day Theatre 5 was opened, the temperature was low so that it could not be used. This was then used for spinal injections. SW confirmed that no implant work was being done in either theatre as it was felt the theatres were currently not at their optimum. CM advised that formal reports had been received from estates regarding the ventilation. LW reported a temperature range from 9C – 26C Reference was made to the VRE outbreak meetings in November 2016 when theatres 4, 5 & 6 were validated. No validation had been received from Estates for any of the other theatres. This should be carried out every 6 months on all theatres. LW had requested this personally. **Action: CM to follow up.** An Estates representative for the CB IPC Sub Group had been requested; to date no response had been received. **Action: LW to speak to Geoff Walsh**	**CM** **LW**
17/012	**Exception reports from Directorates/Working Groups** ▪ General Surgery, Vascular , Wound Healing - nil ▪ Head & Neck, Maxillo Facial and Ophthalmology - nil ▪ Urology - nil ▪ Theatres & Anaesthetics, SSSU, Day Surgery & Sterile Services Incorrect lens in theatre. A patient the previous week had required a specialist lens. When opened by the Anaesthetist this had been found to be the incorrect lens. Again, an issue of WHO Safety Checklist sign in. An investigation into the procurement of the lens is underway. ▪ Trauma and Orthopaedics: Ward B6 Acinetobacter baumanii. Beds closed. CM provided the following summary of events: A patient was admitted to A6S in March, and isolated in a side room. The patient became unwell at the beginning of April and sadly died. The decision was taken to screen the other patients on the ward. One patient was colonised. B6S was closed to admissions. After another week of screening, a further 2 patients were colonised. An environmental screening was carried out and chairs, stools were colonised. Screening of the environment was undertaken, outcome awaited. Screening of the entire ward was undertaken due to the possibility of colonisation of shared equipment. CM confirmed that all 5 patients were colonised with the same type of organism, as was the equipment. The ward is to undergo a re-furbishment. GE explained the financial implication for the ward, as all visitor chairs, lockers etc must be replaced. There had previously been no replacement programme for ward furniture. CM provided an update from the previous week's outbreak meeting. The 2nd patient was now isolated. CM is due to visit the ward with Estates 10/5/17. Discussion: • The ward environment is extremely poor. • Longstanding lack of attention from Estates is deemed to have contributed to this latest outbreak. • The organism is very drug resistant, and therefore there are limited treatment options. • Concerns have been raised about the environment in the past but nothing had been done. Wards need to be decanted, but there no vacancy ward on the UHW site to accommodate this. Bathrooms are currently being refurbished with patients in situ which is not ideal. • Both deputy Ward Managers on B6 are working very hard to resolve what they can.	
17/013	**Policies and Procedures** <u>Falls and Fragility Fracture Audit Programme – Measurement of lying and standing</u>	

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	blood pressure and SBAR Lying and Standing BP **RECEIVED and NOTED.**	
17/014	**Alerts and other Safety Notices** Public Health Circulars 1. CEM/CMO.2017/1 – Influenza Season 2016-17 – Cessation of use of antivirals now recommended. **NOTED** NICE guidelines: 2. CG146 (Feb 2017) – Osteoporosis: assessing the risk of fragility fracture. Dr Johanssen had responded. This refers to primary care management, and is not appropriate to secondary care. 3. CG164 (March 2017) – Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer This had been forwarded to Brendan Boylan, PCIC 4. CG173 (Feb 2017) – Neuropathic pain in adults: pharmacological management in non-specialist settings Tony Turley had responded. The guidance refers to primary care and is not applicable to the acute setting. 5. CG74 (Feb 2017) - Surgical Site infections: prevention and treatment A response will be sent in terms of Ortho SSI (quarterly reports). 6. CG80 (March 2017) – Early and locally advanced breast cancer: diagnosis and treatment For General Surgery, no response received to date. **Action: Andy J to chase.** 7. NG67 (March 2017) – Managing medicines for adults receiving social care in the community – not applicable. 8. IPG574 (Feb 2017) – Lateral interbody fusion in the lumbar spine for low back pain No response to date. 9. IPG575 (Feb 2017) – Trabecular stent bypass microsurgery for open-angle glaucoma. Sent to Prof James Morgan. Nil response yet. CW advised that this procedure is not currently undertaken. 10. MTG31(Feb 2017) – Humigard for preventing inadvertent Perioperative hypothermia . Sent to Alun Tomkinson and Geoff Clark. Not applicable. **11.** DG27 (Feb 2017) – Molecular testing strategies for Lynch syndrome in people with colorectal cancer. **Action: AJ to chase up with the colorectal surgeons** 12. MTG30(Dec 2016) – XprESS multi sinus dilation system for treating chronic sinusitis **Action: Andy J to chase Graham Roblin. Procedure not done currently**. Patient Safety Notices 13. PSN037 – Resources to support the safety of girls and women who are being treated with Valproate. Applicable to the Clinical Board. All to be aware. MDA 14. MDA/2017/003(Wales): Alaris syringe pumps (GH, CC, TIVA & PK models) – risk of uncontrolled bolus of medicine. RH had contacted Clinical Engineering who were looking at all pumps and will replace them as they come through. Other Alerts	**SW** **Andy J** **Andy J** **Andy J**

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	15. Changes to Lucozade Energy, Ribena and Orangina: Important changes for Health Care Professionals. Used for Glucose Tolerance Test and treatment of hypoglycaemic episodes. Now give 170 ml quantity.	
PART 3: STRATEGIC DIRECTION AND SERVICE DEVELOPMENT		
17/015	**Key Messages from Board/ Committees/ Groups** 1. UHB Medicines Management Group Minutes 16th March 2017 & 20th April 2017 **NOTED** in the absence of Pharmacy representative. 2. SBAR: Piperacillin 4g/Tazobactam 500mg powder and solvent for solution The main warehouse had burnt down. The UHB has stock at present. Pharmacy will advise going forward. It was noted in the meeting that early administration of appropriate antibiotics in early sepsis is vital, and that these are essential to the UHB. 3. Decontamination Committee Minutes 17th February 2017. Noted: use of flexible endoscopes for non intended purposes 4. Safeguarding Steering Group 22 March 2017 Minutes Next meeting scheduled for w/c 15/5/17. March meeting focused on: o reorganising smaller meetings, in particular monitoring and review of Child Safeguarding. o FGM – 60 cases per year. All to be aware how to act if this is suspected. The issue of lack of Domestic Abuse training for staff involved was highlighted. It is very difficult to get information to individuals. **Action: Andy J to feed this back to the next meeting.** 5. Research Governance Group update The Group had met the previous week. Nil to report. New professors were noted: Prof Torkington and Prof Rachel Collis.	**Andy J**
PART 4: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
17/016	**Surgery Clinical Board Director of Nursing Quality & Safety Report March 2017 & April 2017** 1. IP&C RCA database LW sought assurance that all colleagues looked at these. The information was very useful. CE noted that the information from closure forms is important to cascade to nurses on the ward. 2. HCAI Surgery Review to end of March 2017 End of year targets 2016/17 had not been met for MRSA and C Diff. Some reporting issues have resulted in incidents attributed to the Clinical Board in error. Eleri Davies is looking at ways of validating the data. C Diff – target 24, reported 28 (minus 6 not ours). For the majority no preventative actions were identified. MRSA – 3, one of which was known MRSA on admission, and one recent transfer in. MSSA – 15. Themes: insertion lines, VIP documentation could improve. Rollout of AnTT will address these issues. 2017/18 – Targets to be reset, including a new E.Coli target. May 2017 – No C.Diff, MRSA or MSSA to date. 3. WHC/2017/011 HCAI Annual programme Overview of rates reported across Wales, will inform new CB targets. LW reviewed the Q&S Report and noted the following:	

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	▪ Never Event – medication wrong route. ▪ In42308: where an X-ray taken on 16/12/16 was not formally reported until 29/12/17. It is essential that if a radiological request is made, teams go back and review those X-rays themselves. In this case the patient had sadly died. Two similar cases were being investigated by the Ombudsman. There were now a total of 4 similar cases, which had been escalated to the Executive team, and had been sent to WG. Discussion: - This applies to SAU, MAU and A&E, ensure reports are chased. - Lack of formal procedure for what radiographer should do with abnormal results. It was agreed that as a professional, an e.g. radiographer would be expected to phone and relay this. This does not however happen in SAU, MAU and EU. - An example was cited where there had been an adverse outcome for a patient where a test result had not been reported and which had been settled out of court. - There is no system to track the request. Clinicians are aware that it is their responsibility to follow up, but this is not supported by the system. - An adaptation to RADIS would highlight any abnormal report. C&V is the only HB in Wales which does not track this, hence this SI was flagged to WG. - In terms of policies of how unexpected results are reported, the UHB will not be able to move forward. - Reference was made to the RRAILS process, where an alert for AKI is sent via email message to the requester. - Another incident was cited where a patient was screened in radiology and found to have a large aortic aneurysm. The report however was sent to the GP instead for direct to the vascular surgeons. The patient sadly died on the day of the outpatient appointment. **Action: LW is in discussions with radiology to see what processes can be put into place.** ▪ Grade 3 and 4 Hospital Acquired Pressure Ulcer is deemed a POVA and is referred direct to MASH.	
17/017	**LIPS (Leading Improvement in Patient Safety)Progress Report – General Surgery** An update was provided on 2 projects: 1. Medication errors, commenced autumn 2015. Ward Nurses, pharmacist, registrars, and separately improving prescribing. End result for 2016 = 27 errors in prescribing and administration; 2017 to date = 5. Substantial improvements. One action is to reduce disturbances/distractions to staff. Work is continuing, but it is agreed that there are lessons to be learnt. This was shared via the nursing structures. Brief reference was made in the meeting regarding illegible prescriptions. 2. Vascular Rehabilitation. A small team, struggled in making changes with regard to rehab beds in the UHB, due to changes to personnel and the retirement of the ALAC CNS. The group continues to meet to try to progress. CE informed colleagues of a Concerns team project in statement writing. There is now a guidance template which helps to structure people through the process. This will be taken to UHB QSE, and when approved be uploaded to the intranet.	
PART 5: GOVERNANCE		
17/018	**Concerns (Clinical Incidents, Complaints, and Claims)** <u>Open Sis, No Surprises,</u>: 18 as of 8/5/17: ENT – 1, longstanding, directorate is urged to progress General Surgery – 6. 2 longstanding, 4 more recent, quite complex and ongoing.	

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	Perioperative – 5 Trauma & Orthopaedics – 6 since Jan 2017 It was acknowledged that colleagues had been working very hard to close these SIs. However, the expectation from the Executive Team was that the longstanding SIs will be closed. It was explained that WG allows 60 working days, which is acceptable for simple SIs, but challenging for more the more complex. <u>Regulation 28 report & Open Inquests</u> <u>Regulation 28 Report</u> CE explained that this had been generated from the Coroner to prevent further deaths. The incident concerned a patient within Medicine Clinical Board, who had fallen, sustained a head injury and sadly died. The RCA was completed and reported to WG as an SI. The RCA had been shared with coroner who identified areas of learning and concern, to be shared with all Clinical Boards. A shortcoming was identified in how the patient was risk assessed for risk of falls. There was no clear plan until the 4th fall to the floor. An issue was identified regarding specialling, which varied. The patient was cohorted into 4 bedder, and at time of 8th fall, the HCSW had left the area at night to go to sluice. A contributory factor was that specialling was not continuous. Neurological observations had been taken by a HCSW. This practice had now ceased within the Medicine Clinical Board. Observations are now taken by a qualified nurse. Actions completed: - Falls focus group had been set up - Ward staff had been reminded of the process that should happen - HCSW not now doing neurological observations Discussion around the table: - Does the UHB need an Acute Deterioration Group? The issue of e.g. neuro obs had been raised as a concern at various groups. Could it be beneficial to form a group of like minded individuals to include a person who has this within their gift? - Deterioration, escalation, trigger points, management plans. - LW had been in conversation with Dr Turley in the working being done UHB wide on Hospital by Day and Hospital by Night teams. - <u>Inquests</u> – 2. Ongoing. <u>Closed SIs:</u> Closure forms sent to WG since 14/3/17 – see above <u>Falls Report</u> 11 injurious falls for the period April 2016 to May 2017. Themes: Lack of neuro obs. Teams were doing everything possible to prevent falls for the majority of the time. A specialling person cannot physically prevent falls or hold a falling person up. A Falls Delivery group has been formed – anyone over 65 is deemed to be at high risk of falls. Community working is in place with the aim of preventing un-necessary hospital admission E-learning – noted that this is out of date. The intranet page is being updated. <u>Complaints, Claims and other Concerns</u> All New Clinical Negligence claims opened 8/2/17 – 12/3/17 – nil All Clinical Negligence Claims Settled 8/2/17 – 12/3/17 – One a staff claim the other a patient claim. Personal Injuries Negligence Claims settled 8/2/17 – 12/3/17- nil New Personal Injuries Negligence Claims opened 8/2/17 – 12/3/17 - nil	

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	Ombudsman's Reports received:nil	
17/019	**Internal Audits** Draft Internal Audit Project Brief The Internal Audit team will be re-auditing the Quality and Safety mechanisms of the Clinical Board. **External Audits** External QuAD Audit – UHL 13th December 2016 The report had been recently received. Main issues raised were in the Anaesthetic and Recovery areas. Nil of major concern. The report had been fed back to Anaesthetic and Recovery Clinical Leaders who were developing an action plan which would be shared.	
17/020	**Fundamentals of Care – Directorate Feedback** Teams to persevere with Hand Hygiene and Bare Below the Elbow compliance, particularly with registrars/staff groups other than nursing.	
17/021	**Health Care Standards Self Assessment** These had been submitted to deadline, 20/4/17. Thanks were extended to all for their work. The Clinical Board is awaiting development of these into the UHB Self Assessment, and feedback on performance via Internal Audit.	
17/022	**SBAR Blood Glucose Monitoring Training and Assessment 7/2/17** **Blood Glucose Monitoring Practice Update 2/3/17** Attention was drawn to instances of cases which had gone to court where Drs/Nurses had shared badges, and competency was not up to date. Evidence of badge sharing within the UHB is extremely concerning. It was noted that some staff had been on wards for 18 months and did not have an up to date active card. **Action: All LNs to inspect wards and provide assurance of competency.** Perioperative: Cascade training is in place in all areas, link workers identified. New staff should be captured in training.	**LNs**
17/023	**Restocking of blood and blood products and Hep E negative blood** Perioperative Directorate had shared all the attached information widely. CW advised that the Blood Transfusion Service was considering the RCA approach where there is a lack of traceability. They had been advised to link with Patient Safety.	
17/024	**Patient Surveys** National Survey Report for Surgery (March 2017) Colleagues are asked to review the appendices relevant to their wards for feeding back to their areas.	
17/025	Research & Development Nil to report	
PART 6: DATES OF NEXT MEETING **Tuesday 18 July, 08.00 – 10.30, Council Room, UHW**		
PART 7: URGENT BUSINESS		
17/026	1. SI – wrong addressograph on X-ray form. Andy J had completed the investigation, and saved on the S Drive. It is felt that until a more robust process is in place, such as full electronic requesting there is the potential for similar to occur. 2. Angela Jones acknowledged the work on A1L, excellent training figures, 100% in some cases. The Surgical ward had been very successful in the UHB awards in March. Andy J had won his category and Angela had won the research category.	

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	3. The Director of Nursing, and Maria Roberts, Patient safety, had picked up some of the Resuscitation work, where high NEWS scores are not being escalated. Additional NEWS sessions will be run. Another issue is where CPR is undertaken when a DNACPR is in place, or conversely CPR not commenced until the arrival of the Resus team. 4. UEFA Championship, 28th May – 3rd June. All to raise awareness. **Action: TB to check if Bank office have made B&A staff aware of road closures etc.**	**TB**
Part 8: ITEMS FOR INFORMATION NOT INCLUDED ON THE AGENDA		
17/027	**Alerts and Other Safety Notices – NOTED FOR INFORMATION** Welsh Health Circulars WHC (2017) 001 – The New Treatment Fund – Access to medicines recommended by the National Institute for Health and Care Excellence (NICE) and the All-Wales Medicines Strategy Group (AWMSG) NICE guidance for Information only CG68 (March 2017) – Stroke and ischaemic attack in over 16s: diagnosis and initial management NG60 – HIV testing: increasing uptake among people who may have undiagnosed HIV. Information only. NG64 (Feb 2017) – Drug misuse prevention: targeted interventions. Information only NG65 (Feb 2017) – Spondyloarthritis in over 16s: diagnosis and management (Information only) MIB100 – Mollii suit for spasticity (for information) MPG2 – Patient Group Directions (for information) MIB97 – TopClosure Tension Relief System for wound closure	
17/028	**Recent Reports & Communications** Blood Transfusion Group Reports – **RECEIVED FOR INFORMATION**.	

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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 23 May 2017, 8.30am, Council Room, UHW

Preliminaries		**ACTION**
1.1	**Welcome & Introductions** Cath Heath (CH), Director of Nursing (Chair) Rachel Burton (RB), Director of Operations Mary Glover (MG), Lead Nurse, Acute Child Health Paula Davies (PD), Lead Nurse, Community Child Health Diane Rogers (DR), Interim Head of Operations & Delivery, Acute Child Health Heather Gater (HG), Interim Head of Therapies, Acute Child Health Rachael Sykes (RS), Health & Safety Advisor Bev Thomas (BT), Assistant Head of Operations & Delivery, Community Child Health Angela Jones (AJ), Senior Nurse, Resuscitation Anthony Lewis (AL), Clinical Board Pharmacist Matthew McCarthy (MM), Patient Safety Team Sarah Spencer (SS), Senior Midwife Cheryl Evans (CE), Head of Operations & Delivery, Obstetrics & Gynaecology Laura Bassett (LB), Risk Manager, Obstetrics & Gynaecology Alison Jones (AJ), Interim Clinical Supervisor for Midwives Jenny Thomas (JT), Clinical Board Director Catherine Salter (CS), Health & Safety Representative	
1.2	**Apologies for absence** Rim Alsamsam, Suzanne Hardacre, Jane Maddison, Wendy Bridges	
1.3	**To receive the Minutes of the previous meeting 28 March 2017** The minutes of the meeting were agreed to be an accurate record.	
1.4	**QSE bring forward action log / Matters Arising** See updated action log.	
PART 1: HEALTH & SAFETY		
2.1	**Feedback from UHB Health & Safety Operational Group Meeting 15 March 2017** • Enforcement agency report feedback has been received. Information with regards to the refurbishment of lifts is ongoing. Three lifts are being replaced; however prioritisation of repairs is also underway. • Hydrotherapy pool, joint action plan with Estates and Therapies implemented. • Contractor Falls investigation is ongoing • Legionella Case in Adult Services, there have been no changes since the last updates but requests are made to continue to be vigilant and regular flushing of outlets should be undertaken. • Propping open of Fire Doors – concerns were raised and it was noted that if the room is occupied, this is ok. Frank Barrett will be developing some guidance • H&S Action Plan – H&S management training ~~has been implemented and this will be one day training for all managers.~~ is being developed specifically around ensuring that they recognise their duties under the relevant H&S policies and their broader	

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	legislative compliance duties. • HSE fines have been implemented and it was noted that the figures are likely to be substantial and will come from the Health Board budget. • Proposal of introducing fees for non attendance at manual handling and ~~fire safety~~ violence and aggression training is being reviewed. Further updates are awaited; however it will be a charge to the Directorates for any non attendance. Queries were raised with regards to the criteria and it was noted that this is being worked through at present. • Shower Chairs and replacement Hoists have been purchased and work is being taken forward with regards to maintenance and servicing of all hoists throughout the UHB.	
2.2	**Health & Safety Report** Noted for information. The report provided an update on the number of incidents that are being reported. It was noted that there are a number of "no harm" incidents that need to be reviewed and closed as necessary. It was acknowledged that there has been a significant amount of progress made however there are still a number of incidents that remain open. The Directorates were asked to review all open incidents to ensure that all that can be closed, are actioned. It was acknowledged that some of these incidents include SI incidents and also Stillbirth incidents which are unable to be closed until all actions are complete. Work is ongoing in order to work through this. CH agreed to contact CD&T in order to review options for the incidents including missing notes from Medical Records. Discussion ensued and it was agreed that the incidents that are awaiting review are the priority incidents in order to ensure that appropriate issues are being raised and actioned. DR noted that there are some issues in relation to ensuring that all medical staff are registered onto Datix to ensure all the Clinical Leads can be trained in order that the Clinical Leads can review and action incidents accordingly. The Directorates were asked to review and work through the best process to address these incidents whilst this is ongoing. No incidents have been reported to the HSE since the last report.	**DMT's** **CH** **DMT's**
2.3	**COSSH Report for Noting** Noted for information. The group were asked to ensure that all areas are up to date. COSSH reviews need to be undertaken on a 3 yearly basis.	**DMT's**
2.4	**Workplace Inspections Update** Some inspections have been undertaken and it was noted that CS is happy to undertake any further workplace inspections that are required. It was noted that within O&G these are undertaken by Wendy Bridges and a database is kept of all inspections undertaken. Discussion ensued and it was agreed that this information will be shared with CS following the meeting.	**CE/LB**
2.5	**Staff Side Health & Safety Issues** Concerns were raised in relation to glare from the windows within Children's Outpatients. It was acknowledged that work is progressing in order for this to be addressed. CS advised that feedback received with regards to the Computers on Wheels "COWS" within Obstetrics & Gynaecology have been very positive. Discussion ensued in relation to the structure for H&S and it was acknowledged that within some other Clinical Boards, there are separate H&S meetings. It was noted that this has been trialled within the Clinical Board previously and was not successful. RS noted that this has been the most successful process for the Health & Safety issues and this was supported by other members across the Clinical Board.	

2.6	**Exception Reports and Escalation of key H&S issues from Directorates** • A further two hoists have been sourced for the children's hospital and work is ongoing to implement them. • Lone Worker devices - a compliance report is circulated on a monthly basis in order for managers to ensure that devices are being adequately reviewed. There were no significant issues to note with regards to usage of lone worker devices for this Clinical Board. • Process of security of building of Global Link has been escalated and TDSI access after 5pm is being reviewed. Discussion ensued and it was noted that there have also been issues with the fire doors. A fire assessment and training is being arranged. Options of a security guard at the building between 5-7pm is also being reviewed in order for a final sweep of the building to be undertaken, as well as putting down the barrier at the end of the day. Further updates will be provided as this work progresses. CS noted that there is a personal safety group meeting that may be useful to attend. RS/CS agreed to forward on the details of the meeting in order to ensure that there is appropriate representation from Community Child Health.	**RS/CS**
PART 2: QUALITY & SAFETY		
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	**Presentation on Stillbirth Audit** Presentation was provided by LB. It was noted that the forum was set up following the MBBRACE report in order to undertake an MDT full case review of all cases, with the exception of medical terminations. All fetal losses of >22weeks are reviewed and discussed at the Clinical Risk Meetings, with all actions being recorded. The learning outcomes are reviewed and appropriate actions put into place such as RCA etc. 12months data has been reviewed and it was noted that there has been no specific trend identified, however from some of the data identified highlighted monitoring process. It was agreed that the Grow and Gap charts that have recently been implemented, should provide a further assurance for monitoring. Discussion ensued where it was agreed that the presentation would be shared with the group for information and onward dissemination where appropriate for lessons learnt to be shared. It was noted that this was implemented prior to the MMBRACE report, however it was acknowledged that work is underway in order to review the neonatal deaths in conjunction with the Acute Child Health Directorate to ensure that this is a multidisciplinary meeting including obstetrics and maternity representation allowing a robust and linked up approach for all cases.	
3.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues)**	
	Acute Child Health • Work is progressing on the RCA investigations which are almost complete • Health Visitor forms continues to be an issue. This has been highlighted with the safeguarding team. It was agreed that the ACH Directorate Report would be circulated with the minutes of the meeting for information.	
	Community Child Health • Division of safeguarding will be relocated to UHL and Saturday Club for CCNS has been cancelled for the UEFA weekend	

	• Baby boxes, there are ongoing discussions in relation to the implementation of baby boxes. It was agreed that a presentation would be provided at the next meeting in order to agree a way forward • Emergency equipment within the children's centres is progressing and training continues • LAC services nursing and medical pressures are being reviewed and will be escalated once work is completed. • Safeguarding incident with regards to FGM level of risk. Training need has been identified and the safeguarding team are leading on some training for staff. • Nurse staffing within CCNS service continues to be a pressure. It was agreed that the CCH Directorate Report would be circulated with the minutes of the meeting for information.	**PD**
	Obstetrics & Gynaecology • Medication database has been implemented following discussions at the last meeting in order to actively monitor and review medication errors. • Ongoing issues with regards to security tags for babies. Audit is being undertaken to ensure that all babies are appropriately tagged. • Resilience day for staff has taken place and was very well received by all and it was noted that there has been a very positive impact on staff moral within the Unit. • Information governance cases are awaiting review from the Medical Director and feedback is awaited. All action plans and actions have been completed. The Datix system is also being used in order to identify any information governance issues. • Heating on MLU is an issue and it was noted that the heating has been condemned. Work is underway in order to repair, however the plan is that this work will not be finished until August 2017. It was noted that this will be regularly monitored in order to ensure this can be managed whilst the repairs take place.	
3.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** • Expansion of risks associated with Paediatric Surgery has been undertaken • Vivid Seven Echo Machines are coming to the end of life • Diabetic Staff levels • Stem Cell Collection with Oncology, further discussions are taking place with Oncology colleagues associated with nursing levels and support It was noted that risk assessments are being undertaken for the risks highlighted above and once complete, will be added accordingly to Directorate Risk Register and Clinical Board Risk Register where necessary.	
3.4	**Paediatric Surgery Update** JT provided an update in relation to the issues within Paediatric Surgery. A number of issues have been identified with regards to care and a notes review has been undertaken in order to understand all issues and concerns. An external review is being progressed, with anticipation that this will be undertaken by the end of July 2017. It was reiterated that the acute service is safe and is being adequately supported and managed. Management of all cases are being reviewed regularly in order to ensure that any issues and concerns are being addressed. It was noted that there have been significant improvements to the ward environment and work is progressing well.	
3.5	**Clinical Supervision of Midwives Governance Structure**	

	Noted for information. The interviews will take place on 01st June with a view to appointing on a 3 year rotation. Key performance indicators are being reviewed and will feed into the overall governance process which allows information to be fed up and down as required. The Welsh Government implementation group has also been set up to benchmark against other units and it was acknowledged that Wales are leading the way.	
HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
4.1	**Initiatives to promote health and wellbeing of:** **Patients** • Befriending Services, working with SCOPE has been implemented in outpatients • Feedback machines have been implemented into the Children's Centre in order to gain further feedback. 79% of feedback received has been positive. **Staff** • Monthly resilience training is being implemented, commencing on 24th May 2017	
4.2	**Gentamicin 20mg/2ml ongoing supply issue** The SBAR was noted for information and highlights the supply of paediatric strength gentamicin. It was noted that prioritisation protocols have been implemented and supplies are being managed via Pharmacy. Further suppliers have been identified and it is hoped that the risk can be minimised, with the anticipation of normal supply being available from 15th June 2017.	
4.3	**Update on Neonatal IV Antibiotics** Work has been progressing. Microbiology testing is being reviewed on a 36hour basis in order to manage this more effectively. It was noted that out of hour's provision is difficult for Microbiology and this is currently being reviewed. Further updates are awaited however it was noted that there has been some improvement seen with reporting. RB agreed to follow up with CD&T Clinical Board for further updates.	
SAFE CARE		
5.1	**Update on Serious Incidents** • Neonatal Death RCA is underway • Retained Swab – follow up meeting held and action plan has been produced • No surprises of Norovirus on Pelican and Island Ward were reported and the wards have now been reopened. Thanks were expressed to all staff for their hard work and diligence in managing the infection control issues.	
5.2	**RCA Overview and Closure Form for Noting – 43721** This case relates to a baby fall where a father fell asleep with the baby in his arms. Following the fall, the baby was rapidly reviewed and neurological observations completed. A CT scan was performed following the paediatric review. Appropriate follow up was arranged for the baby prior to discharge. It was noted that all actions have been completed following this incident and the "Babies Don't Bounce" risk assessment tool was appropriately used prior to discharge to the ward. Discussion ensued in relation to guidance from the Neonatal Unit. LB agreed to provide information to DR following the meeting. As part of the lessons learnt it was agreed that the completed falls investigation will be shared at the next Children & Women Clinical Board Quality & Safety meeting. Also, learning from this incident is being considered as part of work on a new guideline for the management of baby falls.	**LB**

5.3	**Infection Prevention Control Update** **HCAI Annual Programme** Deferred to the next meeting. The Clinical Board Annual Programme is being presented at the IP&C Meeting in June and will be brought to the next Clinical Board meeting to note.	
	Concerns were raised in relation to follow up for patients with Whooping Cough. It was noted that it was the expectation of the nursing staff to complete and it was felt that this should have been Public health responsibility. MG agreed to provide further details to the Clinical Board for further discussion with Public Health. It was however acknowledged that this was well managed by the nursing staff involved.	**MG**
5.4	**Safeguarding** There were no issues to note for this meeting.	
5.5	**Patient Safety Alerts (internal/external)** • Welsh Health Circular 2017 011 - HCAI REDUCTIONS BY MARCH 2018: C.DIFFICILE, S.AUREUS BACTERAEMIAS AND E.COLI BACTERAEMIAS • MDA/2017/003 - Alaris® syringe pumps (GH, CC, TIVA & PK models) – risk of uncontrolled bolus of medicine • Welsh Health Circular 2017 014 - Patient information on the Putting Things Right (PTR) arrangements • PSN037 - Resources to support the safety of girls and women who are being treated with Valproate All alerts were noted for information and the group were asked to ensure wide dissemination and action as appropriate. No exception reporting was noted for the Clinical Board.	**ALL**
5.6	**CAMHS Pathway Update** Work is progressing and it was noted that a further update will be provided at the next meeting.	
EFFECTIVE CARE		
6.1	**Newborn Bloodspot Poor Quality Sample Feedback - February 2017** Deferred to next meeting.	
6.2	**Checking Pregnancy Before Surgery – Guidance** The policy was noted for information. It was acknowledged that relevant discussions have taken place and the policy has been agreed and ratified. This will now be progressed through UHB meeting for final ratification.	**MG**
DIGNIFIED CARE		
7.1	**Latest Cleaning Scores Report – for information** The latest scores were noted for information. Feedback has been provided in order to ensure that Ward Managers are included in audits.	
TIMELY CARE		
8.1	**Performance with National targets/the NHS Outcomes and Delivery framework relating to timely care outcomes** The Q&S dashboard was noted for information. There were no specific issues to raise that	

	were not covered elsewhere on the agenda.	
8.2	**Operating Theatre Strategic Plans** Deferred to the next meeting. No impact for C&W Clinical Board at present.	
INDIVIDUAL CARE		
9.1	**Update on latest 2 minutes of your Time feedback** **To note latest feedback from"2 minutes of your time" maternity care survey** Noted for information. Feedback has been received and it was noted that there have been a number of positive comments received across all areas. The issues that have been raised are in relation to facilities for snack provision out of hours and it was noted that work is being undertaken in order to ensure that there are snacks available out of hours. There are options to review options for vending machines for the Children's Hospital. Further information is awaited from Facilities. The Ronald McDonald building is being opened in July 2017 and day passes will be available for patients and families. Queries were raised in relation to accommodation criteria and it was noted that this is managed by Noah's Ark. Concerns were raised in relation to postnatal women (out of area) accessing the accommodation. SS agreed to discuss further with Alison Oliver outside out of the meeting in order to understand the scope of the service being provided.	**SS**
STAFF AND RESOURCES		
10.1	Feedback on current position for :- • PADR • Sickness Work is progressing throughout the Clinical Board in order to improve PADR and Sickness across all areas. There were no specific issues to note for this meeting, and the Directorates were thanked for the work being undertaken to date.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
11.1	**South Wales Fetal Cardiology Service – Final Draft** Circulated for information and noting. It was acknowledged that all discussions have taken place with WHSSC etc outside of the meeting. DR agreed to discuss with Carol Evans outside of the meeting in order to provide assurance with regards to a previous risk.	**DR**
11.2	**Endoscope Decontamination Survey 2016 - Closure Report** Noted for information.	
11.3	**Medication Errors Report** Noted for information.	
ANY OTHER BUSINESS		
12.1	**UEFA Update** Update was provided in relation to the plans for the UEFA Championship. There is a robust plan in place corporately, however it was acknowledged that a secondary tier needs to be considered for specialties to ensure that there are formal arrangements in place should it be required. There are plans in place for all Directorates and further information will be shared once available. The Directorates were asked to ensure that there is appropriate representation at all UEFA planning meetings following the meeting.	

12.2	**C&V Immunisation action plan 2017-18** Deferred to next meeting.	

DATE AND TIME OF NEXT MEETING
The next meeting is scheduled for **Tuesday 27 June, 8.30am, Council Room, UHW**

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

DENTAL CLINICAL BOARD

MINUTES OF QUALITY, SAFETY & PATIENT EXPERIENCE GROUP MEETING
15th June 2017 at 8.00 AM
Annexe Meeting Room

Present: Mr Andrew Cronin (Chair)(AC) N Drage (ND) Dinah Jones (DJ) **In attendance:** Jonathan Peck	Dr G Bhamra Eira Yassien (EY) B Chadwick (BC) Catherine Evans (CE)	S Bhatia (SB) J Gillespie (JG) Prof I Chestnutt (IC)
Apologies Received from: R Griffiths		

		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 13th April 2017 were accepted as an accurate record. **Matters Arising** There were no matters arising. AC did note that after discussions with Fiona Jenkins it had been acknowledged that the current agenda format, used to align with the Clinical Health Board, could be altered to be more specific to Dental. A meeting to discuss this further was yet to be arranged. AC commented that Mandatory Training was an important issue and felt this should be an item added to the agenda.	
2.1	**Oral Surgery, Medicine and Pathology - Mr A Cronin** Minutes from the OSMP Audit Group meeting on the 19th May 2017 were received and noted. ND noted his discussion with Melanie Wilson, who was strongly in favour of the guidelines on the management of patients who are at risk of MRONJ but she felt that there was insufficient evidence to stop giving antibiotic prophylaxis altogether for 'high risk patients'. Melanie Wilson had also suggested a prudent patient standard approach. AC noted that if there is a discussion with patients there is a possibility an additional appointment may be required as part of the informed consent process.	

	AC noted the audit proposals that were presented: • Where have all our Paeds GA cases gone? – Alex Siddle. • Audit of rheumatology patients on biologic immunomodulators requiring oral surgery procedures. – Alex Siddle on behalf of Emma Brown. AC commented that more discussion and work was needed to determine the strength and value of the proposed audits.	
2.2	**Restorative Dentistry - Dr G Bhamra** Minutes from the Restorative Dentistry Audit Group meeting on the 26th May 2017 were received and noted. GB noted the presentations given: • Robert Baker, Eilidh Meyers, Michael Pope – An audit of the dental complexity levels of inpatients within Cardiff & Vale UHB requiring dental care. • Andreas Chatzipantelis – Audit in Cobalt / Chrome Denture remakes in the UDH • Andreas Chatzipantelis – Review of CAD / CAM service for the fabrication of Cobalt / Chrome frames in the UDH AC enquired as to the quality of this service. GB informed the group that the quality was very good. The machines were expensive, in excess of £60,000, but the process was tried and tested and had been in use in the motor industry for over 20 years. • Kasim Butt – Audit of root canal obturation by undergraduate students at UDH • Fiona Young – Dementia Awareness Presentation • Claire Digby – Importance of COF Forms AC noted that the COF forms should be filled out anyway. GB replied that the forms were being filled but were not necessarily being filled out in full. GB has requested a full presentation to be given in the future on the importance of COF forms. EY commented that smoking cessation referrals were now being monitored at clinical board. The question needed to be asked of patients and the COF forms completed in full to reflect the patients' response. BC commented that undergraduate clinics were not being recorded as they were managed using the SALUD system.	
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 19th May 2017 were received and noted. SB noted the presentations given: • Poh Kum Thai – Audit 6639: Invisalign treatment outcomes in UDHW AC queried the cost of Invisalign treatment in comparison to fixed appliances. The group discussed. IC commented that some Invisalign treatment packs are provided free of charge to the hospital. • Claire Paul – Guidelines for Periodontal Screening and Management of Children and Adolescents under 18 years of age. SB also noted the presentations given at the latest audit meeting on 13th June 2017: • Juliette Brouard – Safeguarding: Would you be concerned? • Helen Poole – Smoking Cessation Update	
2.4	**Community Dental Service - Mr J Gillespie** Minutes from the CDS Quality & Safety Group meeting on the 25th May 2017 were received and noted. JG informed the group of a concern involving non-compliance by the UHB with Health Inspectorate Wales processes. This had been escalated to the Chief Executive and was in the process of being dealt with. JG commented on an email he had received stating that no amalgam was to be used in deciduous teeth or teeth in under 15 year olds. The group discussed. JG will email	JG

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	to IC for information and discussion.	
2.5	**DSG HSC: Minutes of the Dental Division and School H & S Advisory Group - Prof I Chestnutt** IC informed the group that the May meeting had been cancelled. IC commented that the latest Hand Hygiene audit results had showed an improvement. EY commented 'bare below the elbow' had been discussed at the latest Big Room meeting and was something that is going to be pushed for in the future. BC noted that guidance would have to be amended if 'bare below the elbow' was to be implemented. There was also the issue of students who had already enrolled being made to stop using sleeves. IC will speak with Rowena Griffiths to determine how other clinical boards have addressed the issue.	IC
2.6	Medicine Management	
3.1	Patient Story / 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.	
5.2	**Patient Safety Incidents** The document was received and noted. • AC acknowledged in particular incident 44607 - A gentleman arrived in the health centre and drove his mobility scooter at great speed down the corridor towards the dental department. The group discussed. • AC acknowledged in particular incident 45573 - The doppler machine was no longer working. The patient's mother and aunt said that the nurse had just changed a dressing and had cut the wire with a scissors in order to change that dressing. The wire had been left attached to the patient and no comment had been made to any of our staff. CE commented that this incident should maybe be re-allocated to the ward. • AC acknowledged the majority of incidents were sharps related.	
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	

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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	
9.4	IMPAX - Generic screen saver time out	
Items to be recorded as Received and Noted for Information by the Committee		
	ENC9 - Ongoing Audits as at 060617 - The document was received and noted.	
	ENC10 - Patient Safety Notice PSN037 - Final Version - The document was received and noted.	
	ENC11 - RG - Draft report v2 In41431 - The document was received and noted. AC summarized the Never Event for the group.	
	ENC12 - RG - action plan In41431 medication error v1 - The document was received and noted.	
	CE brought to the groups attention – NatSSIP (National safety standards for invasive procedures). AC commented that he had attended a meeting in recent weeks where Richard Hughes gave a presentation on how to reduce incidents. Julia Charles also attended. The Dental Hospital already had many processes in hand such as the WHO checklist and received good feedback.	
10	**Date of Next Meeting** TBA | TBA | TBA	

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