



**ANNUAL SPECIAL MEETING OF THE
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

**9am on Tuesday 17th October 2017
Corporate Meeting Room, UHB HQ
University Hospital of Wales**

SPECIAL QUALITY SAFETY AND EXPERIENCE COMMITTEE

9am on 17th October 2017
Corporate Meeting Room, HQ, University Hospital of Wales

AGENDA

1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Committee meeting held on 12 th September	<i>Chair</i>
5	Action Log	<i>Chair</i>
6	Chair's Action Taken since the last meeting	<i>Chair</i>
7	Analysis of Trends and Themes in Serious Incidents and Never Events	<i>Executive Nurse Director</i>
7a	Paediatric Naso Gastric Tube Never Event (presentation)	Oral <i>Ch & W Clinical Board</i>
7b	Use of World Health Organisation (WHO) Checklist (presentation)	Oral <i>Surgery Clinical Board</i>
8	National Safety Standards for Invasive Procedures Follow Up (presentation)	<i>Executive Nurse Director</i>
9	Items to bring to the attention of the Board/other Committee	Oral
10	Date of next meeting 9am on Wednesday 6th December 2017	

**UNCONFIRMED MINUTES OF A MEETING OF THE QUALITY, SAFETY AND
EXPERIENCE COMMITTEE HELD AT 9am ON 12 SEPTEMBER 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

Present:

Maria Battle	Chair
Margaret McLaughlin	Independent Member – Third Sector
Cllr Susan Elsmore	Independent Member – Local Authority

In Attendance:

Abigail Harris (part)	Director of Planning
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Representative
Clive Morgan	Deputy Director Therapies and Health Sciences
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Hayley Dixon (part)	Director of Operations, Dental Clinical Board
Prof Ivor Chestnutt (part)	Clinical Director, University Dental Hospital
Prof Mike Lewis (part)	Clinical Board Director, Dental
Peter Welsh (part)	Director of Corporate Governance
Rowena Griffiths (part)	Governance and Quality Manager, Dental CB
Ruth Walker	Executive Nurse Director
Dr Sharon Hopkins	Director of Public Health Medicine
Stephen Allen	Chief Officer CHC

Apologies:

Akmal Hanuk	Independent Member – Community
Ivar Grey	Independent Member /Chair of Audit Committee
Martyn Waygood	Independent Member – Legal
Angela Hughes	Acting Assistant Director Patient Experience
Fiona Jenkins	Director of Therapies and Health Sciences
Steve Curry	Interim Chief Operating Officer

Secretariat:

Julia Harper

QSE 17/128 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, colleagues from the Dental Clinical Board.

QSE 17/129 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/130 DECLARATIONS OF INTEREST

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

**QSE 17/131 MINUTES OF THE COMMITTEE HELD ON
20th JUNE 2017**

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

QSE 17/132 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 would be undertaken when recruitment had been made into the Falls post. It was anticipated this could be received in January 2018.

Action – Mrs Carol Evans

QSE 17/088 CHC Report – Mr Allen requested evidence from the UHB as to the effect of slow repatriation on the UHB in order to raise the issue more widely.

Action – Mr Steve Curry

QSE 17108 Plans for CMHT Accommodation – Some funding had been made available for Barry and further plans were being finalised. It was agreed that this would be better considered at the Strategy and Engagement Committee.

Action – Mrs Abigail Harris

QSE 17/048 Trends and Themes in Sis – Patient Wristbands – An electronic solution was taking longer to scope but, at the request of the Chair, would remain on the agenda until a decision was made on the business case.

Action – Mrs Ruth Walker

QSE 19/099 Care of the Deteriorating Patient - The current model would not change whilst a clinical services model was being developed for the Strategy and Engagement Committee. It was agreed to keep this on the QSE agenda.

QSE 17/133 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/134 PATIENT STORY – DENTAL

Prof Mike Lewis, Clinical Board Director, Dental introduced his long term patient, Mrs Davies, who initially presented 15 years ago following kidney transplant. Prof Lewis commented that as part of the transplantation treatment, patients were immune suppressed to ensure that transplanted organs were not rejected. Unfortunately, when this occurred, patients normal defence mechanisms were unable to cope with cell changes.

Mrs Davies explained to the Committee that she could feel changes in her mouth. Of the 10 biopsies she underwent over a number of years, 5 of them were cancerous and a number of operations were required, the last being in 2008. Mrs Davies explained that with Prof Lewis' support and guidance, each operation was as minimally invasive as possible in order for her to keep her tongue. Further discussion also took place with the consultant nephrologist, Dr Kesh Baboolal. It was agreed between the consultants and Mrs Davies, that her drug regime be changed and reduced gradually in order to reduce the changes to her cells and the risk of further cancer and that bloods would be checked regularly to ensure the transplanted organ was not rejected.

Mrs Davies explained that she had been given very easy access to Prof Lewis and was able to contact him directly whenever she noticed any changes in her mouth. This helped reduce her fear as she knew she would be seen promptly. She also had regular reviews and gradually the length of time between reviews was extending.

It was clear from the patient's experience that careful consideration had been given to all available options balancing risks and benefits and that she had been central to the decision making. This was a fine example of empowering the patient with tailored and complex treatment and was central to the UHB's Strategy. Communication was a theme of many complaints and this particular case demonstrated how much better it was for all concerned when communications were good.

The Chair thanked Mrs Davies for sharing her patient experience which was an inspirational story for the Committee.

QSE 17/135 DENTAL CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions on the report:

- The work to improve care and treatment of patients with a sensory loss was commended.
- A small investment had been made to undertake an assessment in order to pursue "Louder than Words" accreditation. Initial feedback would be available within the next week.
- In terms of reducing referral to treatment time (RTT), it was likely that more investment would be required in order to meet and maintain the

26 week target. It was noted that there had been a significant rise in demand for oral surgery.

- Flu vaccination rates were better than last year but there was still more work to be done.
- There was a good and active prevent programme which should be shared with other Clinical Boards.
- It was noted that oral health (tooth decay) was one of the best indicators of current and future overall health.
- The national oral health strategy had recently been updated to achieve earlier impact.
- The report did not address how themes from complaints were being taken forward. It was noted that a meeting had been set up to determine the action to be taken and how the Clinical Board would listen to the experience of patients.
- The report provided assurance on systems and processes. In the future, the Committee needed to be told how practice had changed as a result of incidents and feedback.
- Given there had been 100,000 attendances, many of which were managed by students under supervision, there were only 66 informal and 19 formal concerns raised.
- Mr Allen of the CHC offered support with the patient satisfaction process if required.
- Improvements had been noted in the level of discussion and recording of Clinical Board QSE sub committee minutes.
- The Clinical Board confirmed that a comprehensive audit was planned regarding mental capacity and 67% of staff had completed mandatory training.
- Regarding mandatory training, there were 13 on line modules and completion of these resulted in a loss of clinical time. The Clinical Board requested that future consideration be given risk assessing topics against individual staff roles as there was an impact on job planning. The Chair agreed to share this with the new Director of Workforce and OD.

Action – Miss Maria Battle

It was noted that there was a Mandatory Training Steering Group as part of LED and this received and considered requests from departments to expand the number of topics/modules. Each request had to justify the time spent on a topic. This discussion would be feedback to the Steering Group.

Action – Ms Catherine Salter

ASSURANCE was provided by audits carried out by internal audit including:

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

that had provided reasonable and substantial assurances on the processes in place within the Dental Clinical Board.

The Quality Safety and Experience Committee:

- **APPROVED** the content of this report and approach taken by the Dental Clinical Board
- **NOTED** the progress made and the areas for further action.

QSE 17/136 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC Chief Officer, Mr Stephen Allen, drew the Committee's attention to the UHB's achievement of 64% of the CHC's recommendations and commented that by yesterday, this had increased to 70%. However, some of the key themes raised in previous reports remained outstanding.

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

QSE 17/137 CHC: GENERAL PRACTICE BRANCH SURGERY VISITS NOVEMBER/DECEMBER 2017

The Chair invited comments and questions on the report.

- It was queried how some surgeries managed appointments better than others and whether it was down to capacity or efficiency.
- The CHC had received 1,476 responses (34%) and distributed 4,400 surveys.
- The CHC had held conversations with practices on how it could better support patients and surgeries.
- It was noted that there were times when practices, because of their independent nature, were not able to be influenced.
- There was a growing creep in the number of struggling practises and this could lead to more branch closures, which was a concern.
- It was important that the UHB recruited more GPs and continued to provide ongoing support to branch surgeries.
- Overall there was a very high level of satisfaction with branch surgeries.

It was **AGREED** that long term sustainability of General Practice should be considered and discussed at the Strategy and Engagement Committee and this would be referred to the Committee Chair.

Action – Mrs Julia Harper

QSE 17/138 POLICIES FOR APPROVAL

1. ALL WALES MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR) POLICY

The Committee **NOTED** that the CHC did not want to participate in Appeals as this was considered a conflict of interest and was being discussed with Welsh Government.

ASSURANCE was provided by:

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

The Committee:

- **APPROVED** the UHB's adoption of the All-Wales IPFR Policy.
- **SUPPORTED** the full publication of the All-Wales IPFR Policy in accordance with the UHB Publication Scheme.
- **NOTED** the Policy may change given the reservations raised by the CHC.

2. POINT OF CARE TESTING (POCT) POLICY AND PROCEDURE

The Policy was considered in conjunction with the POCT Governance Review report. It was noted that the Policy was in line with the Welsh policy and Ministerial letters and that there was a Welsh project to develop electronic monitoring in future.

The Nurse Director commented on the importance of the policy given the legal/disciplinary cases involving staff at another health board in relation to blood glucose monitoring. Assurance was provided that spot checks were rigorous and there was regular audit.

The greater concentration of work in the hospital was noted, however, conversations were being held with independent contractors through Medicines Management Group and the Local Medical Committee.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

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

3. NUTRITION AND CATERING POLICY AND PROCEDURE FOR INPATIENTS

The Policy was considered in conjunction with the Nutrition and Hydration report.

ASSURANCE was 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:

- **APPROVED** the Nutrition and Catering Policy for Inpatients, subject to formatting changes and separation of policy and procedures.
- **AGREED** to strengthen the procedure with reference to the involvement of carers at mealtimes (John's campaign).
- **APPROVED** the full publication of the Nutrition and Catering Policy for Inpatients in accordance with the UHB Publication Scheme.
- **AGREED** that the Policy be updated in the near future to include the outcome of the current work on NG tubes.

4. VENEPUNCTURE FOR NON CLINICALLY QUALIFIED RESEARCH STAFF POLICY

Assurance was provided that the Policy only related to the taking of blood and not the insertion of lines. It was also noted that patient consent was necessary for any such procedure.

ASSURANCE was provided by:

- This policy and related procedure which would ensure that non clinically qualified staff involved in research undertook the same rigorous training and education that was currently in place for clinically qualified staff and would ensure that standards of quality were being met.

The Quality, Safety and Experience Committee:

- **APPROVED** the Venepuncture for Non Clinically Qualified Research Staff Policy and related Procedure, subject to it being made explicit that it only related to the taking of blood.
- **APPROVED** the full publication of the Venepuncture for Non Clinically Qualified Research Staff Policy and related procedure in accordance with the UHB Publication Scheme.

QSE 17/139 UPDATE ON THE REVIEW OF OUTSTANDING POLICIES

The Assistant Director, Patient Safety and Quality presented the position paper that demonstrated progress and the plan to bring the outstanding policies up to date within 6 months.

Action – Mrs Carol Evans

The Committee noted that Internal Audit had provided reasonable assurance and the follow-up was also satisfactory.

ASSURANCE was provided by:

- Progress that had 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:

- **NOTED** the progress that has been made.
- **APPROVED** the proposal to achieve a position where all clinical policies were in date.

4

QSE 17/140 IMPLEMENTING THE NATIONAL STANDARDS FOR INVASIVE PROCEDURES

The Executive Nurse Director, Mrs Ruth Walker advised this report was a position statement. Whilst the UHB was currently non-compliant, good progress was being made.

ASSURANCE was provided by:

- Work that had progressed to implement the Standards to date.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the progress that had been made to date and
- **AGREED** to receive an update report at the October 2017 meeting in order to decide whether the UHB was compliant or not with the Patient Safety Notice 034.

Action – Mrs Ruth Walker

QSE 17/141 PATIENT SAFETY SOLUTIONS – ALERTS AND NOTICES – UPDATE ON OUTSTANDING AREAS OF NON-COMPLIANCE

The Nurse Director, Mrs Ruth Walker advised Committee that work had moved on apace since the last report to the Board.

LIMITED ASSURANCE was provided by:

- The UHB was currently 90% compliant with all Patient Safety Solutions (PSS), and this would 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 were being undertaken to address the outstanding areas of non-compliance.
- Risk assessments that were in place to mitigate any outstanding risks.

The Committee:

- **CONSIDERED** the update provided within the report.
- **CONSIDERED** the risk assessments associated with outstanding areas of non-compliance.

- **AGREED** that compliance with PSA002 – the prompt recognition and initiation of treatment for Sepsis for all patients could be declared.

**QSE 17/142 BLOOD PRODUCTS – HEALTH AND CARE
STANDARD 2.8**

The Medical Director, Dr Graham Shortland advised that this was a regular, annual report to the Committee.

ASSURANCE was provided by:

- The current annual self-assessment for Health and Care Standard 2.8 was assessed as “Meeting the Standard”.
- Evidence of continuing improvement was provided for 2017/2018.

The Quality, Safety and Experience Committee:

- **AGREED** the report.

QSE 17/143 NUTRITION AND HYDRATION REPORT – AUGUST

The report covered the model piloted on wards A4 and East 2. All Welsh recommendations were included within the action plan and the very positive impact on patients was noted.

The pilot demonstrated reduced length of stay and it was hoped this could be expended across the UHB although it was noted the considerable pressure it put on ward nursing staff. Therefore a big project was being set up to reach agreement for a consistent approach to rolling out and supporting a number of initiatives.

The Committee noted that another assessment of nutrition and hydration would be undertaken by the CHC. Mr Allen hoped to see some consistency across wards with regard to protected meal times, visiting times, and the number of hot drinks available during the day. Such information was particularly important for carers and different standards caused confusion when patients were moved from ward to ward.

REASONABLE ASSURANCE was provided by:

- The status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the action plan particularly in relation to the model ward pilot and the pilot of the nutrition and dietetic service within the Emergency Unit.
- **WAS ASSURED** that the Nutrition and Catering Steering Committee kept regular review of the action plan to ensure and update on progress.

QSE 17/144 POINT OF CARE TESTING GOVERNANCE REVIEW

The Review was considered in conjunction with the POCT Policy. The Medical Director, Dr Graham Shortland advised that the UHB had a good POCT Team but it was small and experienced increasing pressure through the introduction of new technology. It was therefore planned to ask each Clinical Board to contribute to the development of the team as they were the beneficiary of its services and expertise.

ASSURANCE was provided by:

- The current governance and reporting structures in place.
- Further initiatives to strengthen the PoCT functionality.
- Training and educational programme.

The Quality, Safety and Experience Committee:

- **AGREED** the continuation of the current Governance Structure for Point of Care Testing and
- **NOTED** the initiatives for service improvement that were being put in place to further strengthen governance.

QSE 17/145 RISK TO PATIENTS DURING THE CHANGEOVER TO THE NEW NEURAXIAL CONNECTOR

The Medical Director, Dr Graham Shortland reminded Committee that it had been following progress on this patient safety initiative. He thanked Mrs Sian Rowlands for her support with the assessment of the risk associated with the changeover. He also advised that Management Executive would need to discuss the financial implications.

ASSURANCE was provided by:

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

The Quality, Safety and Experience Committee:

- **AGREED** the continued work of this group.
- **APPROVED** the initial risk assessment in Appendix 1.

QSE 17/146 CORPORATE RISK AND ASSURANCE FRAMEWORK

The Director of Corporate Governance, Mr Peter Welsh advised Committee that there had been no significant change since the last report. The review of

the risk management process continued and it was hoped that ownership of risk and risk descriptors would become more meaningful. It was anticipated the new process would be in place next year.

ASSURANCE was provided by:

- Mitigation of our 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.

QSE 17/147 WRPS THEMED REVIEWS OF EMERGENCY DEPARTMENTS AND COMPOSITE THEMED REVIEW AND ACTION PLAN

The Executive Nurse Director, Mrs Ruth Walker, reminded Committee that the Welsh Risk Pool undertook an external review of high risk areas. This was a positive report that covered all Wales as well as the detail for the UHB. The key issues were induction, staffing and skill mix, morale, rotation of clinical nurse practitioners, capacity protocols, the separation of adults and children and incident reporting. It was pleasing to note that all had improved since the last report.

ASSURANCE was provided by:

- Positive findings of the Cardiff and Vale UHB review.
- Improvement plan developed to address the recommendations.

The Quality, Safety and Experience Committee:

- **CONSIDERED** 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.
- **NOTED** that the missing appendices would be circulated separately.
Action – Mrs Julia Harper

QSE 17/148 PROVISION OF A DECANT WARD AT UHW AND UHL

The Director of Planning, Mrs Abigail Harris presented the report that was prepared at the request of the Committee because the UHB did not have a decant ward to enable ward refurbishment or manage infection outbreak.

At UHW a prefabricated ward had been ruled out on grounds of connectivity. However, the UHB was working with Welsh Government on a replacement for B4 haematology. During the summer, the UHB was able to release capacity to undertake refurbishment of half a ward at a time with 2 whole wards

completed. The area in the Duthie Library would be available again for increased capacity in the coming winter. It was important, however, for work to continue on a complete UHB bed plan as part of the wider clinical services plan. In addition, priority areas for next year's refurbishment would be identified.

Since the report was written, there had been a change in thinking for UHL. There was a possibility of a new ward being built on a car park and with reduced length of stay, a whole ward may be released.

It was noted that in New Zealand the whole care system had changed by supporting more people at home and they had managed to deliver the same Strategy the UHB was working towards. There were lessons that could be learned.

In terms of Gwenwyn Ward, UHL, it was noted that health and safety concerns had been raised by staff who had been told they would be merged with another ward. The Nurse Director explained that Gwenwyn was no longer a suitable environment for the client group. It was a small mixed sex area and there had been allegations of serious incidents. Any move would be subject to a full risk assessment to ensure safety features were included for staff. These concerns would be feedback to the Chief Operating Officer.

Action – Mrs Ruth Walker

ASSURANCE was 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 would result in the availability of B4H at UHW becoming vacant.
- The Surgical Clinical Board Business Case, 'Development of Emergency Surgery' which sought 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:

- **NOTED** the content of the report recognising that the options considered required the development of a number of Business Cases to secure Welsh Government funding.

QSE 17/149 CANCER PEER REVIEW – NEURO ENDOCRINE TUMOURS

The Medical Director, Dr Graham Shortland commented on the concerns about the UHB's co-ordination of this service. Steps were being taken to address service delivery and significant funding had been received from WHSSC to improve the service.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the 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
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **AGREED** to share the report with Health Inspectorate Wales.
Action – Dr Graham Shortland

QSE 17/150 LEADING IMPROVEMENT IN PATIENT SAFETY (LIPS) UPDATE

The Executive Nurse Director, Mrs Ruth Walker, reported that there was a good number of participants and projects, more importantly, many projects aligned with the UHB's Strategy or transformation work. It was important to keep up the pace on conclusion of each project and include changes into everyday business. On the suggestion of the CHC, it was agreed to advertise the positive impact these projects had after the forthcoming celebration event.

ASSURANCE was 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:

- **NOTED** progress of the LIPS programmes.
- **APPROVED** future plans.

QSE 17/151 ANNUAL CLINICAL AUDIT PLAN

The Medical Director, Dr Graham Shortland, thanked Mrs Carol Evans and her team for the work undertaken, but recognized there was still more to do. However, it had been noticed that Clinical Boards were at last beginning to focus on audits that would address their problem areas.

ASSURANCE was provided by:

- The development of a Clinical Audit Plan.
- The development of the Clinical Audit Strategy.

The Quality, Safety and Experience Committee:

- **APPROVED** the Clinical Audit Plan and
- **NOTED** the Clinical Audit Strategy.

4

QSE 17/152 CARERS

The Executive Nurse Director, Mrs Ruth Walker updated Committee on further progress since the report was written. Funding had been obtained for full time school and carer development workers until June 2018 to support the high number of school-age carers. The UHB would look to sustain these schemes when the funding ended, including the use of volunteers. An event was being arranged to promote the schemes and develop a “one stop shop” for carers in conjunction with local Councils and the Third Sector. An Expert Carers Panel was also being developed. In addition, a carers engagement officer would be appointed until June 2018.

Action – Mrs Angela Hughes

It was noted that Carers was one of the priorities of the Regional Partnership Board. It was also noted that the pace of work changed depending on the availability of funding.

The CHC commented that many GP practices had carers champions and further discussion would be welcomed. In terms of the carers leaflet, it was suggested that the Sensory Loss Group look over the draft as the watermark made it difficult for people with sensory loss to read. It would also be helpful if actual links were put into the leaflet rather than the general statement “ask staff” as not all staff would have the necessary information to pass on.

It was noted that given the recent changes on the Carers Measure, the mandatory training package would need urgent updating. The Nurse Director would ensure that Mrs Angela Hughes liaised with LED to make the changes.

Action – Mrs Ruth Walker

ASSURANCE was provided by the progress and actions highlighted within the report.

The Quality, Safety and Experience Committee:

- **NOTED** and **APPROVED** the contents of the paper.
- **AGREED** to share the report with Third Sector, the Regional Partnership Board and the two Children’s Boards to ensure connectivity.

Action – Mrs Ruth Walker

**QSE 17/153 FEMALE GENITAL MUTILATION (FGM)
SAFEGUARDING UPDATE**

The Executive Nurse Director, Mrs Ruth Walker presented the position paper. In terms of handling community reaction, it was noted that the Head of Midwifery was holding engagement meetings and ensured that conversations were held with ladies during the clerking process. There was still some resistance to reporting FGM within some community groups but it was reiterated this was a legal requirement. It was noted that this was also being addressed by Cardiff Council during work with individual mosques.

ASSURANCE was 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:

- **NOTED** this report

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

QSE 17/154 NICE GUIDANCE

ASSURANCE was provided by:

- The process of disseminating NICE guidance and recording levels of implementation.

The Quality, Safety and Experience Committee:

- **NOTED** the compliance with the current process and the intention to disseminate NICE Quality Standards.

QSE 17/155 HIW ANNUAL REPORT OF THE UHB

The Nurse Director, Mrs Ruth Walker thanked Mrs Carol Evans for all her work on this growing agenda. This was a very positive report and it was presented for noting only as each of the individual reports had already been considered by the Committee over the last year.

Asked about progress on issues around learning disability, it was noted that discussions with the provider were ongoing. Relationships were being built

with all concerned to determine the shape of the future service. The Committee would be receiving an update in December.

With regard to a recent court case, it was noted that the UHB had not been alerted. As a result, commissioning arrangements had been strengthened. It was further noted that this was also a priority area for the Regional Partnership Board.

ASSURANCE was provided by:

- A reduction in the number of immediate assurance issues to one, compared to the previous year.
- HIW statement that the UHB had demonstrated itself to be a learning organisation.
- HIW statement that it enjoyed a positive working relationship with the UHB.

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the Cardiff and Vale UHB Healthcare Inspectorate Wales Annual report for 2017- 2020.

UHB 17/156 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The Minutes were received and noted.

- 1. CLINICAL DIAGNOSTICS AND THERAPEUTICS – MAY, JUNE * JULY**
- 2. MENTAL HEALTH – JUNE**
- 3. PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MAY**
- 4. SPECIALIST SERVICES – MARCH, APRIL, MAY & JUNE**
- 5. MEDICINE – MAY & JUNE AND ACUTE AND EMERGENCY WAITS – MARCH/APRIL**
- 6. SURGERY – MAY**
Concern was expressed that the WHO checklist was not being used as it should be. It was noted that this would be an area for discussion at the Special meeting in October and the Clinical Board would be asked to attend.
Action – Mrs Carol Evans
- 7. CHILDREN AND WOMEN – MAY**
- 8. DENTAL – JUNE**

QSE 17/157 AGENDA FOR THE PRIVATE QSE

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

QSE 17/158 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There was nothing to bring to the attention of the Board.

QSE 17/159 REVIEW OF THE MEETING

There was nothing to add to the meeting.

QSE 17/160 DATE OF NEXT MEETING

The Special meeting would be held at 9am on Tuesday 17th October 2017 and the next normal meeting would be held a week earlier than planned originally, on Wednesday 6th December at 9am.

ACTION LOG FOLLOWING QSE COMMITTEE SEPTEMBER 2017 MEETING

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
QSE 17/024 QSE 17/048 QSE 17/084 QSE 17/132	21.2.17 18.4.17 20.6.17 12.9.17	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. It was anticipated this could be done by January 2018 following recruitment into the Falls post.
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 17/56	18.4.17	Patient Safety Solutions Alerts and Notices		Share with the UHB evidence obtained from patients regarding wristbands.	S Allen, CHC	This would be shared at a meeting on 15th September .
QSE 17/088 QSE 17/132	20.6.17 12.9.17	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	Impact of this on UHB to be provided to the CHC by Mr Steve Curry.
QSE 17/090	20.6.17	Regulatory and Accreditation Visits		Letter of commendation to be sent to Clinical	M Battle	

5

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		to CD&T		Board		
QSE 17/098	20.6.17	CRAF		Comments to P Welsh on whether the risk descriptors and controls identified were adequate to provide assurance to the Committee by 20 th July.	ALL Members and Attendees P Welsh to 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	September update - a meeting had been set up.
QSE 17/135	12.9.17	Dental CB QSE Assurance Report		Raise with WOD Director concerns about mandatory training Share feedback with Mandatory Training Steering Group	M Battle C Salter	To be raised at the next meeting on 6 th November.
QSE 17/138.3	12.9.17	Nutrition and Catering Policy		Strengthen Policy re carers and split policy from procedure	C Morgan / F Jenkins	Author is currently amending the format.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				Publish Policy	J Harper	
				Update to include work on NG tubes	F Jenkins	
QSE 17/139	12.9.17	Out of Date Policies		Plan to update all out of date policies within 6 months	C Evans	By April 2018
QSE 17/149	12.9.17	Cancer Peer Review –neuro endocrine tumours		Share report with HIW	Dr G Shortland	
QSE 17/152	12.9.17	Carers		Request Mrs Hughes liaise with LED to update mandatory training	A Hughes	Discussions being held with LED
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS/OTHER COMMITTEES						
QSE 16/192	18.10.16	Critical Care Outreach Team		Clinical Model for managing the deteriorating patient to be agreed.	Dr G Shortland	This item had been considered at Committee several times without agreement on a way forward for an action plan and timeline.
QSE 17/048	18.4.17	(Identifying and Managing the Deteriorating Patient)		Discuss at Management Executive the options for strengthening on site clinical and managerial support.	S Curry	Full discussion to be held at at QSE meeting in June 2017.
QSE 17/099	20.6.17			Finalise ongoing shape and purpose of services at UHL through the	S Curry	Mrs Harris reported that the current arrangements will not change. A clinical services model

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				acute medicine review with the Planning Team.		was being developed. It was agreed to keep this on the agenda.
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 2017 - Deferred
QSE 15/135 QSE 16/006	01.09.15 23.2.16	Corporate Risk and Assurance Framework Exception Report -		Business Case for Critical Care Outreach (CCO) and Hospital at Night to be considered at Investment Panel.	A Casey changed to S Curry	December update: Awaiting funding for Advanced Nurse Practitioners to address Hospital at Night
QSE 16/202 QSE 17/023	13.12.16 21.2.17	Care of the Deteriorating Patient : Critical Care Outreach Service		Need to resolve Critical Care Service issues at UHL.	Dr G Shortland / S Curry	February 2017 - Reported to HSMB in December that more work was required to make the plan resource neutral. Update agreed for September 2017 (Linked to 2 items above)
QSE 15/171 QSE 16/148 QSE 17/005 QSE 17/048 QSE 17/132	20.10.15 13.9.16 21.2.17 18.4.17 12.9.17	Trends and Themes in SI's		Revisit decision on patient wristbands.	R Walker	Feb 2017 - Solution agreed but funding yet to be identified for 2017/18. Present report for funding consideration to the Management Executive and provide more detail for the next QSE meeting in June . Business case now going to BCAG 13 TH June 2017. This was taking longer to scope

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						and at Chair's request, would remain on the agenda until a decision was made.
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 Deferred to December 2017
QSE 17/009	21.2.17	CHC Report – Boredom and Loneliness		Receive an update in 6 months to a year.	R Walker	QSE 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 – included in Trends and Themes on October agenda
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 December 17
QSE 17/053	18.4.17	Donation of Organs and Tissues after Death Policy		Identify a Patient Story linked to faith for a future Board meeting.	A Hughes	November 2017 Board meeting

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
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. Deferred
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 17/063 QSE 17/084	18.4.17 20.6.17	Healthy Restaurant and Retail Policy		Chair requested confirmation of when healthy eating would be advertised in the restaurant.	A Harris	Complete
QSE 17/063 QSE 17/084	18.4.17 20.6.17	Healthy Restaurant and Retail Policy		Request PPP Committee to consider the comments and review value for money of all Wales food contract.	A Harris	Referred to PPP Committee Secretariat (or its successor on 19/4/17) Strategy and Engagement Committee received a report on Food Outlets and Non Patient Catering at the September 2016 meeting. In terms of a value for money review, we will scope

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
						the work required and understand the impact of coming out of the national contract which may have significant workload implications. At this point, a possible timeframe for completion can be provided to the Strategy and Engagement Committee. CLOSED at QSE
QSE 17/138.1	12.9.17	IPFR Policy		Publish Policy	J Harper	Complete
QSE 17/138.2	12.9.17	POCT Policy		Publish Policy	J Harper	Complete
QSE 17/147	12.9.17	WRP Themed Review of Emergency Departments		Circulate missing appendices separately	J Harper	Complete
QSE 17/138.4	12.9.17	Venepuncture for non clinically qualified research staff		Make explicit only relates to the taking of blood Publish Policy	G Shortland J Harper	Complete Complete
QSE 17/137	12.9.17	CHC Report – Branch Surgery Visits		Refer for discussion at the Strategy and Engagement Committee, the sustainability of general practice	J Harper	Refer to Strategy and Engagement Committee – sent.
QSE 17/087	20.6.17	PCIC Quality and Safety Report		New Committee to be asked to consider this developmental work and	P Welsh	New Committee – sent.

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
		Specialist Nursing staff were key to supporting patients and reducing the need for clinic follow up appointments eg Diabetes.		connectivity with University syllabus Scrutinise PCIC's top priorities and the impact of the Local Delivery Plan at new Committee	P Welsh	New Committee – sent.
QSE 17/108 17/132	20.6.17 12.9.17	Plans for CMHT Accommodation		Timescale for the delivery of BIG 2 - discuss with P Welsh where and when this should be received.	A Harris	This would be better considered at the Strategy and Engagement Committee – sent.
QSE 17/140	12.9.17	National Standards for Invasive Procedures		Decide whether the UHB was complaint or not with the Patient Safety Notice034.	R Walker	Report to October Special QSE Meeting – on October Agenda
QSE 17/156.6	12.9.17	Surgery CB QSE Minutes		Invite Surgery Director of Nursing to Special QSE to discuss use of the WHO checklist	C Evans	October Special QSE – On October Agenda
QSE 17/148	12.9.17	Provision of Decant ward at UHW and UHL		Feedback concerns from staff about merger of Gwenwyn ward to COO.	R Walker	Complete
QSE 17/027	21.2.17	Sub Committee QSE Minutes		Bring together the Clinical Board quality and safety Leads to review good practice	C Evans	Carol Evans will be attending the Directors of Nursing weekly meeting on 20 th June to discuss. Complete

MINUTE	DATE	SUBJECT		AGREED ACTION	ACTIONED TO	STATUS
				with regard to minutes.		
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. Complete
QSE 17/066	18.4.17	Minutes from Clinical Board QSE Sub Committees		Discuss depth and breadth of the Dental agenda with the CB.	C Evans	Meeting arranged for 23 rd June Complete
QSE 17/152	12.9.17	Carers		Amend the Carers leaflet to reflect comments made at the meeting	A Hughes	Complete
				Share report with Third Sector, Regional Partnership Board and 2 Children's Boards	R Walker	Appropriate distribution was Complete

AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS OCTOBER 2016 – SEPTEMBER 2017
Name of Meeting : Quality, Safety and Experience Committee
Date of Meeting : 17 th October 2017
Executive Lead : Executive Nurse Director
Author : Patient Safety Manager, Telephone 02920 74 6387
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" elements of the Health Board's Strategy.
Financial impact : There are significant potential financial implications associated with this work in relation to clinical negligence claims.
Quality, Safety, Patient Experience impact : The work outlined within this paper 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 and Health Impact Assessment Completed: Not Applicable

7

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents are reported and investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) is monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertake related assurance reviews. The Delivery Unit also applies scrutiny to Never Event processes.

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report and **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

SITUATION

The purpose of this report is to present the Committee with an analysis of the themes and trends in Serious Incidents (SI) reported to Welsh Government between October 2016 and September 2017.

BACKGROUND

Welsh Government (WG) guidance on Serious Incident (SI) reporting and investigation procedures was updated in November 2013. It forms part of the Putting Things Right guidance which underpins the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011.

The guidance stipulates that WG should be notified of an SI through the agreed electronic process within 24 hours of the incident occurring where possible. WG then reviews the incident and allocates a 60 working day timeframe for investigation of the incident.

The UHB has a process in place for the management of SIs and this is now well embedded, with a high level of ownership across Clinical Boards.

At the conclusion of the investigation, organisations are required to submit a closure form which summarises the findings, recommendations and learning from the investigation of the incident. The UHB continues to be praised by WG on the quality of the closure forms submitted as they demonstrate that a thorough investigation has been undertaken, root causes identified and solutions put in place to try and prevent similar incidents in the same set of circumstances.

The UHB has made considerable progress over the last 12 months and at the time of writing this report, has 80 SIs open with WG. This contrasts with a position in October 2015, where the UHB had 282 SIs open. Based on the current rate of reporting, the UHB would expect to have between 60-70 SIs open at any given time, so we are now coming close to a position where the majority of SIs are being managed within appropriate timescales. Given the level of complexity of some investigations, it will never be possible to conclude all investigations within 60 working days, and WG currently requires 90% of SIs to meet this target.

ASSESSMENT AND ASSURANCE

A detailed review of the themes and trends of SIs is attached as Appendix 1.

In summary, 220 Serious Incidents were reported to WG between 1st October 2016 and 30th September 2017. Five of these incidents were classified as Never Events.

To compare, 207 Serious Incidents were reported to WG in the previous report to Committee for October 2015 – September 2016. Five of those incidents were also classified as Never Events. Therefore, there is a small increase in the number of SIs reported to WG. The volume of Never Events has remained static.

The electronic incident reporting software purchased from Datix and implemented in 2015 is now well embedded in the UHB. Revisions to the

system, continued provision of a helpdesk, user support groups and a regularly updated intranet site assisted the transition to an electronic system. A revised Incident Reporting Policy was agreed at the Health and Safety Committee in July 2017 and supporting procedures are in development.

The UHB has greatly improved its position in relation to the upload of incidents to the National Reporting and Learning System (NRLS). With a paper-based system, the average time to upload was greater than 120 days. This is currently in the region of the 67 days. The Patient Safety Team continues to explore methods by which the position can be further improved.

A key benefit of the electronic software is that it has allowed the establishment of various trigger mechanisms which ensures earlier central knowledge and escalation of concerns. This acts as an important safety net.

Where appropriate, actions have been implemented to address arising clinical risk in response to individual incidents. Following investigation, it is recognised that focused attention is required on particular areas to address the root causes and ensure shared learning across the UHB, in particular relation to:

- Injurious patient falls
- Serious self-harm incidents in patients known to Mental Health
- Never Events
- Grade 3 and 4 healthcare acquired pressure ulcers
- Healthcare Acquired Infections
- IR(ME)R breaches due to patient misidentification

[Appendix 1]**AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS
OCTOBER 2016 – SEPTEMBER 2017****1. Introduction**

This report presents an analysis of trends and themes related to SIs reported to WG during the period October 2016 – September 2017. Detail of the individual incidents has previously been reported at each Board meeting.

2. Background

An SI is defined as an incident that occurred in relation to NHS funded services and care resulting in:

- The unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Permanent harm to one or more patients, staff, visitors or members of the public where the outcome requires life-saving intervention or major medical/surgical intervention or will shorten life expectancy;
- A scenario that threatens or prevents an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- A person suffering from abuse;
- Adverse media coverage or public concern for the organisation or the wider NHS;
- Never Events.

All SIs are currently investigated using Root Cause Analysis (RCA) methodology. RCA training continues to be delivered to support identified staff in their role as investigating officers. There is an excellent in-house training session delivered by the UHB Patient Safety Manager and this is very well evaluated. In recognition of the need to assist staff with identifying suitable recommendations and compiling appropriate action plans post investigation, a series of workshops on action planning are scheduled across the UHB in the autumn of 2017. The first of these was held in September 2017, was well attended and also well evaluated.

A weekly Executive Serious Concerns meeting continues to be held, led by the Executive Nurse Director, which reviews Serious Incidents and Concerns on a weekly basis as they are reported and seeks to gain early assurance on lessons learned from Clinical Boards by reviewing investigation reports and implementation of action plans. The weekly meetings are also attended by the Medical Director, Assistant Medical Director for Patient Safety and Quality alongside representatives from Patient Safety and Quality and Concerns Departments. Clinical Boards will periodically attend the meeting to review the position in their area.

This weekly meeting process is considered to be good practice. The UHB has regular requests for senior staff to attend as observers from other Welsh Health Boards.

Number of Serious Incidents reported to WG and overview of Never Events reported in this reporting period

The table below demonstrates the number of SIs and Never Events reported to WG between October 2014 and September 2017:

Serious Incidents reported to WG	Number of incidents	Number of Never Events
October 2014 – September 2015	181	5
October 2015 – September 2016	207	5
October 2016 – September 2017	220	5

It is evident that the number of SIs reported has increased. This is largely in response to the reporting of injurious patient falls as SIs from 2014/2015 and improved reporting of grade 3 or 4 healthcare acquired pressure damage in 2016/2017. This will be explored in greater detail later in this report. The number of Never Events remains unchanged in this reporting period and these incidents will be explored in further detail.

Never Events

The five Never Events reported between October 2015 – September 2016 were:

- A retained swab in an adult patient following major trauma surgery
- A retained throat swab in an adult patient following a surgical procedure
- Two wrong tooth extraction incidents
- A child received enteral nutrition via a misplaced nasogastric tube

The five Never Events reported between October 2016 – September 2017 were:

- An incorrect site procedure in Orthopedic surgery
- A wrong tooth extraction incident
- Wrong route administration of medication (oral medication administered intravenously)
- A retained guidewire following urgent central line insertion
- A retained swab following a forceps delivery

Although all of these incidents are very regrettable, none of the patients were seriously harmed.

The key area of focus therefore, is to prevent incorrect site procedures and avoid retained foreign objects post procedure in all clinical settings. All Never Events are subject to review and close scrutiny by the Delivery Unit (DU). Their scrutiny is welcomed by the UHB since it offers an opportunity to ensure that the internal investigation procedures are rigorous. Additionally, their involvement offers an opportunity to share learning with other

organisations following similar events. The UHB is aware of the need to ensure timely conclusion of Never Events as part of the assurance following these significant incidents. Investigation procedures are regularly reviewed to determine where improvements with timely conclusion of Never Events can be achieved.

A paper describing the work being undertaken across the UHB to implement WG's Patient Safety Notice 034 National Safety Standards for Invasive Procedures, is also presented to the October 2017 Committee. This focuses on the prevention of Never Events involving invasive procedures.

Although each Never Event is unique, there are some common arising themes, including:

- Failure of staff to follow established processes and policies, particularly related to dissemination of policies or education required by staff to ensure policy implementation
- Communication of key information between staff
- Impact of distractions within clinical environments
- Requirement for increased vigilance with the WHO Surgical Safety Checklist
- Value of strong clinical leadership and impact of culture on safety

To avoid the recurrence of an incorrect site surgery the following measures have been taken:

- Double checking of theatre lists before they are submitted
- A series of targeted audits aligned with Theatre QUAD Standards to ensure compliance with best practice is in place
- Establishment of a rotation programme through a particular specialty Theatre for staff to gain more experience
- Work undertaken with the team in relation to the management of verbal aggression
- Circulation of an internal patient safety notice with regards to the requirement for full completion and legibility of consent forms
- Re-enforcement of key UHB policies related to Pre-operative marking of the operation site

The Dental Clinical Board have undertaken a significant amount of work to prevent a future wrong tooth extraction. This includes:

- Benchmarking visits to Centres of Excellence in England to observe best practice
- A review of mid-grade Dentist rotas
- Appointment of a Clinical Lead for Oral Maxillofacial surgery
- Greater emphasis on the UHB Consent to examination or treatment and the Patient Identification policy in dental induction processes
- Issue of a Safety briefing to alert staff to the risks associated with the incorrect dental extraction/intervention if the patient has multiple dental caries in the surrounding area.

Following the very unusual incident in which the intravenous administration of a drug intended for sublingual use occurred the following measures have/are being taken:

- Nifedipine has been removed from all areas other than where it is specifically required on a regular basis and staff are familiar with administration
- The UHB Good prescribing Guide and 'app' will be updated to clarify the position with regards to the administration of sublingual Nifedipine
- The Paediatric Good Prescribing Guide (which is currently under development) will contain a section with specific reference to the use and administration of oral Nifedipine
- Staff in this particular area have been reminded of their roles and accountability with regards to the administration of medicines in line with their professional codes. This included nursing and medical staff

The Children and Women's Clinical Board have undertaken a number of actions to prevent the likelihood of a retained swab in the future. These include:

- Establishment of a regular audit plan aligned with theatre QUAD standards to provide continuous feedback on compliance with best practice
- Reinforcement of correct procedures with staff directly and inclusion in safety briefings and in the departmental newsletter
- Development of a Standard Operating Procedure (aligned to the implementation of the National Standards for Invasive Procedures) to clarify roles and responsibilities in relation to swab counting
- A Review of the packs used for instrumental deliveries is being undertaken with procurement so that a dedicated, suitable instrumental delivery pack can be identified.
- A review of job descriptions is being undertaken to clarify roles and responsibilities of different members of the Obstetric and Midwifery Theatre Team
- A structured education and training programme is being put in place for Band 5 Obstetric Theatre Nurses, Scrub Midwives and Nurses with scrub responsibilities so that they are updated on latest policy developments and have increased exposure to main theatres to develop confidence and experience in the obstetric theatre environment.

The investigation of the retained guide wire has just been completed and a number of actions are currently being agreed. The UHB is exploring the option for a technical solution as such products now exist on the market. However this will incur expense and the risk is very low compared with the number of such procedures which take place on a daily basis throughout the organisation.

4. Categories of Serious Incidents reported to WG

The following table provides a breakdown of the category of SIs reported to Welsh Government between October 2014 – September 2017 by year.

October 2014 – September 2017 Incident Tier 1 type	Total Oct 2014 –Sept 2015	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017	Trend
Administrative Processes (Excluding Documentation)	6	3	19	↑
Anaesthesia Care	-	3	3	↔
Behaviour (self-harming behaviours to self or others)	32	34	32	↓
Blood/Plasma Products	1	2	-	↓
Communication	3	-	1	↓
Diagnostic Processes/Procedures	9	17	18	↑
Documentation	-	-	2	↑
Exposure to Environmental Hazards	3	-	-	↔
Infection Control Incident (Healthcare Associated Infection)	11	12	12	↔
Injury of unknown origin	-	2	-	↓
Maternity Care	3	1	2	↑
Medical Devices, Equipment, Supplies	1	1	3	↑
Medication/Biologics/Fluids	6	4	4	↔
Neonatal / Perinatal Care	-	-	2	↑
Patient Accidents/Falls	58	74	50	↓
Personal Property/Data/Information	3	2	-	↓
Pressure Ulcers	2	13	30	↑
Security of Organisation's Property, Data and Buildings	-	1	2	↑
Service Disruptions (environment, infrastructure, human resources)	-	-	1	↑
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	6	18	28	↑
Unexpected Deaths or Severe Harm	37	20	6	↓
Total	181	207	220	↑

Across the UHB in October 2016 – September 2017, the five following broad categories were the most frequently reported in SIs:

- Patient Accidents/Falls
- Behaviour (for example, self-harm)

- Pressure Ulcers
- Therapeutics processes/procedures
- Administrative Processes (excluding documentation)

These will be reviewed in turn.

Patient Accidents/Falls

The following table demonstrates the number of SIs related to falls by Clinical Board.

SIs relating to falls by Clinical Board	Total Oct 2014 – Sept 2015	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017
Children and Women's Services	-	3	1
Medicine Services	38	32	27
Mental Health Services	6	19	10
Specialist Services	3	6	3
Surgical Services	8	11	9
Total	55	71	50

There has been a decrease in falls related SIs since the previous report to Committee. This is encouraging. Medicine continues to report the highest number of injurious falls and this relates to the high numbers of elderly patients but again there has been 16% reduction achieved in 2016-2017. Mental Health Services have achieved a 47% reduction in their injurious falls over the last 12 months. Action they have taken is described below.

The prevention and management of falls is a high priority for the organisation and a number of initiatives are underway to continue this trajectory of improvement:

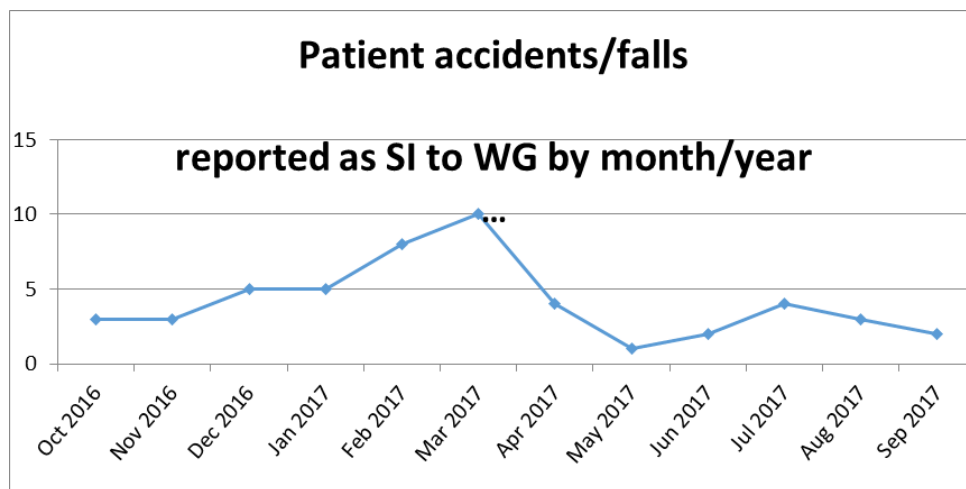
- A Falls Delivery Group has been re-launched. In addition to health, partner organisations including Housing, Fire and Rescue, Welsh Ambulance and Care and Repair contribute actively to the Group. The Group receives performance metrics at the bi-monthly meetings. The metrics need refining and it is anticipated that the Falls Strategy Lead post holder will pursue this. At the most recent meeting in September 2017, incident reporting data identified that clinical areas reporting high volumes of patient falls are not necessarily the areas reporting injurious falls. Further analysis of the data is required.
- A Falls Strategy Implementation Lead has been recruited. This provides an opportunity for the UHB to review the falls related strategy to strengthen the UHB's compliance with the Welsh Health Circular (WHC

(2016) 022) *Principles, Framework and National Indicators: Adult In-Patient Falls.*

- In response to a series of incidents reported at the previous meeting from Children and Women Clinical Board, an improvement project was undertaken by staff in the Leading Improvements in Patient Safety (LIPS) programme called 'Babies Don't Bounce'. This aimed to ensure that certain interventions were in place to reduce the risk of falling babies. There has been one such incident this year and investigation determined that all the planned interventions had been instigated.
- A reduction of SIs related to patient falls in Medicine Clinical Board is evident. The Clinical Board developed an overarching improvement plan that included actions identified on concluded investigation reports. The improvement plan continues to be monitored and reviewed.
- Mental Health Clinical Board implemented a bespoke training package on falls prevention and management in 2016 in Mental Health Services for Older People. Falls activity since then is being closely monitored in order to determine the impact of the training since early indications are encouraging.
- Specialist Clinical Board presented their falls data at their quality and safety meeting in October 2016. Analysis indicated that particular improvements were required on falls documentation and the role of the multidisciplinary team in falls prevention and management. Documentation was to be taken forwards via the Clinical Board's Lead and Senior Nurse Forum and the quality and safety lead for the Clinical Board is addressing MDT review. The intention is to revisit this work in the autumn of 2017.
- Surgery Clinical Board – The Trauma and Orthopaedics Directorate undertook education updates and audit following patient falls incidents being reported. 80% of Registered Nurses completed training in 2017 on falls and a documentation audit identified that each of the patients following the education programme had improved completion of falls related assessments.
- A falls pathway is being scoped between primary and secondary care to ensure that there is consistency across all areas for patients experiencing falls. Opportunities to develop work with GPs are evident and are being explored with the GP membership on the Group.
- The importance of patients maintaining their independence is being led by the Head of Integrated Discharge.
- Review of models for 'specialising' patients have been led by Medicine Clinical Board. An example is the trial of 'bay tagging' where no significant increase in falls or incidents have been noted.
- A 6-month Individual Strength and Balance Programme is in place in the community setting initially, led by physiotherapy.
- The Group is reviewing the model for management of non-injurious falls in the community setting. There is potential to reduce demand on Welsh Ambulance and Emergency Medicine via this work.
- A number of key members of the Group are also representatives on national steering groups or task forces for falls related work. This facilitates early sharing of resources and information with the UHB. Many

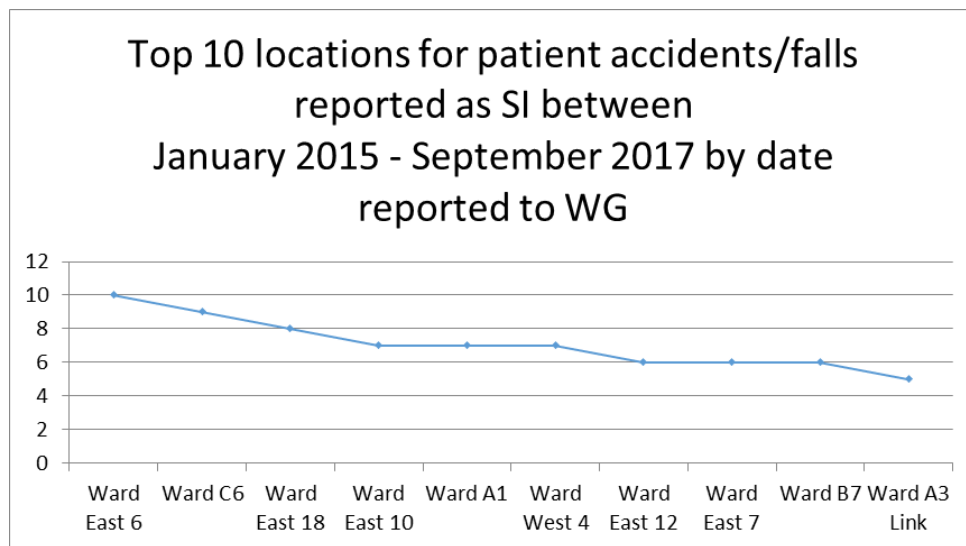
such external groups aim to prevent falls in and promote ageing well. Campaign material using #steadyonstaysafe is in development.

The graph below indicates the number of patient falls reported as SIs to WG by month since January 2015 when electronic incident reporting was implemented. The improving trend is encouraging and will continue to be closely monitored:



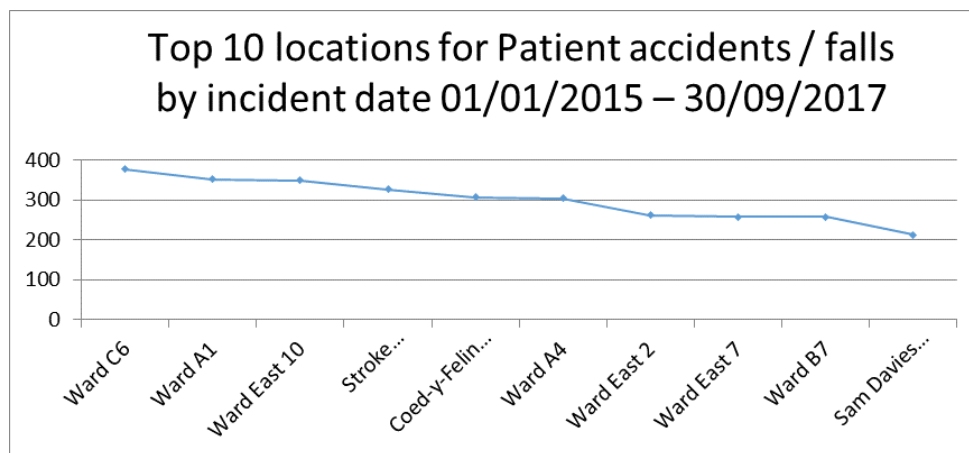
7

The following graph outlines the top 10 locations where patient falls reported as SIs have occurred since January 2015. Identifying this information assists with targeting interventions.



The vast majority of reported falls do not result in any harm to the patient.

The graph below demonstrates the top 10 locations where patient falls have been reported in the UHB since January 2015. It was identified at the last Falls Delivery Group, that, with the exception of Ward C6, there is no correlation between wards who report the most falls and wards who have reported the most injurious falls. This warrants a further piece of work which will be taken forward by the Falls Strategy implementation lead, once they take up post.



7

Tragically, in the last report to Committee which covered the period from October 2015 –September 2016, there were five SIs related to patient falls where patients died following the incident. This year there has been a reduction in that number to three such incidents.

Two of the patient deaths are reported by the Mental Health Clinical Board. One occurred in the community setting and involved an adult client known to addiction services who appears to have sustained a head injury following a fall in a public place. The other incident involves an inpatient of Mental Health Services for Older People who sustained a subdural haematoma following an inpatient fall. Both of these incidents are under investigation by HM Coroner and internal investigation processes are also underway. Work being undertaken by the Mental Health Clinical Board has already been described.

The third incident was reported by Medicine Clinical Board. An acutely unwell patient presented to University Hospital of Wales and was transferred to an appropriate clinical area at University Hospital Llandough. The patient was found on the floor on the ward; it was not known if the patient fell or collapsed. He subsequently died from ongoing problems with liver failure and the Coroner was satisfied that his cause of death was related to this.

Behaviour

There were 32 SIs reported in this timeframe where the high level category was 'behaviour' compared to 34 last year. A range of incidents are included within this category, but largely comprise:

- Patients who have sustained significant injury following self-harm
- Patients who have died by suicide in community or prison settings
- Patients who have died related to substance misuse in community settings

Such incidents where the patient has died are subject to internal investigation and HM Coroner's inquest. No Regulation 28 Prevention of Future Deaths Reports have been issued to the UHB as a result of these incidents in the reporting period.

Any deaths that occur in custody will also be subject to investigation by the Prison and Probation Ombudsman. One such death which occurred in the prison, has been reported by Primary, Community and Intermediate Care Clinical Board in this timeframe and a Coroner's jury inquest is awaited.

There was one other SI reported by PCIC Clinical Board in this reporting period in the Behaviour category which related to a staff member's behaviour which is undergoing information governance investigation.

There were two deaths of teenagers where the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) process was initiated following them being found hanging in separate incidents. Neither incident has identified any opportunities where interventions could have prevented the outcome. The Coroner did not conclude suicide in this case as he was of the view that the intentions of the patient were unclear. The inquest for the other patient is awaited.

The majority of the SIs in the Behaviour category were reported by Mental Health Clinical Board.

Seven of the incidents were self-harm resulting in injury (but not death) or harm to others.

The remaining 21 incidents involved the death of the patient. The following information is determined from inquest processes where they have concluded:

- 6 deaths were alcohol or drug related
- 1 death was considered by the Coroner to be unexplained
- 1 death was found to be related to a physical illness and natural causes was concluded
- 3 deaths where the patients' intent was considered by the Coroner to be unclear i.e. suicide could not be concluded
- 7 deaths were considered by the Coroner to be suicide
- 3 inquests are awaited

The trend is very similar to the previous year.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) produces an annual report where data from the four

UK countries is analysed. Key points that are raised for action in clinical practice include:

- Ensure appropriate use of crisis and home treatment teams as they are unlikely to be suitable for patients at high risk of suicide or those who live alone

This view has not been expressed so explicitly in earlier NCISH reports. The Mental Health Clinical Board is currently in the process of reviewing the Crisis Resolution Home Treatment Team (CRHTT) Operational Policy and will of course consider the latest evidence in relation to safety and effectiveness, which will include the NCISH report. It is however pleasing to note that current evidence indicates that those CRHTTs that provide 24 hour assessments are able to manage higher risk patients, and the UHB CRHTTs are one of the few that has retained 24-hour service provision (there is a national trend to close services at night in order to meet other demands/pressures). The UHB also has a crisis house which further evidence has shown to mitigate the risk. As the NCISH report does not compare CRHTTs with/without crisis houses the Mental Health Clinical Board will be monitoring the developing evidence base.

- People discharged from hospital services should be followed up within 2 – 3 days of their discharge

Whilst NCISH recommended this, the UHB is currently working to the WG guidance to offer follow-up 5 days post-discharge. As yet WG have not reviewed this target in light of the NCISH recommendation.

- There should be access to specialist services for people with alcohol and substance misuse problems

The UHB has specialist drug and alcohol services in place

- There should be restricted access to suicide methods for example, limit access to opiate analgesics

There is some contradictory evidence around this (eg men are at risk of “method substitution” so if you take one option away from them they will find another) but the authors of NCISH have consistently supported restricting access to means. With this in mind, Hafan y Coed was designed to be a low ligature risk environment; NCISH acknowledge that the drive to make inpatient areas ligature-safe is responsible for the national reduction in inpatient suicides, but obviously this is more challenging in non-hospital environments. The UHB believes our inpatient units are as safe as they can be, our crisis teams always remove large quantities of medication/ropes etc from people’s home if they know of its presence, and our prescribers always consider less lethal medications in patients with a known risk of suicide.

- There should be development in expertise for new groups of people at risk including those with socio-economic problems; isolated people; recent immigrant population

The UHB acknowledges that this will be a challenging recommendation to implement locally. WG recommends all staff are trained in Wales Applied Risk Research Network formulation – we anticipate that the WARRN authors consider current evidence such as these recommendations when reviewing their training packages. In the meantime, our Mental Health clinicians are aware that the above “new groups of people” are at risk and would always consider socio-economic issues when assessing suicide risk.

- Liaison psychiatry services should be available 24 hours for those at risk of self-harm

Nursing cover is provided in the day time hours. Currently the night time hours are covered by junior doctors on call. Further development of the service to provide 24 hour nursing cover would require investment.

Mental Health Clinical Board will continue to mature their investigation procedures in line with learning from local and national experiences. They have a very well embedded Lessons Learnt process and all deaths of patients known to mental health services are subject to a multidisciplinary care review. If anything of concern is identified during this process a full RCA is undertaken. Findings are consistent with key points identified by NCISH. Particular local action is underway with the third sector to promote engagement with services in hard to reach people with substance misuse problems. Ongoing review of ligature points in mental health settings is important and the Health and Safety Department are assisting Mental Health Clinical Board with a ligature point audit.

Pressure Ulcers

WG requires healthcare acquired pressure ulcers that are grade 3 or 4 to be reported as SIs. The UHB has increased the number of such SIs reported to WG in 2016-17 but there is room for further improvement and WG have indicated that the UHB has previously been a low reported when compared with other organisations in Wales. Datix software was altered in June 2017 in order to strengthen information systems so that pressure damage incidents can be detected and managed in a more timely manner. Whilst this has led to an increased identification of pressure damage SIs, it is evident that staff need additional guidance on appropriate information to include when reporting pressure damage.

The table below demonstrates the pressure damage incidents reported to WG by Clinical Board.

Healthcare Acquired Pressure Ulcers Grade 3 and Grade 4 reported as SIs	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017
Children and Women's Services	1	0
Medicine Services	7	10
Mental Health Services	1	1
Specialist Services	2	4
Surgical Services	2	15
Total	13	30

This is a developing area and increased levels of reporting are expected again in the forthcoming year. The Director of Nursing for Surgery Clinical Board leads a pressure damage group and this has been operational during 2017.

The task and finish group have several work streams that they are looking at: Documentation development/final stages of design/roll out;

- Root Cause Analysis tool
- Additions to the VA1 form (safeguarding referral) that captures Grade 3, 4 and un-stageable pressure damage
- UHB pressure damage policy
- UHB pressure damage audit tool
- Review of the Mental capacity assessment tool

Interrogation of e-Datix reports to understand the prevalence and reporting of tissue damage UHB wide in order to inform relevant Q&S groups. This includes triangulation of data between Protection of Vulnerable Adults, SI's and Clinical Board data

Plan Do Study Act (PDSA) cycles of;

- Testing a new pressure damage passport
- Disclaimer sticker (for use when a patient is non-compliant to the care/advice being offered)

UHBs Total Bed Management contract;

- The team have been heavily involved with this and it split into two main work streams;
 1. Working with procurement to work up and design the new contract clinical specifications for when the contract is due for renewal 2018/19
 2. Working with procurement and the current bed management company to put in robust training and education plans for the roll out of new mattresses which have been purchased.
- Working with the company and R&D office to ensure all services evaluations of products are captured on the correct UHB documentation.
- Reviewing the algorithm for mattress use.

A Celebration event on 16th November will take place in support of 'World stop pressure ulcer' day. .

Pressure damage incidents are included in key performance indicators for Clinical Boards to ensure there is appropriate scrutiny in place and this is discussed regular as part of Nursing professional Performance review and also as part of executive Clinical Board performance reviews.

Therapeutic processes/procedures

There were 28 SIs reported where the high level category was 'therapeutic processes/procedures' in the current reporting period compared to 18 in the previous report. The incidents range across the Clinical Boards and are largely unique. However, the following key issues can be identified:

- **Children and Women Clinical Board** – the incidents relate mainly to Acute Child Health. All were very different in nature and involved:
 - A sub-standard surgical procedure carried out on a child in 2012, which was retrospectively reported and is currently being managed as a clinical negligence claim
 - A premature baby who presented later with a lump near her clavicle which was found to contain the tip of a Hickman line. While this was initially felt to be a Never Event it was established that the line was intentionally left in as this causes less tissue damage in premature infants.
 - A young child, who experienced a pneumothorax following insertion of a naso-jejunosomy tube
 - A young child who died following surgery at Bristol

All incidents have been fully investigated and no correlation between incidents is evident.

- **Medicine Clinical Board** – Five patients with delays in treatment or procedures under the care of Gastroenterology have been reported. This has been part of an ongoing concern in the directorate since the first patient was identified in May 2015. There have been no new incidents reported since June 2017. A total of 19 patients have thus far been identified as part of this cluster. An overarching improvement plan is in place.
- **Medicine Clinical Board** – recognition and escalation of the deteriorating patient due to issues with National Early Warning Score calculation has been evident in some incidents within this and other categories at UHW and UHL sites. Re-training is underway as certain parameters were causing confusion, for example, addition of oxygen score for patients on long term oxygen use.
- **Specialist Clinical Board** – a patient experienced unexpected complications following transplant surgery. Investigation determined that this could not have been predicted, however the patient information has been updated to include the possibility of the very rare complication of amputation. Advice and support has been sought from the Mental Capacity Act Manager. The Clinical Board is hosting a focused meeting on consent

issues in the autumn of 2017 having held a similar focus on mental capacity issues earlier this year. A Grand Round in October 2017 provided an opportunity for medical staff to attend a lecture on consent from the Director of Legal and Risk Services.

- **Surgery Clinical Board** – as indicated, there are two incidents of complications associated with central line insertion. These include insertion of a central venous catheter in to the wrong blood vessel in the first incident and perforation of a blood vessel in the second incident. As part of the NatSSIPS work being undertaken in the UHB, a specific work stream will be set up to look at the safe insertion of central lines.
- **Surgery Clinical Board** – there have been two wrong site block incidents which remain under investigation and a wrong site procedure in orthopaedics. Focused work will be developed as part of NatSSIPs and following conclusion of the investigations.

Administrative Processes (excluding documentation)

19 SIs have been reported in this category in this reporting period. No particular themes are evident on review of the incidents but the following observations have been made:

- **Children and Women Clinical Board** – Two SIs were reported where there was delayed transfer of children to the Paediatric Intensive Care Unit being retrieved from elsewhere. One incident remains under investigation and so it is not yet possible to draw conclusions.
- **Clinical Diagnostics & Therapeutics Clinical Board and Surgery Clinical Board** – an improved algorithm is in development to assist staff with managing referrals via abdominal aortic aneurysm screening procedures to ensure adherence to the pathway.
- **Mental Health Clinical Board** – a number of different incidents were reported regarding management of patients who wish to self-discharge and subsequently come to harm leading to revision of the relevant operational policies.
- **Mental Health Clinical Board** – Five incidents were reported whereby Adult Mental Health admitted 17 year old patients who were awaiting assessment by or transfer to CAMHS. These incidents were generally overnight stays and no harm came to the patients whilst they were under the care of the UHB. The incidents were highlighted to CAMHS.

Trends to monitor

As previously indicated there are two other categories of SIs to draw attention to:

- Healthcare Associated Infections
- Ionising Radiation (Medical Exposure) Regulation breaches

Healthcare Associated Infections (HCAI)

Certain incidents involving HCAI must be reported to WG as SIs. These include:

- Any death where a healthcare associated infection (including *Clostridium difficile* and methicillin resistant *Staphylococcus aureus*) is mentioned on the death certificate as either the underlying cause of death or contributory factor
- An outbreak* of a healthcare associated infection in a hospital that results in the closure of a ward/bay to admissions and causes significant disruption. closure of a bay which does not cause significant disruption to service should be reported as a No Surprise
- Transmission of infectious diseases

The table below indicates that 12 HCAI SIs were reported to WG in the reporting timeframe representing no change.

Infection Control Incident (Healthcare Associated Infection)	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017
Children and Women's Services	2	0
Medicine Services	3	4
Specialist Services	3	6
Surgical Services	4	2
Total	12	12

7

Infectious outbreaks affecting the Neonatal Unit in Children and Women Clinical Board have been well documented in previous reports to Committee. However, a considerable amount of work has been undertaken and there have been no further SIs of this nature reported this year.

It is evident from the SIs reported that the UHB must continue to strive to improve performance relating to HCAI. Individual staff must ensure the strictest adherence to standard IP&C best practice to underpin the strategic overarching actions underway. This is monitored via the Infection Prevention and Control Group which is chaired by the Executive Nurse Director. Key performance indicators for Clinical Boards in relation to this agenda are also monitored monthly with the Executive team.

There are a number of initiatives underway across the organisation to improve IP&C practice. These include:

- The introduction of peripheral vascular cannula insertion packs.
- Development of care bundles for central venous catheter insertions which will align with NatSSIPS work being undertaken.
- Roll out of Aseptic Non-Touch Technique (ANTT) to all invasive interventions.
- *C. difficile* ward rounds.
- Introduction of Fidaxomicin as an option for *C. difficile* treatment.
- Medical Director led Antimicrobial Stewardship Patient Safety WalkRounds is now well embedded.

- New, easier to use Root Cause Analysis tool to incorporate the new WG reduction expectation pertaining to E-coli.
- RCA's to be reviewed and lessons learned to feed into the Clinical Board IP&C/QSE meetings.
- Consideration being given for more interventions for IV drug abusers and wound management in the community (community acquired MSSA).
- Implement plans to screen for sensitive *Staph Aureus* in defined areas.
- MRSA admission screen compliance audits undertaken by the IP&C team with results reported to CB IP&C meetings and the IPCG.
- Continued reinforcement of isolation of patients with diarrhoea, hand hygiene, antimicrobial stewardship and more effective management of the disease.
- The establishment of a mini-collaborative to take forward initiatives to reduce the incidence of E-Coli

The position will continue to closely scrutinised at a number of levels across the organisation.

Ionising Radiation (Medical Exposure) Regulation Breach Incidents

Prior to February 2017 NHS Wales organisations were required to report breaches of the IR(ME)Regulations to WG and Healthcare Inspectorate Wales. This was revised in February 2017 to sole reporting to HIW unless there was a particular need to also report the matter to WG as an SI in its own right. IR(ME)R breach incidents are subject to the same scrutiny internally and via HIW following this change in practice.

There have been eight incidents reported to HIW in this reporting timeframe. The issues identified include:

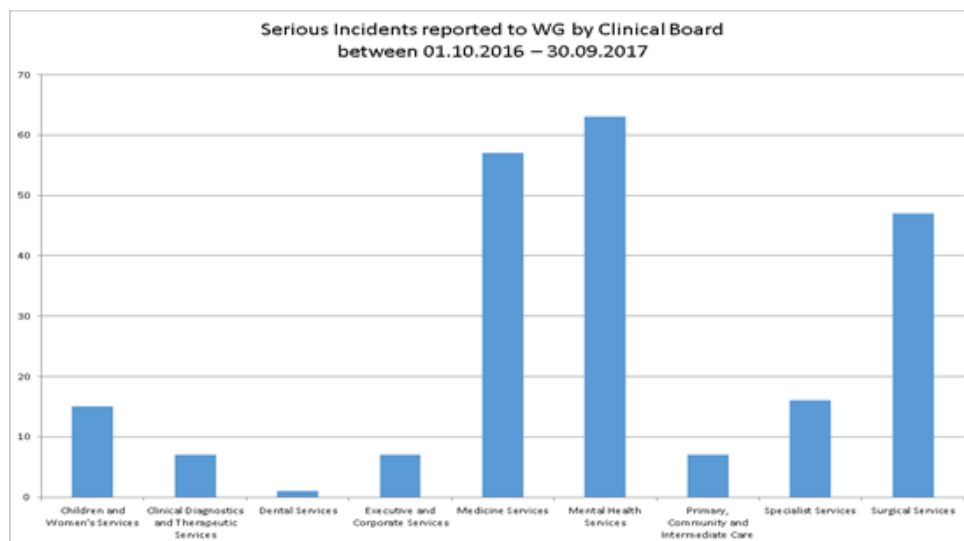
- The importance of checking whether radiological investigations have already been undertaken before completing a request form for another examination as it can be difficult for Radiology to identify that this is not a valid repeat for clinical reasons; this was the case in four of the incidents
- Two incidents were due to patient misidentification incidents that originated in clinical areas where the request form was completed for an unintended patient.
- An equipment failure incident led to a patient requiring repeat examinations to be undertaken.
- A patient correctly had an abdominal/pelvic scan undertaken but the chest area was inadvertently included.

Education is provided to staff in various forums who request radiological examinations of the importance of justification of the examination and patient identification procedures.

The patient identification policy is undergoing review with a view to concluding that process by December 2017.

The Patient Safety Team is progressing work regarding printing solutions for electronic wristbands for inpatients. A procurement exercise was completed in NHS Wales in 2017. Visits to other Health Boards to view their systems are planned.

5. Serious Incidents by Clinical Board



Trends across Clinical Boards remain largely the same with Medicine and Mental Health reporting the greatest number of SIs. This is due to larger numbers of patient falls in Medicine and the numbers of deaths of patients known to mental health services. There has been an increase in the number of SIs reported by Surgical Clinical Board this year and this is due largely to an improvement in compliance with WG requirements for the reporting of pressure damage.

6. Closure of Serious Incidents with Welsh Government

The UHB is required to submit a closure form to Welsh Government on conclusion of a Serious Incident investigation process. This provides assurance on the measures that have been taken to avoid a similar incident in a similar set of circumstances. Closure forms are subject to review within Clinical Boards quality and safety mechanisms, prior to sign off by the Executive Nurse Director or Assistant Director of Patient Safety and Quality.

A trajectory to improve the position of closure form submission to WG was established with the Clinical Boards in April 2016. This has been subject to performance monitoring arrangements and is reviewed as the position is improving. This has been very effective in securing a marked improvement and the UHB has made considerable progress over the last 12 months. At the time of writing this report, the UHB has 80 SIs open with WG in contrast to the position in October 2015, where the UHB had 282 SIs open with WG.

IMPLEMENTING THE NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES (NatSSIPs)
Name of Meeting : Quality, Safety and Experience Committee Date of Meeting: 17 th October 2017
Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality; Carol.A.Evans2@wales.nhs.uk 02921846117 and Patient Safety Facilitator; Matthew.McCarthy@wales.nhs.uk 02920746548
Caring for People, Keeping People Well : This supports 'Delivering outcomes that matter for people' and 'avoiding waste, variation and harm'.
Financial impact : There is no financial impact directly associated with this paper however, the Standards aim to reduce the likelihood of Never Events with which there are related costs from clinical negligence claims.
Quality, Safety, Patient Experience impact : Implementation of NatSSIPs is 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

<p>ASSURANCE AND RECOMMENDATION</p> <p>ASSURANCE is provided by:</p> <ul style="list-style-type: none"> • Work that has progressed to implement the Standards to date • Infrastructure that is established to roll out implementation across the UHB over the next two years <p>The Quality, Safety and Experience Committee is asked to:</p> <ul style="list-style-type: none"> • CONSIDER the progress that has been made to date and the implementation plan • AGREE to report compliance with Patient Safety Notice 034 – 'Supporting the introduction of the National Safety Standards for Invasive Procedures

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' (NatSSIPs).

Significant progress has been made across the UHB to consider each applicable directorate's position against the standards and to understand the priority areas for further work. 18/26 departments have completed a self assessment of their position; the 8 remaining directorates are close to completing their self assessment. Designated leads for all but one Directorate have been identified. There is sufficient information to allow the corporate Patient Safety Team to undertake a high level analysis and set out the next steps required.

The Committee received a previous update on NatSSIPS at the September 2017 meeting.

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 and reduction of unnecessary variation to ensure that procedures are as safe as possible regardless of where they are performed.

Health Boards are expected to develop their own Local Safety Standards for Invasive Procedures (LocSSIPs), which reference the national standards.

ASSESSMENT AND ASSURANCE

In order to implement the Standards across the organisation 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 with 25/26 Directorates having identified a NatSSIPs lead. Within the task & finish group there have been productive discussions and sharing of good practice between staff from different clinical areas.

The Patient Safety Team has 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 clinical practice.

The UHB has undertaken 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 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 with self assessment completion is as follows:

Clinical Board/Directorate	Self-assessment status	Lead appointed
Surgery Clinical Board		
Perioperative Directorate (Theatres and Anaesthetics)	Completed	Yes
General Surgery	Completed	Yes
Urology	Completed	Yes
Ophthalmology	Completed	Yes
ENT	Completed	Yes
Trauma and Orthopaedics	Completed	Yes
Medicine Clinical Board		
Gastroenterology and Endoscopy	Completed	Yes
Emergency Medicine	Completed	Yes
Internal medicine	Completed	Yes
Acute Medicine	Underway	Yes
Clinical Gerontology	Completed	Yes
Dermatology and Rheumatology	Completed	Yes

Specialist Clinical Board		
Haematology	Completed	Yes
Critical Care	Underway	Yes
Cardiothoracics	Completed	Yes
Immunology and Genetics	Underway	Outstanding
Neurosciences and ALAS	Underway	Yes
Nephrology and Transplant	Underway	Yes
Clinical Diagnostics and Therapeutics Clinical Board		
Radiology	Completed	Yes
Therapies	Underway	Yes
Out-patients	Completed	Yes
Pharmacy	N/A	-
Therapeutics and toxicology	N/A	-
Laboratory medicine	N/A	-
Children and Women Clinical Board		
Obstetrics	Completed	Yes
Gynaecology	Completed	Yes
Acute Child Health	Completed	Yes
Community Child Health	N/A	-
Dental Clinical Board		
Hospital Dental	Completed	Yes
Community Dental	Completed	Yes

The responses received from directorates to date have been collated centrally and the following key themes have been highlighted from the self assessments as areas for improvement and standardisation:

- Variation in policies and guidelines relating to either invasive procedures or procedure areas
- Variation in processes for the scheduling and management of lists for invasive procedures
- Differences in handover processes between clinical teams
- Implementation of the WHO checklist, outside the traditional theatre areas
- Staffing requirements for invasive procedures which occur outside of normal working hours
 - Guidelines and governance arrangements for invasive procedures which can take place in different areas across the UHB, such as chest drains or central line insertions

The self-assessments have also highlighted many examples of good practice and innovative ideas which will be shared with other invasive procedure teams.

The NatSSIPs task & finish group will consider the best way to bring together teams from different clinical areas to address the issues highlighted in the self assessments. It is proposed that the work is planned over the medium term with a risk based approach to prioritising individual work streams. Data on recent Never Events or Serious Incidents will be used to inform this process. An implementation action plan is attached at Appendix 2.

Identified work streams include:

- Reviewing documentation relating to invasive procedures, such as checklists, care plans and proformas.
- Implementing, adapting and using the WHO checklist effectively, both in and out of the theatre environment.
- Scheduling and listing procedures – both elective and emergencies.
- Chest drain insertion in different clinical environments.
- Central venous catheter insertion in different clinical environments
- Nasogastric tube insertion
- Improving the quality of handovers between different clinical teams.

It is vital that review and adoption of NatSSIPs is driven by the individual procedure teams. Sharing of good practice and innovative ideas is being facilitated through the task & finish group.

It is important that the focus of NatSSIPs implementation should be on improving safety for patients who are undergoing invasive procedures in our care, rather than purely on creation of additional written documents. In order to support procedure teams in considering their current practice and guidelines against NatSSIPs, a number of standardised templates have been created.

It is proposed that the written policies or procedures required as part of NatSSIPs be broken down into three main categories:



The **UHB LocSSIPs** will address organisation-wide issues, such as governance (NatSSIPs Standard 1).

The **Area LocSSIPs** will cover major procedure areas, such as main theatres, interventional radiology or maternity theatres.

The **Procedure LocSSIPs** will cover individual procedures or groups of procedures which may take place outside the traditional theatre environment. This for instance would cover procedures such as chest drain insertions, central line insertions who are common procedures across many areas.

It is important to note that NatSSIPs does not require the creation of a LocSSIP for every individual procedure or variation thereof.

There are many existing procedures or guidelines in place at a local level which can be used as a basis for the development of LocSSIPs. The templates will allow for procedure teams to easily compare their existing guidelines to the NatSSIPs standards. This assists teams to identify any areas for further discussion or development.

The NatSSIPs task & finish group will consider the best way to review existing written procedures and guidelines using the LocSSIPs templates and through the planned work stream groups.

Ongoing work in relation to NatSSIPs will ensure that:

- Appropriate governance is in place for invasive procedures within the UHB, regardless of where they are performed.
- Work which has already been undertaken on improving safety in operating theatres is rolled out to other procedure areas.
- Unnecessary variation between different procedure areas is reduced, while allowing for necessary local differences.
- All staff involved with invasive procedures are aware of their responsibilities in respect to safety. This will be supported by clear and robust LocSSIPs, developed by procedure teams.

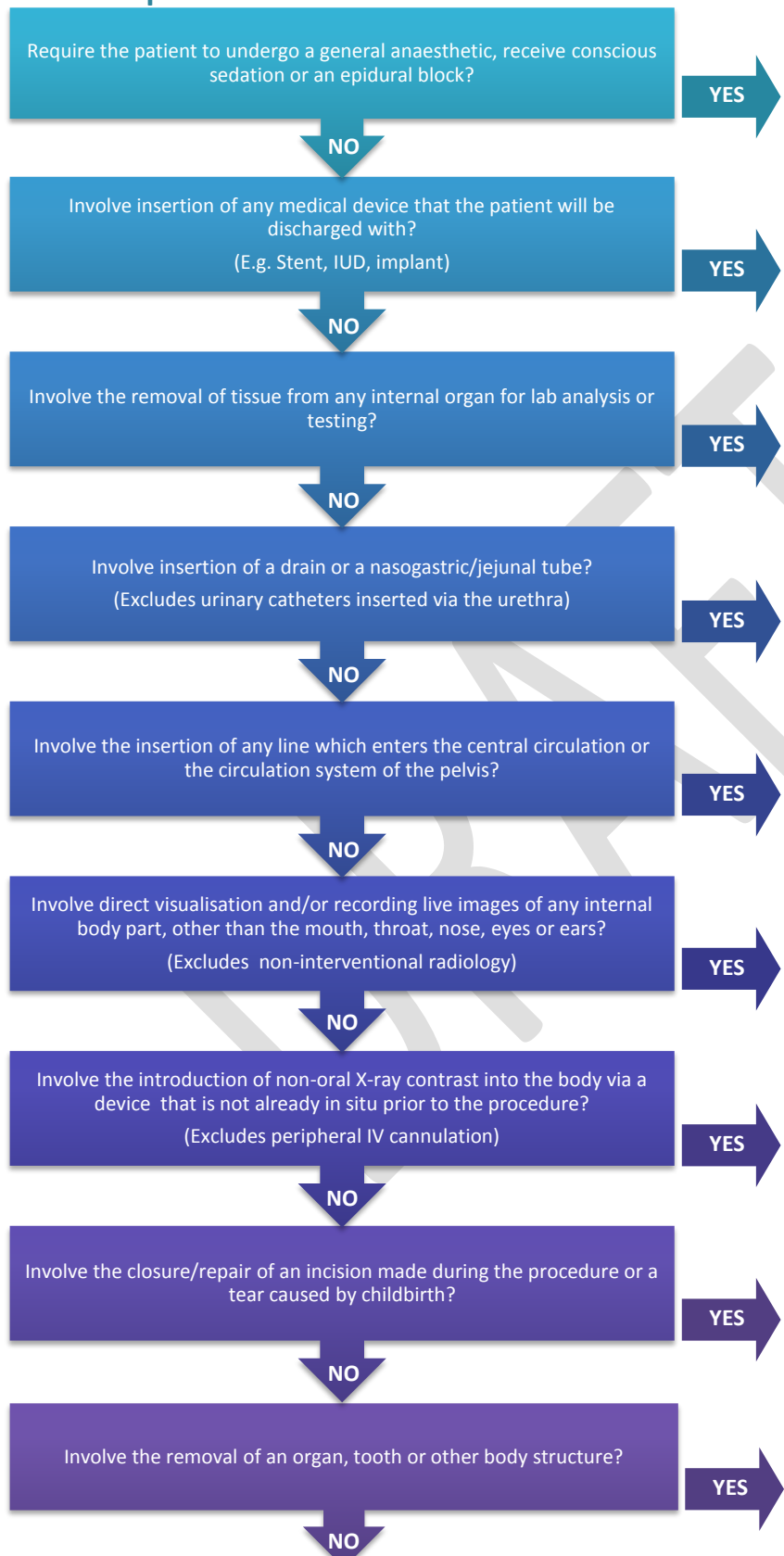
In light of the progress made with implementation of NatSSIPs and the identification of key work streams as part of a medium term plan, the Committee is asked to **AGREE** to report compliance with Patient Safety Notice 034 – ‘Supporting the introduction of the National Safety Standards for Invasive Procedures’.

It is recommended that regular updates on the progress with the NatSSIPs work is reported to the Committee.

Cardiff and Vale UHB – NatSSIPs invasive procedure definition flowchart



Does the procedure:



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

Procedure does not fall under the Cardiff and Vale UHB NatSSIPs definition

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)

For further advice or information about NatSSIPs, please contact
the Patient Safety Team on UHW ext 46991



National Safety Standards for Invasive Procedures (NatSSIPs)

Action plan for implementation of Patient Safety Notice 034

Reference: PSN034

Executive Director(s) responsible: Ruth Walker, Executive Nurse Director

Prepared by: Maria Roberts, Patient Safety Manager

Approved by: NatSSIPs Task and Finish Group

Date agreed: July 2017 v1; October 2017 v2

Action required	Role of responsible person	Progress update	Additional information / evidence where applicable	Completed?
Phase 1 – September 2016 – end September 2017				
Welsh Government published Patient Safety Notice 034 National Safety Standards for Invasive Procedures on 28.09.2016; received by	Patient Safety Facilitator	Safety Notice received on 28.09.2016 and distributed by Patient Safety Team in line with usual procedures on 29.09.2016		Completed

Action plan – National Safety Standards for Invasive Procedures – October 2017 update

Patient Safety Team; to be circulated across Clinical Boards and via internal communication mechanisms in line with usual procedures				
Surgery Clinical Board held a Never Events workshop in November 2016 which Executives and Delivery Unit staff also attended	Director of Nursing Surgery Clinical Board	Workshop held and plans underway to hold a further workshop on NatSSIPs were highlighted at this workshop	See here	Completed
Welsh Government, Delivery Unit and Public Health Wales hosted an all Wales learning event on 28 th March 2017	External bodies	Representatives from the UHB attended, predominantly from Patient Safety and Quality Department and Surgery Clinical Board		Completed
UHB task and finish group meeting held on 8 th May 2017	Assistant Director of Patient Safety and Quality	Inaugural meeting held	See here	Completed
Perioperative quality and safety study day held at the Royal London Hospital in Whitechapel on 11 th May 2017	External body	Patient Safety Team attended having made contact with Dr Annie Hunningher, Consultant Anaesthetist who is leading work on NatSSIPs in that organisation. The Patient Safety Team has maintained contact with Dr Hunningher following the event.	https://www.periopsafety.net/ https://docs.wixstatic.com/ugd/442154_fa1b6136018a4493922a3e02cd92e0a6.pdf	Completed
Surgery Clinical Board hosted a meeting with guest speaker Dr Will	Director of Nursing Surgery	Attendance achieved from across the UHB to introduce NatSSIPs to a broader audience. The Patient Safety	See here	Completed

Harrop-Griffiths, Consultant Anaesthetist at Imperial College Healthcare NHS Trust and Chair of the NHS England NatSSIPs group on 12.05.2017	Clinical Board	Team has maintained contact with Dr Harrop-Griffiths following the event.		
Gap analysis tool circulated to all Clinical Boards on 01.06.2017	Patient Safety Facilitator	Tool circulated for completion by 30.06.2017		Completed
Launch of TalkDebrief© research project with Dr Cristina Diaz-Navarro, Dr Mark Price and Dr Andrew Hadfield at the Life Sciences Hub in Cardiff Bay	TalkDebrief© project team	Debriefing is a core component of NatSSIPs. The TalkDebrief© project is a separate undertaking but the team has contributed to the NatSSIPs work underway in the UHB	http://www.talkdebrief.org/	Launch completed; research project ongoing
Second meeting of the UHB task and finish group 12.07.2017	Patient Safety Manager	Meeting held; further discussion and support offered to directorates needing additional assistance with their gap analysis tool	See here	Completed
NatSSIPs intranet page launched on 11.08.2017 with mechanism established for monthly review of content	Patient Safety Manager	Intranet page launched		Completed
Third meeting of the UHB task and finish group 11.09.2017	Assistant Director of Patient Safety and Quality	Meeting held; further support offered to directorates continuing to require assistance with their gap analysis tool	See here	Completed
Board and Quality, Safety	Assistant	Update on progress with NatSSIPs	http://www.cardiffandvaleuhb.w	Completed

Action plan – National Safety Standards for Invasive Procedures – October 2017 update

and Experience Committee to be updated on progress with NatSSIPs in September 2017	Director of Patient Safety and Quality	provided to Board and QSE Committee as scheduled in September 2017	ales.nhs.uk/sitesplus/documents/1143/Boardbook%20September%2020171.pdf http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Public%20QSE%20Boardbook%2012%20September%202017.pdf	
Update to be presented to Quality, Safety and Committee on 17 th October 2017 in order for decision to be made regarding declaration of compliance	Assistant Director of Patient Safety and Quality			On schedule
Phase 2 - October 2017 – October 2018 – progress UHB wide themes and issues				
Continue NatSSIPs task and finish group on quarterly basis; agree most suitable method for patient and public involvement	Assistant Director of Patient Safety/designated Chair			To meet quarterly
Identify an overall medical lead				December 2017

<p>Following receipt and review of the gap analysis tools received by 30.09.2017 the following workstreams have been identified as a priority:</p>	<p>Assistant Director of Patient Safety</p>	<p>Detailed actions considered necessary for these potential workstreams will be confirmed by December 2017</p>	
<p>Reviewing documentation relating to invasive procedures, such as checklists, care plans and pro-formas.</p>	<p>Patient Safety team/UHB NatSSIPs leads</p>		<p>March 2018</p>
<p>Implementing, adapting and using the WHO checklist effectively, both in and out of the theatre environment:</p>	<p>Patient Safety team/UHB NatSSIPs leads</p>		
<p>Establish a WHO Checklist in practice' group</p>	<p>Patient Safety team</p>		
<p>Radiology (pilot area)</p>	<p>Radiology lead</p>		<p>March 2018</p>
<p>Dental (pilot area)</p>	<p>Dental lead</p>		<p>March 2018</p>
<p>Wider roll out using a risk based approach</p>	<p>Patient Safety team/UHB NatSSIPs leads</p>		<p>Completed by October 2018</p>

Scheduling and listing procedures – both elective and emergencies.	Patient Safety team/UHB NatSSIPs leads			
Radiology (pilot area)	Radiology lead			March 2018
Dental (pilot area)	Dental lead			March 2018
Wider roll out using risk based approach	Patient Safety team/UHB NatSSIPs leads			Completed by October 2018
Chest drain insertion in different clinical environments.		Chest drain group, with medical lead and agreed TOR has been established.		In place
UHB Procedure LocSSIP to be agreed	Chair Chest drain group			March 2018
Central line insertion in different clinical environments.				By Dec 2017
UHB group with medical lead and agreed TOR to be established				June 2018
UHB procedure LocSSIP	Chair central line insertion			

to be agreed	group			
Nasogastric tube insertion	Chair NG task and finish group	NG task and finish group with agreed TOR is established		In place
UHB procedure LocSSIP to be agreed				June 2018
Improving the quality of handovers between different clinical teams. Establish a 'handover' working group	Patient Safety team			December 2017
Develop UHB and Area LocSSIPs				October 2018
Local Clinical Audit plans for 2018-2019 to demonstrate regular audit of NatSSIPs compliance	Clinical Board QSE leads/Clinical Audit leads			April 2018

<p>across the UHB</p> <p>Commence NatSSIPs gap analysis in remaining UHB Clinical Boards:</p> <p>Mental Health</p> <p>Primary care</p>				<p>To be completed by September 2018</p>
<p>Evaluate Phase 2 and agree priorities for Phase 3</p>	<p>NatSSIPs task and finish Group</p>			<p>To be completed by September 2018</p>
<p>Phase 3 - October 2018 – October 2019 – progress specific Clinical Board actions and further embedding of NatSSIPs; monitor compliance</p>				
<p>Continue NatSSIPs task and finish group on quarterly basis</p> <p>Agree detailed workplan for 2018-2019 based on evaluation of phase 2</p>				<p>To meet quarterly</p> <p>October 2018</p>

Progress work identified in mental health clinical board as result of gap analysis	Patient Safety team/ NatSSIPs lead			April 2019
Progress work identified in Primary, Community and Intermediate Care clinical board as result of gap analysis	Patient Safety team /NatSSIPs lead			April 2019
Consider possibility of arranging a NatSSIPs study/feedback day to present the outcome of the NatSSIPs project to UHB staff	NatSSIPs task and finish group			June 2019

DRAFT