Quality, Safety & Experience Committee

Tue 14 December 2021, 09:00 - 12:00

Agenda

09:00 - 09:00
0 min

1. Standing Items

1.1. Welcome & Introductions

Susan Elsmore

1.2. Apologies for Absence

Susan Elsmore

1.3. Declarations of Interest

Susan Elsmore

1.4. Minutes of the Committee Meeting held on 15 September 2021

Susan Elsmore

1.4 QSE Minutes 15.09.21MD v2.NF (cp) edit 2.pdf (13 pages)

1.5. Action Log – Following the meeting held on 15 September 2021

Susan Elsmore

1.5 Action Log QSE for Dec 2021 meeting.pdf (1 pages)

1.6. Chair's Action taken since last meeting

Susan Elsmore

09:00 - 09:00
0 min

2. Items for Review & Assurance

2.1. PCIC Clinical Board Assurance Report

Ruth Walker / Richard Desir / Lisa Dunsford

2.1 PCIC assurance report November 2021 RD final.pdf (21 pages)
2.1a PCIC QSE annex to Annual Plan.pdf (1 pages)

2.2. Pressure Damage Update

Ruth Walker

2.2 Pressure damage collaborative Dec 21.pdf (9 pages)

2.3. Quality Indicators Report

Ruth Walker

Presentation from Angela Hughes and Raj Krishnan

2.4. Exception Reports

Ruth Walker / Meriel Jenney / Rachel Gidman

Verbal Update

2.5. HIW Activity Overview & Primary Care Update

Ruth Walker / Angharad Oyler

The 2.5A Appendices can be found in the Supporting Documents

- 2.5A HIW update on activity_QSE December 2021 - V2.pdf (5 pages)
- 2.5B Cover Report HIW SBAR November 2021.pdf (4 pages)
- 2.5B Appendix 1 HIW SBAR November 2021.pdf (5 pages)
- 2.5B Appendix 2 HIW SBAR November 2021.pdf (2 pages)

2.6. Board Assurance Framework – Patient Safety

Nicola Foreman

- 2.6 BAF Covering Report.pdf (2 pages)
- 2.6a Patient Safety BAF Risk.pdf (2 pages)

09:00 - 09:00
0 min

3. Items for Approval / Ratification

Ruth Walker

3.1. Incident, Near miss and Hazard reporting Policy

The Policy/Procedure can be found in the Supporting Documents

- 3.1 Incident Cover Report.pdf (2 pages)

3.2. Patient Identification Procedure

The Policy/Procedure can be found in the Supporting Documents

- 3.2 Patient Identification Cover Report.pdf (2 pages)

3.3. Patient Falls Policy

The Policy/Procedure can be found in the Supporting Documents

- 3.3 Cover Report Falls Policy.pdf (2 pages)

09:00 - 09:00
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees:Exceptional Items to be raised by Assistant Director Patient Safety & Quality:

a) Children & Women's Clinical Board Minutes - 28.09.21 & 02.11.21
b) Specialist Clinical Board Minutes - 16.07.21 & 06.08.21 & 27.08.21
c) CD&T Clinical Board Minutes - 28.07.21 & 27.08.21
d) Mental Health Clinical Board Minutes - 17.06.21 & 19.08.21
e) Medicine Clinical Board Minutes - 19.08.21
f) PCIC Minutes -
g) Surgical Clinical Board Minutes - 21.09.21

- 4.1a C&W QSE Minutes September 2021.pdf (8 pages)
- 4.1aa C&W QSE Minutes November 2021.pdf (8 pages)
- 4.1b Speialist QSE Minutes July 2021.pdf (6 pages)
- 4.1bb Specialist QSE Minutes 6 August 21.pdf (7 pages)
- 4.1bbb Specialist QSE Minutes 27 August 2021.pdf (6 pages)
- 4.1c CD&T QSE Minutes July 2021.pdf (11 pages)

- 4.1c CD&T QSE Minutes August 2021.pdf (11 pages)
- 4.1d Mental Health QSE Minutes June 2021.pdf (9 pages)
- 4.1dd Mental Health QSE Minutes August 2021.pdf (9 pages)
- 4.1e Medicine QSE Minutes August 2021.pdf (11 pages)
- 4.1f PCIC QSE Minutes November 2021.pdf (10 pages)
- 4.1g Surgical QSE Minutes September 2021.pdf (12 pages)

4.2. Corporate Risk Register

Nicola Foreman

- 4.2 QSE - Corporate Risk Register Covering Report - December 2021.NF.pdf (3 pages)
- 4.2a - QSE Corporate Risk Register December 2021.pdf (4 pages)

4.3. Patient Safety Solutions

Ruth Walker / Joy Whitlock

- 4.3 QSE Patient Safety Solutions update.pdf (3 pages)

4.4. Section 23 – Ombudsmen Report.

Ruth Walker

- 4.4 Section 23 - Ombudsmen Report.pdf (4 pages)

4.5. Update From Clinical Effectiveness Committee

Meriel Jenney

Verbal Update

4.6. Value of Volunteers

Ruth Walker

- 4.6 Value of Volunteers - QSE Template.pdf (5 pages)

09:00 - 09:00
0 min

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

Susan Elsmore

09:00 - 09:00
0 min

6. Any Other Business

Susan Elsmore

09:00 - 09:00
0 min

7. Review of the Meeting

Susan Elsmore

09:00 - 09:00
0 min

8. Date & Time of Next Meeting:

Tuesday 22 February 2022
9am

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 15th September 2021 at 09.00am
Via MS Teams

Chair:		
Ceri Phillips	SE	Vice Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Akmal Hanuk	AH	Independent Member – Community
In Attendance		
Rebecca Aylward	RA	Director Of Nursing – Medicine Clinical Board
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Geraldine Johnston	GJ	Director of Operations – Medicine Clinical Board
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Nick Lewis	NL	Director of Umbrella Cymru
Aled Roberts	AR	Clinical Director for Medicine Clinical Board
Ray Thomas	RT	Peer Support Worker (Umbrella Cymru)
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Deputy Chief Executive Officer.
Observing		
Marcia Donovan	MD	Head of Corporate Governance
Wendy Wright	WR	Deputy Head of Internal Audit
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Susan Elsmore	SE	Chair of the Committee / Independent Member – Local Authority
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Steve Curry	SC	Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategy and Planning
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Catherine Phillips	CP	Executive Director of Finance

QSE 21/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 21/09/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 21/09/003	**Declarations of Interest** No Declarations of Interest were noted.	
QSE 21/09/004	**Minutes of the Committee Meeting held on 15 June 2021**	

	The minutes of the meeting held on 15 June 2021 were received and confirmed as a true and accurate record of the meeting **The Committee resolved that:** a) The minutes of the meeting held on 15 June 2021 were approved as a true and accurate record of the meeting.	
QSE 21/09/005	**Action Log following the Meeting held on 15 June 2021** The Action Log was received and the Committee noted that the majority of the actions had been completed or were on the agenda for discussion during the meeting, or were due for discussion at a future meeting. The Executive Nurse Director (END) advised the Committee that the Independent Member – Legal (IML) had expressed at the previous Quality, Safety & Experience (QSE) Committee, around pressure damage. It was noted that the END and the Director of Nursing for the Surgical Clinical Board (DNSCB) had met with the IML to discuss what would be helpful to Independent Members to demonstrate the progress made with regards to the pressure damage agenda. A paper would be provided to the December QSE meeting. The Independent Member – University (IMU) asked when an update on Stroke Performance would be provided to the Committee. The Deputy Chief Executive Officer (DCEO) responded that an update would be brought to the December QSE meeting. **The Committee resolved that:** a) The Action Log from the meeting held on 15 June 2021 was noted.	
QSE 21/09/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
QSE 21/09/007	**Medicine Clinical Board Assurance Report** The Patient/Staff story was received. The Director of Umbrella Cymru (DUC) advised the Committee what Umbrella Cymru was and noted that the service provided specialist support in relation to gender and sexual identity and had done since 2015. It was noted that Umbrella Cymru had a working partnership with the Cardiff and Vale University Health Board (CVUHB) Welsh Gender Service (WGS). It was noted that Trans and non-binary patients had felt very isolated during the Covid-19 pandemic and that the service had to change to reduce that.	

	It was noted that overnight, Umbrella Cymru had changed their operating model and had moved to a digital model that was opened until 7pm at night Monday to Friday as well as an online instant chat function which operated until 10pm at night so that patients could get in touch. It had helped to alleviate some of the issues around isolation. The DUC introduced the Committee to a patient who had also worked as a Peer Support Worker (PSW) within Umbrella Cymru. The PSW advised the Committee that as a patient, they were unsure if they would even be offered an appointment with the WGS due to Covid-19 and noted that, as a frontline worker in Health and Social Care, there was concern that they could be quite exposed to the virus if an appointment had been provided within a hospital. They noted that the digital element of the appointments had provided reassurance and ease of access to the service. The Director of Operations – Medicine Clinical Board (DOMCB) advised the Committee that the reasoning behind asking the PSW and DUC to present was to highlight the impact of the pandemic and the introduction of virtual appointments had been positive and received well by patients. She added that the partnership with Umbrella Cymru was unique and no other gender clinics across the United Kingdom had that partnership and noted that the support provided to patients with this partnership was very important. The Assistant Director of Patient Experience (ADPE) advised the Committee that the changes outlined by the DUC and PSW had a very positive impact on the Patient Experience because the team used to receive a lot of complaints regarding the WGS but noted that now, feedback was great. The IMU asked how the partnership working had come about and asked where the partnership would be going forward. The DUC responded that gender services had been a point of discussion for a number of years and the development of a partnership in Wales was something to be proud of. It was noted that the major benefit of partnership working was the impact pre end-to-end and post end-to-end and it ensured that Patient's GPs were helping people to access gender specialists across the country. It was noted that in relation to moving forward with the partnership, development would be looked at within the WGS to accommodate more specialities being brought in and the increase in the number of patients. The DCEO asked what more could be done by CVUHB to help. The PSW responded that a lot of patients had noted that communication would be key and to manage their expectations around waiting times would be received very well.	

	They added that information around what to expect at WGS appointments would also be very well received. **The QSE committee resolved that:** a) The Patient Story was noted. The Medicine Clinical Board Assurance Report was received. The Clinical Director for Medicine (CDM) discussed the Medicine Clinical Board Assurance Report and highlighted the key issues regarding the Quality & Safety (Q&S) agenda that was discussed at Medicine Clinical Board meetings. These included: • Nursing Vacancies • Transformation Programmes • 'Backdoor' challenges. It was noted that the nurse vacancies issue was further challenged by the extra capacity in terms of meeting pandemic demand and the return of the acute non-Covid demand. It was noted that the Transformation agenda had been ambitious and that out of the first Covid-19 wave, CAV24/7 had been created and out of the 2nd Covid-19 wave, the Right Bed First Time efforts had been up scaled. The CDM advised the Committee that they would already be aware of the backdoor challenges faced by the Medicine Clinical Board (MCB) and noted that moving patients out of the hospital footprint and transferring care back to the community had proved challenging. The IMU asked for further information around the Royal College of Physicians Gaining Insight from Inpatient Falls -Hot Debrief Pilot. The Director Of Nursing for the Medicine Clinical Board (DNMCB) responded that the pilot was being done on the short stay Older Peoples Unit and a great deal of success had been seen as well as good engagement from staff. It was noted that performing a "Hot Debrief" following a patient fall was the right approach and that getting the Multidisciplinary team together and exploring some of the issues, proved very valuable to the patient and learning. It was noted that with support from the Patient Falls Lead, it would be rolled out to other areas. The END advised the Committee that the pilot would become part of the ordinary practice and that it would be incorporated into the Ward Accreditation piece which would be discussed later on. The IMU asked what the initiatives were that were highlighted in the report around stroke data.	

	The CDM responded that the team had been working hard to look at stroke performance given the challenges faced in some of the performance measures that were used. It was noted that Care of the Elderly (COTE) stroke cover had been looked at which focused on workforce resource to man the system. Another challenge that was being looked at was CT scanner availability due to increased workload from the Major Trauma Centre. It was noted that swallow screening and recording data had been looked at and highlighted that it had involved looking up single patient journeys and timing patients through the pathway which had not produced enough results to provide feedback and improve performance at this point in time. The END advised the Committee that she was concerned about the 4 hour and 12 hour performance in the Emergency Unit (EU) and noted that alongside the investigations with the Welsh Ambulance Service NHS Trust (WAST) around releasing of ambulances, it was recognised that it was not just a MCB issue alone and asked the MCB to highlight the work being done to improve flow in the EU department. The CDM responded that the flow through EU was a symptom of flow through the system which is why discussion around backdoor working would affect front door working but noted that it did not mean MCB were not worried about the amount of time patients remained in the EU. He added that the MCB were focusing on transformation and keeping people out of EU by using CAV247, and, rapidly turning people around when they touched the EU. In addition patients were being processed through the EU and Acute Medicine as rapidly as they could to mitigate the risk of people remaining in the EU for long periods. The END asked the MCB to share how they had managed some of the challenges with regard to registered nurse vacancies. The DNMCB responded that the last time she had reported to the QSE Committee the MCB had a vacancy factor of around 25%. It was currently 10% which demonstrated that the MCB had done a good job to recruit to the operational vacancy posts. It was noted that there were 115 additional beds due to Covid-19 which equated to 85 whole time equivalent registered nurse gaps. This proved to be an unbelievable strain upon teams. She added that the conditions on wards were very difficult but noted that the best care was being provided within the resources that were available. The END asked if there was anything else the QSE Committee could do to help. The DNMCB responded that it had been difficult to recruit to the additional capacity areas due to the lack of assurance of long term funding and asked for help from CVUHB to recruit permanently to the roles and to look at the enhanced overtime rates and overseas recruitment.	

	The END responded that a paper relating to enhanced overtime and overseas recruitment would be presented to the Management Executives in the near future. The Director of Corporate Governance asked for information regarding the risk that had been identified as having a score of 25. She noted that it would suggest that the control in place was having no impact. The CDM responded that at the time of collating the data for the Medicine Clinical Board Assurance Report the second wave of Covid-19 had been a significant risk and a lot of patients were dying as a result. It was noted that a review all of the unfortunate cases was something that the MCB was committed to. He added that the learning from the first and second waves of the pandemic would be on how to manage hospital acquired Covid-19. He highlighted that the significant risk was perhaps less in the third wave but noted that patients were still dying. The DNMCB responded that control mechanisms had been put in place and noted that the risk could be lowered once the learning had been considered. The DCG noted that it would be important to keep risk registers under constant review due to the forthcoming Public Enquiry. The Vice Chair of the Committee (VCC) concluded that the report had been very informative and thanked the MCB for their attendance. **The QSE committee resolved that:** a) The contents of the Medicine Clinical Board QSE assurance report were noted. b) The mitigation being taken to improve quality, safety and experience and to reduce harm was agreed.	
QSE 21/09/008 Saunders,Nathan 12/09/2021 15:57:30	**Perfect Ward Report** The Perfect Ward presentation was received. The DNMCB advised the Committee that the Ward Accreditation was the development of a set of standards so that areas for improvement could be identified and areas of excellence celebrated. It was noted that Ward Accreditation was used quite frequently in England and highlighted that the CVUHB were the first Health Board in Wales to introduce it. It was noted that the framework could be utilised in both Primary and Secondary care settings and that the aim would be to achieve a Bronze, Silver or Gold accreditation. The DNMCB provided the Committee with an overview of what each award would provide:	

- Bronze – The ward provided the fundamentals of safe care and the team were engaged in audit and knew how they were performing. Efforts would be made to act on patient feedback

- Silver – The ward had a safety culture and could demonstrate excellence in some care domains. The team could use data and insights to undertake improvement work and staff and patient feedback would be listened to and acted upon.

- Gold – The ward excelled across all care domains. There would be a culture of safety and improvements would be maintained. The team would support wider organisational efforts to improve and resources would be managed affectively.

It was noted that the "Perfect Ward" was a big component of the accreditation and could be used on any smart device and highlighted that iPads had been procured for all ward areas to use.

It was noted that the wards that were using Perfect Ward and had implemented the audits. They had been very pleased with the outcomes because it was something that was easy to use, was intuitive and had put their own input into the platform.

The DNMCB advised the Committee that it would be important for all wards to have a visible dashboard to see how they would perform on a daily basis and noted that the dashboards were being built.

The timeline for the rollout was identified which included:

- November 2021 – Roll out of the Audit Platform – Perfect Ward
- December 2021 – Launch the Accreditation Framework
- August – December 2021 – Development of Ward dashboards.
- March 2022 – Accredit the first Bronze wards.

The END noted that the Perfect Ward would help inform the Learning Committee and also the Effectiveness Committee.

The DCEO noted that the Perfect Ward aligned really well with the whole of the CVUHB Quality and Assurance agenda.

The VC concluded that it was an innovative approach to get quality into the DNA of the CVUHB system.

He asked if the Perfect Ward could be aligned to the Independent Members' safety walkabouts.

The DNMCB responded that it would be a good idea and noted that Independent Members could come and use the audit tool to see how it worked.

The QSE committee resolved that:

a) The Perfect Ward presentation was noted.

QSE 21/09/009	**Quality, Safety and Experience Framework Update** The Quality, Safety and Experience Framework Update was received. The END advised the Committee that the Patient Experience team had worked extremely hard to get to a point where the Framework could be approved by the QSE Committee. The Assistant Director of Patient Experience advised the Committee that the team had taken a year to ensure that all of the stakeholder involvement had been recorded. It was noted that everything had started to line up and it was highlighted that the 8 big enablers had been worked upon and had provided the focus required. This included: • Safety culture • Leadership and the prioritisation of QSE • Patient Experience and Involvement • Patient Safety Learning and Communication • Staff Engagement and Involvement • Data and insight • Professionalism of QSE • Quality Governance arrangements It was noted that to further strengthen the Quality Governance arrangements two additional Committees would be established: • The Clinical Safety Group –Chaired by the Executive Medical Director • The Organisational Learning Committee – Chaired by the Executive Nurse Director The Assistant Medical Director (Patient Safety and Clinical Governance) (AMD) advised the Committee that the process had started with regards to the World Patient Safety Day and noted that World Patient Safety Day 2021 would be on September 17th. The END advised the Committee that because CVUHB had been ahead of the curve and had engaged with so many people regarding the Framework it allowed CVUHB to participate in some of the conversations in relation to the National Framework. If approved, the Framework could be formally launched on World Patient Safety Day, the same time as that National Framework was due to launch. The IMU advised the Committee that as the Framework was launched and rolled out, colleagues working in relevant locations (which included the most remote parts of the Organisation) would need to be aware of the expectations and the gains that could be achieved by engaging with the Framework.	

	The Assistant Director of Patient Experience responded that there had been really good engagement with PCIC and that the Framework had been aligned to the overall Strategy. The END added that CVUHB had not had a very robust Framework for commissioning of services before and noted that the Framework would apply to a commissioning function which would give the opportunity to develop further. **The QSE committee resolved that:** a) The Quality, Safety and Experience Framework 2021-2026 was approved. b) The Terms of Reference for the Clinical Safety Group were approved. c) The Terms of Reference for the Organisational Learning Committee were approved.	
QSE 21/09/010	**Quality Indicators Report** The Quality Indicators Report was received. The END advised the Committee that the paper was for noting and highlighted 2 key areas to note: • Serious Incident reporting – The numbers had dropped significantly due to a change in policy and it was noted that the reporting mechanism had been refreshed but there was still less numbers being reported. • The key IP&C indicators were being measured with the 2019/20 infection position which would be a significantly different situation to what was seen in prior years. It was noted that Welsh Government (WG) were reviewing that. The VC asked for clarification regarding the classification of pressure damage grades and noted there was concern in the increase of grade 4 pressure sores and asked if this was something that the QSE Committee needed to be aware of. The END responded that it should be identified and noted that a review would be needed to see if that was an accurate position because there was some concern that they had not been captured soon enough or had been captured twice. It was noted that more work was required concerning the tissue validity nurses and that the QSE Committee should have a view on the grade 3 and 4 pressure sores, although consideration for the type of patients currently in the system would be required. **The QSE committee resolved that:** a) The contents of the Quality Indicators report and actions being taken forward to address areas for improvement were noted.	

QSE 21/09/011	**Exception Reports – Verbal** The END advised the Committee of the pressures being seen in the Assessment Unit and Emergency Unit and noted that teams were working and aligning with WAST colleagues. It was noted that the CVUHB Maternity Services were under greater pressure than they had ever known and assured the Committee that it was being looked at. The DCEO advised the Committee that Unscheduled Care was his biggest concern at present and noted that some additional red capacity was needed. It was noted that one of the seventh floor wards at the University Hospital of Wales had needed to be converted into a Covid-19 ward due to the increased numbers. The END advised the Committee that moving to “red zone” was about the IP&C picture and a number of outbreaks were being managed that were not Covid-19 related. She noted that the balancing of those outbreaks was operationally very challenging. The VC asked to convey on behalf of the QSE Committee the appreciation and thanks to staff as they deal with the pressures. **The QSE committee resolved that:** a) The Exception Report was received.	
QSE 21/09/012	**HIW Activity Overview & Primary Care Update** The HIW Activity Overview & Primary Care Update was received. The END advised the Committee of one area she wished to bring to the attention of the Committee: • HIW were currently consulting on a ‘Service of Concern’ process. It was anticipated that the introduction of a Service of Concern designation would increase transparency around how HIW discharged its role and would ensure a focused and rapid action could be taken to ensure that safe and effective care was being provided. It was noted that it was different to anything that CVUHB had done before and would focus particularly on service delivery. The END commented that, by way of an example, if concerns were raised following feedback from the Emergency Department, HIW could come and look at that service and raise it as a “Service of Concern”. It was noted that it should then inform conversations to be had with WG concerning the way in which CVUHB worked.	

	The IMU asked if the WAST local review had happened as it was unclear in the report. The END responded that the review had taken place and noted that there was some complexity in relation to how CVUHB could respond. She added that HIW had looked at each Health Board separately and had asked for improvement plans from each and noted that CVUHB had a good relationship with WAST and that they had not expressed a great deal of concern about the Organisation. It was noted that more work was needed to be able to release ambulances back into the community in a timely way. The VC asked the END if assurance could be provided regarding the HIW visits within Primary Care and asked if appropriate remedial actions had been taken by GP practices. The END responded that there were action plans in place and she was satisfied that they were being monitored carefully. She noted that not all Primary Care Contractors were CVUHB staff and so work would be needed to ensure that these staff members could align to the same CVUHB action plan. **The QSE committee resolved that:** a) The level of HIW activity across a broad range of services was noted. b) The appropriate processes in place to address and monitor the recommendations were agreed.	
QSE 21/09/013	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The DCG advised the Committee that the Board Assurance Framework (BAF) would be provided to the next Board meeting and noted that the QSE Committee had the opportunity to review it to see if there were any additional items that needed to be added to the risk and to check that the controls were in place and working. It was noted that the DCG and END had already discussed the pressures being faced at the front door and the detail would be carried forward into the Board report. The VC asked if the risk identified by the MCB with the score of 25 needed to be added to the register. The DCG responded that it did not need to be added to the BAF but noted that it should be on the Corporate Risk Register and her team would attend to that. **The QSE committee resolved that:**	

	a) The attached risk in relation to Patient Safety was reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	
QSE 21/09/014	**Incident, Near miss and Hazard reporting Policy** The revised Incident, Hazard and Near Miss Reporting Procedure was received. The END advised the Committee that all polices noted had been through a robust process and was confident that it had been agreed at all levels. **The QSE committee resolved that:** a) The revised **Incident, Hazard and Near Miss Reporting Procedure** was approved	
QSE 21/09/015	**Patient Identification Policy** The Patient Identification Policy was received. **The QSE committee resolved that:** a) The updated version of the Patient Identification Policy which had been shared for consultation was approved.	
QSE 21/09/016	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from the Clinical Board QSE Sub-Committees were received: a) Children & Women's Clinical Board Minutes b) Specialist Clinical Board Minutes c) CD&T Clinical Board Minutes d) Surgery Clinical Board Minutes e) Mental Health Clinical Board Minutes f) Medicine Clinical Board Minutes g) PCIC Minutes **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees be noted.	
QSE 21/09/017 Saunders,Nathan 12/09/2021 15:57:30	**Corporate Risk Register** The DCG advised the Committee that there was nothing further to add and that the report be taken as read. **The Committee resolved that:**	

	a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the work which is now progressing was noted.	
QSE 21/09/018	**National Patient Safety Incident reporting policy** The National Patient Safety Incident reporting policy was received **The Committee resolved that:** a) The contents of the paper were noted.	
QSE 21/09/019	**Update From Clinical Effectiveness Committee** The Clinical Effectiveness Committee update was received. The AMD advised the Committee that in December 2020 the Clinical Effectiveness Committee (CEC) was established, and had rapidly gathered momentum. It was noted that, to date, the CEC had met six times and that in May 2021, for the first time, Clinical Boards and Directorate members had been invited to attend to present their national audit findings. The AMD noted that the CEC now met on a monthly basis. **The Committee resolved that:** a) The level of Clinical Effectiveness Committee activity across a broad range of services was noted. b) It was agreed that the appropriate processes were in place to address and monitor recommendations.	
QSE 21/09/020	**Items to bring to the attention of the Board / Committee**	
QSE 21/09/021	**Any Other Business** The VC advised the Committee that today was Carol Evans' last QSE Committee meeting and read out a statement from the Committee Chair who had asked for it to be passed on for noting.	
QSE 21/09/022	**Review of the Meeting** No further comments were made.	
QSE 21/09/023	**Date & Time of Next Meeting:** **Tuesday 26 October 2021 (QSE Special)**	

Action Log

Quality, Safety & Experience Committee

Update for meeting 14 December 2021
(Following the meeting held on 15 September 2021)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 21/02/005	Perfect Ward Report	To share a report on the commencement of the "perfect ward".	28.09.21	Ruth Walker	**COMPLETE** On **September** Agenda:
QSE 21/09/013	Board Assurance Framework	The risk identified by the Medicine Clinical Board rated a score of 25 needed to be added to the Corporate Risk register.	14.12.21	Nicola Foreman	**COMPLETE** To confirm with the DCG at the December meeting if complete.
Actions In Progress					
QSE 21/06/012 21/09/005	Pressure Damage Report	A pressure damage update would be brought to the December 2021 meeting following conversations with Independent Member - Legal	14.12.21	Ruth Walker	On **December** Agenda **item 2.2** Stuart Walker asked for it to be brought back for further discussion.
Actions referred to Board / Committees					
QSE 21/06/023	Items to bring to the attention of the Board	Stroke Performance and Pressure Ulcer updates to be shared with the Board	14.12.21	Stuart Walker / Ruth Walker	Date required from QSE as to which Board meeting to go to.

Report Title:	**Primary, Community & Intermediate Care (PCIC) Clinical Board Assurance Report**						
Meeting:	**Quality, Safety & Experience Committee**				**Meeting Date:**	14/12/2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Director of Nursing Primary, Community & Intermediate Care Clinical Board (PCIC)**						

Background and current situation

The report has been prepared to provide assurance to the Quality, Safety & Experience Committee that the Primary, Community and Intermediate Care Clinical Board is committed to the delivery of safe, dignified and effective care for all patients and service users within the Cardiff and Vale UHB geographical area.

The Quality, Safety and Experience Report is developed around the themes in the Health and Care Standards. The report highlights the current position against a range of key quality indicators, identifying emerging themes, areas of concern, as well as good practice, and any associated actions to secure improvements.

The report is aligned to the UHB's *Shaping Our Future Well Being Strategy 2015 – 2025*; PCIC QSE annual plan (appendix 1) and going forward the *Quality, Safety and Patient Experience Framework 2021-2026* and *The Health and Social Care (Quality and Engagement) (Wales) Act 2020.*

- **Progress over the last 18 months**:

To support ongoing monitoring of the quality, safety and experience as a result of the impact of Covid-19, the following was developed:

- a Covid- 19 safety risk register
- reestablishment of Quality and Safety meetings within all Business Units
- Investment in the PCIC QSE team
- Development of QSE Annual Plan

The PCIC Quality, safety and experience committee meetings have continued during the pandemic and are pivotal in ensuring that PCIC monitors and manages governance or performance issues with our managed services and our independent contractors. They include evaluation and intelligence gained from a number of "soft" and "hard" sources including concerns, incident reports, safeguarding reports. Within General practice performance is managed against the National Health Service (Performers Lists) (Wales) Regulations 2004 (as amended), the NHS

Wales Act 2006 and the Medical Profession (Responsible Officer) Regulations 2010, supported by the GMC *Good Medical Practice* and GDC *Standards for the Dental Team.* A collaborative, formative approach is the preferred option but a number of sanctions can be imposed ranging from reflections to be reported during appraisal, re-training and restrictions on practice up to and including suspension and removal from the Medical Performers List or Medical Performers List (Dental). There are currently 17 practitioners under active management by the team including one for whom a Medical Practitioners Tribunal Service hearing is scheduled.

- **Challenges:**

The COVID-19 pandemic has and continues to place extraordinary and sustained demands on health systems and providers of essential primary and community services.

Our recent experience in dealing with the first and second waves of the Covid-19 pandemic has reinforced the importance of both health and social care working together to ensure the health and well-being of our population.

The COVID-19 pandemic has led to a significant increase in the demand for palliative and end of life (EoL) care, particularly in the community. Figures from the Nuffield Trust 2021 show the "hidden" impact of Covid 19 pandemic and those wishing to die and to be cared for at home. The biggest rises in deaths at home per 100,000 people were 67% in Vale of Glamorgan (from 47.3 to 79.1), 50% in Cardiff (41.4 to 62). Between October 2019 and October 2021 there was 23% increase in those receiving EoL care on the North West locality district nursing caseload. Palliative and EoL care services face growing pressures due to the increasing number of older people and increasing prevalence of chronic illness.

Our main challenge has been the recovery from the Covid 19 pandemic and supporting our workforce to find the resilience to cope with an ever-increasing workload. This has been exacerbated by lack of clinic space to run clinics and has meant an increasing waiting list for our patients.

PCIC community nursing support to the care homes and hospice continue to play a pivotal role in the care of the elderly, frail and vulnerable in society. This in turn helps to relieve pressure on the hospitals.

The overall support offered from community nursing includes: daily call to check on Provision of Personal Protective Equipment (PPE) supplies and cases; training on specific enhanced PPE; bi-weekly calls for Infection, Verification of death; visits by nurse assessors to monitor and staffing failing care homes and where appropriate offer of on-site training advice; participation in outbreak teleconference calls; briefings on key messages and changes around aspects such as end of life care, advanced care planning and medicines management during the pandemic.

Significant pressure has also been felt within GMS which is now very fragile. As a snapshot:

- 1 GMS contract resignation, 6000 patient list size
- 1 GMS contract resignation, 6500 patient list size
- 1 formal list closure and 1 application pending to close the lists to new registrations– circa 20,000 combined patient list size
- 1 sustainability application in relation to low student registrations affecting financial viability of the practice – circa 7000 patient list size

- 15/59 practices escalating at level 3 or 4 (5 being practice closure) – Circa 90,000 combined patient list size
- Active support to 5 fragile practices – List size combined circa 30,000 patients

In summary the Covid 19 pandemic has highlighted a number of strengths and weaknesses in the primary and community and intermediate care system. One strength is the incredible efforts and dedication of health care workers and non-clinical staff focused on providing the best care possible to patients, even in the most challenging of working conditions, who were redeployed to areas to support the wider systems such as inpatient hospital area and mass vaccination and testing.

However, the data (PREMS and PROMS) needed to understand the quality of the care being delivered to patients during this pandemic have proven difficult to obtain. As a result, there is a lack of information that would help clinicians improve care delivery in the moment and learn for the future. This situation highlights how the current approach to quality and safety measurement remains too labour intensive, contains significant data lags, and lacks sufficient standardization that allows for rapid sharing of data.

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

For ease we will discuss key issues using the health and care standards:

Safe Care:

National Incident Reporting Framework/Serious Incidents

Performance against the 60-day Welsh Government closure target for serious incidents/NRI's (Nationally Reportable Incidents) is set against the backdrop of number of historical SI's. As of June 2020 12 SI's were open beyond the closure target. Performance improved during the 18-month following deep dive sessions and the roll out of RCA training afforded to all leads within the PCIC business units. Constraints due to Covid 19 were responsible for some of the delays in closures throughout 2021.

As of November 2021, PCIC had 6 open NRIs (formerly SIs.) However, 3 had been returned to the corporate patient safety team for final closure. Areas in which NRIs have occurred over the last 18 months include:

- Optometry case (medication),
- HMP Cardiff (unexpected deaths) and
- General Practice (inappropriate or delayed referrals, medication and unexpected deaths of children).

The highest numbers of NRIs have been in HMP and there is currently a focus on fully understanding the care that is delivered within the prison. An action plan is in place following the most recent death in the prison with scrutiny from the Executive Nurse Director and Interim Medical Director.

A previous NRI for phenobarbital overdose has now resulted in the recent dissemination of learning via a patient safety notice PSN061.

The PCIC QSE team have good working relationships with the corporate patient safety team which ensures critical challenge, sharing of information to support the timely closure of SI's/NRI's. Corporate support is particularly useful in facilitating complex, cross board responses. Regular meetings are taking place with corporate Quality and Patient safety leads which has led to the number of serious incidents reducing.

Pressure Ulcer Scrutiny Panels

Pressure damage remains the most reported incident within the Clinical Board via E-Datix, and these are shared at Clinical Board QSE to identify any common themes or trends. PCIC have a robust process around pressure damage and the last 18 months saw the introduction of the pressure ulcer scrutiny panels. The panels discuss any category 3 or 4 pressure ulcers that have occurred in our care to determine if they have been avoidable or not. Scrutiny panels do the following:

- Ensure that investigations are conducted and completed in accordance with the guidance (All Wales review tool for pressure damage).
- Provide an appropriate Professional Forum for presentation of cases which are investigated well with all relevant detail.
- Identify causation with any emerging themes or trends.
- A platform for learning from each other's experiences that supports and improves evidence-based quality patient care.

We have recently been successful in making changes to Datix so that pressure ulcer data can now be identified per district nurse team, rather than locality.

Pressure ulcer scrutiny panels continue to meet weekly to discuss category 3 and 4 pressure ulcers and to determine whether they are avoidable or unavoidable. A recurring theme from the scrutiny panels is gaps in documentation that leads to a pressure ulcer being identified as avoidable. Based on the discussions at panel the following is an indication of avoidable vs unavoidable pressure damage in our 3 localities:

Locality	Total Incidents	Avoidable	Unavoidable	outcome pending investigation	Other Not pressure damage
North West					
July	7	0	7		
Aug	8	1	7		
Sept	9	0	8	1	
South and East					
July	7	2	5		
Aug	3	1		1	1
Sept	5	2	3		
Vale					
July	18	5	12		1
Aug	9	0	9		
Sept	9	0	8	0	1

Chronic Wound Care

It is increasingly acknowledged that pressure damage and wounds are both common and expensive and that we can no longer continue to consider skin health and wound care and treatment as a “Cinderella” service.

Based on data obtained over the period between April 2019 and March 2020 Cardiff & Vale UHB invested over £8 million in providing wound care to community-based patients with 30% of this spend covering wound dressing and compression product acquisition. It is unclear from the available data the value or the quality obtained from this high expenditure given lack of easily accessed granular data upon wound care processes and outcomes. The lack of outcome measures was particularly limiting to the review undertaken by the Welsh Wound Innovation Centre. Several recommendations/benefits are offered to improve understanding of the value of the wound care delivered by Cardiff & Vale community staff.

Working in partnership with the Welsh Wound Innovation Centre and CAV UHB Innovation team, PCIC can harness the academic, clinical, research, innovation, and improvement strengths of QI and Values Based Care (VBC). PCIC can advance the prevention and treatment of wounds in an innovative and cost-effective manner to benefit the patient, citizen, and public purse. Furthermore, given the significant levels of expenditure on wounds and increasing demand, we believe that there is a requirement to transform wound care for the benefit of health and wealth as without this focus there will continue to be waste, harm and variation.

Learning from events (LFE)

The last 18 months have seen PCIC hold numerous learning events. They have been held when an incident has happened, including those that have not always fallen into the NRI criteria. For example:

- Findings – Death of a patient on district nursing caseload following traumatic catheterisation leading to Fournier’s Gangrene and organ failure.

  Learning -_To support the recommendation in the action plan for In127548; it was identified that there was insufficient monitoring of catheter training and competence following initial training and assessment. The Bladder and Bowel team therefore supported the training of a catheter assessor in each district nursing team (Feb 2021). There are now a total of 35 assessors across 14 district nursing teams and there are approx. 84 staff assessed which includes e-Learning and competency assessment within a 3 year assessment window. This information however requires continuous updating; with a scheduled review in December 2021 by the Professional Practice Development Nurses (PPDN) team to review the training compliance within the DN teams. Additional training needs will be assessed following the review of training compliance.

- Findings – Wrong extraction of adult tooth. The investigation and incident took place in 2017 and a LFE process reviewed the recommendations from the incident which included:

  Learning Clinical Director has reviewed the action plan put in place to try and avoid this happening again, this includes an extraction checklist which could be incorporated into the WHO checklist. All extractions under both GA and LA will include confirming the correct tooth using “Pause before You Pull”.

The National and Local Safety Standard for Invasive Procedure (NatSIPPs and LocSIPPs) have been reviewed for effectiveness for all patients and whether it is user friendly. It will be reviewed at the dental QSE meeting and be part of the Continuous Professional Development . Staff training on NatSIPPs and LocSIPPs has been organised for 2021/22.

- Findings - there had been miscommunication with CHAP, our Cardiff Health Access team (now Cardiff and Vale Health Inclusion Service CAVHIS), when they received information regarding Covid vaccinations that was meant for general practices.
  Learning - Due to the information received the CHAP team commenced a vaccination programme in error. No harm to individuals occurred; however, changes have since taken place regarding targeted dissemination of information.

- Findings - Another learning event took place following a safeguarding meeting, when an individual in a care home was admitted to hospital due to the omission of warfarin. There was clear frustration between the GP practice and the care home staff
  Learning - meeting resulted in a change in how important information is communicated, plus we sourced a period of training for the care home staff.

Patient Safety Notices

There is a robust process in place for the distribution of safety alerts and patient safety notices – we do however, sometimes struggle to receive responses from our clinical teams and have unfortunately recently breached the storage of safe medicines safety notice. An identified member of QSE staff within the Clinical Board is now responsible for all alerts received, and is responsible for the dissemination and actions where applicable and finally the monitoring of patient safety compliance.

Infection Prevention Control and RCA
PCIC are about to recommence the RCA process for any clostridium difficile infection that originates in the community. The RCA tool has recently been changed and the process is planned to recommence in December 21. Once we have embedded the RCA process for C. diff. we will liaise with the UHB IPC team to progress to investigate other infections (eg E. coli., klebsiella, MRSA).

Mortality reviews

In keeping with the recently published *Quality and Safety Framework - Learning and Improving (2021)* to develop a learning from deaths framework, PCIC are building on the continued national roll out of the Medical Examiner Service and processes already in place for reviewing mortality.

Effective care

In March 2020 Welsh Government wrote to Health Boards advising that the mandated National Clinical Audit and Outcome review Programme (NCAORP) had been suspended temporarily to allow organisations to focus resources in responding to Covid. While the requirements for Health Boards has resumed PCIC acknowledges the need to strengthen the local and national

clinical audit process within each of the business units. This was a prerequisite of the additional investment within the team and an identified member of the team will have the responsibility to act as a Clinical Audit Lead and produce the audit plan for 2021/2022. They will include the following:

National Audit

National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Undertaken in Primary Care
Safeguarding Maturity Matrix Audit	Undertaken in DOSH

Local Audit – District Nursing
In July PCIC embarked on a community nursing quality audit in keeping with the All Wales District Nursing Audit approach. 6 DN teams were audited:

Vale : Barry 1 and 2
South East: Pentwyn and Splott
North West: Riverside and Radyr

The audit consisted of the following:

- Records (documentation) audit
- Patient outcomes for End of Life, wound
- Patient experience survey
- Staff survey
- Team leaders audit

Key highlights:

Overall the patient experience survey tells us that patients feel that they receive good care from District Nurses. Some feel that the service could be enhanced if visits were timed, but most understand that this is not possible. They have received positive verbal compliments such as: "*nurses are marvellous, deserve more pay, are kind*", but not all nurses showed their ID or introduced themselves. Many patients felt that this wasn't needed as they knew the nurses; however, some felt that the nurse should show their ID.

There is marked variability in the leadership audit from the band 7 DN team leaders. It is clear from some of their feedback that they are unable to ensure their nurses are up to date with mandatory training and appraisal numbers are low. However, some teams have managed to achieve good levels of training and appraisals. Work is under way to establish how they manage to achieve high compliance; this will be shared with team leaders who are struggling. All team leaders feel that they do not have enough nurses to complete the work as required.

The staff survey for all teams highlighted that most nurses work over their contracted hours. However, it is not clear if this is through bank/overtime or for no extra pay. Most nurses feel that they provide good care but this is because they work extra hours. One nurse stated that she makes sure she provides good care but this is to the detriment of her own mental health. Most

nurses felt that they cannot complete the documentation as required due to workload (since the audit the district nurses are now using a dictation device to record the care given which is then uploaded onto PARIS; this ensures that the documentation can be contemporaneous and less time consuming). Many nurses have had to miss essential training due to workload pressures, however the majority of nurses also feel that they have the skills required to do the job. There appears to be an open culture in the 6 teams audited although there were a few nurses who felt this was not the case.

We were only able to gather a snapshot regarding patient outcomes as not all patients audited fitted into the outcome categories.

- Diabetes:

Not many patients who had diabetes had blood glucose parameters set or any escalation plan in place if parameters were breached

- Catheter:

There is a mixed picture in teams; some patients have catheter management plans in place but not all. Most long-term catheters are reviewed within 12 weeks.

- Wound:

Variability regarding wound measurements and care plans

- End of life:

Not many patients audited; however, the majority of patients who are end of life are asked where they would prefer to die and most achieve this. There was one patient who did not have a comfortable death and this resulted in a complaint and learning for the GP.

There was marked variability in the standard of documentation audited. Areas of concern are foot and nail assessments, MUST (malnutrition universal screening tool), “Read About Me” and in some places the Mental Capacity Act.

Dignified Care

External Inspection

HIW publish their findings from external reviews and outline the work undertaken to provide an independent view on quality of care by inspecting a range on NHS services, including GP surgeries and dentists from 1 April 2020 to 31 March 2021. The contents of the report are shared in full with the clinical board.

Tier 3 inspections have recommenced during the Covid Pandemic with, including a review of Mass Vaccination centres in March 2021. Feedback included:

- A significant amount of work had been undertaken at pace by the health board to provide temporary environments with sufficient capacity to deliver their vaccination programme.
- Despite the unique environments of the sites visited, appropriate arrangements were in place to enable them to function as mass vaccination centres.
- Patients who completed the HIW survey provided very positive feedback of their experiences at the centres.
- Volunteers and clinical staff spoke to patients in a friendly and respectful manner
- Both centres allowed for safe social distancing, and the flow of patients throughout the centres was efficient and timely
- Patients were being assessed for symptoms of COVID-19 before being allowed to enter the centres

- The registered supervisor of non-registered vaccinators was always there to discuss any concerns they had when needed.
- Governance arrangements underpinning the continuing safe delivery of the programme could be improved.

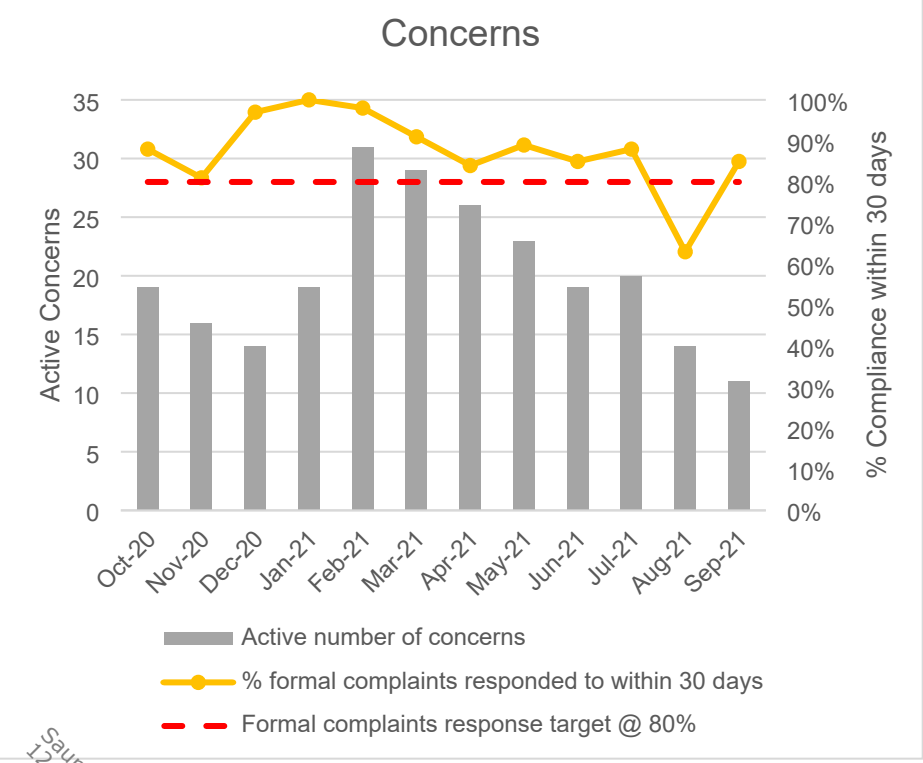
Recommendations for improvement focused on vaccine storage and traceability, staff awareness of evacuation procedures in the event of an emergency appropriate and consistent clinical assessment of patients prior to receiving their vaccination, staff acknowledgement of the Patient Group Direction, adherence to the health board's uniform policy, the need to undertake audits to maintain patient safety, updating of the standard operating procedure for each centre to ensure they accurately describe the agreed processes for each centre, and ensuring vaccinator competencies

Concerns

The monitoring and management of, and learning from, concerns is a key priority for the Clinical Board. PCIC is achieving good performance with the response to complaints. We aim to achieve early resolution when possible with a phone call to the complainant. Concerns processes are being reviewed regularly to ensure we are using our resources as efficiently as possible.

Performance to achieve complaint response within 30 days:

	Number of open concerns	Performance target 80%
July	19	88%
August	14	63%
September	11	85%



Themes identified from concerns received:

September and Oct 2021

Business Unit	Total Number	Access to a service	Communication/Admin	Behaviour/Attitude	Clinical	Other
MVC	1		1			
CAV24/7	4	1		1	2	
GP	1				1	
Dentist	3	1			2	
Optometry	0					
Vale	2	2				
N&W	1	1				
S&E	2	2				
Other	3	1	1		1	
	17	**8 (48%)**	**2 (12%)**	**1 (5%)**	**6 (35%)**	

Interface Incidents (GPs opportunity to raise concerns):

September and October 2021

	Total Number	Discharge Summary missing or incorrect	Breach of Welsh Health Circular e.g GP asked by secondary care to f/up	Incorrect Pathway followed	Clinical	WAST Delays	Admin error/ Other
Interface Incidents	17	2 (12%)	9 (53%)	1 (6%)		3 (18%)	2 (11%

The PCIC Senior management team has commenced a period of safety and quality walkarounds to improve senior visibility and ask the important 'how are you?' question to the clinical teams. These have been well received.

Compliments and Patient Stories

Complaints provide a mechanism for feedback and should be viewed positively, to promote learning and drive improvements. However, there are a plethora of mechanisms for providing feedback and within the 'balancing' quadrant as illustrated below. With the use of patient stories at PCIC QSE Committee (Patient Experience Framework 2015) it is clearly identified that compliments and patient stories are also a fundamental feedback mechanism.

PCIC receive many compliments each month, a snap shot of which are included in the bi-monthly QSE report. A frequent theme of our compliments is the care provided for patients at the end of their life.

Patient Experience Framework (2015)

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

Mass Vaccination and Patient Feedback

The clinical board actively and routinely seeks out patient feedback and aims to be a learning clinical board which is underpinned by quality and service improvement work. Using patient feedback to drive quality improvement and learning a clinical audit schedule via perfect ward has been introduced and is undertaken weekly across all Mass vaccination centres. The audit schedule forms a vital part of clinical governance and ensures the MVC compliance with the required standards to maintain patient safety.

View point feedback Units are located in each of our Mass vaccination centres and overall the feedback has impressive. These reports are shared regularly reports and we publish our patient experience data and quality improvement plans with a range of stakeholders including patients and frontline staff.

Our latest (22/11/2021- 28/11/2021) shows that out of the 368 patient responses across all MVC

- 88.3% said their experience was very good
- 6% said their experience was good
- 1.6% said their experience was average
- 0.8% said their experience was bad
- 3.33% said it was very bad

The MVC uses the patient experience improvement framework (2015) to identify areas where they need to focus to have the biggest impact. It is part of their continuous learning and quality development and is reviewed at each QSE meeting,

Patient Story

'I visited a patient for clexane administration, during the visit I took a set of observations (there wasn't a clinical need at the time, it was just for baseline observations). It was then noted that the patient's heart rate was 38bpm. The patient then said that she felt clammy. I rang 999 and stayed with the patient until the paramedics arrived. Repeat observations were taking in the meantime, the patient's heart rate had dropped to 36bpm and blood pressure dropped to 84/60mmHg – the patient was scoring a NEWS of 6. Luckily, in this scenario we had previously recorded the patient's baseline observations so could evidently see that these observations were not the patient's usual. The paramedics arrived, checked patient over and said that the ECG showed the patient was in 'complete heart block' and was at high risk of cardiac arrest at any moment.
The patient was admitted to hospital immediately and had a pace maker fitted. The patient was then medically fit for discharge following recovery and was sent home. The family rang the district nurse hub to give thanks. This scenario has highlighted the importance of checking patients' observations in the community and following the escalation guidance.'

The requirement to undertake baseline observations and roll out NEWS in community nursing was initiated during the Pandemic.

Compliment Examples are as follows:

- End of life care provided in the Barry team:

The family of a patient who received end of life wanted to express at this extremely difficult time how wonderful the District Nurses of the Barry team were in their Mum's End of Life Care. They have contacted Victoria to pass on their thanks to the team and gave a special mention to Leanne and Alice who they said were 'Angels'.

- Vale urgent primary care hub:

Flowers and a card for arranging an ENT appointment

- DOSH:

A specific mention for Mandy MacDonald who explained everything in detail to ensure the patient was happy and grateful for the outcome. Patient and mum said that they would recommend the service to anybody.

- OOH:

'*I contacted the Urgent Out of Hours service early this morning (around 6:45am 25/9) with some symptoms that I was quite worried about so I was feeling really anxious and unwell when I initially phoned.*
Both women (the initial call and the doctor) I spoke to were kind and reassuring and straight away I felt much calmer.
The service was so quick and efficient- I got through immediately, was able to speak to the

doctor within half an hour and pick up the prescription that I needed within an hour.
As a student living away from home it can be really stressful when you're on your own and not feeling well and it made such a big difference when people have such a nice, kind and calm manner'.

- Barry DN team and Night visiting team:

'The Vale District nursing team had been attending (our home address) to change dressings for my father for over 6 months and then in the last few weeks of his life became an integral part of my father's care and also support for my mother and I. The professionalism, humility and also humour they brought to our lives kept us going at what I could only describe as dark low points. No matter what time of day or night we had to call them out they were always helpful and nothing was too much trouble.

There were so many different nurses that attended it's too may too mention however Lois was a more frequent attendee and was with us at the beginning and helped guide us through a process that neither of us had ever encountered previously.

I cannot thank everyone enough, without doubt they got us through some dark times and were true heroes.

Individual care

Safeguarding

All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals, with the appropriate actions taken and shared more widely if required.
There are currently 31 open health cases, which has increased significantly. All senior nurse have attended Health Lead Professional training so are able to support the Lead Nurses in management of safeguarding.

	June	July	September
North West	3	6	8
Vale	3	6	8
South East	12	12	15

Timely care

The Covid-19 pandemic has had both positive and negatives on the patient experience.

<u>CAV 24/7 – Positive for Patient experience</u>
Opportunities were afforded in the first and second wave to develop innovative and pioneering models of care. CAV 24/7, is the first service of its kind in Wales, and amongst the first across the United Kingdom. The phone first triage system was introduced to allow patients to be seen at the right place, first time (not always an Emergency Department) and keeps the staff and patients safe, allowing patients to wait in the comfort of their own home before their allocated time slot to arrive. This has also supported patients and staff to socially distance by avoiding

overcrowded waiting areas. The aim of CAV 24/7 is the ability to control the flow of patients into the department, but not attempting to reduce patient numbers into the department. It has provided the opportunity to make a huge change to patient experience and staff satisfaction. Future developments include the expansion of CAV 24/7 with more direct access to outpatients and hot clinics and increased direct referrals to specialties.

Negative Impact on Patient Experience

It is important to understand how long our patient are waiting for clinical service and the impact that this has on their health and wellbeing.

Bladder and Bowel service:

Specific part of the service	Number of patients on the waiting list As @September	Number of patients on the waiting list As @ November
Home visits	185	211
Generic clinic	86	41
Specialist clinic patients Patients referred to the specialist clinic include more complex presentations eg neuropathic, multiple disease, bladder and bowel dysfunction etc. A relativity small number of these referrals will be MS patients secondary progressive MS patients tend to require home visits.	103	106
Total of new patients waiting to be seen	**374**	**358**
Reassessments	27	25

The Bladder and Bowel team now have clinics in Rumney and Barry hospital (both generic and specialist). Clinics commenced in July so it will take time to reduce the numbers of new patients on the waiting list.

Community Dental Service:

New patient waiting dental assessment	1026
Patients waiting appointment after being cancelled due to COVID - 19	511

Erectile Dysfunction Clinic

Waiting List	Total Number of Patients	Longest Waiter
Needs Assessment	85	16/08/2017
Psychosexual	27	03/04/2018
Urological	102	05/12/2016
TOTAL	**214**	

Staff and Resources

The Clinical Board consists of 1039.84 WTE staff. As of October 2021, the professional break-down is as follows:

PCIC Vacancies October 2021

Row Labels	Sum of FTE Budgeted	Sum of FTE Actual	Sum of Difference	Sum of % Difference
Add Prof Scientific and Technic	36.33	33.74	2.59	7.13%
Additional Clinical Services	93.39	76.90	16.49	17.66%
Administrative and Clerical	216.09	222.72	-6.63	-3.07%
Allied Health Professionals	105.66	85.27	20.39	19.30%
Estates and Ancillary	46.42	37.99	8.43	18.17%
Medical and Dental	32.08	23.90	8.18	25.50%
Nursing and Midwifery Registered	437.40	361.35	76.05	17.39%
Unregistered Nursing	72.47	78.06	-5.59	-7.71%
Grand Total	**1039.84**	**919.92**	**119.91**	**11.53%**

PCIC have recently invested in the QSE and Education team and it is via education, training, development, that we will shape the healthcare workforce in PCIC, supporting high-quality care for the people of Cardiff and Vale.

There are a range of professional frameworks, many of which are uni-professional, guiding the workforce at differing levels of practice and enabling practice across a range of health and care settings and sectors. In fact, last year HEIW reviewed the many existing frameworks (about 80) to inform some work in line with the policy context in Wales which is clear. PCIC align to this policy context; we want our workforce to have equitable access to learning and development opportunities that enable them to fulfil their potential and meet the needs of our population.

However, this is set against significant workforce challenges.

As of October 2021, the Clinical Board currently had a voluntary resignation turnover rate of 24.4% Cumulative sickness reported for was 6.07%. The current frontline Registered Nurse (RN) vacancy position is 10.6%.

Locality		RN WTE	RN Vacancies	RN Vacancy %
North West	5 DN teams CRT Nurse assessors	94.55	9.61	
South East	5 DN teams HMP CAVHIS DOSH Nurse assessors	106.77	6.8	
Vale	4 DN teams VCRS Bladder and Bowel Tissue Viability ART Nurse assessors	93.48	9.98	
CAV 24/7		28.8	8.2	
		323.6	34.59	10.6%

PCIC still have 12 Registered nurses redeployed to either MVC or secondary care settings. This is having an impact on the base team as they need to cover the workforce gap that has been left, plus we are finding that staff who have been redeployed tend to remain in their redeployed role for a prolonged period of time. This has a detrimental impact on the health and wellbeing of some staff.

Unregistered workforce:

Locality	HCA WTE	HCA Vacancies	HCA Vacancy %
North West	17.13	0.24	
South East	18.98	1.4	
Vale	9.69	2.18	
OOH/CAV24/7	0	0	
Total	45.8	3.2	6.9%

Although the sickness table includes all staff in PCIC it is clear that we have an increasing trend in our sickness % - evidencing the anecdotal findings that we currently have an exhausted workforce. Stress and anxiety is a common theme as a result of dealing with the Covid pandemic plus increasing demands on a stretched workforce.

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

The key QSE risks currently for the PCIC Clinical Board are:

- Independent Contractors

Risk .
There are sustainability issues across all primary care contractor services (GMS/Dental Services/Optometric Services) as a result of recovery and reset due to Covid-19.

Source of uncertainty .
The existence of Covid-19, the role of primary care contractor services in recovery and reset of service provision as well as preventing future surges will require significant additional and wide-ranging changes in practice and service delivery. There is an expectation that primary care contractor services reset and recover their services in line with contractual regulation and Welsh Government direction as patients return to access services following

Consequences/Impact . Covid-19. Evidence suggests a tsunami of 'catch up' workload across all contractor professions compounded by meeting contractual requirements and regulations, maintaining Covid-19 restrictions and managing workflow constraints. This will significantly impact all contractor professions (GMS/Dental Services/Optometric Services) and pose a significant sustainability risk in maintaining primary care services, managing increased demand, complexity of patients, meeting contractual obligations as well as a financial and workforce impact.

There are a number of elements to this Risk pertinent across primary care contractors:

• A huge surge in patient demand for support and appointments as lockdown is lifted.
• Essential service catch up – the update and resumption of services that have been put on hold because of Covid-19 outbreak
• Safety-netting of patients, who may have been missed via the initial referral to secondary care from primary care; and management of patients where elective surgery/procedures have been postponed
• Diagnostics appointments delayed or cancelled by hospitals adding a re-referral workload
• Additional referral workload, where referrals have been pushed back into or managed in the community to ease acute congestion.
• Need for longer consultations to deal with accumulated problems.
• Need to maintain Covid restrictions with particular impact where an Aerosol Generating Procedure (AGP) is performed,reducing capacity on site due to infection prevention control (IPC) procedures.
• Financial risks associated with inability to generate the same level of income from enhanced or additional services (GMS) or inability to maintain the same level of activity (Dental/Optometry) owing to reduced capacity due to IPC restrictions.
• Significant additional work managing mental health and post Covid-19 syndrome issues: The Royal College of Psychiatrists has already predicted a surge in mental health problems, including psychological aspects of Covid-19 infection and post Covid-19 medical syndrome; social issues as a result of unemployment and financial crises; psychological impact, for example, of bereavement due to Covid-19 and impact on family members, and impact of lockdown on families and individuals; survivors with new disabilities.

• Chronic disease management: All aspect of chronic disease management will need to be enhanced to accommodate additional Covid-19 risks including appointment and contact modifications
• Workforce and sustainability issues prevalent before Covid will re-emerge and impose consequent pressures on the primary care team to manage and support
• Organisational risk if unable to maintain access to services

Current risk 16 – target risk 12

- **Complex packages of care**

Risk:
There is a risk of breakdown in sustainability of existing complex packages of care in the community as well as delays in discharging individuals to the community who require specialist domiciliary or nursing support at home.

Source of uncertainty/cause/event:
There are a limited number of specialist care agencies operating in Cardiff and Vale that support complex care packages in the community. There is an increasing demand to support individuals with complex health care needs in the community. The domiciliary care sector as a whole is experiencing significant recruitment challenges and the ability of agencies to staff and sustain large packages of cares is frequently compromised. Some agencies are issuing notice on existing packages and there is not sufficient capacity with other providers to take on additional packages of care. There are limited residential options for younger complex care patients locally.

Consequence/impact:
• Where packages are failing and there are gaps in cover there is a direct impact on patients and families to provide additional support.
• Increasing amounts of senior nurse and nurse assessor team time spent on case managing and supporting fragile packages of care
• Lack of available community options leading to having to transfer individuals to residential care placements or admit to hospital to deliver safe and sustainable care impacting on individual choice of location of care.
• Increasing costs of care in the community
• Individuals being delayed in hospital or the UHB being unable to support their choice of care destination.
• Reputational Risk for the UHB

Current risk rating 12 – target risk 12

- **Out Of Hours**

Risk:
Inadequate/unsafe service provision.

Source of uncertainty/cause/event:
increased demand and demand in the service; inability to cover core clinical shifts

Consequence/impact:
Possible patient harm, adverse effect on patient safety, failure to meet required standards for the service, reputational risk to UHB.

Current risk rating 12 – target 12

GMS Sustainability

Risk: There is a risk that GP practices are becoming unsustainable and may find themselves considering whether they can continue to provide their contract.

Source of uncertainty/cause/event:

- Difficulty in recruiting and retaining GPs in practice
- Increasing amount and complexity of general practice workload as population numbers and patient demand increase
- Condition and size of GP premises, and security of ownership or tenure of GP premises
- Resulting in reduced general practice capacity which will affect the UHBs ability to ensure that residents of Cardiff & Vale can access general practice services and other essential healthcare.
- Increased demand on remaining contractors will also adversely impact on patient access by making waiting times longer, place increased demand on telephone lines, etc. May lead to list closures, further limiting patient access to GMS services.
- Subsequent risk of increased demand on unscheduled services e.g. A&E and OOH services if people can't register with or access GMS services.

Consequence/impact: Resulting in reduced general practice capacity which will affect the UHBs ability to ensure that residents of Cardiff & Vale can access general practice services and other essential healthcare. List closures - increased demand on remaining contractors will also adversely impact on patient access by making waiting times longer, place increased demand on telephone lines, and further limiting patient access to GMS services. Subsequent risk of increased demand on unscheduled services e.g. A&E and OOH services if people can't register with or access GMS services.

Current risk rating 16 – target 12

- **Workforce**

Risk:
Insufficient staffing capacity and resilience to ensure consistent and high-quality service delivery and limited ability to create additional capacity at times of increased service demand.

Source of uncertainty/Cause/Event:
Particular concern areas being key service areas that need to be maintained - CAV24/7 OOH, CHAP, DOSH, DNs, CRTs. Also, persistent issues relating to recruitment and retention for PCIC services. Covid has led to service remodeling, redeployment, displacement of teams, and sickness relating to long Covid and post-Covid exhaustion.

Consequence/Impact:
Unable to provide patients the service required, impact on quality and safety. Staff under huge pressures in their working environment.
Insufficient capacity and resilience to ensure consistent and high-quality service delivery and limited ability to create additional capacity at times of increased service demand. Due to vacancies in DN teams, redeployments, sickness, post COVID-19 exhaustion

Current score is 16 with a target of 12.

ASSURANCE is provided by: Please see attached supporting documentation (Appendix 1).

Recommendation:

The Committee is asked to:

APPROVE the actions being taken by the PCIC Clinical Board.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Equality and Health Impact Assessment Completed:	Not Applicable

Quality and Safety Annual Plan 2021-22			
Priority	**Headline Activity**	**By when**	**RAG rating**
Quality, Safety and Experience Framework 2021-2022	1. PCIC QSE Committee ToR approval	Q1	G
	2. QSE dashboard and refreshed reporting arrangements to Board and QSE	Q1	G
	3. Finalised QSE Committee and Group governance structures for all business units	Q1	G
	4. PCIC to undertake refresh of Risk registers and commence Risk Register Training module	Q1	G
Organisational Safety Culture	5. Undertake an organisation wide Patient Safety Culture assessments	Q1-Q4	R
Leadership and the prioritisation of quality, safety and experience	6. Strengthen QSE leadership and governance – appointment of senior nurse QSE	Q1	G
	7. Work with Welsh Government to implement the requirements of the Health and Social Care (quality and Engagement) (Wales) Act 2020	Q4	R
	8. PCIC to Establish and roll out QSE Audit Programme	Q2 – Q4	A
Patient experience and involvement in quality, safety and experience	9. Patient and engagement Safety Survey development with patients	Q2	A
Patient safety learning and communication	10. Review of QSE corporate structures to include Learning from NRI's, Clinical Effectiveness Committee and Organisational Education Committee	Q3 – Q4	A
	11. Development and sharing of the learning from events work to share good practice across the UHB	Q2	A
	12. Roll of out PCIC RCA training Programme	Q1	G
Staff engagement and involvement in safety, quality and experience	13. Agreement of a Framework for supporting staff who have been involved in concerns about patient care.	Q2	A
	14. PCIC to establish programme of SMT QSE Leadership visits	Q1	G
	15. Maximise the learning from near misses	Q2 – Q4	A
	16. Implement Once for Wales Concerns Management System in line with National Programme Board requirements	Q1-Q4 ***	R
	17. Implement process to strengthen governance in relation to National and Local audits, NICE Guidance and Patient Safety Solutions	Q1	A
	18. Implement Once for Wales service user experience system in line with National Programme Board requirements	Q1/Q2/Q3/Q4 ***	R
	19. Reduce healthcare acquired pressure damage – engage with Pressure Damage Collaborative	Q2/Q3/Q4	A
Professionalism of patient safety, quality and experience	20. Support the roll out of SMT Leadership rounds - supplemented by DoN and Deputy DoN review. Refresh uni-professional forums	Q1	G
	21. Undertake a review of Non- Medical Prescribing Process /Supervisory model	Q1	G
	22. Undertake a review of Patient group direction framework	Q1	G
Education and Learning	23. Develop a PCIC Education and learning group. This will have a direct link to PCIC QSE group	Q3	A

KEY: Green = Complete; Amber = ongoing; Red = not yet commenced

Report Title:	**Presssure Damage Collaborative update**	**Agenda Item:**	**2.2**
Meeting:	Quality and Safey Committee	**Meeting Date:**	15th Dec 2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Ruth Walker Executive Nurse Director**		
Report Author (Title):	**Clare Wade – Director of Nursing Surgery Clinical Board**		

Background and current situation:

The purpose of this report is to provide an updated assurance report to Quality, Safety and Patient Experience Committee on the goal of reducing heath care acquired pressure damage within the Health Board

The Director of Nursing for Surgery Clinical Board is the Professional lead on this piece of work for the UHB that looks at reducing the occurrence of healthcare acquired pressure damage within Cardiff and Vale UHB.

To ensure that there is a Multidisciplinary approach to this scheme of work a Collaborative was formed in June 2021. The goal of the Collaborative is:

- reduce the incidence of healthcare acquired pressure damage with the Health Board by 25% by July 2022
- speed up adoption of innovation into practice to improve clinical outcomes and patient experience

The Collaborative has secured input from the Patient Safety Team, Improvement and Organisational Learning Team, Learning Education and Development, and various experts within the Health Board to help progress existing work and help identification and to support learning and improvement. The Collaborative will help focus and drive forward improvements in care. Every team member of the collaborative is invested in solving the problems face and developing innovative solutions. We have created a collaborative to structure a system to support our leadership methodology and continually communicated our vision and our plans.

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

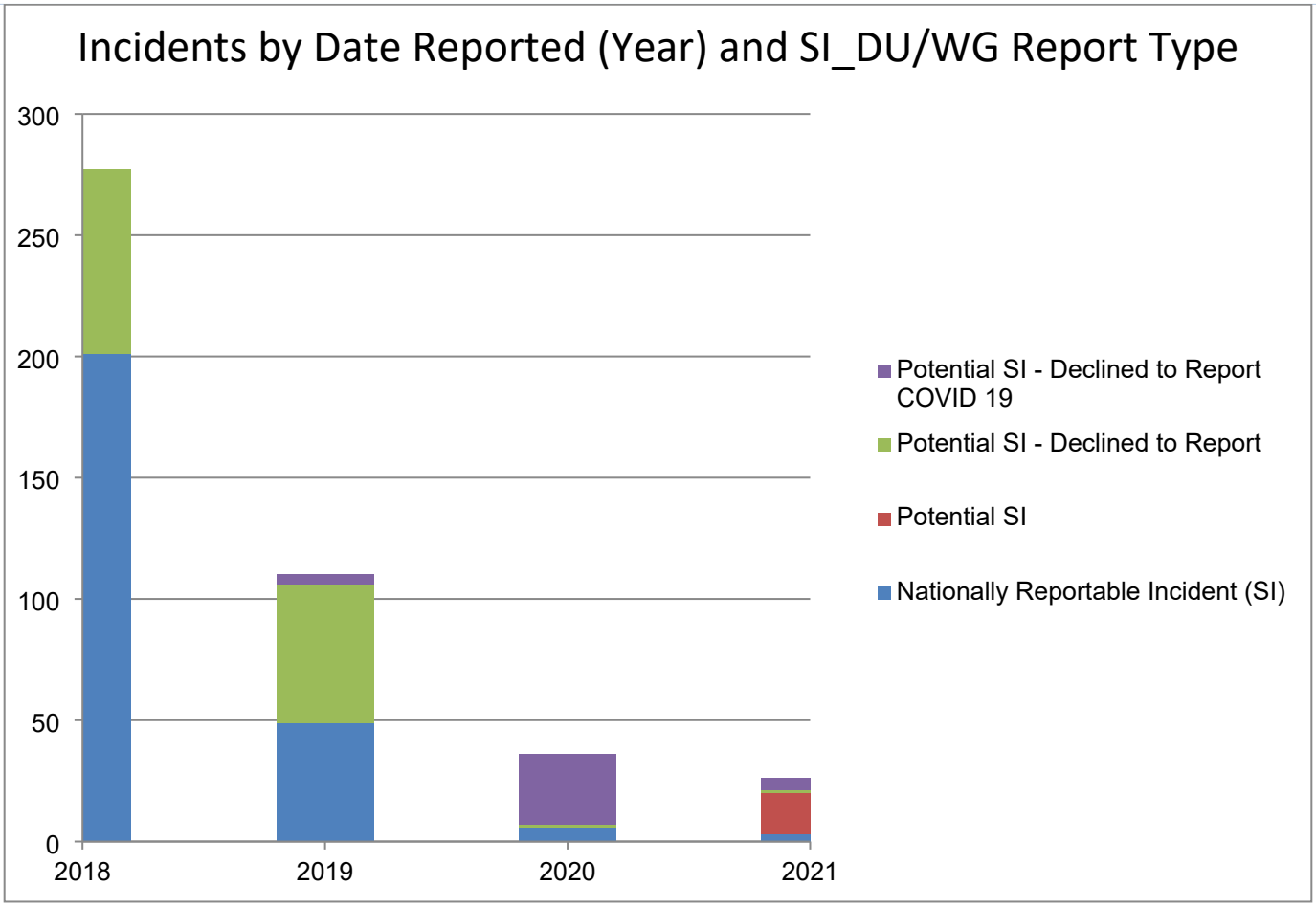
Pressure ulcers are painful and debilitating and, if left untreated, can lead to serious harm and death (National Patient Safety Agency, (NPSA) 2010; Whitlock et al, 2011). Every year up to 20% of patients in acute care in England and Wales are affected by pressure ulcers.

The costs of treating a pressure ulcer are estimated to range from £43 to £374 daily with hospital-acquired pressure ulcers increasing the length of stay by an average of five to eight days per pressure ulcer (Bennett, Dealey and Posnett, 2012). In Wales pressure ulcers affected 8.9% of all in hospital patients (Clark, Semple, Irvins et al, 2017).

Extensive work through previous All Wales initiatives such as 1000 Lives Plus and Fundamentals of Care has helped raise the profile of pressure damage and driven the development of rigorous and practical ways of recording and preventing pressure ulcer incidents. Initiatives such as SKIN bundles were introduced in Wales in 2009 through Transforming Care and aimed to improve patient care by reducing pressure ulcers. However, when pressure damage unfortunately occurs, the learning from such an incident must be effective if the risk to further patients suffering the same harm is to be reduced.

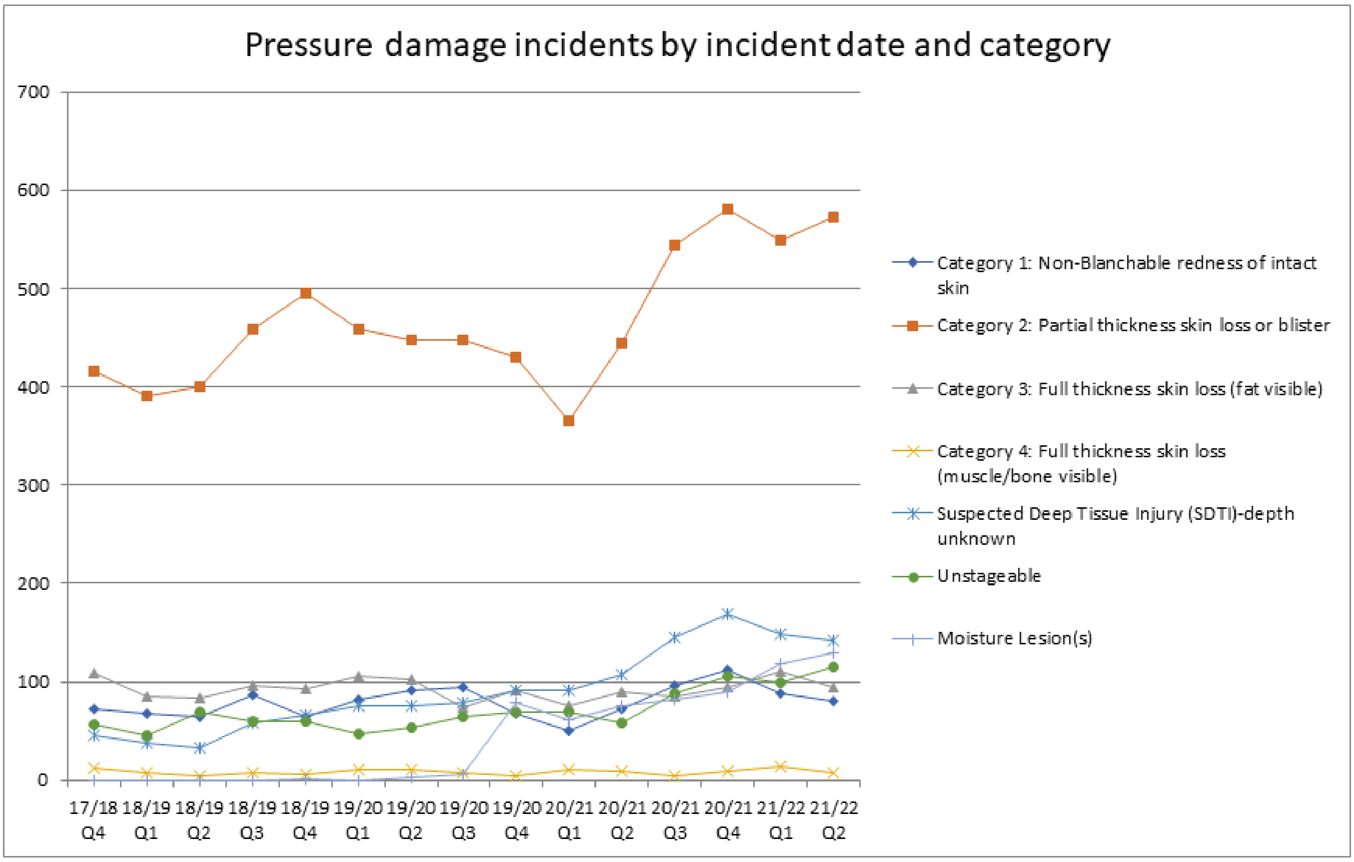
The below graph shows the decrease in the number of WG reportable pressure damage over the last 3 years.

Between April 2019 and March 2020, the UHB reported 49 Serious Incidents to Welsh Government in relation to Health Care Acquired Grade III, Grade IV or unstagable pressure damage. Between April 2020 and March 2021, the UHB reported 6 Serious Incidents to Welsh Government in relation to Health Care Acquired Grade III, Grade IV or unstageable pressure damage. However, it should be noted that the SI reporting process for Heath Acquired Pressure Damage ceased during the height of the COVID pandemic. The Health Board has still captured this data however and carried out appropriate investigations to ascertain learning and improvement during this period.

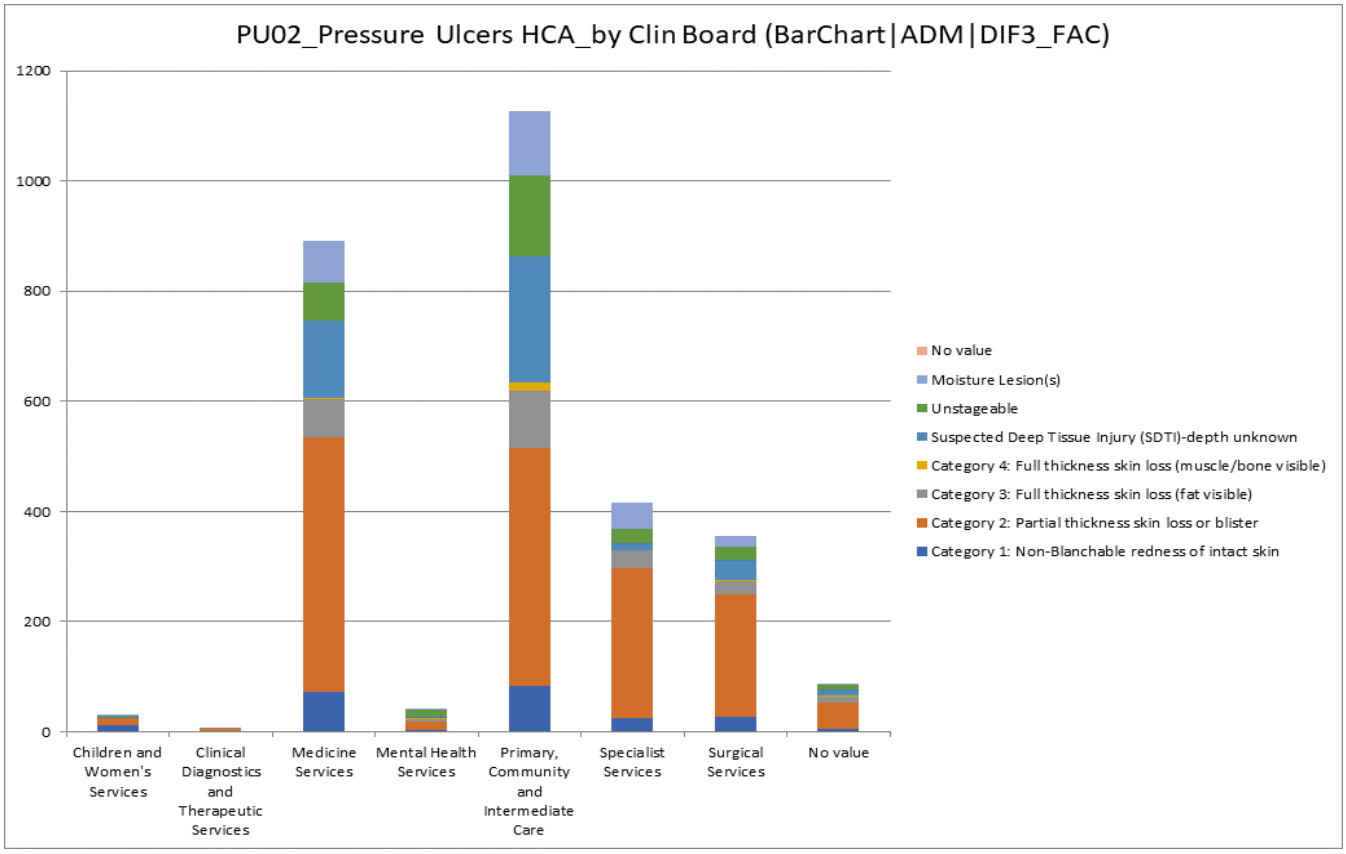


The below graph shows the number and categories of pressure damage (heath care and non-health) care acquired) **reported** by the Heath Board since 2018. The highest reported category of pressure damage for all years is Grade 2 which makes up 49% of the incidents reported. The Health Board has seen an increase year on year since 2018 in the number of reported pressure damage incidents so despite the wide-ranging work that had been carried out by the previous UHB Task and Finish Group this had not impacted on the number of pressure ulcer reported across the Health Board. It should be notes however that this data also includes reported moisture lesions which was only captured from 2019 onwards which affects the overall numbers. The Collaborative has commitment to reduce health acquired pressure ulcers for our patients both in hospital and in the community however there are currently some challenges in pulling out the data separating heath care acquired and non-healthcare acquired damage.

	Incident Date								
Pressure damage classification	2018		2019		2020		2021		Total
Category 1: Non-Blanchable redness of intact skin	289	10.46%	332	10.62%	287	8.29%	302	7.93%	1210
Category 2: Partial thickness skin loss or blister	1665	60.24%	1850	59.18%	1784	51.53%	1884	49.49%	7183
Category 3: Full thickness skin loss (fat visible)	374	13.53%	375	12.00%	342	9.88%	330	8.67%	1421
Category 4: Full thickness skin loss (muscle/bone visible)	32	1.16%	36	1.15%	29	0.84%	39	1.02%	136
Suspected Deep Tissue Injury (SDTI)-depth unknown	173	6.26%	296	9.47%	436	12.59%	515	13.53%	1420
Unstageable	231	8.36%	227	7.26%	286	8.26%	363	9.54%	1107
Moisture Lesion(s) [Category only available on Datix from 2020]	0	0.00%	10	0.32%	298	8.61%	374	9.82%	682
Total	**2764**		**3126**		**3462**		**3807**		**13159**



As can be seen by the below chart the highest reporting Clinical Board over the last year is PCIC. It is challenging based on the e-datix reporting system that we use within the Health board currently to stop duplication of pressure damage being reported as patients travel across or access our health care system at different points. As Cardiff and Vale proactively encourages the reporting of incidents and pressure damage it is likely that there is much duplication of pressure incidents in the current e-datix system. The collaborative are in the process of developing a QI dashboard for pressure damage which will triangulate data from both e-datix and our business intelligence system (BIS) to provide a more robust streamlined reliable data set and measurement.



Assessment and Risk Implications

Assessment

The Pressure Damage Collaborative since its formation in April 21 has progressed with a robust work plan. This work has led to the development of 7 subgroups lead by experinced clinical leads from the Health Board under the following headings

- Information and Data
- Education and training
- Incident Management and SI process
- Heel offloading.
- Pressure redistribution work stream
- Documentation
- Perfect Ward roll out

The key actions taken by the colloborative so far since July 2021 are listed below:

- Bariatric cushion procurement completed
- Duo 2 replacments being evaluted (Aria Pro)
- Scoping RL Datix Cloud IQ system training package for incident reporters and incident managers to include coaching for novice incident managers

- Scrutiny Panel Terms of Reference and Standard Operating procedure drafted and sent out for comments
- Pathway to redress and litigation already in place. Flow chart for pressure damage redress to be agreed between Clinical Boards and Concerns Team
- Agreed use UHB wide of AsskinG – updated standardised skin bundle
- Perfect Ward is now rolled out to 45 wards will be rolled out by end of October
- Audit results will be able to be extracted onto a live dashboard for display against other metrics (i.e. Datix)
- Draft QI dashboard created and shared with collaborative, detailing a range of possible metrics available
- Meeting held to determine most useful/ priority metrics to display. 10 data sets identified, of which 8 metrics are possible to create
- Work underway to display these 8 metrics on a ward level dashboard
- Launch of pressure damage Collaborative Twitter page @CV_UHBPressure
- Development of Skin Safety Card and Pressure Ulcer Quick Reference guide (Appendix 1 and 2)
- Restart of Pressure Ulcer and Prevention Virtual Study Sessions
- Updated Stop the Pressure film for both Staff and Patients - https://youtu.be/Bv7wRrG0M5I

Risks to the Collaboratives Goal

- We cannot deliver this goal in isolation of other important work that is already being undertaken across the organisation. The current overwhemling and unprecidented pressures on inpatient occupance and our workforce requirement in the Health Board may impact on the ability to deliver the reduction goal by July 2022
- As our goal is ambitious and needs to be achieved while recognising the work that is required to deliver the reduction of 'four harms approach' to our Covid-19 recovery plans
- There may be some short-term limitation with the delay in the roll out of the new "Once for Wales" reporting system
- The slow roll out of the All Wales E-documentation programme may cause duplication of work and effort

Recommendation:

The Quality, Safety and Experience Committee is asked to NOTE the contents of this report and the actions being taken forward to address areas for improvement.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	xx	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1

Appendix 2

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

Pressure Ulcer Prevention and Management

Quick Reference Guide

Reporting Process

Confirm Category of Pressure Ulcer

Inform Nurse in charge/Team Leader

Refer to TVN/Podiatry for Category III, IV, Suspected Deep Tissue Injury and Unstageable ulcers

Complete incident report on Datix system (all categories)

If pressure damage has developed in Cardiff and Vale funded Heath Care setting:-

Complete an All Wales Pressure Ulcer Investigation Tool for category III, IV and Unstageable pressure ulcers to determine causal factors

If the pressure damage is deemed avoidable an As1 form should be completed and a notification to WG as a Nationally Reported Incident

Pressure Ulcer risk assessment (Purpose-T) to be completed within 6 hours of admission or first visit for community patients with documented detailed skin inspection for individuals identified 'at risk' of developing pressure ulcers

Give the patient/relative/carer information relating to prevention and treatment of pressure ulcers

Commence aSSKINg bundle (unless no risk identified)

Select optimal support surfaces according to Cardiff and Vale's Mattress/Cushion Selection Guidance

Off load heels (unless contraindicated) for patients who do not move independently/have Sensory deficit/loss of feeling/neuropathy

Plan a repositioning regime (at least 4 hourly) dependent on level of risk identified*

Avoid positioning onto damaged skin

Encourage self-repositioning where possible

The frequency of repositioning will need to be changed if skin damage develops

Record all repositioning on aSSKINg bundle/repositioning chart

If any pressure damage develops reassess using purpose-T and consider changing the support surface if appropriate

Document actions taken to reduce risk and evaluate the effectiveness of implemented change update care plan accordingly

Document condition of skin over bony areas/under medical devices in nursing evaluation at least once daily or if a change is noted

Complete a wound assessment chart for wounds with broken skin and commence a wound care plan (Paris users will need to use 'Pressure Ulcer Care Plan')

Re-evaluate and document patient's risk of developing pressure damage *at least once weekly/if the patient's general or skin condition changes or if transferred from another area

Report Title:	**HEALTHCARE INSPECTORATE WALES ACTIVITY - ITEM 2.6**								
Meeting:	Quality, Safety and Experience Committee						**Meeting Date:**	**14.12.21**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Executive Nurse Director								
Report Author (Title):	Head Patient Safety and Quality Assurance								

Background and current situation:

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview of the reviews/inspections carried out by Healthcare Inspectorate Wales (HIW) since the last over-arching report to the Committee in December 2020. The paper seeks to assure the Committee that action is already being implemented in response to the findings of inspections and that appropriate monitoring of progress against the actions is being undertaken.

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

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

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

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

HIW have recently published their winter bulletin. The HIW position with regard to their assurance and inspection programme remains unchanged in that it is driven by risk, whilst also seeking to support the response and recovery of healthcare services from the pandemic. The situation is continuously under review with a mixture of offsite and onsite assurance work to deliver their function.

HIW recognise that there is a range of indicators showing increased pressure on healthcare services due to COVID-19, broader respiratory conditions and pressure across the system, and will continue to risk assess every piece of work and engage Health Boards where appropriate. In recognition of feedback and reflection on recent inspections, HIW will now move away from unannounced inspections for 'green' and elective, scheduled pathways. They will provide

around 24 hours' notice for these inspections with the intention of ensuring teams have time to communicate with staff and allow time for arrangements to be put in place for the inspection. This is expected to be the approach for all inspections that fall into this category, however, HIW still reserve the right to operate in a fully unannounced visit where they determine there to be an extremely high risk to patient safety as a result of the way a service is operating

HIW published their new 'Service of Concern' process on the 15th of November. The most significant change relates to how a service being managed through the Service of Concern process is described. In externally facing communications and for the purpose of our website, it is the intention to describe any such service as a 'Service Requiring Significant Improvement' rather than a Service of Concern. In addition, the HIW website will include an explanation of the reasons underpinning their determination.

HIW believe that approach to be a more constructive way to describe services and support any necessary improvement, with Service of Concern being a term reserved for the process rather than the outcome of the process. It is anticipated that the introduction of a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including Health Boards, to ensure that safe and effective care is being provided. It is anticipated that the process will be introduced in Autumn 2021.

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

IRMER Announced Inspection

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of The Diagnostic Imaging Department within The University Hospital of Wales on 17 and 18 August 2021. A draft report has been received and publication on the HIW website is expected shortly.

The following areas were incorporated the inspection:

- Emergency Department
- Paediatric Hospital (Children's Hospital of Wales)
- Main Department.

HIW explored how the service:

- Complied with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017)
- Met the Health and Care Standards (2015).

During the inspection HIW found that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017.

There was very positive feedback provided from patients about their experiences when attending the department. Arrangements were found to be in place to promote privacy and dignity of patients and that staff treated patients in a kind, respectful and professional manner. A number of initiatives had been implemented to ensure that the department was an inclusive place for all patients and that their communication needs were considered.

Discussions with staff throughout the inspection provided assurances that arrangements were in place to ensure that examinations were being undertaken safely. The report reflected positively that staff were aware of their duty holder requirements under IR(ME)R. However, a number of areas were highlighted in regards to ensuring the documentation required under IR(ME)R was in place, including making sure that written IR(ME)R employer's procedures accurately reflect clinical practice.

Overall, HIW found that staff were happy with the level of support provided by the department leads. However, concerns were highlighted in relation to several instances of staff feeling there may have been discrimination in the workplace.

An improvement plan has been submitted and accepted by HIW which includes actions to ensure measures are in place to eliminate potential areas of discrimination, to ensure that staff complete their mandatory training within defined timeframes and that all staff have an annual appraisal.

The department is currently revising the employer's written procedures as required under IR(ME)R to ensure they accurately reflect clinical practice, removing ambiguity and duplication to provide clarity and a more consistent approach.

Update on Thematic Reviews

WAST

As part of Healthcare Inspectorate Wales' (HIW) annual reviews programme for 2020-21, a local review of the Welsh Ambulance Service Trust (WAST) has been undertaken. The focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience.

The report was published in October 2021 and found that the issue of prolonged handover delays is a regular occurrence outside Emergency Departments (ED) across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.

The report acknowledges that whilst there are clear expectations and guidance for NHS Wales, the problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.

The review found that overall, handover processes at EDs across Wales are broadly similar; some variations exist in processes between individual EDs within Health Board areas. Whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it was clear that the systems alone are not enough and more collaborative work between WAST and Health Boards is required to resolve the issue of prolonged handover delays. HIW acknowledges that a significant number of whole system activities are underway to address the recommendations in the report and are liaising closely with Wales' Chief Ambulance Commissioner regarding the response.

A copy of the report, patient survey and Terms of Reference can be found in the **supporting documents**.

Mental Health Crisis Prevention in the Community
HIW announced their intention to carry out a National Review of Mental Health Crisis Prevention in the Community earlier this year. The fieldwork has been completed for our National Review of Mental Health Crisis Prevention in the Community. The report is scheduled for publication in December 2021. The Terms of Reference can be found in the **supporting documents**.

National Review of Patient Flow (Stroke pathway)
HIW have commenced a National Review of Patient Flow (Stroke Pathway), and are currently finalising the Terms of Reference. A Stakeholder Advisory Group is currently being convened to help steer the work. HIW aim to share findings as part of their series of Quality Insight Bulletins before concluding with a national report published late autumn 2022.

Review of Maternity Services in Wales – remains on hold.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the level of HIW activity across a broad range of services.
- **AGREE** that the appropriate processes are in place to address and monitor the recommendations.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term		Integration	x	Collaboration	X	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Saunders,Nathan
12/09/2021 15:57:30

REPORT TITLE:	**HIW Primary Care Contractor Report**						
MEETING:	Quality, Safety and Experience Committee				**MEETING DATE:**	**14.12.2021**	
STATUS:	**For Discussion**		**For Assurance**	✓	**For Approval**		**For Information** ✓
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	**Primary Care Support Manager – James Rugg**						

PURPOSE OF REPORT:

SITUATION:
The purpose of this report is to provide an update to the Quality, Safety and Experience Committee on the routine Welsh Government practice and performer inspections undertaken by Healthcare Inspectorate Wales (HIW). The UHB Primary Care Team provide an update report on the outcomes received, reviewed and action taken.

REPORT:

BACKGROUND: All General Practices and General Dental Services / Personal Dental Services are inspected on a three-yearly rolling cycle to ensure that appropriate standards of premises, systems and care are in place. The inspections are announced and are undertaken by an HIW Inspection Manager, at least one external reviewer (Qualified Dentist, GP or Practice Manager with recent experience of GMS) and where possible a member of the local CHC. The HIW inspections produce an Action Plan which is assessed and followed up on by HIW. The UHB then ensures ongoing compliance with the outcomes of the inspection.

Since the start of the Covid-19 pandemic HIW visits have taken place remotely in the form of a Covid-19 "Quality Check" for both GMS and GDS. The following information was also provided:

"*HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.*

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focused on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance"

ASSESSMENT:

HIW review each report and produce the action plan for the visit. Any responses from the practice which do not provide sufficient assurances are escalated within HIW and a more detailed response and actions requested from the practice. This communication is copied to the UHB. The outcome of the action plan is assessed by HIW and satisfaction with steps taken or proposed by the practice are included in the final report.

The Primary Care Team undertakes a review of each practice report and any potential actions for follow-up required. These steps are in addition to any satisfaction HIW have with the outcome and so are managed with sensitivity. Concerns Raised, or Immediate Assurance letters are also followed up.

The review and summary of reports are attached **(GDS Appendix 1 & GMS Appendix 2).**

General Dental Services:

Since the last SBAR report to the committee March 2021 there have been no new HIW reports received by the Primary Care Team.

Outstanding actions from HIW visits highlighted in previous reports have been updated and included in Appendix 1.

Birchgrove Dental Practice (Moorcastle) ended its NHS Dental Contract with Cardiff & Vale UHB on 30th September 2021 and are now solely a private practice. They have therefore been removed from the appendix.

The Primary Care Team have received no concerns raised, or immediate assurance letters in relation to GDS practices since the last report to the committee.

General Medical Services:

Since the last SBAR report to the committee August 2021 there have been two GMS HIW reports received by the Primary Care Team.

The following reports were received:

- Western Vale Family Practice
- St Isan Road Surgery

Both reports are positive and describe the processes that have been put in place during the Covid-19 pandemic and make reference to the challenges that have been overcome.

The Quality Check report from Western Vale Family Practice found that clinical rooms were carpeted and there was no risk assessment for the process of cleaning. The practice has since produced a risk assessment and action plan, and seeks to apply for an improvement grant to remove the carpets in the new financial year. All other areas in the report are positive with no further recommendations.

The Quality Check report from St Isan Road Surgery listed a number of positives in relation to the practice's response to Covid-19, and found that the practice was following all appropriate guidance and has relevant policies and staff training in place.

The Primary Care Team have received no Concerns Raised, or Immediate Assurance letters in relation to GMS practices since the last report to the committee.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- Note the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors
- Be assured that appropriate remedial actions are being taken by practices in relation to immediate assurance notifications
- Note that there is a robust process in place within the Primary Care Team to manage the receipt of inspection reports and ensure review and follow up by the practice

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If “yes” please provide copy of the assessment. This will be linked to the report when published.

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2020) - TABLE OF INSPECTIONS

Total 7	*Practice Name*	*Inspection Date*	*Summary*	*RAG*	*UHB Actions*	*Update*
65	Six Gables Dental Practice Ltd	Quality Check Summary Activity date: 26 May 2021 Publication date: 01 July 2021	The report makes reference to a number of positive findings, including: • Provided with various documents for the prevention and control of infection, which included Protocols and Risk Assessments for working during the Coronavirus Pandemic. • Evidence of training records, which showed compliance with mandatory training. • Process of checking emergency equipment and medicines was provided. There we no suggestions for improvements. Pending review from DPA to look for any follow-up Health Board Actions.		• DPA to review Quality Check summary document • Awaiting improvement plan agreement to be published on HIW website. • We spoke to The Practice Manager on 26 May 2021 who provided us with information and evidence about their service	The DPA is happy with the response of the practice and the evidence provided, the status has therefore been reduced to green.
62	Mount Pleasant Dental Practice (E Akbas)	05/11/2019 (Report found on website) Published 06/02/2020	A quality patient experience, with friendly and professional staff. Areas of improvement identified including note keeping, compliance to practice policies and quality assurance including audit. • Sharps bins to be relocated to avoid contamination of clean areas which should be clearly designated • The practice must ensure complaints procedure (Putting things Right) is displayed, mechanism for feedback and display how feedback was acted upon. • Fire safety training and assessment to carried out		• DPA summary report complete. • DPA letter • Ongoing investigations into provider	Response from practice, ongoing correspondence.

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2020) - TABLE OF INSPECTIONS

			• Clinical audit including smoking cessation. • Audit of note keeping to identify areas of improvement • Record of policy awareness updates by staff including whistleblowing			
61	Newport Dental Practice (321 Newport Road S Yeganeh)	02/10/19 Report published 03/01/2020 (Full report found on website)	The practice was found to be committed to a positive patient experience and rated excellent by patients. Areas of improvement were recommended in compliance with current regulations, standards and best practice guidelines. • Immediate improvement plan initiated re emergency drugs and resuscitation equipment • The practice must provide evidence to HIW that the dental nurse has undertaken the required number of hours (five) of verifiable training in disinfection and decontamination. • Feminine hygiene bins must be made available within the appropriate toilets and feminine hygiene waste must be disposed of appropriately. • Patient records must be fully maintained in keeping with current guidance and professional standards for record keeping (including those recommended within this report).		• Immediate improvement action taken and practice confirmed. • DPA summary report Complete • DPA letter	• HIW satisfied with immediate improvement plan. • DPA's in correspondence with provider
60	N Dental (Grangetown)	24/10/18 Report published 25/01/19 UHB and practice did not receive report. RH requested final report.	Overall a good report confirming safe and effective care. We hope the report highlights areas to further improve the service. • Welsh and English language information to be made available • The practice must ensure that the clinical waste storage remains locked at all times. • The practice must ensure it completes its COSHH protocol and mercury handling policy to be included in its policy file.		• DPA summary report completed. • DPA letter	Waiting for further correspondence from practice.

HIW PRIMARY CARE INSPECTION PROGRAMME (Dental Practices)
FOLLOW UP ACTIONS (up to November 2020) - TABLE OF INSPECTIONS

			• The practice must ensure that Infection Control audits comply with WHTM 01-05 • The practice must ensure that the wear and tear of both treatment chairs is repaired or replaced on moving premises. • The practice must ensure that the floors in both surgeries are properly repaired to an acceptable standard whilst waiting for a move to alternative premises. • The practice must ensure there is a specific policy in place covering medical emergencies and cardiopulmonary resuscitation. • The practice must ensure that all items within the first aid kit are up to date. • Local radiography rules displayed • The practice should undertake a broad range of Audits and MMD to ensure they are meeting with best practice • A secure system for holding records outside of archive • The practice must ensure that when updating the practice policies and procedures they signpost which area of the regulations they are covering			
55	Cathays Dental Practice (Gracias, Kevin)	06/08/19 Improvement letter 08/08/19	• The service must ensure healthcare waste is being stored appropriately and securely within the dental practice premises in line with best practice guidelines.		• Practice emailed 09/08/19 for confirmation of action. • Response received 09/08/19 • DPA's satisfied	• Email response received 09/08/19 • HIW email response 12/08/19 • Ongoing support being provided to practice
52	Cathedral	26/03/2019	Overall, Cathedral Dental Clinic was working hard to provide a high quality experience for their patient		• Letter sent to practice	• HIW satisfied with improvement plan submitted

	Dental Clinic	Improvement Plan issued from HIW	population. • Update practice leaflet with current staff and Violent and abusive behaviour policy • Statement of purpose on website and available on request • Clear and prominent signage stating CCTV in operation • Update CCTV policy and guidance including storage, retention and disclosure • Fire safety training, exit signage throughout practice and risk assessment submitted to HIW • HTM01-05 guidance to be followed including dirty to clean workflow and clearly marked transport boxes • System to check use by dates for emergency drugs and equipment • Review adequacy of private consent forms • Performers require annual documented appraisal • Emergency drugs and emergency flow charts kept in clear folders		28/6/2019 requesting confirmation / evidence of completed improvement plan • DPA letter resent 10/10/19 requesting evidence. • Response received 21/10/19 unsatisfactory, more evidence requested 25/10/19 • Full response with evidence received 12/11/19	29th April 2019 • Ongoing correspondence

HIW Immediate Assurance Letters (received since last update)

Members should note that Immediate Assurance letters for Primary Care are *issued* to the Practice for response and *copied* to the UHB for Information and to feed into the broad Performance Management of the practice.

	Practice Name	*Inspection Date*	*IA Letter Date*	*Summary*	*UHB Actions*
	N/A				

HIW Concerns Raised (received since last update)

	Practice Name	*Contact*	*Follow Up*	*Summary of Concerns*	*Summary of UHB Actions*

		from HIW			
	N/A				

KEY

Issues	Status
Minor issue e .g : Price list not displayed - Translation services not present - Patient Feedback	**GREEN**
Issue requiring remediation, but not likely to pose patient safety issue. E. g - QA arrangements - Policies updating and signing - Complaints Processes	**YELLOW**
Serious Issue requiring remediation due to **potential** patient safety concern. e.g: - Safeguarding procedures - IR(Me)R Issues - Record Keeping Issues - Staff Training Records - Access to staff areas - HTM 01-05 issue : Minor	**AMBER**
Serious Issue requiring immediate remediation due to present patient safety issue:, e. g : - Decontamination processes - Cross Infection control - Emergency Drugs/Equipment - HTM 01-05 : Major	**RED**

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

Practice Name	*Inspection Date*	*Summary*	*RAG*	*UHB Actions/Update*
St Isan Road Surgery	05/10/2021	The report makes reference to a number of positive findings in relation to the practice's Covid-19 response, including: • *Up-to-date risk assessments* • *Appropriate policies* • *Cleaning schedules and audits* • *Complete staff training records* There were no suggestions for improvement.	G	No further actions suggested
Western Vale Family Practice	15/07/2021	The report makes reference to a number of positive findings and one area for improvement: *We recommend that the practice either develop a local risk assessment which must define the pre-planned preventative maintenance and ensure a cleaning programme is put in place as per guidance on infection control in the built environment (WHBN 00-09) or the practice should further reconsider replacing the carpets in all consulting room.*	G	18/10/2021 – The risk assessment, and the listed recommendations contained within, have been accepted by both HIW and the HB. A new cleaning protocol has been developed and the practice will apply for an improvement grant in the new financial year to remove carpets from clinical rooms.

HIW Immediate Assurance Letters (received since last SBAR update)			
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*
N/A	N/A	N/A	N/A

HIW Immediate Concerns raised (received since last SBAR update)			
Practice Name	*Inspection Date*	*Summary*	*UHB Actions*

HIW PRIMARY CARE INSPECTION PROGRAMME (GMS)
TABLE OF INSPECTIONS AND FOLLOW UP ACTIONS

N/A	N/A	N/A	N/A

Report Title:	**Board Assurance Framework – Patient Safety**								
Meeting:	Quality, Safety & Experience Committee						**Meeting Date:**	14th December 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Goverance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is to provide Members of the Quality, Safety and Experience Committee with the opportunity to review the Patient Safety risk on the Board Assurance Framework which links specifically to this Committee.

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

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

The attached Patient Safety risk (last considered by the Board in November 2021) is considered to be a key risk to the achievement of the organisation's Strategic Objectives. This risk has been adjusted to take into account recovery and the impact on patient safety this will bring.

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

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

There are currently ten key risks on the BAF, agreed by the Board in May 2021, which are impacting upon the Strategic Objectives of Cardiff and Vale Health Board. Patient Safety is one of those key risks and specifically identifies:

'There is a risk to patient safety due to COVID 19 Recovery and this has resulted in a backlog of planned care and an aging and growing waiting list'.

It is good practice for Committees of the Board to also review risks on the BAF which relate to them. The role of the Committee in relation to the risk is to review it, check that the controls are in place and working and agree any further actions required in order to mitigate the risk. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time. The Executive Director Leads for this risk are the Executive Medical Director, the Executive Nurse Director and the Executive Director of Therapies and Health Sciences.

Recommendation:

The Quality, Safety and Experience Committee is asked to:

Review the attached risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Patient Safety - Lead Executives Meriel Jenny , Ruth Walker and Fiona Jenkins

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within A&E. Due to a sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to post Covid 19 recovery. Due to the ability to balance risk in the community in transferring patients to EU		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care during COVID 19 creating both longer and ageing waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Spire Hospital • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Implementation of Organisation and Transformation centres to focus upon patient flow within hospital sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (2) • CAHMS position reviewed at Strategy and Delivery Committee (2) • Mental Health Committee aware of more people requiring support(2) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes		

Gap in Assurances	Discharging patients is out of the Health Boards control		
Actions	**Lead**	**By when**	**Update since Sept 21**
1. Recovery plan in place and constantly being reviewed	Steve Curry	31.03.22	Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: the risk of inadequate planned care capacity
2. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Ruth Walker	31.03.22	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

Report Title:	**Revised Incident, Hazard and Near Miss Reporting Procedure**	**Agenda Item no.**	**3.1**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	14.12.21
Status:	**For Discussion**	**For Assurance**	**For Approval** **Y** **For Information**
Lead Executive:	**Ruth Walker**		
Report Author (Title):	**Tara Cardew (Head of Patient Safety)**		

Background and current situation:

Following the changes made by NHS Wales Delivery Unit to the way Organisations report their more serious patient safety incidents, the Cardiff and Vale Incident, Hazard and Near Miss Reporting procedure has been updated to reflect these changes.

The Health and Safety element has also been updated to reflect the executive lead being People and Culture and additional information on evidence gathering has been included in section 4.

The policy can be found in the **supporting documents**.

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

The updated procedure supports the changes made to national incident reporting by NHS Wales Delivery Unit and outlines the key requirements of members of the UHB in meeting these changes.

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

This updated procedure has been shared for consultation with key stakeholders. The new National Incident Reporting process has been shared with Clinical Board colleagues for dissemination and a paper highlighting these changes has also been presented at this meeting.

Recommendation:

The QSE Committee is asked to APPROVE the updated version of this policy.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	Y	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes – included in appendix ……. *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Updated Patient Identification Policy**	**Agenda Item no.**	**3.2**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	14.12.21
Status:	**For Discussion**	**For Assurance**	**For Approval** **Y** **For Information**
Lead Executive:	**Ruth Walker**		
Report Author (Title):	**Tara Cardew (Head of Patient Safety)**		

Background and current situation:

The Patient Identification Policy is locally held and sets out the procedures which must be followed to ensure that patients are correctly identified at all stages of their interaction with the Health Board. This updated policy applies to all of our staff in all locations including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.

This policy has been reviewed and updated in line with UHB governance arrangements.

The policy can be found in the **supporting documents**.

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

Cardiff and Vale University Health Board (UHB) are committed to ensuring that all patients are correctly identified using standardised personal information and will achieve this through the implementation of this policy.

This policy will provide a framework to enhance Patient Safety across the UHB, the policy aims to reduce incidents of misidentification that may cause harm to a patient.

The policy will:

- Provide instruction on the process of checking patient identity and when this should occur.
- Describe how to standardise wristbands
- Explain the responsibilities of staff when checking patient identification.

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

Patient misidentification has been recognised as a widespread problem within healthcare Organisations and has been recognised by the former National Patient Safety Agency (NPSA) as significant risk within the National Health Service (NHS).

The extent to which patient misidentification happens is thought to be widely underestimated by clinical staff, as very often they are unaware that a misidentification has occurred.

In July 2007 a “Safer Practice Notice” was issued by the former NPSA 1 that highlighted the risks of incorrect patient identification and required all NHS Organisations in England and Wales to standardise the design of patient wristbands (ID bands), the information on them and the processe used to produce and check them in order to improve patient safety. The UHB is now compliant wi this notice and has introduced electronic printing of identity bands across the UHB.

Recommendation:

The QSE Committee is asked to APPROVE the updated version of this policy which has been shared for consultation.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	Y	Long term		Integration		Collaboration	Y	Involvement	

Equality and Health Impact Assessment Completed:	Yes (attached) *If “yes” please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Patient Falls Policy**							
Meeting:	Quality, Safety and Experience Committee					**Meeting Date:**	14/12/2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	
Lead Executive:	**Executive Medical Director**							
Report Author (Title):	**Falls Delivery Group**							

Background and current situation:

The Falls Policy has undergone a small correction to the post falls section and flow chart to specify that neurological observations must be undertaken by a registrant. This amendment has been drafted to reflect a request from the Coroner.

The policy can be found in the **supporting documents**.

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

This is an existing policy and procedure that required a small amendment to reflect a Coroner's request.

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

The amended policy has been reviewed and approved by the Falls Delivery Group.

Recommendation:

The Committee is asked to:

- **Approve** publication of the revised Policy.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care	√

				sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	√	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	√

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	**Yes** *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

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

MINUTES
CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 28th September 2021, 8.30am via Microsoft Teams

PRELIMINARIES		**Lead**
1.1	**Welcome & Introductions** Andy Jones (AJones) (Chair), Director of Nursing Angela Jones (AJ), Senior Nurse Resuscitation Service Abigail Holmes (AH), Deputy Head of Midwifery, Obstetrics & Gynaecology Directorate Sarah Davies (SD), Governance Midwife Obstetrics & Gynaecology Directorate Rachael Sykes (RS), Health & Safety Advisor Ashleigh Trowill (AT), Assistant Service Manager, Children Young People & Family Health Services (CYPFHS) Directorate Martin Edwards (ME), Assistant Clinical Director, Children's Hospital for Wales (CHFW) Services Directorate Natalie Vanderlinden (NV), Designated Education Lead Officer (DECLO) Paula Davies (PD), Lead Nurse Children Young People & Family Health Services (CYPFHS) Directorate Emma Radford (ER), Interim Cancer Services Lead Manager Rhodri John (RJ), Directorate Manager, Obstetrics & Gynaecology Directorate Suzanne Hardacre (SH), Head of Midwifery Obstetrics & Gynaecology Directorate Karenza Moulton (KM), Lead Nurse, Children's Hospital for Wales (CHFW) Services Directorate **In Attendance** Kirsty Hook (KH), Risk Governance & Patient Experience Facilitator Rafal Baraz (RB), Consultant Anaesthetist/Clinical Lead for Clinical Governance (Patient Story Presentation)	
1.2	**Apologies for absence** Clare Rowntree, Matt McCarthy, Becci Ingram, Anthony Lewis, Janice Aspinall	
1.4	**To note the Minutes of the previous Q&S meeting held on 03rd September 2021** The minutes of the meeting held on 03rd September 2021 were agreed to be an accurate record.	
1.5	**To note and update the action log of the meeting of 03rd September 2021** The action log was noted and updated provided against the actions. The ongoing actions were noted as; **Imms Delivery Risk Assessment** It was noted that the risk is changing daily and the risk is more focused around the electronic consent forms than staffing now. Update will be provided when complete. **POCT** Meeting arranged with Seetal Sal with regards to the options available and update will be provided at the next meeting. **Safeguarding Training** Deferred to next meeting. **Diabetes Peer Review**	**PD** **RJ**

	The response to the peer review and action plan is in progress. No further update for this meeting at present. **Maternity Lifts** Issues are ongoing until replacement can be completed. Continuing risks with the lifts being out of action regularly. There are a number of estates issues associated with volume and timeliness of getting jobs completed. It was agreed that these issues would be escalated following the meeting, to raise concerns and request update on necessary actions.	**AJones**
PRESENTATIONS		
8.30am	**COVID Patient Story** Rafal Baraz was welcomed to the group. The patient story shared involved an emergency CS in a rapidly deteriorating patient with COVID-19. The patient was admitted feeling generally unwell, however rapidly deteriorated over a period of 4days resulting in an MDT plan to undertake an emergency CS. A number of reflections were noted; • No problems with PPE availability • Team briefing was helpful but also difficult in getting everyone together quickly • Communication in theatre was extremely difficult due to FFP3 masks/echo • Language barrier was difficult as it was not felt language line was appropriate due to circumstance and environment in theatre • Inability to enter CT control room due to this being a COVID positive patient and therefore difficult to see the monitor • Delay transferring patient from CT scanner to ICU due to the need to contact security as the lift key could not be found Learning points have been identified following this case, including the need for x2 consultant anaesthetists being available, transfer grab bag with appropriate equipment to be available to allow a smoother transfer and ensuring that the transfer monitors should have x2 fully charged batteries, both of which have now been rectified. Patient made good recovery and was discharged home. It is understood that baby was also doing well. It was agreed that this is an excellent example of how well the MDT process works within the Labour Ward with Anaesthetics providing a very high standard of care and a positive outcome. Despite the challenges faced, this did not affect the standard of care provided to the patient. It was agreed that the presentation would be shared for information and onward learning.	**KH**
HEALTH & SAFETY		
2.1	**To note the latest Health & Safety Report** The report was shared for information. x1 SI reported for Paediatric Critical Care where a member of staff hurt her back whilst handling a bariatric patient and lost 4 days of work. There were no RIDDOR incidents reported for June-August 2021 to the HSE. **H&S Dashboard – September 2021** The latest dashboard has been received and it was agreed that this will be shared for information following the meeting. **Manual Handling Update – Sam Skelton – 8.45am** Deferred to a future meeting. Discussion ensued with regards to work being undertaken on Manual Handling and it was noted that bespoke training needs to be considered for maternity services, and it was agreed that SH would discuss with SS outside of the meeting.	

2.2	**Feedback from UHB Operational H&S Meeting** • Update provided on the H&S review undertaken. Fire Safety team are moving over to the Health & Safety Team. Robert Warren is the Fire Safety Manager for the UHB and Rachel Gidman is the Executive Lead for the UHB and Violence & Aggression. • H&S Management System being set up, and will be piloted before roll out. H&S Strategy and KPI's will be set going forward. • Monthly meetings will be held with Clinical Boards re: RIDDORS and updates will also need to be reported at the UHB Operational H&S Group meetings. • Reporting of staff COVID cases to HSE was discussed. Actions have been undertaken to ensure there are robust processes in place. It was noted that workplace exposure cases need to be reported as RIDDOR going forward. • Training for Manual Handling and V&A are now available on ESR for booking. Staff need to ensure that managers are aware of the training space as there is a DNA charge in place. For V&A Training, module A&B are available on E-learning, module C is face to face training as this is a practical course. Risk assessments should be undertaken for all areas, to ensure that the appropriate training is undertaken for staff. It was noted that a paediatric care control course is available, developed specifically for paediatric inpatients/CAMHS patients. All to review compliance on ESR and risk assess for staff so that updates can be taken forward to remove this. Manual Handling workplace competency assessor programme pilot has commenced, and will be rolled out once feedback is received on the pilot. Feedback to date has been positive, specifically with regards to support available. • PPE powered respirators and hoods, now need to be purchased by Clinical Boards. Any areas using these items, should keep a small stock due to lead in time following ordering. Vertaflows will replace Duraflows – the replacements are being trialled at present, and further information will be shared when available. All were asked to ensure that appropriate risk assessments for the powered hoods and respirators are completed and returned to Caroline Murch as soon as possible. Information has been shared previously however it was agreed the information would be shared again for completion. • Significant increase in referrals to Occupational Health with regards to long covid, shielding and pregnant staff and also an increase in stress at work referrals. If any areas have high levels of workplace stress, Occupational Health are happy to work with the departments and signpost to resources available. • Workplace inspections are starting to be recommenced. It was noted that the environmental COVID risk assessments are not in place in all areas and requests were made to review and ensure that all appropriate assessments undertaken and complete. It was noted that a corporate non-clinical risk assessment that has been undertaken for Woodland House which should cover non-clinical community services.	**ALL** **ALL** **AJONES**
2.3	**To note the latest COSSH Report** Noted for information. All were asked to review and ensure that all necessary updates are undertaken. It was suggested that there may be staff that are not currently undertaking a clinical role that could help in getting some of the outstanding risk assessments updated.	
2.4	**Fire Safety Update** Drop in training sessions are being undertaken across UHW and UHL and all were asked to encourage staff to attend where possible.	**ALL**
2.5	**Feedback from H&S Staff Side** No issues to note. All were asked to continue to send out messages to staff with regards to employee wellbeing and the support that is available to them. It was acknowledged that these are significantly unprecedented times at the moment, however work continues with regards to new starters and workforce plans are in place to support.	

2.6	**Update on Workplace Inspections** Covered as part of item 2.2. All were asked to look to get the workplace inspections in place as soon as possible. It was noted that some areas are undertaking workplace inspections already and areas encouraged to get these booked in where possible.	**ALL**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
3.1	Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues, Long waiting patients update) **O&G Directorate** Report was noted for information. • Cancer reported x5 breaches for August, x5 for September and potentially x4 for October. The main reasons for these breaches is as a result of theatre capacity. Outpatients waits is circa 23weeks across all specialties. There are currently 1200 patients on the inpatients waiting list. Validation exercise is being undertaken for all inpatient lists, 23 patients have been removed from the list who no longer require surgery. Letters are also being provided to all patients providing an update on the current position and providing advice to patients. • Workforce pressures continue. Whilst Band 5 will be in place, they will need induction. Some band 6's due, however recruitment processes are slow. Assurance was provided that this has been escalated to Executive colleagues, WHSSC and other external partners with regards to the pressures being faced which is not unique to Cardiff & Vale at present and there is an acknowledgement of the challenges that are being faced and the risks being carried as a result of this. • Employee wellbeing resilience is poor at present. Some challenge received from the MSLC with regards to closures of MLU which is being managed at present. • Timeliness of repairs and a number of specific issues which are not being actioned appropriately. It was agreed that an update would be requested from Estates outside of the meeting, and if required a bespoke meeting will be arranged to discuss the way forward and appropriately manage and mitigate the risks. **CHFW Directorate** Report was noted for information. • Waiting list position is remains static. Lists have been lost due to anaesthetic cover and availability of theatres. Temperature controls within theatres is also an issue which has been raised with Estates and is impacting on lists. Staff restrictions is also impacting on lists due to the number of beds that can be staffed. Longest wait is 114weeks for Urology, Outpatients is 44weeks and General Paediatric waits 53weeks. • PICU Ceiling outcome is awaiting the final the report, and work is progressing towards a resolution. • New starters have commenced, which is a positive position. • Staff wellbeing and staff morale is low; however, support is being provided. • Activity has increased significantly across the CHFW, with attendances to CAU and ED specifically high at present. RSV attendance is also increasing. The majority are in community and not resulting in hospitalisation however there are higher admissions than are usually seen this time of year. **CYPFHS Directorate** Report was noted for information. • The Neurodevelopment waiting list continues to grow with 1076 patients waiting at the end of August. The longest wait for the service at the end of June was 125 weeks. The parallel assessment module has now been operationalised on PARIS which will allow a variety of health professionals to undertake initial assessments in a bid to manage the waiting list. Commencement of ND profiling tool pilot due in October 2021.	**KH**

	• CAMHS at the end of August 395 patients waiting for a choice assessment. Vacancy rate of 25% within the service which is impacting the ability to meet demand. • Waiting list for Primary Mental Health is starting to see a reduction, as a result of the ongoing waiting list initiative with Helios. Part 1 compliance being reported at 22% and progress continued to be made. As a result of the improvement in this compliance, this is however having an impact on the internal waiting lists within the service, meaning that the wait is longer and could mean a further assessment prior to being seen. An extra ordinary meeting to discuss the CAMHS service with regards to intervention and internal waiting list that this growing and the risks associated has been arranged. Agreed that there is a need for a longer-term plan for the service. • Continence team has 783 patients waiting with the longest wait at 111weeks. • There has been a significant increase in the demand for therapy services since the easing of lockdown restrictions earlier this year. The demand for OT has doubled from 93 patients waiting in April 21 to 278 patients waiting at the end of August 21. The service is now failing to meet its RTT target of 14 weeks and the longest wait at the end of August 21 was 20 weeks. Meeting has taken place with Early Help with regards to potential funding opportunities to help support this service. • Number of accommodation issues across a number of services, specifically with regards to no clinical space being available for psychologists at Woodlands House • Stress in the workforce is high and wellbeing support is being provided however acknowledging that this is a significant factor at present. **Cancer Services** • Staff shortages due to sickness is impacting on service. Support is being received from O&G to help support with MDT's etc.	
3.3	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **CHFW Services Directorate** Sweat Testing machine currently being used is not compliant with new guidance. Risk assessment has been completed and added to the risk register. This will be shared with the Clinical Board for information. KM agreed to follow up and submit. **CYPFHS Directorate** Electronic consent form for Imms Programme has experienced interface issues with CYPRIS, WIS and PARIS. Urgent meeting has been arranged to review this and look at potential resolution going forward. Risk assessment will be updated following this meeting and further feedback will be provided as this progresses.	**KM** **PD**
3.4	**Estates Update** • Delivery Suite • Antenatal Clinic • TDSI Access to NICU • MDT room – air conditioning unit is broken. This has been escalated however a solution is required asap. It was agreed that an update will be requested from Gareth Simpson outside of the meeting and feedback will be provided as soon as is received.	**KH**
SAFE CARE		
4.1	**Update on Serious Incidents** The report was shared for information. There are currently x5 open SI's within the Clinical Board and some are still awaiting an update and confirmation of Investigating officer. It was agreed that an update on progress would be requested outside of the meeting.	**KH**

4.2	**SI's/RCA's for discussion** **RCA NT (333701)** Baby who experienced seizures and was admitted to NNU. Baby had experienced a perinatal stroke, and continues to receive follow up. The root cause of the stroke remains undetermined and it was felt that whilst there was a slight delay in admission to NNU, it was felt that this would not have altered the outcome for the baby. Incidental learning was noted with regards to seizures of a baby born in low risk setting being very rare and also no risk factors were noted and therefore care provided was considered appropriate. Also, information provided on rupturing of membranes should be worded carefully to ensure full understanding of reasons to suggest this. Concern was also raised with regards to comments made by neonatology staff and how these conversations are interpreted. Presented historically to the extra ordinary meeting and it was noted that all actions undertaken were considered to be appropriate. This has been raised with Neonatology and information has been shared with staff with regards to appropriateness of conversations. Learning has been shared widely, and a plan is in place to use this case as a patient story to highlight importance of informed choice and communication and will be used through clinical supervision of midwives. The Clinical Board agreed that the RCA could be shared with the family.	
4.3	**SI's/RCA's/Closure Forms for noting** **Closure Form - In120800** Case relates to a 14yr old boy admitted to Hafan y Coed Adult Mental Health Unit. Significant challenging behavioural issues, the service was aware of his case, however there was no continuing care package in place at that time, hence the admission to Hafan y Coed. Social care services were looking to provide a bespoke provider to manage his care, however there were significant delays. Young person is still at home with a package of care in place whilst a longer-term package of care is awaited. It was recognised that efforts were made by Health to ensure a bespoke package of care; however, mum still feels that it was not an appropriate place for her son to be placed. There has been incidental learning from this case and work continues with Adult Mental Health to look at options for a designated area for children & young people for the future.	
4.4	**Infection Prevention Control Update** The report was shared for information. It was noted that a Clinical Board IPC Meeting is being set up in order to discuss and review lessons learnt through IPC RCAs undertaken. NICU has had a Staph Capitus outbreak which is being managed, 9 cases reported since February. Jungle has had a pseudomonas outbreak and meetings have been arranged to review this. Increase in COVID cases across Paediatrics and Gynaecology. RCA's from April 2021 which remain open, and all were asked to review and action as soon as possible.	**ALL**
4.5	**Safeguarding** • Violence against Women Domestic Abuse Training with Group 1 training available via e-learning	

	• Changes with Health IDVA with additional support is now in place. Noted that 1 in 6 victims are male, and there have been over 300 referrals reported since April 2021, 10% of these have been Cardiff & Vale staff. • Presentation from DOSH and a presentation on PRUDIC Process and some improvements are ongoing. It was agreed that the minutes of the meeting would be shared for information following the meeting.	**KH**
4.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • ISN 2021/Aug/021 Clexane Different Supplier • ISN 2021/Sept/022 Safe 2 Move • ISN 2021/Sept/023 EDTA European Tubes • ISN 2021/Sep/024 Sodium Citrate Tubes All patient safety alerts have been circulated widely across the Clinical Board. Requests were made for assurance of sharing and any appropriate actions to be received so that the compliance forms can be completed and submitted to patient safety.	**ALL**
4.7	**NICE Guidance** Work is progressing on ensuring that compliance forms are completed and returned to Clinical Audit in a timely manner. For such guidance that is not fully compliant, there is a need to ensure that discussions and reasons for non-implementation/compliance are clearly discussed and documented and risks/mitigations assessed and escalated accordingly.	**ALL to note**
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**Updated Versions of COVID-19 Algorithm & SBAR for Resuscitation** Noted for information. Update provided to reiterate that for all cardiac arrests, AGD PPE must be worn.	**ALL to note**
5.2	**HIW Maternity Services National Review – Phase Two and Follow up** Noted for information. Due to current operational pressures, this has been deferred to next year. Phase 2 is focused on Community and Post Natal process.	
5.3	**Paediatric Medicines Safety Update – August 2021** Noted for information.	
ANY OTHER BUSINESS		
6.1	**COVID Risk Assessment** Concern has been raised with regards to a formal process for this. Staffing has been significantly compromised across all areas of the Clinical Boards and further to discussions last week, any individuals isolating at home due to contact with a positive case, where the clinical risk was so great, a risk assessment would be undertaken to ascertain if the individual could come back (repeat PCR, daily lateral flow testing, individual at home and staff members were not symptomatic, PPE followed etc). Requests to be sent through to AJ for discussion and agreement with IPC prior to return. AJ agreed to follow up on UHB guidance and information being received to support this process and provide appropriate governance.	**AJONES**
6.2	**Faculty for Provision of Advanced Paediatric Resuscitation**	

	Concerns associated with faculty for provision of advanced resuscitation courses for Paediatrics. Requests for faculty has been sent out. Concerns were raised that courses may need to be cancelled if faculty cannot be found. A list of trained staff will be circulated for information, to review options to cover the training. Noted that unless the criteria are being met for instructors, they cannot provide training.	**AJ**
6.3	**Impact of Staffing Shortages on CTG Training and PROMPT Training** It was noted that due to current operational pressures being experienced, there is no ability to release staff to undertake the training at present, acknowledging that this is a priority as soon as the service is able.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 2nd November** (rearranged from 26 October 2021), **8.30am, Via Microsoft Teams**

2021 Meeting Dates

The meetings for 2021 will follow the same pattern as this year and take place on the **4th Tuesday of each month between 8.30 – 10.30am**. All meetings will be held via Microsoft Teams – links will be circulated.

23rd November
21st December

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

MINUTES

CHILDREN & WOMEN'S CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Tuesday 2nd November 2021, 8.30am via Microsoft Teams

PRELIMINARIES		Action
1.1	**Welcome & Introductions** Andy Jones (AJones), Interim Director of Nursing Clare Rowntree (CR), Clinical Board Director Suzanne Hardacre (SH), Head of Midwifery / Directorate Lead Nurse Obstetrics & Gynaecology Abigail Holmes (AH), Deputy Head of Midwifery, Obstetrics & Gynaecology Sarah Davies (SD), Governance Midwife Obstetrics & Gynaecology Debbie Jones (DJ), Patient Safety Facilitator Emma Davies (ED), Interim Risk & Governance Manager, Obstetrics & Gynaecology Matt McCarthy (MM), Patient Safety Facilitator Angela Jones (AJ), Senior Nurse Resuscitation Service Ashleigh Trowill (AT), Service Manager, Children Young People & Family Health Services Diana Wakefield (DW), Safeguarding Natalie Vanderlinden (NV), Designated Education Clinical Lead Officer (DECLO) Karenza Moulton KM), Lead Nurse, Children's Hospital for Wales Services Faye Mortlock (FM), Clinical Nurse Specialist, Infection Prevention & Control Louise Waughinton (LW), Associate Clinical Nurse Specialist, Infection Prevention & Control **In Attendance** Kirsty Hook (KH), Interim Risk Governance & Patient Experience Facilitator	
1.2	**Apologies for absence** Martin Edwards, Anthony Lewis, Kylie Hart, Annette Beasley	
1.3	**To approve the Minutes of the previous Q&S meeting held on 28th September 2021** The minutes of the meeting held on 28th September 2021 were agreed to be an accurate record.	
1.4	**To note and update the action log of the meeting of 28th September 2021** The action log was updated and actions closed by exception. The following actions remain open, with the latest update noted. **Imms Delivery Risk Assessment** Work is ongoing and this will be shared once finalised. **Diabetes Peer Review** Work is ongoing. Action plan has been completed and a risk assessment has been completed against this action plan. Copy of the action plan to be shared for noting. **Maternity Lifts** Escalated again with Estates and issues are ongoing. Concerns were raised that the new lifts are also breaking down regularly. It was agreed that incidents will continue to be datixed as issues continue.	**PD** **KM**

	Estates Issues Update requested following the last meeting. No further update received to date. Agreed this would be followed up again – to remain open on action log until update has been received. **Electronic Consent – CYPFHS** Work is ongoing. Some issues have been resolved. Meetings are ongoing to troubleshoot, however noted that generally the position is improving. E Consent has been a significant positive impact.	**KH**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
2.1	**Patient Story – Gynae Journey** The background to the patient story was provided of a patients gynae story and the impact her diagnosis of her cancer and the experiences she received had her, following the birth of her baby. It was noted that there were very positive and holistic care received and good practice, there was acknowledgement that some experiences were less compassionate and there is a need to ensure that all patients are individuals and should be treated through the distribution of values of behaviours. It was noted that this would be shared again following the meeting to have the very positive feedback also, acknowledging that this was shared at the time. It was noted that meetings have been undertaken with the patient and the values and behaviours issues have been addressed, and is being revisited again. It was agreed that an action plan would be completed on the issues that were raised to show that these have been addressed. Discussion ensued with regards to the specific reference to "night staff" and it was noted that this is being reviewed to look at rotation of staff to ensure training needs are met and addressed. This challenge was acknowledged within other areas also.	
2.2	**Health and Care Standards – key areas from Directorate QSE Reports (including any Exception reports and required escalation of key QSE issues & Business Continuity Update)** **Obstetrics & Gynaecology** • Campaign for uptake of COVID vaccinations for pregnant women is ongoing which is having a positive effect. • Flu Friday's have commenced for staff. • Infographic on Aspirin for Women has been produced in response to recent findings from the perinatal mortality review meeting. • BFI Assessment due to take place in March 2022 and there is a drive to ensure staff are up to date to meet the requirements. • Funding has been secured to continue psychological support sessions for all staff which will continue until March2022 Flu Fridays have commenced and numbers are increasing • MBRRACE Perinatal report 2021 was launched on October 13th. Highlighted issues around ethnicity, deprivation and maternal age. C and V noted to have the lowest stillbirth rate in Wales. Neonatal death rate similar to other comparable units with regard level of care and population. • Number of RCA's ongoing – 9 Obstetric cases (x3 SI's), 3 Gynaecology cases, 7 timelines and 5 Birth Injury Tools being completed. Ongoing risks noted with regards to delays in completion of RCA's which is continually being reviewed and confirmed protected time for Obstetricians has been agreed which will commence from April 2022. • Ongoing issue regarding maternity lifts continue to be escalated • Closure of MLU • 128 Red Flag DATIX current reporting not representative of issue: DATIX not always completed for Red Flag event. community staff are supporting inpatient staff and this position is improving due to increase in staff.	

- X2 reported falls in September. All actions have been completed and it was noted that there was no significant harm caused to patients.
- 100% compliant with social birth plans. Referrals received from Cardiff Social Services has doubled since last year, and also children being added to the safeguarding register have increased significantly.
- Welsh Government funded Adult Counsellor position within SARC still not filled but despite this and the fact that referrals remain high; still managing to contact within time frame at the moment. There has been an increase in child and adult referrals with mental health issues. Face to face appointments have resumed for children but at limited capacity. Out of hours service intermittent due to staffing. New police sexual offence team in place which will improve links with SARC.
- Marked focus on CTG training for staff. Increased number of sessions planned to ensure compliance. Recording of compliance highlighted at Maternity and Neonatal Performance Board. System being developed to improve registration of CTG training undertaken and to alert staff that training needs to happen.
- PROMPT training: on-going discussion with National PROMPT team with regard implementing training at local level.
- Induction of labour rates increased within September. This has been reviewed and a pathway for induction has been produced to ensure that cases are appropriate. Audit will be undertaken to review the impact of the actions taken, and it was noted that this pathway has already seen a positive effect.
- Self referrals booking time has been embedded in practice. This has had a very positive impact and it was agreed that this would be shared as part of good practice across the Clinical Board.
- Sickness pathway being developed to streamline sickness notification to operational leads.
- There have been a number staff shortlisted for awards recently across the Directorate. Well done to all staff who have won or been shortlisted for awards.
- RCM Awards: 27.10.2021
    - C and V RCM branch awarded Slimming Worlds Caring for you during a Global Pandemic award (Caring for you – Supporting Staff Through Engagement, Positivity and Kindness)
    - Bereavement team shortlisted for Excellence in bereavement care award.
    - RCM Branch shortlisted for Members Champion award
- RCN Wales Awards: 10.11.2021
    - Abi Holmes: Finalist for CNO Nurse of the Year.
    - Kath Fischer-Jenkins: Finalist for Children and Midwifery Award
- Regional Safeguarding Awards: 19.11.2021
    - Shortlisted - Elan Team: Exceptional commitment to practice demonstrated during COVID restrictions

CHFW

- PICU Ceiling issues continue. Discussions are ongoing with regards to options for repair and the balance of risk of closing x3 beds and plans are being completed to ensure maintaining capacity and utilisation of beds.
- TB clinics support has been requested and evening and weekend clinics have been provided, along with bloods support which has been a very significant and positive piece of work completed by the outpatient team.
- Significant staffing pressures at present, and newly qualified staff become non-supernumerary within the next two weeks which will be a positive way forward.
- RSV surge is starting to be seen, acknowledging that the majority of cases are within the community however those being admitted are very sick, with several patients on high flow.

	• X1 open NRI which is progressing and x2 meetings have been arranged this week for consideration of potential NRI cases within PICU, and support being provided to x1 NRI being undertaken by PCIC. **CYPFHS** • Care group structures and processes are progressing and work is ongoing to support • Complexity of cases within Emotional Mental Health is ongoing • School based Fluenz programme continues, however mop up sessions are being considered as part of the MVC's • E Consent process continues and the operational model within PCIC is being followed however it was noted that a more sustainable model needs to be reviewed going forward • Safeguarding stats have doubled compared to last year which is having a significant impact • Healthy Child Wales Programme – problems are being experienced due to sickness within the staff and the full programme is not being delivered but is being monitored and prioritisation is being undertaken where necessary. An SBAR will be provided for the next meeting • Network rota for CAMHS risk assessment is being considered following a shift on call system. This process is being managed by Cwm Taf Health Board and discussions continue with Cwm Taf, Aneurin Bevan Health Boards and the Network and challenges continue to be monitored. • RCA DC presentation now finished and needs to be presented at the next Extra Ordinary Meeting for discussion and sign off by the Clinical Board. • SL Inquest process continues with CAMHS. • Issues with regards to BLS training and bag and mask processes being experienced within the community and it was agreed that further discussions would be undertaken outside of the meeting. Plan is in place but needs to be reviewed. • Safeguarding T&F has been developed to review a standard of practice that is achievable going forward. • CHAPS Service pressures with regards to provision of care for asylum seekers, along with an increase in LAC referrals of children that have been taken into care post pandemic which is impacting on services. • Recruitment and workforce development continue • Meetings are ongoing with Adult Mental Health to review options for 16-18yr olds who require Mental Health Assessment. It was acknowledged that amongst the challenges that are being experienced across all services, there is really positive work being undertaken by all staff and thanks were expressed to all.	
2.3	**Waiting Times Update (including Long Waiting Patients)** **O&G** **Cancer** The Directorate is still reporting breaches each month. Predominantly, the reasons for breaches are in the majority of cases, due to a reduction in theatre capacity and consultant availability. The Directorate has also received an increasing number of tertiary referrals. Additional sessions have been provided to the Directorate, however, the Consultant oncology team do not have the capacity to take on additional work. All internal processes have been reviewed including vetting, improving first outpatient appointment times and has a rigorous internal governance process to ensure that all cancer cases are managed within the requirements of the single cancer pathway. There have also seen improvements in diagnostic (Pathology and Radiology) turnaround times and good relationships exist with these departments and the Directorate. The Directorate is writing an SBAR for Clinical Board discussion, with a view to seeking investment within the oncology service.	

Outpatients

- Currently there are 1400 patients on the waiting list without an appointment, with circa 500 patients with appointments between now and December. The average weeks wait for an appointment across the specialties, is 24 weeks. Some specialties have a high waiting list and the directorate is actively looking to reduce these waiting times.
- There is currently a validation exercise being undertaken in respect of the OP waiting list. 600 patients have been written to, asking whether they still wish to remain on the remaining list

Inpatients

- The Directorate continues to have a reduced theatre allocation compared to pre-covid. Concerns from patients are increasing and there is concern amongst consultants that patients (level 3 / 4) are still not being treated.
- Alternative approaches to inpatient stays are being considered, including an alternative for the treatment of fibroids by real time ultrasound and radiofrequency ablation. This procedure is an alternative to uterine artery embolisation or hysterectomy, which requires an inpatient procedure. A business case is being written for health board approval.
- Insourcing: The Directorate has completed a procurement exercise with other specialties across the health board for 'insourcing', to address the IP waiting list. The tender has not yet been awarded and the confirmed number of patients to be treated via 'insourcing' has not yet been confirmed. Further updates will be provided on this as it progresses.
- An exercise is being undertaken in respect of upgrading all priority level 3 patients who have waited longer than 3 months for their procedure to level 2
- The Directorate is attending the weekly theatre scheduling meeting with a view to bid on any cancelled theatre lists from other Directorates

Primary Care

Dr Mari McDonald has been appointed to the GP interface role between gynaecology and primary care. The role will include developing better understanding between primary and secondary care, to improve pathways and closer working relationship to benefit the patient experience and patient outcomes, whilst continuing to promote multidisciplinary working to improve patient pathways. Mari will be working with us one day a week and where possible will attend any gynaecology / consultant team meetings.

In the meantime, consultants have been asked to get in touch with ideas / suggestions for improvement that they may have in respect of primary care and patient groups.

SARC

The ISVA (independent sexual violence advocate) service are currently holding a large caseload as an impact of Covid delaying court cases, and also continued referrals into the service. Additional recruitment will be undertaken to try and reduce pressures on our ISVAs, especially given their work holds a high risk of burn out and vicarious trauma.

CHFW

Position has worsened primarily due to cancellations with Anaesthetics in Theatres which is out of the control of the Clinical Board. The longest wait for Paediatric Surgery is currently at 117weeks.

Waiting lists are increasing at present as on average there are only 8 cases completed per week being completed compared to the usual 15 cases, and this is as a result of cancellation due to lack of nursing staff, as well anaesthetist and theatre time. Work continues to improve this position, and with the newly qualified staff now on board, the cancellations due to lack of beds should reduce significantly.

CYPFHS

	• Neurodevelopment service pressures continue. 1124 patients waiting, with the longest wait at 129 weeks. Weekly monitoring is being undertaken and parallel assessments is continuing to help with activity. New service manager has commenced in post, and work is underway to appoint a clinical lead for the service. • Primary Mental Health (PMH) remains on weekly monitoring, increase in referrals has been received in October. This is being supported by Helios. Soft launch of Single Point of Access has commenced. • CAMHS – 427 waiting a choice assessment which has significantly increased to more than double since the end of March 2021. Recruitment drive continues to reduce the waiting list in time • Continence waiting list continues to grow. At end of September there were 784 patients waiting with the longest wait 117 weeks. • Therapies activity has increased across OT, Physio and SLT – 643 patients waiting across all services. Longest wait for OT at 22 weeks, but SL&T is also breaching the 14 week RTT with the longest wait reported at 15 weeks.	
2.4	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** **Clinical Board Level Scrutiny of Risk Registers** Risks scored 15> for the Clinical Board have been submitted to Corporate Risk for consideration and feedback. Work will continue with the Clinical Board and Directorates as part of Clinical Board risk assurance process, with any exceptions reported as necessary for discussion/action.	
SAFE CARE		
3.1	**Update on Serious Incidents** X4 open SI's which are ongoing and x1 new NRI reported regarding resuscitation issues within Theatres. X2 fact finding meetings are being held this week to review whether these incidents need to be reported to the Delivery Unit and for necessary actions to be commenced in line with these discussions. Discussion ensued with regards to the cluster of incidents that took place within Maternity in August 2021 and one incident was reported to the Delivery Unit. It was noted that a further meeting is awaited to discuss progress on these cases with Executive Director of Nursing. It was agreed that this would be followed up. Once for Wales System – queries were raised with regards to a specific flag for ALN within the new system. DJ agreed to follow up with the Datix Team and feedback to NV. **POCT Update** No update available. KH agreed to follow up outside of the meeting.	**DJ** **KH**
3.2	**DATIX Open Incidents Report** The group were asked to ensure that all open incidents are being reviewed and necessary actions being undertaken to close where possible, in readiness for the new Datix system being implemented. It was noted that once the new system is online, any incidents from the current system will become read only and will need to be re-inputted onto the new system again. Thanks, were expressed to all for their ongoing work in ensuring that these incidents are actioned and ongoing reviews are being undertaken where required.	**ALL**
3.3	**SI's/RCA's/Closure Forms for discussion** None noted.	

3.4	**Infection Prevention Control Update Report** LW will be covering the Clinical Board following the departure of FB whilst a permanent appointment is being made. Thanks, were expressed to FB for all her support across the Clinical Board and wish her well for her new venture, and welcome to LW for her support in the interim. Staph Capitus follow up meeting within NICU is awaited, but it is hoped that this will be a closure meeting as there has only been x1 further case reported in September and x1 imported from Swansea Bay so this is no longer an outbreak so can be closed. CAU Audit was undertaken with 100% compliance across all areas of care. First Floor Maternity audits awaited, a walkabout has been arranged with IP&C and Estates as there remains a few issues at present.	
3.5	**Safeguarding** **Safeguarding Training Update** Training timetable has been circulated. There was a specific push for attendance at the training and sessions are being provided via Microsoft Teams at present. **Update on recent PRUDIC Cases** There were no specific actions for Clinical Board on the recent PRUDIC Cases reported. With regards to the case involving the Cot Death – specific updates should be included within PARIS system and ensuring that family details are taken following admission. Updates have been undertaken for the MARFS within the CHFW to reiterate the required information and facilitate submission of MARFS more easily. Audit of these changes will be undertaken to review the impact.	
3.6	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • PSN055 Safe Storage of Medicines • ISN 2021/Sep/025 Hydrogen Peroxide • PSN060 Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route • ISN 2021/Sep/026 Human Albumin • PSN062 Elimination of bottles of liquefied phenol 80% • ISN 2021/Oct/027 Checking Resuscitation Equipment – Incident on ?? and it was suggested that the purchase of a defib for NICU should now be considered and it was noted that there are no specific issues within the Clinical Board in relation to checking of resus trollies. • WHC/2021/023 – Care Decisions for the last days of life All patient safety alerts have been shared widely across the Clinical Board for information and any appropriate action. All PSA's require completion of a compliance form and there have been no specific exceptions reported. The group were asked to send through completed compliance forms outlining actions taken in order for a Clinical Board response to be submitted to patient safety.	**ALL**
3.7	**Updated Guidance for Line Managers to Risk Assess staff to attend the workplace if identified as a close contact of a COVID-19 positive case** Guidance shared for information, and outlines the process required prior to consideration of the staff member returning to work. Considerations to be given to what areas the staff member should return to.	

	Concerns were raised with regards to issues of undertaking a PCR test for asymptomatic patients, and it was agreed that this should be shared with Public Health Wales as this is significantly impacting on services. AJ agreed to follow up outside of the meeting.	**AJones**
INDIVIDUAL CARE		
4.1	**Update from Learning Disability Liaison Team** Noted for information and onward sharing.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
5.1	**September Falls Review Panel Learning Infographic** Noted for information and onward sharing.	
5.2	**CNO/DCMO Letter - Vaccinating Pregnant Women Campaign Launch** Noted for information and onward sharing. Discussed as part of item 2.2	
5.3	**Medicines Safety Newsletter – September 2021** Noted for information and onward sharing. Noted that of specific note, there are now x2 types of Clexane available within the Health Board and ensuring that all are aware of the changes.	
5.4	**NBS performance reports August 2021** Noted for information and onward sharing.	
ANY OTHER BUSINESS		
	None noted.	

DATE AND TIME OF NEXT MEETING

The next meeting is scheduled for **Tuesday 23rd November 2021, 8.30am, Via Microsoft Teams**

Further 2021 Meeting Dates
21st December, 8.30am, Microsoft Teams

2022 Meeting Dates
The meetings for 2022 will follow the same pattern as this year and will take place on the **4th Tuesday of each month (unless otherwise stated below) between 8.30 – 10.30am unless otherwise stated**. All meetings will be held via Microsoft Teams – links will be circulated.

Tuesday 25th January (H&S Focus)
Tuesday 22nd February
Tuesday 22nd March
Tuesday 26th April (H&S Focus)
Tuesday 24th May
Tuesday 28th June
Tuesday 26th July (H&S Focus)
Tuesday 23rd August
Tuesday 27th September
Tuesday 25th October (H&S Focus)
Tuesday 22nd November
Tuesday 20th December

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 16 July 2021
Teams Meeting
MINUTES

In Attendance:

Claire Main (CMain), Interim Director of Nursing, Specialist Services Board
Catherine Wood, (CW) Interim Director of Operations, Specialist Services Board
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Tracy Johnson (TJ), Patient Safety
Sharon Daniels (SD), Directorate Support Manager, Nephrology & Transplant
Alannah Foote (AF), Directorate Support Manager, Nephrology & Transplant
Claire Mahoney (CM), CNS Infection Prevention & Control
Angela Jones (AJ), Senior Nurse, Resuscitation
Aled Lewis (AL), Consultant Nephrologist
Suzie Cheesman (SC), QSE Facilitator
Emma Swales (ES), Senior Nurse, Nephrology and Transplant
Gareth Jenkins (GJ), Service Manager, Haematology
Jennifer Proctor (JP), Lead Nurse, Haematology, Immunology
Sarah Lloyd (SL), Interim General Manager for Critical Care and MTC
Ben Jones (BJ), Consultant, ICU
Sarah Doherty (SD), Clinical Nurse Specialist, Haematology & Immunology
Lisa Higginson (LH), (Interim) Lead Nurse, N&T
Colin Gibson (CG), Consultant Clinical Scientist, ALAS
Joanne Clements (JC), Lead Nurse, Critical Care
Tessa Northmore (TN), Senior Nurse, Neurosciences
Lisa Davies (LD), Directorate Manager, Nephrology & Transplant
Fiona Kear (FK), Assistant Service Manager, Haematology & Immunology
Rachel Barry (RB), Lead Nurse, Neurosciences
Mathew Price (MP), Interim Directorate Manager, Neurosciences
Lorraine Donovan (LD), Senior Nurse, Neurosciences

Present:

Malissa Pieri, Lead Nurse, Epilepsy Service
Michelle Esposito, Epilepsy Surgery Nurse Specialist

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting.	
1.2	Apologies for absence Received from Hywel Roberts, Carol Evans, Guy Blackshaw, Jane Morris	
1.3	To review the Minutes of the previous meeting 25 June 2021 Amendment on page 2 point 2.1 should read "… it is anticipated that 2 of these will be closed this month." With this amendment the minutes were agreed as an accurate record. Saunders,Nathan 12/09/2021 15:57:39	

ACTION	Matters Arising • 2.4 CMain asked if all had confirmed their IP&C leads, if not could they please send this information through. • 3.2 Mortality Reviews, CB has sent out further information on the mortality review processes. • 3.3 CMain asked if there was any further update on the issues of providing medicine at Rookwood, RB replied LD will update in due course.	Directorates
1.4	Patient Story CMain welcomed Malissa Pierri, Lead CNS for Epilepsy Service. Malissa gave a presentation on the story of Patient Karen and the current situation within the Epilepsy Service. CMain thanked Malissa for presenting this sad story from a service where amazing work is undertaken and asked if anyone from the Neurosciences would like to add to this. RB added that the Directorate had considered this case as an SI and have tried all routes to re-open the Telemetry Service, she gave some background information into why the service had been closed and is as yet unopened. The situation remains an issue with no immediate sign of resolution. MP added that there are a number of patients in the same potential dilemma that Malissa has identified and he reported that there has been an increase in patients contacting the Department raising concerns, these patients were very understanding of the delays due to the Covid pandemic but now they are requiring access to those beds. SC asked if there was anywhere else the patients could be accommodated other than C4? CMain replied that although not in a wave of Covid as previously, the Covid impact is still very much present and affecting all of our Services. Covid itself isn't driving the hospital admissions in the same way however, the knock-on effect of having our services altered over the last 18 months has driven the amount of activity we have on site and how we manage our patient flow, the way the wards are laid out and how we disseminate staff, all of this is having a much longer term effect than Covid itself and we need to bear this in mind, we can't just go back to business as usual as we would have like to have done once each wave has passed. There are a number of elements in terms of in getting the Telemetry beds back on C4, some of the equipment is highly specialised and situated in a specific position on C4, it is not practicable to move the equipment. There have been lots of discussions around gaining access to the beds but there are competing needs and everyone is working through these. Ways of reducing surge capacity and different layouts of units need to be looked at and particularly over the last few weeks, we have seen a real peak in activity, back to higher than Winter Pressures, in terms of numbers of patients accessing emergency services, all of this has had to come into consideration. We are looking through all the options and getting closer to resolution but it remains an on-going challenge. Claire added that part of the reason for inviting the Team to present today was to showcase the highly specialised work being undertaken and to highlight the significant risks that this and many other services are carrying in terms of being unable to start activity that would have run pre-Covid. Malissa added that the Telemetry beds are not just about surgical cases, over the past 18 months lots of patients have been getting increasingly anxious and that the presentations of conditions such as dissociated	

ACTION ACTION	seizures rise massively with lots of patients visiting Accident and Emergency and we cannot exclude those as seizures, this is having ramifications for areas such as Intensive Care where patients are intubated and ventilated as a result of not having telemetry where we can confirm that these are dissociated seizures and therefore step down the care. CW asked if there was any data in terms of those patients who would have gone to the telemetry beds as a diagnostic but as a result of these beds not being available have had to go to Critical Care and be intubated instead? MP said that she didn't have this to hand but that she was sure that she would be able to get this to CW. MP and CW to talk outside of this meeting. SC asked if the patient concerns were being logged formally through the Concerns Department. MP replied that they are just phoning the Department but added that all calls are being logged and all this information is easily accessible. CMain asked if this information could be passed onto the Concerns Team in order to keep a track of what's happening alongside the formal concerns. She added that although we are all very good at identifying and holding our own risks we are not so good at sharing that information more widely and it would be good to pull this information together so that is very clear from an organisational perspective the wider impact of the changes to our services.	**CW/MP** **MP**
2.1 ACTION	Open Serious Incidents TJ updated the group. There are currently 5 open SI's all coming to end stages, it is anticipated that 2 of these will be closed this month. There is one query potential SI's which the TJ needs to discuss with Tara, a gentleman from A4N. JP is going to chase the clinical team today to give their opinion on the MRI see what their conclusion was on the head injury and hope to pass this information on today. CMain thanked all in the team for timely actions with these cases. Open Inquests SC updated the group that the date for the inquest on LP, Inquest ID 3754 will be held on 3 August 2021 and they are meeting with counsel and witnesses on 21 July to prepare. The improvement plan needs to be signed off. CMain informed that RP has been chasing this, as there is no-one from Cardiac at today's meeting this will be followed up outside of the meeting.	**CMain**
2.2	Alerts/Patient Safety Notices The following notices have been disseminated to the Group, nothing further to discuss. • Internal Safety Notice Ref 2021/Jun/013 New PCA Giving Sets • Patient Safety Notice PSN056/October 2020 Foreign body aspiration during intubation, advance airway management or ventilation	

	• Patient Safety Notice PSN058/July2021 Urgent assessment / treatment following ingestion of “super strong” magnets • Internal Safety Notice Ref 2021/Jul/017 Change to Operation of Fresenius Volumetric Pumps	
2.3	Closure Forms There were no closure forms to report on this meeting	
2.4	Healthcare Associated Infections • Specialist IP&C Report July 21 CM referred to the attached report which gives details of the current situation and wanted to highlight that in relation to WG expectations the current situation is on a par with last year except for Klebsiella bacteraemia which is up 100% CM reported that since the last QS&E meeting there have been two new positives on West 10 and 2 new positives on West 8 and the planned two-weekly meetings are now taking place weekly, the last of those meetings was held on 13 July where the decision was made to close the wards to new admissions. CM advised that there have been lots of issues related to the new build which are all being looked at with a view to being rectified as soon as possible. RB added that all are incredibly disappointed at the closure of the unit as all had hoped that the issues would have been resolved on the move from Rookwood. RB said that there are a lot of actions underway and that this is being reported as an SI, SC said that this was being considered as an early warning notification. RB confirmed that they had notified and involved WHSCC in the last outbreak meeting and would continue to do so. LD thanked the IP&C Team for their support, the presence of Vince on the ward has been extremely helpful in getting the staff and patients to gain an understanding of the situation. CMain asked if there were particular areas affected by Klebsiella, CM replied that there was one particular area which may have had more infections but it was across the board, she added that in general there has been an increase in Klebsiella bacteraemia and that potentially this could be linked to Covid.	
3.1	Feedback from UHB QSE Committee SC reported that the draft papers from the QSE Committee meeting held 15 June 2021 were attached for information and there were no issues to highlight	
3.2	Mortality Review CMain reported that CB had sent out a summary of the position to date and how the process is changing. This will be discussed when the team are next present at this meeting.	

	There have been a few level 2 mortality requests coming through from UHL for the Cardiology patients, we will check on the impact of this in due course.	
3.3	Exception reports and escalation of key QSE issues from Directorate QSE groups Haematology GJ wanted to highlight an ongoing issue with the plumbing in the Teenage Cancer Unit, this has been going on for some time but recently the problem has been getting worse. The issue is being investigated by Gareth Simpson's team and GJ understands that they are meeting today to undertake a bigger piece of work. CMain asked that GJ update the group once the review has been undertaken. CM asked if she could be informed if similar instances occur so that she could also contact Estates and possibly get such matters expedited. Neurosciences RB said that other than the Telemetry and Rookwood issues already discussed there were no additional issues to report Nephrology and Transplant LD reported that a Peer Review for the Home Therapies Team was undertaken earlier in the week, LD will feedback once official reports have been received. Also, on 15 July an HDA inspection from a Transplant perspective took place, LD reported that this went really well. Critical Care BJ reported that there were no new issues to report, the on-going issues relate to staffing issues, infrastructure and IP&C, none of which have a quick solution. Major Trauma SL reported that there was nothing significant to report but would like to acknowledge that recently, due to risk issues around the site, the bed capacity of the poly trauma unit was being used increasingly and whilst this has not posed any risk they are keeping track on this in order to confidently report to the rest of the Network that it is not having an impact on the Major Trauma Pathway. Cardiac No-one present at today's meeting. Pharmacy Nothing to report. ALAC	

ACTION ACTION	No issues to report. CG informed the group that the Clinical Board Medical Devices Safety Officers are starting to meet regularly again and asked for anyone to let him know if there are any issues to raise on their behalf at this group. CG asked that Healthcare standard 2.9 be reintroduced onto the agenda for this meeting CMain asked if there were any other issues. SC reported that there has been an SI in CD&T relating to the practice of an ST1 in Radiology and some issues relating to ultrasound scan, the issue has been escalated and the referring clinicians have been asked to review the patients to see whether they need additional imaging. There are a few out standing for specialist services details of which have been sent to GB, it was hoped to have all information back in time for a meeting on Monday 19 July. CMain said that GB is on leave this week and asked if the details could be sent over to her to help resolve this. LD asked if she could have the details for the N&T patient to try and get some responses. JP asked for details of the Haematology patients to check up.	**CMain**
4.1	Medication Safety Executive Briefing for Healthcare Professionals. Issue 53 June 2021, 2nd edition For information only.	
4.2	Referrer Guidance for Radiology For information only.	
4.3	PHW Briefing RSV and parainfluenza (09.07.2021) For information only.	
4.4	Draft Safety Notices and Important Documents Management Procedure For information only.	
4.5	Safety Notice / Important document Compliance Form For information only.	
5.1 ACTION	<u>Any Urgent Business</u> RB informed the group that she has now taken the lead role for flu vaccinations for the Clinical Board, she reported that there are lots of discussions underway to look at the roll-out of this years' flu vaccination. RB will give regular updates. CMain added that flu will be added as a regular agenda item	
6.1	<u>Next Meeting</u> Friday 6 August 2021 8am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 6 August 2021
Teams Meeting
MINUTES

In Attendance: Ceri Phillips (CP), Lead Nurse Cardiac Services (CHAIR)
Catherine Wood, (CW) Interim Director of Operations, Specialist Services Board
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Claire Mahoney (CM), CNS Infection Prevention & Control
Ben Jones (BJ), Consultant, ICU
Sarah Doherty (SD), Clinical Nurse Specialist, Haematology & Immunology
Colin Gibson (CG), Consultant Clinical Scientist, ALAS
Joanne Clements (JC), Lead Nurse, Critical Care
Lisa Davies (LD), Directorate Manager, Nephrology & Transplant
Fiona Kear (FK), Assistant Service Manager, Haematology & Immunology
Rachel Barry (RB), Lead Nurse, Neurosciences
Lisa Simm (LS), Interim Directorate Manager, Neurosciences
Kevin Nicholls (KN), Service Manager, Cardiac Services
Laszlo Szabo, (LSz), Consultant in Transplant Surgery
Judith Burnett, (JB), Senior Nurse, Critical Care
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Jonathan Elias, (JE), Senior Nurse Critical Care
Daniel Jones, (DJ), Asst. General Manager for Critical Care & MTC
Joanne Bagshawe, (JBa), Senior Nurse, Haematology & Immunology
Keith Wilson, (KW), Consultant Haematologist

Present: Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CP welcomed all to the meeting.	
1.2	Apologies for absence Received from Hywel Roberts, Carol Evans, Guy Blackshaw, Chris Williams, Aled Lewis, Khalid Hammadi, Bryony Roberts, Anne-Marie Roberts, Jennifer Proctor, Ravi Nannapaneni, Lisa Higginson	
1.3	To review the Minutes of the previous meeting 16 July 2021 The minutes were agreed as an accurate record. Matters Arising • 1.4 CW confirmed that she had received the appropriate information from Malissa and has discussed this with the Service, however, due to the absence of the relevant medical staff, it would not be possible to open the Telemetry Service for the next couple of weeks but she had all necessary information to furnish the conversation when the timing was appropriate.	

PART 2: SAFE CARE		Action
2.1	RP informed the group that SC is on annual leave and that TJ has ended her secondment with the Patient Safety Team, he was unaware of who would be covering Specialist Services going forward, as no allocation has been made to date. <u>Open Serious Incidents</u> RP reported on the following SI's • IN108123 PJ - the investigation has been completed and shared with the individuals named in the report for their comments before being shared more widely. Three of the named individuals are from Aneurin Bevan Health Board, one of whom has responded, the IO, Lisa Evans, will be setting a deadline for the others to respond by in order to proceed to Action Plan. CP asked when this investigation would be shared with the Directorate, RP replied that this would be shared as soon as the named individuals confirm that they are happy with the accuracy of the report. KN asked if there was anything required from the Directorate, RP confirmed that nothing was needed. • IN136398 ME – advice from Patient Safety was that a full investigation was not necessary and that a robust time-line would suffice, however, there is also an obligation to respond to the family, RP has produced a timeline which has been completed and shared and ready to progress to Improvement Plan, there may be common elements between this case and the previous case. • IN137783 TL – the investigation is complete and will progress to Improvement Plan. CB reported that there was an additional SI to be aware of, it is a cross clinical board incident involving patient CJ. RP confirmed that he was aware of this case and said that within Datix the case sits within another clinical board but there is significant input from Critical Care. <u>Open Inquests</u> RP reported that there were no issues with the Inquests listed, with the exception of LP which will be discussed in the Closure Section.	
2.2	<u>Alerts/Patient Safety Notices</u> The following notices have been disseminated to the Group, • Welsh Health Circular – Policy on Single-Use and Re-useable Laryngoscopes CG will discuss this under Agenda point 2.5 • National Patient Safety Alert NATPSA/2021/006/NHSPS – Inappropriate anticoagulation of patients with a mechanical heart valve – nothing further to discuss CP reported that she has received information regarding a global shortage of the blood tubes used in Wales. It is estimated that within the Health Board there is currently 3 weeks of stock. Processes within the HB of setting up governance to manage this are being set up, with immediate action required. Today, a team will be visiting all clinical areas	

	to review stock within those areas and leave 1 weeks' supply of stock in each area, removing the remainder to form a central store, this will ensure that availability of the blood tubes is maximised while a contingency plan is drawn up. CP asked that all teams be informed of this situation and added that any further information will be cascaded.	
2.3 ACTION ACTION	<u>Closure Forms</u> • IN124739 – FS, it had been anticipated that Dr Melissa Rossiter and Dr Eniola Folaranmi would present this case. RP explained that due to the complex nature of this case, it should be presented by the 2 consultants. It was decided to invite them to the next meeting of this Group. • IN103961 – LP, RP gave details of the key components of this complex case and summarised the findings of the Coroner at the inquest held on 3 August 2021. A letter of response from the Health Board is being prepared and will be delivered by Tuesday 10 August 2021. CP asked for any questions. CB asked how information regarding this would be disseminated to Critical Care, RP replied that it was intended to share the Improvement Plan with Senior Nurses initially, he expected that CMain will be approaching staff within Critical Care. CP added that there had been a collaborative approach to the Investigation and Improvement Plan in terms of the Senior and Lead Nurses across the Directorate, and will discuss this with CMain on her return from leave, CP would anticipate that there will be a meeting with the key people from Critical Care, Cardio-thoracics and RP to go through the Improvement Plan. CG explained that when an incident report is input on Datix, if it is mentioned that it is medical device-related, Clinical Engineering will report it to the MHRA but only for those devices that they manage directly, if any other devices are involved, they are in a sense nobodies responsibility to report, which is a gap in the system that needs to be closed, CG will take this back to the MHU MDSO Group to look at resolving this issue.	CMain CP/CMain
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report August 21 CM referred to the attached report which gives details of the current situation. CM updated that with regard to the MDR Klebsiella outbreak situation on West 8 and West 10, weekly meetings are still being held, the wards remain closed. Since the last QS&E meeting there have been two new patients identified through screening, one on West 8 and one on West 10. It has been identified that there has been a period of increased incidence in relation to Staph Aureus bacteraemia on the Dialysis Unit as detailed in the report, a PII meeting has been arranged for next week to determine the reasons for this increase. There is currently one ward with a Covid outbreak, there was an index case on Heulwen who was completely asymptomatic and doubly vaccinated, detected on routine screening, resulting in six further patients testing positive as they were in a multi-bedded area. All contacts are being monitored. There has been one COVID positive case on B5, a non-compliant, unvaccinated patient who had been ambulatory on and off the ward, meeting family and friends, resulting in eight contacts on B5 North	

	which is currently closed to admission. In relation to Health Care Associated Infections most are on a par with the same period last year with the exception of Klebsiella bacteraemia currently at 114% more Klebsiella bacteraemia cases. RB added that the situation on West 8 and West 10 continues to be very difficult, a huge amount of work has gone into various actions which have been particularly in focus as the increase in cases coincided with the relocation of the Unit from Rookwood to UHL and different practices are being embedded both as a result of the outbreak and following the move to UHL. There has been a lot of support from the IP&C Team for which everyone involved is very grateful. Whilst the Unit remains closed there are additional issues in terms of not being able to admit to the Regional Service, the situation is being monitored closely and the Unit is linking in with the Clinical Board who in turn are linking in with WHSSC, there are a small number of patients who, if the Unit was not closed, would have transferred in for their rehab.	
2.5	<u>Health Care Standard 2.9 Medical Devices</u> CG informed the Group that the Clinical Board MDSO's have resumed regular meetings with the aim of providing a more effective link between the Clinical Boards and the CVUHB Medical Equipment Group and asked that all contact him if there were any issues anyone wanted to raise regarding medical devices, in particular in relation to capital bids. Terms of reference of this group were sent via email from CG. Two issues to mention briefly: • **WHC Policy on Single-use and Reusable Laryngoscopes (item 2.2 on the agenda)** - this is discussed at the Decontamination Group meeting on 04.06.21. Latest update from Mark Campbell 'The project to reach compliance to the WHC is underway. The project group have agreed the way forward is to implement C-MAC video laryngoscope into each area where intubation is occurring across the UHB. Compliance will be partially reached by the September deadline with hope fully the equipment and contract in place to complete phase 1 of the implementation which will be main theatres UHW. Phase 2 will be in approx. 4-6 months form go live and will be the SSSU and finally phase 3 will be Main theatres / Day case at UHL. For September a timeline of implementation will be presented to WAG and hopefully the phased approach will be agreed. Compliance comes as the C-MAC systems are process through an automated endoscope washer after each use'. • **<u>Clinical Engineering COVID 19 folder</u>** – this resource is hosted by the All Wales Healthcare Science Network SharePoint site and available to all NHS staff across Wales. An email providing an example of the content and how to access it is had been sent separately.	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	<u>Feedback from UHB QSE Committee</u> Nothing to report	
3.2	<u>Mortality Review</u> CB reported that she had sent an email after the meeting on 25 June to ensure that everyone was aware of the recent changes and hoped that	

	every Directorate now had an electronic copy of the new Stage 2 form. Completed forms should be emailed to the Patient Safety Team and RP. All outcomes of Stage 2 reviews and any actions sit with each CB. At the last Mortality Review Group meeting the different processes currently in place were discussed, Stuart Walker and Raj Krishnan (RK) were very keen to recognise that the individual departmental work is on-going and but both were very keen that everybody moves to the same system in order to monitor all outcomes more easily. All directorates across the hospital must be using the same Stage 2 forms and the same feedback systems into their relevant Clinical Boards with the aim that the person, to whom the feedback is reported, start to develop a process of extracting themes which can then be fed back to the Mortality Review Group. There is also a plan to look at formal target reviews, RK is planning to contact all relevant Q&S leads in due course. CB informed that it is intended that all deaths from September 2021 onwards would go through the Medical Examiner process with the exception of those patients being referred directly to the Coroner. Medical Examiners review of cases supersedes the Stage 1 mortality form but the Stage 1 process should be maintained in cases which have been referred to the Coroner. CB reminded the Group that the Welsh Clinical Portal Covid Surveillance Mortality form should be completed when completing bereavement paperwork, it is an important part of Public Health Wales' system for monitoring Covid in Wales, CB asked that, given the recent junior doctor changeover, this information be disseminated throughout the teams. CP asked that all shared this important information to their Teams	
ACTION	KW asked that a copy of the Stage 2 form be re-sent to him	**CB**
3.3	<u>Exception reports and escalation of key QSE issues from Directorate QSE groups</u> <u>Neurosciences</u> Nothing to report <u>Nephrology and Transplant</u> As the meeting had run overtime LD had left the meeting at this stage due to attending the Hub, CP will check whether there was anything to report. <u>Haematology</u> KW wanted to ensure that the repeated problem of waste material leaking into the offices in the Department was on the Risk Register. The most recent occurrence resulted in a ceiling coming down in the consultant's office. RP replied that if this problem is on the Haematology Risk Register and has a score of greater than 50 it will automatically be escalated to the Executive Board as a matter of course. CW added that the Clinical Board are aware of the situation and the long-standing history of the problem and that she has personally picked this up with the Executive Director for People and Culture as well as Estates because this is quite clearly an issue of both physical and psychological safety for the Team that has to be resolved. CW is confident that there will be some movement on this and will come back to KW directly.	
ACTION		CW

	Critical Care CB reported that there has been a leakage of "brown fluid" in A3N persistently over the blood gas machine which poses an electrical risk as well as everything else. Plasma Exchange - there is currently a patient waiting to come to UHW to undergo a Plasma Exchange but there is no-one available to undertake this, resulting in a 5-day delay in treatment for that patient. This is less of a problem for the condition this patient has but would be a problem if a ViTT or TTP patient was admitted this weekend. RB replied that this is a neurology patient and there is an issue with the availability of a neurology nurse this week, however, there is a shadow rota in place within Specialist Services for any emergency patients who may require plasma exchange, CB replied that when she looked at the rota there was no-one available this weekend, JC confirmed that the rota had recently been updated and that there is now cover for the weekend. CP asked that JB, RB and JC link in with herself outside of the meeting to ensure the rota is fully covered. CB added that Critical Care have a significant infrastructural problem at present in that the only amber cubicle unit cannot fit a bariatric bed through the door resulting in the loss of two bed spaces if there is a bariatric patient requiring isolation. CP will discuss this with CMain.	
ACTION		CP/CMain
	Major Trauma Nothing to report Cardiac CP reported that with Cardiology and CTS being split there are significant issues gaining access to cubicles, particularly over the last couple of weeks with difficulty in managing Covid positive patients alongside the pre-surgical patients along with other IP&C issues. The Clinical Board are aware of this and everyone is working hard to resolve the situation.	
ACTION		CP/CMain
	Pharmacy SG reported that the plan to reinvigorate the CAV Convention Clinical Working Group for Valproate, pregnancy prevention plans for people of child-bearing potential on Valproate was discussed at a recent Corporate Medicines Management Group meeting. The new lead for this Group is Helen Kemp a GP and newly appointed deputy Clinical Director in PCIC, the emphasis for this group looks to be Specialist Services specifically, Neurosciences. It is anticipated that there will be some disruption to supply of some heparin products, Pharmacy will provide further information.	
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	Feeds Memo For information only.	
4.2	Re-useable Respirators Guidance For information only.	

PART 5: ANY URGENT BUSINESS		
5.1 ACTION	Any Urgent Business RB reported that it is likely that there will be more information to come over the next few months. RB will be attending a planning meeting next week, it is almost certain that there will be a consideration of a Covid booster and flu vaccination being required for staff. RB will update at the next meeting of this Group. CP asked that flu be added as a standard agenda item under Part 2	CMain
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Friday 27 August 2021 8am via Teams	

Specialist Services Clinical Board
Quality, Safety & Experience Committee
Date and time: 8am, Friday 27 August 2021
Teams Meeting
MINUTES

In Attendance: Claire Main (CMain), Interim Director of Nursing, Specialist Services Board (CHAIR)
Ceri Phillips (CP), Lead Nurse Cardiac Services
Richard Parry (RP), Q&S Facilitator
Steve Gage (SG), Pharmacy Lead
Claire Mahoney (CM), CNS Infection Prevention & Control
Ben Jones (BJ), Consultant, ICU
Lisa Simm (LS), Interim Directorate Manager, Neurosciences
Kevin Nicholls (KN), Service Manager, Cardiac Services
Laszlo Szabo, (LSz), Consultant in Transplant Surgery
Judith Burnett, (JB), Senior Nurse, Critical Care
Caroline Burford, (CB), Consultant in Intensive Care Medicine
Jonathan Elias, (JE), Senior Nurse Critical Care
Joanne Bagshawe, (JBa), Senior Nurse, Haematology & Immunology
Keith Wilson, (KW), Consultant Haematologist
Emma Swales, (ES), Senior Nurse, Nephrology & Transplant
Lorraine Donovan, (LD), Senior Nurse, Neurosciences
Sharon Daniels, (SD), Directorate Support Manager, Nephrology & Transplant
Jane Morris, (JM), Senior Nurse, Patient at Risk Team
Beverley Oughton, (BO), Senior Nurse, Cardiac Services
Lisa Higginson, (LH) Interim Lead Nurse, Nephrology & Transplant
Ravi Nannapanneni, (RN), Consultant Neurosurgeon

Present: Dr Eniola Folarami, (EO)Consultant Paediatric Surgeon
Mandy McGee, PA Specialist Services

PART 1: PRELIMINARIES		Action
1.1	Welcome & Introductions CMain welcomed all to the meeting.	
1.2	Apologies for absence Received from Cath Wood, Tom Holmes, Colin Gibson, Rachel Barry, Fiona Kear, Angela Jones, Mathew Price, Nick Gidman, Raza Alikhan, Guy Blackshaw, Lisa Davies, Tom Hughes	
1.3	To review the Minutes of the previous meeting 6 August 2021 CMain thanked Ceri for chairing the last meeting. The minutes were agreed as an accurate record. Matters Arising • 2.3 CMain confirmed that meetings will be held with the relevant people to disseminate the learnings from the case IN103961 once all the teams are back in work after the summer holidays. • 3.3 Issues with the offices in Haematology, CMain informed the group that portacabin accommodation was in process but will get an update	CMain

ACTION	from Sarah Lloyd. • 3.3 Critical Care infrastructure CMain will discuss this outside of the meeting. CB clarified that the bariatric bed issue related to patients with VRE, the bariatric bed cannot physically fit through the doors of the isolation cubicle in the Non-Red area. • 3.3 Cardiac access to cubicles CMain confirmed that this was acknowledged as a request. • 5.1 Flu updates will be a regular agenda item, CMain informed the Group that there are flu vaccination sessions being rolled out in September and she will ensure that all are informed as early as possible.	CMain
PART 2: SAFE CARE		**Action**
2.1	<u>Open Serious Incidents</u> RP reported on the following SI's • IN103961 LP – this case was presented at the last meeting, the case is going through the closure process and there is nothing further to add. • IN146473 SB – there is an NRI meeting scheduled for this case today. RP reported that all other incidents are at the Improvement Plan stage and it is hoped to present on these cases at either the QS&E meeting scheduled for 17 September or the 18 October meeting. CB asked whether the responsible consultant, Dr Nick Stallard, knew of today's meeting to discuss patient SB. CMain replied that the meeting today is a falls management meeting rather than case management and that he would not be invited to this meeting but would be involved at a later stage. KW said that it would be difficult to draw any conclusions until it was determined whether the patient bled and fell or fell and bled, CMain explained no conclusions would be drawn at today's meeting, it is a factfinding meeting around the fall and processes in place. HP said that the only way to unravel the question of whether the bleed is primary or secondary would be to canvas opinions from the Neurosurgeons and Neuroradiologists on the pattern of the bleeding, a coroner would not be able to identify this but would take advice from the clinicians. CMain said that part of the falls meeting would be to set out these questions and to scope out the roles and responsibilities of the investigation. CB asked whether the case of patient CJ could be added to the list of SI's, as it was highly relevant to Critical Care even though the incident happened on a Surgical ward and technically sits within the Surgery CB. RP replied that the list is generated from Datix but it would be possible to add it as an incident of note and monitor it in this way. CMain added that she would link in with her surgical counterpart to ensure that Specialist Services are involved in the review of the RCA and any findings. <u>Open Inquests</u> RP reported that there were no issues with the Inquests listed.	
ACTION		CMain

2.2	Alerts/Patient Safety Notices The following notices have been disseminated to the Group. • July 2021 Learning from Falls Review Panel, CMain asked that everyone please ensure this is circulated within their teams • Principles for Safe Patient Placement v1 • Framework for Safe Patient Placement v8 CMain informed that these documents are for review at this stage, and asked everyone to look at these documents to ensure that they are aligned with this current guidance as there are a couple of areas which have adaptations or local arrangements in place specific to their clinical areas and patient needs. The documents are based on the learning gained over the last 12 to 18 months on hospital outbreaks. The aim is to try to put in place structures to ideally avoid outbreaks or alternatively show the risk and decision-making process when moving patients around	
ACTION	different clinical areas. A checklist will be with every patient which will assess the patients' Covid risk. The official launch will be in the next couple of weeks. Carla English will be invited to present this topic at the next meeting.	CMain
	SG asked about the blue category listed in the document as it seems to assume that there is long-term protection from re-infection and this is not necessarily the case. CMain replied that all patients will be clinically assessed and decisions will be made on this basis rather than time points. CMain asked that all review the document against their current practices and ideally move to the centralised document or acknowledge that it has been reviewed against other guidelines in place. • ISN Ref 2021/Aug/018 Histopathology Results	
ACTION	KW said that this document was welcomed but asked whether the red flag should be against the patient rather than the requesting clinician.HR agreed that this was a partial fix. CMain said that she would feed these comments back to the Patient Safety team.	CMain
	CB reported that this system is already in place at Cwm Taf, CMain said that she would follow this up. BJ said that he had discussed this at length with IT, however he could see potential problems in Critical Care for a variety of reasons including ➢ other Clinicians usually request the pathology tests before the patient arrives in Critical Care so these would need to be re-reported. ➢ there are 28 consultants in the department if the results are not shared between all then results may be missed ➢ There are approximately 500 blood tests are requested each day • ISN Ref2021/Aug/019 Risk of Neonatal Burns nothing further to discuss • ISN Ref 2021/Aug/020 Tympanic Thermometers Overheating nothing further to discuss	
2.3	Closure Forms CMain welcomed Dr Eniola Folaranmi (EF)to the meeting to talk through the details of a complex serious incident which took place within the Major	

	Trauma Service. • IN124739 – FS, Dr Folaranmi summarised the key components of this complex case which occurred within the Major Trauma Service and gave details of the outcomes. CM thanked EF and said that there was a lot of learning to be gained from this case and asked for any questions. HR commented that this was a really good piece of work with solid actions produced at the end, he asked whether this case was going to be presented to the Paediatric & Surgical and possibly Anaesthetics Teams, as all the issues raised were related to directorates that are not present at this meeting today. EF replied that feedback had been provided to the individual members involved in the management of this clinical incident but that it was as good suggestion to make a formal presentation to Paediatrics and Surgery and Anaesthetics and he would look into this. CMain thanked EF for his presentation.	
2.4	<u>Healthcare Associated Infections</u> • Specialist IP&C Report August 21 (2) CM referred to the attached report which gives details of the current situation. CM reported that West 8 and West 10 in UHL remain closed due to the MDR Klebsiella outbreak, as a new case has been detected on screening on West 10. There had been an increase in incidence of Staph Aureus bacteraemia cases related to the satellite dialysis units, a PII meeting has been held, there were no common themes identified, however since then an audit of one of the units revealed that none of the patients have been receiving their decolonisation skin wash in the community, this issue is going to be investigated in the other units as this could potentially be a cause for the increase in the SA bacteraemia cases. The Covid outbreak on B5 is on-going, there is currently a total of 8 patients and 1 member of staff affected, unfortunately 2 patients have died with Covid listed as part of the death certificate. There are 2 positive patients and 3 contacts on the ward. There have been several patients on B4 Haematology affected with HCA para-influenza outbreak. Several potential contributory factors have been identified and staff testing is being considered. In relation to Health Care Associated Infections most are on a par with the with last year there is a significant decrease in E coli bacteraemia, down 45% there is also a decrease in Pseudomonas bacteraemia. There is a significant increase in Klebsiella bacteraemia of 117%.	
2.5	<u>Health Care Standard 2.9 Medical Devices</u> <u>Nothing to report</u>	
PART 3: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		Action
3.1	<u>Feedback from UHB QSE Committee</u> Nothing to report	

3.2	Mortality Review Nothing to report	
3.3 ACTION ACTION ACTION	Exception reports and escalation of key QSE issues from Directorate QSE groups Critical Care HP reported that there have been 2 cases this week where patients have received unnecessary CT scans as a result of ophthalmology doctors dilating the eyes of patients without documenting it. Datix reports have been completed. This has happened in the past and was resolved by ophthalmologists recording the prescription of eye drops on the drug charts. HP asked if Pharmacy could inform Ophthalmology of the importance of prescribing the eye drops and entering them on the drug chart. SG agreed that he would take this up with his counterpart in the Surgical CB. CMain informed that RP had also discussed this with Claire Wade who is going to discuss this with the Ophthalmology team. Haematology KW showed the current situation in his office with fluid running down the walls into a variety of buckets, he explained that this current problem started last week and worsened over the weekend. There are now 5 workstations out of action with the affected staff working from home until further notice. This will have a direct effect on patient through-put which will decrease, he added that the Commissioners will need to be informed of this situation in keeping with the No Surprises policy, there could be financial penalties as well as the detrimental effect on the patients. CMain replied that a Portacabin has been ordered as a solution to the problem. KW informed that the current WG guidance on those members of staff who have been contacted via the "Covid App" is proving difficult to manage. Where the level of contact is "dubious" and the member of staff is doubly vaccinated, asymptomatic, with negative PCR and daily lateral flow tests, it is felt that the combined risk of lack of staff plus the impact of winter viruses would mean that Haematology Directorate would be unable to deliver the necessary clinical services unless able to deviate from the current guidance. CMain replied that she had escalated this matter on behalf of a number of Directorates involved in caring for clinically vulnerable patients. A meeting has been planned with Public Health this week to seek clarity on this guidance and CMain will check on the outcome of this meeting and will circulate to the Group. Neurosciences LD reported that despite the move from Rookwood Hospital taking place 3 months ago the pool is still not operational which is causing a great deal of distress and anger, she had been approached by a group of Spinal patients who had asked whether WG or the press know of the situation whereby they are unable to receive the most essential part of their therapy. LD has been in contact with the contractor and Estates department and it is hoped that Willmott and Dixon are coming to inspect. CMain and LD to discuss this further outside of the meeting. CB reported that there are an increasing number of patient families being invited to come into the hospital to discuss the patients' injuries and treatment and this has led to an expectation from the families of being able to visit the patient on Critical Care which is not permitted at present. CB asked that this information be passed onto Neurosciences colleagues	 SG CMain LD/CMain

ACTION	as there is a concern that these families will be raising complaints. CMain asked that JE and JB link in with LD and the team to inform them of the visiting processes in place at the moment. Nephrology and Transplant LH reported that N&T had a site visit from HTA this week and that there were no recommendations for changes to practice, once the official report has been received LH will share with CMain. Major Trauma Nothing to report Cardiac CP reported that the issues in gaining access to cubicles continues to cause problems, particularly at the moment with an increase in inter-hospital transfers to go to Cardiac Surgery, there are 2 patients on the ward currently who are unable to isolate due to lack of cubicles. CP added that workforce and staffing shortages are causing significant pressures. TAVI pathways have been affected due to lack of availability of staff. Pharmacy SG thanked all for their support during the change of computer systems and asked for their continued support and patience while everyone becomes accustomed to the new system. He asked if there were any plans to heparinise some blood sampling tubes due to the current shortage of blood tubes, CMain said that she was not aware of any planned change to practice. HR added that the green lithium heparin tubes do not seem to be affected by the shortage at present	JE/JB/LD LH
ACTION		
PART 4: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
4.1	• August dressings memo For information only.	
PART 5: ANY URGENT BUSINESS		
5.1	Any Urgent Business Nothing to report CMain thanked all for their hard work particularly over the past few weeks with challenges due to staffing issues, volume and acuity of patients coming through.	
PART 6: DATE OF NEXT MEETING		
6.1	Next Meeting Friday 17 September 2021 8am via Teams - **Cancelled** Friday 8 October 2021 8am via Teams	

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

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD
QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 28TH JULY 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Sandeep Hemmadi	Clinical Board Director
Kim Atkinson	Acting Head of OT
Gareth Jenkins	Service Manager, Medical Physics
Suzie Cheesman	Patient Safety Facilitator
Jonathan Davies	Health and Safety Adviser
Tracy Wooster	Sister, Outpatients
Nia Came	Head of Adult Speech and Language Therapy
Robert Bracchi	Medical Advisor to AWTTC
Jo Fleming	Quality and Safety Lead, Radiology
Bolette Jones	Head of Media Resources
Judyth Jenkins	Head of Dietetics
Jacqueline Sharp	Acting Head of Physiotherapy (for Emma Cooke)
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Paul Williams	Clinical Scientist, Medical Physics
Mathew King	ADOTH/Head of Podiatry
Sian Jones	Operational Service Manager
Seetal Sall	Point of Care Testing Manager
Nigel Roberts	Laboratory Service Manager, Biochemistry
Rhys Morris	CD&T R&D Lead

Apologies:

Matthew Temby	Clinical Board Director of Operations
Lesley Harris	Professional Head of Radiography UHL
Louise Long	Public Health Wales Microbiology
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Alun Roderick	Laboratory Service Manager, Haematology
Scott Gable	Laboratory Service Manager, Cellular Pathology
Tim Banner	Head of Patient Services, Pharmacy

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/220 Welcome and Introductions

Sue Bailey welcomed Gareth Jenkins, Medical Physics and Tracy Wooster, Sister in Outpatients Department to the meeting and introductions were made.

CDTQSE 21/221 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/222 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 9th June 2021 were **APPROVED.**

CDTQSE 21/223 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 21/134 Revision of Paediatric Metabolic Risk Assessment Score

Judyth Jenkins reported that an appointment is being made to the staffing establishment to fully deliver the service. When this appointment is in place the risk assessment will be changed.

CDTQSE 21/155 Opportunities for R&D in Point of Care Testing.

Seetal Sall and Rhys Morris have discussed potential projects and how to collaborate going forward.

CDTQSE 21/198 New Urine Collection System Packs

Nigel Roberts reported that a plan has been discussed with procurement for a transition process to be put in place to move from the universal containers to the new system packs. He noted that whilst there will be a transition phase, departments will only be able to order the new type of containers.

CDTQSE 21/199 Internal Safety Notice

Edward Chapman to produce an Internal Safety Notice highlighting the issues with contaminated equipment being sent to Clinical Engineering for repair and disposal.

Action: Edward Chapman

CDTQSE 21/202 Issues with Pigeons at CRI

Sian Jones is linking in with procurement to ensure payment is made for this work to progress. Sue Bailey has emailed Mathew King with an update on progress.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/224 Patient Story – Cellular Pathology

The patient story will be deferred to the next meeting.

CDTQSE 21/225 Feedback from UHB QSE Committee

The UHB QSE Committee minutes of the meeting held on 13th April were circulated.

It was noted that the number of Serious Incidents have reduced. Work is being undertaken on Never Events including a campaign.

The Development of Human Factors Training Strategy was discussed. This will be useful for services.

Data was presented around the Covid challenges.

CDTQSE 21/226 Health and Care Standards

Sue Bailey noted that the outcomes of this year's self-assessments are included in the Patient Safety Newsletter which will be circulated following the meeting.

Action: Helen Jenkins

The newsletter also contains a link to the safety culture survey results.

CDTQSE 21/227 Risk Register

There were no updates to report.

CDTQSE 21/228 Exception Reports

Sue Bailey has received a concern on the size of the printing font on addressograph labels which has resulted in the barcode not being able to be scanned. This issue has been escalated.

Dietetics have been working with Pharmacy on the new Wellsky Pharmacy system. The implementation date for nutritional products has been deferred to 23rd August.

Issues in CPU has required menu revisions and there are issues with supplies following the menu changes. The Dietetics Team are liaising with all relevant parties.

Seetal Sall reported that she had been in discussions with Pharmacy on the impact of the Wellsky system on the POCT service and has not yet received an implementation date. She was advised to contact Elaine Lewis for an update.

Mathew King sought advice on a contact for the Non-Medical Prescribers Group as some members of staff have recently qualified as non-medical prescribers. A statement also needs to be added as an addendum into their job descriptions. It was suggested that he contacts Timothy Banner and Louise Williams in Pharmacy and Donna Davies regarding the job descriptions.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/229 Initiatives to Promote Health and Wellbeing of Patients and Staff

A briefing was circulated from Public Health Wales on respiratory infections in children.

Maria Jones retires at the end of the week and Sue Bailey wished to formally thanked her for her leadership with the Clinical Board flu campaigns. Sue Bailey will attend the Flu Lead meetings going forward and the Clinical Board are seeking volunteers from registered staff to provide the flu vaccinations.

The Clinical Board is advertising for a Clinical Board Lead Nurse and the advertisement is currently open for applications.

SAFE CARE

CDT QSE 21/230 Concerns and Compliments Report

In June 2021, the Clinical Board is reporting a Red/Amber status for its performance against concerns management.

The Clinical Board received 32 concerns, 5 breaches in response times and 7 compliments. 15% of the formal concerns received were resolved informally. The departments reporting breaches in response times are Physiotherapy, Outpatients/Patient Administration, Radiology, and Laboratory Medicine.

Occupational Therapy is reporting a green status with 0 concerns and 2 compliments. Medical Illustration is also reporting a green status, receiving 0 concerns and 1 compliment.

The main themes identified form the formal concerns received this month relate to difficulties arranging appointments and waiting times.

There has been a drive from directorates in the last month to address outstanding concerns and there should be an improvement in performance reported at the next meeting.

CDTQSE 21/231 Ombudsman Reports

Nothing to report.

CDTQSE 21/232 RCA/Improvement Plans for Serious Complaints

Pressure Damage Management Investigation Chart Presentation

Suzie Cheesman reported that there are two processes for staff to follow when managing and investigating grade 3, 4 and unstageable pressure damage. One route via Patient Safety and the other via Safeguarding.

It was recognised that there was a need to develop a flow chart that included the safeguarding and patient safety requirements, to clarify the processes that staff need to follow. The flow chart is easy to follow and is available on the Patient Safety intranet page and within the patient safety newsletter.

Sandeep Hemmadi asked for examples of what would constitute an unavoidable pressure damage. It was noted that If a patient comes into hospital, all risk assessments have been completed and every measure has been put in place to prevent a pressure damage e.g. patients in Critical Care, then this is classed as unavoidable. Non-compliance in the community is another example i.e. where patients do not follow advice or use equipment provided to them in the community.

Helen Jenkins will circulate the flow chart.

Action: Helen Jenkins

Podiatry produced a tool for nursing staff to undertake with patients, however it was rejected at Nursing and Midwifery Board as it was not considered as a task for nurses to undertake. Sandeep Hemmadi will consider revisiting this issue and asked Mathew King to send him the tool.

Action: Mathew King

CDTQSE 21/233 Patient Safety Incidents

Suzie Cheesman presented an update on the changes to the Incident Reporting Policy. From 14th June 2021 the way in which Health Boards report incidents to NHS Wales Delivery Unit changed. The term Serious Incident (SI) has now been replaced with Nationally Reportable Incident (NRI).

The National Patient Safety Incident Reporting Policy supersedes the Serious Incident Section 9 pf the Putting Things Right Guidance.

Never events, inpatient suicides, maternal deaths, avoidable healthcare acquired pressure damage and incidents affecting a significant number of patients will continue to be reported immediately to the Delivery Unit.

In addition, the following changes will take place:

Phase 1 - immediate effect requires incidents potentially causing major or catastrophic harm to be reviewed internally by Clinical Boards with onward reporting to the DU if any causative or contributory factors are established.

Phase 2 (implementation date to be confirmed) involves the thematic reporting of healthcare incidents based on common factors regardless of the harm outcome.

In order to determine the facts surrounding major or catastrophic incidents to make a decision around external reporting, the clinical areas need to complete a patient fact finding tool and return this to the Patient Safety Team within 5 working days.

The Patient Safety Team will review and if it is established that there has been suspected action or inaction that has likely to have caused or contributed to the catastrophic harm this will be reported to the Delivery Unit in the next 2 working days. If it is later discovered that there was no harm then the incident can be pulled.

Clinical Boards in conjunction with the Patient Safety Team will determine the level of investigation required and the timeframe period for completion can be 30, 60, 90 or 120 days depending on complexity. If the investigation is not completed in the reported timeframe, a reason for the delay will need to be provided.

Clinical Boards will undertake a proportionate investigation. On completion of the investigation rather than submit a closure form, Clinical Boards will complete 1 of 3 forms:

A learning from event form where causative factors have been determined.

If there were no causative factors an outcome report will be submitted.

A downgrade request form will be submitted where further investigation finds the incident did not meet the criteria for national reporting.

It was noted that Datix has not yet changed its terminology and still uses the term Serious Incident. Existing incidents prior to 14th June 2021 will use the previous closure form.

Suzie Cheesman will circulate the slides.

Action: Suzie Cheesman

SI Report

The Clinical Board is currently reporting 3 Open SIs:

In143602 relates to a Radiology trainee performing an independent ultrasound.

In122136 relates to a case in pacing theatre. The RCA is completed and Sue Bailey will complete the closure form.

In92837 relates to a neuroradiology patient and delays to treatment. This incident involved a number of services across Clinical Boards. The action plan and closure form are completed and will be sent to the Delivery Unit.

CDTQSE 21/234 New SI's

Nothing to report.

CDTQSE 21/235 RCA/Improvement Plans

Nothing to report.

CDTQSE 21/236 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 21/237 Regulation 28 Reports

Nothing to report.

CDTQSE 21/238 Patient Safety Alerts

ISN 2021 013 Pump Giving Sets

This alert was circulated across the Clinical Board and also received for noting.

ISN 2021 014 Esketamine

This action has been circulated widely across the Clinical Board for information.

ISN 2021 015 VRIII Fluids

This notice is relevant to Pharmacy and has been circulated to the directorate for information sharing.

ISN 2021 016 Unsecured Medical Gas Cylinders

This notice has been circulated across the Clinical Board and cylinders in Radiology are to be secured.

ISN 2021 017 Fresenius Volumetric Pumps

This action has been circulated widely across the Clinical Board for information.

PSN 058 Ingestion of Super Strong Batteries

This notice has been reviewed in Radiology and the protocols are being managed.

AWTTC have updated their system Toxbase to include this.

CDTQSE 21/239 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 21/240 Medical Device Risks/Equipment and Diagnostic Systems

Gravity Set Notices

This notice was circulated from Procurement and was received and noted.

CDTQSE 21/241 IP&C/Decontamination Issues

Nothing to report.

CDTQSE 21/242 Point of Care Testing

Seetal Sall is progressing with clinical input implementation of Point of Care Testing equipment for Covid and RSV and doing evaluation with Public Health Wales.

CDTQSE 21/243 Key Patient Safety Risks

Safeguarding

The UHB Safeguarding Group is being held tomorrow.

A revision to the safeguarding allegations procedure has been circulated.

It was noted that safeguarding documentation is stored on the Clinical Board safeguarding information hub on Teams.

CDTQSE 21/244 Health and Safety Issues

Jonathan Davies reported that a health and safety dashboard is being circulated to Clinical Boards.

Sue Bailey asked managers to ensure that their staff maintain their fire training compliance and she is willing to provide cascade training if requested.

A fire inspection was undertaken in dietetics UHW and there are a number of enabling works required. She was advised to link in with Scott Gable who is the Clinical Board Fire Safety Manager to progress this.

CDTQSE 21/245 Regulatory Compliance and Accreditation

Good compliance is noted overall across directorates. There has been slippage in the metrics reported for Radiopharmacy and an action plan to address this is being put in place.

HIW are undertaking an inspection in Radiology

HTA will be inspecting Stem Cell in August.

A Welsh Audit Office follow up audit is currently being undertaken in Radiology.

CDTQSE 21/246 Policies, Procedures and Guidance

The Draft Policy for the Delivery of Injection Therapy by Physiotherapists was presented. This is a revision of the existing policy. There are no major changes but the policy reflects the latest up to date legislation. No concerns were raised relating to the policy and this was **APPROVED.**

EFFECTIVE CARE

CDTQSE 21/247 Clinical Audit

Sue Bailey will discuss with Sandeep Hemmadi as very little information on clinical audits is received.

Action: Sue Bailey/Sandeep Hemmadi

An Internal audit was undertaken in ultrasound governance and there are actions to be addressed around strengthening the governance arrangements and engagement from other Clinical Boards. The audit provided assurance relating to equipment maintenance and training

CDTQSE 21/248 Research and Development

The Clinical Board R&D meeting was held yesterday.

Rhys Morris noted that HIW no longer be providing funding of R&D Leads. A few months ago, £100k pump priming was offered to this Clinical Board for nominated projects and this funding will also no longer be available. Dr Matt Wise is looking to fund some of this internally if possible. However, going forward this Clinical Board will need to consider how R&D can be taken forward, particularly where R&D is undertaken by staff who do not have job plans and therefore do not have sessions allocated to this.

The group discussed the barriers to generating R&D and a lack of experienced staff was raised as a major constraint. Dr Jane Jones has agreed to look into the provision of a course for staff lacking in experience.

CDTQSE 21/249 Service Improvement Initiatives

From 2nd August the Health Board will be mandating ETR only for inpatient settings, with some areas agreed as exceptions such as in Maternity and Orthopaedics.

The Clinical Board will be appointing 2 digital lead roles. The roles will be split with 0.5 wte used to work from a business practice perspective and 0.5 wte for a clinical digital lead.

CDTQSE 21/250 NICE Guidance

Nothing to report.

CDTQSE 21/251 Information Governance/Data Quality

There is a lack of guidance for transgender patients nationally in terms of the complexities of processing records and a group has been set up in the Health Board to look at this issue. This will involve a significant piece of work, and a working group is being set up.

DIGNIFIED CARE

CDTQSE 21/252 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 21/253 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 21/254 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 21/255 Equality and Diversity

Nomination are needed for Equality Champions and representations around the protected characteristics in the UHB. The Clinical Board is committed to this and will take learning from other areas on how these roles can be implemented.

TIMELY CARE

CDTQSE 21/256 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 21/257 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

In June the number of patients waiting 8 weeks or greater in diagnostics was 1193. This is an increase from 156 in May.

For Therapies, there were 340 patients waiting 14 weeks or greater at the end of June. This is an increase of 178 from May.

CDTQSE 21/258 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 21/259 National User Experience Framework

There are currently no surveys being undertaken.

STAFF AND RESOURCES

CDTQSE 21/260 Staff Awards and Recognition

Sue Bailey provided positive feedback from the Clinical Board Staff Recognition Awards that were held virtually. The event showcased the breadth of work that is being undertaken across the Clinical Board and she congratulated everyone who was nominated.

CDTQSE 21/261 Monitoring of Mandatory Training and PADRs

The metrics are discussed at directorate performance reviews. Helen Jenkins to ask Alison Hughes to provide figures for the next meeting.

Action: Alison Hughes

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The following minutes were received:

Biochemistry Quality Minutes July 2021

ANY OTHER BUSINESS

Nothing further to report.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 27th August 2021 at 10am via Teams.

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

CLINICAL DIAGNOSTICS AND THERAPEUTICS CLINICAL BOARD QUALITY SAFETY AND EXPERIENCE SUB-COMMITTEE

MINUTES OF THE MEETING HELD ON 27TH AUGUST 2021

Present:

Sue Bailey (Chair)	Clinical Board Director of Quality, Safety and Patient Experience
Kim Atkinson	Acting Head of Occupational Therapy
Jonathan Davies	Health and Safety Adviser
Tracy Wooster	Sister, Outpatients
Robert Bracchi	Medical Advisor to AWTTC
Jo Fleming	Quality and Safety Lead, Radiology
Emma Cooke	Clinical Director of AHPs
Judyth Jenkins	Head of Dietetics
Sion O'Keefe	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Nigel Roberts	Laboratory Service Manager, Biochemistry
Alun Williams	UHB Welsh Language Officer

Apologies:

Matthew Temby	Clinical Board Director of Operations
Sandeep Hemmadi	Clinical Board Director
Gareth Jenkins	Service Manager, Medical Physics
Suzie Cheesman	Patient Safety Facilitator
Nia Came	Head of Adult Speech and Language Therapy
Bolette Jones	Head of Media Resources
Paul Williams	Clinical Scientist, Medical Physics
Mathew King	ADOTH/Head of Podiatry
Lesley Harris	Professional Head of Radiography UHL
Louise Long	Public Health Wales Microbiology
Edward Chapman	Head of Clinical Engineering/ Medical Devices Officer
Alun Roderick	Laboratory Service Manager, Haematology
Scott Gable	Laboratory Service Manager, Cellular Pathology
Tim Banner	Head of Patient Services, Pharmacy
Mathew King	ADOTH/Head of Podiatry
Sian Jones	Operational Service Manager
Seetal Sall	Point of Care Testing Manager
Rhys Morris	CD&T R&D Lead

Secretariat:

Helen Jenkins	Clinical Board Secretary

PRELMINARIES

CDTQSE 21/262 Welcome and Introductions

Sue Bailey welcomed Alun Williams, UHB Welsh Language Officer to the meeting.

CDTQSE 21/263 Apologies for Absence

Apologies for absence were **NOTED.**

CDTQSE 21/264 Approval of the Minutes of the Last Meeting

The minutes of the previous meeting held on 27th July 2021 were **APPROVED.**

CDTQSE 21/265 Matters Arising/Action log

The action log was **RECEIVED** and it was noted that a number of actions had been completed. The outstanding actions were updated as follows:

CDTQSE 21/199 Internal Safety Notice for Contaminated Equipment Being Sent to Clinical Engineering

Ed Chapman to provide an update at the next meeting.

Action: Edward Chapman

CDTQSE 21/226 Pressure Damage Tool

Mathew King to send the Podiatry pressure damage tool to Sandeep Hemmadi.

Action: Mathew King

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

CDTQSE 21/266 Patient Story

Jo Fleming presented a patient story from Radiology relating to the patient pathway for patients who attend Radiology and require immediate assessment following their imaging, where there is a significant finding needing urgent treatment.

These patients present quite often from their GPs and are therefore unlikely to receive their results or treatment imminently. There had been a number of incidences where Radiographers/Assistant Practitioners had been imaging patients and suspected that there was an acute finding on the images, such as a fracture and were trying to contact A&E through means and methods to try to organise patients to receive treatment if this was required.

This was highlighted recently by two cases. The first case was IRMER related, where a patient attended UHL for a shoulder x-ray from their GP. The patient following a fall had sustained a fracture and Radiology staff in UHL contacted a reporting radiographer in A&E who reviewed the x-ray. It was advised that the patient should attend A&E. When the patient attended A&E, the radiographer and the nurse practitioner failed to notice that the patient had already been imaged. The patient received a further x-ray, which resulted in a reportable IRMER incident. The

patient was advised they had received an unintended exposure and given the opportunity to discuss any concerns and were offered support.

The second case involved an elderly patient who attended UHW for hip pain and his x-ray showed that he had bone erosion around his hip replacement. The diagnosis was confirmed and it was advised that it was unsafe for the patient to return home. He needed an urgent orthopaedic referral and admittance to A&E was required. This was a lengthy process, and in this case, Radiology needed to contact a consultant in A&E as a bed and an orthopaedic review was required. During this time the patient was obviously becoming more distressed despite being kept informed of progress. A bed was identified in A&E and he was escorted to the department who then took over his care.

Work was undertaken jointly with A&E to develop a procedure. The procedure contains examples of diagnoses and contacts for each aspect. A proforma was also produced for any patient referred to A&E directly from Radiology. Patients will attend A&E with a referral slip with details of any imaging that the patient has already received to avoid duplicate imaging being undertaken. These patients also no longer need to make an appointment via CAV 24/7 which shortens their pathway.

This procedure was implemented at the end of May and the process has been activated on a number of occasions and is working well and has made a positive change for patients.

Sue Bailey was pleased to note that the procedure is effective as she acknowledged that identifying an unexpected finding is challenging. It is appropriate that the patient receives the right treatment and avoids a lengthy process. She asked if an update can be presented at a future meeting when the process is further embedded.

Sion O'Keefe asked if the procedure could be shared with him as there may be shared learning and aspects applicable to Outpatients.

Action: Jo Fleming

CDTQSE 21/267 Feedback from UHB QSE Committee

The minutes of the meeting held on 15th June 2021 are not yet available.

CDTQSE 21/268 Terms of Reference

The QSE Sub-Committee Terms of Reference have been updated and were **APPROVED.** They will be presented to the next Clinical Board Formal Board Meeting for Matt Temby and Sandeep Hemmadi to sign them off.

Action: Sue Bailey

CDTQSE 21/269 Health and Care Standards

There was no update to report.

CDTQSE 21/270 Risk Register

A new risk has been added relating to the air conditioning in the Stem Cell Unit and concerns around the stability of this system.

Jonathan Davies referred to the Alert Level 0 guidance around clinical space. The potential increase in the numbers attending in meeting rooms is the main concern. Where possible staff should be physically and socially distancing in the Health Board and should maintain 2 meters where possible, although in meeting rooms this can reduce to 1 metre if needed providing other measures are in place.

For clinical services, guidance is awaited from the UHB IP&C Team around waiting rooms, patient education classes etc. in terms of bringing in more patients.

AWTTC has previously raised a risk relating to the Spira system and Robert Bracchi highlighted the potential uncertainty of whether the licence will continue.

Sion O'Keefe reported an ongoing condensation leak from the air conditioning in Health Records which is causing a potential slip hazard. A workplace inspection is being undertaken today.

Emma Cooke reported that the hydrotherapy pool at Rookwood is still not open due to estates work required relating to the temperature of the pool. Estates are visiting today and Emma Cooke will escalate if the issue continues to be unresolved.

CDTQSE 21/271 Issues for Escalation

Physiotherapy is trying to put in place an exercise programme that allows exercises to be sent digitally to patients, however there are information governance issues that are not being progressed by the IT security team. Emma Cooke to send the details to Sion O'Keefe who will take this forward.

Action: Emma Cooke/Sion O'Keefe

The supply issue relating to the blood vacutainer tubes has now been raised in the media. It was noted that good work has been undertaken in this Health Board to put robust processes in place for maintaining stock levels.

Patients are being advised that there is potential that their routine blood tests will not be performed or delayed if this is clinically safe, to allow rationalisation and prudent use of the tubes.

Judyth Jenkins reported that the Wellsky system has now been implemented for feeds and supplements. There have been significant issues with deliveries being sent to the wrong locations and processes are being put in place to resolve this.

HEALTH PROMOTION PROTECTION AND IMPROVEMENT

CDTQSE 21/272 Initiatives to Promote Health and Wellbeing of Patients and Staff

The link to the Wales Safer Communities Network Survey has been circulated.

Sue Bailey is currently undertaking the Clinical Board Flu Lead role to plan for the vaccinations that are due to commence in September. She noted that Occupational Health Team will be holding mini mass flu vaccination clinics at UHW and UHL.

New Flu Champions have been nominated and will assist in supporting the flu vaccination campaign across the Clinical Board.

It was noted that no update has been received yet relating to the Covid booster jabs.

SAFE CARE

CDT QSE 21/272 Concerns and Compliments Report

In July 2021 the Clinical Board reported a green status. It received 45 concerns with 40% resolved within early resolution timeframes. 0 breaches were reported and 8 compliments were received.

There are no departments reporting a red status.
The areas reporting a green status are Outpatients/Patient Administration, Radiology, Occupational Therapy, Podiatry, Medical Illustration, AWTTC and Medical Physics.

Whilst Physiotherapy reported an amber status, of the 14 concerns it received, 43% were closed through early resolution.

The key themes for concerns relate to difficulties arranging appointments and waiting times for scan or test results.

CDTQSE 21/273 Ombudsman Reports

Nothing to report.

CDTQSE 21/274 RCA/Improvement Plans for Serious Complaints

Nothing to report.

CDTQSE 21/275 Patient Safety Incidents

The Clinical Board is reporting 3 open SIs:

In143602 relating to concerns around ultrasound examinations and if these had been completed effectively. A further meeting is arranged on 9th September.

In122136 relates to a Cardiac pacing incident. The closure form in progress.

In92837 relates to a Neuro Interventional case. The closure form has been completed.

CDTQSE 21/276 New NRIs (National Reportable Incidents)

Nigel Roberts reported that there is a potential incident relating to a tumour marker. The results were negative and no patient harm was reported. A meeting is being arranged but it is unlikely that this will be reportable.

Another reportable IRMER incident has occurred relating to a duplicate chest x-ray.

CDTQSE 21/277 RCA/Improvement Plans

Nothing to report.

CDTQSE 21/278 WG Closure Forms – Sign Off

Nothing to report.

CDTQSE 21/279 Regulation 28 Reports

Nothing to report.

CDTQSE 21/280 Patient Safety Alerts

ISN 2021 018 Histopathology Results

This alert was issued following an SI where a result was not acted upon. A facility has been implemented on Welsh Clinical Portal for clinicians to be informed if there is a cellular pathology result on the system for them to review.

ISN 2021 020 TympanicThermometers

This alert has been circulated widely across the Clinical Board. The potential risk of the thermometers overheating was noted.

ISN 2021 021 Clexane

This alert relates to Clexane pre-filled syringes where different instructions were noted for the two different systems. The alert has been circulated across the Clinical Board to advise of this.

CDTQSE 21/281 Addressing Compliance Issues with Historical Alerts

Nothing to report.

CDTQSE 21/282 Medical Device Risks/Equipment and Diagnostic Systems

Sue Bailey to contact Ed Chapman to discuss representation at this meeting.

Action: Ed Chapman

CDTQSE 21/283 IP&C/Decontamination Issues

Reusable respirator guidance has been circulated to the relevant services. Radiology, Occupational Therapy, Outpatients and Dietetics departments provided assurance that the necessary action has been taken. Emma Cooke to check that this has been acted upon within Physiotherapy.

Action: Emma Cooke

CDTQSE 21/284 Point of Care Testing

Nothing to report.

CDTQSE 21/285 Key Patient Safety Risks

Safeguarding

Sue Bailey attended the UHB Safeguarding Group. A reminder was issued to ensure staff's training compliance is up to date. Compliance across the UHB is 65%.

Updated guidance is uploaded in the Safeguarding Hub channel in Clinical Board Teams.

CDTQSE 21/286 Health and Safety Issues

The Clinical Board Health and Safety dashboard for August 2021 has been circulated.

Mandatory training figures need improvement in the manual handling and fire safety modules.

At the last Clinical Board Health and Safety Meeting there was discussion around the Menopause Policy. Sue Bailey asked managers to implement the risk assessment for appropriate members of staff. The issue was raised that the format of the risk assessment is not user friendly.

Face to face fire training is being reinstated and dates will be circulated shortly. Sue Bailey offered to undertake fire safety cascade training to areas where compliance needs addressing.

CDTQSE 21/287 Regulatory Compliance and Accreditation

Positive feedback and assurance is being provided to the Clinical Board Regulatory Compliance Group from directorates that are subject to regulatory and accreditation inspections.

An IRMER inspection has been held in Radiology. This was a very thorough inspection with a lot of requests for information from the inspectors. Overall the feedback was positive.

Good feedback received on waiting areas. The inspectors recommended condensing documentation to avoid duplication and further work is needed to describe the process for IRMER audits. Concerns were raised on the staff survey relating to discrimination. The inspector did not specify the details of this, therefore the department is looking at raising awareness amongst staff of how to escalate if they feel they have been discriminated against. Sion O'Keefe suggested Radiology links in with Sian Jones who is undertaking work on discrimination that can be used for shared learning.

CDTQSE 21/288 Policies, Procedures and Guidance

UHB Procedures are out to consultation relating to clinical trials in terms of informed consent and the archiving of clinical trials.

EFFECTIVE CARE

CDTQSE 21/289 Clinical Audit

The Hard to Swallow Report has been circulated. Nia Came to provide feedback on the report at the next meeting.

Action: Nia Came

CDTQSE 21/290 Research and Development

Nothing to report.

CDTQSE 21/91 Service Improvement Initiatives

Offers of appointments have been made for the two Clinical Board digital leads roles. The roles are temporary for the next 6 months whilst benefits of the roles are realised.

A maturity matrix of how services are progressing with digital matters will be undertaken.

CDTQSE 21/292 NICE Guidance

Nothing to report.

CDTQSE 21/293 Information Governance/Data Quality

Sion O'Keefe reported that there will be a working group set up in relation to Trans and gender diverse patient records. An independent view will be taken on how the Health Board is dealing with patient information for this cohort of patients to ensure that clinical information is appropriately divulged.

DIGNIFIED CARE

CDTQSE 21/294 HIW/CHC, DECI (Dignity and Essential Care Inspections) Reports and Improvement Plans

Nothing to report.

CDTQSE 21/295 Initiatives to Improve Services for People with:

Dementia

Nothing to report.

Sensory Loss

Nothing to report.

CDTQSE 21/296 Initiatives Specifically Related to the Promotion of Dignity

Nothing to report.

CDTQSE 21/297 Equality and Diversity

Alun Williams reported that this Clinical Board has representation on the membership of the Equality Standards Group. This Group has been set up to ensure that the UHB is progressing against the Equality and Welsh Language agenda. There are 29 themes to be addressed and this Clinical Board has a requirement to identify 17 champions. The Clinical Board is meeting with Keithley Wilkinson for advice on the roles and how to link the equality and diversity agenda to work being undertaken in the Clinical Board around staff culture.

The UHB is progressing against the Welsh Language Standards however there have been numerous concerns of failures around compliance. Services need to ensure that appointment leaflets are available bi-lingually and there should now be focus on meetings, reception areas and phone calls. All members of staff must register their Welsh language skills on ESR.

There is a new Sharepoint site set up for guidance and advice on Welsh language and opportunities for staff to develop Welsh language skills. Alun Williams offered to meet the champions to discuss their roles and requirements. There are some staff who are fluent in Welsh and staff who are willing to learn Welsh and Sion O'Keefe will coordinate for them to meet with him.

Action: Sion O'Keefe

Sion O'Keefe noted that colleagues in Digital are taking forward opportunities for digital facing comms with patients. It will need to be ensured that communication is provided in the patient's preferred language.

Alun Williams will send the link to Sharepoint to Helen Jenkins for circulating.

Action: Alun Williams/Helen Jenkins

TIMELY CARE

CDTQSE 21/298 Initiatives to Improve Access to Services

Nothing to report.

CDTQSE 21/299 Performance with National Targets/the NHS Outcomes and Delivery Framework Relating to Timely Care Outcomes

There are 2247 patients waiting 8 weeks or more for diagnostics.

In Therapies there are 491 patients waiting 14 weeks or greater.

Due to challenges in terms of staffing and increase in referrals, the figures for August are also likely to increase but the forecast for September is predicting an improvement in both areas.

Emma Cooke reported that Physiotherapy is receiving an additional 500 referrals from Primary Care compared to pre-Covid. This partly relates to the delay of patients not being physically seen which has increased demand on services. This is also reflected in the increase of concerns being received relating to the service.

Dietetics is also receiving an increase in referrals and patients are querying the length of waiting lists. Access to rooms and the maximum capacity of the numbers of patients that can be seen physically in a room at one time is a challenge.

Part of the issues with virtual appointments is the challenge of patients having to navigate into a virtual waiting room. Sion O'Keefe noted that work is being undertaken to improve this, but this will take time to be implemented for all services. It was noted that there are some patients who do not have the technology and capability and may not be appropriate for a virtual appointment.

CDTQSE 21/300 Delayed Transfers of Care

Nothing to report.

INDIVIDUAL CARE

CDTQSE 21/301 National User Experience Framework

No questionnaires are being circulated at present. Some patient experience work is still ongoing in Outpatients and the priority in the coming year is to collate rich data based on the patient experience.

STAFF AND RESOURCES

CDTQSE 21/302 Staff Awards and Recognition

Nothing to report.

CDTQSE 21/303 Monitoring of Mandatory Training and PADRs

Action plans have been produced in directorates to improve PADR compliance. Overall compliance in the Clinical Board is 59.3%.

Statutory and Mandatory training compliance is 74%.

Violence and Aggression Module C needs to be removed from individuals' training records where this module is not required as part of their role.

ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE

The following minutes were received:

Clinical Board Health and Safety Group Minutes August 2021.

ANY OTHER BUSINESS

Maria Jones retired at the end of July. A Clinical Board Lead Nurse role has been advertised and interviews have been arranged.

DATE AND TIME OF NEXT MEETING

The next meeting will be held on 29th September 2021 at 9.30am via Teams.

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

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
17th JUNE 2021 VIA TEAMS

Present: Mark Warren, Director of Nursing Mental Health (Chair)
Jayne Bell, Consultant Nurse for Complex Clinical Risk MH
Paul Cantrell, Consultant Forensic Psychiatrist, Interim Clinical Director, Adult MH
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director, Patient Safety & Quality
Mark Jones, Directorate Manager Adult Mental Health
Neil Jones, Deputy Clinical Board Director Mental Health
Robert Kidd, Consultant Clinical & Forensic Psychologist
Bala Oruganti, Consultant Psychiatrist
Tara Robinson, Lead Nurse, Adult Mental Health
David Seward, Mental Health Act Team Lead
Melanie Smolinski, Service Lead Cynnwys
Sunni Webb, Mental Health Act Manager
Jo Wilson, Directorate Manager MHSOP/Neuro

Apologies: Catherine Evans, Patient Safety Facilitator
Nicola Evans, Head of Workforce & OD Mental Health
Vicki Gimson, MHCB Pharmacist
Claire Humphries, Safeguarding Nurse Advisor
Annie Procter, Clinical Board Director, Mental Health
Andrew Vidgen, Consultant Psychologist, Assistant Clinical Director, Adult MH
Ian Wile, Director of Operations & Delivery Mental Health
Norman Young, Consultant Nurse Headroom

Minutes: Joyce Fox

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 22nd April 2021 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

Risk Register

Neil Jones referred to the Children and Women's Clinical Board's (CWCB) QSE report in the UHB QSE meeting. The CWCB had held a Risk Assessment and Governance Workshop to analyse and review all risk assessment processes. It was agreed that Neil contact Clare Rowntree, CB Director for CWCB, to learn the outcome of the workshop. **Action Neil Jones**

PRESENTATION: New Patient Safety Incident Reporting Structures – Carol Evans, Assistant Director Patient Safety and Quality

Carol Evans presented the new National Patient Safety Incident reporting structures which came into effect 14th June 2021.

Phase 1 of the National Patient Safety Incident Reporting Policy (Welsh Government) came into effect on 14th June, relating to the individual reporting of the most serious incidents which occur in healthcare.

Overarching Requirements:

A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare. To report with seven days.

Specific National Incident Reporting Categories:

- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months
- In-patient Suicides
- Maternal Deaths
- Never Events
- Incidents where the number of patients affected is significant
- Unusual, unexpected or surprising incidents

Special Reporting Arrangements:

- Pressure damage
- Unexpected deaths in the community of patients known to MH&LD Services
- Safeguarding
- PRUDIC (unexpected death of a child)
- Abuse/Suspected abuse
- Healthcare Acquired Infections (HCAIs)

National Incident Reporting Flow Cha

Carol presented the National Incident Reporting Flowchart (Phase 1)

The nationally reportable incident to be reported to NHS Wales Delivery Unit no later than 7 working days following the occurrence.

The anticipated investigation time frame to be set of 30, 60, 90 or 120 working days. Investigations should seek to establish whether any action or inaction by the Responsible Body, unintended or otherwise, caused or contributed to the reportable incident.

The options available are:

- Causative or Contributory - Submit "Learning from Event Report" to the NHS Wales Delivery Unit

- Non-Causative or Non-Contributory - Submit "Outcome Report" to the NHS Wales Delivery Unit

- Downgrade - At any point where further information changed the initial assessment, organisation can submit a downgrade request form to the NHS Wales Delivery Unit

Mark Doherty queried the reporting of injurious falls. Carol Evans confirmed that local decisions can be made regarding injurious falls reporting, obviously a fall that involves surgical intervention or a serious head injury should be reported immediately. We are piloting the Royal College of Physicians hot debrief tool at the moment where we look at the circumstances around the fall.

Phase 2 of the Policy will come into effect in July 2021, focusing on new ways of national reporting, including thematic reporting of healthcare incidents.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

Unconfirmed Minutes of the UHB Quality, Safety and Experience Committee meeting dated 13th April 2021 had been circulated:

QSE 21/04/007 **Children and Women's Clinical Board QSE Assurance Report**

Mark Warren noted the Assurance Report, highlighted CAMHS interface and informed that a meeting regarding CAMHS Admission Avoidance was being held the next day.

QSE 21/04/009 **Exception Reports – IP&C Position**

Mortality rates related to Covid-19 from November 2020 to January 2021 were noted. Work is on-going.

QSE 21/04/013 **Gosport Review**

A verbal update on the Gosport Independent Panel Report regarding the inappropriate use of high dose opiate medication in older people was received at UHB QSE.

Robert Kidd questioned our position. Carol Evans said that she had attended a meeting with staff in April regarding the report and the UHB QSE Committee was very happy with the level of assurance that was given.

2.2 Health and Care Standards

The annual self-assessment of Health Care Standards was not undertaken last year due to Covid-19 and are not required this year. Carol Evans reported that the Patient Safety Group have aligned specific standards. The Standards are going to be revised as part of the implementation of the Quality Act. Trying to move away from asking Clinical Boards to complete onerous self-assessments.

2.3 Regulatory compliance

No report.

2.4 Risk Register

The Risk Register was discussed under Action Log above.

The current Corporate Risk Register was presented:

MHSOP Nursing Staff Recruitment
Poor Clinical Environment – Park Road, Pendine CMHT, Gabalfa CMHT and CAU
Violence and Aggression
Patient Conveyancing
Young Person in Adult Mental Health Placement

Carol Evans suggested contacting Aron Fowler, Head of Risk and Regulation in relation to Risk Register Training for the MHCB.

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Meeting dated 11th May 2021, Minutes.

Adult

Tara Robinson said the main issue is the management of beds and protecting a dedicated Covid space.

Tara said that staffing remains an issue. Mark Jones agreed and said that in May 2021 there was 8.41% sickness rate which is unprecedented in the Directorate and is a challenge and feeling the covid burn out. We are exploring Staff Wellbeing and how to support staff.

Policies

The Policies below were discussed and minor amendments made:

Guidance for Section 17 Leave of Absence
Missing Persons Procedure
Nurses Role in Offering Advice re Medication
Liaison Psychiatry Operational Policy

Expected Death Review Template

The expected death template was circulated for comments.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY -** Meeting dated 12th April 2021:

Staffing

Mark Doherty confirmed that staffing is challenging.

Jo Wilson said the level of observations and referrals from Medicine CB have increased pressure on staff.

Key nursing appointments:

New post of Nurse Lead Practitioner in MHSOP who will develop pathways in all elements of the service.

MHSOP will soon appoint two Clinical Nurse Specialists, one in functional care and one specifically in the care of psychosis

MHSOP have appointed a Senior Nurse for Physical Health Care. The effect of this role in the care and responsiveness provided has been very beneficial.

Llanfair Unit

Mark Doherty informed that MHSOP have one in-patient ward in Llanfair Unit which was a challenge and caused enormous problems in terms of falls management, medical input and emergency responses. Therefore, the intention is to bring the ward up to Llandough Hospital as soon as possible.

Jo Wilson said that Daffodil Ward in Llanfair Unit will be maintained as a Covid ward.

The **PSYCHOLOGY & PSYCHOLOGICAL THERAPIES QUALITY & SAFETY** Meeting dated 9th June 2021:

Covid

Rob Kidd said that the Welsh Government appeared to be saying that social distancing is likely to remain for the rest of year therefore we need to think about future practices when providing group work.

Rob said that the zoom facility is needed for group work, including the eating disorders group, therefore he has made a request to retain the zoom licence.

Safe care

Outcome Measures Training next week with Improvement Cymru.

Psychological representation in Sentinels and RCAs. Hoping to progress soon.

Carol Evans informed the Committee that they were aiming to provided RCA training early September 2021.

Effective care

The following Reports had been circulated to QSE Members:

PCIC Service User Feedback Report

Veterans NHS Wales Annual Report

Psychological Therapies Hub Evaluation

MENTAL HEALTH ACT Meeting dated 9th June 2021:

Sunni Webb said that concerns had been raised by the Mental Health & Capacity Legislation Committee regarding staff attending tribunal Hearings by telephone as the patient's behaviour was not able to be observed. Paul Cantrell said that this could easily be sorted by separation and supporting the patient with a healthcare assistant. Sunni said that the Tribunal was going to trial video conference style tribunals.

Sunni said she had incorporated paragraphs in relation to this in the Power of Discharge Group Protocol for Managers.

The **MEDICINES MANAGEMENT GROUP** Meeting dated 7th May 2021:

The Minutes were received and noted.

INFECTION PREVENTION AND CONTROL GROUP

Mark Warren reported that the IPC Hub had, that morning, fedback an increase in Covid rates in Cardiff and other areas.

HEALTH PROMOTION, PROTECTION AND IMPROVEMENT

3.1 Initiatives to promote health and wellbeing of Patients and Staff:

Smoking

- Mark Warren said that Mental Health Units will be required to phase out all smoking by September 2022.

- Tara Robinson informed the group that the first meeting of a Working Group had been held the day before to move towards the September deadline.

- To support patients with nicotine replacement therapy or improve awareness that they are unable to smoke

Staff Wellbeing

- It was noted that staff morale was very low. Tara Robinson suggested a Steering Group to consider how to thank staff for their contribution over very recent months.

- Jayne Bell asked the Clinical Board to consider using Papyrus, a UK Charity which gives advice and support to staff who cope with suicide or bereavement as part of their work. Mark Warren would look into this as extra support for staff. **Action: Mark Warren**

- Jayne Bell said that she is hoping to deliver suicide awareness training one day a week to teams identified by the Directorate. The seminar room –can be used for up to 17 attendees or up to 30 people on-line.

- Neil Jones wished to it to be noted that an SBAR around CPA/WARRN would be completed regarding the risk assessment work.

- Tara Robinson highlighted that in-patients had no psychiatrist to support reflective practice which needed to be addressed. Rob Kidd said Andrew Vidgen and Emily Hill are discussing how they may offer more reflective practice sessions.

SAFE CARE

4.1 Suicides

There had been two recent suicides. RCAs are looking at these and it was acknowledged how hard it had been for staff during this time.

4.2 Patient Safety Alerts

No alerts to note.

4.3 Key Patient Safety Risks

Falls

Mark Doherty confirmed that the new Falls Lead for the UHB, Annie Burrin, was attending MHSOP falls meetings.

EFFECTIVE CARE

5.1 Clinical Board Clinical Audit Plan

Bala Oruganti said that MH is participating in the National Clinical Audit of Psychosis Audit and hopefully will get the result in the next 3 or 4 months.

Bala Oruganti said that he is participating in the MSHOP Audit.

Bala said that he would share audits with front line staff but also present some at this meeting.

Carol Evans said that they hoped to purchase the AMaT web based system, which will give access to all local and national audits.

NICE Guidance

Nothing to discuss.

5.3 Research and Development

There is a MHCB Research & Quality Improvement Conference on 22nd October 2021.

DIGNIFIED CARE

6.1 HIW

There had been two very positive Quality Check Reports - one for East 12, MHSOP and one for Hazel Ward, Hafan y Coed. Both in March 2021.

Hazel Ward:
Carol Evans referred to the ligature audit which should have taken place in January 2021 but did not take place due to Covid. Mark Jones confirmed that the Audit took place in April by Health & Safety.

Jayne Bell said a Task & Finish Group for low lying ligature risks had been set up. Darren Shore had been invited; Tara will get update on who will be attending.

Mandatory training – ensure up to date.

A Cleaning audit has been carried out.

East 12:
Environmental risk assessments audit has been carried out

Infection, Prevention and Control risk assessment has been carried out.

The escalation process which covers urgent issues, staffing, bed management, shift co-ordinator guidance is going to be formalised. It will be a guidance for internal difficult situations that cannot be resolved and when to escalate them.

Translation Services

All staff to be made aware of how to access translation services for clients and family.

Diversity

Robert Kidd referred to Diverse Cymru Aware Scheme, supporting people faced with inequality and discrimination. Mark Warren drew attention to a Senior Team presentation from Keithley Wilkinson regarding staff experience around diversity.

TIMELY CARE

7.1 Access to Services

Rob Kidd said that a number of staff would soon be going on maternity leave therefore cover for these staff would be needed, particularly within the Psychological Therapies Hub, IAS and Veterans NHS. Mark Warren referred to Part 1 Mental Health Measure – focus on response times to primary care referrals. Mark noted that our compliance was low and the fact that a number of staff will be going on leave would add to this. It was agreed that a plan was required.

Care Aims

Jayne Bell requested that the Clinical Board consider Care Aims on next meeting's agenda.

Action: Mark Warren/Dan Crossland

INDIVIDUAL CARE

8.2 Compliments

Compliments received for:

MHSOP and Neuropsychiatry – Plaudits June 2021.

STAFF AND RESOURCES

9.1 Disciplinary Trends

Rebecca March is delivering training to Managers on disciplinary investigation/core workforce skills around the Just Culture work.

9.2 Staffing

PADR

May 2021 non-medical 34%; medical 49% PADRs slipped due to Covid; reminder to staff to complete PADRs this year.

Sickness

High level of sickness in Adult Mental Health.

Staff Survey

No update yet on staff survey results from the NHS Staff Survey.

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

10.0 Joint Review of CAMHS Use of Adult Beds

Jayne Bell said that the Delivery Unit have just confirmed that she can share the joint review re CAMHS use of adult beds, with the warning that it is still in draft and not to be shared wider. Jayne will send to Mark Warren who can decide who needs to see it.

10.1 Missing Person Procedure – MHCB In-patient Facility or a Missing Community Patient

The Missing Person Procedure MHCB is to be followed when an in-patient from a mental health ward is missing or a community patient subject to a community treatment order or conditional discharge who is deemed to be high risk to themselves or others, is missing in the community.

Tara Robinson said the Procedure had been discussed at the Adult Mental Health Directorate QSE where the use of photo IDs was raised. A Working Group led by Darren Shore is going to be set up to discuss patients having pictures taken on admission, and the result will be added to the Procedure at a later date as an additional item. Mark Doherty said that MHSOP use photo ID in dementia settings and a representative would attend the Working Group.

Tara said she would highlight the changes made to the Procedure. The working reviewed Procedure has been shared.

The Procedure was Approved.

DATE OF NEXT MEETING

Thursday, 19th August 2021 at 9.30am
(next Clinical Board Q&S Lessons Learned Meeting is on 22nd July 2021)

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

MENTAL HEALTH QUALITY, SAFETY AND EXPERIENCE COMMITTEE
19th AUGUST 2021 VIA TEAMS

Present: Mark Warren, Director of Nursing Mental Health (Chair)
Paul Cantrell, Consultant Forensic Psychiatrist, Interim Clinical Director, Adult MH
Catherine Evans, Patient Safety Facilitator
Neil Jones, Clinical Board Director Mental Health
Robert Kidd, Consultant Clinical & Forensic Psychologist
Tara Robinson, Lead Nurse, Adult Mental Health
David Seward, Mental Health Act Team Lead
Melanie Smolinski, Service Lead Cynnwys
Sunni Webb, Mental Health Act Manager
Paul Williams, Deputy Directorate Manager, Adult Mental Health
Joanne Wilson, Directorate Manager MHSOP/Neuro

Apologies: Jayne Bell, Consultant Nurse for Complex Clinical Risk MH
Mark Doherty, Lead Nurse MHSOP/Neuro
Carol Evans, Assistant Director, Patient Safety & Quality
Nicola Evans, Head of Workforce & OD Mental Health
Mark Jones, Directorate Manager, Adult Mental Health
Andrew Vidgen, Consultant Psychologist, Assistant Clinical Director, Adult MH
Norman Young, Consultant Nurse Headroom

Minutes: Joyce Fox

PART 1: PRELIMINARIES

1.1 Welcome and Introductions

The Chair welcomed all to the meeting.

1.2 Apologies for Absence

Apologies for absence were noted.

1.3 Minutes of Last Meeting

The Minutes of the Mental Health Quality and Safety meeting held on 17th June 2021 were accepted as an accurate record.

1.4 ACTION LOG/MATTERS ARISING

Risk Register

Neil Jones referred to the Children and Women's Clinical Board's (CWCB) QSE report in the UHB QSE meeting. The CWCB had held a Risk Assessment and Governance Workshop to analyse and review all risk assessment processes. It was agreed that Neil contact Clare Rowntree, CB Director for CWCB, to learn the outcome of the workshop.

Neil Jones reported that he did speak to Clare Rowntree and thereafter Scott McLean, Director of Operations, CWCB. Scott is happy to come and talk to us. Risk Assessment training/process was delivered to MHCB senior team members by Tim Davies on 9th August. It was suggested that if Directorates wish to have risk register training themselves, to contact Timothy Davies, Risk & Regulation Officer.

Staff Wellbeing

Jayne Bell asked the Clinical Board to consider using Papyrus, a UK Charity which gives advice and support to staff who cope with suicide or bereavement as part of their work. Mark Warren would look into this as extra support for staff.

Mark Warren said he had looked at what Papyrus provided in terms of staff support. It is about people who come across suicide in their work rather than for people whose job it is to look after people who are higher suicide risk. Mark would look to see what else is available. Cath Evans said that there were quite a few resources that NHS staff could access and would send a link to Mark. Neil Jones referred to Schwartz Rounds; Schwartz Rounds are conversations with staff about the emotional impact of their work. Schwartz Rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work. Neil said it may be worth the Clinical Board's consideration.

Rob Kidd wanted to note the connection of this to the clarification about the standard operating procedure for the fast track referrals of staff to traumatic stress that is facilitated by employment wellbeing. Rob wondered if Charitable Funds could be used to facilitate events by external people on wards to enable staff to talk about what they are experiencing.

There was a discussion regarding debriefing and about the kind of debrief.

Mark Warren said he would set up a sub group to pull the staff support agenda together; the group would include Psychology and HR.

Tara Robinson highlighted "Compassion Circle" being held on 14th September at 2.00pm for Directorates.

Care Aims

At the last meeting, Jayne Bell requested that the Clinical Board consider Care Aims on the agenda.

Jo Wilson said that names are being compiled for the training sessions that are taking place in September/October 2021. Jo thinks Jayne wanted us to start having a conversation about what we do once the people are trained and what kind of forum and support we can have offer.

Mel Smolinski said that she was on the last Care Aims training with Clare Quinn who wanted to raise the importance of creating a kind of reflective space and regular spaces where people can continue to think about how they are implementing caring, and how to set up structures that support that.

Mark Warren said he would keep Care Aims on the agenda.

PRESENTATION: Incident Reporting Changes

Carol Evans had presented the New Patient Safety Incident Reporting Structures at the last meeting. Catherine Evans asked whether there were any questions and advised that if the incident

is a community related death, do not think you do not need to report it because you may need to complete it after our review if contributory factors are identified. There are changed on datix to help monitor this to ensure incidents are followed up.

GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

2.1 UHB Quality, Safety and Experience Committee

Minutes of the UHB Quality, Safety and Experience Committee meeting dated 15th June 2021 were not available.

2.2 Health and Care Standards

Mark Warren said that at the last meeting, Carol Evans said she was not going to ask Clinical Boards to complete onerous self-assessments.

2.3 Regulatory compliance

No report.

2.4 Risk Register

The Risk Register was discussed under Action Log above.

Neil Jones said that good work had been done on recovery plans and it was important to keep these up to date.

2.5 Directorate QSE Groups

The **ADULT DIRECTORATE QUALITY & SAFETY** Meeting dated 18th August 2021.

Adult – Tara Robinson

Tara Robinson said we had feedback from the recent professional judgement audit in May. We have to provide a review of the reports back to HEIW. Key issue was the number of unfilled shifts and there appeared to be a high level of incomplete or missed care, which is a concern. Staff reported that in a number of acute areas they were missing breaks. We had a higher level of 2 to 1 or close observations than other Health Boards, and that bed flow, particularly in Cedar was the highest within Wales. I have asked for the presentation to be shared so that I can share it with Mark and Neil.

Cath Evans said, concerning the staff shortages and breaks, we report this every week to Ruth Walker and the Management Executive. We receive a lot from other Clinical Boards but very few from Mental Health. Whilst acknowledging staff are busy and short staffed, completing incident forms will add to the evidence. Tara said she would remind senior nurses to complete the data. Jo Wilson agreed that it will be a struggle to complete datix every time there is a shortage as they are already very busy. The Night Manager reports staff shortages to Ruth Walker. Should we stop doing the daily report and complete datix instead? Mark Warren said the daily report is evidence and is reported through the UHB in staff meetings to the DoNs. Tara said there is a further form in addition to the daily reporting form which we have to complete on the weekend. The Night Shift Co-ordinator completes this.

We had further discussion around the interim staffing principles. There is to be an Audit end of September early October. That will feed into the agreement to take the interim staffing principles

forward. Hopefully all Wales discussion end of December. That will have a significant impact upon our financial cost.

The other issue is the Vaccine Clinic. We are struggling as we have not got enough people able to administer the vaccine.

Senior Nurse Manager and Locality Manager interviews are being held on 20th, 26th and 27th August.

Neil Jones, Clinical Board Director

Neil referred to risk and pressure around Rambo Vidal. The team will need to put business cases and exit strategies in place by the end of September. Neil wants it recorded at this meeting as it has significant risks attached to it.

The **MHSOP/NEUROPSYCHIATRY QUALITY & SAFETY**

The June meeting was cancelled. The next meeting is on 6th September 2021.

Jo Wilson said they were going to have one Q&S meeting for Neuropsychiatry, one for MHSOP Community, one for Young Onset Services and another one for In-patient services.

Key area is the trouble we are having with setting up or re-instating out-patient clinics again because the UHB is re-assessing the use of sites and the use of all space, which is very limited. We are having trouble re-instating face to face out-patient space.

The Community Team – we are in the equivalent of one ward space for 96 members of staff which, with social distancing, is impossible. We are using home working, we have a bit of premium space in Llanfair Unit.

Covid Plans – our Covid Ward, East 10, is now occupied so Medicine colleagues have been helpful and we have a plan in place that if someone tests positive we can work with Medicine to look after those patients.

Professional Judgement Audit – MHSOP also had missed care due to low staffing

The **PSYCHOLOGY & PSYCHOLOGICAL THERAPIES QUALITY & SAFETY** Meeting dated 4th August 2021:

Rob Kidd said there was a discussion around Form 1 CPA assessment and asked for guidance in terms of what was happening with the Mental Health assessment form.

Neil Jones said this is linked to the discussions around Form 4 and the use of WARRN. WARRN is considered to be the favoured risk tool. Neil said it would be very difficult to maintain training and practice around two risk tools so the question he would ask for the Directorates is to consider the Wickets assessment and WARRN and say how prepared they would be to move over to both those documents and what would need to be in place. Gail Evans, Michelle Twynham and Julie Williams (Cynnwys) and Alison Carpenter deliver WARRN training.
Neil will compile a document to send out to Directorates to consider. **Action Neil Jones**

Connect with People Suicide Awareness and Mitigation training – need to make sure of the evaluation of that training and roll out. Rob said he had an opportunity to look at this safe tool and the assessment is great. Rob said that the point he wanted to raise was the safe tool and safety plan does not meet the NICE Clinical Guidance 115 about having a CBT inspired conversation about suicide attacks.

Neil Jones said that the Safe tool is a pilot and will continue to monitor.

Covid

There was a long discussion about Covid protocols and the gradual return to face to face groups. Discussed how to proceed with joining up our highest level DBT offering from Cynnwys, the DBT skills offering that is being developed in each Locality and the Emotional Regulation Skills training.

Melanie Smolinski echoed the hope to set up a meeting to clarify the eligibility criteria and what is running and how often. There is a lack of available interventions at secondary care level so hopefully this workstream will map more clearly.

TSS Service Staff Priority Pathway

Rob Kidd said Q&S discussed the fast track referral to TSS for staff who have been traumatised by an incident, and we now have clarity that Employee Wellbeing make that referral.

Safe care

Discussion around Procedural guidance how staff manage information sharing of an untoward incident.

Effective care

Nice has published a new Clinical Guidance on shared decision making. Rob urged all to view this document.

Eating Disorders:

Rob Kidd said they are considering sending a letter to those who have waited more than six months, saying they are sorry for the delay and include resources they can access whilst waiting. Neil Jones said he would encourage contact.

Prevent training:

Rob said they needed to pick up on this as it had been quiet lately.

MENTAL HEALTH ACT

Sunni Webb said that the Exception Report highlighted the on-going 136 and tribunal issue.

Sunni informed the Committee that the first VC tribunal pilot is tomorrow.

In relation to 136, the decision is that we are going with Richard Jones's latest advice in that the clock starts ticking in A&E unless the person has gone there for treatment completely unrelated to their mental disorder. We will ensure that everyone is aware. The 136 Policy is out of date and will be updated. **Action: Sunni Webb/Neil Jones**

NATIONAL SERIOUS & UNTOWARD INCIDENT STEERING GROUP (NSUISG)

There is a NSUISG meeting being held at the same time as this meeting today. Minutes dated 13th April 2021 state that low lying ligature points should be a high risk when completing audits.

Mark Warren referred to a recent inquest regarding a patient who used a plastic bag to commit suicide. The Coroner requested that staff ensured that plastic bags were locked away.

HEALTH PROMOTION, PROTECTION AND IMPROVEMENT

No report.

SAFE CARE

4.1 Patient Safety Incidents

There had been two recent in-patient deaths on acute wards.

During a resuscitation incident at Hafan y Coed, the resuscitation team required the use of a Intraosseous device. Tara Robinson said that they now have an IO device within the unit, on long term loan and will sit within ECT for access by Shift Co-ordinators. We will need to procure some needles as they do not have much life left on them. A Thank you was extended to Kelly Panniers for arranging this.

Rob Kidd said that as we now have a Health Information Analysist, could they complete some kind of live data on incidents on the ward highlighting the hot spots. Catherine Evans said that her colleague, Matt McCarthy, was very involved with data and this may be something he could look at.

Rob said they had done a survey using the essences tool, which asks staff how safe they feel.

4.2 Patient Safety Alerts

Internal Safety Notice 2021/Jun/014 - Esketamine withdrawal from C&V UHB

Pfizer have discontinued Esketamine however Ketamine is available. Internal Safety Notice 2021/Jun/014 had been circulated and noted.

Internal Safety Notice 2021/Jun/015 – Combination fluids of glucose 5% and sodium chloride 0.45% containing different strengths of potassium chloride (0.3% or 0.15%) are available.

Combination fluids of glucose 5% and sodium chloride 0.45% containing different strengths of potassium chloride (0.3% or 0.15%) are available**.** There is a risk of these fluids being accidentally mixed up. The Internal Safety Notice had been circulated and noted.

Internal Safety Notice 2021/Jun/016 – Unsecured Medical Gas Cylinders.

Medical Gas Cylinders which are not secured can topple causing injury. The Internal Safety Notice had been circulated and noted.

4.3 Key Patient Safety Risks

Pressure Damage

Tara Robinson said that Kelly and Julia are working on to the reduction of hospital acquired pressure damage by 25% which we have to achieve by July 2022. There are various workstreams around this.

EFFECTIVE CARE

5.1 Clinical Board Clinical Audit Plan

No report.

NICE Guidance

Neil also urged everyone to read the new Nice Clinical Guidance on shared decision making.

CG142 – Autism Spectrum Disorder in Adults: diagnosis and management. Updated June 2021. It has amended the recommendations on identification and assessment to clarify that when the Autism-Spectrum Quotient (AQ-10) is used to assess for possible autism, the score at which the person should be offered a comprehensive assessment is 6 or above.

In Wales, there is a WTTC Guidance on smoking cessation in hospital environments.

5.3 Research and Development

Neil Jones said from the last R&D meeting in July there were 13 research projects. Some interesting work on Participate.

- One issue is that despite Cardiff University investing money into CRIS they have struggled to connect their system with PARIS and have got to the end of the funding period. Some of our intended evaluation work also uses CRIS so we are investing into building a new link between PARIS and their system

- Jon Bisson, the R&D Lead over the last couple of years has stood down. We will advertise this post shortly.

- The MHCB Research & Quality Improvement Conference is on 22nd October 2021 via Teams.

DIGNIFIED CARE

No reports.

TIMELY CARE

7.1 Access to Services

Care Aims on the next meeting's agenda.

INDIVIDUAL CARE

8.2 Concerns

A common theme seems to be access to services, neuro developmental disorders, and around ADHD diagnosis.

Paul Cantrell said regarding neuro developmental and how it adversely effects CMHTs and demands on psychology and social work, especially in relation to ADHD and the disjunction between the IS and ADHD. We are undertaking work in the Adult Directorate during Autumn to set up some form of dedicated Neurodevelopmental Service.

STAFF AND RESOURCES

9.1 Disciplinary Trends

Workforce and OD Update attached.

190821 WOD Brief
Mental Health Clinic

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

Sunni Webb had circulated the following documents. Sunni said they had updated and review them and made them more beneficial for staff to use:

10.0 Section 5(2) Doctor's Holding Power Procedure

Summary of the amendment is:

Inserted clarity on the legal position relating to the use of section 5(2) and inpatient status in the Emergency Department, General Hospital and in relation to a conditionally discharged patient subject to restrictions by the Ministry of Justice.

Enhanced section to clearly explain the procedure in relation to receiving the HO12 on behalf of the Hospital Managers.

Inserted section in relation to support from the independent Mental Health Advocacy Service.

Inserted:

- *Appendix 1 – Summary of complete s.5(2) procedure*
- *Appendix 2 – HO12, Example*
- *Appendix 3 – Ending of section 5(2) form*

The Procedure was Approved.

10.1 Section 5(4) Nurse's Holding Power Procedure

Summary of the amendment is:

Inserted section to clearly explain the duties and responsibilities of qualified nurses and the procedure in relation to receiving the HO13 on behalf of the Hospital Managers.

Inserted section in relation to support from the independent Mental Health Advocacy Service.

Inserted:

- *Appendix 1 – Informal to 5(2)/5(4) flowchart*
- *Appendix 2 – HO13 example*

The documents have been circulated widely to Management, the Legislation & Governance Group and Doctors. Comments have been incorporated into the documents.

The Procedure was Approved.

10.2 Power of Discharge Hospital Managers Hearings Conduct Protocol

All amendments had been highlighted throughout the document

The Protocol was Approved.

10.3 Associate Hospital Managers Power of Discharge Handbook

All amendments had been highlighted throughout the document

The Handbook was Approved.

10.4 Missing Person Procedure – MHCB In-patient Facility or a Missing Community Patient

The Missing Person Procedure MHCB is to be followed when an in-patient from a mental health ward is missing or a community patient subject to a community treatment order or conditional discharge who is deemed to be high risk to themselves or others, is missing in the community.

This Procedure was distributed, drafted and re-distributed; discussed in the June meeting with further amendments and is now revised.

The Procedure was Approved.

DATE OF NEXT MEETING

Thursday, 21st October 2021 at 9.30am
(next Clinical Board Q&S Lessons Learned Meeting is on 23rd September 2021)

Meeting Notes
Medicine Clinical Board
Quality, Safety & Experience Committee
Date and time: 19th August 2021 14:30 – 16:00
Venue: Teams Meeting

Preliminaries	
A1	**Welcome & Introductions** Those present: Rebecca Aylward Chair Katherine Prosser Quality & Governance Lead Sarah Follows General Manager Acute & Emergency Medicine Sam Baker Practice Development Nurse David Pitchforth Lead Nurse Integrated Medicine Jenna McClaren Senior Nurse Acute & Emergency Medicine Ruth Cann Senior Nurse Integrated Medicine Carly Simpson Senior Nurse Integrated Medicine Annie Burren Patient Safety Improvement and Falls Lead Lisa Green Senior Nurse Acute & Emergency Medicine Catherine Bingham Service Improvement Manager Integrated Medicine Jacqui Westmorland Covid-19 Senior Nurse Vicci Page Deputy General Manager Specialised Medicine Meline Haywood Project Manager Integrated Medicine Matthew McCarthy Patient Safety Facilitator Barbara Davies Lead Nurse Specialised Medicine Emma Keen Service Manager Integrated Medicine Craig Davies Deputy Service Manager Acute & Emergency Medicine Geraldine Johnston Director of Operations MCB Jane Murphy Deputy Director of Nursing Natasha Whysall Senior Nurse Integrated Medicine Aled Roberts Clinical Board Director Iain Hardcastle General Manager Integrated Medicine Gill Spinola Senior Nurse Specialised Medicine Keithley Wilkinson Equality Manager Cardiff & Vale UHB Rhiannon Owen Service Improvement Manager Acute & Emergency Medicine Angela Jones Senior Nurse Resuscitation Team
A2	**Apologies for absence noted**: Carol Evans Senior Nurse Sian Brookes Lead Nurse Ceri Richards-Taylor Dr Jeff Turner Dr Lyndsey MacDonald Senior Nurse Cath Morris Derek King Infection, Prevention and Control
Quality & Safety	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY	
1.0	**To receive the minutes of the previous meeting:** June's QSE meeting notes were approved

1.1	**Maters arising:** Nil noted
1.2	**Patient Story**: Acute & Emergency Medicine Senior Nurse LG shared a patient story of two sisters who presented to the Emergency Unit with Salmonella sepsis following an outbreak in the community. On arrival to the department both the Emergency Department and UHB were at Escalation Level 4, and WAST Level 6. Both Sisters were nursed in the Ambulatory Care area of the Emergency Unit, initially one in the examination cubicle and one in a hard-back chair. It was noted that there was a delay in initial EU and medical clerking secondary to the number of patients in the department. Treatment was initiated for both Sisters, and staff noted one Sister who was sat in the chair, kept walking into the cubicle to be with her Sister. To support them being together a chair was placed in the treatment cubicle, however the area was not appropriate to place two trolleys secondary to space constraints. The requirement for both Sisters to have inpatient cubicles were escalated via the MCB Hub and LCC for the period of time they were both in the department. Whilst awaiting inpatient beds, the Sisters would take it in turn to either lay on the trolley, and chair. However, the Sisters were taking it in turns to lay on the floor despite staff constantly asking them not to do this. Both of the Sisters began to experience faecal incontinence (diarrhoea) including whilst on the floor which made it extremely difficult for nursing staff to provide appropriate care. Nursing staff recognised that both Sisters had increased output and low BP despite IVI an appropriate treatment. There was continued escalation to the LCC for inpatient beds. One of the Sisters was allocated a ward bed and was later transferred to Critical Care for aggressive Intravenous fluids to replace a low Magnesium and Potassium. The patient was discharged home several days later. Nursing staff felt they could not provide the effective care to both of these Sisters and poor patient experience. Concerns were raised about patients in the Ambulatory Area of the Emergency Unit not being prioritised for ward beds, but recognised there was an exceptionally high demand for cubicles during their stay. AR raised concerns regarding the lack of cubicles and inappropriately holding patients in the Acute & Emergency footprint, and how effectively this can be managed with LCC. SF highlighted the Directorate are recording an hour by hour basis the congestion and number of patients in the department. Pre Covid-19 the department would normally see 100/110 patients in the footprint, compared to now 190 patients predominately through the night. CD confirmed that there were up to 8 cubicles requests during this time, with the longest wait for 80 hours. RA advised this patient story should be developed as it gives good evidence of the pressures within the department and should be shared more widely.
1.3	**Feedback from UHB QSE Committee**: June's minutes currently not available.
1.4	**Directorate QSE minutes:** Received for: nothing to share in terms of exception reporting and shared for information. Rheumatology Dermatology Clinical Gerontology Gastroenterology Acute & Emergency Medicine
1.5	**National Incident Reporting Policy:** MC shared the new changes to the Incident Reporting Policy which came into place in June 2021. Incidents are now managed by the Delivery Unit rather than Welsh Government. The term SI has been replaced with Nationally Reportable Incident.

	The National Patient Safety Incident Reporting policy supersedes the Serious Incident (section 9) of the Putting Things Right guidance. Never Events, in-patient suicides, maternal deaths, avoidable healthcare acquired pressure damage reporting remains unchanged. The following changes include Phase 1 (immediate effect) where incidents which potentially cause major or catastrophic harm, where Clinical Boards have 5 working days to establish if there were any causative or contributory factors that impacted on this outcome. There is also the option to request our own time for the completion of the investigation from 30, 60, 90 or 120 working days to complete an investigation. Phase 2 is still being worked on by the DU around thematic reporting such as falls with the aim to collect intelligent data to support quality improvement work. The focus is currently on Phase 1. The guidance also advises a proportionate investigation to establish whether any action or inaction, unintended, or otherwise, caused or contributed to the reportable incident recognising that an RCA investigation will not always be required. Closure forms have also changed, if causative factors have been determined a Learning From Event form will need to be submitted. If there were no causative factors an Outcome Report can be submitted. A downgrade request from can now be submitted where further investigation finds that the incident did not meet the criteria for national reporting. RA expressed the difference in terminology and that it is focused on the learning and improvements which is positive.
1.6	**Strategic Equality Plan** KW presented the attached Improvement Through Inclusion Strategic Equality Plan – Caring about Inclusion 2020 – 2024 and the key agenda for the UHB and Clinical Boards. This lays out our commitment to equality and diversity, eliminate discrimination, advance equality and foster good relations. Four key areas: Communication, respect, access in its wider context and quality of care and equality of pay. KW asked how as a Clinical Board we can get this embedded into Directorates as its important to spread this message. BD commented that serious consideration should be given to embed this across our forums in terms of education, development days. Significant work already underway with the Service Improvement Manager for Welsh Gender Services. SB keen to link in for HCSW and Registered Nurses development days.  Improvement Through Inclusion -
1.7	**Significant Nurse Staffing Risk** Secondary to time constraints this will be carried forward.
HEALTH PROMOTION PROTECTION AND IMPROVEMENT	
2.0	**Healthcare acquired Covid investigations update**: JW advised that both Rapid and Full investigation tools continue to be completed. The initial trial of the Safe 2 Move Risk Assessments reflected some issues with getting the risk assessment completed from EU/AU up to the wards, by identified that C4 were very proactive in completing the risk assessment on transfer to SRC. MEAU in UHL have been very engaged and completing the risk assessments for East 2. The Principles for Safe Patient Placement and Framework for Patient Placement to support the correct patients being in the correct place has been shared by Ruth Walker with three key principles: consider all Infection, Prevention and Control and organisational risks, isolate the patients, and cohort the patients if isolation cannot be achieved.
2.1	**Influenza/Covid vaccination update:** KP outlined the UHB and Clinical Boards plan for this years Flu Campaign. Occupational Health have organised 4 mini mass vaccination clinics across UHW

	and UHL to support as many staff as possible to have their Flu vaccine early. One these clinics have finished Clinical Boards will then be able to request vaccines. The Clinical Board would like to try and replicate mini vaccination clinics to support Champions and the current staffing concerns across the Clinical Board. This would also support the new changes to the electronic consent forms and reporting figures. By changing to electronic consent forms it is hoped that the data cleansing and reporting will be more accurate and timelier. KP will be able to update once Flu training has been released on ESR, and for Teams training for new Champions. There have been discussions regarding whether Flu Champions could support the Covid-19 staff booster programme, but currently this will not be part of their roles. The Covid-19 booster programme is due to start in October and KP has a meeting arranged to discuss with RA and relevant Lead Nurses regarding who would be the first priority groups across the Clinical Board.
2.3	**Falls Dashboard**: AB outlined a falls dashboard which has been pulled from BIS showing the number of falls across the Clinical Board and Directorates noting the number of falls, and any injurious injury. Significant decrease in falls overall noted, however the acuity of patients feels like winter. AB raised concerns regarding falls being reported per ward as part of Ward Accreditation as the numbers can fluctuate particularly around winter pressures, and reluctant to put a figure on what falls should be eg, on Gold, Silver and Bronze. It is more important to know their data, what the themes are and what are they doing about it. Currently in the process of identifying what the boundaries would be for falls and Ward Accreditation.
SAFE & CLINICALLY EFFECTIVE CARE	
3.0	**Serious Incidents update:** Serious Incidents presented for closure: Acute & Emergency Medicine In92337 An 80 year old lady with a background history of Hypertension, Type 2 Diabetes on Insulin, Stage 3 Kidney Disease and Osteoarthritis had a telephone consultation with a General Practitioner (GP) on 5th August 2020 complaining of a two week history of 'burping and regurgitation of food, describing a burning acid feeling relieved somewhat by Gaviscon. This was thought to be epigastric pain in nature and the patient was commenced on Omeprazole 20mgs once a day. On 16th August 2020 the patient had a home visit from the GP Out of Hours Service, complaining of a two week history of epigastric pain exacerbated by eating. The pain was described to radiate to the central chest and relieved by Gaviscon. The impression was that the pain was most likely secondary to the stomach, but a cardiac cause could not be excluded without further investigations. Hospital admission for assessment was discussed, but the patient declined for that evening, and agreed to contact their own GP the following morning and seek advice about investigations. The patient was reviewed in their GP's surgery on 17th August 2020 following the submission of an eConsult request. The impression was that of Gastro-oesophageal reflux disease with a potential duodenal ulcer. Prescribed Omeprazole was increased to 40mgs once a day, blood tests arranged and worsening advice given. It was suggested that if the patients symptoms continued for a further four weeks an Endoscopy should be considered. On 21st August 2020 the patient had a telephone consultation with a Practice Nurse and GP as the patient was experiencing episodes of hypoglycaemia, background of Diabetes, and continued to complain of epigastric pain. The patient was advised to stop taking the evening dose of Gliclazide and Felodipine. A potential side effect of Felodipine is abdominal pain and worsening of Gastro-oesophageal reflux disease.

On 24th August 2020 the patient had a telephone consultation with a GP at 11:30am reporting being short of breath over the weekend. The patient was noted to be speaking in sentences so a face to face consultation was arranged for 12:50pm. The patient explained during the consultation that they had been experiencing aching in the chest for three weeks, which was getting worse, and was now short of breath. The patient had begun to develop episodes of chest pain at rest with radiation to the jaw and ears. The impression was noted that this might be Unstable Angina and possibly Anaemia.

The patient was referred by the GP for a medical assessment, via Bed Bureau Patient Access Services at 12:56, noting 'potential Unstable Angina and Anaemia with shortness of breath, oxygen saturations 98% with no Covid-19 concerns'. At this time the GP medical intake for admissions was at University Hospital Llandough (UHL).

The patient arrived at UHL at 14:40pm on 24th August 2020 via own transport. Initial Covid-19 screening and triage was undertaken by a Registered Nurse who directed the patient into the 'purple stream (patients suspected to have COVID-19, or require Covid-19 to be excluded based on the presenting condition) area of the Medical Emergency Assessment Unit (MEAU), based on a presenting condition of shortness of breath. Secondary to there being no trolley capacity available at the time in the purple area, the patient was placed in the 'purple ambulatory care' area. This area consists of three recliner chairs where patients can wait for assessment or discharge based on MEAU Ambulatory Covid-19 Area guidelines.

The patient was triaged at 15:30pm by a Registered Nurse, noting a three week history of shortness of breath and chest pain. A heavy chest which radiated to the back was described. Observations were recorded, noting a National Early Warning Score (NEWS) of 3, with a pain score of 7-8. A blood test including a Troponin was taken. As part of the triage an ECG should be performed. As the patient was sitting in a chair in the ambulatory area with other patients, an ECG was not performed as per the MEAU – Ambulatory Covid-19 guidelines. A triage code of 'yellow/category 3' was documented based on the Manchester Triage Score, meaning the patient should be seen by a clinician within one hour. The Nurse in Charge of the purple area was advised that the patient needed to have an ECG performed, and needed to be prioritised for a trolley space.

The patient was checked by nursing staff at 16:30pm, and a Foundation Year (FY) 2 Doctor attempted to review the patient. Secondary to there being no trolley space capacity, the medical clerking/review could not be conducted. At 17:50pm the FY 2 Doctor returned and started to prepare results and notes to review the patient. Welsh Clinical Portal was accessed with a raised Troponin of 7083ng/litre reported. A normal Troponin result is between 0-16ng/litre. Nursing staff were advised immediately that a trolley space was required for the patient in order to perform an ECG.

The patient was moved into a Crash Room, following a patient who was for discharge being requested to sit in a chair in the waiting room. An ECG was performed on the patient at 18:18pm and ST elevation was noted by nursing staff, confirming an ST elevation Myocardial Infarction. The ECG was shown immediately to medical staff. The patient was connected to a heart monitor and a repeat set of observations performed at 18:30pm with a NEWS score of 5 recorded. Following a medical review Acute Coronary Syndrome treatment was prescribed and administered. This included a Glycerine Trinitrate infusion, Aspirin and Clopidrogel. A repeat ECG was performed and a chest x-ray undertaken, which identified bilateral effusions in keeping with heart failure. The Cardiology doctor on call was contacted at University Hospital of Wales (UHW) and transfer to the Cardiac Catheterisation department for Percutaneous Coronary Intervention. Welsh Ambulance Service Trust (WAST) were contacted at 19:15pm to request a '999' transfer to UHW.

WAST Paramedics arrived at MEAU UHL to collect the patient at 19:39pm for transfer to UHW Cardiac Catheterisation department. Whilst on the back of the ambulance being prepared for transfer the patient suffered a Pulseless Electrical Activity (PEA) cardiac arrest. Cardiopulmonary Resuscitation (CPR) was commenced immediately on the ambulance, and the patient was transferred back into a Crash Room for ongoing resuscitation in line with resuscitation guidelines. Sadly after 45 minutes of attempted resuscitation it was agreed to cease CPR and the patient was pronounced dead.

The investigation concluded the following root causes:

- An ECG was not performed on the patient until 18:18pm, nearly four hours following presentation to MEAU with chest pain radiating to the jaw and shortness of breath.
- The patient was placed in the purple stream based on a presenting complaint of shortness of breath and chest pain. Initial Covid-19 screening on presentation was deemed appropriate to have placed the patient within this area, but consideration should have been given to move to the amber stream once Covid-19 had been ruled out.
- The patient was placed in the ambulatory care area inappropriately secondary to the lack of trolley space in the purple stream.
- The lack of trolley capacity within the purple area delayed an ECG being performed.
- The patient was incorrectly triaged using the Manchester Triage System secondary to the pain score and the cause of the chest pain being excluded.
- The MEAU – Ambulatory Covid-19 Area guidelines guided staff to not perform an ECG as the patient was sat with other patients. The guidance did not provide support to staff on what to do in these circumstances if an ECG could not be performed. The urgency to undertake the ECG was not appreciated by the nurse in charge of the purple area, or escalated to the overall nurse in charge of MEAU as they believed it was not alarming chest pain.

The investigation identified the following incidental findings:

- GTN as part of the Acute Coronary Syndrome pathway was prescribed to commence at 0.6mls per hour. This was incorrectly commenced at 1.2mls per hour which is not in line with prescribing guidance. This has been manged in line with the UHB's medications management guidance.
- The patient was not appropriately prepared for transfer to the mortuary in line with last offices. The Health Board guidance for the care of the deceased following an expected death was reiterated to all staff immediately after this incident.
- There is a need for Primary Care to consider a differential diagnosis when a patient repeatedly presents with ongoing chest/epigastric pain, and referral for assessment.
- An ECG was not performed at triage secondary to capacity constraints and the patient being in the ambulatory care area.

Improvement plan In122783.doc

Improvement Plan attached:

KP shared how extremely difficult an investigation this was to undertake, and for the staff concerned. This is also subject to a concern and Her Majesties Coroner's inquest.

Integrated Medicine
In136315

The completion of a root cause analysis investigation identified the following:

The patient was admitted to University Hospital Llandough (UHL) on 3rd March 2021 after falling at home the previous day. After assessment in the Medical Admissions Unit (MEAU) the patient was transferred to an inpatient ward for ongoing care. On 4th March 2021 the patient was reviewed by the multidisciplinary team, led by a Consultant Geriatrician. Appropriate standard risk assessments were undertaken in line with UHB Policy and a plan of care made. There was no requirement for enhanced observation. On 5th March 2021 the patient was unable to participate in physiotherapy as he reported feeling 'muddled' and did not want to get out of bed. The patient was nursed in bed for the remainder of the 5th March and overnight was noted to be unsettled and trying to climb out of bed although he was calm and settled afterwards.

On 6th March 2021 at 17:00 the patient was observed by a HCSW who saw him stand up from the chair. The HCSW was taking observations of another patient opposite. As the HCSW walked towards the patient, he fell backwards, hitting their head on the table and then the floor. The patient also sustained a skin tear to the right arm which had caught on the foot of the table. The patient did not loose consciousness and was attended to immediately by ward staff. A 3m deep laceration of the back of the head had been sustained. The patient was reviewed post fall, neurological observations commenced and a request for a CT head scan was made. The CT scan identified an 'acute right sided subdural haematoma with an ongoing bleed. Mass-effect resulting in 5mm left sided subfalcine herniation'. The ward doctor discussed the results with the neurosurgical team but surgical intervention was not considered to be appropriate. At 21:00 the patients Glascow Coma Scale (GCS) had reduced, and the nursing staff escalated their concerns to the medical team who attended and examined the patient. Unfortunately the outcome was considered to be poor and the nursing plan re-orientated to comfort care. The doctor who examined the patient met with his family and explained the clinical situation and prognosis. The patient received regular nursing care and the family where offered open visiting in order to spend time with the patient. The patient died peacefully, death was verified at 14:35 on 8th March 2021.

The investigation highlighted the following notable/good practice:

- Excellent multidisciplinary care and communication demonstrated between General Practitioner, Community Resource Team, home carers and family.
- Thorough history taking and plan made on admission to MEAU UHL.
- Facilitation of the patients wishes to sit out of bed when he expressed a strong desire to do so.
- Good communication with the family by the ward multidisciplinary team.

The investigation also highlighted that the Coronavirus pandemic, causing a reduction in physical activity, leading to de-conditioning, and the fact that the patient was elderly, frail and living with Parkinson's disease was a contributory factor.

The investigation identified the following incidental findings:

- There was a plan to record the patients Fluid Balance Charts and weigh him twice per day. These tasks were not completed adequately.

	• The Injurious fall was not escalated to senior staff within the Medicine Clinical Board in a timely manner. This was addressed with the Ward Sister and Lead Nurse immediately. • When the patients behaviour changed temporarily overnight on 5th/6th March, it would have been best practice to commence a behaviour chart. • Simulation falls training was available pre pandemic but staff were unable to be released secondary to ward acuity. Due to the pandemic, Practice Educator Nurses had been redeployed to work clinically and training was suspended. Staff on ward had not received recent training on falls prevention and management. The investigation concluded that this was an unpreventable fall in an acutely unwell older gentleman with increasing frailty and multi morbidity. The following recommendations were noted: • A training needs analysis should be undertaken to consider whether training for falls prevention and management should be mandatory for all staff. • Clinical Boards throughout the UHB should arrange for ward level training of staff to address shortcomings in the completion of patients weight and fluid balance charts. Practice Development Nurses have implemented a rolling training package which captures the recognition of a patients deterioration, why patients become confused and dehydrated, documentation and falls including the use of the Hover jack. To date (30/06/2021) all clinical areas in UHL and Barry hospital have undertaken this training. Further sessions are planned for St Davids Hospital and Lakeside Wing, to then progress to UHW. Medicine Clinical Board continue to provide ad hoc falls prevention and management training for staff as required. Simulation training is complex to initiate secondary to the ongoing Covid-19 pandemic and social distancing. On 15th June 2021 at the UHB Corporate QSE meeting it was agreed that falls prevention and management training become Mandatory. The Clinical Board will work with LED and the Falls Lead to promote this once established.
3.1	**Infection Prevention and Control up-date and HCAI reduction:** DK sent apologies but information noted: 284 days since last MRSA 13 days since last MSSA 21 days since last C difficile 11 days since last E. Coli 276 days since last Pseudomonas 21 days since last Klebsiella Currently only on target for Pseudomonas, MRSA and E. *Coli,* recognised that the increase in MSSA and C. *difficile* can in part be attributed to increased antibiotics and Covid-19 patients. There were seven incidents or outbreaks in July affecting 14 patients and no staff resulting in 41 bed days lost. C4C scores – all wards within the Clinical Board were compliant for the four week period 14th June – 5th July 2021.
3.2	**Point of Care Testing; any actions required following circulation of information from POCT team** No issues to raise.
3.3	**Medical devices/equipment issues**

	SB advised that T34 pumps pre 2019 are being replaced by Bodyguard T and no formal training is being provided. Information will be shared with wards from the equipment library and staff will be asked to read and sign that they have received this information.
.4	**PSN/ISN/MDA's:** The following PSN/ISN's were shared for information and dissemination: • CEMCPhA 2021 Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121 • • CPho_MedsLet_2017 – Dalacin supply disruption • ISN 2021 Jun 013 Pump Giving Sets • ISN 2021 Jun 014 Esketamine • ISN 2021 Jun 015 VR111 Fluids • CPhO/MedsLet/2021/16 Update on the disruption supply of Verteporfin 15mg powder for solution for infusion • Intrafix SafeSet Back Check Valve
3.5	**Cardiff Hot Debrief Pilot June 2021** A Burrin presented a Hot Debrief Pilot that was undertaken on A1L. Its aim was to draw out learning which could be shared immediately following a fall with a two-part approach including a hot debrief (as soon as possible after the fall; on the same shift and an after-action review), involving both patient and carers. This pilot can be completed electronically or manually, and some area's have requested the additional use of 'Measles Maps'. The debrief consists of capturing what the patient said happened, what staff said happened, measurables; where, when and how, performance against multifactorial risk assessments (MFRA) and what was learnt from the fall. The pilot identified there was a drop in the number of falls reported, learning identified to support NICE 2015 falls guidance for the completion of lying and standing blood pressure, and the lack of formal delirium assessments. The pilot identified there were no falls from over bedrails, and Measles Maps identifying common areas for patient falls. This pilot is being widened to other inpatient areas, eg Sam Davies Ward Barry Hospital.
3.6	**Learning from Falls Review Panel July 2021** Shared for information; Areas to note include the completion of lying and standing blood pressure within multifactorial risk assessments for falls for all inpatients who can stand. Screening for Delirium using 4AT, completion of neurological observation in line with NICE 2015 post falls guidance. The use of Kirton chairs must be demonstrated to have a benefit and should be avoided where there is rehabilitation potential, a through individualised risk assessment must be undertaken to ensure there is no inappropriate use as this could represent restraint and careful consideration is needed for their use.
DIGNIFIED CARE	
4.0	**Feedback from Internal Medical Examiner UHL** Secondary to time constraints this will be deferred to the next meeting.
TIMELY CARE	
5.0	**MEAU attendance Standard Operating Procedure**: Lisa Green shared the attached SOP to support MEAU and WAST and appropriate admissions/actions required when presenting to MEAU. Agreed in principle but those

	present advised to send KP any comments before final sign off. To be shared with WAST colleagues for comments.  MEAU attendance SOP 2021 (post KP).c
5.1	**52 week RTT update** Specialised Medicine: VP shared the summary position for Specialised Medicine: Dermatology month end position is that there will be 1898 patients breaching, of those 529 are breaching 36 weeks position and 1369 breaching 52 weeks. Rheumatology month end position is that there will be 671 patients breaching, of those 254 are breaching 36 weeks position and 417 breaching 52 weeks. Gastroenterology month end position is that there will be 439 patients breaching, of those 44 of those are waiting over 52 weeks. Dermatology position is slightly improving, and some improvement noted in Rheumatology secondary to the validation of the lists. Recovery action plan in place across Specialised Medicine which includes waiting list initiatives, recovery funding, clinical validation and strict referral acceptance. The implementation of a model Endoscopy Unit, insourcing, and working with Surgical colleagues to secure regular lists for RFA procedures. Integrated Medicine Stroke performance Integrated Medicine CB shared the summary position for Integrated Medicine: Arrears to focus on are Clinical Pharmacology, with a potential for 22 patients to breach 26 weeks. Other area of concern is Parkinsons there are 23 patients potentially breaching 26 weeks. Stroke Position: noted 83% of patients assessed by a Stroke Consultant. For June 53% of patients were scanned within 1 hour of arrival, 60.3% of patients received a swallow assessment within 4 hours of arrival, and 50.8% of patients admitted to the Stroke Unit within 4 hours of arrival. Main constraints have been around access to CT scans and IP&C guidance, and bed capacity on the Acute Stroke Unit secondary to Covid-19 outbreaks. Emergency Unit Performance update CD shared the current position in EU. A weekly dashboard focuses on 4 hour performance which is currently around 68%, and noted for the first time we are not the best performing Health Board. 144 12 hour breaches noted for the last 7 days. Continue to report the lowest number of 12 hour breaches across Wales, 544 were reported for July. 193 lost hour for WAST last week, noting Sunday and Monday's are the most challenging. Continue to remain the best performing but recognise improvement still needs to be used. The footprint within the Emergency/Acute footprint is slowing flow through the department with an average from midday onwards of over 100 patients. Social distancing is a significant challenge. Small increase noted in Paediatrics. An increase seen in the number of DTA's within the department which is adding to the congestion.
INDIVIDUAL CARE	
6.0	**National User Experience Framework** Feedback from 2 minutes of your time survey – relevant improvement plans: These are currently not being received, but will remain a standing agenda item.
6.1	**DTOCs** No information received but will remain a standing agenda item.

6.2	**Compliments** Secondary to time constraints this will be deferred until the next meeting.		
6.3	**Safeguarding** Secondary to time constraints this will be deferred until the next meeting.		
6.4	**Concerns update** Secondary to time constraints this will be deferred until the next meeting.		
6.5	**Learning From Events Feedback:** LFE 3546 AB LFE 3858 BM Secondary to time constraints this will be deferred until the next meeting.		
Staff and Resources			
7.0	Staff well-being	Chair	
PART 2: Items to be recorded as Received and Noted for Information by the Committee			
AOB			

Date and time of next meeting: 21st October 2021 14:30 via Teams

MINUTES
PCIC CLINICAL BOARD
QUALITY, SAFETY & EXPERIENCE COMMITTEE
Date and time: Tuesday 16th November, 2021 10.30 am – 12.30 pm

Attendees:
Richard Desir (RDe) Director of Nursing
Rhys Davies (RD) Locality Manager, North West
Lisa Dunsford (LD) Director of Operations
Clare Evans (CE) Head of Primary Care - item 6.7 only
Helen Kemp (HK) Deputy Clinical Board Director
Anna Kucynska (AK) Community Director
Danielle James (DJ) Operational Manager for GP OOH
Karen May (KM) Head of Medicines Management
Karen Mills (KMi) Senior Nurse, HMP Cardiff
Anna Mogie (AM) Deputy Director of Nursing
Rob Parr (RP) Organisation Development Manager
Carol Preece (CP) Lead Nurse South East Locality
Laura O'Connor (LO) Quality and Safety Officer (minutes)
Andrea Rich (AR) Palliative Care
Rachel Thomas (RT) Assistant Director of Operations
Lynne Topham (LT) Acting Assistant Director of Operations
Wendy Wade (WW) Service Manager PCIC
Diane Walker (DW) Deputy Director of Nursing
Lisa Waters (LW) Senior Nurse for Quality and Education
Suzanne Wicks (SW) Clinical Negligence Claims Manager

Apologies
Rachel Armitage, Quality and Safety Manager
Helen Donovan, Lead Nurse Vale Locality
Nicola Evans, Head of Workforce PCIC

ITEM NO.	TITLE	ACTION
1.	The Chair warmly welcomed the group to the meeting.	
2.	Apologies for absence were noted as above	
3.	No declarations of interest were received.	
4.	The Minutes of the meeting held on 7th September, 2021 were approved except for the following amendments: • Date changed from 14th July 2021 to 7TH September 2021 • LOC to ensure RDe and RD are clearly defined throughout, as they are two separate people. There were no other matters arising.	

5	The PCIC Quality & Safety Action Log was updated. See separately.	
6.1	OOH Business Report DJ highlighted from the report the following: OOH's main risk remains the high levels of staff sickness and vacancies continue to be unfilled. This has impacted on patients as the average waiting time to answer the phone has increased significantly. To combat this, 17 new call handlers have been trained to help support the service however the effect of this will not been seen immediately . The fixed term contracts have been extended and work is progressing on recruiting a substantive salaried GP's. There has been an increase in demand in Dental Services. Therefore, Dentist triage on weekends has been extended until the end of March 2022 and Daytime dental triage now sits under the management of OOH / CAV 24/7 A proposal to recruit more Dental nurses has been submitted to Senior Management Team.(SMT) and the Emergency Dental Service Manager job is out for advert. The provisional date for ''go live' for the 111 roll out is 7th December 2021. The transitional care unit has now opened and talks are ongoing regarding the management of this after 1st December 2021. Staff will be on a temporary 6-month fixed term contract to commence 1st December 2021. DW to draft a response for the concern team to circulate to the public regarding wait times. The group noted the above.	DW
6.2	N&W Locality Business Report RD emphasised the following from the report: An increase in short term sickness and long term sickness is affecting all teams. Additionally, staff turnover has also increased. The Out of Hours District Nurse team's workload has increased and vacancies remain unfilled which is impacting the service. CRT are facing considerable challenges and have one full time equivalent staff member remains deployed to the Mass Vaccination Centre. The limited Acute Response Team service is under pressure in particular the anti-coagulation services and prescribing. This increased pressure currently seen in	

Commented [DW(aVU-PC1]: ART sits in the vale – so you need to add that the pressure currently seen in ART is having an impact on the DN teams in the north west

	ART is having an impact on District Nurse teams in the North West. The Malinko Electronic Scheduler has been partially rolled out and staff training has commenced. The ongoing Community Health Council issues relating to Continuing Health Care remain a risk as the locality is unable to contract the full care hours and families are having to fill those gaps. Lastly, it was noted that compliance is high for those Trained in Level 2 Safeguarding Adults. RD reassured the group that despite the challenges listed above there is no evidence to suggest it has been affecting patient care as it stands. The group noted the above.	
6.3	Vale Locality Business Report In Helen Donovan's absence, Wendy Wade provided a brief overview of the report submitted. WW highlighted the following: There are still ongoing space constraints in the Vale which is preventing services from re-starting post COVID-19. WW also advised that the limited space in hospices and domiciliary care capacity continues to be a problem. The main risk which is on the risk register is Acute Response Team (ART). It has been escalated to SMT and there is a task and finish group now in place to review how to better support the team. DW expanded on this and advised a deep dive had been carried out and the report was published at end of October 2021. This highlighted 7 governance concerns. One particular concern was in relation to the clinical oversight of patients on anti-coagulation therapies. The service is currently still operating as the risk to patients is low however these concerns do need addressing. Regular meetings are taking place to mitigate the risks and staff are not accepting patients that do not follow the strict defined pathway. GP Practices and secondary care have started to question this so communication will be released to them shortly. RDe and HK are due to meet the haematology consultant and lead nurse and colleagues in Secondary Care to discuss this further. WW reported positively that nursing recruitment has improved in the DN teams and further recruitment has begun for more nurse assessors. LW confirmed that Adult Safeguarding Level 2 compliance is 70%, Children Safeguarding is 71.93% and Violence against Women is 63.51% for the Vale.	

Commented [DW(aVU-PC2]: Partially rolled out

Commented [DW(aVU-PC3]: CHC in this context stands for Continuing Health Care

Commented [DW(aVU-PC4]: Does this refer to training?

	ACTION: All Localities were requested to provide NEWS compliance for next meeting. Lastly, the group were informed that there is a pressure ulcer prevention day on the 18th December.	**All localities managers**
6.4	S&E & HMP Business Report CP echoed the previous concerns regarding short and long term sickness, with stress and exhaustion frequently cited. All District Nurse teams are reporting escalation levels 3 or 4. Out of 5, 3 teams are significantly under capacity. Roath and Splott teams have been impacted the most, with only 2 staff members available for weekend shifts. CP gave an example that there was 15 unallocated calls on one particular day. 4 risks for HMP Cardiff on the risk register have been escalated to Senior Management Team. There is an action plan in place following the recent death of a prisoner in HMP. There are 2 fast track disciplinary ongoing and there is one formal investigation ongoing regarding a patient at HMP Cardiff LW confirmed that Adult Safeguarding Level 2 compliance is 62.11%, Children Safeguarding is 56.9% and Violence against Women is 62.6% for the Vale. **RDe asked for an update at the next meeting in regards to domestic violence as there has been a 50% increase in cases.** The group congratulated the DOSH team on the number of compliments they had received and Kirsty John for being named the Royal College of Nursing Nurse of Year.	CP
6.5	Medicines Management KM highlighted the following from the report submitted. Work is ongoing around Patient Experience and how the pharmacy interacts with other sectors to promote seamless care. Regarding oral conception prescribing documentation is still in draft form. Final documentation once approved will brought to a future meeting. The risk for Valproate prescribing has been added for escalation for Senior Management Team. KM also explained that the Pharmaceutical Needs Assessment (PNA) was published on the 1st October. The	KM

	Framework is being reviewed to allow the Health Board to impose sanctions on Pharmacies who are not delivering contract obligations. This will include breaching and remedial notices and allows payments to be withheld. An All Wales approach is being looked at. AM raised concerns over the new local medication policy, in that the governance is unclear on whose responsibility it is for the assurance of prescribing? Whether this be the Health Board, Local Authorities or the Pharmacies. KM advised that this is being debated still as the reference that Cardiff and Vale UHB will be responsible to ensure medications are being prescribed correctly is not in other Health Board's policies or national guidance. The group noted these discussions. The group noted the above.	
6.6	Palliative Care AR highlighted the following from the report submitted. Discussions are being held to whether the fact that Opioids are being used in unlocked syringe drivers in hospital settings should remain on our risk register. The syringe driver chart roll out is still being discussed at the All Wales Palliative Pharmacy Group so AR will update the group once finalised at a future meeting New SLA contracts are being drawn up with Marie Curie and City Hospice to start in April 2022. Both Advanced Care Practitioners finish in December 2021 and there are no currently no funding in place after this date. A leaflet drop has been organised to GP Practices, District Nurse Teams and Nursing Homes before end of November. Marie Curie Hospice are still at reduced capacity which is impacting on secondary and primary care. The team are reviewing the competences set out for staff in the All Wales DNA CPR Section 5 Working Group, which relates to non-medical staff signing the new DNA CPR form. Discussions are also being held on who is responsible to ensure staff remain competence and whether training will be needed. Lastly AR informed the group that the Family Project which looks to improve the education and support available for families after hospital discharge regarding end of life is underway. Skills and Communication Training has been scheduled for clerical and Marie Curie hospice staff. RDe raised cross-boundary concerns in regards to the Palliative Care Pathway, brought to attention following a	

	patient incident. RDe to meet with Jo Lane to discuss the potential need to review this pathway and the need for an agreement to be implemented between Health Boards.	RDe
6.7	Primary Care CE apologised for not submitting a report for this meeting. CE advised the group that one GMS contract has been returned affecting circa 6000 patients. One formal list closure is in place and one application is being considered. CE highlighted that across all GP Surgeries there are rising escalating levels. It was noted that these are the highest levels since the start of the COVID-19 pandemic. 16 Practices are reporting escalating levels, however not all practices are using the escalating tool so the true extent of the problem is unknown. This has put additional pressure on the Primary Care Team and discussions are being held Nationally to help better support practices through the winter. RDe asked what the impact on patients this was having. CE replied that patients are affected, as there are backlogs and demand is higher. HK emphasised that if the demand is higher and the resources are not in place to support this demand, more incidents and complaints will occur. A paper has been submitted to the Senior Management Team with a proposed package of support however it was noted that recruitment and training of staff is currently more difficult. CE next updated the team on Dental Services. Dental Practices remain on the Amber Pathway, currently working at 40% capacity. Sickness and lack of recruitment remain an issue. The centralised waiting list holds approximately 7000 patients waiting to access a NHS Dentist. This issue has been raised Nationally as it is patient impacting. Out of Hours had enlisted additional staff over the weekend to help support. HK suggested that colleagues in secondary care might need to support Primary Care and ask the group for suggestions how to best approach this. Finally CE updated the group on Optometry Services. Contract negotiations are progressing well. The team won three awards for digital healthcare and have been nominated for another award. In terms of Reset and Recovery, funding has been granted to support GMS Chronic Diseases and Optometry Services. The group noted the pressures on the Primary Care Team and thanked them for the continuing hard work.	

6.8	MVC report AM advised the group that the booking centre have reduced capacity and the time taken to book patients for their COVID-19 vaccinations has increased significantly. Patients who need to amend or cancel their booking are unable to do so slots become vacant. This has also been reflected in the number of concerns being received by the HealthBoard from the public. Following the Health Inspectorate Wales visit in April to the Mass Vaccination Centre all actions have now been implemented. The Welsh Language Commissioner formal report following their investigation is still awaited. Lastly, Anti-vaccination protesters have been present at the centres so staff have been informed and supported on how to deal with this.	
6.9	WOD report RDe invited RP to provide an update to the group on Workforce Matters. It was decided that the workforce department would provide a report for all future meetings going forward, starting today. RP verbally updated the group with the following: • Health board staff vacancies are considerably higher than what they should be at 11.53%. Health Board target is 5%. Nursing has 17.5% roles vacant. Medical and Dental is 25.5% and Healthcare Support at 19.3% RP clarified this the data above is for staff employed by the Health Board and not Independent Contractors so the full picture could be worse. • Sickness has continued to rise, an increase of 1% a month. • Turnover is extremely high at 24% AK asked whether exit interviews are being carried out to understand why staff are leaving. RP replied yes but emphasised the need to be more proactive as it is too late to resolve the problem, once the person has left. RP explained that recently 11 exit interviews took place and the common themes will be shared at a future meeting with the group. • Statutory and Mandatory training is 71% compliance. • Non-medical appraisal compliance has decreased to 39% and medical appraisal compliance is 73%	RDe/RP

	• 7 disciplinary cases and one employment claim tribunal. RDe asked that the overview data presented above is broken down into Localities to better understand the extent of the problem and how and where support is needed. AM stressed that Line managers need to start recognising that excessive alcohol consumption amongst staff is on the rise and support needs to be offered to staff. RDe asked that communication needs to be issued to staff in relation to recognising and supporting alcohol consumption for staff. In response to this RP asked the group to also encourage staff to become advocates for health& wellbeing. RP then presented the findings of the Staff Survey. Notably, • Low scores in terms of staff not being able to make improvements in their area of work • Communication between managers and staff was not very good. • Nearly half the Staff didn't not feel comfortable challenging inappropriate behaviour or felt that effective action was taken. • Staff do not feel involve when changes to services are made. • Generally Positive feedback regarding the standard of care being provided and staff felt that the patients were put first, however 20% were not happy with the standard provided. • 74% of staff felt their job did give them a good sense of belonging. The group agreed that actions need to be taken forward and the findings needs to be shared with staff. HK recommended that another survey should be carried out as this survey was post-COVID-19 and the data may be different now. LOC to circulate the PowerPoint slides after this meeting. HK advised the group that she attended a meeting about the introduction of the healthcare support unit. It was piloted to support staff who were involved in coroner's inquests but it has been recommended that it be available for any staff members involved in any investigations, serious incidents or a concern. The group agreed this was beneficial for all staff. Furthermore, HK informed the group that the Governance Team are currently considering 10 GP's cases, 4 of which are being investigation by the GMC. 9 Dental Cases, 3 cases with the GDC for managing,	RP RDe LOC

	Next, HK enlightened the group on how the Governance team have also been looking at how the Mortality Reviews will implemented in PCIC. The Patient Safety Team will review all cases (stage 1) and then escalate appropriately to the Governance team. (Stage 2) The case will then be investigated by the Governance team and feed back to the medical examiner. Currently only deaths occurring in hospital are reviewed however in the Summer 2022 all cases in the community will be reviewed as well. The Governance team currently have 4 cases but are expecting significantly more. There are approximately 180 deaths each month, 50% occur in hospital 50% occur in the community and approximately 20% of those will need a stage 2 review. The group noted the significant workload this will mean and the additional resources needed. HK confirmed training is being arranged for staff involved in this process. LT advocated for training for staff at HMP Cardiff for investigations and coroners inquests. SW echoed this and offered support for all staff from her team.	
7.	Patient Story – HMP Cardiff KM presented the patient story. KM described an incident involving an inmate at HMP Cardiff on end-of life care.	
8.	Risk Register Update Due to time constraints, the risk register was not discussed. No comments were received outside of the meeting.	
9	Once for Wales Implementation Group Update – Datix queue management Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	
10	PCIC Quality Report Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	
11	Update on the future plans for HCAI review Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	

12	Audit Schedule Update	
13	Concerns/compliments • Compliment about Community Testing Unit Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	
	See item 8.	
14	HMP Action Plan update This agenda item was covered in the South East Locality Business Report.	
15	Negligence Claims Update Deferred to 15th February meeting.	
16	Waiting List Update from QSE report See appendix 8. Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	
17	Vacutainer issue/risk update Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	
18	Education and Learning Committee Update Due to time constraints, this agenda item was not discussed. No comments were received outside of the meeting.	

SURGERY CLINICAL BOARD
QUALITY AND SAFETY GROUP
Tuesday 21st September 2021, 08:00-10:00 hours
MS Teams

MINUTES

Present:

Richard Hughes	Consultant Anaesthetist (Chair)
Clare Wade	Director of Nursing
Annie Burrin	Patient Safety and Quality
Arul Kandan	Deputy General Manager T&O
Catherine Twamley	Interim Lead Nurse Surgery, Urol, Ophth & ENT
Catherine Evans	Patient Safety Facilitator
Carly Podger	Finance
Carolyn Alport	SCB QSE Lead
Dean Whittle	Pharmacy
Emma Wilkins	Interim Service Manager
Helen Luton	Lead Nurse T&O
Jon Barada	Theatre Manager
Julie Cornish	Research
Laura Jones	Assistant Service Manager
Rafal Baraz	Consultant Anaesthetist
Rowena Griffiths	Governance & Quality Lead Manager Dental
Terry Stephens	Procurement Nurse, Procurement
Tracey Johnson	Practice Development Nurse
Vincent Saunders	IP&C

In attendance:

Zoe Brooks	Surgery Clinical Board Secretary
Denis Williams	Directorate Manager
Gemma Roberts	Pain Management Nurse

PRELIMINARIES *(Chair)*		
SCB/QS: 21/89	**Welcome and Introductions** Members were welcomed to the meeting and introductions were made.	
SCB/QS: 21/90	**Apologies for Absence** Adrian Turk Barbara Jones	
SCB/QS: 21/91	**Minutes of meeting held March 2021** The Group approved the minutes of the previous meeting.	
SCB/QS: 21/92	**Action Log** Please see Action Log for update	

SCB/QS: 21/93	**Surgery Research Update** JC – Research and Development Lead reported on research achievements, highlighting that a Surgical Research Manager had been appointed and had been in post for around 4 months. It was noted that the Research Manager was working five days a week, with his time divided by directorates, those being ENT, Dental and Colorectal. The Group were informed that a Commercial Research Brochure was being developed by the Surgical Research Manager and was available in Draft format. JC gave an overview of the content of the brochure, highlighting post and potential commercial trials as well as processes for initiating trials. It was noted that the purpose of the brochure was to strengthen the process for quick turn around and allowing for better understanding of how to initiate a commercial trial. JC welcomed any feedback or assistance from the Group. CW – Director of Nursing suggested that JC link in with Medical illustration to help pull the brochure together and tie in with the Health Board's format. It was reported that the Surgical Research Manager had done some great work since being in post which included assisting to secure a grant for studies. JC noted the significant benefits of this post and highlighted the importance of their input.	
SCB/QS: 21/94	**National Reporting Changes** SBAR received and noted by the Group. It was note that as of the 14th June 2021 the way the Health Board reported incidents to NHS Wales Delivery Unit had changes; the term Serious incident had been replaced with nationally reportable Incidents. CE – Patient Safety highlighted that The National Patient Safety Incident reporting policy superseded the Serious Incident section (Section 9) of Putting Things Right guidance; which in effect seen the following changes take place: • Phase 1 (immediate effect) required incidents potentially causing major or catastrophic harm to be reviewed internally by Clinical Boards with onward reporting to the DU if any causative or contributory factors are established. • Phase 2 (implementation date to be confirmed) involves the thematic reporting of healthcare incidents based on common factors regardless of the harm outcome. The Group were informed that in order to determine the facts surrounding the incident to decide on need for external reporting, the clinical areas would need to complete a Patient Safety Fact Finding tool and return to the Patient Safety Team within 5 working days (for those incidents graded major or catastrophic harm). Subsequently, the Patient Safety Team would then submit a Nationally Reportable Patient Safety incident form to the Delivery Unit within the next 2 working days if it is assessed or suspected an action or inaction is likely to have	

	caused or contributed to the unexpected or avoidable death, or caused or contributed to severe harm. CE shared a flow chart, demonstrating these changes and the process. The Group felt that these changes were positive and would reduce the amount of work generated when completing RCA's. The Chair thanked CE.	
PART 1: GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
SCB/QS: 21/95.1	**Matters Arising** **Top ten waiting patients by Directorate** DW - Interim General Manager Performance Information Innovation gave a presentation on top ten longest waiting patients by directorate. The data provided in the presentation was spilt between Outpatients waiting, Inpatient/day case and follow up cycle. The Graph presented for outpatients, demonstrated Ophthalmology as the highest wait at 245 days and Breast at the lowest wait at 43 days. DW highlighted the significant piece of work that had been carried out around waiting lists. It was noted that patients had been contacted via letter to ask if they believe they should be removed from the waiting list and if so the reason for this. It was highlighted that the figures captured in the graph could include patients who are yet to respond and therefore could see these figures reduce. The Group were informed that a further exercise was to take place, in-order to keep these figures as accurate as possible. DW raised concerns around RCS level 2 and 3 patients and requested that these patients are regularly being reviewed due to the length of waiting times. It was felt that this was important to ensure correct coding was being used and all data was up to date on the system. CW – Director of Nursing asked that the Level 2 and 3 patients are reviewed and an update is provided at the next meeting. **Action:** Directorates The Chair queried the Clinical Boards plans to help with Covid Recovery and these waiting times. DW reported that a number of recovery schemes were being established such as the introduction of Module Theatres to help with the backlog. CW reported that a Surgery Clinical Board Covid Recovery meeting took place every Wednesday and welcomed anyone who would like to attend.	
21/95.2	**Intravenous Lidocaine protocol**	

	GR – Pain Nurse reported on the recent consensus statement released in relation to Intravenous Lidocaine. It was noted that Cardiff and Vale UHB had been using this for many years intra-operatively with no concerns, however, post operatively use had been ad hoc. It was noted that a new consensus statement had been realised due to a number of near misses and patient harm following post-operative infusions. It was suggested that i.v.Lidocaine be regarded as high risk medicine and as such it was advised that it may be beneficial as part of a multimodal perioperative pain management strategy. As a result, existing protocol had been revised to reflect the new guidance. GR gave an overview of an eight-page prescription booklet that had been developed as a result of the review, highlight and explaining the following documentation: - • Checklist for consultants • Monitoring form • Nursing Care plan • Dedicated medication label for meds chart • AAGBI guidance • New weight-based protocol for PCA devices. DW – Pharmacy queried where the booklets would be kept and who would supply these. GR confirmed that Pain Management would order and supply these booklets.	
21/95.3	**Wrong Tooth Extract** CW- Director of Nursing reported that wrong tooth extraction was now not classified as a Never event. It was noted that England made these changes over the past year and Welsh Government had now followed suit. The Chair queried if this was the case for both adult and children? CE- Patient Safety confirmed that previously this only included children where milk teeth had been extracted, however it now applied to both adult and children; any wrong tooth extract. RG – Dental advised that this was on the agenda for the next local quality and safety meeting.	
21/95.4	**IPC Feedback** The report was received and noted by the Group. CW- Director of Nursing reported that the Surgical Clinical Board report had been submitted to the Corporate IP&C meeting on the 8th September 2021 and had been shared with this Group for information.	

21/95.5	**Updated Version of Covid-19 Algorithm & SBAR** Documentation was circulated for information and sharing purposes. CW- Director of Nursing highlighted that the document reflected that compressions were classed as an Aerosol Generate procedure and as such correct protocols should be followed.	
21/95.6	**Sodium Citrate Tubes** Internal Safety Notice (ISN) was received and noted by the Group. It was noted that the ISN related to the changes in the new tubes (previously plastic and now glass and requires slightly more blood). The Chair asked that this be circulated within the Directorates for information.	
21/95.7	**Wright Medical Field Safety Notice: AEQUALS PYROCARBON Humeral Head Implant** The Board Secretary reported that this notice had been received from Theatres and not through the usual route and added to the agenda in case of relevance for this Group. AK – Interim General Manager T&O was not aware of this notice and agreed to report back at the next meeting. **Action** AK	
SCB/QS: 21/96	**Feedback from UHB QSE Committee:** No meeting during the period; next meeting scheduled for October.	
SCB/QS: 21/97	**Health and Care Standards – sign of self-assessment/ ongoing review of implementation/ improvement plan:** It was noted that submissions had taken place, however this was carried out corporately and not through the Surgery Clinical Board. CW- Director of Nursing reported that no feedback had been received.	
SCB/QS: 21/98	**Regulatory compliance and external accreditation (where relevant):** No update	
SCB/QS: 21/99	**Exception reports and escalation of key QSE issues from Directorate QSE groups and specialities** **Directorates Exception reports received and noted by the Group.** **Theatre Manager – JB** reported on the following key topics for **Peri-Operative** Directorate: - • It was reported that a maintenance request had been raised for a pipe to be fixed in Main Theatres- Amber zone at UHW; awaiting meeting with estates to establish a plan.	

- Increase in vacancies reported for PESU Day Surgery; the area is also supporting Lakeside Wing. It was noted that the staffing challenges were evident across the UHB.
- Ongoing issue reported in relation to the ventilation in theatres 4 & 6. It was noted that this was mainly as issue on a Monday as the theatres are not in use over the weekend. It was highlighted that the Assistant General Manager for Peri-operative was working with the estates team to confirm the plan for addressing the issue.
- Concerns were raised around issue with the operating lights in CAVOC 1; where the lights move during surgery. It was reported that a Risk assessment had been completed and as a result Surgical lists had been moved to another theatre; awaiting attendance of Steris the manufacturing company to resolve.

JB shared the minutes of the Peri-operative QSE meeting that took place on the 27th August for information.

Consultant Anaesthetist – RB gave an overview of some of the items raised within the Anaesthetics exception report: -

- The Group were informed of an incident that involved a 28year old male patient, who fainted on the sight of cannular being inserted, prior to having treatment for Tooth extraction. On fainting, the patient sustained a fractured skull. Correct protocols were followed and RCA completed. Patient went on to receive treatment for tooth extraction at St Joseph's Hospital 7 weeks later.
- RB reported on the new PCA device rollout. It was noted that the old devices had become obsolete and manufacturers were no longer providing parts.

Dental Services – RG reported that the last Dental QSE meeting scheduled for June had been cancelled.

It was noted that the Hand Hygiene audits had recommenced in April 2021; some areas of concern. RG highlighted that a meeting was being established with Mangers to look at improving compliance.

The Group were informed that two formal complaints were under investigation. It was reported that these were continually monitored and the Lead Nurses were fully engaged with concerns team.

Lead Nurse Surgery, Urology, Ophth & ENT – CT raised the following items: -

- A number of open Serious incidents was reported within General Surgery.
- It was highlighted that 1 SI reported for ENT and Ophthalmology, relating to an unexpected death and harm to a CPAT patient. RCA had been completed and SI meeting had taken place.
- A number Executive walkaround had taken place during the period, no formal feedback had been received however a number of positive comments were made.

- CT raised concern around a number of outstanding maintenance requests throughout the directorate and highlighted that these continue to be chased. It was noted that the most problematic area was thermal comfort within SAU. It was reported that a number of complaints was made during the summer and as a result the trade Unions had been contacted by the staff.
- Concerns were raised in relation to the absence of a Green zone lift. It was noted that there were three lifts within A block, however one was for the use of the Air ambulance and another for Waste. It was suggested that designated waste times could be introduced with deep cleans in between and therefore could be used as a Green lift. CT highlighted that further discussion was needed and agreed to pull a meeting together with Estates.

Lead Nurse T&O – HL reported on the following: -

- Final report for recent BOA had been received, HL advised that this was being reviewed and would be presented at the next meeting. It was noted that a number of recommendations had been received, in particular around Theatres.
- The Group were informed that there had been a suspension of blood tests for Metal on metal patients due to the shortage of blood bottles. It was highlighted that this would commence once the shortage issue had been resolved.
- Two cases of C.diff was reported on A6 South and A6 North during the period. It was noted that RCA was underway.
- Concerns were raised around a long standing issued of lost patients for mammogram follow up. It was reported that a meeting had been established to discuss process. It was highlighted that appointments had been booked for five patients that were identified, however no appointments were available until November due to lack of radiology cover.
- Issues were raised around access for patients on CAVOC ward to X-Ray. It was noted that a review of the pathway for the green zone was needed.
- HL reported difficulties with AGP patient's isolation for Ward A6 over the past few weeks. It was noted that the procedure for B6 had been shared and HL felt that these procedures would be introduced to Ward A6.

Pharmacy – DW highlighted a number of items discussed at the Corporate Med's Management meeting that was held on the 5th August.

- Hydroxychloroquine monitoring - Optometric Advisor from Cardiff and Vale UHB attended the meeting to outline the progress on development of a robust monitoring service across NHS Wales.
- It was highlighted that an SBAR had been submitted regarding the Physicians Associates (PA); were increasing level of concern was raised around PA activities in the prescribing arena (mainly in Medicine and Surgery). It was noted that the UHB did not support transcription of medicines by nurses or others. It was suggested that a scope of practice would be issued in relation to prescribing and transcribing.

	• Paediatric fluid prescribing guideline CHfW and EU – It was reported that updated guidance had been approved for implementation.	
PART 2: HEALTH PROMOTION PROTECTION AND IMPROVEMENT		
SCB/QS: 21/100	**Initiatives to promote health and wellbeing of Patients and Staff:** **SCB H&S/IP&C Meeting** CW- Director of Nursing reported that this meeting met on the 18th August, where the main focus was around keeping areas as Covid safe as possible. **Decontamination Group update -** No update **Water Safety Group Update** JB- Lead Nurse Perioperative Care, highlighted that a meeting had taken place during the period, where the ask from the Water Safety Group was for areas to re-commence with flushing audits and return them to IP&C. It was also noted that discussions took place around water coolers and the need for areas to ensure risk assessments had been completed.	
SCB/QS: 21/101	**Bring forward –progress on relevant improvement plans (previously approved/discussed):** CW- Director of Nursing highlighted that feedback from the BOA report would be presented at the next meeting in November.	
PART 3: SAFE CARE		
SCB/QS: 21/102	**Patient Safety Incidents** The following reports were received and accepted by the Group. • Overall Trends • New SIs – It was noted that there were ten SI's open and over the timeframe. The Group were asked to review and close these as soon as possible. • RCA/Improvement plans • WG closure form status • WG closure forms – sign off • Regulation 28 reports (of relevance) CE reported on an upcoming inquest relating to a patient who had two miss doses of medication back in December 2018 following knee surgery. It was noted that as a result the patient was taken to intensive care and sadly passed away a few months later. CE highlighted that a number of key members of staff had been called as witnesses and Legal and Risk were providing support. CW- Director of Nursing Introduced and welcomed Carolyn Alport to the Group and reported that CA had recently been appointed as the Surgery Clinical Board	

	QSE Lead. It was highlighted that CA would be liaising with directorates to ensure completion of investigations/closure of Si's and assisting where possible.	
SCB/QS: 21/103	**Patient Safety Alerts (internal/external)** The following items were discussed and assurance given that action had been taken by the Directorates. • CMO Letter – Blood Transfusion procedures • NPSA Inappropriate anticoagulation of patient's with mechanical heart valve • Histopathology Results – CW Director of Nursing highlighted the relevance of this alerts due to the number of SI's reported within Surgery. CW asked that this is taken to all local QSE meetings for information and discussion. • Tympanic Thermometers • Risk of neonatal Burn • Clexane Different Supplier – DW- Pharmacy reported that there had been a temporary change to the supplier of Clexane and highlighted that the two types may be in circulation. It was noted that there was a slight difference in the technique required, which was demonstrated within the notice. • 3ml EDTA European Tubes	
SCB/QS: 21/104 SCB/QS: 21.2/104	**Health Care Associated Infections** Report received and noted by the Group. VS – IP&C informed the Group that C.diff cases were up by three against last years figures. It was also reported that MRSA was up by one; there were no cases reported last year and only one incident reported to date. It was highlighted that in relation to other HCAI such as E.coli the Clinical Board was doing well against last years figures. VS raised issue around the increase in C.diff across the Health Board over the past few months and felt that the Health Board would not meet its target for the year. The Chair queried the status of the Health Board's position in relation to patients contracting Covid within the health Care setting. VS reported that the Health Board is seeing a greater number of Covid positive patients attending the Emergency Unit; with a number being admitted. It was noted that there was one reported outbreak at Llandough – Mental Health Unit, where three patients tested positive and it was confirmed that this was healthcare acquired. **IP&C Report**	

	Report received and noted by the Group – It was noted that this report was for information. VS raised concerns around the delay in RCA's being returned to IP&C. The Group were asked to re-iterate to managers the importance of these being completed in a timely manner. The following documentation was circulated to the Group for information. The Group were asked to familiarise themselves with the contents and share amongst their teams. • Principles for safe patient placement during Covid-19 • Guidance for health and social care workers returning from Amber countries - letters and guidance	
SCB/QS: 21/105	**Any key patient safety risks:** **Q&S performance data** **The report was received and noted by the Group** CW Director of Nursing gave an overview of August's data highlighting the following key items: - • It was reported that there was a slight reduction in National reportable Incidents; 10 for August. • Mortality Reviews were at 100% for August; 30.8% up on July. • It was noted that prescribing had been at a consistent rate of around 98% since April. • There were 6 reported medication incidents. • 83% of formal complaints were responded within 30 days. • There were 2 POVA's involving staff, reported in August; 5 since April 2021. **Falls reduction and Pressure and tissue damage reduction and prevention reports** AB- Patient Safety reported on Falls awareness week, adding that a learning and feedback leaflet was being circulated following the falls review panel, to highlight themes. CW – Director of Nursing advised that a Pressure Damage Collaborative Group had been established, with the aim to reduce hospital acquired pressure damage incidents by 25% by July 2022. **Medical devices/equipment issues** The Chair reported that the last Medical Equipment meeting had been cancelled. However, discussed the upcoming medical equipment bids, advising that there had been a review of the paperwork. The Group were asked to look out for the release of the form and submit requests in as soon as possible.	

	Blood management The Group received documentation on the status of blood sampling supply issues. It was noted that this had been an ongoing issue and regular updates were being circulated. The Zero tolerance report for July 2021 was also revived and noted by the Group. **Q&S Workplan 2021 -2022** Report received and noted by the Group.	
SCB/QS: 21/106	**Mortality data analysis -** No Update	
PART 4: EFFECTIVE CARE		
SCB/QS: 21/107	**Monitoring of CB Clinical Audit plan** It was agreed that QUAD Audits would be discussed at the next meeting in November 2021. **Action**: ZS to add to the agenda.	
SCB/QS: 21/108	**Implementation of key NICE Guidance** No new Nice Guidance received during the period. It was noted that one notice was outstanding and awaiting a reply from General Surgery. CW Director of Nursing agree to chase this up. **Action**: CW	
SCB/QS: 21/109	**Research and development update -** No Update	
PART 5: DIGNIFIED CARE		
SCB/QS: 21/110	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans -** No Update	
SCB/QS: 21/111	**Initiatives to improve services for people with:** No update **Dementia** **Sensory loss** **Learning Disabilities**	
SCB/QS: 21/112	**Any initiatives specifically related to the promotion of dignity** CT Lead Nurse General Surgery reported that a bid was submitted and approved for a Band 3 Memory Link worker, for a twelve-month period. It was noted that the successful candidate would assist vulnerable patients on the wards.	
PART 6: TIMELY CARE		
SCB/QS: 21/113	**Performance with national targets** It was noted that this topic was discussed as part of other agenda items.	

PART 7: INDIVIDUAL CARE		
SCB/QS: 21/114	**Feedback from surveys – relevant improvement plans** No update .	
SCB/WS: 21/115	**Complaints and Compliments** It was noted that many compliments were received and this was shared with the areas involved. CW Director of Nursing highlighted that a significant number of complaints received were relating to waiting times. It was reported that directorates were writing to patient to assure them that they were still on the waiting list and advising them to contact their GP if their condition had deteriorated.	
PART 8: Staff and Resources		
SCB/QS: 21/116	**Staff awards and recognition** It was highlighted that the Surgery Star Awards was scheduled for the 26th October. It was noted that a significant number of nominations had been received and shortlisting was due to take place. CT Lead Nurse General Surgery reported that two Nurses within General Surgery were RCN in Wales Nurse finalists. It was noted that this event was taking place on the 10th November, were the two were being recognised for their great work with the SSDEC project. The Group congratulated the nurses and wished them luck for the 10th November.	
SCB/QS: 21/117	**Safer Staffing levels** It was noted that a significant piece of work was carried out in May 2021 on safer staffing levels and this had now been signed off.	
SCB/QS: 21/118	**Staff Surveys -**No update	
SCB/QS: 21/119	**Monitoring of attendance at relevant training e.g IP+C, Safeguarding, MCA, DoLs pressure damage, falls prevention** The Chair highlighted the importance of staff being released to attend training. However, appreciated the difficulties due to demand on wards. It was noted that Fire Safety face to face training was being established for early October; the Group were encouraged to make every effort to attend.	
DATES OF NEXT MEETING 16th November 2021 – 8-10PM – Ms Teams		

Report Title:	**Corporate Risk Register**								
Meeting:	Quality Safety and Experience Committee						**Meeting Date:**	14th December 2021	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information**	✓	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.

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

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

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

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

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board.

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

At the Health Board's November Board meeting a total of 12 (from a total of 19 live) Extreme Risks reported to the Board related to patient safety and are linked to the Quality, Safety and Experience Committee for assurance purposes. Details of those risks are attached at Appendix 1 but can be summarized as follows:

Risk Score (1 to 25) - Clinical Board	15/25	16/25	20/25	25/25
CD&T				
Medicine			1	
PCIC				
Specialist Services	3	1	1	
Surgery				
Digital Health				
Estates				
Children and Women			1	
Mental Health				
Capital Estates and Facilities			**5**	
Total:	**3**	**1**	**8**	**-**

An updated Register will be shared with the Board at its January 2022 meeting.

ASSURANCE is provided by:

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

RECOMMENDATION

The Committee is asked to:

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

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care	x

			sectors, making best use of our people and technology		
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x	
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives		

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

CORPORATE RISK REGISTER DECEMBER 2021

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital Estates & Facilities	2	Mar-21	Risk/Issue: UHW Cardiac Theatre GF AGSS Pump is faulty Impact: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Dec-21	Quality, Safety & Experience Committee	Patient Safety Planned Care Capacity Capital Assets
	3	Mar-21	**Obsolete Medical Gas Delivery Equipment** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete in Barry. Medical Gas (Nitrous Oxide) manifolds are obsolete in UHW Maternity (manifolds 1&7), UHW A&E, UHW Dental (manifolds 4&10). In addition the UHW Medical Gas Pressure reducing set is obsolete. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety. quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Dec-21	Quality, Safety & Experience Committee	Patient Safety Capital Assets
	4	Mar-21	Risk/Issue: UHW Tunnels corroded Main O2 Pipeline due to building leakage Impact: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	20	Regular inspection and maintenance.	5	4	20	Repair building leak and renew section's of corroded pipework.	5	1	5	Dec-21	Quality, Safety & Experience Committee	Patient Safety Capital Assets

	5	Mar-21	Risk/Issue: UHL Main Boiler F&E TANKS are badly corroded and require renewing Impact: Corrosion causing tanks to leak and loss of Heating throughout Hospital	5	4	20	No controls in place as cleaning tanks may result in leakage	5	4	20	Renew or reline tanks to prevent leaks.	5	1	5	Dec-21	Quality, Safety & Experience Committee	Planned Care Capacity
	6	Jun-21	**Risk/Issue:** Ventilation verification of critical systems has identified UHW CHFW 1st Floor Rainbow ward Day Case Theatre and recovery does not comply with HTM's for Ventilation. the areas are supplied with air from a general air plant and require a standalone AHU the extract system is insufficent causing an excess of nitrous oxide within the area when in use. **Impact:** Adverse impact on the safety of staff working in these areas, faiulre to comply with HTM regulations.	5	4	20	System is subject to statutory testing and inspection in line with legislation and HTM regulations. Regular maintenance.	5	4	20	Preparing plans to renew the AHU.	4	1	4	Dec-21	Quality, Safety & Experience Committee	Workforce
Medicine CB	7	Mar-21	The Clinical Board has experienced a significant number of healthcare acquired Covid-19 outbreaks during both pandemics. It is currently unknown to what extent the level of harm that has been sustained for both patients and staff. The Clinical Board currently do not have an accurate oversight for the total number of patients who have acquired Covid-19, and those patients that have died. The Clinical Board are therefore unable to provide meaningful evidence that would support the UHB in the investigations required, and to understand any learning or themes.	5	5	**25**	A senior nurse has been appointed for COVID-19 for a six month secondment to lead on the investigations for healthcare acquired COVID-19. To implement COVID 19 HCAI Governance framework to identify learning and themes. To review IP&C processes within clinical areas. To support the UHB in completeing the required level of investigations to establish level of harm for patients and staff. Completion of the required Covid-19 Rapid Assessments and the accurate completion of Datix. Support from IP&C and Covid-19 outbreak meetings to ensure that accurate and timely information is obtained.	5	4	**20**		4	3	**12**	Dec-21	Quality, Safety & Experience Committee	Planned Care Capacity
	8	Aug-21	Delay and interuption to induction of labour due to inadequate staffing levels. This has the potential risk of poor outcomes for mothers and babies. This also effects the women's experience. Approx 70 DATIX submitted between 01.08.21 - 16.09.21	4	5	**20**	1.Undertaking an in depth review of our that there is continued assurance that sickness is being managed according to the policy. 2. Introduced a weekend planning meeting each Friday at 12pm so that we have assurance that weekends are covered 3. Introduced a postnatal / newborn spot screening clinic at UHW on the weekends. This means that women will attend ANC at UHW or UHL for their care rather than a midwife visiting. This will release a community midwife to come in to support the hospital setting but keep the home birth service going. 4. Operational Ward Managers – while they have a clinical component to their role, we have requested that they roster one clinical shift per week so that they're included in the overall numbers 5. Midwives offered bank / additional hours and overtime 6. Elan midwives to provide on call support to wider community teams with home birth service 7. Digital Midwife, Practice Education Facilitator, Fetal Surveillance Midwife & Women's Experience Midwife – to provide at least one clinical shift per week. 8. Research and Development Midwives to be temporarily redeployed back to providing frontline clinical care until the staffing situation improves 9. Clinical Supervisors for Midwives to be redeployed 50% back into clinical practice. 50% CSfM to continue to provide ongoing support to clinical practice / capability / action learning	4	5	**20**	1.Band 6 vacancies to be filled - interviews scheduled 2. 24 midwives have been offered 27 hrs each upon qualification in September.3. continues to be escalated to clincal board and executative leve	4	2	**8**	Dec-21	Quality, Safety & Experience Committee	Patient Safety

Specialist Services CB	12	Sep - 21	**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	**25**	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	**20**	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	**10**	Dec-21	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Planned Care Capacity
	13	Jan-16	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	4	**20**	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently. The unprecedented demand during the current Covid19 Pandemic has resulted in a temporary increase in the unit footprint and capacity which has ameliorated this issue whilst at the same time exacerbating the Crtitical Care workforce risks detailed elsewhere.	5	3	**15**	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	**10**	Dec-21	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Planned Care Capacity
	14	Jul-20	**Critical Care - Clinical Environment** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and also compromises the care of patients where temperatiure is a critical concern. The well being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dedydration. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, phamaceutical storage, device storage and management hubs areas.	5	4	**20**	**The clinical area is divided into zones to where patients are grouped according to IP&C risk to reduce the risk of cross-infection.** **Staff entering the clinical area are required to wear full PPE to reduce the risk of cross-infection.**	5	3	**15**	**There is an urgent need for a capital investment program and business case developed to address this need.**	4	3	**12**	Dec-21	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	15		**Haematology and Immunology - Office Accommodation** Insufficient and/or inappropriate office accommodation is available for clinical and managerial staff across the directorate. Ongoing serious maintenance/estates and Health and Safety issues in the BMT offices in Jubilee Gardens which presents a significant risk, including poor ventilation and water leaks in the area causing damage to UHB property, disruption to services and a serious Health & Safety risk to staff based in that area.	4	4	**16**	Issues escalated to Clinical Board and Medical Director's Office as a Health & Safety issue for staff. Health & Safety team and Estates Management aware. Estates team are monitoring the situation. Directorate has undertaken an internal office review to ensure maximum utilisation of current footprint. Engagement with Estates Team and Health & Safety.	4	4	**16**	Sufficient office accommodation is not currently available on this site. Accomodation Working Group unable to identify additional office space at present. Alternate suitable office accommodation needs to be identified to allow clinical and managerial staff to continue to work in a more appropriate environment.	1	1	**2**	Dec-21	Quality, Safety & Experience Committee	Capital Assets Workforce

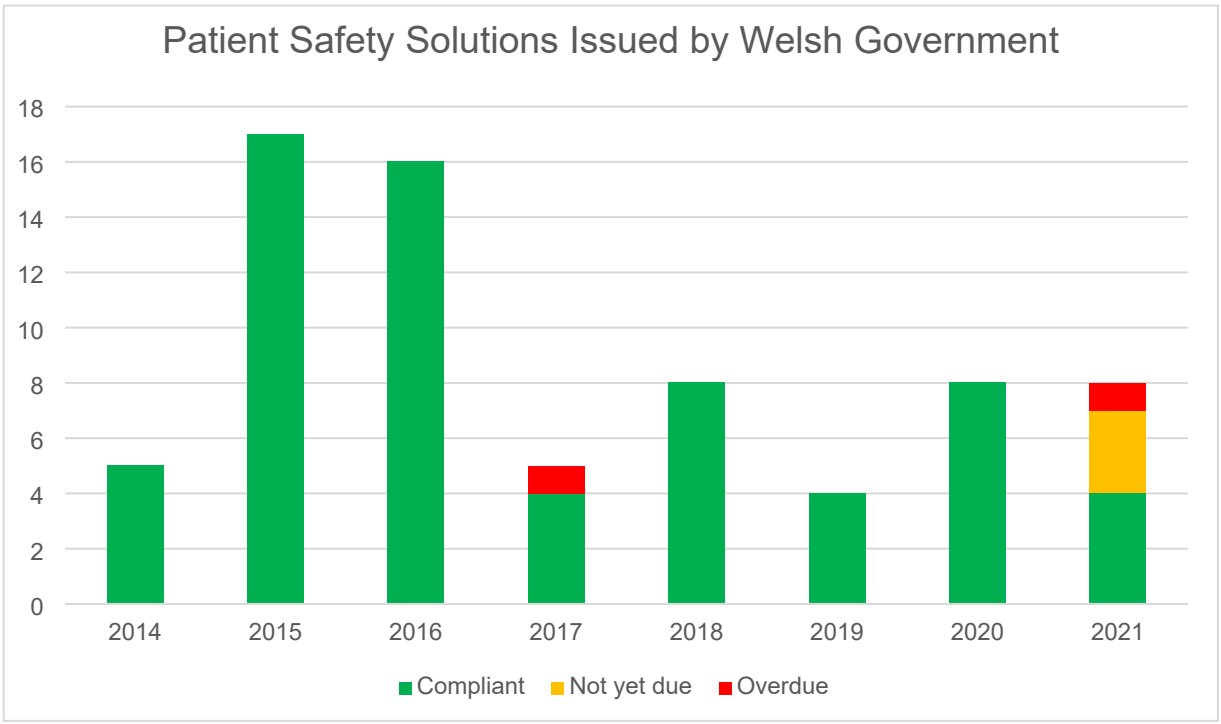
16	Aug-21	**CARDIOTHORACIC** Deaths on Cardiac Surgery waiting list Provision of Cardiac Surgery - including ability to meet 36 week RTT, ability to treat urgent patients, impact of staff shortages (theatre and CITU staff), impact of lack of access to inpatient beds leading to increased mortality and morbidity of patients on the WL	5	4	**20**	Daily validation of cardiac surgery waiting lists by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly cardiac surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Standardised communication processes for patients on the waiting list for cardiac surgery. Forward planning for Cardiac surgery. Recruitment and retention of theatre personnel. Obtain anaesthetics	5	3	**15**	Theatre staff shortages, limited flexibility on CITU beds. Inability to undertake weekend working Limited assurance due to significant establishment gaps in both theatre scrub staff and anaesthetics Commisioning review of potential outsoucing contract. Recruitment of anaestheic and theatre personnel. Daily flow monitoring to ensure timely transfer between CITU and Ward C5	5	1	**5**	Dec-21	Quality, Safety & Experience Committee	Patient Safety Planned Care Capacity

Report Title:	**Patient Safety Solutions**	**Agenda Item no.**	**4.3**
Meeting:	**Quality, Safety and Experience Committee**	**Meeting Date:**	14 December 2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**Y**
Lead Executive:	**Executive Nurse Director**		
Report Author (Title):	**Patient Safety and Organisational Learning Manager**		

Background and current situation:

The Patient Safety and Improvement Team have allocated resource 0.2 WTE to manage Patient Safety Solutions (PSS), reporting to the Quality, Safety and Experience and Clinical Effectiveness Committees.

The current position to 30th November 2021 is as follows:



The current PSS database can be found in the **supporting documents** which details all PSS, including Internal Safety Notices.

Details of the **overdue PSS'** below can be found in the **supporting documents:**

- **2017 PSA008 NG Tubes:** Notification received from WG on 29th November 2021 that there will be an all Wales approach to medical training for NG Tubes insertion and interpretation imaging to confirm placement. There is now a clear route to compliance, led by C&V, for a practical solution which has been agreed in principle by the All Wales PSS Forum.

- **2021 PSA012 Pleural Effusions:** This alert coincided with planned service improvement by the respiratory team. A new Policy document, incorporating, consent, patient information and checklists has been drafted and is currently with the Clinical Board for approval prior to publishing and implementing. It is anticipated that compliance will be declared in early 2022.

Details of the below **PSS' In Progress** can be found in the **supporting documents:**

- **PSN057 Emergency Steroid Therapy Cards (Adrenal Crisis):** A task and finish group is actively working towards compliance for this notice. The group has been working closely with the information team to identify all patients known to the UHB who may be at risk so that safety information can be shared with them. The all Wales PSS Forum is also considering what national actions may be necessary and are working closely with pharmacy and primary care colleagues. Compliance is due 31st January 2022. Currently the group anticipates that the timescale is challenging and depends upon the availability of clinical colleagues supporting this work over the winter period.
- **PSN060 Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route:** Work on this notice is currently on hold (with the knowledge of the Delivery Unit) due to anticipated changes to the wording to bring the notice in alignment with the version shared by NSH England. As currently published, health boards are required to give all oral liquid medications by syringe which would be extremely costly. It is anticipated that an updated notice will be issued specifying that graduated cups and spoons can be used. All HB's agreed with the C&V position and we await an updated instruction from the Delivery Unit.
- **PSN061 Standardised strength of phenobarbital liquid:** The first meeting regarding this notice is due to take place 2nd December 2021. C&V have led the way in making this national change. It is recognised that only a small number of patients will need to change their medication and delays in achieving compliance (due February 2022) are not anticipated.
- **PSN062 Eliminating Bottles of Liquefied Phenol 80%:** Podiatry services are currently amending their protocol and sourcing an alternative to liquefied Phenol. They are confident that compliance will be achieved by the deadline of 25th February 2022.

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

The Delivery Unit are now responsible for the national management of PSS and have made welcome changes, most notably the reinstatement of a national forum of patient safety leads for PSS for the exchange of ideas, learning and solutions. In addition, this forum is also consulted on impending PSS, and invited to comment on their content. It is anticipated that this will prevent some of the historic issues where PSS were published despite there being no possible solution, e.g. PSA003 regarding the change over to new medical devices to prevent neuraxial drug errors.

In order to provide robust assurance, additional resource is required, both in increasing the patient safety team PSS lead to 1.0WTE and the implementation of AMaT software, both of which are pending approval in the business case currently being considered.

Within the current arrangements, a compliant notice is sent to the Clinical Boards who complete and return it to a member of the corporate team. This supports the monitoring and reporting processes.

Recommendation:

The Quality, Safety and Experience Committee are ask to **note** the progress with compliance to implement of Patient Safety Solutions (PSS)

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Saunders Mathan 12/01/2021 15:57:30

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

Report Title:	**Ombudsman report Section 23**	**Agenda Item no.**	**4.4**
Meeting:	**Quality Safety and Experience Committee**	**Meeting Date:**	14/12/21
Status:	**For Discussion**		
Lead Executive:	**Ruth Walker, Executive Nurse Director**		
Report Author (Title):	**Angela Hughes, Assistant Director of Patient Experience**		

Background and current situation:

On 7th December 2021 the Ombudsman issued a section 23 Public report against Cardiff and Vale University Health Board. under the**.** Public Services Ombudsman (Wales) Act 2019

The Ombudsman's report is prepared under S.23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

Section S.23(4) states:

"The Ombudsman may publish a report prepared under this section if, after taking account of the interests of the person aggrieved (if any) and any other persons the Ombudsman thinks appropriate, the Ombudsman considers it to be in the public interest to do so."

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

The Ombudsman has published section 23 public report in response to a compliant response which has been accepted in full by the UHB.

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

Background to the report

Mr D underwent a laparoscopic right hemicolectomy in November 2019 to treat suspected Crohn's disease. Intra-operatively, a reduced hemicolectomy was performed in light of the surgical findings. Mr D deteriorated in the immediate post-operative period and required a further laparoscopy to control internal bleeding. However, as part of this secondary procedure he was left with an ileostomy. He was transferred to the Critical Care Unit, where he remained for some days and was discharged on the 22 November 2019. The ileostomy was successfully reversed in March 2020.

Concerns investigations by the Health Board

Mr D's partner ("the complainant") raised a concern with the Health Board January 2020. The concerns raised (18 in total) broadly related to communication with Mr D and/or his partner (including in relation to consent), concerns regarding the length of time taken to identify post-operative complications and concerns regarding post-operative stoma care. The Health Board

responded with a Regulation 24 response on the 20 April 2020. No qualifying liability was identified.

A further concern was raised by the complainant on the 29 July 2020. The complainant raised concerns regarding the appropriateness of the initial surgery, given the uncertainty of his diagnosis. It appears there was some uncertainty regarding a possible diagnosis of Crohn's disease and a possible diagnosis of appendicitis. Further concerns regarding communication and post-operative stoma care were raised. A further Regulation 24 response was sent on the 13 November 2020 on the basis there was no qualifying liability.

Ombudsman's investigation

Mr D escalated his concerns to the Ombudsman, who sought input from the following clinical advisors: a Consultant Colorectal & General Surgeon, a Senior Registered Nurse and a Colorectal Nurse Specialist.

Expert advisors

The colorectal surgery advisor is of the view that Mr D's presentation and investigation results were not strongly indicative of Crohn's disease, and were not strongly indicative of a need for surgery. As such, the decision to proceed with surgery was unreasonable and had little merit. Further, it was felt that non-surgical options for Crohn's were not explored prior to surgery. The advisor is of the view that the intra-operative findings were in keeping with appendicitis. At this point, surgery should have been exploratory only, with a view to investigating a diagnosis further. The advisor has also identified that there are important omissions from the surgical notes and is critical of the delay in diagnosis of post-operative bleeding on the basis that no NEWS scoring was noted between 8 pm on the 13 September and am on the 14 September. the advisor was, however, unsure if earlier identification would have changed events.

The advisor felt there was a failure to adequately incorporate Mr D's Asperger's Syndrome into his care plan and a failure to consider a psychiatric referral on the 21 November in light of his mental state. The Colorectal Nurse advisor was unable to determine whether Mr Ds Asperger's Syndrome was communicated to the community stoma nurses. S/he felt many of the concerns he raised in relation to post-operative nursing care were related to communication difficulties.

Ombudsman's report

The Ombudsman's report concludes that it was inappropriate to proceed to operate on Mr D in light of the uncertainty of diagnosis, and in light of a failure to consider alternative medical treatment in the first instance.

Furthermore, he is critical of the intra-operative decision to proceed to resection the bowel, particularly as the intra-operative picture was more in keeping with recovery from delayed appendicitis, rather than Crohn's.

He concludes that there were failures to adequately monitor Mr D post-operatively, leading to a delayed diagnosis of internal bleeding, and there were failures to include Asperger's Syndrome within his care plan and escalate any possible psychological concerns to an appropriate clinician.

The Ombudsman's recommendations were as follows:

1. A written apology be provided in relation to the clinical care and communication failings identified. This apology should reference the flawed diagnostic and surgical decisions made. It should acknowledge the distress and suffering experienced as a result, and the further distress the report will likely lead to. There should be an acknowledgement of the failure to accommodate Mr D's Asperger's Syndrome and communicate with him in an appropriate manner.

2. The Health Board make a payment of £10,000 in recognition of this distress.

3. Within 3 months, the Health Board should provide evidence that:

    a. The report has been shared with Clinical Directors of the teams involved and the relevant clinicians reflect upon the events, including at appraisals and revalidation
    b. Clinicians undergo training in regard to diagnosis, treatment and medical management of Crohn's and recurrent appendicitis.
    c. The report is shared with the Director of Nursing and reflected upon by the relevant nurses.
    d. The inpatient nursing team reflect on the importance of regular post-operative observations and the importance of preparing accurate care plans. Training should also be given with respect to the care and management of patients with Asperger's Syndrome.

In this case whilst we accept that is this is one experts opinion and that it is contrary to our internal clinicians view, we remain surprised that this is a report going into the public domain. Differences in opinion regarding cases is not a rare occurrence in surgical and medical cases where expert opinions are sought without the value of hindsight and are in most cases a measured professional judgement based upon evidence and experience.

The Health Board will monitor the recommendations through an improvement plan and we will provide evidence to the Ombudsman that we have complied with the recommendations. We have written a sincere letter of apology to Mr D and offered to meet with him to discuss the implementation of the improvement plan.

Recommendation:
To consider the content of the report and note agreed action taken.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Value of Volunteers**	**Agenda Item no.**	**4.6**
Meeting:	**Quality Safety and Experience Committee**	**Meeting Date:**	14/12/21
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**
Lead Executive:	**Ruth Walker, Executive Nurse Director**		
Report Author (Title):	**Angela Hughes, Assistant Director of Patient Experience**		

Background and current situation:

The role of hospital and community volunteers has adapted during the pandemic to support the changing agenda. This paper celebrates some of the Volunteers activity. We have continued to recruit and undertake induction at pace and virtually for volunteers with sessions on weekends and evenings to accommodate those who work or study alongside volunteering activity.

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

A healthy organization and culture has a robust volunteering framework which embodies and demonstrates the organizational values while supporting and enhancing the patient experience. This report aims to celebrate this work.

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

Volunteers have continued to provide support in a varity of settings across the UHB and have worked with colleagues to adapt and change the support in line with the challenges that emerged during the COVID 19 pandemic.

Information and Support Centers – July-September 2021

During the last quarter volunteers have provided valuable way finding support to over 4,634 visitors at UHW and UHL along with answering enquiries covering issues such as cancer, mental health and carers rights.

Feedback from an information enquiry August 2021;

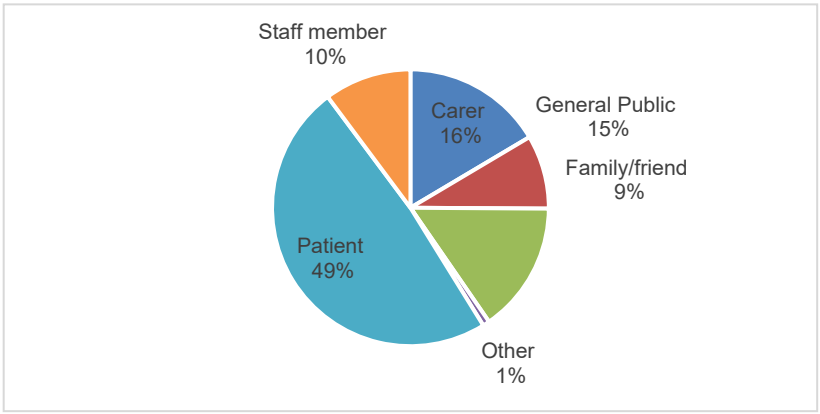
Thank you for this information, this is really helpful. Many thanks

The UHL Information Centre continues to be the hub for staff to collect essential items for patients who have no relatives or visitors.

The number of leaflets ordered for the Information Centre's totaled 6,798 during this period.

As restrictions continue to lift we have noticed a considerable rise in the variety of visitors attending the Information Centre's, this is noted in the graph below.

Also a marked increase in the provision of facemasks for visitors attending our sites, 775 were issued during this period.



Volunteer Services

Helpforce Volunteers Awards

The Helpforce Annual Volunteer Awards were announced on Friday the 29th of October, the Patient Experience Team were successful in three groups receiving the Highly Commended awards in the following categories,

Partnership and Systems Working in volunteering- Mass Vaccination Centre Volunteers - Cardiff & Vale University Health Board, British Red Cross, and St John Ambulance Cymru

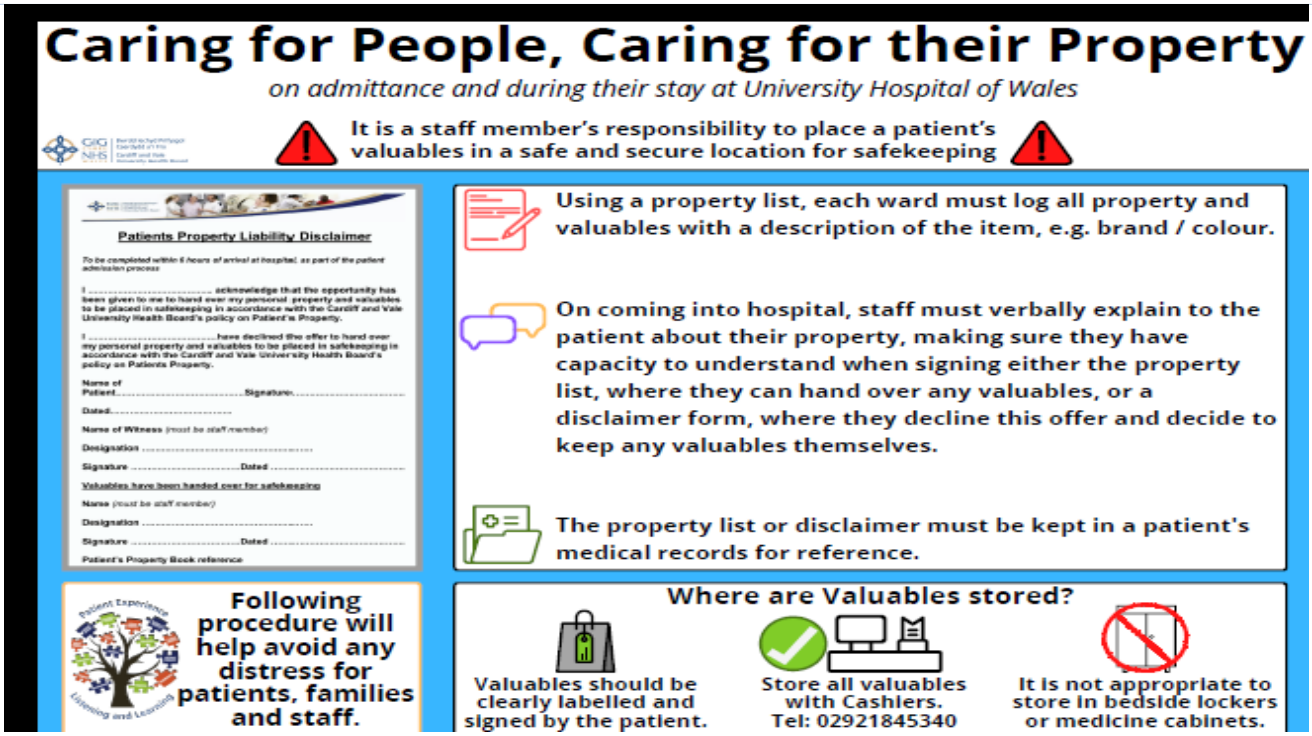
Outstanding Staff Champion for Volunteers. - Sarah Davies - Cardiff and Vale Health Board

Outstanding Volunteering Team of the year - Hospital Runner Team at Cardiff and Vale University Health Board

Our volunteers provide so much support, time and care for our services, staff, patients and communities and this is a fantastic recognition of their contribution during the pandemic.
https://helpforce.community/connecting/awards-2021

Caring for People, Caring for their property

The Patient Experience Team have developed a Patients Valuables Information Poster for inpatient areas, this was designed to support the Patient Property Policy. Staff, patients, carers, relatives will be able to see the posters to better understand what the options are with their property when they are admitted and during their stay at the hospital.



Transitional Care Unit

Our Volunteer Service Managers are currently working closely with Senior Nurses to support patients being transferred to the Transitional Care Unit TCU at St David's Hospital, to date they have met with staff and planned the reintroduction of volunteers to the unit who will be able to support and facilitate activities both group and 1:1, help build and maintain social skills, support with digital learning and virtual visiting, while befriending to improve wellbeing and help with boredom and isolation.

Vaccination Centers

Voluntary Service Team continue to support all vaccination center's with a recent request for support at a local medical center where volunteers supported the Aneurin Evans Pharmacy, West Quay Medical Centre, Barry from 4th October - 14th November roll out of patient vaccine booster clinics.

Project Search Work Experience

The Voluntary Services Team is working in conjunction with Nicky Punter and Cardiff Council Project Search Work Experience project, the team will be supporting students with learning disabilities allowing them to engage in public facing volunteering roles. The team will be working with a group of approximately seven students who will undertake volunteering at UHW Concourse area from November to January 2022 with a possibility of this date being extended.

Return of Existing Volunteers

The Team have been working closely with Health and Safety/ Occupational Health and IPC to develop risk assessments and enhanced induction processes to support volunteers who are returning from being on hold since the pandemic began. All volunteers undergo specific Covid safety training and volunteer inductions before starting in public facing volunteer roles only. The team are also engaging with various wards to discuss the safe return of volunteers to wards areas.

Horatios Garden

Horatio's Garden – A Memorandum of Understanding has been agreed between the Health board and the Charity to implement a volunteer placement at the new Spinal Unit specifically in the Garden. Horatio's Garden Volunteers will be recruited to support with planting and maintaining the garden and eventually supporting and joining patients in the garden.

Volunteer Feedback

"*I started volunteering 2.5 years ago first on ward befriending was really interesting and rewarding also got to help with activities. Due to Covid we had a change in position so now I help out on info centre during my time. I have met really nice people and been learning along the way. I struggle with my mental and physical health and volunteering has help so much keeping me focused also has built my confidence. Thank you*"

"*Thank you for letting me be part of the Volunteer Team!"*

"I Feel valued by the nursing staff and reception staff and even security. They are full of admiration for what we do as volunteers. The general public are also very appreciative."

"*Volunteering with Patient Experience team was the first step to get the job I dreamed of"*

Recommendation:

The QSE Committee are asked to **note** the work and support undertaken by volunteers In the UHB.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*