**ANNUAL SELF ASSESSMENT**
**HEALTH AND CARE STANDARDS**

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| **S**<br>**Situation** | **3.1 Safe and Clinically Effective Care** |
| **B**<br>**Background** | **Please Confirm the rating from the following definitions*: Getting Started/ Getting There/ Meeting the Standard/Leading the Way***<br><br>**Getting There** |
| **A**<br>**Assessment** | **Provide 250 words (maximum) to give necessary contextual narrative**<br><br>**People are safe and protected from avoidable harm through appropriate care, treatment, information, support and early detection of risks.**<br>The management of Serious incidents is integral to the provision of safe care. Performance around the reporting investigation and closure of Serious Incidents is recorded and reported through the Executive Performance Reviews. Systems ensure non-compliance or variance from best practice is properly recorded and audited and any risks identified are managed appropriately.<br>Serious Incidents are reported through the QSE sub committees and an annual special report is taken to QSE.<br><br>The monthly reporting of Key performance indicators including the management of patients safety incidents, hospital acquired thrombosis, health care acquired pressure damage, IP&C indicators safeguarding and prescribing indicators drives up quality, gives assurance around service provision and acts as a “smoke signal”. The performance dashboard has been reported monthly through the Executive Performance Reviews monthly in 2017/18.<br><br>Monitoring of IP&C data around MSSA/ MRSA E coli and C difficile is undertaken monthly and performance is measured against targets set by Public Health Wales. The Medical Director undertakes Antimicrobial Stewardship Walkround with the IP&C team to areas of increased |

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| | IP&C reporting.<br><br>There is a robust Quality Safety and Experience structure in existence across the health board with sub committees in each of the Clinical Boards. The majority of committees have a generic agenda that is aligned to the health and care standards to prompt consideration of all seven themes.<br><br>As well as the QSE committees there a number of formal multi disciplinary and multi professional forums in existence within the Clinical Boards to discuss and consider risk. These include:<br><br>• Mortality and morbidity reviews in Surgery, Specialist and C&W Clinical Boards.<br>• Perinatal Mortality reviews in C&W<br>• Mental health hold two weekly sentinel event meetings to review serious incidents<br>• Multi professional risk management meetings held in O&G<br>• Medicines management meetings held bi monthly in C&W<br>• Performance frameworks are in place in PCIC to monitor Welsh Government requirements (tier 1 and nationally agreed targets) service acuity and audit.<br><br>In addition the majority of the clinical Boards have at least one person in post to manage patient safety and governance.<br><br>**Practice evolves to reflect new evidence and provides an efficient and effective response to promote safe and clinically effective care.**<br><br>An assurance process around the National Clinical Audits is now embedded with requisite improvement plans being developed and reported through the Medical Director to Welsh Government. QSE subcommittees are utilised to discuss the results of these audits and to support the development of improvement plans.<br><br>Local clinical audit activity is underway to give assurance around the quality and safety of the care we deliver. This year it was agreed to subdivide clinical audit into a three tier system<br>Tier 1 being National Clinical Audit<br>Tier 2 audits undertaken to address quality and safety priorities |

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| | Tier 3 audits undertaken for any other reason including revalidation.<br><br>A UHB clinical audit database is administered by the clinical audit team and records all registered audits and their results. This process allows for the dissemination of clinical audit results reported into the database to be disseminated to the Clinical Boards for consideration at QSE. There is some doubt about the extent of local clinical audit that is being registered and reported through the agreed health board process and therefore it is not possible to give assurance around the consideration given to the results of all of these audits.<br><br>The National Clinical Enquiries into Patient Outcomes and Death (NCEPOD) publish several reports each year. A revised process of gap analysis and action planning to ensure that care provision is in keeping with best practice guidelines is being undertaken around the most recent publication and will be reviewed.<br><br>There are a number of UHB wide committees, that have representation from all of the clinical boards, that consider local performance around specialist areas eg Falls, Pressure damage, medical devices. As well as considering risk these groups are tasked to consider and implement Best Practice guidance where appropriate. There are local examples of excellent practice:<br><br>• CD&T 60 day improvement cycle has been established – a forum to better understand, constructively challenge and promote improvement and innovation.<br>• PCIC clinical Board is undertaking regular clinical audits linked to the National Audits<br>• Matrics Cymru is followed to provide evidence based psychological care<br>• Clinical Supervision for midwives is in place with lead roles for audit, guidelines and monitoring of improvement plans.<br><br>**Systems and processes comply with safety and clinical directives in a timely way, including alerts.**<br><br>A corporate programme of unannounced internal inspections as well as inspections internal to the Clinical Boards give assurance about the quality of care delivery and documentation.<br><br>External inspections are reported through QSE along with |

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| | requisite improvement plans.<br><br>NatSSIPs - Clinical Boards have identified all of their Invasive procedure and a process is in place to develop LocSSIPs around a number of procedures already.<br><br>**People receive a high quality, safe and effective service whilst in the care of the NHS which is based on agreed best practice guidelines including those defined by condition specific Delivery Plans, National Institute for Health and Clinical Excellence (NICE), NHS Wales Patient Safety Solutions, and professional bodies.**<br><br>There is a formal process for the dissemination of Patient safety alerts, Best Practice guidance Welsh health Circulars etc. QSE sub committees are utilised to discuss the implementation and awareness raising of guidance. |
| **R**<br>**Recommendation** | **The following improvement actions have been identified as key deliverables for 16/17**<br>• Ratification of Clinical Audit Procedure<br>• Roll out of a revised clinical audit database<br>• Continued development of LocSSIPS<br>• Development of a corporate audit programme to give assurance around Patient Safety Alerts<br>• Review of the NICE dissemination process<br>• Review of NCEPOD revised process |