Confirmed Minutes of the Public Quality, Safety & Experience Committee
Held on Tuesday, 13th October 2020, 09:00am – 12:30pm
Via Zoom

Chair		
Susan Elsmore	SE / CC	Committee Chair & Independent Member – Local Authority
Present		
Michael Imperato	MI	Independent Member – Legal
In Attendance		
Stephen Allen	SA	Chief Officer – Community Health Council
Gary Baxter	GB	Independent Member – University
Suzie Cheesman	SC	Patient Safety Facilitator
Maureen Edgar	ME	Research Governance Coordinator
Carla English	CE	Patient Safety Facilitator
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Charles Janczewski	CJ	Interim UHB Chair
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Chris Lewis	CL	Deputy Finance Director
Angharad Oyler	AO	Clinical Supervisor for Midwives
Annie Procter	AP	Consultant in Medical Genetics
Maria Roberts	MR	Head of Patient Safety
Rhian Thomas	RT	Independent Member – Capital and Estates
John Union	JU	Independent Member - Finance
Ruth Walker	RW	Executive Director of Nursing
Stuart Walker	SW	Executive Medical Director
Dawn Ward	DW	Independent Member – Trade Union
Mark Warren	MR	Director of Nursing Mental Health
Joy Whitlock	JW	Head of Quality and Safety

Ian Wile	IW	Head of Operations and Delivery
Secretariat		
Raj Khan	RK	Corporate Governance Officer *(via Zoom)*
Nathan Saunders	NS	Corporate Governance Officer *(via Zoom)*
Apologies:		
Steve Curry	SC	Chief Operating Officer
Fiona Kinghorn	FK	Executive Director of Public Health
Rajesh Krishnan	RK	Consultant Paediatric Nephrologist

QSE 20/10/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**ACTION**
QSE 20/10/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 20/10/003	**Declarations of Interest** There were no declarations of interest.	
QSE 20/10/004	**Chair's Action taken since the last meeting** There had been no Chairs Action taken.	
QSE 20/10/005	**Hot Topics** The Executive Director of Nursing (EDN) wanted to make the Committee aware of a small cluster of COVID-19 positive cases at Llandough Hospital. 3 patients and 1 member of staff. Epidemiology has been done and traced to the same cluster. This is not escalating and learning between sites has been very positive. The Executive Medical Director (EMD) advised the Committee that we're in a difficult phase of the pandemic. There is an increase in community COVID-19 positive cases which is not reflecting on hospital admissions at present. There are plans in place for the delivery of COVID-19 response with capacity demand and assessments. Quality and Safety risks are associated with the entirety of this. The EMD advised the Committee of a fairly significant event with the commencement of the major trauma service. A child didn't get the treatment required in a timely fashion in relation to emergency vascular input being required but there is no paediatric vascular surgery sub speciality. It does not currently exist. There is a potential for a bit of a gap	

	in service provision all across the UK in that regard. The EMD attended a meeting prior to this QSE committee meeting and a reassuring outcome and a solution is now in place. The CC asked if staff resilience is measurable. The EDN responded that she has had open zoom sessions and has 'walked the floor' – Some of the stories told to her are quite harrowing. The fear of lack of resilience is more challenging to staff but RW is confident that people will step up as they did in the earlier stages of the COVID-19 pandemic. Access to the wellbeing service is good and feedback is positive. The EMD responded that there are some real time workforce staff evaluations out there to measure and get real time data but we do not use these so reiterated that what the EDN mentioned about going out and speaking to staff is the way that we can measure staff resilience. We need a flexible and agile response and the wellbeing agenda is very active at the moment. The CC advised the Committee that she visited the council's warehouses containing PPE stores and was satisfied with the fact of knowing the local authority have a 12 week supply of PPE. The CC wanted to know if that assurance can be given in relation to the UHB. The EDN gave that assurance and mentioned that the UHB have large quantities of PPE in store. Independent Member – Trade Union (IMTU) asked the EMD if there is a particular staff group with decreased resilience and are we doing enough and contingency planning around that group to prepare us to respond as well as we have to COVID-19 previously and to keep the scheduled care going through this which we did not do during the first wave. The EMD responded and said we have to get this right. It is all about predicting in advance when change is going to come and alerting staff to this change as quickly as possible and also deescalating areas as fast as we can. The EDN added that the staff are the most precious asset and we must be honest with them. Being clear and looking out for the signs when resilience becomes something different.	
QSE 20/10/006	**Quality, Safety and Experience Themes and Trends 2019-2020** The Head of Patient Safety (HPS) introduced the presentation and confirmed the following: The report figures are taken from October 2019 to September 2020– Data does not align with the report provided by the Director of Nursing Mental Health (DNMH) in **QSE 20/10/007** as that report uses calendar years.	

	The HPS advised the Committee that the concept of Never events are becoming increasingly contentious and the thinking is being challenged. There are external requirements with reporting serious incidents (SI) and we currently report to the Welsh Government (WG) and from October 2020 we report our SI to the Health in Wales delivery unit. We have a target of reporting to the delivery unit within 24 hours of the incident and that can be quite challenging. The HPS advised the Committee that internally there is a very good reporting mechanism initially but what's been recognised is that we need to improve on the timeliness of the investigation process and also to strengthen the sharing of the lessons so the flowcharts we use are going to be changed to have a different tracker process so that we can have a tighter grip on this. The Committee was advised that electronic reporting was introduced into the UHB in January 2015 The HPS advised the Committee that in 2018 there was a sharp rise in serious incidents due to the WG asking for all pressure damage grades 3, 4 and unstageable. WG revised this in 2019 and asked us to report only avoidable grades 3, 4 and unstageable pressure wounds along with other serious incidents. There's been a decrease this year as the Welsh Government have altered the requirements of what we need to report to them due to the ongoing COVID-19 pandemic. The HPS advised the Committee that they actively encourage staff to use Datix to report any incident and so far in 2020 the amount of Datix reports have decreased from 2019. The HPS provided the Committee with an update on unexpected deaths – 26 – There haven't been any incidents that are going through the safeguarding process where actions for health have been required and all of the cases have been closed in the safeguarding routes. The HPS wanted to inform the Committee of the challenges we have with the coroner's inquest and the coroner's information being crucial to us in closing the loop of understanding about what our incidents are telling us. We have seen a significant impact because of COVID-19. We normally expect inquests to be held within 6 to 9 months of a patient's death however at the moment the Coroner is listing cases toward the end of 2021 due to ongoing COVID-19 pressures. This has an impact on them as well as families of patients. The HPS advised the Committee that when reviewing patient incidents in regards to falls / accidents, we also review the incidents that aren't reported to WG. The falls preventative measures are largely in place for patients. In previous years there have been concerns on the risk assessments of patients, however an improvement has been seen this year which is encouraging.	

	The HPS advised the Committee that some of the actions that people are asked to take once an accident has taken place need continuous reinforcement for example ensuring that nursing staff are undertaking neuro observations as they should be and also use of the hoverjack, a manual handling device that helps us to safely lift patients from an unwitnessed fall. The Committee was advised that the falls delivery group continue to meet and excellent community work is underway and much of this work was started by Oliver Williams, a physio working with the patient safety team and led on falls. The HPS advised the Committee that The Assistant Director of Patient Safety and Quality (ADPSQ) has been in liaison with colleagues from other health boards and some learning for us which we'll find useful is to establish a full scrutiny panel. The ADPSQ advised the Committee that in terms of recruitment to replace Oliver Williams' role we'll shortly be concluding on recruitment. There will be a refocus on the inpatient falls that is needed because community work is very well established. The HPS advised the Committee that the Incident reporting mechanism for pressure damage is proving challenging because of the reporting process. There is a lot of duplicates of incidents, and they are having to make staff aware of the free text use so that we know what people are reporting. Audit is a much better measure of what is happening with pressure damage. It is important for the wound healing team to work in conjunction with medstrom and they do their annual audit and show us what the prevalence of pressure damage is. This is a far more reliable measure than incident reporting. The HPS wanted to reassure the Committee that the pressure damage group is continuing and is chaired by the Director of Nursing for Surgery Clinical board. The HPS advised the Committee that a member of staff is currently working with the patient safety team, Carla English who has come to us from patient access. This has been instrumental in helping the PCIC clinical board in taking forward the work they are doing as they have a scrutiny panel process in place. This was well established in the Vale locality and there was some work that was needed to strengthen in the NW and SE locality and that work is ongoing and we are working with Claire Wade from surgery in the pressure damage group to spread learning. At this point in the report, The CC asked if anybody had any questions. **Questions** IMTU asked about a tracker process and asked the HPS to expand on a tracker process.	

	The HPS responded that we do have tracker processes in place but these are currently based more on an individual incident basis. We need to broaden it for clinical boards to look at it more across the themes of the incidents they are seeing in their own clinical areas. Some of the work that's come out of the recent Quality and Safety experience workshop gives us an opportunity to tap into and reinvigorate processes. The Patient Safety Facilitator (PSF) added that the Assistant Director of Patient Experience (ADPE) has a very good tracker system in place already with the clinical board. A good tracker system is in place for complaints so they would like to put in a similar process as it works very well in the complaints setting. In terms of organisational learning, we have strengthened the resource we have got within in the team. We have created a new role for patient safety and organisational learning and we have recruited 2 very strong candidates into the post. Part of that is to look at the processes we have got within the organisation to spread learning. The Executive Director of Therapies & Health Science (EDTHS) mentioned that she is the executive lead for falls and wanted to talk about this. She was concerned that there will be a focus on inpatient falls but the evidence suggests we should put most of our attention on the community which is why that has been the most significant part of the work in recent times. The EDTHS wanted to make the Committee aware that there is a greater need to concentrate on developing community prevention. **5 minute comfort break before continuing the report.** The HPS advised the Committee of the importance of using Patient Identification procedures to reduce incidents. The EDN advised the Committee that she had attended a meeting that morning with 2 clinical boards, Children & Women and Mental Health as well as local authority colleagues. More work is being started in the area of trying to prevent children from getting into crisis and how that is managed. The ADPE then took over the report and informed the Committee: The UHB have a very robust system when looking at complaints. Cross referencing is performed to see if a complaint is related to a serious incident and whether the SI has been incident reported and if it's already in the SI process. During the COVID-19 pandemic, most health boards have reported that they've seen a significant decrease in the number of concerns that they have received. Cardiff and Vale are in a similar position to where we were last year so we have not seen a significant decrease. The way concerns are raised has changed over the years. We have tried to be much more accessible to people. Social media is playing a big part in newly made concerns. Anybody who raises a concern will be contacted within 2 working days.	

	The ADPE advised the Committee that there had been a positive response to the CAV24/7 service. There were still patients turning up at the door without phoning so a quick review was done to find out if patients had phoned prior to attending and if they had not, what were the reasons why. 2 distinct groups came through in the review. People with mental health conditions and parents with children. The ADPE advised the Committee that there have not been many complaints from patients waiting on waiting lists due to the fact that these patients have been proactively contacted to say that they're still on the waiting list. Part of the reason for contacting these patients was to encourage nudge therapy. Nudge therapy enables a patient to take control of their own health by doing things like healthy eating and stopping smoking amongst other things. There is an ongoing evaluation of the impact of that. The ADPE advised the Committee that due to COVID-19, there is an expectation to see an increase in clinical negligence claims and personal injury claims. The CC explained that these reports have been exemplary and a lot information has been provided. Independent Member – Finance (IMU) wanted to make the point that he found the report very informative and is very reassured by what the UHB are doing. The CC recommended sharing the 67 page slideshow with all board colleagues. The EDN advised the Committee that a discussion surrounding the presentation needs to be had about if it could be presented to the CHC and recommended it be shared to all board members.	
QSE 20/10/007	**Analysis of Themes and Trends in Deaths of Patients with Mental Illness - learning, action taken and improvement since last year** The Director of Nursing Mental Health (DNMH) introduced the report and confirmed the following: • COVID-19 is playing a big part in the number of total unexpected deaths for 2020 and it's expected this total will exceed the 2019 figure. • The theme of people dying 10 to 15 years earlier than expected due to mental health continues. The DNMH advised the Committee that whilst continuing to provide services to secondary care environments, the reach across primary care has become enormous. The number of suspected suicides will increase just because of the amount of people we see. Our traditional patient base has increased enormously.	

	The DNMH advised the Committee of a national pattern being experienced in Cardiff and Vale in relation to older adult patients. The DNMH advised the Committee of an example of how the patient experience should be; If a patient in the vale presents to Mental Health services in the vale, that patient will be assessed and seen by that service. The patient is not having to go to a number of teams to access services. The DNMH advised the Committee that 2 senior nurses have been appointed to post to lead work on UHL site and that the immediate impact is really positive. The DNMH advised the Committee that they are taking an overall systemic approach will make the biggest difference to lessening any unexpected deaths. At this point in the report, The CC asked if anybody had any questions. **Questions** IMTU asked what the ratio between assessment and treatment should be and what we're aiming to get towards. The DNMH responded that there is no figure for a direct ratio in the unexpected deaths group. What has been noticed is that people are being bounced between services. This system does not work and is being looked at. Independent Member – Legal (IML) asked, are there any other profile alerts or trend for suicides? The DNMH responded that the only trend identified is the increase in 2020 of women – The women don't seem to be from any particular age group or social background. It is widespread. The EDN asked if the DNMH could tell the committee more about the comment on the work Jane Bell is doing around the change of culture in and around risk management – What the work is looking like and how it is being taken forward in the clinical board and partners. The DNMH responded that Jane Bell and Consultant Psychologist Miranda Barber have signed up to a training package in suicide prevention. Stepping away from Mental Health treatment approaches almost into a more Public Health role of suicide prevention. Training will be delivered to GPs and primary care level approaches and there is hope for 3rd sector to be involved as well as own UHB staff. This should help to change the culture and avoid people being moved about within services. The Head of Operations and Delivery (HOD) added that Jane Bell and Miranda Barber are working with the recovery college to develop a bespoke course on recognition of suicide and self-management skills.	

	Independent Member – University (IMU) asked about the age demographic of the mortality profile. The DNMH responded that they have included people ranging from 40 to 60 who have died prematurely. The Chief Officer – Community Health Council (COCH) asked if since moving Mental Health teams to a central location has there been a change in the way people access the services. The DNMH responded that Adult MH remain in the localities, older adult based in UHL. There does not seem to be any feedback around that and nothing to say that the pattern of access has changed. The biggest change has been digital platforms especially in the younger age group. The use of face to face video conferencing remains very popular. The older age group may not have access to this the same way the younger do. IMTU asked if there was anything more that could be done to get ahead of the curve of drug and alcohol issues that are expected over the next 18 months. The DNMH responded that digital solutions is the biggest way forward but making sure that everybody has access to that. We need to look at ways to ensure this and perhaps working with the 3rd sector can help. There is no definitive answer but the 3rd sector have got a huge part to play in that. The EDTHS wanted to draw attention to the mental health clinical board's website Stepiau.org and make everybody aware that it is has fantastic information for self-help and self-care and guided care. The CC asked due to the homeless population being rehoused during COVID-19, is there any correlation between this and the reduced rates of drug and alcohol related unexpected deaths in 2020. The DNMH responded that it has certainly made a different to their general health and wellbeing and with that a reduction in deaths. The CC asked are you working with the area planning boards, local authority colleagues and the 3rd sector in looking at ways to bolster your services. The DNMH responded, yes, the area planning board are looking at a new way of commissioning and delivering services and we are also working with the police as well. The CC asked how morale is across the UHB. The DNMH responded that people are anxious about things shutting down again and systems changing and the whole issue of COVID-19. Morale is tricky, but once things start to change people will become the resilient workforce that they were at the beginning. Sickness rates are very good.	

	People have accepted social distancing and the PPE as the normal. We need to try and support everyone as best as we can. The HOD added that they have tried to introduce more formal measures around staff support and have released psychology sessions to support specific staff dealing with COVID-19 related deaths. The CC asked the HOD to take back the thanks of everybody from the committee for everything they are doing and really appreciate it.	
QSE 20/10/008	**Items to bring to the attention of the Board/Committee.** There were no items to be brought to the attention of the Board or sub Committees.	
QSE 20/10/009	**Review of the Meeting** The CC facilitated a review of the meeting. Members confirmed that: • It was a very well chaired meeting. • Information needed regarding screen sharing for future use. • Very informative and detailed presentations. • Zoom worked well but queried as to why Zoom was used instead of Microsoft Teams. We need to be using 365 in future. • Our gratitude needs to reach all of the relevant and right people. The CC noted a final remark. A clear show of unified leadership from the executives and especially in regards to Quality and Safety from the EDN and EMD. It really shows.	
QSE 20/10/010	**Date and time of next Meeting:** 15th December 2020 at 9.00am	