Minutes of the Public Quality, Safety & Experience Committee

Held on 26th November 2024

Via MS Teams

To view the meeting: CAVUHB Public Quality, Safety & Experience Committee Meeting 26.11.2024 (youtube.com)

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Andy Jones	AJ	Director of Nursing/Midwifery – Children & Women CB
Mark Doherty	MD	Director of Nursing – Mental Health Clinical Board
Eloise Hamon	EH	Public Health Wales – Specialist Training (ST3)
Abigail Holmes	AH	Director of Midwifery and Neonatal Services
Katrina Griffiths	KG	Associate Director of People and Culture
David Fluck	DF	Executive Medical Director
Neil Jones	NJ	Clinical Board Director – Mental Health
Lauranne Cullen	LC	Llais Regional Director
Laura McLaughlin	LML	Risk Manager – Obstetrics and Gynaecology
Timothy Banner	TB	Clinical Director Pharmacy & Medicines Management
Observers		
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Angela Hughes	AH	Assistant Director of Patient Experience
Akmal Hanuk	AH	Independent Member – Community
Richard Skone	RS	Deputy Executive Medical Director

QSE 24/11/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 24/11/002	**Apologies for Absence** Apologies for absence were noted.	

QSE 24/11/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 24/11/004	**Minutes of the Committee meeting held on 08.10.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=130 The minutes of the Committee meeting held on 08.10.2024 were received. **The Committee resolved that:** a) The minutes of the meeting held on 08.10.2024 were approved as a true and accurate record of the meeting.	
QSE 24/11/005	**Action Log following the Meeting held on 08.10.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=156 The Action Log following the Meeting held on 08.10.2024 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 08.10.2024 was noted.	
QSE 24/11/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 24/11/007	**Mental Health Clinical Board – Assurance Report** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=220 The Director of Nursing – Mental Health Clinical Board (DoN-MHCB) presented the Assurance Report which provided the Committee with a summary of the arrangements, progress and outcomes within the Mental Health Clinical Board. This included: • National Reportable Incidents / Sentinels • Risks • Tendable • Audits • Improvement Plan Compliance • Health Inspectorate Wales (HIW) reports • Primary Mental Health performance • Clinical Risk Management / Patient Safety • Invited Review Service Report May 2024 of Hafan y Coed, Mental Health Services CAVUHB site visits carried out: 25-26th October 2023 • All Wales In-Patient Safety Programme • The National Confidential Inquiry into Suicide and Safety in Mental Health • Quality Network for In-Patient Working Age Mental Health Services • Safety Incident Response Accreditation Network • Workforce • Developments	

	• Concerns and Compliments <u>Royal College of Psychiatrists (RCP) Review</u> The Clinical Board Director for Mental Health (CBD-MH) provided a summary of the RCP review: • The RCP conducted a service review which was presented to the UHB in July 2024. It was an independent critique which followed a three phased approach to consider the standards of care provided. • During the COVID pandemic (2021-22) there was a higher-than-expected number of CAVUHB Mental Health Hospital suspected suicides (5 inpatients, 1 patient within an hour of discharge) • Six online interviews were conducted with members of the investigation team, the relevant wards in Hafan-Y-Coed (HYC) were visited, and they interviewed over 70 staff and Executives. • Judgement was based on the standards outlined in the QWNA standards (standards for acute inpatient service for working age). Investigations were reviewed against the standards for serious incident reviews (commonly referred to as SIRAN). • Identified themes included: risk assessments, care planning and formulation, therapeutic engagement, continuity of care, diagnosis and treatment, use of the MHA, observation levels, response to concerns raised by families, and serious investigations. • They strongly noted the following comments by the RCP: ▫ Many recommendations were about ensuring current policies were implemented and carried out well, that there was continuity of care, and staff had sufficient time and expertise to engage well with patients and their families. ▫ Improvements required good clinical leadership at all levels. Skill mix reviews would help to identify faps in capacity and expertise. Supervision, appraisals, mentoring, and time off for training would help to maintain professional skills. ▫ Many of the appropriate inpatient standards were identified within QWNA standards. • A subsequent meeting was planned with the Executives for February 2025. • Work undertaken so far: - ▫ Risk assessments – WARNN ((Purpose Wales Applied Risk Research Network) had already been introduced and they continued to work with mental health partners in the development of those tools. ▫ Care planning and formulation – ▪ Spot audits had been undertaken - it was clear there was confusion in inpatient spaces around the interpretation of the Mental Health Measure and the code of practice. The expectation was that in all inpatient treatment wards, all individuals should have a valid and complete care and treatment plan within 72hrs of transfer/admission. ▪ On all wards, levels of nursing observation engagement should be recorded in case notes and intervention plans at the point of admission. Ward rounds should be comprehensive and include reference to observation levels. ▪ All patients should have weekly 1 hour time booked to discuss their care plan and progress. ▫ The skill mix of staff was ongoing. ▫ Continuity of care – An outlier policy was already in place before the RCP recommendation. Staff were finding the time expectations difficult. ▫ Use of MHA and diagnosis and treatment – all medical staff had been written to regarding confusing statements around mental health which may be construed to be de facto detentions, and regarding good practice around diagnosis and treatment.	

	▫ Serious investigations – CAVUHB had become the first organisation in Wales to become SIRAN accredited. • No organisation in Wales currently met the QNWA standards. • The RCP issued 41 recommendations, of which 20 were complete. The Chief Operating Officer (COO) thanked the MH team for their work and highlighted that it was the CBD-MH's last week as Clinical Board Director. The CC thanked the CBD-MH for their work as clinical lead for the Clinical Board. The Executive Medical Director (EMD) asked for a clear timeline on the remaining actions for assurance, and for clarity on when they would complete the RCP recommendations. The CBD-MH responded that each ward would apply for the QNWA accreditation process with the RCP. The first year would involve building a plan to meet the 206 standards for the accreditation, and the second year would focus on completing the accreditation process. The CC asked when an updated self-assessment would be expected, as the work reflected the situation 12 months ago. The CBD-MH responded that it could be undertaken within three months. The END highlighted the exceptional performance of the mental health team in the nursing awards. The Committee Vice Chair (CVC) reflected on the estate's risks outlined within the report and expressed concern about the environmental issues flagged and the impact these conditions had on both patients' and staff's safety. She asked about the mitigations being implemented to address these risks. The DoN-MHCB responded with the following: • The remoteness of some of the wards was a challenge as decay could go unnoticed. This would have an impact on patients who were already under stress, and it did not send a good message to their staff. • Cedar Ward – it took time for estates to diagnose the problems. One of the difficulties was that the assessment ward gave patient's a poor first experience, but that they hoped this would be fixed within a few weeks. **The Committee resolved that:** 1) The progress made by the Clinical Board to date was noted; 2) The content of the report and assurance given by the Mental Health Clinical Board was noted.	
QSE 24/11/008	**Deep Dive - Perinatal Mortality Review Tool (PMRT)** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=2489 The Director of Midwifery and Neonatal Services (DMNS) presented the Perinatal Mortality Review Tool (PMRT) – Deep Dive report to the Committee which provided an overview of the systematic review process for maternal and neonatal deaths. She also reported on the improvements in neonatal death rates and the ongoing work to address care concerns and improve outcomes.	

	The EMD suggested that more work was needed around health inequity to provide valuable information and help to understand regional disparities to identify potential areas for intervention. The DMNS agreed and highlighted the success of the ELAN team in demonstrating that antenatal continuity of care improved outcomes. The challenge lay in achieving this within the current community model and emphasised the importance of engaging with vulnerable and hard-to-reach communities to build trust with a named midwife, which could significantly improve outcomes for these groups of women. **The Committee resolved that:** 1) The contents of the report was noted.	
QSE 24/11/009	**Equity, Equality, Experience and Patient Safety Action Plan - Update** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=3941 The Executive Director of Public Health (EDPH) reminded the Committee that the framework/support tool/guiding principles were introduced to make the organisation more equitable and deliver excellent preventative and clinical services. The Public Health Wales – Specialist Training (PHW-ST) provided the Committee with a six-month update on the Equity, Equality, and Patient Safety Action Plan and highlighted the progress made in various areas such as Planned Care, Equitable Employee Experience, Unscheduled Care, Maternity Care, Prevention, Analytics, Primary Care, Representation, Mental Health, and Patient Safety. She also noted the challenges related to data availability and staffing. The CC noted that they needed to get more granular data in relation to inequalities and deprivation and suggested that the EDPH meet with the Director of Digital & Health Intelligence (DDHI) to move this forward. The EDPH responded that she had regular conversations with the DDHI around this and highlighted a lack of resources in the central team and the need to connect data more widely, including using more regional information sharing system data to address these issues. **The QSE Committee resolved that:** a) The update was noted.	
QSE 24/11/010	**Regulation 28 PFD Improvement Plan** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=4447 The END informed the Committee that the plan addressed the aftermath of a high-profile case involving the death of an inpatient prisoner, which was covered widely in the media and went through the coroner court. The END highlighted the following points: 1. The Head of Prison Health and the senior nurse had both changed roles. The new senior nurse had a background in mental health and prison care, and the new Head of Healthcare came from the A&E department at UHW.	

	2. They were conducting a gap analysis on the nursing team's ability to identify deteriorating patients. 3. They had started to use Tendable to audit the quality metrics in the prison, despite initial security challenges. 4. They had improved GP coverage by collaborating with PCIC and clusters of GPs which had resulted in a more robust rota than before. **The QSE Committee resolved that:** 1) The update was noted.	
QSE 24/11/011	**Sexual Safety** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=4602 The Associate Director of People and Culture (ADPC) presented the report and slides to the Committee which provided a summary of the new legal duty on employers to prevent sexual harassment in the workplace and outlined the steps taken by the health board to comply with the regulations. This included targeted training, clear reporting pathways, and enhanced well-being support for colleagues. The Independent Member – Trade Union (IM-TU) asked how many sexual harassment cases there had been within the UHB over the past 6-12 months. The ADPC responded that she would investigate the number of cases and share with the Committee. The CC noted that the NHS Staff Survey results and responses around this were included in the paper, and that even one negative response is too many. He commended the plan and asked for an update in the future once the Action Group had reported. The ADPC agreed and noted that a Task & Finish Group (T&FG) had been established to develop an All-Wales Policy which may take some time, and therefore the UHB policy was likely to be finished first. The CVC asked whether there was an initiative which focused on empowering staff to manage unacceptable patient behaviour. The ADPC responded that the policy specifically addressed colleague-to-colleague behaviour. However, if there was an incident involving patient-to-staff behaviour, they would refer to the appropriate process to support colleagues in handling these situations. The Director of Corporate Governance (DCG) noted that this discussion tied into the broader work on defining a quality management system and eradicating avoidable harm. **The QSE Committee resolved that:** 1) The contents of the report was noted.	
QSE 24/11/012	**Medical Examiners (Wales) Regulations 2024 and Care After Death** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=5116	

	The Assistant Director of Quality and Patient Safety (ADQPS) presented the report to the Committee which provided a summary of the new Medical Examiners (Wales) Regulations 2024, the All Wales Learning from Mortality Review Framework, and the death certification process. The COO asked whether there had been any pushback. The ADQPS responded it had been the opposite. Consultant colleagues provided feedback that the volume of emails had significantly decreased and made communication more targeted. Additionally, recent data from the Concerns team indicated that there had been a significant reduction in the number of concerns raised. The ADQPS noted that it was heading in the right direction. The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) added that there was nothing negative about the new digital care after death process, and that the rates of engagement with the digital pathways would increase. **The QSE Committee resolved that:** 1) The assurance around UHB processes to consider Medical Examiner Referrals was noted; and 2) The assurance provided around the revised Care After Death processes was noted.	
QSE 24/11/013	**Controlled Drugs Accountable Officer Annual Update April 2023 – March 2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=5717 The Clinical Director Pharmacy & Medicines Management (CDPMM) presented the Controlled Drugs Accountable Officer (CDAO) Annual Update April 2023 - March 2024 to the Committee which provided a comprehensive overview of the management and use of controlled drugs (CD) within CAVUHB. The report also detailed the following: • The responsibilities of the CDAO • The establishment of the Cardiff and Vale Local Intelligence Network and the submission of quarterly occurrence reports • The Medicines Code • Self-Declarations • CD Destructions and Authorised Witnesses (AW) • Monitoring • National Prescribing Indicators • Licenses • Next steps The CDPMM suggested bringing this report back to the QSE Committee annually for assurance. The EDPH asked whether all pharmacies within CAVUHB needed to be licensed to issue CDs and whether this licensing requirement would impact the equity of access. The CDPMM responded that community pharmacies were registered pharmacies regulated by the General Pharmaceutical Council (GPC) and were exempt from needing a license. Because hospital pharmacies were not registered with the GPC, they needed a separate license from the Home Office. The CC asked about the national prescribing indicators and the opioid burden, specifically regarding the data collection on high-strength opioid prescribing.	

	The CDPMM responded that he would liaise with his team around what was being done to address the data problem regarding monitoring opioid prescribing, and feed back to the Committee. **The QSE Committee resolved that:** 1) The progress that has been made during the last 12 months was noted.	
QSE 24/11/014	**Director of Public Health Annual Report** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6289 The EDPH presented the Director of Public Health Annual Report and summarised the following: • The theme of this year's report was child health, which focused on children aged 0-5 years. This aligned with the development of the Babies, Children, and Young People's Plan • There was a two-pronged approach to address health inequalities and improve health across CAV • It covered four themes: childhood vaccination, good food and movement, oral health, and breastfeeding. Each chapter included recommendations • The report was independent and applied to multiple organisations • It aimed to highlight important health issues such as poverty, tooth decay, and obesity amongst children • Input from the Youth Board using the Thorn, Bud and Rose model to identify problems and solutions was included. **The QSE Committee resolved that:** 1) This year's Director of Public Health Annual Report: Prioritising the early years-investing for the future was noted.	
	Items for Approval / Ratification	
QSE 24/11/015	**Policies** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6571 The following policies were discussed: 1) UHB 519 - Request for approval of the 'Development and Approval of UHB Procedure Specific Consent Forms Principles and Framework' **The QSE Committee resolved that:** a) The policies were approved.	
	Items for Noting & Information	
QSE 24/11/016	**Minutes from Clinical Board QSE Sub-Committees and the Safeguarding Steering Group (SSG)** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6755 **The QSE Committee resolved that:**	

	1) The minutes were noted.	
QSE 24/11/017	**Joint Commissioning Committee Quality and Patient Safety Committee (QPSC) Chairs Report – 12.11.2024** To view the minute: https://youtu.be/YedfzZS4lLg?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=6776 **The QSE Committee resolved that:** 1) The Joint Commissioning Committee Quality and Patient Safety Committee (QPSC) Chairs Report – 12.11.2024 was noted.	
	Items to bring to the attention of the Board / Committee:	
QSE 24/11/018	*No items.*	
	Agenda for Private QSE Meeting	
QSE 24/11/019	*i) Minutes and Action Logs from the Private QSE Committee on 08.10.2024* *ii) Any Urgent / Emerging Themes – Verbal Update* *iii) Ophthalmology WET AMD*	
	Any Other Business	
QSE 24/11/020	*No items.*	
	Date & Time of Next Meeting:	
QSE 24/11/021	Tuesday 7th January 2025 at 2pm via MS Teams	