Minutes of the Public Quality Committee

Held on 13th May 2025 via MS Teams

To view the meeting: CAVUHB Quality Committee 13.05.2025

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
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Executive Director of Public Health
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Jo Harrall	JH	Senior Programme Manager Quality Excellence and Learning
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Rim Al-Samsam	RAS	Clinical Board Director – Mental Health
Catherine Twamley	CT	Interim Director of Nursing – Specialist Services Clinical Board
Thomas Holmes	TH	Interim Clinical Board Director – Specialist Services
Michael Stephens	MS	Interim Clinical Board Director – Specialist Services
Tara Robinson	TR	Interim Deputy Director of Nursing – Mental Health
Suzanne Wood	SW	Consultant in Public Health Medicine
Karen Gillespie	KG	Acute Oncology Clinical Nurse Specialist - Medicine
Observers		
Lauranne Cullen	LC	Regional Director for Llais
Natasha Goswell	NG	Deputy Executive Nurse Director
Bevan Howells	BH	NHS Graduate Management Trainee
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Steve Riley	SR	Independent Member – Local Community
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety

QC 25/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QC 25/05/002	**Apologies for Absence** Apologies for absence were noted.	
QC 25/05/003	**Declarations of Interest**	

	No declarations of interest were raised.	
QC 25/05/004	**Minutes of the Committee meeting held on 01.04.2025** The minutes of the Committee meeting held on 01.04.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 01.04.2025 were approved as a true and accurate record of the meeting.	
QC 25/05/005	**Action Log following the Meeting held on 01.04.2025** The Action Log following the Meeting held on 01.04.2025 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 01.04.2025 was noted.	
QC 25/05/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 25/05/007	**Specialist Services Clinical Board – Assurance Report** A patient story was presented to the Committee about a gentleman's journey through neuro rehab after suffering a subarachnoid haemorrhage. He highlighted the kindness and support received from various multidisciplinary professionals, the importance of therapeutic engagement, and his progress in regaining his independence. The Interim Director of Nursing – Specialist Services Clinical Board (IDN-SSCB) presented the report and slides to the Committee which detailed the arrangements, progress and outcomes within the Specialist Services Clinical Board in relation to the quality, safety and patient experience agenda over the past 12 months. The Committee Vice Chair (CVC) asked whether there were any challenges or concerns with the Joint Commissioning Committee (JCC) services. The CVC reflected on the previous year's Internal Audit report which made recommendations to their Terms of References (ToRs) and asked whether the implementation of AMaT had made a difference. The IDN-SSCB responded that the AMaT system was being used, but it primarily held individual action plans. There was a piece of work ongoing to create a single comprehensive action plan across the organisation which corresponded with themes. Regarding commissioning services, the Director of Operations – Specialist Services Clinical Board (DO-SSCB) described the two biggest areas of concern: 1. Cardiac Surgery Activity – they were not delivering the volume of activity commissioned due to staffing issues, leading to long waiting times and associated mortality and morbidity risks. This was listed as high on the risk register. 2. JACIE Accreditation for Bone Marrow Transplant (BMT) and CAR-T Services – the current facilities did not meet the required standards, and there were ongoing discussions with Welsh Government (WG) about reproviding these facilities. An inspection was due in September 2025, and failure to re-accredit could impact the delivery of the services.	

	The Executive Medical Director (EMD) asked whether there was an improvement plan in place for the MRSA and MSSA issues. The EMD highlighted the use of AMaT and felt it was not being fully utilised. He noted that there was a medical examiners module on the system, which may be useful for their mortality dashboard. There was the need for help with the risk management module to create local risk registers which fed up into the corporate risk register. The IDN-SSCB highlighted the efforts made to manage MRSA and MSSA infections amongst nephrology patients, particularly those associated to the line infections: • The focus last year was on improving the line management – full review of patient pathway, the treatment room on B5 was redesigned, bespoke line insertion packs, education of ANTT and sterile procedures, the development of formal competency-based learning and assessments, and the redesign of care plans. A lot of this had been rolled out to Critical Care. • Challenges remained however, and they were an outlier due to the huge increase of patients with lines over the past 5-7 years. The Interim Clinical Board Director – Specialist Services (IMCBD-SS-MS) added that renal failure patients on haemodialysis often had permanent tunnel lines for dialysis for long periods of time. The goal was to transition them to fistulas, but the prevalence of lines had increased globally. With around 200 patients dialysing permanently with lines, there was a disproportionate incidence of bacteraemia. The task was to minimise these cases whilst acknowledging the numbers would be higher than the UHB's standard. The Director of Corporate Governance (DCG) noted that Corporate Governance utilised the AMaT system already being used in the clinical governance space. They were the only health organisation in the UK to develop a risk register module, but it was now down to capacity to input all the data. **The Committee resolved that:** 1) The contents of the report was noted, in particular the highest risk areas for SSCB include: - Critical Care infrastructure - Maintaining JACIE accreditation in haematology - Access to renal theatre lists - Risks aligned with Epilepsy Services - Cardiac Surgery waiting lists	
QC 25/05/008	**Quality Indicators Report** The Assistant Director of Patient Experience (ADPE) presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety and patient experience priorities. It provided data through the end of April 2025 where available and detailed ongoing actions to drive necessary improvements. Additionally, it included exception reporting to highlight emerging trends and issues related to quality and patient safety. The CC noted concern about 'Never Events' which were critical quality metrics for the Cabinet Secretary. The trend was negative and prompted the need for clarification on measures being taken to address these. The ADPE responded that it was challenging as the definition of 'Never Events' was subjective. The key was to ensure the same type of 'Never Event' didn't reoccur. Robust reviews were essential, and each event was thoroughly examined.	

	The EMD highlighted that the high reporting culture indicated a strong safety culture. They needed to focus on harm caused - 'Never Events' were often process driven, and recent theatre reviews would help to improve processes. The Executive Nurse Director (END) noted this had been discussed in IQPD so WG were aware. He referred to the issue with the WHO checklist, and noted they now had a WHO collaborative which did a significant amount of work in reducing and mitigating the number of 'Never Events' and had been spread across the organisation. The END noted that the UHB used a just culture and ensure there was a robust improvement plan and learning from incidents. It was reassuring that people were not afraid to report when things went wrong. **The Committee resolved that:** 1) The assurance provided by the report was noted.	
QC 25/05/009	**Learning From Mortality** The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) presented the report to the Committee which highlighted the extensive work on learning from mortality in CAVUHB, in partnership with the medical examiner, coroner, and other partners. It detailed the digitisation of death reporting processes, the scrutiny of deaths by the Medical Examiner service, the review of referred cases, and the Learning from Mortality Group. They were looking to use AMaT the Morbidity & Mortality (M&M) module to document conversations and learning. The focus was on improving end-of-life care, lost to follow-up, managing deteriorating patients, and adhering to the Mental Capacity Act (MCA). The CC acknowledged the alignment with other initiatives and the integration into the Shaping Our Future Quality Excellence (SOFQE) Framework. It was crucial that learning was implemented to prevent future mistakes and delays, and to enhance overall service quality and outcomes. The EMD noted that it was now about disseminating the learning throughout the organisation. **The Committee resolved that:** a) The summary of Mortality Scrutiny being undertaken within CAVUHB was acknowledged; b) The learning efforts and partnerships in place to embed learning arising from mortality scrutiny and subsequent internal UHB review was recognised.	
QC 25/05/010	**Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services** The Clinical Board Director – Mental Health (CBD-MH) and the Interim Deputy Director of Nursing – Mental Health (IDDN-MH) shared the report and slides and highlighted the following: • During 2021-22, the Royal College of Psychiatrists (RCP) was invited to review the high inpatient suicide rates at the UHB and revealed significant areas for improvement. • Key changes in the Clinical Board included: enhanced risk assessment training, better family engagement, implementation of open dialogue, improved care planning and formulation, therapeutic engagement, continuity of care, Mental Health Act (MHA) diagnosis and treatment training, training around observation levels, accreditation with SIRAN, 3 members of the QSE team were Peer National Reviewers.	

	The CVC highlighted that the paper referred to potential implications because of the changes in practices for the staffing model, the funded Nursing Establishment in inpatient wards, and recruitment to senior clinical roles. The IDDN-MH responded that they were aligning their nursing establishment with QNWA standards to address activities they were currently unable to perform. Significant changes and a cultural shift towards a co-produced approach to improvements had occurred since the serious incidents. They were working closely with stakeholders, the lived experience team, and care groups to embed these changes, focusing on compassion, safety and community engagement in care development and decision making. The ADPE noted that the work with lived experience groups had been crucial in shaping plans, and this approach could benefit all clinical boards by providing valuable insights into patient experiences. She suggested discussing this outside of the meeting. The CBD-MH informed the Committee that she had recently attended an open dialogue course which was eye-opening. By combining open dialogue, lived experience and family engagement into a unified project, it shifted the focus to empower patients and families to take charge of their treatment. The END highlighted the following: • The improvements in risk assessments, care planning and formulation, and therapeutic engagement, all required more staff and time. • They were mitigating in-hospital mental health staffing levels by using primary care and community funds. However, they needed to redirect these funds back to their intended areas. • A business case for £6m would be presented to the Value & Benefits Realisation Group (VBRG) to address this. • Despite financial challenges, they were committed to improving staffing levels and will regularly bring updates back to the Quality Committee on their progress. The CC suggested that a progress update on the improvement plan to come back to the Committee in August's meeting. **The Committee resolved that:** 1) The contents of the report was noted.	
QC 25/05/011	**Shaping Our Future Quality Excellence Framework** The END introduced the item and noted that as part of the strategic framework, they had focused on eradicating avoidable harm and brilliant basics. They faced big challenges including patient waiting times and Infection Prevention & Control (IP&C). The Quality Excellence Framework Programme Board had several projects aligned with these challenges. The Senior Programme Manager Quality Excellence and Learning (SPMQEL) presented slides to the Committee and highlighted the following: • The SOFQE Programme aimed to improve key quality areas, shifting from variable to consistent and repeatable care and outcomes. It focused on eradicating avoidable harm across various domains, not limited to patient harm. • They had a monthly Programme Board led by the END who was the Senior Responsible Officer (SRO), who managed, coordinated and prioritised projects. • There were four current operational projects which included the Quality Management System Project, the Hospital Acquired Infections Project, the Lost To Follow-up Project, and the Acute Deterioration Project. Additionally, they were	

	incorporating a medicine safety project. The Programme Board agreed that morning to incorporate a Medicine Safety Project into this work. • Three of these projects aligned with the NHS Exec Safe Care partnership work, using local and national guidance. The Executive Director of Public Health (EDPH) asked whether any projects addressed equity and data collection for protected characteristics. The SPMQEL responded that currently there was not anything specific, but each project had a significant data and digital element. She suggested discussing this with the END at the following Programme Board. The EMD agreed that all the projects needed to consider these issues, and equity needed to be applied as a lens to all projects. The END agreed with the EDPH's request to include equity was integrated into all their work. The END thanked the team for their significant efforts in driving the programme forward. This framework would support quality, innovation and transformation within the organisation, and addressed key themes like deteriorating patient, medicines management and patient lost to follow-up issues. They would continue to report on progress. The ADPE noted the following: • They lacked sufficient data on equity, and whilst they collected equity data through Civica during redress cases, complaints or claims, it was often incomplete. • They needed to capture this data for everyone in the system. • They should view this as a programme-wide lens, as evidence showed that people with particular characteristics were adversely affected. The CC thanked the team for their excellent work. **The Committee resolved that:** 1) The Shaping Our Future Quality Excellence Framework was noted.	
QC 25/05/012	**Discharge Advice Letters** The AMDPSCE presented the report with the Committee and highlighted the following: • There was a lot of variances in the quality and completeness of Discharge Advice Letters (DALs) issued across the organisation, which was crucial for patient care continuity. • DALs should include diagnosis, care and treatment details, medication changes, investigations, critical information for patients and GPs, and necessary follow-ups. • DALs were managed through the Welsh Clinical Portal (WCP), owned by Digital Healthcare Wales (DHCW), which led to data ownership issues. • The Electronic Prescribing and Medicines Administration (EPMA) would hold DALs in the future, which allowed data ownership and quality reporting. • Efforts were being made to raise awareness through Clinical Boards and QSE Committees. • The Surgical and Medical Clinical Board's ward standards required DALs to be completed, printed and given to patients before discharge. • Education for resident doctors focused on creating focused and relevant DALs. • Ongoing work to improve DALs processes, create dashboards, and Standard Operating Procedures (SOPs).	

	The EDPH suggested that Public Health Wales (PHW) had a behavioural support team that specialised in writing letters to prompt action, which may be helpful for improving DALs. The CC suggested that updates on the progress of this work come back to the Committee at a future date. **The Committee resolved that:** 1) The contents of the report was noted.	
QC 25/05/013	**Board Assurance Framework (BAF)** The DCG presented the Board Assurance Framework (BAF) and highlighted the following: • The BAF outlined the strategic risks that could prevent the UHB from achieving their organisational strategy. • There were four strategic objectives and six strategic risk themes, divided into two categories: service delivery (quality and health equity), and enabling risks (people, digital, infrastructure, and sustainability). • Each Committee should consider how to incorporate the relevant strategic risks into their agendas. For this Committee, the focus was on the quality and health equity strategic risks. The DCG asked the Committee how best to use the BAF to address these strategic objectives and seek assurance on their risks. The EDPH highlighted the need for equity to be at the forefront of people's minds, rather than bringing specific items. The EMD emphasised the need to ensure all actions within the BAF were aligned with what was discussed during these Committee meetings. The CVC suggested a retrospective review the past 12 months of Committee contents to identify which elements were related to the BAF. The DCG noted the focus should instead be on the Forward Plan and meetings between the Chair and Lead Executives. He suggested an annual discussion on the BAF at the Committee to serve as a sense check. The Chief Operating Officer (COO) noted that not enough attention was paid to the BAF and the Corporate Risk Register. The DCG responded that the BAF was a standing item on the UHB Board agenda, but it was requested for the BAF to be reviewed by the Committees. The DCG noted that the corporate risk register also went to Board, but the key was to integrate this into their Strategic Leadership Team (SLT) meetings. Incorporating all of the risks into a single point of truth on AMaT was crucial. The END noted that SOFQE was the main driver and framework for quality, and they needed to ensure the BAF aligned. The END praised the BAF for being very readable and easy to navigate. He agreed that they needed to socialise this within the organisation, as it was the main document clarifying their strategic and corporate risks.	

	It was suggested that the CC, the DCG, and the Corporate Governance Officer (CGO) meet to discuss the Forward Plan and how it aligned to the BAF. **The Committee resolved that:** 1) The BAF was discussed and noted.	
	Items for Approval / Ratification	
QC 25/05/014	**Policies** UHB 529 - Policy for the Management of Suspected and Proven Neutropenic Sepsis in Adults The Acute Oncology Clinical Nurse Specialist – Medicine (AOCNS-M) presented the policy for approval to the Committee. The EDPH asked whether the introduction of a policy would change how people were treated upon arrival. The AOCNS-M responded with the following: • The recommendation stemmed from various reports which suggested all UHBs should have a policy. • When the Oncology service was developed, collaboration issues between oncology and haematology, due to neutropenic haematology patients, delayed the policy's progress. • Regarding clinical management, the team had been audited against NICE guidance when patients come through the front door. The recommendation to have a policy had driven continued work, and health pathways had also contributed. The END noted that CAVUHB not having a neutropenic policy had been a huge clinical concern. Whilst many patients were managed at Velindre, their limited beds meant Cardiff-based patients often defaulted to UHW. **The Committee resolved that:** 1) The policy was approved.	
QC 25/05/015	**Suicide and Self-Harm Prevention Strategy** The EDPH explained that this was the second Suicide and Self-Harm Strategic Plan for CAV, which built upon the first plan from 2020 to 2024. It was developed in partnership with a wide range of partners. The EDPH noted that higher rates of suicide were seen in more deprived areas, particularly amongst unemployed men aged 25 to 44. The Consultant in Public Health Medicine (CPHM) highlighted the following: • This was a five-year plan with a one-year delivery plan • In 2023, there were 56 registered suicides. From 2020-2022, there were 822 admissions for self-harm. • An event in October 2024 developed a vision and eight objectives with stakeholders, including those with lived experience and those bereaved by suicide. • The draft strategic plan went to consultation from February to April 2025 and received 20 responses and offers for help. • The National Suicide Prevention and Self Harm Strategy was launched on April 1st, 2025.	

	• The strategic plan aligned with the national strategy and included the outline vision and eight priority areas. The EDPH clarified that this strategy had previously gone to Senior Leadership Board (SLB) for discussion and consultation. The CVC noted that there was no direct reference to the prison population within the plan. Given the challenging environment and higher instances of suicide in prisons, she asked whether it was covered elsewhere within the strategy. The EDPH responded that they had recently undertaken a health needs assessment for the prison population. The CPHM confirmed that the Prison Governor was spoken to and included within the consultation phase. There was not any specific feedback from them. However, many elements like training, development, and creating safe spaces covered the prison population. The CVC suggested that if there was any learning or nuance around the prison population, whether it could feed into the strategy after the one-year delivery plan. The CPHM confirmed that they would create two-year implementation plans up to the end of 2030. They would ensure there was prison representation at the workshop planned for Q4. The Senior Service Improvement Programme Manager (SSIPM) asked how they would measure the success of the strategy. The CPHM responded that most of the outcome measures were listed at the end of the implementation plan document, and that there were both qualitative and quantitative measures for each of the 8 strategic objectives with specific measures for each. **The Committee resolved that:** 1) The Cardiff and Vale of Glamorgan Suicide Prevention and Self-Harm Strategic Plan 2025-2030 and the first-year delivery plan 2025-26 was approved.	
	Items for Noting & Information	
QC 25/05/016	**Minutes from Clinical Board QSE Sub-Committees, the Safeguarding Steering Group (SSG), and the Infection Prevention and Control Group (IPCG)** **The Committee resolved that:** 1) The minutes were noted.	
QC 25/05/017	**Primary Care Eye Health Needs Assessment** **The Committee resolved that:** 1) The update was noted.	
	Items to bring to the attention of the Committee	
QC 25/05/018	*No items.*	
	Agenda for Private QSE Meeting	
QC 25/05/019	*i) Minutes and Action Logs from the Private QSE Committee on 01.04.2025* *ii) Any Urgent / Emerging Themes – Verbal Update*	

	Any Other Business	
QC 25/05/020	*No items.*	
	Date & Time of Next Meeting:	
QC 25/05/021	24th June 2025 at 2pm via MS Teams	