Minutes of the Public Quality Committee

Held on 24th June 2025 via MS Teams

To view the meeting: CAVUHB Quality Committee 24.06.2025

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
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
Louise Denham	LD	Food Vale Co-Ordinator – Public Health
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Yvonne Hyde	YH	Head of Nursing for Infection Prevention & Control
Tara Cardew	TC	Head of Patient Safety
Observers		
Amy English	AE	Deputy Regional Director - Llais
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Steve Riley	SR	Independent Member – Local Community
Mike Jones	MJ	Independent Member – Trade Union
Lauranne Cullen	LC	Regional Director for Llais
Paul Bostock	PB	Chief Operating Officer

		ACTION
QC 25/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	
QC 25/06/002	**Apologies for Absence** Apologies for absence were noted.	
QC 25/06/003	**Declarations of Interest** No declarations of interest were raised.	
QC 25/06/004	**Minutes of the Committee meeting held on 13.05.2025** The minutes of the Committee meeting held on 13.05.2025 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 13.05.2025 were approved as a true and accurate record of the meeting.	
QC 25/06/005	**Action Log following the Meeting held on 13.05.2025** The Action Log following the Meeting held on 13.05.2025 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 13.05.2025 was noted.	
QC 25/06/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	

QC 25/06/007	**Deep Dive – Nationally Reportable Incidents (NRIs)**
	
	The Deputy Regional Director – Llais (DRD-L) asked what prompted the deep dive topic.
	
	The CC responded that the Cabinet Secretary was aware of the larger than usual number of NRIs, and the Committee wished to analyse and understand the situation.
	
	The Assistant Director of Quality and Patient Safety (ADQPS) introduced the paper to the Committee and highlighted the following:
	• In 2024, 153 NRIs were recorded in the UHB.
	• Until mid-2023, NRIs were incidents associated with what was perceived to be initially levels severe or catastrophic harm. In 2023, Wales introduced a new category of NRIs to include all incidents that would be reported through a Perinatal Mortality Review Tool (PMRT) process.
	• 34% of NRIs were now from MMBRACE cases, leading to an uplift in the number of reported incidents.
	• A paper was brought to the Quality Committee in November 2024 which detailed maternal and neonatal cases, and improvements.
	• Themes from NRIs included cases associated with endoscopy, never events, deteriorating patients, follow-up failures, medication safety, and infection prevention & control (IP&C)
	• Endoscopy: -
	  o COVID caused delays in endoscopy surveillance for patients who required ongoing monitoring.
	  o They had now eradicated this legacy backlog. They had undertaken a number of case reviews which resulted in widespread learning.
	• Never Events: -
	  o The Theatre Review was published the previous month, and there were concerns around how the WHO checklist was implemented across the organisation.
	  o A WHO checklist collaborative was implemented who were working through the checklist and putting in more robust methodology and responsible individuals.
	  o Work had been undertaken with Medical Education around invasive procedures - e.g. a standardised process for local anaesthetic procedures was now mandated and included competency assessments.
	• The "Shaping Our Future Quality Excellence" (SOFQE) programme had been implemented to drive a health board wide programmes of improvement priority areas that have emerged because of patient safety incidents. This programme has a number of projects underneath.
	• Lost to Follow Up: -	

- Three tranches of work underpinned this: 1) ensuring the continuity of care for patients at the point of an outpatient appointment and appropriate subsequent care; 2) standardising referrals into the UHB; and 3) internal referral processes.

- The Deteriorating Patient
  - A revised early warning score (NEWS) 2 system would be implemented across the UHB by the end of July 2025, with training provided.
  - Work had been completed to implement a similar system in neonatal services and aim to do the same for maternity and paediatric services by Autumn 2025.
- IP&C: -
  - IP&C efforts included improving data insights to not only look at bloodstream infections and bacteraemia's.
  - They had introduced the "Brilliant Basics" communications programme, targeted at all UHB staff.
- Medication Safety: -
  - Electronic Prescribing and Medication Administration (ePMA) systems were being implemented to interrogate both prescribing and medication administration.
  - They would focus on several areas including the safe prescribing and administration of opioid medications and insulin, the eradication of omitted doses, and antimicrobial prescribing.
- For the SOFQE programme, senior responsible officers were appointed to oversee each programme, with progress reported monthly to an executive programme board.

The CC asked for regular updates on the progress of the SOFQE programme in areas such as lost to follow-up, deteriorating patient care, IP&C, and medication safety.

The Executive Nursing Director (END) responded that the NRI themes were all incorporated into the different projects, which reported into the programme board. The SOFQE programme was now embedded in the organisation and focused on learning, innovation, and transformation.

It was suggested that the CC and END meet to discuss the frequency for SOFQE Programme themes to be brought to the Committee.

The Committee Vice Chair (CVC) noted that medicines management and prescribing risks had been frequently highlighted in recent inspections and asked if the electronic prescribing implementation would address the recommendations and concerns from Health Inspectorate Wales (HIW) reports.

The ADQPS responded that the ePMA implementation would address some HIW concerns, but it wouldn't cover all issues, especially around medication storage safety. Ongoing programmes and internal audits would continue to address these areas, with a focus on UHB-wide learning through the SOFQE initiative.

The Executive Medical Director (EMD) noted the ePMA was an important safety step but only addressed part of the errors. The medication safety programme within SOFQE would include storage, medication, administration, and prescribing.

The END suggested that once ePMA was embedded, that the CVC visit a ward to see logistically how it worked.

The CC asked to what extent they were working with the improvement team.

The ADQPS responded that the improvement team were central to shaping the SOFQE programme.

	The Committee resolved that: 1) The emerging themes from the Nationally Reportable Incidents was noted 2) The assurance provided by the improvement work associated with these themes was noted	
QC 25/06/008	**Prevention of Future Deaths Update - Ref: 1051 and Ref: 1553** The END introduced the item and highlighted that the Prevention of Future Deaths (POFD) was a decision that the coroner makes following a hearing, which held an organisation accountable for improvements to prevent similar issues. They had received two cases. The Assistant Director of Patient Experience (ADPE) • They did not just respond to the coroner – they considered implications and embedded improvements across the UHB to mitigate future risks. • The first PFD Report related to the Silencing of Alarms at Central Monitors: o Whilst they responded to the coroner, they realised this was a risk where there was telemetry for any patients across the UHB. o Significant progress had been made, with new central monitoring systems and configurations in place. o The PFD was shared across Wales and was monitored with regular updates to the Director of Nursing (DoN) forum. • Second PFD Report related to a sad death in St David's Hospital: o The PFD focused on fall prevention management, recognising at-risk patients, and using enhanced supervision. o A robust, sustainable training programme for staff had been implemented, which included risk assessments and mitigation. o Improvements included deploying extra-low beds and ensuring up-to-date risk assessments. o The work was shared on an All-Wales basis and monitored The CC commented that to aspire towards quality excellence, they must ensure that learning permeated all relevant areas and not just restricted to letters from coroners. The CVC asked whether they needed to report all actions to the coroner for sign-off. Additionally, she asked whether they shared new practices and learning with other UHBs. The ADPE answered that their initial response to coroner's letters was within 56 days of receiving a PFD, but they are not obligated to report further. However, they ensured lessons were learned from all inquests and shared this information with the All-Wales Inquest Network. **The Committee resolved that:** a) The assurance provided by the report was acknowledged.	
QC 25/06/009	**IP&C Position Update** The END introduced the item and highlighted that some of the UHB's IP&C measures were not meeting the WG reduction targets. The END and Head of Nursing for Infection Prevention & Control (HNIP&C) presented the IP&C Position Update which covered the goals set for various infections, the current status of these infections within the UHB, and the specific measures being implemented to improve IP&C and patient outcomes. The CC asked to what extent would the improvements continue	

	The HNIP&C responded that the introduction of ePMA would enable better oversight of prescribing. An education tool had been developed and would be available on all PCs across the UHB and would focus on key areas like handwashing, cleaning, and prescribing. The END highlighted the following points: • C.diff was a national issue – the HNIP&C represented CAVUHB at a C.diff Learning Collaborative Co-Design event. • This work was supported by executive colleagues to maintain cleaning standards despite financial constraints. • The Chief Nursing Officer (CNO) had been preparing enhanced cleaning standards, which needed to be socialised across the organisation. • There was an issue with medical reporting of Aseptic Non-Touch Technique (ANTT) training due to different logging systems for consultants and resident doctors. There would be a focus on ANTT training in executive reviews and plan for a full breakdown of training in the following meeting. • There was great importance in maintaining good handwashing techniques, clean clinical standards, and proper uniform and dress codes. The EMD highlighted that the report stated that 50% of C.diff cases were hospital-acquired, and MRSA and Staph aureus rates were high. Previously, even one MRSA case was significant. This was an urgent matter. The EMD asked whether the UHB's visiting regimes were too relaxed, and whether they needed to limit the number of visitors, or engage with more visitors to stress the importance of handwashing and IP&C. The HNIP&C responded that: • All visitors were asked to wash their hands. However, due to limited staff, monitoring everybody was challenging. • All patients should receive a C.diff information leaflet to share with their families, which provided guidance on handwashing and laundry. • Limiting visiting times was a sensitive issue, especially since visitors often helped with patient care. • Flow and capacity were major issues, and they lacked enough single rooms to meet demand. The ADPE noted that during the pandemic, they used volunteers to remind visitors about handwashing and checking for infections, and suggested they utilise this approach again to emphasise public responsibility and its impact. The HNIP&C added that there was an IP&C cell that the END chaired with Comms colleagues present to help disseminate information to the public. She noted that they could consider more campaign, e.g. Cardiff University had a campaign during the school holidays in the shopping centre. The END concluded that it was not just about visitors, they needed staff to listen in equal measure. They must build a culture where everyone understands their role in improving infection control. The CC asked for another IP&C update to return to the Committee in Q2. **The Committee resolved that:** 1) The IP&C update was noted.	

QC 25/06/010	**Clinical Effectiveness Committee Report** The Head of Patient Safety (HPS) introduced the report and highlighted the following: • This was a biannual report summarising the national audits presented at the Clinical Effectiveness Committee (CEC). The report highlighted audits from the last two CEC meetings. • Common theme was data collection challenges – e.g. the National Neonatal Audit Programme (NNAP) faced significant data collection issues in 2023, which led to over-reporting of mortality cases and under-reporting of congenital anomalies. The issues were reported to MMBRACE but beyond the deadline for amendments. They had since transitioned to BadgerNet. • They were undertaking a project to assess resources for data collection across the UHB to support clinical teams in audits - there was good engagement from clinical teams and notable work presented • The CEC reorganised around specialties to group and theme audits, aiding clinical boards in supporting audits and improving patient care The CC asked what analytical support they had to translate the generated data into meaningful information. The EMD noted that the national audits provided a lot of analysis and feedback to sites. He suggested that the real question ought to be what they were doing within those teams to address the issues raised by the national audits. The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) noted that some themes from SOFQE appeared in their national audits. It was crucial to understand their position within these audits and use the data proactively to guide decision-making. The CC asked how they were using that data to develop improvement schemes. The ADQPS highlighted that: • National audits provided prospective data such as the stroke audit and the National Hip Fracture Database. Data was accessed monthly or quarterly to drive improvements. • Some data in the report was two years old, which didn't relate to their current position • Across Wales, a national data resource was being developed for centralised data collection. • The UHB did not have a centralised data analysis team at present, but some areas like the National Emergency Laparotomy Audit were well-resourced • Clinical boards needed to monitor data continuously and have improvement plans. Clinical boards should provide assurance to CEC, not be the first point of contact for audits. The AMDPSCE referred to the neonatology team working with infection control to reduce infection rates on the unit. This significant effort aimed to lower infection rates through various measures. This audit was well-recognised and influenced operational decision-making. **The Committee resolved that:** 1) The assurance provided by the national audit data and some of the areas of improvement covered in the report were noted.	
	Items for Approval / Ratification	
QC	**Policies**	

25/06/011	*No policies for approval.*	
QC 25/06/012	**Regional Health Protection Partnership** The Executive Director of Public Health (EDPH) introduced the report and provided the following summary: • The public health vision focused on reducing inequalities and protecting the health and wellbeing of the local population through health protection. This element of work focused on health protection. • CAVUHB had strong relationships with local authority colleagues, particularly in environmental health and Shared Regulatory Services. • This year's plan included improving primary care relationships, developing a communications and engagement strategy, strengthening ties with the third sector, and developing and testing a pandemic response plan. • The plan had been approved by the Amplifying Prevention Board and the Strategic Leadership Team (SLT) and would be presented to the two public service boards. The CC asked how they could ensure that the implementation of preventative schemes and health protection measures wouldn't increase inequalities. The EDPH responded that they saw more communicable diseases in deprived areas and groups, and they worked closely with those working with those groups (like the CAV Health Inclusion Service and the prisons). Their vaccination plans included health inequalities plan to increase uptake and reduce differentials. **The Committee resolved that:** 1) The Health Protection Regional Partnership Plan was approved.	
QC 25/06/013	**Vale Food Strategy** The EDPH and the Food Vale Co-Ordinator – Public Health (FVC-PH) presented the paper and slides to the Committee which outlined the Vale Food Strategy. The Strategy outlined the vision for a healthy and sustainable food system in the Vale of Glamorgan (VoG), and the actions to be taken to address this. The EMD asked whether enough work was being done internally for staff to promote this and role model good food practice. The FVC-PH responded there was an opportunity to do more. Some colleagues in the public health team were working on initiatives like the Restaurant and Retail Standards to raise awareness about healthy food and its impact on our daily decisions. The CC asked for an update on the strategy's progress at a future Committee. **The Committee resolved that:** 1) The Vale Food Strategy 2025-2030 was approved.	
	Items for Noting & Information	
QC 25/06/014	**Minutes from Clinical Board QSE Sub-Committees** **The Committee resolved that:** 1) The minutes were noted.	
QC 25/06/015	**Joint Commissioning Committee Quality Safety and Outcomes Sub-Committee Highlight Report**	

	The Committee resolved that: 1) The Joint Commissioning Committee Quality Safety and Outcomes Sub-Committee Highlight Report was noted.	
QC 25/06/016	**Internal Audit Report – Follow Up Health Roster System** **The Committee resolved that:** 1) The Internal Audit Report – Follow Up Health Roster System was noted.	
	Items to bring to the attention of the Committee	
QC 25/06/017	*No items.*	
	Agenda for Private QSE Meeting	
QC 25/06/018	*i) Minutes and Action Logs from the Private QSE Committee on 13.05.2025* *ii) Any Urgent / Emerging Themes – Verbal Update*	
	Any Other Business	
QC 25/06/019	*No items.*	
	Date & Time of Next Meeting:	
QC 25/06/020	5th August 2025 at 2pm via MS Teams	