

**Unconfirmed Minutes of the Quality, Safety & Experience Committee**

**Held on 29 November 2022 at 09.00am**

**Via MS Teams**

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| **Chair:** | | |
| Susan Elsmore | SE | Independent Member – Local Authorities / Chair of the Committee |
| **Present:** | | |
| Gary Baxter | GB | Independent Member – University |
| Mike Jones | MJ | Independent Member – Trade Union |
| Ceri Phillips | CP | Vice Chair of Cardiff and Vale University Health Board |
| **In Attendance** | | |
| Paul Bostock | PB | Chief Operating Officer (in attendance until 10am) |
| Barbara Davies | BD | Lead Nurse in Specialised Medicine |
| Nicola Foreman | NF | Director of Corporate Governance |
| Angela Hughes | AH | Assistant Director of Patient Experience |
| Meriel Jenney | MJ | Executive Medical Director (in attendance until 11am) |
| Mathew King | MK | Interim Assistant Director of Therapies and Health Science |
| Fiona Kinghorn | FK | Executive Director of Public Health |
| Jane Murphy | JM | Interim Director of Nursing – Medicine Clinical Board |
| Suzanne Rankin | SR | Chief Executive Officer |
| Aled Roberts | AR | Clinical Director for Medicine Clinical Board |
| Jason Roberts | JR | Executive Nurse Director |
| Alexandra Scott | AS | Assistant Director of Quality and Patient Safety |
| Richard Skone | RS | Deputy Medical Director |
| **Observing** |  |  |
| Timothy Davies | TD | Head of Corporate Business |
| Marcia Donovan | MD | Head of Corporate Governance |
| Beth Jones | BJ | Senior Nurse for Specialised Medicine |
| Katherine Prosser | KP | Interim Quality and Governance Lead – Medicine Clinical Board |
| **Secretariat** | | |
| Nathan Saunders | NS | Senior Corporate Governance Officer |
| **Apologies** | | |
| Fiona Jenkins | FJ | Executive Director of Therapies and Health Sciences |
| Louise Platt | LP | Director of Operations for Medicine Clinical Board |
| Catherine Phillips | CP | Executive Director of Finance |

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| **QSE 22/11/001** | **Welcome & Introductions**  The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh. | **Action** |
| **QSE 22/11/002** | **Apologies for Absence**  Apologies for absence were noted.  The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting.  The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group. |  |
| **QSE 22/11/003** | **Declarations of Interest**  No declarations were noted. |  |
| **QSE 22/11/004** | **Minutes of the Committee meeting held on 30 August & 11 October 2022**  The minutes of the meeting held on 30 August 2022 and 11 October 2022 were received.  **The Committee resolved that:**   1. The minutes of the meeting held on 30 August 2022 and 11 October 2022 were approved as a true and accurate record of the meetings |  |
| **QSE 22/11/005** | **Action Log following the Meeting held on 30 August 2022**  The Action Log was received, and all ongoing actions discussed.  **The Committee resolved that:**   1. The Action Log from the meeting held on 30 August 2022 was noted |  |
| **QSE 22/11/005** | **Chairs Actions**  The Chairs Action around the Approval of the Research Governance Policy (UHB 099) was received.  **The Committee resolved that:**   1. The Chairs Action was noted. |  |
| **QSE 22/11/006** | **Medicine Clinical Board Assurance Report (including a Patient Story)**  The Clinical Director for Medicine Clinical Board (CDMCB) introduced the Lead Nurse in Specialised Medicine (LNSM) who presented the Committee with a Patient story.  It was noted that the Patient Story reflected the complex experience of a Patient at the University Hospital of Wales (UHW) and their extended length of stay.  The LNSM advised the Committee that the Patient’s case was very complex and identified a number of areas in which the Health Board had input into the care of the Patient and the actions taken around:   * Patient admission * Interventions * Early MDT approach * Discharge Planning * Re-Admission * Further Discharge Planning   It was noted that a number of lessons had been learnt which included:   * Failure to engage GP in the MDT approach added to the Patient’s readmission * Access to psychology was limited * Acute care environments did not support the therapeutic interventions required for Patients with multi-faceted complex needs   The Independent Member – University (IMU) noted that the Patient within the story had a very complex case and that the issues seen around psychology had offered another interesting aspect to the complex case in terms of holistic management.  The Vice Chair of the University Health Board and Committee (the Vice Chair) asked if the lessons learnt could be pooled across the Organisation with regards to how Patients with complex needs were managed because there were currently Patients inappropriately located in care settings for a number of reasons but those areas did not necessarily address their Clinical or emotional needs.  The CDMCB responded that the ward in which the Patient had been admitted was no stranger to complex cases and noted that a Patient whose length of stay exceeded the expected length of stay was usually due to the Patient’s needs falling between services and that attention was required as to why a Patient’s length of stay was so high.  The LNSM added that in terms of sharing the complexity of the learning across the Organisation, it should be looked at and shared effectively between Clinical Boards.  The Chief Executive Officer (CEO) noted that they had been discussing the need for psychological therapy to be embedded as an element of the Health Board’s “universal offering” as opposed to an “as and when” required approach.  The Medicine Clinical Board Assurance Report was received.  The Executive Nurse Director (END) advised the Committee that in relation to the National Reportable Incidents (NRI) management, the Medicine Clinical Board (MCB) had undertaken a lot of work to close down the NRIs.  It was noted that the Medicine Clinical Board (MCB) was investigating 8 NRIs and that 5 of the investigations were being progressed for closure and 3 were subject to His Majesty’s Coroners inquests.  The CDMCB advised the Committee that maintaining safe and timely Patient flow across the Clinical Board continued to be a significant risk to the MCB, especially within the Emergency Department (ED).  He added that the MCB had received a lot of support from the Health Board around areas which included:   * A frailty zone - a 6-day Frailty service in the Assessment Unit had commenced in November 2022 * Right bed, first time - Ward A1 was reset to ensure Patients with a predicted length of stay under 72 hours were admitted and Ward C5 had introduced a Clinical led flow model with respect to Board rounds and noted that the small change in the timings of Board rounds had seen a big impact on communication and team working in relation to Patient discharges and flow.   The Interim Director of Nursing – Medicine Clinical Board (IDNMCB) advised the Committee that the biggest risk for the MCB was staffing.  She added that the lack of a consistent workforce impacted on standard of care and added that staff were expressing their concern with regards to not having enough nurses to look after Patients.  It was noted that different models of healthcare were being looked at with other Health Boards in Wales, as well as gaining valuable insights via Tendable.  The IDNMCB advised the Committee that the MCB was trying to build its workforce around the Patient rather than looking at the traditional model of care and had recognised the huge amount of work that was needed.  The Vice Chair asked what actions were in place to increase the percentage of MCB staff undertaking their Values Based Appraisal (VBA), as the current level stood at 22.20% which was poor.  The IDNMCB responded that the MCB and Directorates were working hard to review and improve compliance with VBAs and pay progression.  She added that the paperwork had been looked at and reduced to encourage a more streamlined approach which would help to make the process more discussion based.  The Assistant Director of Patient Experience (ADPE) advised the Committee that the MCB had a high level of activity but had remained very focussed on the QSE agenda and that as a Clinical Board they were always receptive to trying any innovation that could support and improve experience.  The END concluded that with regards to the staffing and remodelling work, the Committee could not underestimate the challenge to the MCB. He added that there was a Quality Framework that had to be followed and so work would be undertaken to look at that Framework to ensure safety within the system.  **The QSE Committee resolved that:**   1. The assurance report provided by the Medicine Clinical Board Report Medicine Clinical Board QSE was noted; and 2. The mitigation being taken to improve quality, safety and experience and reduce harm was agreed. |  |
| **QSE 22/11/007** | **Quality Indicators Report**  The Quality Indicators Report was received.  The ADPE advised the Committee that she would take the report as read and would highlight key areas for noting.  It was noted that one of the areas picked up within the report was around information collated through the Tendable platform which enabled the team to analyse some of the best use of resources questions.  It was noted that one of the questions included was:   * Are Nurse Staffing Levels Appropriate vs Are you undertaking a task that a non-clinician could to?   It was noted that the more nurses felt that staffing levels were inappropriate, the more they reported doing tasks that could have been undertaken by a non-clinician.  The ADPE advised the Committee that the correlation was, in part, contributing to the consistent reduction in staff wellbeing scores.  It was noted that the over the next 12 months, a more electronic format of the Quality Indicators Report would be received by the Committee to provide a live database and real-time reporting.  The END advised the Committee of the Health Board’s Infection, Prevention and Control (IPC) position and noted that the grouped total Cdiff, Ecoli, MRSA and MSSA infections had shown no in-year improvement against the 2018/2019 baseline.  He added that the Cdiff rate in-year had increased, compared to baseline of December 2018 and noted that the Board had received that information at their last meeting in November.  It was noted that the END and the Deputy Medical Director (DMD) co-chaired the Cdiff group and that the root cause analysis would be undertaken and learnings shared with the relevant areas.  The IMU asked where the Health Board was in relation to pressure damage and noted that the report tried to discern pressure damage correlation with staffing.  The ADPE responded that pressure damage management was difficult because so many variable factors came into it which included:   * Patient waiting a long time in ambulances. * Delays in admission to beds on wards for Patients with a “decision to admit”.   She added that the collated data was used to examine whether there was any correlation between short staffing incidents and pressure damage and falls reporting, and to examine the theory that short staffing incidents led to a reduction in falls, as there were not enough staff to mobilise the Patients, and therefore an associated increase in pressure damage as a result.  It was noted that the data did not suggest that, but it was also noted that the data did not account for rates per 1000 bed days.  The END added that pressure damage had remained on the agenda for a long time and noted that it would most likely always be there because it was a constant risk for Patients and safety and that constant validation was essential.  He added that there was a pressure damage collaborative group which looked at all of the data and reported back to the team for use in the Quality Indicators Report.  It was noted that the END had requested permission from the CEO to contact Health Boards in NHS England to understand what their collaborative was working to and they noted that by early 2023 there should be benchmarking data to provide to the Committee.  The IMU asked if the Clinical areas using the HappyOrNot feedback systems received the positive feedback as noted in the report because one area had not received the feedback when the IMU had undertaken a Patient Safety walkaround.  The ADPE responded that all Clinical areas should receive their feedback and noted that she would send the relevant Clinical area their feedback for the one that was missed.  The Vice Chair concluded that it was pleasing to read within the report that the approach was to focus upon improving the overall system, and ensuring that ‘as few things as possible go wrong’ and ‘as many things as possible go right’. Further, that there was a focus upon the whole system shift in which the Health Board’s QSE priorities in Community and Primary Care carried equal attention to that in the Secondary and Tertiary care services.  **The QSE Committee resolved that:**   1. The content of the report and the developing process to monitor Quality Indicators was noted. | **JR/RS**  **AH** |
| **QSE 22/11/008** | **Maternity Services Update - Verbal**  The verbal Maternity Services Update was received.  The END advised the Committee that an unannounced visit from the Health Inspectorate Wales (HIW) had been undertaken in November 2022.  He added that from that visit, further correspondence had been received regarding significant improvement plans which had been worked through to complete the assurance plan.  It was noted that the Health Board was awaiting further correspondence and that more details could be provided in the Private session of the Committee.  The END concluded that as soon as the final report was published and the Health Board had completed the action plan, it would be received by the QSE Committee for assurance in 2023.  **The QSE Committee resolved that:**   1. The verbal Maternity Services Update was noted. |  |
| **QSE 22/11/009** | **HIW Activity Overview Including:**   1. ***HIW Report regarding the Emergency Unit*** 2. ***HIW Report from visit to Stroke Centre*** 3. ***HIW Report regarding Cardiothoracic services***   The END advised the Committee that he would take the paper as read and that he had a good relationship with the HIW. The purpose of the report was to provide the Committee with an overview of the reviews and inspections carried out by HIW.  It was noted that unannounced inspections undertaken by HIW had allowed HIW to see the services in the way they usually operated. The inspections had focused on 4 themes which included:   * Quality of the Patient experience * Delivery of safe and effective care * Quality of management and leadership * Delivery of a safe and effective service   The END advised the Committee that HIW had undertaken unannounced visits in 5 areas which included:   * Cardiothoracic Services UHL:   It was noted that no immediate concerns were identified and that an update had been provided to HIW on completion of the Improvement Plan and that all actions had been completed, with the exception of relocating Cardiothoracic Surgery to UHW (planned for May 2023).   * Emergency Unit and Assessment Unit UHW:   It was noted that HIW had acknowledged that staff were working extremely hard in very challenging circumstances and that they had welcomed the inspection team.  A number of immediate improvements were identified by HIW, and an action plan was developed and submitted to provide immediate assurance.  It was noted that good progress had been made with regards to the implementation of the Improvement Plan, but some actions remained in progress.   * Stroke Services:   The END advised the Committee that a national review of Patient flow in the Stroke pathway had commenced in 2021 and that throughout the review HIW were considering how Health organisations in Wales addressed access to acute care at the right time and considered if care was received in the right place.  It was noted that the report and associated recommendations and improvements would be reported to the Committee upon publication.   * Maternity Services:   The END advised the Committee that as previously mentioned, a number of immediate assurances recommendations were issued following the inspection and that the report and associated improvements would be presented to the Committee upon publication by HIW.   * Nuclear Medicine Department UHL   It was noted that an IRMER compliance inspection was undertaken in UHL in October 2022 and that initial verbal feedback was overall positive, with no immediate concerns identified.  The END concluded that the report and any associated improvements would be presented to the committee upon publication by HIW.  **The QSE Committee resolved that:**   1. The assurance provided by the progress made against the improvement plans was noted 2. The recent inspections in Maternity and Nuclear Medicine that were yet to be published were noted. | **JR**  **JR**  **JR** |
| **QSE 22/11/010** | **Community Health Council Reports**  The Community Health Council Reports were received.  The END advised the Committee that he would take the reports as read and noted that the Committee had made the decision that the Health Board would start reporting on visits that the Community Health Council (CHC) had undertaken.  It was noted that the main themes highlighted by the reports included:   * Lack of Day Room and TV facilities * Improvement required to showering facilities for patients with mobility issues * Improvement required to storage facilities * Improvement required to parking availability   The END concluded that the CHC reports provided great emphasis on Patient feedback and that the Clinical Boards would progress the required actions, and all improvement plans were approved by the END, the Executive Director of Strategic Planning (EDSP) and were signed off by the CEO prior to submission to the CHC.  **The QSE Committee resolved that:**   1. The contents of the report and the CHC feedback and recommendations were noted. |  |
| **QSE 22/11/011** | **Board Assurance Report – Patient Safety**  The Board Assurance Report – Patient Safety was received.  The Director of Corporate Governance (DCG) advised the Committee that there were a number of new risks linked to Patient Safety which were received by the Board last week.  She added that the new risks included:   * Maternity * Critical Care * Cancer * Stroke * Planned Care.   Further, that the 2 risks were already on BAF, namely:   * Patient Safety * Urgent and Emergency Care   It was noted that the highest scoring net risks were:   * Patient Safety with a score of 20 * Maternity with a score of 20 * Critical Care with a score of 20   The DCG concluded that the risks had been linked to the END, the EMD and the COO and they would be jointly responsible for the risks going forward.  **The QSE Committee resolved that:**   1. The risks in relation to Patient Safety, Quality and Experience were reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety. |  |
| **QSE 22/11/012** | **Corporate Risk Register**  The Corporate Risk Register (CRR) was received.  The DCG advised the Committee that the risks on the CRR were the risks held corporately across Clinical Boards and Corporate Directorates.  It was noted that at the Health Board’s November 2022 Board meeting a total of 17 extreme risks were reported to the Board and they had related to Patient Safety and were linked to the Quality, Safety and Experience Committee for assurance purposes.  The DCG noted that at the November Strategy and Delivery Committee meeting, it was confirmed that whilst the Haematology risk had remained on the Haematology Risk Register since 2010, it was certainly not the case that the risk had been left unmanaged and that detail had now been added to the CRR to reflect the actions and work which had been undertaken in order to address that risk.  The IMU thanked the DCG for presenting a fuller picture with regards to the Haematology risk and for capturing all of the proposals that had been attempted in the past to manage that risk, so that anybody coming afresh to the Health Board could receive assurance that the risk had been actively managed as best at it could be.  **The QSE Committee resolved that:**   1. The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted. |  |
| **QSE 22/11/013** | **Safeguarding Annual Report**  The Safeguarding Annual Report was received.  The END advised the Committee that the Safeguarding Annual Report was received by the Committee every year and that it provided a backward look at the significant amount of work that the Safeguarding team had achieved each year.  It was noted how diverse the agenda of the Safeguarding Report was. It included the introduction of two significant Acts of law in Wales which had impacted on the safeguarding workstream across the Health Board and had required significant changes in process, additional training and supervision as well as the relocation of existing resources.  The END added that further legislation from the Home Office had also defined the need to raise awareness of Domestic Homicide and Female Genital Mutilation (FGM) and Modern Slavery.  He added that it was important to note the implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) which had determined much of the safeguarding work undertaken across Wales.  It was noted that the report captured all of that work implemented and provided assurance to Committee that the onward focus of the team was to continue to maintain the safety of adults and children in Cardiff and the Vale.  The CC noted that the QSE Committee meeting fell at the beginning of the white ribbon campaign which was a campaign to eliminate violence against women and girls and noted there was a lot of activity around the campaign.  She asked if there was anything else the Committee needed to be aware of as the reporting period was from April 2021 until March 2022.  The END responded that the only other area to mention was that safeguarding formed part of the Health Board’s mandatory training. He highlighted the challenges and difficulties for staff to maintain their mandatory training, although he added that the safeguarding modules tended to be the highest completed within the Health Board because staff recognised the importance of safeguarding.  The Vice Chair asked to what extent since March 2022 had Liberty Protection Safeguards (LPS) featured in discussions.  The END responded that the Health Board was trying to ensure that safeguarding was aligned to LPS whilst noting that LPS had been “on the horizon” for a long time and it was unknown when it would come into effect.  He added that safeguarding would be the fundamental bedrock of LPS moving forward  The IMU asked to what extent did the Health Board oversee and capture the mandatory training of independent contractors, such as dentists and GPs.  The END responded that as part of All Wales contracts, external contractors were expected to complete their mandatory training in line with the Health Board’s requirements.  The DMD added that under the contract between those independent practices and the Health Board, there was an obligation upon the contractors to maintain training and that they were also subject to reviews as part of that contract.  **The QSE Committee resolved that:**   1. The assurance provided by the Annual Report 2021/22 was noted |  |
| **QSE 22/11/014** | **Mortality Indicators Update**  The Mortality Indicators Update was received.  The EMD introduced the paper and noted that the report described the development of a more mature reporting structure for mortality.  The Assistant Director of Quality and Patient Safety (ADQPS) advised the Committee the Learning from Death Framework set out three tiers of mortality indicators:   * Organisational Mortality   It was proposed that the Health Board adopted a crude all cause and inpatient mortality as a tier 1 mortality indicator   * Clinical Board Mortality   It was noted that the identification of Clinical Board mortality indicators would further support the proposed approach to mortality oversight and learning from death could be achieved by identifying trends in mortality data that supported additional actions and scrutiny.   * Speciality Mortality   It was noted that once Tier 2 indicators (Clinical Board Mortality) were established, work would progress to identify appropriate indicators in each Directorate.  The ADQPS noted that there were multiple clinical databases in use across the organisation and mortality data was included in many of those resources and the Specialties that benefited from those included:   * Emergency laparotomy surgery * Neonatal Unit * Intensive Care * Interventional cardiology * Renal * Trauma and orthopaedics   It was noted that the Learning from Death Framework would support an approach of systematic Ward to Board reporting and monitoring of mortality, robust and accurate mortality data which needed to be made readily available.  The CEO advised the Committee that benchmarking would be important and consideration would be required as to how to embed that into the system. Her concern was that a rate could mask the numbers, hence why reporting the numbers was important.  The Executive Director of Public Health (EDPC) advised the Committee of the work done carried out in relation to fatal drug poisoning and suggested that it would helpful to link the work with the Mortality Framework in the Health Board.  She added that she would welcome a discussion with the EMD offline  The DMD advised the Committee that as a Health Board, Cardiff and Vale had always been information rich and noted that what the ADQPS had proposed was a way of looking at the mortality information in a structured way.  **The QSE Committee resolved that:**   1. The approach proposed as part of the Learning from Death Framework and the assurance it would provide was noted. 2. The proposed Tier 1 Mortality Indicators were approved 3. The proposed Tier 2 Indicators were noted. | **FK/MJ** |
| **QSE 22/11/015** | **Policies for ratification including:**   1. Concerns, Complaints, Claims Policy (UHB 332) 2. Medical Equipment Policy and Procedure (UHB 082) 3. Ionising Radiation Policy (UHB 344) 4. Exposure of Patients to Ionising Radiation Procedure (UHB 345) 5. Radioactive Substances Risk Management Policy (UHB 463) and Procedure (UHB 464) 6. Exposure of Staff and Public to Ionising Radiation Procedure (UHB 465). 7. Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365)   The END advised the Committee that all of the policies had been received by their appropriate clinical groups and noted that the purpose of the Committee was to ratify each one and to recommend the Concerns, Complaints, Claims Policy to the Board for approval.  **The QSE Committee resolved that:**   1. The Medical Equipment Management Policy (UHB 082) and Management of Medical Equipment Procedure (UHB 082) was ratified 2. The Radioactive Substances Risk Management Policy (UHB 463) was ratified. 3. The Radioactive Substances Risk Management Procedure (UHB 464) was ratified. 4. The Exposure of Staff and Members of the Public to Ionising Radiation Procedure (UHB 464) was ratified. 5. The Ionising Radiation Risk Management Policy (UHB 344) was ratified. 6. The Exposure of Patients to Ionising Radiation Procedure (UHB 345) was ratified 7. The Venepuncture for non-clinically qualified research staff Policy (UHB 364) and Procedure (UHB 365) were ratified. 8. The Concerns, (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy (UHB 332) was recommended to Board for approval |  |
| **QSE 22/11/016** | **WHSSC QPSC Chair's Report**  The WHSSC Quality & Patient Safety Committee Chair's Report was received.  The DCG advised the Committee that WHSSC had requested that the Committee note the report and that any questions raised could be referred back to WHSSC.  The Vice Chair advised the Committee that he was the Chair of the WHSSC QPSC and noted that he could answer any questions that were raised.  No questions were raised.  **The QSE Committee resolved that:**   1. The WHSSC QPSC Chair's Report was noted. |  |
| **QSE 22/11/017** | **Minutes from Clinical Board QSE Sub Committees:**  **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:**  The Minutes from Clinical Board QSE Sub Committees were received.  The CC asked when the Clinical Effectiveness Committee (CEC) would meet next.  The ADQPS responded that the next meeting of the CEC was 13 December 2022.  **The Committee resolved that:**   1. The Minutes from the Clinical Board QSE Sub-Committees were noted. |  |
| **QSE 22/11/018** | **Items to bring to the attention of the Board / Committee**  The ADPE advised the Committee that the Concerns, Complaints, Claims Policy needed to be received and approved by the Board. |  |
| **QSE 22/11/019** | **Agenda for Private QSE Meeting**   1. Minutes of the Private Committee Meeting held on – 30.08.22 2. Any Urgent / Emerging Themes – Verbal 3. Maternity Services Update – Ockenden Framework Review 4. DNAR Orders at St David’s Hospital – Update |  |
| **QSE 22/11/020** | **Any Other Business**  No other business was raised. |  |
| **QSE 22/11/021** | **Review of the meeting.** |  |
|  | **Date & Time of Next Meeting:**  Tuesday, 10 January 2023 via Teams |  |