CONFIRMED MINUTES OF THE SPECIAL ANNUAL MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 17 OCTOBER 2017 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Susan Elsmore	Independent Member, QSE Chair
Maria Battle	UHB Chair
Michael Imperato	Independent Member – Legal
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Abigail Harris	Director of Planning
Angela Hughes	Interim Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Catherine Salter	Staff Health and Safety Representative
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Salter	Staff Representative
Gill George	NHS Delivery Unit (Observer)
Dr Graham Shortland (part)	Medical Director
Dr Laura Potts (part)	Welsh Clinical Leadership Fellow (Observer)
Maria Roberts	Patient Safety Manager
Matt McCarthy	Patient Safety Facilitator
Melanie Harris	NHS Delivery Unit (Observer)
Ruth Walker	Executive Nurse Director
Steve Curry	Chief Operating Officer

Apologies:

Akmal Hanuk	Independent Member – Community
John Union	Independent Member - Finance
Sara Moseley	Independent Member – Third Sector
Peter Welsh	Director of Corporate Governance
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC

Secretariat: Julia Harper

QSE 17/172 WELCOME AND INTRODUCTIONS

The Chair, Cllr Susan Elsmore introduced herself as the new Chair of the Committee and welcomed everyone to the meeting, in particular, the new Independent Member, Mr Michael Imperato and informed Committee that the UHB Chair and former QSE Chair, Miss Maria Battle would remain as a Member and Mr Stuart Egan joined the Committee until the year end.

QSE 17/173 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 17/174 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

QSE 17/175 MINUTES OF THE COMMITTEE HELD ON 12th SEPTEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 17/176 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

QSE 17/090 Regulatory and Accreditation Visits to CD&T – Miss Battle confirmed that a letter of commendation had been sent. **Complete**

QSE 17/135 Dental CB QSE Assurance Report – Miss Battle confirmed that a meeting was planned with the new WOD Director.

QSE 17/177 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

No action had been taken in between meetings.

QSE 17/178 ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS AND NEVER EVENTS

The Executive Nurse Director, Mrs Ruth Walker advised the Committee that this was a Special Annual Meeting to provide assurance around actions taken on serious incidents (SIs) and ensure they were managed robustly. In previous years the focus of the meeting had been on processes but these were now well embedded in Clinical Boards.

The UHB had been somewhat slow in closing SIs because of the need to demonstrate thorough investigation, analysis, solution and action but the position of 282 open SIs last year had improved and now stood at 80. There had also been a slight decrease in the number of SIs reported. It was stressed that overall, the percentage of serious incidents that lead to harm

was less than 1% compared with the number of treatments provided in the UHB.

Mrs Walker also advised the Committee that the UHB had seen a rise in the number of incidents reported relating to patient falls as well as Grade 3&4 pressure damage.

The report identified a number of themes from SIs and the Executive Nurse Director explained the internal governance and performance management arrangements for SIs.

It was noted that a number of issues affected the time taken to investigate and close an incident: the availability of staff and case notes, the length of the patient pathway and in particular, POVA referrals that required multi agency investigation. Community incidents and deaths referred to the Coroner often resulted in lengthy investigations. Welsh Government was always kept advised of process delays. The Board received a report on SIs at every public meeting – the only UHB that reported and published such information openly.

The Committee discussed the reporting of pressure damage and the difficulty of definitions. The UHB had to report hospital acquired pressure damage but this was tricky to determine within the 24 hour reporting requirement. All patients had an assessment on admission and ongoing assessment if identified as being at risk. When investigating if the pressure damage occurred while in hospital and could have been avoided, there had to be a balance, for example, maintaining a stable spine through the use of a collar could lead to pressure damage. In addition, in the community, a person's choice to sleep in a chair as opposed to going to bed could also increase their susceptibility to pressure damage.

The Committee considered the importance of patient flow, length of stay and delayed transfers of care that all resulted in patients staying longer in hospital and thus, there was a higher potential for falls. Positively, a falls lead had taken up post recently.

There was a fine balance between the need to mobilise patients and the potential to fall, but the need to maintain independence though mobilisation was very important. A video link to a case study would be circulated to the Committee.
Action – Mrs Julia Harper

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Serious Incident reporting process. Serious Incidents were reported and investigated within the required process. Furthermore, closure of SIs with Welsh Government (WG) was monitored at the Executive and Clinical Board performance reviews and by WG. Periodically, Internal Audit undertook related assurance reviews. The Delivery Unit also applied scrutiny to Never Event processes.

The Quality, Safety and Experience Committee:

- **NOTED** the report and **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

QSE 17/179 PAEDIATRIC NASO GASTRIC TUBE NEVER EVENT (PRESENTATION)

Avril Gowman, Senior Nurse, Paediatric Surgery and Becky Williams, Deputy Ward Manager attended the meeting and gave a presentation on a naso gastric tube never event that occurred in May 2016. Ms Gowman gave a summary of the incident, the root causes and the remedial action taken. Importantly, there had been no similar occurrence in the last 18 months.

The Committee noted that the Policy had been revised, but not yet agreed and a timeframe for approval was requested.
Action – Mrs Carol Evans

The Committee also saw for themselves one of the training mannequins and noted that more would be purchased following evaluation of the most appropriate type. This enabled all novice nurses to practice in safety.

The staff had managed to maintain a good relationship with the family by being honest and open and by sharing the root cause analysis and the action that had been taken. The family, though initially angry, had confirmed they would have no reservations using the Children's Hospital again.

The Clinical Board had set up a 6 month supernumerary preceptorship programme for newly qualified nurses. This has been warmly welcomed by staff and had improved staff retention.

The Chair thanked colleagues for the excellent presentation.

QSE 17/180 USE OF WORLD HEALTH ORGANISATION CHECKLIST (PRESENTATION)

Dr Linda Walker, Director of Nursing, Surgery and Dr Richard Hughes, Consultant Anaesthetist and Chair of the Surgery Quality and Safety Sub Committee gave a presentation on the use of the WHO checklist that had been in use across the world since 2009/10. Despite the checklist, UK figures showed a rise in the number of retained foreign objects and wrong site surgery.

As the WHO checklist was only used in operating theatres, it had become clear that a system was required in other areas that undertook invasive procedures. This led to the development of National Safety Standards for Invasive Procedures (NatSSIPs), supported further by Team Briefing and Debriefing.

It was important to ensure all staff were aware and trained in the use of the tools and that junior staff felt able to challenge senior colleagues if they did not follow the procedures. Senior Management supported staff and took action when necessary and clinical leaders audited the quality of the checklists to ensure they were being completed thoroughly. The move towards Debrief was innovative and part of a 2 year research project. In addition, this had already spread to the resuscitation team who championed the project across the UHB.

The Chair thanked colleagues for the excellent presentation.

QSE 17/181 NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES FOLLOW UP (NatSSIPs) (PRESENTATION)

Mr Matt McCarthy, Patient Safety Facilitator gave a presentation on the 13 standards and the gap analysis for areas undertaking invasive procedures outside theatres. In addition, he drew attention to the information available on the UHB intranet pages and the availability of a shared drive.

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that the presentations demonstrated the depth and breadth of patient safety work that was ongoing throughout the UHB. She thanked the Patient Safety Team for all their work and for being ahead of the curve. The Medical Director agreed to support this work through the nomination of a medical lead.
Action – Dr Graham Shortland

ASSURANCE was provided by:

- Work that has progressed to implement the Standards to date.
- Infrastructure that was established to roll out implementation across the UHB over the next two years.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the progress that has been made to date and the implementation plan.
- **AGREED** to report compliance with Patient Safety Notice 034 – Supporting the Introduction of the National Safety Standards for Invasive Procedures.

QSE 17/182 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

It was agreed to provide assurance to the Board that lessons were being learned from SIs and the UHB was proactively taking forward improvement actions.

QSE 17/183 ANY OTHER BUSINESS

1. Feedback from NHS Delivery Unit

The Chair invited colleagues to give any feedback on the meeting. Ms George and Harris were grateful for the opportunity to attend the meeting and were pleased to see the examples of the learning, the team approach and the sharing of lessons and good practice with other services. They suggested that the CSI Team be asked to share and embed success stories across the UHB.

The Committee noted the constant improvement journey.

QSE 17/184 DATE OF NEXT MEETING

The next meeting would be held at 9am on Wednesday 6th December 2017. Dates for 2018/19 were also proposed:

13th February	17th April
12th June	14th August **or** 18th September
16th October	18th December
19th February 2019	16th April 2019