CONFIRMED MINUTES OF THE ANNUAL SPECIAL MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 16 OCTOBER 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Susan Elsmore	Independent Member, QSE Chair
Akmal Hanuk	Independent Member – Community
Prof Gary Baxter (part)	Vice Chair/Independent Member – Cardiff University
Dawn Ward	Independent Member – Trade Union
Michael Imperato	Independent Member – Legal

In Attendance:

Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Director of Finance
Dr Graham Shortland	Medical Director
Maria Roberts	Head of Patient Safety
Nicola Foreman	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Dr Tom Cromarty (part)	Trainee Doctor (Observer)
Urvisha Perez (observer)	Wales Audit Office

Apologies:

Maria Battle	UHB Chair
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Interim Director of Public Health
Robert Chadwick	Director of Finance
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry	Interim Chief Operating Officer

Secretariat: Julia Harper

QSE 18/171 WELCOME AND INTRODUCTIONS

The Chair, Cllr Susan Elsmore welcomed everyone to the annual special meeting. She explained that there would be a presentation later in the meeting and that in the meantime, Members were asked to consider two questions:

- What do human factors mean to you?
- How do you define resilience?

QSE 18/172 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/173 DECLARATIONS OF INTEREST

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

QSE 18/174 MINUTES OF THE COMMITTEE HELD ON 18th SEPTEMBER 2018

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

QSE 18/175 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. Due to the short time frame since the last meeting, and the challenging agenda, it was agreed that the updated action log would be received at the December meeting.

QSE 18/176 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair reported that it had not been necessary to take any action in between meetings.

QSE 18/177 HOT TOPICS

The Executive Nurse Director, Mrs. Ruth Walker referred to the recent announcement on Cwm Taf's maternity services. The Committee had received the MBRRACE report on perinatal mortality at the last meeting. In light of recent developments, the UHB had reviewed its own reporting processes and assurance was provided that they were robust and in maternity there was good multi-disciplinary challenge. There were currently no concerns about the UHB's maternity service and this would be reported back to Welsh Government.

In terms of the issues found in Cwm Taf, a culture of not reporting in Royal Glamorgan's maternity services was found. Whilst staff were very busy which may account for non-reporting, it was noted that there was also a lack of challenge when incidents were reported that demonstrated a lack of transparency and openness. Mrs Walker also advised that the UHB was providing advice and support on the completion of root cause analysis and had seconded a number of staff.

The UHB continued to monitor its own service. Information on incidents was prepared for performance reviews that demonstrated a comparison over time. The Patient Safety team also attended Clinical Board QSE Sub Committee meetings and this UHB Committee received the minutes of the Sub Committee meeting. The maternity department held a weekly meeting and

was honing in on triggers for incidents and a Still Birth Forum met regularly. There was a follow up process for dealing with parents who had lost a baby and links with information from neonatology was being developed.

It was noted that Cwm Taf treated around 80 UHB patients per annum. It was important, therefore, to raise issues as a commissioner with Cwm Taf and it was agreed that Mrs Walker would discuss this separately with the UHB's commissioning officer.
Action – Mrs Ruth Walker

Independent Member, Mr Michael Imperato, advised Committee of a recent judgement from the Supreme Court involving Croydon Health Trust and the liability of an A&E receptionist who gave the wrong waiting time to a patient. The Court found that there was no defence despite the receptionist not being a member of clinical staff. Mrs Hughes commented that this had been picked up by legal and risk and a newsletter was being prepared. There would be training implications across the board, including community staff.

QSE 18/178 ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS

The Executive Nurse Director, Mrs Ruth Walker presented the comprehensive report to assure Committee on the trends and themes identified from serious incidents (SIs) and what actions had been taken to address the risks and shortfalls.

In terms of process, the Datix reporting system was available 24 hours a day for any staff member to report not only incidents, but also any worries. A buddy system was also in place for staff without access to a computer. The system generated a report to the line manager and Patient Safety team, incidents were categorised in terms of the level of seriousness and were automatically flagged to the appropriate people. The Executive Nurse Director was notified within 24 hours and a weekly meeting reviewed the most serious incidents. In addition, Welsh Government was notified within 24 hours which required response within 60 working days. There were times when this was a real challenge, especially where the Coroner or Prudic processes were involved. Compliance with timescales was 60% in 2017 and 51% in 2018 though this figure was improving. The number of incidents reported to Welsh Government had also risen from 220 to 290. Clinical Boards were held to account through performance reviews and incidents were also reported via the National Reporting and Learning System (NRLS).

Focused attention was required on several areas to address the root causes and ensure shared learning:

- Never events
- Pressure damage
- Falls
- Behaviour/unexpected death in Mental Health
- Diagnostics

- Healthcare acquired infection
- IR(ME)R breaches due to misidentification of patients

Details of the never events since October 2015 were included in the report along with all the actions taken. In addition, a breakdown of the causes of all Wales never events was included. Whilst there had been 15 Welsh never events mainly related to surgery, there had been 4 in the UHB. These patients were well but being managed through the Putting Things Right process. Human factors had played a part in these events. In terms of previous never events in Dental, it was not yet possible to provide assurance that the same thing would not happen again.

Concern was expressed that safety may be affected during a period of change/transition in the Dental Clinical Board. It was noted that no events had been reported. In addition, improvements and clarity around the supervision of students was being worked through. Dental had visited other hospitals and benchmarked their services and NATSIPS was going to be introduced to reduce the risk of recurrence.

In the last year the 5 most reported categories of SIs were:

- Pressure ulcers
- Patient accident / falls
- Behaviour
- Unexpected death / severe harm
- Diagnostic processes / procedures

The number of pressure damage reports had risen considerably. This was because the UHB was complying with the need to report unstageable pressure damage. Mrs Walker anticipated that the figure would continue to climb for a while before a reduction would be seen. In terms of learning, the UHB had refreshed its approach, retrained staff, looked at investigation and reporting arrangements whilst staff continued to be vigilant. In addition, tissue viability nurses were working closely with staff and pressure mattresses and cushions had been changed, particularly in critical care in response to staff concerns. A prevalence audit had been undertaken led by Medstrom which provided assurance that the UHB was improving.

The number of falls was high but the picture was improving with more work to be completed in the hospital setting. The Committee would be receiving a separate report later in the meeting.

51 instances involving behaviour and unexpected death / severe harm had been reported and details were provided within the report. However, Mrs Walker drew attention to an incident where she had provided assurance to Board that 15 minute observations had been carried out on a patient. During the investigation it emerged that one set of observations had been missed when a member of staff left the shift early leaving a staffing gap. Consideration was being given as to whether a POVA referral was required.

Concern was expressed that this year's trend was similar to last year and therefore either lessons were not being learned or more needed to be done.

In terms of suicide, it was noted that the Committee would receive a presentation in December looking at whether the UHB had done everything it could have to prevent suicides. It should be remembered, however, that many of the suicides involved patients with addiction issues. Such patients needed to consent to engagement with addiction services and it was not always known if death by overdose was intentional or accidental.

Details of the 16 incidents involving diagnostic process and procedures were provided. Improvements had been made in waiting times for endoscopy and work was about to start on targeting surveillance patients. In addition, awareness of sepsis was being raised across the UHB.

Mrs Walker then talked about historical infection outbreaks that had led to the closure and refurbishment of the neonatal unit. The UHB was on course to deliver further improvements but more work was required in terms of isolation facilities. The effect of the estate on infection was also discussed and it was noted that the Committee had received reports on cleanliness and unfortunately routine maintenance often slipped due to finance pressures and other priorities. This had caused problems in the past when routine work was left too long before being addressed. Two areas currently of concern were the bone marrow transplant unit and critical care.

It was important not to squeeze patients in via "onboarding" which another health board had tried. This resulted in higher infection levels which reduced again once the practice was stopped. There was an important lesson to learn with regard to winter pressures, though Heulwen ward that would be opened this winter had more single rooms.

Four incidents involving Ionising Radiation Regulation breaches had been reported to Healthcare Inspectorate Wales, a reduction from 8 the previous year. Cases of patient misidentification were human error and were not linked to the safety alert on patient wristbands. However, a new system for wristbands was being rolled out.

The Committee noted that the UHB was in line with its peers in terms of performance but an outlier in the amount of community work being done. A review report from Welsh Government was received twice a year. The feedback was mainly positive, did not demonstrate the UHB was an outlier and focused on the need to close incidents.

Mr Walker thanked Mrs Maria Roberts for all her work on the patient safety agenda.

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 by exception.

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 18/179 ANALYSIS OF TRENDS AND THEMES IN CONCERNS AND CLINICAL NEGLIGENCE

The Assistant Director Patient Experience, Mrs Angela Hughes presented the report with figures from 1st April to 30th September 2018, highlighting that most complaints came from surgical services and that the majority of concerns (60%) across the UHB were resolved locally with a target of 65%. The response times to complaints had improved and the trajectory was to reach 80% compliance with the 30 day response time by the end of March.

A big area that needed to be tackled was the number of complaints (27%) about outpatient waiting times and cancellation of outpatient appointments, however, the majority of complaints (53%) were about medical treatment.

The report contained details of "you said we did" as feedback had shown that the public liked this format. Mrs Hughes also drew attention to the sustainability of ophthalmology after years of concern and the work being led by Andy Jones on learning disabilities after two patients had died of sepsis. Feedback had been provided to both families. Mr Jones had been shortlisted for RCN Nurse of the Year award for this. As there were still vacancies in ophthalmology, concern was expressed about the pressure put on existing staff to maintain the service. An insourcing initiative had taken place but following a number of concerns this had been ceased. Further details would be provided in private to the Committee.
Action – Mrs Ruth Walker

It was pleasing to see that the number of concerns about paediatric surgery and waiting times had reduced, but concerns around cover in radiology were starting to emerge.

Mrs Hughes commented on the benefits being realised by providing greater support to the Clinical Boards. Early contact with complainants made it possible to agree the specific areas that required investigation and this enabled a more targeted response that resulted in fewer follow up questions.

The annual letter from the Ombudsman had recently been received which would also be shared with the Board.

In terms of clinical negligence, the UHB had not seen the significant increase in claims experienced in other health boards and it was believed this was due to managing concerns through the Putting Things Right process. Nevertheless, 38 new claims had been opened in the last 6 months. A meeting had been held with Welsh Risk Pool and the Obstetrics department to look at high value claims and feedback was awaited. New reporting arrangements for medical negligence would be introduced next April and greater focus would be put on learning lessons.

ASSURANCE was provided by:

- The current position on all key indicators relating to concerns and to clinical negligence claims.
- Substantial assurance awarded for the most recent internal audit assessment of clinical negligence claims in 2017 and for Management of Ombudsman cases in 2018.
- Evidence of the action being taken to address key outcomes that were not meeting the standards required.
- A culture of openness and transparency within the UHB to examine all available sources of information to provide assurance on the quality, safety and experience of services.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the content of this report.
- **NOTED** the areas of current concern and
- **AGREED** that the current actions being taken were sufficient.

QSE 18/180 FALLS ASSURANCE REPORT

In the absence of the Director of Therapies and Health Sciences, Mrs Carol Evans, Assistant Director Patient Safety and Quality presented the report based on data from the last 3 years. On average there were 300 falls per month the majority of which did not result in injury and were not witnessed by staff. The number of falls by site correlated with the number of beds.

In 2018 there was a drop in the number of serious falls. The Falls Delivery Group was developing a multi-agency strategy and the Falls Lead was working on community falls prevention schemes to develop an exemplar for falls, the Cardiff and Vale way. In addition, simulation training was being well received by staff and a business case was being prepared by the Community Resource Team to support patients at home.

It was thought that excessive specialling had been taking place to prevent falls. When that additional support was removed, no increase in harm had been noticed, but this was being monitored.

The Chair invited comments:

- Mr Hanuk suggested that contact be made with Torfaen Council who had undertaken good work on falls prevention.
- The national audit on fractured neck of femur was expected shortly which would provide a good marker of how patients were being treated.
- Multi-disciplinary working should include more than physiotherapy.

ASSURANCE was provided by:

- The UHB was currently demonstrating a stable trend in incidents relating to slips trips and falls. Significant work was underway particularly in the community in relation to falls prevention.
- There continued to be limited assurance relating to inpatient falls causing serious injury. The trend however had shown a decrease for the first six months of 2018-2019.

The Committee:

- **NOTED** that the UHB was continuing to hold the reduced trend seen in 2016.
- **SUPPORTED** the key actions for 2018 with an emphasis on development of the community falls prevention pathway and service.

QSE 18/181 UHB HUMAN FACTORS – INITIATIVES TO SUPPORT STAFF AND IMPROVE SAFETY AND QUALITY PRESENTATION

Consultant Anaesthetists, Dr Mark Stacey and Dr Cristina Diaz Navarro attended the meeting and gave presentations.

Dr Stacey focused on how human factors affected the way staff worked and their interaction with technology. In addition, the environment and systems in place also had an impact. A number of tools had been developed to provide staff with the skills to improve the way they functioned and to become more resilient. There remained a challenge with the environment as much of it was not conducive to wellbeing. It would be hard to change culture before the environment was right.

Dr Stacey also commented on the principles of avoiding error in the first place, trapping error and mitigating the consequences of error.

It was agreed that staff needed to look after themselves first and noted the start of conversations on how new environments could be made to feel good.

Dr Navarro talked about the benefits of clinical debriefing – a process of talking about and reflecting on difficult situations. Evidence pointed to the fact that debriefing improved patient safety and outcomes.

The process was summarised as:

T – target

A – analysis
L – learning points
K – key actions

The values were positivity, a focus on finding solutions, professional communication and taking things step by step. A Charity called the Talk Foundation had also been set up.

It was noted that A&E had been using this process for some time and it had gradually evolved. A project was being run in theatres and it was starting to be used in radiology. Statistics demonstrated that within 6 months, the practice of debriefing was starting to change the culture. The process was also being used in areas overseas.

The Chair invited comments:

- The work on human factors had influenced how never events were investigated.
- Trainees and students felt able to speak up during the pilot in EU.
- There had been great improvement in adherence to the WHO surgical checklist.
- Staff found time to use this technique and benefits were also seen the following day.
- The insight of issues allowed staff to make improvements at the earliest opportunity.
- Mr Hanuk, as Chair of the UHB Charitable Funds Committee, suggested a conversation outside.
- Debriefing should be something people wanted to do and were not told they had to do.
- Work on outcomes of the Debrief process would be worked on during the next 2 years.

QSE 18/182 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

It was agreed to bring to the attention of the Board:

- The Annual Special Meeting of the QSE Committee was the Committee's way of demonstrating assurance to the Board.

QSE 18/183 REVIEW OF THE MEETING

The Annual Special Meeting looked at the trends and themes arising from serious incidents, complaints and litigation. Improvements achieved and actions to be taken were noted but there was still more to be done.

Consideration was given to refocusing work. The work on falls was continuing. Lessons would be learned and positives would be shared as well as negatives.

QSE 18/184 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 18th December 2018.