CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE
HELD ON 19 FEBRUARY 2019
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:		
Susan Elsmore	SE	Chair
Maria Battle	MB	UHB Chair
Akmal Hanuk	AK	Independent Member – Community
Gary Baxter	GB	Independent Member - University
Dawn Ward	DW	Independent Member – Trade Unions
Michael Imperato	MI	Independent Member – Legal
In Attendance:		
Abigail Harris	AH	Executive Director of Planning
Angela Hughes	AH	Assistant Director of Patient Experience
Carol Evans	CE	Assistant Director of Quality & Safety
Caroline Bird	CB	Deputy Chief Operating Officer
Chris Lewis	CL	Deputy Director of Finance
Fiona Kinghorn	FK	Director in Public Health
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Dr Graham Shortland	GS	Medical Director
Nicole Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Secretariat:		Glynis Mulford
Visitors:		
Helen Donovan		Senior Nurse – Vale Locality
Kay Jeynes		Director of Nursing – PCIC Clinical Board
Rebecca Aylward		Director of Nursing – Medicine Clinical Board
Observers:		
Lowri Evans		Welsh Clinical Leadership Fellows
Thomas Cronarty		Welsh Clinical Leadership Fellows
Apologies:		
Robert Chadwick	RC	Director of Finance
Steve Curry	SC	Chief Operating Officer

QSE: 19/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting and introduced the two clinical fellows who observed the meeting.	**ACTION**
QSE: 19/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	

QSE: 19/02/003	**DECLARATIONS OF INTEREST** Independent Member, Michael Imperato declared his interest in the Blood Inquiry Review.	
QSE: 19/02/004	**MINUTES OF THE BOARD MEETING HELD ON 18 DECEMBER 2018** **Resolved – that:** (a) Subject to minor changes the minutes were confirmed as a true and accurate record.	
QSE: 19/02/005	**ACTION LOG FOLLOWING THE LAST MEETING** **QSE 18/190**: **Patient Story** – This action requested to have sight of the project plan relating to reducing length of stay but this was still outstanding. The Committee was assured of a process in place for emergency and cardiac care. The Committee agreed that an update on the situation in reference to what was the medical cover for mental health patients with physical health needs on the Llandough site should come to a future meeting. **QSE 18/191: Mental Health Clinical Board QS&E Assurance Report** – This item would come back in April. **QSE 18/196: Emerging Theme from UK Maternity Service Reviews** – The Director of Transformation would ask if the Long-Term Agreement (LTA) would be addressed in terms of having a clause around quality safety questions. It was agreed that RW would write to SH as lead for commissioning to provide assurance that all LTAs would have a proforma with a specific quality clause around the commissioning function and this would go to Management Executive meeting for further conversation. RW asked Carol Evans to link with Melanie Wilkey to ensure this was covered off. This would be finalised in the LTAs. Regarding the lifts, the maternity work should be completed by May. In terms of the other two lifts there was an agreed programme based on assessment by lift engineers and insurance inspection. An update would be presented in June with schedules up to 2021. The Committee **RECEIVED** and **NOTED** the Action Log from the December meeting	**GS / RW** **RW** **CE** **AH**
QSE: 19/02/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** No action had been taken since the last meeting.	

QSE: 19/02/007	**PATIENT STORY** Helen Donovan, Senior Nurse, Vale Locality and Kay Jeynes, Director of Nursing, PCIC Clinical Board presented 'Sally's story' who was significantly physically disabled due to the rapid onset of MS. Her complex needs were explained and the complicated relationship between all involved. Sally was often non-compliant with her care and treatment. Sally was placed and settled into a care home but had repeatedly asked to go home. The DoLs team were involved and her capacity periodically reviewed. There had been opposing views about this and there was a long process to reach the point of her returning home which was staggered and well supported for the transition. Sally's placement back home was driven by herself and with a review from the MDT agreed she was able to decide where her care was best met and understood the consequences of non-compliance with her care and treatment. Sally had learnt lessons from not complying with care and treatment and realised she was not helping herself. Since her return home there had been a reduction in weight, her confidence increased and she was looking to the future in doing voluntary work and making new friends. The team were still reviewing the care package and stated continuing health care was difficult. The following comments were made: • The Mental Health Capacity and Legislation Committee (MHCLC) noted that concern and care was always taken with the use of DoLs and it was pleasing to see this being undertaken in this case. The team was commended in terms of the story in looking at the Mental Health Act (MHA). • It was acknowledged this has been a difficult journey regarding conversations and the time it takes to implement a care package. The success was not just for Sally but the culture of the organisation. • Regarding Sally's views on becoming a volunteer in the Health Board, the UHB Chair asked if Helen Donovan would work with Sally to achieve her goal. • The approach was commendable and ties in with the HBs strategic approach. • This was an empowerment and patient rights story that enabled the opinion based on what the patient wanted. • The members applauded the team for their work which reflected the patients work and courage. This was an inspiring story encompassing staff resolve, persistence and motivation. It was suggested this item go forward for a Staff Recognition Award. The Chair commended the team for a very encouraging story and asked for thanks to be conveyed to colleagues. Resolved that: a) The Patient Story be **NOTED**	**HD**

QSE: 19/02/008	**PCIC CLINICAL BOARD ASSURANCE REPORT** Mrs Kay Jeynes, Director of Nursing, PCIC Clinical Board, presented the report and the following comments made: • In response to the Decontamination Group not having a representation from PCIC and the issues around decontamination, the Committee was assured that this was a standard agenda item but absence was due to a number of staff leaving the organisation. Further assurance was given that HIW inspections were undertaken with contractors and there had been no issues with decontamination. The Dental Quality and Safety Group met quarterly and there was a Dental Quality Framework with Welsh Government and no issues had been raised. • Regarding the environment issue with the flooding at Riverside, Independent Member, Dawn Ward, asked if there was anything the Committee could do to assist. In response it was stated that it was on the agenda to improve the premises. Furthermore, risk regulations came to force in 2014 with a Regulation and Inspection Social Care (RISCA) regulation new framework that oversees domiciliary providers and care providers. This formed regulations which everyone had to sign up to by the end of year whether in nursing or residential homes. • Other challenges presented were conversations with providers but not the Health Board and how it would fit in with the new clinical model. In addition, City Hospice and Marie Curie was regulated by different bodies. This was being challenged to be regulated by one. The Head of Governance in Welsh Government wrote to Ruth Walker and implied that they were unable to regulate but had awarded more provision to the City Hospice. Work had been undertaken to unpick some of the issues and a solution was being sought by 2020. In the meantime, all assurance was provided from the tendering process. • The End of Life lead would be organising a peer review within the next few months. The detail had been considered and the committee was assured there was nothing else that could be done. • A comprehensive estates plan had been produced listed by locality. The future of Riverside needed to be determined and there was a regular estates review with PCIC. There was a need to work through what was the long-term plan and would need to consolidate with either an existing facility or to develop a Hub in Riverside. A condition survey had been undertaken for all the buildings. • Also, highlighted was community staff at peak times taking between 1 -1½ hours to get to a patient which is distressing for all involved and needed to be resolved as this was a risk to the organisation.	

	Resolved – that: (a) The Committee **APPROVED** the actions taken by the PCIC Clinical Board	
QSE: 19/02/009	**REVISED BOARD ASSURANCE FRAMEWORK – QUALITY, SAFETY AND EXPERIENCE FOCUS** Mrs Nicola Foreman, Director of Corporate Governance presented the Board Assurance Framework. The Committee was informed there would be more check and challenge with controls in place and in time it would provide the Committee assurance to feed up to the Board. Currently, there was only one risk on the register for the Committee regarding Safety and Regulatory Compliance and should see this risk come down within six months. It was commented: • An Internal Audit report gave a rating of Limited Assurance on regulatory compliance. The Interim Head of Governance was making progress on this work. A presentation would be shown to the Audit Committee explaining where we were in terms of tracking with improvements to internal and external recommendations. The CHC reports were slow in response which was down to administrative processes internally but in future would see things more thoroughly tracked. • In terms of regulatory compliance, all regulations would be reviewed and this area was being worked on with executives. This would be raised with relevant Committees and was an ongoing work in progress. • Cross Independent Membership in Committees would provide assurance and it was agreed to review the tracker at Quality, Safety and Experience Committee. There was wider discussion on the other risks and changes being undertaken which would be addressed by their relevant Committees. **Resolved – that:** **(a)** The Committee **REVIEWED** the risk in relation to safety regulations compliance and **NOTED** further work would be undertaken in relation to the risk register	
QSE: 19/02/010	**GOSPORT INDEPENDENT PANEL REPORT** The Executive Nurse Director presented the above report and acknowledged they were not content that all systems and processes required was in place. Therefore, were unable to provide all the assurance it would like but for the Committee to understand where we were with actions to gain the assurance required. Patients affected in Gosport related to drug prescribing and the culture with the inability to challenge process. The Health Board have two community hospitals and as progress was made, updates would be brought to Committee to ensure all issues had been	

	addressed. The following comments were made: • A Medical Examiner would be employed in the Bereavement Department. This role should be in place by April of this year. Welsh Government had not classified it as a statutory role. • It had been understood that the function of the medical examiner officer would be under Shared Care Services and patients would have to pay a crematorium fee. There would be one medical examiner for 3000 deaths and the Health Board currently had around 2,400 deaths per year. There would be a need to look at both sites as this could cause unforeseen delays and would be looking at having part time medical examiners and officers in order to provide a timely service across the Organisation. The timetable was very tight and may not be achievable. A Management Executive paper would be presented in the next few weeks to outline the timetable. • In terms of Committee structure this would be reported to HSMB through to Board and the Medical Director was happy to bring an update on the Medical Examiner role in April. • There was a theme around stock control and monitoring of drugs in clinical areas and less of a theme in controlled drugs (CDs). Some drugs were not classified as CDs. It was recognised learning around stock control was difficult and more work was needed in this area. There had been a number of professional conduct disciplinary cases where drugs had been stolen but it was emphasised there was a good system in place. • There had been a shift in certain medicines not being classified as controlled medicines. Oramorph was no longer a controlled drug. • The NMC standards for Medicines Management had been withdrawn and replaced by the Royal College of Pharmaceutical Standards. The Nurse and midwifery Board received formal notification and actions were in place. • The Medical Director as chair of the Medicines Management Group reviewed the medicines code and progress was being made in terms of Standing Operating Procedures to ensure they were up to date and appropriate. **Resolved – that:** (a) To note the report be **NOTED** and **AGREED** that a further assurance report is presented to the June 2019 Committee *Gary Baxter, Independent Member left the meeting at 11.00am*	**GS**
QSE: 19/02/011	**COMMITTEE GOVERNANCE** Mrs Nicola Foreman, Director of Corporate Governance stated she would be working through all the committee documents for Board. The following comments were made: 1. **Workplan –** This was broadly the same as last year and would be presented as a pack at the end of March Board. There was further discussion around a few amendments for the workplan.	

	Resolved – that: a) The Committee **REVIEWED** the Work Plan 2019/20 b) **APPROVED** the Work Plan 2019/20 c) **RECOMMENDED** approval to the Board of Directors 2. **Terms of Reference:** The document would be **c**irculated to Committee members for reviewing and amendments would be undertaken offline with the Chair and Executive Lead. **Resolved – that:** a) The Committee **APPROVED** the changes to the Terms of Reference for the Quality, Safety and Experience Committee and b) **RECOMMENDED** the changes to the Board for approval. **3. Annual Report:** The contents of the paper were explained and that it provided assurance to the Board what should be covered by the Committee. It was emphasised this was also about accountability to the Health Board. It was suggested that items escalated to Board should also be added to the annual report to assure a formal record. The report showed the variety of issues that came to the Committee and was good governance of the subject matter discussed. It was recommended, subject to changes, that the Annual Report go forward to Board for approval. It was proposed for Clinical Boards to undertake an Annual Report. **Resolved – that:** a) The Committee **REVIEWED** the draft Annual Report 2018/19 of the Quality, Safety and Experience Committee and **RECOMMENDED** the Annual Report to the Board for approval. **4. Effectiveness Review:** – Nicola Foreman would facilitate a survey to review the effectiveness of the Committee. The results would be collated, and an action plan put in place which would standardise governance across all the Committees. **Resolved – that:** **a)** The Committee **APPROVED** that the attached effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.	**NF**
QSE: 19/02/012	**ASSESSMENT UNIT UNIVERSITY HOSPITAL OF WALES – REPSONSE TO THE COMMUNITY HEALTH COUNCILS CONCERNS** Rebecca Aylward, Director of Nursing from the Medicine Clinical	

	Board informed the Committee that concerns were raised by staff and patients around the Assessment Unit (AU) and following the unannounced visit from the Community Health Council (CHC). The Medicine Clinical Board had put in short, medium and long-term actions. Focus had centred on the long-term plan with improvement actions and timescales. Some recommendations had been successfully achieved regarding nutrition and hydration and purchasing seating for patients. It was commented: • The footprint work and discussions with the Surgical Clinical Board were important and put in context of Major Trauma Centre and would like feedback and results of them. • Maria Battle highlighted that staff had raised concerns on patient safety visits but the Committee and the Board were not sighted on metrics and cannot see whether improvements had been made. There was a need to see a trajectory of improvement and vision of where this was going to and would ask the Chief Operating Officer to undertake this. • Regarding staff training it was noted there was not a lot of down time as this was a very busy department. It was a challenge to undertake training and needed to be creative and innovative. The e-module around dementia was readily available and was bringing training to the department in order not to take staff from area. • Queries were raised regarding inequalities of service during weekend periods. The CHC review had identified differences of care at weekend but such differences were not recognised by the Medicine Clinical Board nor reflected by a review undertaken by the department. It was confirmed that this would continue to be reviewed. • There was a need to have some assurance that this issue was not only covered by winter funding but needed to sustain the requirements in the plan that go beyond winter. • To look at the physio and OT function to see if an assessment could be undertaken so that patients could be discharged from the area. There was a need to focus on having people working 7 days. • Queries were raised on how the improvement could be sustained as the Improvement Manager role was for six months only. • The improvements made were working closely with the team, putting clear processes in place and a different way of working embedded within the team. • Data on the patient waiting in the AU the longest time and not the median length of time as the variation was extreme. • The Hydration and Nutrition Committee agreed to review the issues raised within the report. • The department was commended for the high level of work. **Resolved – that:** **a)** The Committee **SUPPORTED** the actions that were being	**SC**

	taken by MCB in relation to the recommendations made to the CHC	
QSE: 19/02/013	**CONCERNS AND CLINICAL NEGLIGENCE CLAIMS** Mrs Angela Hughes, Assistant Director of Patient Experience presented an overview of the above report. The following comments were made: • The Organisation was comparable to other Health Boards with the proportionality of medical and dental staff who were more exposed regarding the nature of complaints and this raised how they could be supported. • The Medical Director assured the Committee that there was a high level of support with a Joint Concerns meeting which was chaired by the Executive Nurse Director. • Trends and themes would be collated at the meeting and provide high level of support to the clinician who may be concerned or may not be engaged. This would feed into a high level clinical governance team. • Both junior doctor and consultant inductions were undertaken which included sessions on clinical governance and being open and transparent. This should be reviewed and sighted on actions to see whether there were improvements and suggested it go forward to the Strategy and Delivery Committee for monitoring. • Regarding the Stroke and Rehabilitation Centre there had been significant changes in leadership, and it would be helpful to have a plan on how this was being taken forward. This had been going on a long time in terms of governance and consideration should be provided on how the Board and Committee would be sighted on actions. It was agreed that a position paper on the plan on how to take this forward would be brought back to the Committee. • There were similar concerns around ophthalmology with the question of clinical leadership and root cause analysis around the route of insourcing. Concerns were received but improvements had not turned over quickly enough. A report from Ophthalmology would be considered for a future meeting. • The Committee was assured that the complaint regarding the car parking issue was being addressed in terms of the difficulties the elderly and disabled were encountering as they were unable to contact the Car Parking office. A further update was requested for the next meeting. • The Committee was assured in terms of capturing complaints that there was a standard process of capturing the concern of those being affected, how they were categorised, what actions had taken place and improvements undertaken. • There was learning from claims and redress cases. It was recognised that there would be cases litigated for a number of years after the event. • Once there was a breach of duty there was learning to be undertaken and this was to be promoted immediately as it was important not to wait until there was litigation in place.	**FJ** **SC** **AH**

	• Welsh Risk Pool (WRP) was changing Breach of Duty, which would be across the whole lifetime of the case. There was a need for staff to be made aware and understand the risk. A whole systems approach was being undertaken. • WRP had commented recently that we were ahead of how we approach some of these claims. An assessment looking at the level of robustness and work needed around root cause analysis would be undertaken. • It was highlighted regarding clinical negligence claims that there was not only a personal impact but also impact of settlement on the NHS which could take millions out of the healthcare system. • Future reporting would try and match the claims with the financial impact. **Resolved – that:** (a) The action was **CONSIDERED** and **AGREED** current actions (b) A more detailed report on stroke rehab unit to be brought to a future meeting (c) To provide a report to the Committee to gain better understanding in ophthalmology regarding service improvement activity to a future meeting (d) Car parking be considered in relation to the phone calls and the ability to contact the parking office	
QSE: 19/02/014	**MORTALITY AND HARM** Dr Graham Shortland, Medical Director gave an update on Mortality and Harm report which was provided on a six-monthly basis. **244.1 - NATIONAL EMERGENCY LAPAROTOMY AUDIT** This was a success story for the Health Board. The work undertaken had been difficult but had seen the biggest reduction across the UK and the key decision maker was clinicians being closer to the front door where significant improvement had been achieved with recognised good practice. The following comments were made: • Members agreed this was a UK exemplar and the First Minister was interested to know how this could be shared across Wales. This was about sustainability and spread across Wales. • The team was commended by the Committee for a great piece of work and were informed that this project would go through the HSJ Awards. **Resolved – that:** The Committee **NOTED** the assurance provide by the 2018 NELA report and the actions that had been undertaken	

	244.2 - HEART FAILURE SERVICES It was commented: • The dedication from staff was noted, highlighting the need for more additional work time. • It would be good to see the work rolled out on heart failure PROMS 2. **Resolved – that:** The Committee **NOTED** the assurance provided by the NCEPOD report Failure to Function and the National Heart Failure Audit and the NCEPOD recommendation checklist.	
QSE: 19/02/015	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS** The Deputy Chief Operating Officer stated that work was ongoing to support this patient group. The overall volume had now decreased and introduced a risk rating and risk stratification for these patients as this reduction was in the higher risk category. Although there was a reverse in trend, in March there would be further reduction by 400 and it was recognised that whilst patients were sitting on the waiting list, processes were in place to mitigate the risks. The following comments were made: • Assurance had been received with regular reporting. • In recognising all the improvement work and feedback through LMC it was raised if we were confident that GPs had an acceptable route in in terms of when these patients were expedited. In response it was stated, overall endoscopy was happy that expediting processes were in place. There was also an internal expediting process. • Members commended and thanked the team for the work undertaken recognising this was a huge Q&S patient issue where significant improvements had been seen. **Resolved – that:** The Committee **NOTED** the current position and work ongoing in relation to the management of patients overdue their endoscopy surveillance procedure	
QSE: 19/02/016	**S16 OMBUDSMAN REPORT** A meeting would be held with the Clinical Board this week to go through actions agreed as a briefing was provided at the previous meeting. **Resolved – that:** (a) The report was **NOTED** for information	
	Maria Battle, Akmal Hanuk left the meeting 11.58am.	

QSE: 19/02/017	**MINUTES FROM CLINICAL BOARD QUALITY SAFETY AND EXPERIENCE SUB COMMITTEES (2.46)** • **Clinical Diagnostics and Therapeutics:** December 2018 • **Mental Health:** September, October, November 2018 • **Primary, Community and Intermediate Care:** July, Sept, Nov 2018 • **Specialist Services:** 9 and 31 Aug, Sept, Oct, Nov 2018 **Medicine:** December 2018 • **Surgery:** November 2018 • **Children and Women:** June, August, November 2018 • **Dental:** January 2019	
	ITEMS TO BRING TO THE ATTENTION OF THE BOARD 1. Escalation to the Board regarding community clinics and the impact this was having on patients and staff. 2. For the Board to note that the Committee had asked for further information on SRC and the triangulation of information and actions being undertaken. 3. To understand areas of concern of ophthalmology with culture, leadership and service.	
QSE: 19/02/018	**REVIEW OF MEETING** 1. Would look at IBabs as some members were having problems. 2. Considerable assurance was received around internal audits and HIW commented on the high quality of the Committee. 3. To review workplan and slim line the list and frequency of some of the reports to lighten the load. 4. New reporting templates were in place and would be reissuing for formality across all the CBs.	**NF**
QSE: 19/02/019	**ANY OTHER BUSINESS** There was no other business to raise.	
QSE: 19/02/020	**DATE OF THE NEXT MEETING OF THE COMMITTEE**	
	Tuesday, 16 April 2019 at 9.00am, Corporate Meeting Room, Headquarters, UHW	