CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 15 OCTOBER 2019 MEDICAL SKILLS SUITE, A2 – B2 LINK CORRIDOR, UHW,

Present:

Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Gary Baxter	GB	Independent Member - University
Akmal Hanuk	AH	Independent Member - Community
Michael Imperato	MI	Independent Member – Legal
Dawn Ward	DW	Independent Member – Trade Union

In attendance:

Caroline Bird	CB	Deputy Chief Operating Officer
Dr John Dunn	JD	Consultant Anaesthetist, Programme Director and Simulation Lead
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	JJ	Executive Director of Therapies and Health Science
Louise Kennedy	LK	Ward Manager A5
Annie Procter	AP	Clinical Board Director, Mental Health
Hywel Pullen	HP	Assistant Director of Finance
Jayne Tottle	JT	Director of Nursing, Mental Health
Dr Cellan Thomas	CT	Maxillofacial Consultant
Geoff Turner	GT	Consultant Gastroenterologist
Paul Twose	PT	Physiotherapist
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Ian Wile	IW	Director of Operations, Mental Health
Glynis Mulford	GM	Secretary

Observers:

Matthew McCarthy		Patient and Safety Facilitator

Apologies:

Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Kinghorn	FK	Executive Director of Public Health

QSE 19/10/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the annual special meeting.	**ACTION**
QSE 19/10/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	

QSE 19/10/003	**DECLARATIONS OF INTEREST** There were no interests to declare.	
QSE 19/10/004	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No Chair's action had been taken since the last meeting.	
QSE 19/10/005	**HOT TOPICS** The Assistant Director of Patient Safety and Quality (ADPSQ) informed the Members that a paper would be presented on the ophthalmology issues in December and that she had instructed experts to review 13 cases the team were concerned with. Health Inspectorate Wales (HIW) had carried out two unannounced visits. One visit took place at the Stroke Rehabilitation Centre, where one assurance issue was raised around regularly checking the resuscitation equipment. It was acknowledged that this was an area of concern and work had been undertaken on this matter. The second visit took place at Rookwood Hospital on wards 4 and 5 and a positive outcome had been received in the care of patients. The ADPSQ had a meeting with HIW who informed her that a summit would be held with all the key external stakeholders including Welsh Government. This was important for the organisation in terms of our escalation status.	
QSE 19/10/006	**SERIOUS INCIDENTS AND NEVER EVENT PAPER OCTOBER 2018-19** The Executive Director of Nursing provided an introduction to the report. The purpose of the report was to look at whether the organisation was learning from quality, safety and patient experience Serious Incidents (SIs). It was important to note that the Health Board did have a culture of reporting incidents. Work had been undertaken by the Patient Safety team to motivate people to report incidents and to ensure that those in leadership positions were able to respond appropriately. Reporting incidents focused mainly on ensuring that there was an understanding as to what had occurred, that the organisation was open and transparent and was a learning organisation. The following comments were made: Over the past year 297 SIs had been reported to Welsh Government. No comparison could be made as there was no comparable data from other Health Boards. Five of the SIs were Never Events (NEs). The number of SIs had gradually increased but there had not been an increase in Never Events. It was identified that these events were reported differently in England to Wales. There was learning from the Dental service with the number of NEs. A 'WHO' checklist had been developed within the service and some changes had been implemented and further recommendations had been made. It was acknowledged that there could be an increase in NEs when changes were made.	

	The Executive Medical Director stated that failure to reduce the number of NEs was a national phenomenon and he did not view this as a failure. The same number of NEs had occurred as in previous years. It was suggested that the report could be seen as a success, with a key component being the reporting culture. Therefore there was a need to take a balanced view in comparison to the number of SIs. The Executive Nurse Director highlighted that the NEs were not repeat events. There was a need to see how things were categorised and that a SI was also serious for the patient. Independent Member - Trade Union asked if the data could be explained on Never Events. It was stated that on page 9 the data covered the whole of Wales and on page 7 it covered four years of data in the Health Board. It was further explained that, when the word 'open' was used it meant that the process was still happening and it usually took 6 months to complete a Root Cause Analysis. It was also highlighted that sometimes cases may be open for longer as they may not have been concluded or predominately, because the investigation had not been completed. In the particular reporting period there had been overlaps of time periods and there had been five NEs in the past 12 months but the Executive Nurse Director was comfortable that actions put in place had been addressed. The Chair asked if we could take assurance that we knew what was going on in our system. The Executive Nurse Director explained that we could not look at one SI in isolation to see if we had a robust quality and safety process in our Health Board. There was a need to look at a number of things such as incident reporting, SI reporting, complaints and compliments, claims, patient experience feedback, internal inspections, clinical audit, inspections, outlier data and mortality data. Individual topics were presented to the Committee but also, behind the scenes, this was being triangulated. The challenge nationally was the RTT position and the financial position which had very robust data supporting the information provided. Some of the information was in the dashboards and this was escalated upwards. Fundamentally the organisation is dependent upon staff being open and transparent about their reporting. It was reasonable to look at improving sources of information and use this as a start point to understand what was happening within system. It was highlighted that in an evidence based survey, the single measure used to ensure we were running a safe service was the staff engagement score. The Executive Nurse Director stated there was a need to ensure we had sufficient people in the Patient Safety Team to review the reports to ensure there was robustness and challenge. Independent Member Trade Union, commented that the staff culture needed to be addressed as the surveys were going in the wrong direction. The Executive Nurse Director informed that staff were reporting incidents but they did not feel they received the level of feedback they should. This was being addressed in the Patient and Safety Team who were reinforcing the importance of this. Independent Member – Community, said he was assured in terms of	

	understanding the reporting structure and the multifaceted factors undertaken to gather and analyse the data was helpful. It was encouraging to hear what staff and patients were saying. In regards to looking at categories of incidents he felt reassured that he had a greater understanding of unexpected deaths and severe harm. The Chair stated that the report centred on the culture and also highlighted there was no complacency. Comments were made on the language used regarding assumptions in the paper and that this should be considered for future reports. **The Committee resolved that:** a) appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern	
QSE 19/10/007	**TRACHEOSTOMY SIMULATION** When introducing the simulation the Executive Nurse Director stated that Tracheostomy had been an issue with more patients having procedures. In the past care for people in a hospital setting was unsatisfactory and the team would share with Members the improvements the team had put in place. Dr John Dunn, Consultant Anaesthetist, Programme Director and Simulation Lead, gave a presentation and introduced the team, Louise Kennedy, Ward Manager on A5 North; Gail Prosser, Practice Educator A5 North; Paul Twose, Physiotherapist and Dr Cellan Thomas, Maxillofacial Consultant. Dr Dunn then provided a presentation for people who were not familiar with simulation and explained how it was used to train the multidisciplinary team. The following comments were made: It was explained that simulation was used to put training, which had been taught theoretically, into action in the simulation suite. Simulation was a safe learning environment with clear learning objectives and could be used to simulate isolated tasks or more complex clinical situations, which could be practised repetitively. Ownership was encouraged and also that champion were identified in each Directorate. When teaching simulation, various competencies were looked at such as; communication, situational awareness, leadership, role clarity and coordination. Medical errors occurred during simulation for a range of reasons, including: medication errors, poor communication and dysfunctional teams. Patients were safer and received higher quality care when providers worked as a highly effective team. Multidisciplinary simulation ensured patient safety and Continual Professional Development for consultants and allied professionals. This created a happy work environment and demonstrated benefits to patients and services. Prior to the simulation, Dr Cellan Thomas explained the scenario that	

	would have been undertaken and the type of patient that would be treated. He explained that when doing complex surgery in the head and neck region certain procedures required a tracheostomy and when this was blocked it was not a good experience for either the patient or staff as it became very stressful. By attempting to replicate and practice stress, a positive outcome at the end was more likely to be successful. In the past when a patient had a blocked trachea the arrest team would be called in but would not know anything about the patient. The nursing staff tended to step back although they would know much more about the patient. Therefore, it was important to train the whole team which involved the arrest call team, the nursing staff, physiotherapists, outreach team and anaesthetist. In summary, it was stated that there was a need to provide medical staff with confidence in performing procedures and to de-brief the team following a procedure. It was emphasised that unless this was practiced medical staff would not understand the real thing and this was a key component of the training programme. **The Committee resolved that:** a) That the presentation and simulation be noted.	
QSE 19/10/008	**ANALYSIS OF TRENDS AND THEMES IN DEATHS OF PATIENTS WITH MENTAL ILLNESS** The Executive Nurse Director stated that there was a growing concern at Board meetings regarding the numbers of unexpected deaths of patients known to mental health services. The conclusions would be fed back to the other members of the Board. Dr Annie Procter, Consultant Clinical Board Director for Mental Health, Ian Wile, Director of Operations, Mental Health and Jayne Tottle, Nurse Director, Mental Health provided an overview of the trends and themes identified from Serious Incidents (SIs) and what actions had been taken to address the risks and shortfalls. The presentation also looked at the growth of the Mental Health Services which provided context to the amount of work the service undertook throughout the year. The diversity of Mental Health Services and a comprehensive overview was presented to the Committee. The following comments were made: Suicide prevention had a good evidence base. The tools available would help with suicide prevention but could not identify when a patient would take their own life. Less than 5% of the service focused on service users in hospital as most were seen in the community. The National Confidential Inquiry into Self-Harm (NCISH) published an annual report which the Health Board audited itself against. The Health Board was set in the middle on suicide rates per 1000 compared to the rest of Wales. This year the NCISH focused on 10 ways to improve safety. The review started with safer wards. Wards within new builds were built to a higher specification and discussions had been undertaken nationally when there had been incidents on the Hafan y Coed wards. For instance, doors which had ligature points, had been removed and funding	

	was secured to replace these with collapsed swing doors. There was early follow up with patients being seen five days post discharge. This would be reviewed to see whether this could be reduced to three days. This could be piloted following the remodelling of the outreach service. The Framework for Dual Diagnosis had been set up recently. This process was used for patients who had self-harmed or tried to commit suicide and came out of NICE guidance which had suggested 3-12 sessions. The Health Board committed to 3 sessions which allowed difficult conversations to take place in a frank and safe way. Thematic reviews were undertaken each year and the next one would be undertaken in December. The theme would focus on zero tolerance for suicide. It was acknowledged that although there would be suicides there was a need to aspire to prevent as many suicides as possible. It was highlighted that over 70% of suicides had not used our services. It was acknowledged that the Mental Health Team had not been efficient with identifying risk in patients with psychoses. Regarding the Community Mental Health Team and community changes; mathematical feedback had been received from the Delivery Unit who provided encouraging figures. The service had wasted people's time 60% less than before the changes had been made and the effect on some principles had started to show some benefits. The Third Sector was commissioned last year to undertake some patient feedback and provide improved data. Care Aims training had been undertaken in the Vale and would be rolled out across the rest of the locality. There had been one patient suicide this year. This had not gone to inquest as yet. There had been 12 community deaths. The circumstances for nine suicides had been hanging and five had not as yet gone to inquest. Two patients had left suicide notes. There had been no obvious theme that connected any of the suicides other than the method. Improvement plans were always in draft as more information could be collated from the Coroner's Inquest. There had been nine deaths that were ongoing and had not gone to inquest. Nothing had been found to suggest the incidents were suicide attempts. There was a need to balance risk taking and wanting people to recover and rehabilitate. It was deemed that patients' should take responsibility against the risks of suicide and self-harm. The principle of mental health was not to be restrictive and to provide people with the option of freedom to choose. The Chair asked Members for comments and questions: The Executive Nurse Director stated that the presentation helped to explain the complexity of the service provided and the way in which the services were managed by introducing different processes and services on a changing demand. Members were able to understand that some of the behaviours presented in mental health were not increasing risk but behaviours to seek attention which did not always change into a risk. The ability of teams to have systems and processes in place with skills and	

knowledge to assess patients was crucial. It was important to empower patients in making the right choices but to support them when they made the wrong decisions. This helped the Committee to understand and provide assurance to the Board that we were not concerned with the service. There was a need to understand this when we had gone through our internal processes and the Coroner had provided a conclusion. No clear themes had emerged and based on the national data available we were not an outlier but took what had been advised as being best practice and implemented this.

The Clinical Board Director of Mental Health stated there was a need to evidence our support for staff and service users, and train them correctly. The service users were an integral part of the conversation.

The Executive Director of Therapies and Health Sciences said there was a need to balance risk and provide people with independence and she was assured that the service covered all the elements required. The strategic changes made around the service provided low level intervention upfront and linked the strategy to reduce the risk.

Independent Member – Legal asked, what was the best way to display the Board-level data as it could potentially be alarming when seen in isolation from the presentation. In response the Executive Nurse Director stated that at the next Board meeting the presentation would need to be reinforced by the size, depth and the complexity and how many people used or were involved in our mental health service and to reinforce some of the messages.

Independent Member – Trade Union, stated she had reassurance from the discussion but needed to take back to other Independent Members who looked at the level of tolerance as zero and was not sure this was aligned correctly.

The Executive Director of Therapies and Health Science left the meeting at 11.38am

The Executive Medical Director quoted the National Confidential Inquiry into Suicide and Homicide and made the following comments:

1. The Celtic nations had a historic higher suicide rate than England. This was felt to be environmental in nature.
2. Out of the Health Boards, Cardiff had the second highest rate in Wales with factors influencing the suicide rate clearly different between the Health Boards.
3. If Cardiff and Vale were compared with the English counties it would have the second highest rate in the data presented. If Cardiff and Vale was the best English county, it would have half the suicide rate in the data presented.

This was not just about mental health services, all of these things highlighted something more inherent was underlying these rates. There was a need to ask as a Health Board whether we were prepared to review what we were we doing and address the bigger issues related to

	socioeconomic causes of ill health. The Executive Nurse Director stated it was important to understand the difference as it was not imported in the bigger picture. The bigger picture for our duty for health to try and prevent people from committing suicide. The presentation stated patients who committed suicide who were involved in our Mental Health services, the picture was slightly better that it would be elsewhere in Wales but in relation to our population this was a Public Health issue. The Executive Medical Director commented when SIs were reported to the Board what was often reported related to the population. Board members received SI around recurrent events which raised concerns and there was a need to be clear of the population component in relation to our Mental Health Service. The Director of Operations for Mental Health highlighted that referrals could escalate to 100k a year because of the contact with primary care services. If the primary care workers and third sector was equipped to have some of the difficult conversations with people and recognised risk factors, there was the potential to get information out of the core of the population of Cardiff. This could contribute to the Public Health debate. The Chair emphasised that the issue was not just about health but included health inequalities, housing and poverty. This was a public sector response which was much broader than health. It was suggested that what was learnt from the session, was that individuals who used our services were part of the population which we serve. The statistical data informed we had a suicide rate that was higher than expected. Many of the people included within the data had not yet used our Mental Health Services. The data suggested that as a community we had to do more with our local authority colleagues to have a debate and to consider a summit regarding the suicide rates in our population. The Clinical Board Director agreed that a much broader conversation would be welcomed and Members acknowledged that more could be done in partnership for the population. *The Clinical Board Director Mental Health, Director of Operations Mental Health and the Director of Nursing Mental Health left the meeting 11.49am* In summary, the Chair stated that the Committee had analysed trends and looked at deeper levels of assurance where hope and a way forward was described. She acknowledged that the service was very complex with interdependencies and how, at times, we may try to simplify the issues. Also highlighted was the prospect of working in partnership across the public sector. **The Committee resolved that:** a) The position taken by the Clinical Board be supported and the presentation be noted	

QSE 19/10/009	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS** Dr Jeff Turner, Consultant Gastroenterologist provided a presentation on the above. The following comments were made: Gastrointestinal (GI) Endoscopy is used when patients are symptomatic or have diagnosed conditions and is part of the national outcome screening programme. The surveillance is important for the organisation in terms of the SI's we experienced. Surveys were undertaken of patients with increased risk of cancer but part of the problem experienced was that historically, surveillance waiting times had not previously been reported to Welsh Government. 24 SIs were experienced over a period of 4 years due to the surveillance backlog and this was a Wales wide issue. A presentation was made on the basis of the work undertaken and focused on how improvements had been achieved within the Health Board on a national level. As part of this a robust action plan had been developed. As there were issues around surveillance, a clerical and clinical validation of around 1000 cases was undertaken, as a result of which, a risk stratification spreadsheet was developed. This meant that the highest risk patients were being reviewed and treated first. The endoscopy rate was identified as high risk in patients over 80. Surveillance clinics had been developed and patients had been invited for face to face discussions around the risks and benefits of surveillance. When patients had an informed conversation it was realised they did not want to undertake the risk. An insource provider was used to clear the backlog but decided to exclude very high risk patients from the cohort. To support the insource company, robust governance structures were in place with a consultant presence every weekend and we were able to review live, all of the people that had received an endoscopy. In September 2018 there were 990 patients with no appointment dates. In comparison to October of this year, the numbers had significantly reduced to a minority of 49 patients without appointment dates. The SIs experienced were as a result of people who had become symptomatic on the waiting list but, with efficiency work in-house and the insource contract, the numbers had reduced quickly. The current situation was that the backlog had been cleared apart from patients who had postponed procedures. Surveillance procedures had been included into their core capacity where patients prospectively were booked in, in advance of their procedure date. Historically there had been challenges about meeting diagnostic waiting time. Currently, due to increased demand significant challenges were being faced. This was again across Wales. Insourcing was still being undertaken but this had reduced after a big efficiency piece of work had been undertaken. The insource company would now be used once a month to meet the waiting time targets and it was confirmed that there had	

	been no further SIs. Members were assured that there was an open and honest reporting culture seen within the Directorate which proactively managed any risk to patients. There was a robust plan to address risk and good team working was highlighted. The Chair invited comments and questions: Independent Member – Legal asked, what does insource mean? It was explained that an external private provider (A gastroenterologist) was brought into the unit with a team to deliver the work. Independent Member – Trade Union asked how did we get to the position in the first place and what plans were in place to ensure this did not happen again? In response, it was stated that, in terms of surveillance, this had changed and the UHB now reported these cases to WG along with diagnostics and cancer waits and the UHB was looking across all areas of the endoscopy service. It was acknowledged that there were very significant challenges and it was predicted that a 6% increase year on year would be seen in the symptomatic referral rates. Part of the national endoscopy programme would look at a longer term sustainable strategy due to the pressure envisaged on the service. The Executive Medical Director commended the team for the turnaround and good clinical leadership, stating there were a number of strategic changes to review which would help provide solutions across the long term demand capacity work. He was also asked to explain what the role of the Joint Advisory Group Accreditation (JAG) was and why it was it important. It was explained that JAG was a national accreditation process and looked at all specifications of the service and exemplified good patient care, experience and environment. JAG had visited the UHB in 2012 where all of the standards were met apart from timeliness. The UHB were looking how to achieve JAG Accreditation and confirmed waiting times were significantly better but this needed to be sustained. An external JAG assessor would visit the unit shortly and provide informal guidance on areas for improvements and provide support in achieving JAG Accreditation. Regular directorate meetings were in place and an action plan would be devised. The Executive Director of Therapies and Health Science commented that the presentation showed good governance when we needed extra capacity, in that patients remain ours and in our facility, and this was to be commended. In regards to endoscopy decontamination, there was a need to plan for the future. It was stated that locally there was scope in Llandough for expansion as it provided bowel cancer screening and other advanced endoscopy. On a regional aspect, as part of the national programme, this was largely in terms of training as there may be challenges as this looked at a core group of patients. It was further considered that whilst insourcing does cost to have an external provider, it provides better governance by having oversight of the patients that come into the system and by having the reports on our local reporting systems. The Executive Nurse Director acknowledged that Dr Geoff Turner had	

	undertaken a number of RCAs to get to the root of the problem and made the necessary changes. He did however acknowledge that sometimes it takes time to understand the issue. The comments on insourcing and outsourcing were relevant and a paper would be brought to a future QSE Committee around this. It was explained that there were no nurse endoscopists initially, but complimented this skill as the capability and numbers were growing and he was using them in an appropriate way. Independent Member – Community asked how we were overcoming the perception of the risk of going through this procedure, and were we going into the community for screening to reduce incidents? In terms of perception, more people were being treated 'direct to test' which endeavoured to strengthen information gathering and developed an endoscopy platform on the internet. The team had also implemented text message reminders. The point of contact for the patient was with administrators in primary care, but there were nurses to provide information and redirect to clinic for face to face conversations. There was a continuation of the intention to expand nurse endoscopists and work was underway to improve their knowledge in endoscopy. In terms of bowel screening, demand would increase five fold over the next five years; this will assist in identifying polyps and cancers at an early stage. Funding had been secured for a pilot on fit testing in a symptomatic group of patients. This could be broadened and would help stratify people's risk in the community. As part of this work, GP training would be undertaken and national initiatives had been looked at. The Chair stated that she would write a personal letter of commendation and thanks from the Committee. She further asked if there was any learning to share across the Health Board. In response, it was stated that the supportive processes put in at the weekend provided great assistance and therefore had their own internal governance structures whereby reports could be reviewed and if things could be improved there was the potential to have dialogue. In summary, the Executive Medical Director stated that the key issues discussed helped to focus on any service that was struggling, for them to be open and transparent, to look at everything and to be frank. The key role in clinical leadership was in developing future planning and demand capacity, and for the clinical governance team to identify areas that need to be addressed. This was an exemplar of using our governance processes. **The Committee resolved that:** b) The current position and ongoing work in relation to the management of patients overdue their endoscopy surveillance procedure be noted	
QSE 19/10/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** • The committee would be comfortable to provide assurance to the Board they had reviewed themes and trends emerging from serious	

	incidents. • Assurance was provided around tracheostomy and endoscopy. Assurance was also provided in relation to the clinical team and its ability to identify significant areas of concern and make the changes necessary to address those areas. • The serious incidents were debated at length and there was a summit to support the multiagency team in place across our partnership arena. There is progress that we need to make on our population suicide position, as currently we were seeing themes and trends from a health perspective that we had concerns about.	
QSE 19/10/011	**DATE AND TIME OF NEXT MEETING** Thursday, 17 December 2019 at 9.00am Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff	