CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 23 APRIL 2019 CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL WALES

Present:		
Susan Elsmore	SE	Committee Chair
Maria Battle	MB	UHB Chair
Michael Imperato	MI	Independent Member - Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Steve Curry	SC	Chief Operating Officer
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	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Christopher Lewis	CL	Deputy Director of Finance
Graham Shortland	GS	Executive Medical Director
Ruth Walker	RW	Executive Nurse Director
Alun Tomkinson	AT	Clinical Board Director - Surgery
Ann Jones	AJ	Patient Safety & Quality Assurance Manager
Clare Wade	CW	Acting Nurse Director – Surgery Clinical Board
Ian Wile	IW	Director of Operations – Mental Health Clinical Board
Jayne Tottle	JT	Director of Nursing – Mental Health Clinical Board
Mike Bond	MB	Director of Operations – Surgery Clinical Board
Val Wilmot	VW	Clinical Nurse Specialist
Glynis Mulford	GM	Secretariat
Apologies:		
Akmal Hanuk	AH	Independent Member – Community
Gary Baxter	GB	Independent Member - University
Robert Chadwick	RC	Executive Director of Finance
Observer:		
Urvisha Perez		Wales Audit Office

QSE:	WELCOME AND INTRODUCTIONS	ACTION
19/04/001	The Chair welcomed everyone to the meeting and noted that it was quorate. A special welcome was given to Urvisha Perez from the Wales Audit Office.	

19/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/04/003	**DECLARATIONS OF INTEREST** The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declaration of interest were received and noted: ▪ Michael Imperato, Independent Member (Legal) declared a conflict of interest in respect of the Blood Inquiry. The declaration was formally noted and it was agreed that Michael Imperato would leave the meeting for any discussions related to the Blood Inquiry.	
19/04/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 19 FEBRUARY 2019** The Committee reviewed the Minutes of the meeting held on 19 February 2019. **Matters Arising:** **19/02/008 - PCIC Clinical Board Assurance Report:** In relation to the environment issue with flooding at Riverside, the Executive Director of Nursing reported that there had been communication with the teams and patient safety visits undertaken. In respect of the mobile units in the Ely Hub and Splott Clinic, it was confirmed that there would be further communication with the team as to date no feedback had been received on the work undertaken. It was confirmed that the Executive Nurse Director would discuss the action needed outside of meeting. **The Committee Resolved - that:** a) the minutes of the meeting held on 19 February 2019 be approved as an accurate record. b) the action needed in relation to the Ely Hub and Splott Clinic would be left to the Executive Nurse Director to discuss outside of meeting.	RW
19/04/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted that: ***19/02/010 – Gosport Independent Panel Report:*** There had been a delay in filling the role of the UHB's Medical Examiner. It was confirmed that NHS Shared Services would be responsible for the Medical Examiner recruitment exercise and that a further update would be brought to a future Committee meeting by the Executive Medical Director. ***19/02/007 – Patient Story:*** The Committee was content that this action had been completed.	GS

	18/196 – Emerging Themes from UK Maternity Service Reviews: The Executive Nurse Director confirmed that the report on maternity services at Cwm Taf Morgannwg University Health Board would be published on 30 April 2019 and following publication a report would be brought to the Committee for consideration. ***19/02/012 – Assessment Unit, UHW – Response to the CHCs Concerns:*** The Executive Nurse Director confirmed that a report would be presented at the private session of the Board scheduled for May 2019. **The Committee Resolved – that**: a) the action log be received and noted. b) all completed actions be archived.	
19/04/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's Action taken since the last meeting of the Committee. The Chair also confirmed that at the private session of the Committee held on 19 February 2019: ▪ Steps being taken to improve radiological reporting times were discussed ▪ A paper on gastroscopy and colonscopy decontamination was presented. ▪ The Blood Review was discussed. It was noted that Michael Imperato, Independent Member – Legal, left the meeting due to his declared conflict of interest. ▪ An overview of Safeguarding matters was provided.	
19/04/007	**PATIENT STORY** The Director of Operations for the Surgical Clinical Board introduced the patient story that was titled '*Patient Knows Best'*. The Clinical Board's Director and Clinical Nurse Specialist delivered a presentation and as part of this it was confirmed that: ▪ there was a need to individualise and improve the patients' journey through the care system as patients were having to repeat their information at various points in the care process and at each appointment. Patient's needed to be placed at the centre of the care process and a single shared record would assist this. ▪ *Patient Knows Best* (PKB) PKB works on any computer, anywhere, anytime as long as you have internet access. It has the ability to hold a patient's medical data, connect to wearable activity devices, communicate with the patients' healthcare team and track signs and symptoms. It was noted that PKB is safe, secure and approved for use by the NHS. ▪ PKB enabled timely feedback from patients and therefore supported the quality and safety assurance agenda. The system strengthened engagement as it enabled the team to communicate	

regularly with patients. It was confirmed that funding had been provided to enable a project to test the use of PKB.

- the use of PKB as part of the paediatric tracheostomy care pathway, enabled close links to be developed with patients and their families as both staff and parents were trained how to look after a tracheostomy. It also enabled families to ask questions and get advice quickly.
- the use of PKB as part of the establishment of virtual clinics had commenced and was an area where development continued. It was confirmed that the approach had been used in audiology with good results in the area of cochlear implants as implants could be tuned away from the hospital site. It was noted that the approach empowered patients to make decisions about their own care and had led to a reduction in the number of patient needing to be seen in clinic; overtime this could lead to decrease follow up appointments.
- the use of PKB to issue questionnaires to assess the need for a follow-up appointment for young people with a hearing impairment had reduced follow-up appointments. It was noted that previously individuals had been seen routinely every three months.
- providing patients and their families with access to appointment slots helped reduce cancellations and DNA rates as they were able to move appointments to suit their availability.
- the PKB project was a transformational piece of work on the digital and as part of this the use of Patient Reportable Outcome Measures (PROMs) would need to be considered.
- the Clinical Nurse Specialist role was evolving as part of the PKB development work.

The Committee Resolved - that:

a) the Patient Story be noted

19/04/008 **SURGERY CLINICAL BOARD ASSURANCE REPORT**

The Director of Operations for the Surgery Clinical Board introduced the Surgery Clinical Board's Assurance Report and outlined the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the previous 12-months. In providing an overview of the detailed Assurance Report it was confirmed that:

- a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly, was in place and that this structure is formally replicated by each of the Clinical Directorates.
- The Clinical Board's Risk Register was monitored at Directorate and Clinical Board level. The top three risks on the Clinical Board's risk register as at March 2019 were discussed, these were confirmed as being:

  - The fabric and plant of the main theatre suite at UHW. The

Committee was advised that remedial works had been carried out on the theatres that posed the most significant concern.

- Escalating pressures from medical outliers. It was noted that an escalation process was in place to attempt to accommodate all Surgical patients within the Clinical Board's bed base. It was also confirmed that work being taken forward with Lightfoot enabled the consideration of real time data.
- Increasing Bank/Agency use. The Committee was advised that there were challenges in relation to the recruitment and retention of registered nurse and Allied Health Professionals, although a viable work plan was in place for the future.

- a formal clinical audit plan was in place, which includes both local and national audits. The need to invest in resources to enable regular and consistent data input to national databases was highlighted.
- between 1 April 2018 and 31 March 2019, 52 *Serious Incidents* and three *No Surprise* events had been reported to Welsh Government. It was noted that the learning from Serious Incidents had been taken forward as a team ensuring ownership and understanding at all levels.
- the Clinical Board's Director of Nursing facilitated a UHW wide group to consider and address pressure damage issues. A summary of the work streams delivered over the last 12-months was discussed. As part of discussions the Independent Member - Trade Union, asked if comparisons between the number of reported grade 3 and 4 pressure damage incidents had been made. In response, it was confirmed that there had been a change to reporting arrangements that required only avoidable Grade 3 and 4 damage to be reported.
- Root Cause Analysis (RCA) reviews of the 12 falls reported between 1 April 2018 and 31 March 2019 that had resulted in an injury had not identified any trends or themes.
- four Never Events had been reported during the previous 12-months, all of which had (or were in the process of having) RCA reviews undertaken. It was confirmed that following the completion of a RCA relating to a medication incident changes had been made to pharmacy systems.
- PADR rates were low and the need for these to be improved was acknowledged.

The Committee congratulated the Surgical Clinical Board for its work over the last 12-months and for the improvements made. The leadership of the Clinical Board Director was acknowledged.

The Committee Resolved - that:

a. The progress made by the Surgical Clinical Board be noted.

b. the assurance provided by the Surgery Clinical Board be acknowledged.

19/04/009	**MENTAL HEALTH SERVICES FOR OLDER PEOPLE – IN-PATIENT CARE IMPROVEMENT PROJECT THROUGH ALOS REDUCTION** The Director of Operations and the Director of Nursing for the Mental Health Clinical Board presented the Committee with an overview of the steps being taken to reduce the average length of stay (ALOS), bed numbers and the resources associated with elderly inpatient care. As part of the overview it was confirmed that: ▪ The Mental Health Service for Older People's (MHSOP) Directorate had a total of 115 beds, of which a little over half (66) were acute assessment beds. ▪ Mental Health services has seen 40% of its beds close over the last 11 years with two MHSOP wards closing in the last five years. ▪ The service on average sees a split of 22% / 78% functional / dementia patients within in the inpatient service, which often results in placing functional patients on a dementia ward. ▪ the MHSOP service, remains an obvious national outlier, for high ALOS and bed numbers in the UK, specifically for its elderly population in hospital beds. It was noted that the MHSOP was initially working towards reducing the number of beds by 9/10 within the 2019-20 calendar year, with a further 4/5 beds released in quarter four. This would require an average length of stay of 89-91 days, which would be in line with upper quartile ALOS in benchmarking peer organisations. The Committee was advised that the intention was to either reduce a small number of beds on each of the assessment wards or close an entire ward. It was confirmed that the latter would require Community Health Council involvement at an early stage for engagement/consultation purposes The Committee was advised that a number of work-streams had been implemented to improve efficiency and effectiveness, including: ▪ discharge planning from admission ▪ effective reporting and monitoring of ALOS and inpatient pathway performance ▪ staff training and awareness of long lengths of stay ▪ closer working with social work, Complex Care Commissioning Team and community teams ▪ Multi-Disciplinary Team (MDT) working and ward rounds ▪ Clarity of MDT roles and responsibilities ▪ Optimisation of support services such as crisis and day services. The dementia service has all the ingredients of a community service that is capable of keeping people out of hospital, with a crisis team, nursing home liaison service and a typically resourced integrated community service. ▪ appointment of a pilot Band 7 clinical post in MHSOP to look at improving inpatient pathways and ALOS in MHSOP ▪ the provision of support by Judith Hill, Head of Integrated Care to	

look at LOS and patient flow; focussing on care at the right time and in the right place.

The Executive Nurse Director advised the Committee that there was Regional Partnership Board funding set aside for dementia and confirmed that that community developments were progressing at a good pace.

The committee Resolved – that:

a) the work being conducted by the Mental Health Clinical Board be noted

b) a phased bed reduction programme of up to 14/15 beds in 2019/20 be supported.

19/04/010 **MENTAL HEALTH CLINICAL BOARD: REPORT ON MEDICAL COVER FOR MENTAL HEALTH PATIENTS WITH PHYSICAL HEALTH NEEDS ON THE LLANDOUGH HOSPITAL SITE**

The Executive Medical Director and Executive Nurse Director provided the Committee with a verbal update in respect of the situation in relation to medical cover for mental health patients with physical health needs on the Llandough Hospital site. As part of this update it was confirmed that:

- concerns had been highlighted with regards to the availability of medical support in the event of a cardiac arrest. The Committee was advised that in the case of an emergency it had been agreed that the cardiac arrest team would attend Llanfair Unit on a 2222 call. It was noted that further work was needed to firm up arrangements for the transportation of patients to the most appropriate care facility.
- there would also be occasions when the most suitable course of action would be to make a 999 call (e.g. following a fall and/or fracture) and Clinical Boards had been asked to communicate this information to their frontline staff.
- if a clinician contacted WAST and was clear that the patient was acutely unwell, WAST had given assurance that they would respond in a clinically based way and transport the patient as an appropriate priority. If any problems arose in relation to ambulance transport, it was confirmed that the team had been advised to go through the Executive Medical Director and/or Executive Nurse Director.
- The Hospital at Night arrangements at Llandough Hospital was an area in need of strengthening. It was noted that support had been offered and the medicine team had been asked to undertake risk based assessments
- The Executive Medical Director confirmed that he was content with resuscitation arrangements at Hafan y Coed, and confirmed that all psychiatrists had been reminded of their responsibilities in respect of the physical health needs of their patients. It was noted that a senior nurse had ben delegated responsibility for providing support in relation to physical health needs, and that the team had

access to the GP service for the management of chronic conditions.

- It was acknowledged that as additional specialities were introduced on the Llandough Hospital site the risks and complexities aligned to the Hospital at Night would need to be closely monitored.

The Committee Resolved – that:

a) the verbal update provided by the Executive medical Director and Executive Nurse Director be noted.

19/04/011 **COMMUNITY HEALTH COUNCILS REPORT: ONE SIMPLE THING – COMMUNICATION IN THE NHS AND THE UHBs RESPONSE**

The Assistant Director of Patient Experience provided the Committee with an overview of the findings of the Community Health Councils report *One Simple Thing – Communication in the NHS* and the UHBs response. The Committee was advised that:

- the report was an all-Wales report and so the findings were generic rather than UHB specific.
- The report was structured around nine themes, namely:
  - Attitude, understanding and listening.
  - Empathy when delivering bad views
  - Keeping people informed and involved
  - Appointments
  - Using technology
  - Coordination of care and communication across services
  - Using Welsh
  - Meeting individual needs
  - Raising concerns
- communication was one of the biggest themes arising from concerns raised by patients of the UHB.

An overview of the steps being taken by the UHB to improve communication was provided.

The Committee Resolved – that:

a) the findings and recommendations set out in the Community Health Councils report *One Simple Thing* and the UHBs response be noted.

19/04/012 **ANNUAL QUALITY STATEMENT FOR 2018-19 (FIRST DRAFT)**

The Executive Nurse Director presented the Committee with the draft Annual Quality Statement (AQS) for 2018-2019 for approval. The Committee was advised that for the 2018-19 financial year the requirements for submitting the report had been brought forward by three months. The Committee noted that the draft AQS had been reviewed by the Management Executive and comments made addressed.

	A high level overview of the draft AQS was provided by the Patient Safety & Quality Assurance Manager. As part of the overview it was confirmed that: ▪ The draft report had been developed in collaboration with colleagues across the health board and in partnership with the Community Health Council, as well as through engagement with the Stakeholder Reference Group. ▪ Each chapter of the AQS was aligned to a Health and Care Standards theme, and contained three components including the Quality, Safety and Improvement framework, patient and staff story and examples of improvements and areas to focus on during 2019-2020. ▪ The patient and staff stories included in the AQS had been developed with clinical teams and patients across the UHB to reflect the approach being taken to ensure that care is being provided in the most appropriate settings. ▪ Due to the timeframes for publication final year figures around performance and delivery would be inserted following the approval of the draft and before publication. ▪ The AQS was subject to audit by Internal Audit prior to publication. ▪ The approach to developing the AQS was changing and guidance from Welsh Government was awaited. It was noted that it was likely that the UHB would develop a website with up to date Quality, Safety and Experience information. ▪ Feedback on the draft was required by 30 April. Due to the timing of the May Board meeting it was necessary to agree arrangements for the sign-off of the draft AQS by the Committee. **The Committee Resolved – that:** a) the draft Annual Quality Statement be approved, subject to any comments received by 30 April 2019. b) final sign-off of the Annual Quality Statement, on behalf of the Committee, would be delegated to the Committee Chair.	All
19/04/013	**POLICIES FOR APPROVAL** The Executive Nurse Director presented the following Policies and related Procedures for Approval: ▪ **Labelling of Specimens Submitted to Medical Laboratories Policy and related Procedure:** This policy and supporting procedure describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. ▪ **Venepuncture for Non Clinically Qualified Research Staff Policy and Related Procedure: T**his policy and supporting	

	procedure identifies the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board **The Committee Resolved - that:** a) the Labelling of Specimen's Submitted to Medicine Laboratories Policy and related Procedure be approved b) the Venepuncture for Non-Clinically Qualified Research Staff Policy and related Procedure be approved	
19/04/014	**HEALTH AND CARE STANDARDS ANNUAL AUDIT REPORT** The Health and Care Standards Annual Report was presented by the Executive Nurse Director; a video accompanied it. The Committee was advised that feedback received from patients as part of the annual audit had confirmed the high standards of care provided across the UHB, with an overall satisfaction rate of 92% (91% in 2017 & 89% in 2016). It was also noted that nearly all patients (98.4%) who participated in this year's audit reported that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital. The Committee discussed the areas that had received low feedback scores i.e. sleep and rest with an overall patient satisfaction rate of 77.82%; provision of help and advice to prevent damage to skin - 79%; 63% in relation to question: *Were you able to speak Welsh to staff if you needed to?* and 73% in relation to: *parents were encouraged to attend ward rounds (paediatric & neonatal areas).* The Executive Nurse Director advised the Committee that a comparison of compliance with operational standards over the last three years demonstrated that clinical areas had achieved greater and more frequent improvement, specifically in relation to: ▪ Nutrition and Hydration: staff knowledge of dietary requirements, frequency of beverage rounds, frequency of water jug changes and availability of snacks ▪ Care planning & evaluation of care for people who lack capacity ▪ Evaluating the care of people with substance misuse problems ▪ Provision of smoking cessation information ▪ Medication charts completed fully and correctly Reduction in compliance, totalling more than 5% over three years, were confined to the following standards: ▪ Fire restraint doors are free from obstruction or closed ▪ Assessment of cultural & spiritual needs ▪ Reviewing patient hygiene and continence needs within agreed timescales ▪ Patient documentation captures their preferred name	

The Independent Member, Legal asked whether timescales for implementation were attached to the Standards, and whether the impact of non-compliance had been clearly set out. In response, it was confirmed that the Health and Care Standards established a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. It was also confirmed that many of the Standards are overlapping and interrelated, and that where concerns had been highlighted a further audit would be undertaken.

The Executive Nurse Director confirmed that a number of the areas for improvement highlighted by the Annual Audit had already been identified by the UHB and as a result improvement work was already progressing. Such areas included, length of stay, pressure damage, discharge and patient flow.

The Chair of the UHB advised that in relation to the Standard relating to the spiritual and pastoral care needs of people and their carers it had been recognised that staff needed further guidance and support to ensure that they asked the right questions in the right way. The Independent Member, Trade Union offered her support and assistance in this task.

The Committee discussed the feedback received in relation to cleanliness and it was recognised that often the age of the UHB estate impacted on a patient's perception of cleanliness. It was agreed that such perceptions needed to be appropriately addressed.

The Committee Resolved – that:

a) The continued improvements made across most standards, especially in relation to; nutrition & hydration, evaluation of care for people with substance misuse problems, availability of smoking cessation information, full completion of medication charts and care planning for people lacking capacity be noted.

b) The high parent satisfaction (95%), based on over 300 responses, achieved within Children's Community Directorate be noted. The Committee also noted that this high rating had the effect of increasing the UHB's overall patient satisfaction to its highest recorded level (92%)

c) The reduced compliance with Standards, that had occurred for three consecutive audits be noted.

19/04/015 **PATIENT SAFETY SOLUTIONS (STANDARD 2)**

The Assistant Director of Quality and Safety presented a high level update on the UHB's position in relation to Patient Safety Solutions, which include alerts and notices from Welsh Government. The Committee was advised that:

- overall compliance with Patient Safety Solutions where the deadline had passed was 93% (compliant with 51 out of 55).
- Two Safety Solutions had been recently issued by Welsh

Government, and work was underway to ensure compliance by the required deadline:

- PSA009 – Wrong selection of orthopaedic fracture fixation plates
- PSN047 – Management of life threatening bleeds from arteriovenous fistulae and grafts

- The UHB had been unable to confirm compliance with the following Safety Solutions:
  - PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. It was noted that the particular issue to address with the Alert related to uptake of competency- based training for all staff who undertake the procedure, regardless of seniority.
  - PSN030 – The safe storage of medicines: This Notice is subject to further consideration by Welsh Government.
  - PSN040 – Confirming removal or flushing of lines and cannulae after procedures. It was confirmed that the outstanding issue to address relates to amending the 'sign out' section of WHO surgical safety checklists in operation. The UHB is currently undertaking a review of all Directorate WHO checklists for this to be considered.
  - PSN043 – Supporting the introduction of the Tracheostomy Guidelines for Wales. It was noted that an audit of all patients in the community who have a tracheostomy is currently being undertaken.

The Committee acknowledged the improvements made by the Patient Safety Team.

The Committee Resolved – that:

a) the Patient Safety Solutions update be noted.

19/04/016 **PATIENT FALLS (STANDARD 2.3)**

The Executive Director of Therapies and Health Science provided the Committee with an overview of the work undertaken in respect of falls prevention and described the UHB's proposed approach to falls prevention going forward. An update on the launch of the Falls Prevention Framework and the outcome of the first Community Falls Prevention Alliance workshop held in March 2019, was also provided.

The Executive Director of Therapies and Health Science advised the Committee that data analysis by Lightfoot has identified that there were:

- 500-600 attendances (including Paediatrics) to the Emergency Department (ED) at UHW as a result of falls each week.
- 40-50 of those patients aged 75+ discharged from ED following a fall, will re-attend ED.
- 7 patients aged 75+ were admitted per week with fractured neck of femur, with an average length of stay of 20-45 days, occupying 30-

50 beds at any one time.

It was also noted that the key focus of the '*Falls Framework: Reducing Risk and Harm*' was primary prevention and the community falls pathway. It was confirmed that the UHB had:

- recently entered into a partnership with Canterbury District Health Board. As part of the Health Pathways and Alliancing approach a Community Falls Prevention Alliance had been set up to address the primary prevention, healthy ageing and community services prevention and management aspects of the framework.
- already made significant progress in implementing a number of schemes such as Model Ward, Get me Home and End PJ Paralysis which all contribute to promoting independence and preventing decline.
- facilitated the first meeting of the Community Falls Prevention Alliance on 25 March 2019, bringing together representatives from multiple services and organisations

An update on Stay Steady Clinics; Simulation Training for inpatient staff and Staying Steady Schools was also provided. It was also confirmed that team members from Canterbury would return in May to continue the work on systems development.

The Committee Resolved – that:

a) the progress made by the Falls Delivery Group in the development of the Framework and Community Falls Alliance be noted.

b) the new Falls Framework: Reducing risk and harm across the UHB be shared, spread and embedded.

c) the development of the Community Falls Prevention Alliance Scope development of an Inpatient Falls Prevention Alliance to address inpatient falls prevention and management be developed.

d) uptake and embedding of Simulation Training for inpatient staff be encouraged.

e) the second running of Staying Steady Schools scheme for 2019 be implemented.

f) Stay Steady Clinics and improved WAST referral pathways to CRT across UHB (Transformation Bid funding dependent) be rolled out.

g) links and availability of strength and balance exercise groups in the community to improve long-term outcomes be improved.

19/04/017 **PRIMARY OUTCOME: PEOPLE ARE SUPPORT TO MEET THEIR NUTRITIONAL AND HYDRATION NEEDS, TO MAXIMISE RECOVERY FROM ILLNESS OR INJURY (STANDARD 2.5)**

The Executive Director of Therapies and Health Science presented the Committee with an overview of the UHB's approach to the assessment of compliance against the Health and Care Standard 2.5. As part of this overview the criteria and evidence used to undertake the assessment was discussed. It was also noted that good progress had been made in

many areas notably staff catering and public health with reference to the delivery of the corporate health standard framework.

The Committee was advised that the implementation of a Model Ward across four wards within the UHB had enabled a standardisation of nutrition and hydration practices across the inpatient setting. It was also noted that the Model Ward had been accepted as a Bevan Exemplar and for a research grant.

Progress in implementing the improvement actions identified as key deliverables for 2018-19 was discussed. The following next steps were brought to the Committee's attention:

- The Nutrition and Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patients dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work
- Ward managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward
- Review the role of the qualified nurse in overseeing the meal service and develop a role profile
- Ensure new descriptor for dysphagia (IDDSI) knowledge is embedded across the Health board
- Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time
- Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit
- Subject to business case approval the Implementation of All Wales catering IT system
- Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream

The Committee acknowledged the work of Rebeca Aylward, Director of Nursing, Medicine Clinical Board and Judith Jenkins, Head of Dietetics in respect of the Model Ward. Committee Members also offered their congratulations to the Multi-Disciplinary Team who had been successful in securing a UK award for efficiency improvements in respect of nutrition and hydration at a the Hospital and Caters Association (HCA) national conference. It was noted that this was the first time the Wales branch of the HCA had won an award in 12-years.

The Committee Resolved – that:

a) progress against the actions identified as key deliverables for 2018-19 be noted.

b) The new challenges set out in the report be noted.

c) A copy of the power-point presentation that accompanied the

paper be circulated to Committee Members.

19/04/018 **OVERVIEW OF REGULATION 28 REPORT 2018/19**

The Assistant Director of Patient Safety and Quality provided the Committee with an update on the Regulation 28 reports issued by the Coroner to the UHB during 2018-2019. It was noted that during 2018-2019 the Coroner had issued five Regulation 28 reports and had written to the UHB on two further occasions to raise issues following the conclusion of an inquest. The Committee was provided with a brief overview of each of the five cases:

The Committee was advised that in two of the cases the UHB had not been informed of the inquest, as a result UHB staff had not been given the opportunity to provide assurance to the Coroner on the processes in place. The UHB's involvement could have potentially avoided the issue of a Regulation 28 report. The Committee was informed that a request for the Coroner's Office to liaise with the corporate departments prior to Inquests had been made.

The Committee Resolved – that:

a) the overview of the recommendations made by Her Majesty's Coroner be received.

b) the actions undertaken in response to the internal investigations and Coroner's recommendations be noted.

19/04/019 **ENDOSCOPY DECONTAMINATION – PATIENT NOTIFICATION EXERCISE**

The Executive Nurse Director provided the Committee with an overview of the Endoscopy Decontamination Patient Notification Exercise (PNE), reminding the Committee that during a decontamination process undertaken in August 2018, the UHB had identified that a gastroscope and a video colonoscope had not been adequately decontaminated in line with the manufacturer's decontamination re-processing instructions. The Committee was advised that this had happened because each endoscope contained a sixth internal channel that staff were unaware of.

The Committee was advised that:

- A multi-disciplinary Serious Incident Management Team (SIMT) had been established and the UHB was worked closely with colleagues from Public Health Wales to investigate the matter.
- A total of 111 patients underwent procedures involving the endoscopes.
- Patients who received procedures with the two endoscopes may have been placed at a very low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV). Based on this clinical advice, Public Health Wales did not recommend screening for all patients as the risk is very low. However, a telephone line was set up and if a patient wishes necessary arrangements for a simple

	blood test screening for BBV, can be made. ▪ No other six channelled endoscopes were in use in the UHB and all endoscopes in use, were being decontaminated in line with manufacturer's instructions. ▪ The UHB, with the support of Public Health Wales and the Community Health Council, carried out a PNE in the weeks commencing 25th March 2019 and 1st April 2019. ▪ A helpline was provided by Public Health Wales and this was made available from 26th March 2019 – 29th March 2019 and from April 1st to April 5th form the hours of 09.00 to 17.00hrs. ▪ Fourteen patients had contacted the UHB via the telephone helpline and eight of those wished to undergo tests. The Committee Chair thanked Clare Wade for preparing the paper and acknowledged the amount of work that had gone into ensuring the PNE was effective. It was confirmed that the information and learning would be shared with other Directors of Nursing and Clinical Boards. The Executive Director of Therapies and Health Science also commended the work of the team and highlighted the need for a central decontamination department and strengthened centralised decontamination facilities and standard UHB wide procedures. It was agreed that the Executive Director of Therapies and Health Science would bring a progress update to a future Committee meeting. **The Committee Resolved – that:** a) the actions taken in response to the decontamination incident be noted. b) the outcomes arising from the Patient Notification Exercise be noted. c) all the necessary steps had been taken to avoid a re-occurrence of this incident and that all reasonable steps had been taken in respect of the affected patients d) the learning from the incident and Patient Notification Exercise should be shared Directors of Nursing and Clinical Boards e) a progress updated should be scheduled for a future meeting of the Committee.	FJ
19/04/020	**CANCER PEER REVIEW: THYROID (STANDARD 3.1)** The Executive Medical Director outlined the findings of the initial review of the UHB's Thyroid Cancer Services which took place on 3 December 2018. As part of his summary the Executive Medical Director noted that while no immediate risks had been highlighted, the following serious concern had been noted: ▪ *Rare, advanced and complex cancer cases*: As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management.	

	The Executive Medical Director outlined the six areas for improvement highlighted as part of the review. It was confirmed that the improvements needed required collaborative working at a regional level and through the Cancer National Network. The fact that members of the Peer Review team also had a role as part of the Cancer National Network was noted. The Executive Medical Director confirmed that he would continue conversations outside the meeting with the Cancer National Network to ensure their full engagement. **The Committee Resolved – that:** a) the report on the Thyroid Cancer Peer Review be noted. b) appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.	
19/04/021	**NATIONAL HIP FRACTURE DATABASE (NHFD): IMPLICATIONS OF THE 2018 NHFD ANNUAL REPORT FOR PATIENT CARE IN CARDIFF AND THE VALE** The Executive Medical Director provided the Committee with an update on the NHFD, confirming that the 2018 Annual Report focused on case mix adjusted 30 day mortality and six new Key Performance Indicators (KPIs). It was noted that Welsh Government require UHBs to report quarterly on their progress against the six KPIs. The eight key findings set out in the NHFD Annual Report, and the UHB's response to these were discussed by the Committee. It was confirmed that: ▪ Findings highlighted a need to re-design the admission and treatment pathways; ▪ Work was in hand to unify the approaches to pre-op. and post-op. care bundles for hip fracture and general trauma patients. ▪ The Clinical board had invested in two trauma nurse practitioners to support patient flow from the Emergency Unit to the perioperative phase ▪ value ward based social worker (± AHP) will be explored through the Lightfoot work streams. ▪ Two different teams would be created and be responsible for flow at the front and back door and design the metrics. A separate team would be formed for the theatre environment who would redesign the way the list was run inside the theatre. Work needed to be undertaken with the ambulance service and for patients to be prepared for theatre. Less theatre time and beds would be used and instead of discharging back to residential home patients could be discharged to their home. ▪ The Challenge was the need for clinicians both in and out of	

	hospital to adhere to the pathways and deliver on making change occur. ▪ The Clinical Board would be happy to update the Committee on the progress of the Lightfoot work later this year. **The Committee Resolved – that:** a) the Surgical Board action plan be agreed. b) an update on the Lightfoot work be added to the Committee Work Plan.	GM
19/04/022	**HEALTHCARE INSPECTORATE WALES (HIW) ACTIVITY UPDATE** The Assistant Director of Quality and Safety provided the Committee with an update on the inspections and reviews undertaken by Healthcare Inspectorate Wales and the findings arising. It was confirmed that: *Thematic reviews* ▪ The final report of a review of *Patient discharge from Hospital to General Practice* was issued in August 2018. It was noted that an action plan was under development and would reported to the Committee in June 2019. ▪ The report of the All Wales Joint Thematic review of Community Health teams was published in February 2019. It was noted that the UHB had developed an improvement plan to address the findings. ▪ The UHB had participated in phase 1 of a review that set out to answer the question *How are Healthcare services meeting the needs of young people?* It was noted that although a phase 2 was anticipated it was not undertaken. HIW published their final report on 22 March 2019 and this will be reported in full at the Committee meeting scheduled for June 2019. *Special reviews* ▪ In March 2018, HIW commissioned an Independent Review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled abuse allegations made against (KW). One of the patients who made an allegation against KW was a patient of Cardiff and Vale UHB and, as the UHB remains a commissioner of learning disability services from ABMUHB, it was recognised as a stakeholder in this process. It was noted that a stakeholder meeting was held on 19 April which was attended by the UHB who have fully engaged in the process as required. *Announced visits* ▪ Vale Locality Mental Health Team: Feedback was largely positive. There were no immediate assurance issues. It was confirmed that the UHB had submitted an improvement plan and was currently awaiting confirmation that HIW was satisfied with the steps being taken to address the findings. It was confirmed that the findings	

would be reported to the Committee in more detail in the next report to Committee in June 2019.

Unannounced inspections

Two unannounced visits had been undertaken, namely:

- a visit to Mental Health Services at Hafan Y Coed during the week commencing 18 March 2019. It was noted that feedback was very positive with no immediate assurance issues and that the findings would be reported in more detail at the June 2019 Committee meeting
- The Emergency and Assessment Units (EU/AU) at University Hospital of Wales during week commencing 25 March 2019. It was noted that while the reviewers could not speak highly enough of the staff that they met over the three day visit, immediate assurance issues in relation to the suitability of the Lounge area in the AU as an area for unwell patients who want to sleep and/or lie down, staffing levels in the Medical Assessment care Unit (MACU), checks in relation to the resuscitation trolley, fridge temperatures had been identified.

The Committee was provided with an overview of the immediate actions taken to address the concerns raised and it was noted that in lieu of the fact that the HIW report was yet to be received a more detailed discussion would take place in the private session that followed.

Primary Care Contractors

It was noted that an announced visit to a Dental Practice in Cardiff and the Vale had resulted in an immediate assurance issue in relation to the recording and monitoring of fridge temperatures. It was noted that this had been addressed by the practice and that HIW had confirmed that they were satisfied with the action taken. It was confirmed that a full update on primary care inspections would be presented to the June 2019 meeting of the Committee

The Committee Resolved – that:

a) the level of HIW activity across a broad range of services be noted.

b) the appropriate processes were in place to address and monitor the recommendations.

c) a further report be considered when the Committee met in June.

d) HIW be reminded of the need to send copies of all reports to the Chief Executive so that robust corporate governance arrangements could be implemented.

19/04/023 **COMMITTEE SELF-ASSESSMENT OF EFFECTIVENESS**

A verbal update was provided by the Director of Corporate Governance

	on the Committee's Self-Assessment of its effectiveness. It was confirmed that the Communications Team were coordinating feedback from Committee Members using Survey Monkey, and that survey questions would be circulated by the end of the week. **The Committee Resolved – that:** a) the verbal update on the Committee Self-assessment process be noted and an update be provided at the meeting of the Committee scheduled for June 2019.	NF
19/04/024	**ITEMS RECEIVED FOR NOTING AND INFORMATION** The Assistant Director of Patient Safety and Quality provided a summary and update in relation to the key patient experience, quality and safety issues escalated by Clinical Boards. As part of this summary the following points were highlighted: *Clinical Diagnostics and Therapeutics Clinical Board* ▪ Issues had been raised by Podiatry in relation to heel pressure ulcers, and escalated to the Chair of UHB Pressure Ulcers Group so that themes and trends could be reviewed. It was noted that the Clinical Board would continue to ensure that such issues were escalated. ▪ Phlebotomy at Barry was reporting a marked increase in demand on its services and there has been an increase in complaints from patients. It was noted that information had been sent out to GP Practice Managers regarding the service, and an extra phlebotomist has also been sent to Barry Hospital to provide additional resource. *Specialist Services Clinical Board* ▪ The issues related to Urology Services for spinal injury patients in Rookwood remained unresolved. It was noted that Urology had raised concerns about the suitability of the area provided in Rookwood for the service but the nature of these concerns remained unclear. ▪ The Joint Accreditation Committee ISCT and EBMT (JACIE) inspections of the South Wales BMT Programme had been positive especially regarding Quality management/data management/processes/protocols, but the state of the physical facilities at UHW site (adults) had been highlighted as a weakness. **The Committee Resolved – that:** a) the key patient experience, quality and safety issues highlighted in the report be noted and further updates brought to future meetings of the Committee.	RW
19/04/025	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD /**	

	COMMITTEE The Committee Chair confirmed that the following items should be brought to the attention of the Board: ▪ The Committee's feedback on the Annual Quality Statement and the action agreed. ▪ The key findings and recommendations arising from the Annual Health and Care Standards audit. **The Committee Resolved – that:** a) the Committee's feedback on the Annual Quality Statement and the action agreed, together with the key findings and recommendations arising from the Annual Health and Care Standards Audit be brought to the attention of the Board.	SE
19/04/026	**REVIEW OF THE MEETING** The Committee Chair facilitated a review of the meeting. Members confirmed that: ▪ Discussions and the level of scrutiny was improving in terms of depth and maturity, with open recognition of the key challenges. ▪ the meeting had been managed well in terms of timing and ensuring a focus on the key issues. **The Committee Resolved – that:** a) the review of the meeting be noted.	
19/04/027	**ANY OTHER URGENT BUSINESS** No other business was raised	
19/04/028	**DATE OF THE NEXT MEETING OF THE QUALITY AND PATIENT SAFETY COMMITTEE:** Tuesday, 16 June 2019, Woodlands House, Heath, Cardiff	