Quality, Safety and Experience Committee - 14 APRIL 2020

14 April 2020, 09:00 to 13:00
Coed y Bwl Meeting Room, Ground Floor, Woodland House

Agenda

1. STANDING ITEMS

1.1. Welcome and Introductions
Susan Elsmore

1.2. Apologies for Absence
Susan Elsmore

1.3. Declarations of Interest
Susan Elsmore

1.4. Minutes of the Committee meeting held on 18 February 2020
Susan Elsmore

1.4 - QSE Mins 18.02.20 - AF.NF.pdf (16 pages)

1.5. Action Log - 18 February 2020
Susan Elsmore

1.5 QSE Action Log 11.03.20 AF.pdf (3 pages)

1.6. Chair's Action taken since last meeting
No Chair's action taken
Susan Elsmore

2. ITEMS FOR REVIEW AND ASSURANCE

2.1. Mortality Review - Learning From Deaths
Stuart Walker

2.1 -Mortality Learning from deaths v1.pdf (7 pages)

2.2. Ophthalmology Waiting Times and the Management of Patient Risk
Verbal
Steve Curry

2.3. Exception Reports – Key Issues
Verbal
Stuart Walker / Ruth Walker

3. ITEMS FOR APPROVAL / RATIFICATION

3.1. Annual Quality Statement
Carol Evans

4. ITEMS FOR INFORMATION / NOTING

4.1.
Carol Evans

UHB Self -Assessment and Improvement Plan Against the Cwm Taf HIW/WAO Governance

Review

4.1 - Governance self assessment - April 2020.pdf (3 pages)

4.1.1 - All-Wales Self-Assess of Current Governance Arrangements improvement plan.pdf (20 pages)

4.2. Clinical Audit and COVID 19

Stuart Walker

4.2 - Clinical audit and covid 19 - 190320.pdf (1 pages)

5. ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

Susan Elsmore

6. REVIEW OF THE MEETING

Susan Elsmore

7. DATE AND TIME OF NEXT MEETING:

16 June 2020 at 9.00am
Coed y Bwl Room, Ground Floor, Woodland House

UNCONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 18 FEBRUARY 2020 COED Y BWL, WOODLAND HOUSE

Present:		
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Gary Baxter	GB	Independent Member - University
Michael Imperato	MI	Independent Member – Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Charles Janczewski	CJ	Interim UHB Chair
Rhian Thomas	RT	Independent Member - Estates
Steve Curry	SC	Chief Operating Officer
Barbara Davies	BD	Lead Nurse Specialised Medicine *(Patient Story)*
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Yvonne Hester	YH	Clinical Nurse Specialist TB Control *(Patient Story)*
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Geraldine Johnstone	GJ	Director of Operations, Medicine Clinical Board
Aled Roberts	AR	Clinical Board Director, Medicine
Gillian Spinola	GS	Senior Nurse Specialised Medicine *(Patient Story)*
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Hywel Pullen	HP	Assistant Director of Finance
Sian Griffiths	SG	Consultant in Public Health Medicine
Glynis Mulford	GM	Secretariat
Observers:		
Stephen Allen	SA	Community Health Council
Urvisha Perez	UP	Wales Audit Office
Aaron Fowler	AF	Head of Corporate Governance
Apologies:		
Robert Chadwick	RC	Executive Director of Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Kinghorn	FK	Executive Director of Public Health

QSE 20/02/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the meeting.	**ACTION**
QSE 20/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
QSE 20/02/003	**DECLARATIONS OF INTEREST** The Chair invited Committee members to declare any interests in relation to items on the agenda. The following declarations of interest were received and noted: Committee Chair and Independent Member – Local Authority declared an interest as Chair of the Regional Partnership Board.	
QSE 20/02/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 17 DECEMBER 2019** The Committee reviewed the minutes of the meetings held on 17 December 2019. **The Committee resolved that:** a) The minutes of the meeting held on 17 December 2019 be approved as a true and accurate record.	
QSE 20/02/005	**ACTION LOG FROM 17 DECEMBER 2019** The Committee reviewed the action log and noted the following updates: **QSE 19/12/009 - Healthcare Standards Self-Assessment Plan and Progress Update:** Updates would be reported as part of the standard reporting process in line with the workplan. There was nothing of note to report to the meeting. **QSE 19/12/014 – Internal Inspections:** In regard to sharing an 'App' designed to improve the quality and consistency of audit outcomes with the Community Health Council. The Executive Nurse Director informed the Committee that the Internal Inspection arrangements were being reviewed and that she had shared a proposed way forward with the Executive team. The new approach would be brought to a future meeting. **QSE 19/12/019 – Healthcare Inspectorate Wales Primary Care Contractors:** The Community Health Council confirmed that a paper relating to their visits to Primary Care Contractors would be brought to the December 2020 meeting. **QSE 19/09/008 – Children and Women's Clinical Board Assurance Report:** The Chair requested this be brought to the April 2020 meeting.	RW SA CH

	QSE 19/09/016 – Centralisation of Endoscopy Decontamination: It was explained that this covered future proofing decontamination. The report commissioned by the Executive Team had been received which was currently being worked through and would be taken to a future Management Executive meeting. **COMPLETED** **QSE 19/12/010 – Point of Care Testing:** Set in process a chain for POCT to be allocated to a Clinical Board. **COMPLETED** **The Committee resolved that:** a) The action log and verbal updates be noted	
QSE 20/02/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No Chair's action had been taken since the last meeting.	
QSE 20/02/007	**PATIENT STORY - MULTI AGENCY CARE PATHWAY FOR PATIENT WITH MULTI DRUG RESISTANT TB** Barbara Davies - Lead Nurse Specialised Medicine, gave a presentation on patient B who was resistant to multi drug Tuberculosis therapy and the cross directorate collaboration involved in the patients care. The patient had a history of poor compliance and posed a public health risk in the community. The Health Board had a duty of care under the public health agenda to manage the patient's treatment. There were also concerns regarding the patient absconding. The patient would require up to two year's treatment and the Multidisciplinary Team did not know how long the patient would require secondary care. There were anticipated challenges which needed to be planned for which included securing third party support. The preparations with the multi-disciplinary team prior to admission was key and links were fostered with the family who met with secondary care staff. This produced a successful outcome for the patients care. Standard Operating Procedures were agreed and put in place prior to admission. The extensive prior planning led to a range of health care professionals and agencies, external to the Health Board, working together to implement a care plan that supported patient B. The patient has been fully compliant with the treatment plan and was discharged from hospital after 13 weeks rather than the anticipated 2 years. Treatment had since taken place in the community and the patient had also received daily supervised treatment from the TB team with support from their GP, Out of Hours and pharmacy. The good news story to take from the presentation was that because of the good work undertaken by Patient B's treatment team, the patient had come to trust the staff so that their care was successfully transferred to the community and their inpatient stay was reduced. There was collaborative working across health care professionals and agencies which prioritised the public health agenda.	

	Thanks were extended to Gillian Spinola Senior Nurse Specialised Medicine and Yvonne Hester, Clinical Nurse Specialist TB Control who attended the meeting and also to the rest of their team for supporting the strategy to manage the situation. The Chair invited comments and questions: Independent Member – Legal asked how complicated was the Public Health Order application made to court and was this a difficult process. It was confirmed that Public Health was instrumental in taking the application forward and the Medicine Clinical Board had a good relationship with the Public Health Consultant who understood the health, family and public implications of the situation. It was further explained that Patient B's lifestyle involved significant travelling which brought other challenges. This type of court order had not been encountered by the Health Board previously, it was therefore important that the team had gone the extra mile to have a relationship with the patient to ensure that the Order was granted. Technology had helped in the process and the patient was fully involved with everything and felt that he could trust the staff. Independent Member – Trade Union confirmed that she understood the complexity around consultation and engaging with Patient B, but queried what support was available for staff? In response it was stated that there was an exceptional ward manager who was willing to meet the patient to ease the journey to admission. Lessons had been learnt from their previous admission and a significant amount of time had been invested in preparation to ready staff members for the patient's admission. The Medicine Clinical Board now had a model template to work from. The Chair commented that the story showcased the Health Board's values in action, particularly the development of a relationship of trust with the patient. The staff went above and beyond considering the circumstances. A commendation was sent from the Committee to Andrew Brown, the Ward Manager of A7, who won the Mentorship Award at this year's Nurse of the Year Awards. Thanks was also extended to the Community Staff who were working closely with Public Health Wales as this was not a role they had undertaken before and it was noted that they had performed extremely well. The Chair raised a question in regard to the management of Corona Virus as the presentation had touched on public health issues. The Executive Medical Director confirmed that this would be discussed outside the meeting. **The Committee Resolved that:** a) The patient story be noted	
QSE 20/02/008	**CLINICAL BOARD ASSURANCE REPORT: MEDICINE CLINICAL BOARD** Aled Roberts, Clinical Board Director Medicine, Geraldine Johnstone,	

	Director of Operations, Medicine Clinical Board and Rebecca Aylward, Director of Nursing Medicine Clinical Board provided detail on the clinical governance arrangements in relation to the Medicine Clinical Board. The report centred on Shaping Our Future Wellbeing (SOFW) and collaborative working with patients. The report addressed healthcare standards, demonstrated the good practice that was occurring in the Clinical Board and focused on the quality improvement standards that were important to 'Wyn'. Aled Roberts highlighted the key actions from the report: **Emergency Department:** The National Emergency Department Quality and Delivery Framework for NHS Wales and the Health Board was included in the three adopter sites that support the framework. There was a huge amount of work around the framework which focussed on improving clinical outcomes within the Emergency Department (ED). This work sought to improve experience and the quality of care and to improve engagement and value for money for ED funding through innovation, improvement and adoption of good practice **Early Adopter Site:** The Health Board (HB) was one of the first early adopter sites to trial what good triage looked like and was currently piloting the Rapid Assessment Triage Zone. The HB would direct patients to this area during the day between 11am and 6pm. The average triage time in the Rapid Assessment Triage Zone was around 13 minutes, this was previously 30 minutes. Compliance time reduced from 260 minutes to 196 within the pilot zone and it was felt that the pilot was improving patient experience. The HB was the only early adopter site that had a Welsh Ambulance Service Trust (WAST) electric stretcher to reduce delays and other HBs had been asked to follow our lead. A record was kept of immediate releases that had been accepted or declined and this model had also been shared as good practice. **Benchmarking:** The HB had been approached by NHS Benchmarking who were interested in the HB's two hourly safety huddles as NHS Benchmarking and were intending to use it as an example of good practice. The format was now standard for best practice in UK. Happy or Not machines had been installed across all ED sites and a weekly report was received and reviewed by teams each week. **Frailty:** The Frailty Team were looking at people attending at the front door who did not need to be admitted to the hospital and who could be supported by social services or in other ways. The HB were working closely with local authority partners at both the UHW and UHL sites to assess and place patients appropriately to avoid lengthy admissions and complex care where this wasn't needed. **Staff and Resources:** The Clinical Board experienced challenges around recruitment and the retention of registered nurses. There was previously approximately 120 band 5 registered nurse vacancies for the wards. This year was a different position and improvement had been	

	made to reduce vacancies to 57. This required a tremendous amount of effort from recruitment. A significant amount of nurses and skilled nurses were recruited from overseas and supported by the Adaptation Programme. It was highlighted that five agency nurses had taken on substantive posts. The recruitment and retention of staff would remain a focus for the Clinical Board. The Chair invited comments and questions: The Chair commented on the low appraisal rating. It was stated that the new system of Value Based Appraisal (VBA) would make a difference as it would be easier to obtain staff engagement. The VBA was being piloted and the feedback was positive. Independent Member – Trade Union asked whether the FIT frailty service was a winter only scheme and if it represented value for money. Members were informed that the work at the UHL site was new this winter and an MDT team consisting of medical, nursing and therapy colleagues was working at the front door with the aim to get people out of hospital and back to their home with the appropriate care. UHW teams were more experienced and on average discharged two people a day to their home and significant savings were made on the time people spent in hospital but also in terms of bed days. For the UHL site this was a new project and the team there were discharging one person per day. In terms of outcomes, the aim of the scheme was to avoid unnecessary time spent in hospital where care could be provided in the community with the right care in place. Stephen Allen – Community Health Council asked to meet with the Clinical Board to help understand the Frailty issue and FIT process. The Chief Operating Officer confirmed that the impact of the scheme was reported on at page 18 of the report. He added that the overall length of stay showed improvement, particularly for patients staying over 14 days and he confirmed that there was some evidence available that more than one factor contributed to this dynamic. The pilot was started in January and looked at the front door in UHL. It had been noted in previous months two admissions had been avoided but in the month of January 2020, 21 unnecessary admissions had been avoided. The Chair confirmed that the Health Board was supported by Local Authority partners and highlighted that the provision of social care was a key element for the improvement of patient flow through the system. The Clinical Board Director confirmed that none of the work undertaken was without engagement with social care and partnership working. Independent Member – Legal asked whether the pathway impacted on the HB's relationship with the Local Authority or whether the relationship was working because of pathway. The Chair confirmed that there was a social care presence on the wards. In response it was stated that the partnerships were evolving as demand increased and that everyone wanted to help flow and avoid prolonged admission. It must therefore evolve across different pathways with a single point of access, with social	

	care operating within the team. Partners both, Local Authority and Third Sector were crucial in this and it was emphasised that collaborative working had been key to the project's success. Executive Director of Therapies and Health Sciences informed the committee that the Deputy CMO had written to all Health Boards asking that they ensure what was reflected nationally was also reflected locally. She highlighted that many of the Clinical Board clinicians were leading on this work and influenced what was occurring nationally. There had been great work on respiratory and stroke. Evidence was given to the Cross Party Group on stroke and HIW had commended Dr T Hughes for his work on stroke, his leadership on staffing and his work looking at future proofing the HB by working with trainees to help the current staffing issues across Wales. The Cross Party Group would be presenting their findings in the near future and a report would be going to Welsh Government. The team were also commended for the reduction of injurious falls on the wards and reducing harm from falls. Assistant Director for Patient Safety and Quality asked, in regard to the graph showing a reduction on the outpatient waiting list, if the data had improved in relation to the specialities where there had been challenges admitting urgent patients and also, if improvements had been made with medical engagement. It was acknowledged that work still needed to be undertaken but that the position was improving. The Quality and Safety meetings were attended by physician colleagues but plugging everyone into the meeting was quite difficult. The Executive Nurse Director informed the Committee that she had briefed the Independent Members about the recent Coroner's Inquest and asked the Clinical Board members what was the biggest learning to take from the inquest and what actions had taken place. It was confirmed that there had been issues around documentation as there had been two different observation charts and there was a need to amalgamate both. Further work was also needed on the early warning scores and this had already started. The nurse had escalated her concerns but maybe her voice was not heard and this had been reflected on. Clinician colleagues between paediatrics and emergency medicine who work closely together would be reflecting on the outcomes. The Chair summarised that it was a pleasure to read the report and felt it was accessible to the lay person. It was transparent around the good things that had been done and showed great leadership in UK best practice. **The Committee Resolved that:** a) the progress made by the Medicine Clinical Board to date and its planned actions be noted; and b) the approach taken by Medicine Clinical Board be approved.	

QSE 20/02/009	**HEALTH INSPECTORATE WALES ASSESSMENT UNIT UPDATE REPORT** The Executive Nurse Director informed the Committee that there had been improvements and changes made to the Assessment Unit and to the Surgical Clinical Board in relation to TACU which were making a difference. It was acknowledged that there was still work to do and the Clinical Board was scrutinising the environment and recognised the issues surrounding patient flow and the need for patients to be placed in the right place first time. This was tied into the Length of Stay(LOS) work and the frailty project and it was noted that the changes and improvement plan could not be undertaken by the Medicine Clinical Board alone. The Chair invited comments and questions: Independent Member – Trade Union commented that some of the recommendations from the Community Health Council were really basic and there was a need for decisive and clear action to put these things right. It was stated that some changes had been put in place and it was hoped that this position would not become standardised. This was the HB's bottleneck and the Independent Member – Trade Union was comfortable that action had been taken to address the standard things but could not accept that this was an environment that was fit for purpose. In response it was stated that the improvement plan completes the actions asked for by HIW. But the question remained whether we were paying sufficient attention to the LOS work and flow of patients through our service. The Chief Operating Officer confirmed that the Assessment Unit could not be divorced from the whole patient pathway and the issues were well established and well known on a national and international basis. At points in the system these pathways produce less desirable points of pressure. On the point of ownership, the patient flow pathway could not be owned by everyone so the Medicine CB had therefore taken ownership. The COO was encouraged that they had not taken a mechanical approach by fixing one point and moving the risk to another part of the system. Continuous improvements could be made by working with the Health Board's partners but this would take time. Stephen Allen – Community Health Council (CHC) commented that it was positive to see changes implemented and he added that patients were providing feedback that they had seen improvements with facilities to make patients comfortable during their stay. The CHC would like to work with the CB and the LA to see if the patients could see what was being done and to allay some of the patient concerns. It was acknowledged that more work was needed around patients and staff in the AU. The Executive Nurse Director commented that a multiagency approach to patient flow and improvements could be reviewed as part of Board Development and further conversation was needed with the executive team.	RW

	The Director of Nursing for Medicine added that the Clinical Board had produced a CB staff newsletter and that they would circulate this to the Committee members. **The Committee resolved that:** a) The progress with implementation of the improvement plan be noted and b) The committee considered that sufficient progress had been made to improve quality, safety and experience in this area.	RA / GM
QSE 20/02/0010	**NCEPOD – KNOW THE SCORE – PULMONARY EMBOLISM REPORT** The Executive Medical Director gave an overview of the report and provided a UHB reflection against the report and other national reports. The appendices highlighted the HBs robust management for embolism work, the NCEPOD recommendation checklist and our response to this. The Executive Medical Director directed the Committees attention to items 2, 3, 9 and 13. 2. The National scoring system and performance against this was fairly modest and national performance generally was very modest. This did not assess our patients on pulmonary embolism and was undertaken as standard clinical practice. Our compliance was poor and nationally the compliance was poor. 3. In regard to CT angiogram reporting the marker should be shown and this was being picked up by the CDT team. This was on the HB's agenda and was being addressed. 9. This showed the process by which we flag up regular findings. It was recognised internationally as a very significant quality area and flagged up as a significant risk. The EMD was not assured by the process as it flagged up abnormal results and carried a degree of risk and the CDT Board was aware of the EMD's concerns. The implementation of the national solution for Wales would partially resolve the issue but there was also a need for radiological reporting and the EMD would like to see a more robust process in place to flag up all unexpectedly abnormal results. 13. This work was flagged as being at the high end of intervention for pulmonary embolism. The HB was not yet compliant but conversations had taken place to set up the service as part of the treatment networks. This was at the forefront of interventional technology and the EMD did not consider this as a failure and he confirmed that the HB's position was in line with other centres. An expert in the field had been appointed and governance work was ongoing to ensure that the HB would soon be compliant. **The Committee resolved that:** a) the assurance provided by the NCEPOD report Pulmonary	

	Embolism: Know the Score and the NCEPOD recommendation checklist be noted.	
QSE 20/02/011	**NATIONAL CLINICAL AUDIT UPDATE** The Executive Medical Director provided the Committee with an update on the National Clinical Audit. He flagged the National Confidentiality Inquiry into Suicide and Safety in Mental Health and confirmed that the latest data for 2017/18 was presented and published in January which showed the following: Cardiff and Vale UHB had the second lowest suicide and homicide rate of any Health Board in Wales and had the second lowest in the UK. In contrast if you dug down into the figures and compared Wales' 7 Health Boards to the 44 regions in England and 17 regions in North Ireland or Scotland, out of the 68 regions Cardiff and Vale UHB came 44th. The question to ask was whether we were happy with the outcome. It was emphasised this encompassed the entirety of services for the population. One of the headlines from the report was that 47% of patients in Wales had their last contact with Mental Health Services within seven days of their death. It was important that Mental Health Services lead the way in multi-stakeholder conversations. In regard to maternity the EMD alerted the Committee that the HB had a maternal death during the week. He highlighted that there was nothing to suggest there were any concerns about her care. The Oesophago Gastric Cancer Review showed in the outcome data that the Health Board was largely in line with national performance. In the Welsh system the HB were doing well but the rest of Wales was not. Regional work needed to be undertaken and the Health Board was leading on this with colleagues in Swansea. The National Emergency Laparotomy Audit showed a clear issue with access to critical care. **The Committee resolved that:** a) The assurance provided by the recent National Clinical Audit results be noted; b) the assurance provided in relation to the actions undertaken in response to the raised mortality rate highlighted in the National Hip Fracture Database be noted; and c) It be noted that, as a result of the recent publication dates in the above audits, action plans are currently in development.	
QSE 20/02/012	**FRACTURE OF NECK FEMUR NATIONAL AUDIT UPDATE** The Executive Medical Director provided an update through a presentation. The report highlighted that the issue of concern related to the high mortality rate in the 2018 data and also flagged up the robust process undertaken to address this. The report showed the review undertaken in relation to inpatient deaths after hip fracture and some initial discussion on the outcomes of the more up-to-date review. The	

	EMD's presentation commented on data not set out in the report which was live until the end of October 2019 and the Committee was presented with slides which displayed a Dashboard presentation of the review: The Health Board was in the lower quartile and worsening in one measure of the review; the proportion of hip fracture injuries whilst an inpatient. The END stated that there was a correlation with patients falling who had a longer LOS. The EDTHS emphasised that we were outliers in LOS. The time to operation and mortality for 30 day rate had both reduced and therefore we were no longer outliers for this measure. The main KPI related to our performance against UK wide performance and provided a clear comparator to where the HB were and the comparative performance data highlighted the things the HB were good at. There had been a significant change. The data also showed the delivery of best practice and confirmed that anaesthesia and surgery were improving. The LOS was stable and significantly longer than the UK national LOS. The headline data highlighted that the previous information had been reviewed and a team had been put in place to manage it. The team were based in MDT care across the frailty pathway and the data showed that there had been significant improvements but it was acknowledged that there was still work to do. The EDTHS commented that there was a need to reduce older patients LOS in an unfamiliar environment and to do a piece of work in supporting our ward services in order to reduce fractures to the neck of femur. Independent Member – University asked if the data had been consistently double the average of the national figures or is it double of the UK figures. In response it was stated this was UK data and some measures were different and it was agreed that the current LOS was longer than what was aimed for. **The Committee resolved that:** a) The UHB position in relation to the National Hip Fracture Database in 2018, in particular the 30 day mortality rate, be noted and; b) the assurance provided by the 2019 National Hip Fracture Data and the improvements that have been implemented to date be noted.	
QSE 20/02/013	**CANCER PEER REVIEW AND LUNG PEER REVIEW** The Executive Medical Director provided a report which summarised the Cancer Peer Review. It was highlighted that the lung report had been omitted from the report but had been received earlier that day. The Teenage and Young Adult report had not been submitted to the UHB but clinical teams were able to take forward actions to improve the service based on verbal feedback. This was to be managed locally by speciality	

	services and solid tumour services and was to be taken by the leadership teams to MDT and Clinical Board. Work was also being undertaken with Velindre to take child services forward. An Executive Cancer Board was being put in place which would be chaired by the EMD. This Board would sit below and report into the QSE committee. The Chair asked for all slides to be shared with the Committee. **The Committee resolved that:** a) the report be noted; and b) it was agreed that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.	SW
QSE 20/02/014	**OPHTHALMOLOGY INSOURCING INCIDENT OVERVIEW** The Executive Nurse Director informed the Committee that the Health Board had contacted affected patients formally with the outcome of the Root Cause Analysis. There had been regular communication with Strategic Health Solutions (SHS) and the reviews had been looked at chronologically and forwarded to SHS but these had been returned. SHS was again reminded and the RCAs resent. Communication was ongoing and it was emphasised that this would not affect the patients contacted. The CB was thanked for taking learning from insourcing so that it would not to be repeated. The service had gone out to procure again. The demand on this service was growing and it explained that this was a national issue. A capacity and demand profile was needed to meet the requirement of the service. The COO added that the profile was not in balance for ophthalmology as it was recognised there was a national shortage of ophthalmologists. The risks were calculated and learning had been embedded in the new procurement process. In terms of clinical oversight, the EMD scrutinised the clinical elements and had put in some additional checks. The END commented that the learning and processes would be embedded across the whole of Wales. **The Committee resolved that:** **a)** the contents of the report be noted and the actions being taken be supported.	
QSE 20/02/015	**HEALTH INSPECTORATE WALES (HIW) ACTIVITY OVERVIEW** The Assistant Director of Patient Safety and Quality provided an update. Since the last report there had been no announced or unannounced	

	visits. In regard to the Maternity Report, a robust improvement plan had been submitted to meet the recommendations. There would be a second phase of the Maternity Review which would entail two days of interviews that would look specifically at governance arrangements in the organisation. HIW would embark on an announced visit in March to Cardiff North CMHT and pre-work would be carried out ahead of the visits. The report on SRC in Rookwood had been published on the HIW website. Since writing the report the END informed that two visits had been undertaken by HIW at two clinical areas in Hafan y Coed where a few issues had been raised alongside positive feedback. One had been raised previously regarding Sleeping Out. Assurance would be brought back to the Committee once the report had been published. **The Committee resolved that:** a) the level of HIW activity across a broad range of services be noted and b) it be agreed that the appropriate processes are in place to address and monitor the recommendations.	RW
QSE 20/02/016	**POLICIES FOR APPROVAL** An overview of the policies and procedures were provided to the Committee for approval, these were the: 1. **Optimising Outcomes Policy** The policy had been adopted by the HB in 2013 to systemically support weight management in elective surgery. Smoking and weight management had been integral prior to surgery and there had not been any changes made to the policy itself and only minor changes had been made to procedure. Preoperative smoking cessation referrals and weight management support were part of the elective surgical pathways and more was to be done to ensure that this was available across the HB. Stephen Allen – CHC asked if there was enough capacity for referrals. In response it was stated that within smoking cessation there was capacity but with weight management support could be delayed. This had to be reviewed on a case by case basis. **The Committee resolved that:** a) The updated Policy be approved; **2. Laser Risk Management Policy** **The Committee resolved that:**	

	a) Laser Risk Management Policy and Procedure be approved. b) the full publication of the Laser Risk Management Policy and Procedure in accordance with the UHB publication scheme be approved. 3. **Procedure and Policy for the Pregnancy Testing of Girls of Child Bearing Age (who are menstruating) Before Procedures and Treatments** **The Committee resolved that:** a) the Policy for the Pregnancy testing of girls of child bearing age who have commenced menstruation before procedures and treatments be approved. b) the full publication of the Policy and Procedure in accordance with the UHB Publication Scheme be approved. **4. South Wales Trauma Network Clinical Guidelines** The Committee could take assurance that the governance arrangements around the guidelines were robust. There would be no additional resources as these were not new processes but the guidelines were being consolidated. **The Committee resolved that:** a) The South Wales Trauma Network Clinical Guidelines be approved.	
QSE 20/02/017	**ANNUAL COMMITTEE WORKPLAN** The Assistant Director of Patient Safety introduced the report and confirmed that there had been no significant changes to the workplan. The Director of Corporate Governance responded to a query from the Interim Chair of the Board who to a queried why there were no Terms of Reference accompanying the workplan. The Director of Corporate Governance stated that there were a number of areas which would require significant changes such as the publication of the Health and Social Care Bill, the work of the WAO on Quality Governance, the work on Governance Structures been undertaken by the Medical Director and Executive Nurse Director therefore it would be an inappropriate time to review them as they would require further changes in a few months. The Committee agreed that the Terms of Reference would be brought back to the September Committee and at that point the work plan for the Committee would be realigned to the Terms of Reference. **The Committee resolved that:** a) the Work plan 2019/20 was reviewed; b) the Work plan 2019/20 be approved subject to further review in September 2020 and aligned to the revised ToR; and	NF

	c) the work plan be recommended for approval to the Board of Directors for use until September 2020.	
QSE 20/02/018	**COMMITTEE ANNUAL BUSINESS REPORT** The Director of Corporate Governance presented the Annual Report to the Committee and confirmed that the report provided assurance on the work undertaken during the year 2019/20 as set out in the Terms of Reference. **The Committee resolved that:** a) the draft Annual Report 2019/20 of the Quality, Safety and Experience Committee was reviewed; and b) the Annual Report be recommended to the Board for approval.	
QSE 20/02/019	**ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE** The ADPSQ highlighted the huge staff engagement Mental Health Clinical Board had for lessons learnt but there was less engagement in their regular quality and safety meeting. There were no minutes received from the Medicine Clinical Board. Independent Member – Trade Union noted that Capital and Estates was not a Clinical Board but a Service Group and a report was not provided regarding quality and safety. The END said that she would take this away to consider in the context of a new workplan. EDTHS stated that all CBs should have an agenda item for medical equipment but the templates were not the same. Medical Equipment needed to be discussed as new legislation would be coming into place. In response the END confirmed that the agenda was standardised to healthcare standards and in regards to medical devices, CBs had the freedom to discuss what they felt needed to be focussed on but she realised that this was a recurring theme. The EDTHS requested that the agenda template be reissued with a message to raise the concerns flagged regarding medical equipment. In regard to the Mental Health CB the Interim UHB Chair asked what patient involvement doother CBs undertake in their meetings. In response it was stated that CBs were able to take their agenda forward to include what was important to them. An example was provided that the directorates in Children and Women engage in a Group but there was a variety of different approaches taken. The following minutes from Clinical Board Quality Safety and Experience Sub Committees were noted: • Children and Women – 22.10.19 • Clinical Diagnostics and Therapeutics – 13.11.19 and 11.12.19 • Mental Health – 17.10.19 and 21.11.19	CE

	• Specialist Services – 19.09.19, 11.10.19 and 22.11.19 **The Committee resolved that:** a) The minutes of the Clinical Boards be noted	
QSE 20/02/020	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Committee Chair asked for items to go forward to the Board / other Committee meetings: • The END highlighted that there had been continual raising of Unscheduled Care Pathway and Length of Stay; • The HIW report feedback; and • An update on audit work which had not been detailed in previous Committees which provide upward assurance.	
QSE 20/02/021	**REVIEW OF MEETING** The Committee Chair facilitated a review of the meeting. Members confirmed that: • Although timings were on the agenda the Chair felt additional time was needed for the Clinical Board reports. The additional time was needed to give the public assurance that our services were safe and the Chair confirmed that she would meet with CHC offline to discuss this. • The meeting and minutes should be made available to the public in a more user friendly format. This should be addressed through the communications team. • Independent Member – Estates – It was positive to see, as a new member, how supportive and positive the comments had been to move things along as it was an extensive agenda. • The Assistant Director of Patient Safety confirmed that the Peer Review Group would look retrospectively at a set of committee papers to assess how the committee could make them look more public friendly and facing. • It was noted that some attendees had wrestled with the number of papers and wondered how to prepare for the meeting. In response it was stated that it was not expected that IMs would need to read all policies and documents provided that they were satisfied that scrutiny had been undertaken during the drafting and agreement of the documents.	
QSE 20/02/022	**DATE AND TIME OF NEXT MEETING** Tuesday, 14 April 2020 at 9.00am Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff	

ACTION LOG

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

FEBRUARY MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 19/12/009	Health Care Standards Self-Assessment Plan and Progress Update	To bring a report on areas of work not doing well but to also include areas of good practice		R Walker	**COMPLETE** 18.02.20 – Updates to be reported as part of the standards reporting process 17.12.19 - To come to a future meeting of the Committee. The Executive Nurse Director to provide a date.
QSE 19/12/010	Point of Care Testing	The report to go forward to the next Board meeting.		SW	**COMPLETED** Report to be submitted to the next Board meeting.
QSE 20/02/009	Health Inspectorate Wales Assessment Unit Update	The Medicine Clinical Board had produced a staff newsletter. To be circulated to members	ASAP	RA / GM	**COMPLETED** GM to circulate following receipt from RA.
QSE 20/02/13	Cancer Peer Review	Executive Medical Director to share presentation slides with the committee.	ASAP	SW/GM	**COMPLETED** GM to circulate following receipt from SW.
QSE 20/02/19	Items Received from Clinical Boards QSE Committees	To reissue the agenda template and raise the concerns relating to medical equipment being discussed at meetings	ASAP	CE	**COMPLETED** Medical Equipment is listed as an item on agenda templates. The Assistant Director of Patient Safety and Quality has encouraged Clinical Boards to include any medical device issues.
~~**QSE 19/12/014**~~	~~Internal Inspections~~	~~To share the App designed to improve the quality and consistency of audit~~		~~R Walker~~	**CLOSED**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
		~~outcomes with the Community Health Council.~~			Plans to proceed with the App have been put on hold. ~~A complete review of internal inspections and accreditations is underway.~~ ~~18.02.20 – Internal Inspections was being reviewed. The new approach would be shared at a future meeting.~~ ~~17.12.19 - App not shared as work is now ongoing to review internal inspections and improvement priorities.~~
Actions In Progress					
QSE 20/02/008	Medicine Clinical Board Assurance Report	Meeting to be arranged with Medicine Clinical Board and Community Health Council to help understand the Frailty and FIT process	To be agreed.	MCB / SA	Meeting to take place outside of the committee at a mutually convenient time for all parties.
QSE 20/02/015	HIW Activity Overview	Feedback to be brought to Committee once the report on the recent Hafan y Coed visits had been published		RW	Written update will be provided when the report has been received.
QSE 20/02/017	Annual Committee Work Plan	Director of Corporate Governance to bring updated Terms of Reference and Work Plan to the September meeting.	September 2020	NF	To be brought to the September meeting.
QSE 19/12/016	Update on Health Eating Standards for Hospital Restaurant and Retail Outlets	Revisions to be made to the Policy and brought back to a future meeting.		F Kinghorn	To come to a future meeting of the Committee. The Executive Director of Public Health to provide a date.
QSE 19/12/019	Healthcare Inspectorate Wales Primary Care Contractors	The Community Health Council to provide a paper to a future meeting of the Committee relating to their visits to Primary Care Contractors		S Allen	To come to the December 2020 meeting.
QSE 19/09/016	Centralisation of Endoscopy Decontamination	To keep the Committee update of progress		F Jenkins	The Executive Director of Therapies and Health Sciences to provide a date.

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 19/09/008	Children and Women's Clinical Board Assurance Report	An update was requested for a future meeting detailing the steps taken with the Children's Charter		C Heath	18.02.20 – An update to be brought to the April 2020 meeting. 09.19 - To come to a future meeting of the Committee
QSE 19/09/011	Gosport Review	To provide timeframes from the recommendations of the Gosport Review		C Evans	To be completed within 12 months.
QSE 19/06/009	Quality and Safety Improvement Framework	For the next strategy for period 2021 – 2024 to be brought to Committee		C Evans	To be added to the agenda following release of the Quality Bill.
QSE 19/06/20	Cwm Taf UHB Maternity – Cardiff and Vale Lessons Learnt	To provide an overview of the impact in terms of patient flow to Cardiff and Vale UHB and how this is being mitigated	Ongoing	S Curry	Further verbal update to be provided at each committee meeting.
Actions referred to Board / Committees					
QSE 20/02/009	Health Inspectorate Wales Assessment Unit Update	Multi Agency approach to patient flow to be discussed at Board Development.	To be agreed	RW	To be added to Board Development agenda at next opportunity.

Report Title:	**Mortality – Learning from Deaths**								
Meeting:	Quality Safety and Experience Committee					**Meeting Date:**	14.04.2020		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Medical Director								
Report Author (Title):	Head of Patient Safety and Quality Improvement								

Background and current situation:

Wales-wide development - Cardiff and Vale University Health Board (UHB) has been participating in the all-Wales collaborative for the development of mortality reviews to improve quality and safety of care we provide for a number of years.

An additional work stream is progressing at Welsh Government level to establish a consistent and robust way of generating wider learning from the deaths of children and young people.

Similarly, a National Steering Group for Wales was established to develop and implement stage two mortality reviews for all deceased people with learning disabilities.

An all-Wales mortality review steering group was established with the proposed introduction of Medical Examiners on which the UHB had representation. The steering group united the 3 mortality workstreams and developed the two stage process for mortality reviews and stage one review tool. A stage two tool is still a work in progress. The steering group is currently being reviewed as we move to implementing the Medical Examiner Service (MES).

UHB development - Mortality reviews have been medically led in the UHB due to stage 1 reviews being done at the time of death certification and the established practice of conducting mortality and morbidity reviews. Inherent challenges have been described in previous papers to this Committee (June 2018 and June 2019).

Some targeted work has recently been undertaken to improve the processes that support the recording of stage 1 mortality reviews in Critical Care. This has resulted in improvement from 66% completion in April 2019 to 100% completion in January and February 2020.

Medical Examiner Service - There are three main drivers for the creation of Medical Examiners (MEs): improved patient safety; death certification accuracy and to support and inclusion of the bereaved relatives. These drivers led to the development of the Coroners and Justice Act 2009: *Notification, certification and registration of deaths.*

A National Medical Examiner has been appointed to provide professional and strategic leadership for the Medical Examiner Service (MES) in England and Wales. In addition, a Lead Medical Examiner for Wales has been appointed to provide professional leadership, guidance and support to MEs.

There will be a single all-Wales MES working on behalf of health boards and trusts. Through a phased implementation around 30,000 deaths per year in Wales will be scrutinized (COVID 19 not withstanding).

'The Medical Examiner Service (MES) will provide an independent scrutiny of all deaths that are not referred directly to the Coroner's Service. This will be done by a Medical Examiner, who is an experience and trained doctor, in order to establish an accurate cause of death and to identify any concerns surrouding the death itself which can then be further investigated if required' ….

'The purpose of a Medical Examiner is to:

- Improve safeguards for the public
- Ensure the correct deaths are referred to a coroner
- Improve the quality of death certification
- Offer an opportunity for relatives to ask questions
- Feed information to the qulaity assurance systems
- Provide general medical advice to coroners
- Collate and share statistical information'

(http://www.nwssp.wales.nhs.uk/medical-examiner-service).

MEs will be supported by Medical Examiner Officers (MEOs). Amongst their duties will be initial screening of medical notes, accurate record keeping, being a local point of contact and source of advice for relatives of the deceased, healthcare professionals and the Coroner and registration service.

The MES will have offices in major District Hospital sites across Wales. Locally this will be University Hospital for Wales and University Hospital Llandough. It is expected that the ME will provide a more robust method of selecting patients who should be escalated to a stage 2 review and reduce the number, particularly for medicine clinical board.

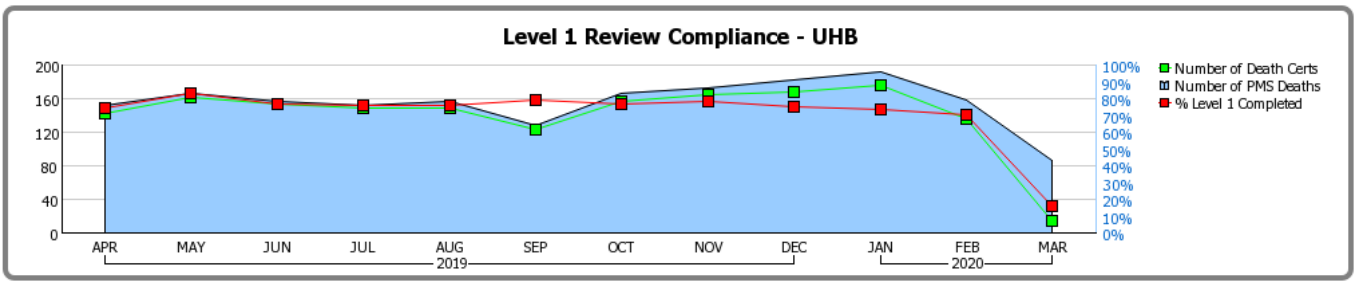
Recording and reporting - The Once for Wales approach has resulted in the procurement of a Datix mortality module.

The MEs will feedback into health board and trust governance systems via the new Datix system. Any issues identified by the ME will be referred into the stage 2 process for consideration by that organisation. (Note that stage 2 mortality reviews form part of the stage 3 investigation process in the Once for Wales system).

The Datix module is being rolled out gradually and will supersede our own Electronic Mortality Audit Tool (EMAT) and enable the UHB to monitor and learn from stage one and stage two reviews.

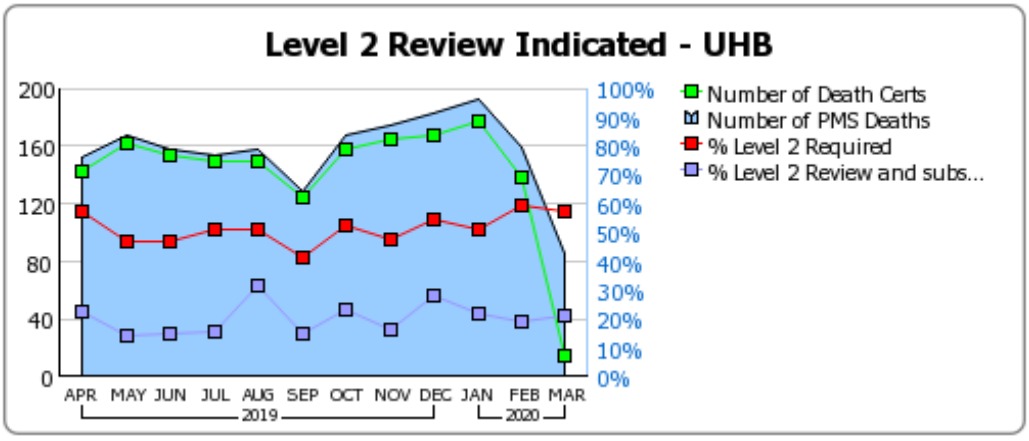
EMAT was developed by the UHB Information Management and Technology deaprtment and is linked to the Patient Management System. It is a platform correlating in-hospital deaths with recording stage 1 reviews. Where stage two reviews are triggered an email is automatically sent to notify the relevant clinical board director and /or nominated other. There is currently no repository for stage two reviews which was pending the agreement of the stage two review tool. Thus clinical boards currently manage their own processes.

Via EMAT information can be drilled down from a UHB level to individual patients. The UHB reports the % stage 1 mortality reviews to Welsh Government (graph 1). Compliance can be disagregated down to individual consultants and individual patients who have not had a review can be identified.



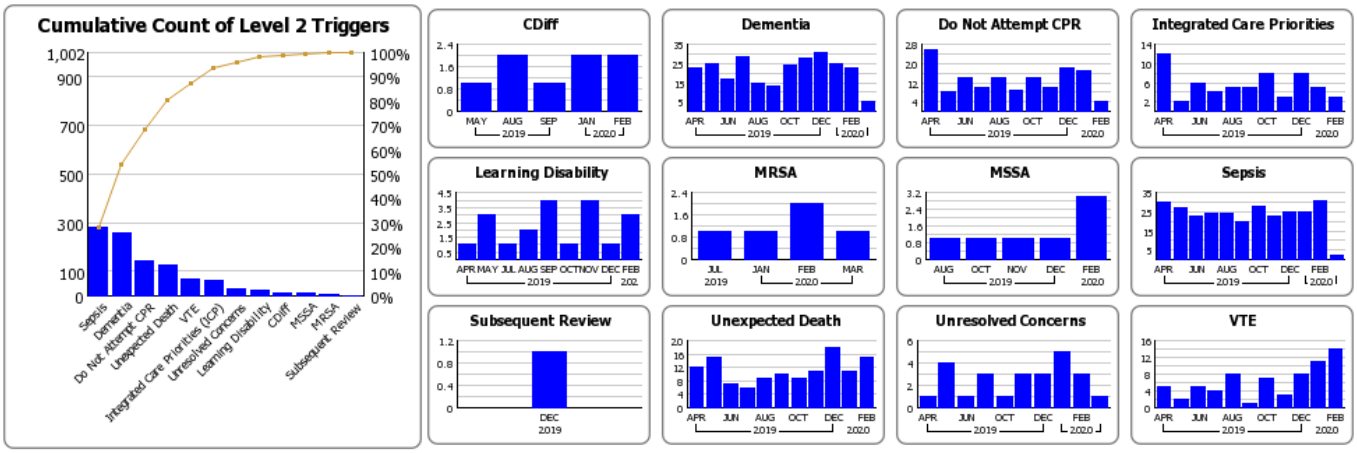
Graph 1 – showing the number of inpatient deaths and % level one reviews recorded (note March 2020 is incomplete).

Designated consultants are notified via an automated email when patients require a stage 2 review. The specificity of EMAT is such that a disproportionate number of patients were unnecessarily triggering a stage 2 review – particularly in Medicine Clinical Board (red line in graph 2 below). EMAT was further developed and the process revised to include a consultant opinion on the need for further reviews. This has lowered the UHB % conversion to that in line with other health boards in Wales (purple line in the graph below)



Graph 2 - % level 2 reviews indicated.

EMAT enables a monthly count of the reasons for triggering a stage 2 review (graphs 3 below). Work is ongoing to improve the quality of care and reduce the incidences of sepsis and the health care associated inforctions.



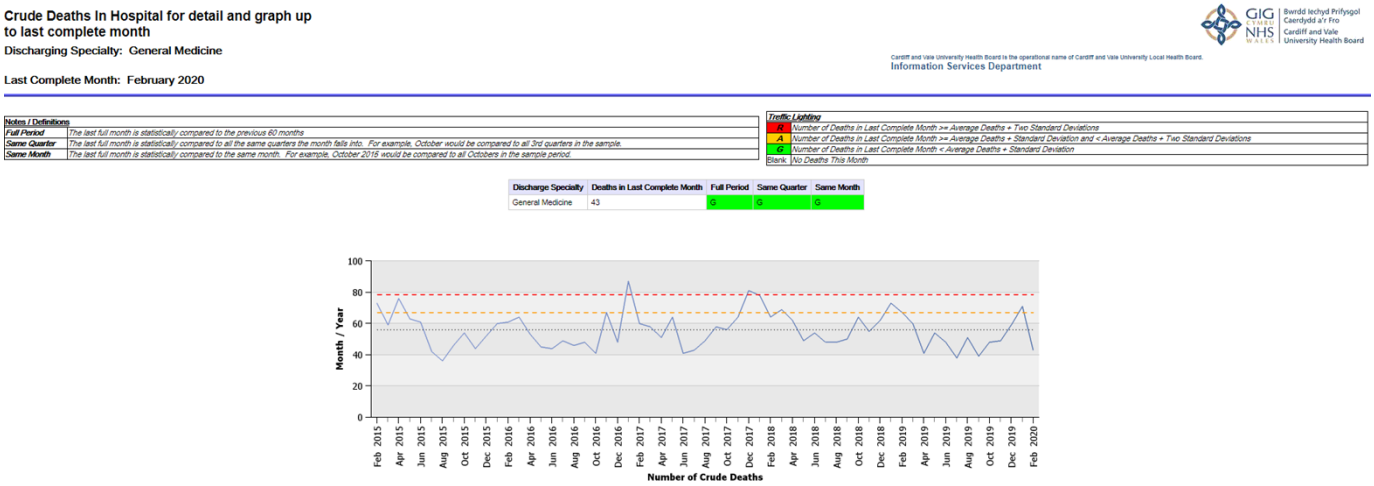
Graph 3 – count of the triggers for stage 2 reviews.

EMAT provides data on the number of inpatient deaths each month. This can be broken down to specialty level. The table indicates whether there is an averge or lower number of deaths (this is shown as green), slightly higer (between one and two standard devitions which shows as amber) or higher than two standard deviations which shows red. At a glance we can see whether there are more than the expected number of deaths (table 1 below).

Deaths in Last Complete Month	Full Period	Same Quarter	Same Month
1	R	R	R
0			
3	G	G	A
2	R	R	A
1	G	G	A
0			
12	G	G	G
5	G	G	G
5	R	R	R
10	G	G	R
43	G	G	G
0			
11	G	G	G
3	A	R	R
9	A	A	R
0			
28	G	G	G
5	A	A	R
2	G	G	G
0			

Table 1 showing the number of deaths and the red, amber, green status.

Where there may be concerns about the number of deaths a specialty level graph with 5 years worth of data can be generated as in graph 4 below



Graph 4 – crude mortality over 5 years.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

The Medical Examiner Service is a new service that is being set up over time. Covid 19 notwithstanding, it is anticipated that the service will be operating fully by 1st April 2021.

ME Training and recruitment - To become an ME there is mandatory training via 26 e-learning modules plus face to face training. In order to remain independent of the Health Boards in NHS Wales and to ensure a consistent approach, the MEs are being hosted via the Shared Services Partnership. Recruitment to medical examiner roles is underway.

The Medical Examiner Service in Wales will operate a service model that has been endorsed by the National Medical Examiner and is compliant with the Good Practice Guidance issued by the National Medical Examiner (January 2020). It will be delivered through four regions, with a Senior Medical Examiner (0.3 WTE) and Senior Medical Examiner Officer (1.0 WTE) in each region as shown in Table 1 below. The Senior Medical Examiners and Medical Examiner Officers will provide an input into quality assurance, appraisal and local management in support of the Lead Medical Examiner and Medical Examiner Officer.

Table 1

Region	Deaths per Year	ME WTEs	MEO WTEs
North Wales (BCUHB)	6,952	1.95	6.47
Mid & West Wales (HDUHB/PTHB)	5,407	1.52	5.03
South Wales Central (SBUHB/CTMUHB)	8,032	2.26	7.48
South Wales East (C&VUHB/ABUHB)	9,198	2.58	8.56
Total	29,591	8.32	27.55

A UHB mortality group is proposed to oversee the local implementation of the MES and the

whole learning from deaths process including the governance arrangements. The group will also collate the learning from deaths information and agree priorites for improvement. The group will be chaired by the Executive Medical Director and have senior representation from all the clinical boards and relevant corporate teams. There are draft terms of reference which need to be ageed.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The recruitment process for MEs and MEOs is being overseen by NHS Wales Shared Services Partnership (NWSSP)

Applications for the ME and MEO roles have not been overly subscribed as yet.
31 standard operating procedures have been identified to underpin service delivery.

Competency frameworks have been developed for MEs and MEOs. Monitoring arrangements will be established on an all-Wales basis to ensure a consistent and accurate approach to escalating to stage two reviews.

A performance framework sets out indicators to monitor outcomes, outputs and process efficiency.

There will need to be robust governance arrangements within the UHB to investigate an learn from deaths and to identify themes and trends and act upon them. There is to date no additional funding to support this.

Until the MES is implemented there will be uncertainty about the impact on the Coroner's Office and the Concerns processes. It is expected that the Coroner referrals will be more appropriate.

Recommendation:

The Committee is asked to note progress and future plans associated with learning from deaths.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities		6.	Have a planned care system where demand and capacity are in balance	
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	
3.	All take responsibility for improving our health and wellbeing		8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**UHB SELF - ASSESSMENT AND IMPROVEMENT PLAN AGAINST THE CWM TAF HIW/WAO GOVERNANCE REVIEW**						
Meeting:	**Quality, Safety and Experience Committee**				**Meeting Date:**	14-04-20	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Assistanr Director Patient Safety and Quality**						

Background and current situation:

The purpose of this paper is to present the UHB self-assessment and improvement plan that has been carried out against the Cwm Taf University Health Board, Healthcare Inspectorate Wales and Wales Audit office review that was published in November 2019. The review can be read here.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Overall the Health Board can provide medium to high level assurance against the majority of recommendations from the review. Areas which have been identified as providing low/medium assurance relate to :

- sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety
- visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.

An improvement plan has been developed to address the necessary improvements.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The report on maternity services at Cwn Taf University Health Board, which was undertaken by the Royal College of Onbstatricians and Gynaecologists and the Royal College of Midwives, identifed a number of serious concerns and service failures. One of the clear questions to emerge, was how a health board that was preceived to be performing well witihn the NHS Wales system of targets and measures had provided maternity services that fell well below the required standards of care. Follwing publication of the report, HIW and WAO took the decision to undertake a review of the Health Board's overall corporate arrangements for quality governance, together with the quality governance arrangements within the surgical services directorate. The findings were grouped under the following themes:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Directorate arrangements for quality and patient safety
- Identification and management of risk
- Management of concerns
- Organisational culture and learning.

The findings highlighted a number of fundamental deficencies in the Health Board's quality governance arrangments. The self assessment tool has been developed so that other Helath Boards can review their internal structures to identify areas for improvement.

Recommendation:

The Quality, Safety and Experience Committee is asked to **NOTE** the findings of the self-assessment and the proposed, necessary improvements.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Following publication of the Healthcare Inspectorate Wales and the Wales Audit Office report titled '*A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board*', the Minister for Health and Social Services has requested that all health boards and NHS Trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment should include a narrative of current arrangements and the current level of assurance: ***high***, ***medium*** *or* ***low***. Whilst reference is made to specific documents in the main report and in the recommendations listed below, each organisation should demonstrate how they are discharging the requirements rather than adhering rigidly to the need to have documentation with the same titles.

Recommendations	***Self-Assessment***	***Plan for future action/review***
	Strategic focus on quality, patient safety and risk	
1. *Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.*	There is a Quality Safety and Improvement Framework 2017-2020 and a Patient Experience Framework 2017-2020 in place. These were approved by the UHB Quality, Safety and Experience Committee and annual progress updates have been presented to the Committee. Progress with implementation of the QSI Framework has also been reported through the Annual Quality Statement. Current level of assurance: **HIGH**	Work to develop the 2020-2025 QSI and PE Frameworks will begin soon and this will involve staff and public and patient engagement. Outcome measures will need to be clearly described and built in to the regular suite of KPIS monitored by the QSE Committee.
	Leadership of quality and patient safety	

2. *There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:*	The Executive Nurse Director is the nominated Executive lead for QSE in the UHB and is supported in this role by the other clinical Executive Directors - the Medical Director and the Director of Therapies and Health Sciences. Quality and Safety issues are discussed at the weekly Management Executive meeting through a regular QSE report which outlines all serious incidents and complaints, safeguarding issues of particular concern, as well as any other emerging QSE issues. This enables all Executive Directors to have oversight of the key QSE issues and concerns. The Director of Planning, Director of Finance and Director of Operations are all members of the UHB QSE Committee. Executive Board Directors regularly present papers to the QSE Committee to provide assurance on QSE issues of concern. There is a weekly Executive led concerns meeting where SIs, complaints, claims and emerging QSE issues and themes are discussed. This allows triangulation of data recorded in Datix together with local intelligence from senior staff at the meeting. There is a standing invitation to the Chief Operating Officer. Over the last few months the clinical execs have implemented the Office of Professional Leadership which is in place to ensure further triangulation	

	with educational , research and innovation along with the ability to explore noise from clinical colleagues Bi - Monthly executive performance reviews include the scrutiny of QSE KPIS and emerging issues with each Clinical Board.	
i. *The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined*	Clinical Board Director – job description is strong on QSE. Latest Clinical Director JD has Patient safety, quality of care and clinical outcomes expected to be at the centre of all aspects of operational management of the Directorate DON in the Clinical Boards – role in relation to QSE is explicit	Revisit of all key job descriptions to ensure consistency in the role of staff undertaking QSE work. We will complete a QSE Governance SOP.
ii. *The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear*	The Directors of Nursing are the identified leads for QSE in the Clinical Boards with the exception of the Clinical, Diagnostics and Therapeutics Clinical Board where there is a dedicated Director of QSE in the CD&T Clinical Board.	There is a requirement to undertake further work to better understand QSE arrangements at Directorate level.

iii. *There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.*	The operational roles in each Clinical Board across the organisation are generally well understood although not specifically described in the Frameworks. The operational roles and the approach to QSE differ between Clinical Boards, which are encouraged to reflect the diversity of the Clinical Boards. They do however have to demonstrate that they all cover the depth and breadth of the agenda. The activity is generally reactive and the focus tends to be on incident management. The Executive Nurse Director is supported by a corporate Quality, Safety and Improvement Function overseen by the Assistant Director of Patient Safety and Quality and the Assistant Director of Patient Experience oversees the complaints, claims and redress function as well as Patient Experience, Volunteers, Feedback, Bereavement, Chaplaincy and Carers The Medical Director is supported by an Assistant Medical Director for Clinical Governance, and QSE for 2 sessions per week. The Executive Director of Therapies and Health Sciences is supported by her Assistant Directors.	National standards for the composition of a suitable resourced corporate QSE function would be helpful Review the Corporate team resources and the dedicated QSE roles in the Clinical Boards to drive improvement.

	There is no reliable benchmarking data available in order to judge the appropriate level of corporate support. QSE structures vary across Wales however the patient safety team is recognised as being 'small' for the size of the organisation. Complaints and claims and Redress – complaints have increased since PTR from 790 concerns per year to over 3,000, all complainants are contacted by the central team and a robust quality assurance process is in place to maintain the quality and timeliness of responses. Redress – all complaints are considered in the context of redress and this is where interrogation of the learning is evident Freedom to speak up (F2SU)-the e mail and phone number are hosted in the Patient Experience team who liaise with Corporate Governance who are responsible for tracking and triaging concerns which come in. National Clinical Audit – the number of mandatory national audits is growing and the UHB responses are variable. We have resources both centrally and operationally to manage these audits which requires a review.	Revisit the current resources allocated to the national audit function and align with the growing demand to improve variability.

	Patient Safety and Quality - The Patient Safety Team has 3 WTE Patient Safety Facilitators who support Clinical Boards and directorates in their quality and safety arrangements. A significant focus of the Facilitators role is overseeing incident reporting and management mechanisms, especially related to Serious Incidents and Never Events. Many SIs will lead onto Inquest processes. Specific dedicated support for the management of Inquests has recently been identified. Current the management of inquests has placed significant pressure on both the Patient Safety and Quality and the Patient Experience team who jointly manage the process. The burden of preparing for complex inquests is held largely by the Patient Safety Team as most deaths have been previously reported and investigated as serious incidents. The lead nurse for bereavement in patient experience currently dedicates approximately 2 days per week to inquest management and staff support. Clinical Boards and directorates are encouraged to ensure they are undertaking analysis of low harm/near miss incidents but corporate oversight of this would be beneficial. Incident reporting rates are on an upward trend but there is further	A review the current dedicated support for Inquest management is required. The Patient Safety Team will be reviewing its workplan in 2020 to align to the revised QSI Framework and prioritise the work of the Facilitators accordingly. The Patient Safety Team will review mechanisms for analysing themes and trends of reported incidents, linking to The Health Foundation research project. The Patient Safety Team will work with the recently appointed AMD for Quality and Safety regarding medical staff and incident reporting. The Patient Safety Team and Patient Experience Team are currently discussing plans for training during 2020. The Medical Director will be undertaking further work to improve the number of incidents that are being reported by medical staff.

	work to do regarding medical staff and their reporting of incidents. The Team provides Root Cause Analysis training and other related training and support (e.g. statement writing, improvement planning). The Team would like to be able to provide more training and have capacity to develop creative solutions for staff engagement and training (e.g. podcasts, videos). There is good collaboration with other corporate services providing similar training in order to ensure efficiency and consistency of messages (e.g. Health and Safety). The Patient Safety Team hosts the Datix system for the UHB. The Datix lead has an excellent reputation for her skill and knowledge, being able to interpret complex process requirements and develop technical solutions to enable the UHB to deliver it's obligations. The forthcoming changes as part of the Once for Wales RL Datix implementation programme will significantly challenge the resource available within this small team (1.9 WTE Datix administration staff and 1.5 WTE support staff). The Patient Safety Team also hosts the Mental Capacity Act Manager (0.8 WTE) who supports the UHB in procedures around consent and mental capacity. The volume of enquiries received and training undertaken is significant and	The Executive Nurse Director has commissioned a review of current arrangements for the management of Mental Capacity Act within the UHB.

	increasing. The MCA Manager will also support the UHB with Court of Protection cases, liaising with clinical staff and solicitors. These cases are often urgent in nature. It is anticipated that the Mental Capacity (Amendment) Bill will replace the current DoLS scheme with new Liberty Protection Safeguards in 2020. The UHB will need to review its systems, processes and structures as a result.	
	Patient Safety Solutions – there are still a small number of long standing areas of non – compliance. Clinical Boards and directorates are encouraged to ensure they include monitoring of ongoing compliance with Patient Safety Solutions in their local clinical audits plans but this would benefit from corporate oversight and scrutiny. Training	The monitoring of ongoing compliance and addressing outstanding PSS is required. Further to investment following a successful bid for a patient safety research project with The Health Foundation, the intention of the Patient Safety Team is to recruit a part-time member to the team who can strengthen this process.
	The Corporate Patient Safety team is taking steps to take a more proactive approach to QSE. This has included working with Dr A Carson-Stevens and Acute Child Health to successfully secure investment for a research project aligned to patient safety and quality improvement priorities. The Team has supported a Consultant Anaesthetist to take forwards a research project regarding the use of TALK – a clinical debriefing tool which is an international research project. The Team has introduced Quality Clinics as a	Further work is to be undertaken to review and scrutinise the implementation of patient safety solutions and ensure ongoing compliance.

	mechanism to guide, support and signpost staff on quality and safety matters. Most Clinical Boards now have a member of staff with a dedicated QSE role either in a substantive WTE post or as part of their current role. Current level of assurance: **LOW/MEDIUM**	
Organisational scrutiny of quality and patient safety		
3. *The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented*	The UHB QSE Committee has clearly defined Terms of Reference which are reviewed annually. There is also an annual work plan in place which is agreed by the Committee for the following financial year. Currently the work plan is aligned with the Health and Care Standards and there is a standardised agenda (this has recently been reviewed and revised)	Revisit the operational groups that support QSE Committee to ensure they oversee the functions to support the Committee and there are no gaps.

to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.	The QSE Committee monitors the QSI Framework and the Patient Experience Framework. This could be more robust and there is a requirement for better outcome measures. There is a formal reporting function in relation to the Health and Care standards. An annual self-assessment is carried out by the nominated groups with an update report to the December Committee. Currently, this does not provide a view of whether sub-group have sufficient support to function effectively. Current level of assurance: **MEDIUM**	A review of the necessary operational structures and supporting groups is required. A review of supporting groups and reporting arrangements is required. A review of whether the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.
4. *Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.*	Independent Members receive an overview of QSE as part of their induction – this is approx.a 3 hour session covering all aspects of the QSE agenda including the function of the QSE Committee and UHB QSE groups. Board development sessions provide opportunities to update IMS on various subjects. The PST recently had an opportunity to attend a Board OD session There is probably room for on-going development of IMs around the QSE agenda. Current level of assurance: **MEDIUM**	

5. *There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real-time user/ patient feedback.*	The Health Board reported the activity in: NHS Outcomes Framework 2019-20 - *Performance Measure Reporting - Evidence of how NHS organisations are responding to service user experience to improve services.* We have implemented year 2 of our framework. We have multichannel communication tools. Over 1,000 surveys are completed each month. We have over 15, 000 pieces of feedback provided per month. Timely reports to Clinical Boards with themes and trends are discussed at their QSE meetings. The UHB has also developed two new surveys which have been administered across both inpatient and outpatient areas. These surveys have been designed to ascertain feedback supporting the Health Board strategy, providing information that we could learn from and importantly act upon; Volunteering agenda, including opportunities for befriender, activity and musician volunteer support. The Happy or Not machines have been used across the UHB sites and in primary care to elicit over 120,000 responses in the last year.	We need to develop a library of patient, staff, volunteer and carer stories

	We use technology e.g. kiosks with bespoke surveys to target areas of concern in a real time feedback system. The wards have feedback on a weekly basis Current level of assurance: **MEDIUM**	
6. *There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.*	There is a Head of Patient Safety and Quality Assurance who has responsibility for the clinical audit function and this includes local and mandatory national audit. The local clinical audit plan is approved at the QSE Committee and a 6 monthly progress update is provided. The approach to the development of the local clinical audit plan has evolved over the past 2 years and audits are categorised as either Tier 1, Tier 2 or Tier 3 and corporate support allocated accordingly. The expectation is that all local audit is registered with the corporate clinical audit team but this is not always the case and therefore it is difficult to know the extent of audit activity and whether any gaps in the standard of care identified are being addressed. The National Audit Plan (NCAORP) is reported to the UHB QSE Committee and regular updates provided. This is area that we continue to strengthen. Assurance is provided to WG in line with established processes. If there are areas of	The UHB needs to ensure that there is more timely access to data. UHBs are not seeing the data until the point that it is published. The UHB needs to introduce a more methodical approach to measuring and monitoring improvement opportunities linked to national audit.

	concern identified in the results of National Audit, exception reports providing assurance to the UHB QSE Committee are presented. There is not enough dedicated Corporate support for the entire NCAORP, and Clinical Boards are expected to identify appropriate resource to ensure that they participate fully in the programme. Currently there is not enough dedicated UHB support for 2 paediatric national audits and therefore the UHB is currently not participating. There are risks associated with this model and these have been outlined in a paper to HSMB in September 2019. There has been recent evidence that outlier status has only been recognised on receipt of an outlier letter from HQIP. This relates to the need to reassess our national audit data as highlighted above. Clinical Audit does not feature strongly in the Clinical Board QSE group discussions and monitoring arrangements and it is not apparent as to how they monitor their improvement activities. Quality improvement linked to clinical audit is a maturing process across the UHB. There is not a methodical approach to monitoring improvement.	

	Good practice is shared at Clinical Board celebration events, Nursing Conference, Therapies and Health Scientist Conference. Current level of assurance: **LOW/MEDIUM**	
Arrangements for quality and patient safety at directorate level		
7. *The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.*	The Clinical Board Director of Nursing/ Director CD&T has responsibility for ensuring that there are robust QSE arrangements in place from Directorate to Clinical Board level and that key issues are escalated appropriately and in a timely way to Executive level. Although this is an explicit role of the DON, there is a shared accountability with the Director of Operations and the Clinical Board Director These responsibilities are described in the job descriptions of the senior management team. The Clinical Boards report on a 14 monthly basis to the QSE Committee. There is a standardised approach to assurance reporting. Current level of assurance: **MEDIUM**	Reporting arrangements for Clinical Boards to the UHB QSE Committee require review.
8. *The form and function of the divisional/group/directorate quality and*	There are well embedded QSE arrangements within Clinical Boards. Each has a QSE groups that meets regularly (approx. monthly) and all	A Governance toolkit, developed in partnership with the Clinical Boards would help to support improved focus, analysis,

safety and governance groups and Board committees have: ***i.*** *Clear remits, appropriate membership and are held at appropriate frequently.* ***ii.*** *Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.* ***iii.*** *Clarity of the role and decision making powers of the committees.*	QSE group minutes are reported throughout the UHB QSE Committee. There are TOR in place. Attendance is variable and medical engagement can be an issue in some Clinical Boards. There is a standardised agenda aligned to Health and Care Standards. This is available as a guide to the issues that should be monitored by the QSE groups. There is variation in the maturity and the depth and quality of discussions. An internal audit of QSE Governance arrangements in 2017 was very positive with all Clinical Boards rated with either substantial or reasonable assurance. All Board Committees have up to date Terms of Reference and workplans which are reviewed on an annual basis and approved by the respective Committee and the Board. In line with Standing Orders the same Independent Member is on the QSE Committee and the Audit Committee. Current level of assurance: **MEDIUM.**	and scrutiny of information in relation to QPS issues and actions. Greater assurance of arrangements at Directorate level is required. More corporate support for Clinical Boards is required.
Identification and management of risk		
9. *The organisation has clear and comprehensive risk management systems at divisional/group/directorate*	Risk Management arrangements at Cardiff and Vale are developing. During the last year a new Risk Management and Board Assurance	Work is currently taking place to develop a programme of education and training for the management of risk. All Clinical Board

and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.	Framework Strategy has been developed and approved by the Board. The Strategy also sets out the Boards 'risk appetite' which was agreed after a facilitated Board Development workshop session run by the Director of Corporate Governance. In addition to the Strategy a revised procedure has also been developed and is currently being implemented. The Strategy and procedure now include clarity regarding what risks get reported where and what risks are escalated to the Corporate Risk Register and Board Assurance Framework. The Board has been receiving a Board Assurance Framework since November 2018 and in November 2019 it received its first Corporate Risk Register which details the key risks from the Clinical Boards and Corporate Directorates Current level of assurance: **Medium**	have Risk Registers but there needs to be work undertaken in ensuring that there is consistency in the approach across the organisation. The new Strategy and procedure will aid this process.
Management of incidents, concerns and complaints		
10. *The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or*	There is dedicated resource for the administration of the system (2 WTE). There is a robust system and process in place to manage the governance of the datix reporting system and is led by the Assistant Director of Patient Safety and Quality. There was a steering group in place to manage implementation of the system and this will be re-	There is resource to currently administer the system but development of the system is limited. This will require review to implement Once for Wales system.

corporate level, and formal mechanisms to identify and share learning.	established to oversee implementation of the Once for Wales System. There are various escalations built in to the system so that serious incidents are flagged in a timely way with senior people in the organisation. There are strict processes in place within the UHB to try and ensure that the system is used as effectively as possible. A recent internal audit flagged a weakness with the recording of investigations and action planning. The audit trail recorded in Datix was not evident although the evidence was available at Directorate level but had not been recorded in the system. There are many dashboards that have been developed within the system to help monitor various functions and many of these are visible to staff within Clinical Boards. Many are developed on a bespoke basis to support clinical staff in managing their incidents. Current level of assurance: **MEDIUM**	
11. *The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of*	There is a robust training programme in place for the investigation of concerns (complaints or incident). All current tools are available on an up to date intranet page developed to support staff in managing investigations. Offered to other UHBs.	Ongoing review of demand and capacity for the training and education requires regular review to take place

concerns and take forward improvement actions and learning.	The PST also run action planning workshops to support staff in the identification of effective solutions. Concerns training – there is a well established training programme linked to the school of nursing and medicine which covers early resolution, formal concerns including breach of duty and causation underpinned with the values and behaviour framework. Regular sessions are carried out through in house UHB programmes including leadership courses. Concerns management is integrated in to Consultant induction There is an up to date incident reporting policy and being open policy and well established serious incident processes. Current level of assurance: **MEDIUM**	Review and revision of all of the formal education and training on QSE which is offered across the UHB to ensure that all necessary QSE functions are covered and it is delivered in a structured way throughout the year. (QSE training needs analysis)
Organisational culture and learning		
12. *The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.*	There is a Values and Behaviours Framework in place. It is regularly reviewed and there is a steering group in place that monitors the framework.	

	UHB action plan has been developed and is currently out to Consultation. Current level of assurance: **HIGH**	
13. *The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.*	There is a lot of evidence of significant organisational learning that takes place as a result of QSE processes. Previous WRP assessment demonstrated that the UHB had best Performance in Wales with regards to LFE in Concerns management. Internal audit have awarded Substantial assurance on the Ombudsman process. The UHB is given good feedback from WG in relation to the quality of closure forms following SIs. Board reports are open and transparent and include examples of lessons learned. The AQS outlines in an open and transparent way, how lessons have been learned and improvements put in place to increase QSE The Patient Safety team have a well developed intranet site, a quarterly Newsletter, and Twitter. Account which are all used to try and share lessons learned.	Organisational learning committee.

	There is a process for sending out Internal Patient Safety Notices although further work is required to ensure that this is an effective method of learning. Current level of assurance: **MEDIUM**	

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Dirprwy Gyfarwyddwr Gofal Iechyd Poblogaeth
Deputy Director Population Healthcare Division

Llywodraeth Cymru
Welsh Government

Health Board Clinical Audit Leads
Medical Directors

19 March 2020

Dear Colleague,

National Clinical Audit Programme

In these unprecedented times there will be questions concerning the continuation of the national clinical audit programme and its surrounding procedures.

Welsh Government has been in contact with HQIP and NHS England and all parties have agreed that during the Covid-19 period, all clinical audit data collection should be suspended and analysis and preparation of current reports left to the discretion of the audit providers.

The Welsh Government are taking a pragmatic approach going forward. We shall not be requesting nor chasing proformas whilst health board priorities are elsewhere.

We shall keep you updated as things progress. Please contact wgclinicalaudit@gov.wales if you have any queries.

Yours sincerely

PROFESSOR CHRIS JONES

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