CONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 18 SEPTEMBER 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Dawn Ward	Vice Chair QSE / Independent Member – Trade Union
Akmal Hanuk	Independent Member – Community
Maria Battle	UHB Chair

In Attendance:

Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Chris Lewis	Deputy Finance Director
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Nicola Foreman	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry (part)	Interim Chief Operating Officer
Stuart Egan	Staff Representative
Dr Tony Turley	Assistant Medical Director, Patient Safety and Clinical Effectiveness
Dr Holly Williams Observer	Quality & Safety Facilitator, Specialist Clinical Board
Vince Saunders Observer	Infection Prevention & Control Clinical Nurse Specialist

Apologies:

Susan Elsmore	Independent Member, QSE Chair
Prof Gary Baxter	Independent Member – University
Michael Imperato	Independent Member – Legal
Abigail Harris	Director of Planning
Fiona Salter	Staff Representative
Dr Graham Shortland	Medical Director
Robert Chadwick	Director of Finance
Dr Sharon Hopkins	Deputy Chief Executive / Director of Public Health

Secretariat: Julia Harper

QSE 18/122 WELCOME AND INTRODUCTIONS

The new QSE Vice Chair, Ms Dawn Ward welcomed everyone to the meeting, and explained that she would Chair the meeting in the absence of the Committee Chair. Members of the Medicine Clinical Board were attending the meeting to deliver the patient story and their quality and safety report and two observers were also in attendance.

QSE 18/123 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/124 DECLARATIONS OF INTEREST

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

QSE 18/125 MINUTES OF THE COMMITTEE HELD ON 12th JUNE 2018

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

QSE 18/126 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log and **NOTED** the number of actions that had been completed. These would be removed. The action log was updated as follows:

Digitalization of Medical Records QSE 18/087 – The UHB Chair reported that a meeting had been set up for 31st October.

CHC Scrutiny Overview QSE 18/088 – Mr Allen confirmed that a meeting would be set up.

QSE 18/127 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

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

QSE 18/128 PATIENT STORY – MEDICINE CLINICAL BOARD

Mr Wayne Parsons, Quality and Governance Interim Lead Nurse delivered the patient story that demonstrated the importance of looking beyond the symptoms of intoxication.

A 20 year old male had been brought to the Emergency Unit following a night out with friends and suddenly lost the ability to speak. He was under the influence of alcohol but not to excess. He had no other obvious symptoms, but friends and his mother kept raising concerns and telling staff that this "wasn't him". The doctor reassessed for stroke and he was scanned. He tested positive for stroke but his symptoms had been masked by intoxication. The story was being used to raise awareness amongst staff before freshers week.

The Chair invited comments and questions:

- In the past patients with a head injury had been misdiagnosed due to intoxication.

- The story had been shared with WAST as ambulance colleagues had not considered stroke.
- Some practical improvements had been made such as faster assessments and raising awareness of staff to question underlying causes.
- If stroke was not diagnosed correctly, patients did not get onto the correct pathway. The effects of stroke on young people had the potential to be profound.
- Over 16,500 potential stroke referrals were received in a year and under 700 were found positive.
- Stroke was largely preventable and lots of preventative work on life style and alcohol was being undertaken.
- The patient's mother made a complaint to the UHB and was pleased with the remedial work undertaken.

The Chair thanked the Clinical Board for sharing this story and noted that Mrs Hughes would help staff create a powerful digital patient/relative story for staff to learn lessons.
Action – Mrs Angela Hughes

QSE 18/129 MEDICINE CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

Colleagues from the Clinical Board attended the meeting to present their comprehensive report covering both challenges and successes in the Clinical Board: Rebecca Aylward, Nurse Director, Jane Murphy, Deputy Nurse Director, Geraldine Johnstone, Director of Operations, Dr Aled Roberts, Deputy Clinical Board Director and Kath Prosser, Quality and Governance Lead.

Ms Aylward commented on the themes in the report for improvement in patient experience and clinical standards. The Medicine Clinical Board had significant risks around surveillance of cancer patients (referrals had increased to around 50-70 per day) and this was a priority. It was a challenge to meet the 8 week target for endoscopy but this was expected to be achieved by the end of September. The focus would then be put on surveillance (around 950-1000 patients). One of the biggest risks in the Clinical Board was the 25% nurse vacancy. A plan was in place and staff were looking at how they could work differently.

The Chair invited comments and questions on the comprehensive report:

- The recruitment video and learning disability bundle were commended.
- Risks were managed on a daily basis through leadership and team work.
- It was noted that staffing a winter ward would be a challenge as some areas were already working with 40% agency staff and there was a high sickness rate.

- Staff would be formally asked if weekly bank pay would be attractive / an incentive. A briefing would be provided for the Chair to share with the Minister.
  Action – Mrs Ruth Walker
- Members discussed the contentious UBH policy of assessing and leaving patients on ambulances which was being used as the UHB deemed this safer than bringing patients into a corridor. Discussions were being held with WAST but the priority was to keep patients as safe as they could be. A consultant would support assessments at the "front door" during winter. In addition, two hour "performance huddles" had been instituted and these included staff from WAST. At this huddle the risk to patients was considered. The CHC advised that good communication was needed with patients and their families when patients were kept waiting on ambulances.
- The Clinical Board was asked to consider what support was needed especially with regard to skill mix to improve care for stroke patients at Llandough.
- The UHB Chair commended the improved performance against Tier 1 targets and the improvements in response times to complaints.
- It was suggested that charitable funds may be able to support the reinstatement of a dietetic support worker.
- A request was made for the Clinical Board Director to write an impact statement to support prosecutions when staff were off work following incidents of violence and aggression.
- The sepsis 6 bundle had been introduced and patients were flagged on the work station.
- It was suggested that links into the local communities could assist with recruitment. Suggestions should be shared with the Director of Workforce and OD.

ASSURANCE was provided by:

- The sustained progress the Clinical Board had made on the range of key quality, safety and patient experience. The focus on governance arrangements, in relation to the promotion of health, the delivery of safe, effective and dignified care. The Clinical Board recognised the key areas of improvement and actions required to further improve the patient experience received.

The Committee:

- **NOTED** the progress made by the Clinical Board and its planned actions.
- **APPROVED** the approach taken by the Medicine Clinical Board.

The Chair thanked the Clinical Board for the report and their attendance.

QSE 18/130 COMMUNITY HEALTH COUNCIL (CHC) REPORT

The CHC had no report to present in September.

QSE 18/131 HOT TOPICS – SERIOUS INCIDENTS INVOLVING WAST (WALES AMBULANCE SERVICES TRUST)

The Executive Nurse Director, Mrs Ruth Walker gave a brief oral update. WAST had not yet completed their investigations and staff were supporting WAST by providing root cause analysis training.

QSE 18/132 POLICIES FOR APPROVAL

The Committee received two Policies that required formal approval and adoption within the UHB.

1 INTERVENTIONS NOT NORMALLY UNDERTAKEN (INNU)

Ms Fiona Kinghorn attended for this item and advised that a complete update had been undertaken during which time outliers had been considered along with the mechanism for the cost/activity run rate. In addition, the list was more frequently updated. The CHC commented on the importance of communicating this information with patients and members of the public therefore, links to the website would be provided to the CHC.
Action – Ms Fiona Kinghorn

ASSURANCE was provided by:

- The policy had been fully reviewed and the intervention list had been comprehensively updated with Clinical Boards. A full Equality Health Impact Assessment (EHIA) had been completed.
- All Clinical Boards had previously reviewed Interventions Not Normally Undertaken activity relating to their areas of service provision.
- The monthly activity list of a subset of procedures provided to Clinical Boards had been reviewed and focused on high volume and high cost interventions.

The Committee:

- **APPROVED** Interventions Not Normally Undertaken Policy and Intervention List and
- **APPROVED** the full publication of the revised INNU policy and List in accordance with the UHB Publication Scheme.

2 INCIDENT HAZARD AND NEAR MISS REORTING POLICY AND PROCEDURE POLICY AND PROCEDURE

The Executive Nurse Director, Mrs Ruth Walker advised that this well used policy had been refreshed and fully consulted on.

ASSURANCE was provided by:

- The former Policy had been in existence for a number of years within the UHB.
- It was updated in 2017 by the Head of Health and Safety.
- It had been necessary to provide a further update to the elements of the Policy that related to patient safety due to updated procedures in the patient safety community being adopted into practice.
- Furthermore, a decision was made to separate the Policy from the Procedure with additional links to the intranet in order to direct staff to the most up to date sources of information and support.
- Existing procedures were in place to monitor incidents reported via the electronic incident reporting system.

The Quality, Safety and Experience Committee:

- **APPROVED** the Incident, Hazard and Near Miss Reporting Policy and Incident, Hazard and Near Miss Reporting Procedure.
- **APPROVED** the full publication of Policy and Procedure in accordance with the UHB Publication Scheme.

QSE 18/133 CORPORATE RISK AND ASSURANCE FRAMEWORK (CRAF)

Mrs Nikki Foreman, Director of Corporate Governance gave an oral update on progress. The former CRAF would be replaced by a comprehensive Board Assurance Framework (BAF) that would combine priorities in the UHB Strategy and identify risks with mitigating action. This would be presented to the Board in November.
Action – Mrs Nikki Foreman

The Committee **NOTED** the update.

QSE 18/134 HEALTH CARE STANDARDS ASSESSMENT

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that this item was considered annually although the system was now one of continuous self-assessment. The Independent Members and Executives were thanked for checking the evidence used in the submission.

ASSURANCE was provided by:
- The comprehensive assessments of each standard.
- Corporate validation of self-assessments
- Internal Audit scrutiny with a reasonable assurance rating

The Quality, Safety and Experience Committee:

- **NOTED** the outcomes of the Health and Care Standards Assessment for 2017/18.

QSE 18/135 PUTTING THINGS RIGHT ANNUAL REPORT

The Executive Nurse Director, Mrs Ruth Walker thanked Mr Angela Hughes and her Team for all their work and for dealing with some of the most difficult situations and for going the extra mile to support patients who were not happy with their treatment.

It was pleasing to see that the number of issues being handled through the informal process had increased and the number of follow up enquiries had gone down due to the improved quality of responses. Complaints meetings were audio recorded to ensure nothing was missed.

Referrals to the Ombudsman had increased but on the positive side a number of letters were not taken forward as the Ombudsman felt the complaint had been investigated in full by the UHB.

Internal Audit had provided substantial assurance on the process and the CHC was also thanked for their support.

It was queried whether the Ombudsman would provide some insight into why/when issues were taken further. It was noted that guidance was being refreshed and if further clarity was required it would be taken up with the Ombudsman.

ASSURANCE was provided by the annual report

The Quality, Safety and Experience Committee **NOTED** the report for information.

QSE 18/136 HTA INSPECTION AND RESPONSE TO INDEPENDENT REVIEW OF MORTUARY AND CELLULAR PATHOLOGY SERVICES AND RCA INTO TISSUE TRACEABILITY

Mrs Sue Bailey, Lead for Quality and Safety in the Diagnostics and Therapeutics Clinical Board attended the meeting to update on this report. It was recalled that a range of concerns on governance, quality, tissue traceability, premises and equipment had been raised by the inspection. In response, the UHB asked for an independent review of the service and a combined action plan was produced. Mrs Bailey reported that all actions identified by the HTA had been completed and a re-visit should be expected at some point. The remaining actions were in progress, with two outstanding: the need to identify a new DI (or the licence could be lost) and organisational work on leadership and culture.

It was noted that a recent internal inspection of systems and processes had gone well. The pathology premises were included on the capital plan as not fit for purpose but capital had not been identified. However, small remedial works had been undertaken that had made a significant difference. It was

suggested there may be an opportunity to utilise charitable funds to make further improvements. It was also reported that the HTA had been impressed with the UHB methodology and had shared it with others.

It was suggested that the UHB responded well in a crisis but was not able to sustain performance and this was where the work on organisational development could assist. As part of learning, a monthly Regulatory Compliance Group had been set up. It was a challenge, but the Clinical Board was aware of where the issues were.

ASSURANCE was provided by:

- The actions developed and progressed

The Quality, Safety and Experience Committee **NOTED:**

- Progress against the HTA inspection findings
- The action plan
- The intended monitoring mechanism through CD+T governance structures

QSE 18/137 PATIENT SAFETY SOLUTIONS ALERTS AND NOTICES

The Assistant Director Patient Safety and Quality, Mrs Carol Evans advised that the UHB was now 94% complaint with safety notices, an improvement from 79% in 2016. Some issues had been non-compliant for a long time. Mrs Evans was pleased to report that after many years the new patient wristband was being rolled out across the UHB, starting at the Barry Hospital. In addition, work on naso gastric tubes was advanced and almost compliant. However, safe storage of medicines was still problematic across Wales. 98% compliance was anticipated by the next report.

ASSURANCE was provided by:

- The UHB had continued to increase compliance with Patient Safety Solutions and was currently compliant with 94% of alerts and notices.
- The actions that were being undertaken to address the outstanding areas of non-compliance.

The Committee **CONSIDERED** the update provided within the report.

QSE 18/138 CLEANING STANDARDS

Mr Lee Wyatt, Head of Estates and Facilities attended the meeting for this item. He reported that Internal Audit had identified that credit for cleaning scores had been enhanced with higher levels of detail. A draft Strategy had been produced and although cleaning targets were being achieved, there was a need to set up a Committee/Group to lead and monitor.

It was noted that it was the responsibility of wards to publish their cleaning scores and that the introduction of hand dryers positively impacted on the time required for cleaning.

The Chair invited comments and questions on the report:

- Improvements in cleanliness had been noticed in communal areas.
- Greater engagement and feedback with ward nursing and cleaning staff was required.
- Ward cleaning scores should be displayed/aligned with infection information.
- First impressions were very important and the level of cleanliness greatly affected these. Unfortunately the lack of ownership of equipment dumped across the UHB was negatively impacting the good work done on cleaning.
- Unison had accepted the recent pay offer. It was important to talk to all Band 1 staff and that they be given the opportunity to take up a Band 2 post with any additional support / training required.
- It was suggested that information was not always clear. The food hygiene rating system was widely understood and could, perhaps, be adapted to demonstrate cleaning scores - it was a patient's right to see these scores.
- It was vital that everyone recognised the importance and value of cleaning staff. This could be recognised through the sharing of staff and team stories and supported through the values and behaviours work - Mr Wyatt agreed to link with Rachel Gidman.
  Action – Mr Lee Wyatt

ASSURANCE was provided by:

- KPI scores on Very High and High Risk areas were meeting targets.

The Committee:

- **AGREED:** Paper update content was appropriate and proportional.

QSE 18/139 BLOOD PRODUCTS (STANDARD 2.8)

Dr Tony Turley representing the Medical Director, advised that the assessment was technical and the key was good regulatory compliance and medical involvement. Compliance was heavily monitored both by the UHB and authorities.

The Chair invited comments and questions:

- The Committee was updated on the national Infected Blood Inquiry that required the UHB to provide a great deal of information. The Executive Nurse Director thanked Mr Carol Evans for leading this work. NHS

Wales had asked the UHB to share its template. The UHB had shared its Initial findings with Haemophilia Wales.

- Blood and transfusion was currently tracked through the telepath system. The UHB would be required to move to the WLIMS system but there were concerns over the national structure and blood stock. The system was only 50% complaint with the NWIS standard and therefore a resilience plan was required. Blood was one of the last modules to be included. The Chair agreed to take this up with the Chief Executive.
  Action – Miss Maria Battle

ASSURANCE was provided by:

- The current annual self-assessment for Health and Care Standard 2.8 had been assessed as "Getting There" (appendix one of the report).
- Evidence of continuing improvement was provided for 2018/2019.

The Quality, Safety and Experience Committee **AGREED** the report.

QSE 18/140 NUTRITION AND HYDRATION (STANDARD 2.5)

The Director of Therapies and Health Sciences, Dr Fiona Jenkins provided the update on the single plan and advised that the full report was available if required. If this plan was linked with the model ward work, many of the actions would be addressed and the Charitable Funds Committee was thanked for funding the pilot ward. Recent visits identified that elderly patients preferred traditional food and their wards would welcome inclusion in the pilot. Unfortunately this was not possible until the pilot concluded and had been fully evaluated.

REASONABLE ASSURANCE was provided by the status report attached.

The Quality, Safety and Experience Committee:

- **NOTED** progress on actions listed within the Patient Nutrition, Hydration and Catering experience management action plan particularly in relation to the model wards and the development work around the nutrition and dietetic service and speech and language service within the integrated team Emergency Unit.
- **WAS ASSURED** that the Nutrition and Catering steering group kept a regular review of the action plan to ensure and update on progress.

QSE 18/141 MEDICAL DEVICES, EQUIPMENT AND DIAGNOSTIC SYSTEMS (STANDARD 2.9)

The Director of Therapies and Health Sciences, Dr Fiona Jenkins stressed that this was a function of all Clinical Boards with limited capital funding available to replace broken equipment. This remained a risk as it was not possible to fund all items required. It was noted that Clinical Boards had

been asked to discuss this issue as a standing item at their Quality, Safety and Experience Sub Committees but minutes demonstrated this was not being undertaken in sufficient detail and therefore it was important to secure better engagement and attendance at Medical Equipment Group meetings.

It was acknowledged that there should be a corporate responsibility for the issue and a system, process and resource was required to manage it, rather than duplicating work in 8 clinical boards. It was agreed that the Executive Directors would discuss this further outside the meeting.
Action – Dr Fiona Jenkins and Mr Steve Curry

LIMITED ASSURANCE was provided by:

- Action plan to the Wales Audit Office report.
- Capital Management Group work programme
- Medical Equipment Group work programme
- The medical equipment library

The Quality Safety and Experience Committee:

- **NOTED** the findings of the Wales Audit Office progress report, the assessment of corporate level compliance to Health and Care Standard: 2.9 Medical Devices, Equipment and Diagnostic Systems and the outstanding medical equipment risks which required capital funding.
- **SUPPORTED** the recommended system level improvement activities.

QSE 18/142 PROTECTING PATIENTS FROM PRESSURE DAMAGE

The Executive Nurse Director, Mrs Ruth Walker presented the report and reminded Committee that the numbers would increase with the new reporting requirements. The figures were likely to climb again as reporting extended into the community. However, the prevalence survey, taken on a single day, reported a rate of 3.1% which was a significant improvement on 9.1% that was the rate for the last 5 years. Mrs Walker confirmed that the UHB was reviewing the situation carefully and taking the necessary action. In addition, work was ongoing with Welsh Government to improve the definitions.

It was noted that the foot assessment tool had not yet been implemented and this would support preventative work on pressure damage. The lead Executive Directors agreed to discuss this further outside the meeting.
Action – Dr Fiona Jenkins and Mrs Ruth Walker

ASSURANCE was provided by:

- The range of actions that were being taken to reduce the occurrence of pressure damage.
- The measures that were being taken to improve the quality and rate of reporting to establish a reliable baseline.

The Quality, Safety and Experience Committee:

- **NOTED** progress and the actions undertaken to help prevent the occurrence of pressure ulcers.

QSE 18/143 CHILD PRACTICE REVIEW

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that they had been previously briefed on this case. This report provided an overview and identified the missed opportunities to identify harm and reiterated the importance of achieving the right route into the service for treatment. In this particular case, the child was seen by the right clinician but the pathway was wrong. The UHB continued to train T&O staff in safeguarding. Unfortunately, perceptions were influenced from the start in this case – the assumption that an adopted child was wanted and loved.

ASSURANCE was provided by:

- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee **NOTED** this report.

QSE 18/144 OMBUDSMAN PUBLIC REPORT

The Executive Nurse Director, Mrs Ruth Walker presented the report. She was disappointed that it had been received as it demonstrated that the UHB had not recognized Ethan's issues. The UHB had to learn lessons noting that its initial investigation into the complaint did not reflect the issues taken to the Ombudsman by the family. The Ombudsman agreed that the UHB should investigate further but also issued a Section 16 report.

The UHB was reviewing arrangements for consultant decision making on waiting list issues. There was some conflict in this area between clinicians and managers but it was clear that ownership rested with clinicians in partnership with managers. The process was very important with 80,000 people on a waiting list.

ASSURANCE was provided by:

- The completion and evidence of the implementation of the recommendations
- The improved and sustained position of the Clinical Board in relation to referral to treatment times

The Quality, Safety and Experience Committee:

- **NOTED** the report for information.

- **AGREED** to receive a further report on completion of the investigation.
  Action – Mrs Ruth Walker

QSE 18/145 SAFEGUARDING ANNUAL REPORT

The Executive Nurse Director, Mrs Ruth Walker presented the report of detailed activity and action taken and asked Committee to note the size and complexity of the agenda. Practice was changing and staff were proactively looking for patients who may have come to harm. The MASH in Cardiff supported multi agency working and had highlighted issues with some of the UHB's own staff - information that would not have been known without MASH.

ASSURANCE was provided by:

- Safeguarding training and raising awareness across the Health Board encompassing all safeguarding themes
- The number of appropriate safeguarding referrals made
- Consistent approach across the Health Board
- Good working partnerships with statutory agencies

The Quality, Safety and Experience Committee:

- **CONSIDERED** this report.
- **AGREED** to signpost all Board Members to this report.

Action – Mrs Julia Harper and Ms Dawn Ward

QSE 18/146 CANCER PEER RE REVIEW – CANCER PATHWAY

Dr Tony Turley, representing the Medical Director, advised Committee that this report covered the cancer pathway process and action plan rather than an individual specialty. The issues identified included IT infrastructure and governance oversight in tertiary services. Details of the latter would be provided to the UHB Chair.

Action – Dr Tony Turley

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the Peer Review assessment and Peer Review reporting process. Any concerns identified were addressed via an action plan and were regularly reported within the required process; at the Clinical Board performance reviews and by WG and the South Wales Cancer Network

The Quality, Safety and Experience Committee:

- **NOTED** the report
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

- **NOTED** that the NHS Wales Peer Review Framework WHC 17 037 had been received and considered by the Committee.

QSE 18/147 MBRRACE – PERINATAL MORTALITY SURVEILLANCE REPORT

Dr Tony Turley, representing the Medical Director, also presented the report on the ongoing work and progress in this area. Measuring criteria had changed and therefore careful monitoring was required especially the action being taken in other Health Boards.

ASSURANCE was provided by:

- A reduction in baby loss since 2016
- The recommendations of the MBRRACE-UK report had been adhered to and measures taken
- Evidence of ongoing work within the Directorate to ensure that the reduction of stillbirth and early neonatal death remained a priority area for improvement

The Quality, Safety and Experience Committee:

- **NOTED** the contents of the report
- **APPROVED** assurance given for reduction of stillbirth and neonatal death within Cardiff and Vale UHB**.**
- **AGREED** to receive a report on mortality and morbidity in February or April 2019 as well as any maternity reports for learning.
  Action – Dr Graham Shortland

QSE 18/148 CARE OF THE DETERIORATING PATIENT – HOSPITAL AT NIGHT SERVICE

Dr Tony Turley, representing the Medical Director advised Committee that the current night cover system was not fit for purpose and gaps in the rota were a concern. Work was ongoing to identify the risks and what improvement measures could be taken with a number of avenues being explored. Further changes in the next year would also impact on the service. It was important that the proposed new model of care provided assurance on risk and safety.

LIMITED ASSURANCE was provided by:

- Control measures that were already being taken and actions identified previously (April 2018).
- Oversight of this risk by the Executive Lead and this Committee.
- Improved monitoring with an improved culture of reporting of incidents
- Plan being developed for Autumn 2018 to address/mitigate shortages

The Quality, Safety and Experience Committee:

- **NOTED** the update
- **AGREED** to receive a further assurance report with timescales in February 2019.
  Action – Dr Graham Shortland

QSE 18/149 QUALITY IMPROVEMENT AND RESEARCH AND INNOVATION (STANDARD 3.3)

Dr Tony Turley presented the current self-assessment and highlighted the need to drive research and innovation as this would help attract and motivate high quality staff.

ASSURANCE was provided by:

- The current self –assessment for Health and Care Standard 3.3 as 'Meeting the Standard' (Appendix 1 of the report).

The Quality, Safety and Experience Committee **AGREED** the report.

QSE 18/150 NICE GUIDANCECANCER PEER RE REVIEW – CANCER PATHWAY (STANDARD 3.1)

Dr Tony Turley was pleased to report that this was an area of success and assurance was provided that the guidance was discussed locally and implemented.

ASSURANCE was provided by:

- The process of disseminating NICE guidance and recording levels of implementation
- The response rate around implementation rates
- The implementation rate

The Quality, Safety and Experience Committee:

- **NOTED** the compliance with the current process and the intention to disseminate NICE Quality Standards.
- **NOTED** the intention to circulate this report to the Clinical Boards for review at their Quality and Safety Meetings.

QSE 18/151 CARERS ANNUAL REPORT

Mrs Angela Hughes, Assistant Director Patient Experience introduced the report and commented on the transitional monies that were available with local authorities to support the Minister's objectives for carers. Work was ongoing with young carers and schools that were embracing peer support. In addition, lots of work was being undertaken in hospital to support carers including staff who were also carers.

ASSURANCE was provided by the Annual Report.

The Quality, Safety and Experience Committee **NOTED** the report for information.

QSE 18/152 MONITORING OF PATIENTS ON THE WAITING LIST

Ms Caroline Bird, Deputy Chief Operating Officer attended the meeting to present the report in response to the CHC report "Our Lives on Hold" and concerns that had previously been received at Committee.

The report considered four areas:

1. Long waits – the long waiting times in paediatric surgery had been eradicated and were now good. Progress had been made in neuro and ophthalmology where long waiting times posed a risk of harm. By the end of the year no one would wait over 52 weeks. Only orthopaedics and spines would have a waiting time in excess of 36 weeks.
2. Monitoring patients on waiting lists – a stop gap process had been put in place and a paper review was conducted on a weekly basis.
3. Cardiac surgery – there was concern that other health boards continued to refer patients very late into the pathway. There was more work to do with these health boards.
4. Communications – information was provided when patients were first put onto the list but no further information was sent whilst patients were waiting which caused anxiety. The CHC was concerned that stress was compounded when people were unable to get a timely appointment with a GP. A national report was being produced in this respect after talking with over 1500 patients.

The UHB Chair was pleased with the successes achieved in referral to treatment time (RTT) and was satisfied with the backstop position.

ASSURANCE was provided by:

- The reducing volume of patients waiting greater than 36 and 52 weeks on a RTT pathway
- The 'backstop' process recently instigated for long waiting patients aimed to ensure that reporting arrangements and performance management acted as a catalyst to both improving waiting times and ensuring that appropriate clinical governance was in place.

The Quality, Safety and Experience Committee:

- **NOTED** the current position and work ongoing in relation to reducing waits, monitoring of and communication with patients waiting greater than 36 and 52 weeks on a RTT pathway.

QSE 18/153 ANNUAL VOLUNTEERS REPORT

Mrs Angela Hughes, Assistant Director Patient Experience was pleased to report that the UHB was now working with over 600 volunteers. Roles were diverse and linked to supporting the UHB's Strategy, but one area hard to fill was getting patient feedback. Mrs Michelle Fowler, Volunteers Manager was thanked for all her work and it was noted that she would soon be joined by a Young Volunteers Manager funded by the Pears Foundation.

ASSURANCE was provided by the Annual Report.

The Quality, Safety and Experience Committee:

- **NOTED** the report for information.
- **AGREED** to thank Volunteers at the next Board meeting.
  Action – Ms Dawn Ward

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

The following items were **RECEIVED** and **NOTED** for information.

QSE 18/154 COMMITTEE DATES FOR 2019/20

Diary dates were noted.

QSE 18/155 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – MAY, JUNE AND JULY**
   It was agreed to ask the Planning Director for an environmental update in the area of bone marrow transplant.
   Action – Mrs Abigail Harris

2. **MENTAL HEALTH – JULY**
   In hindsight, the medical input required in the Llanfair Unit had been underestimated and mental health nurses did not have the same basic training that general nurses received. Physical difficulties had been encountered when trying to move patients who had arrested. Nurses had been trained in resuscitation and an agreement had been reached with the Ambulance Trust that 999 calls should be directed to the clinical desk for priority. In addition, the model of care provided by GPs needed review. However, no instances of harm had been recorded.

As the CHC had not been assured despite a more comprehensive service than previously provided at the Iorwerth Jones Unit, it was agreed that Mr Allen and Mrs Walker would discuss further outside the meeting.
Action – Mrs Ruth Walker and Mr Stephen Allen

3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - MAY**

4. **SPECIALIST SERVICES – APRIL, MAY, JUNE x 2 AND JULY**

5. **MEDICINE – MAY AND JUNE**

6. **SURGERY – MAY**

7. **CHILDREN AND WOMEN – MAY**

8. **DENTAL – JUNE**

QSE 18/156 AGENDA FOR THE PRIVATE QSE MEETING

The private agenda was published as part of the culture on openness.

QSE 18/157 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There following would be brought to the attention of the Board:

- Signpost all Board Members to the Annual Safeguarding Report contained in the meeting papers.
- Volunteers to be acknowledged and thanked at the Board meeting.

QSE 18/158 REVIEW OF THE MEETING

It was noted that much of the meeting had been operational so consideration would be given to more strategic assurance reports.

QSE 18/159 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 16th October 2018 (Annual Special Meeting).