CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 18 June 2019 COED Y BWL, WOODLAND HOUSE, HEATH, CARDIFF CF14 4TT

Present:

Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Michael Imperato	MI	Independent Member - Legal

In attendance:

Jessica Castle	JC	Director of Operations, Specialist Services Clinical Board
Steve Curry	SC	Chief Operating Officer (*for part of meeting*)
Peter Durning	PD	Interim Executive Medical Director
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn		Executive Director of Public Health
Christopher Lewis	CL	Deputy Director of Finance (attending *for Bob Chadwick, Executive Director of Finance*)
Navroz Masani	NM	Clinical Director, Specialist Services Clinical Board
Paul Rogers	PR	Directorate Manager for the Artificial Limb and Appliances Service (ALAS)
Ruth Walker	RW	Executive Nurse Director
Geoff Walsh	GW	Director of Capital, Estates and Facilities (*attending for Abigail Harris, Executive Director of Strategic Planning*)
Mike Bond	MB	Director of Operations – Surgery Clinical Board
Glynis Mulford	GM	Secretariat

Apologies:

Gary Baxter	GB	Independent Member - University
Robert Chadwick	RC	Executive Director of Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Dawn Ward	DW	Committee Vice Chair and Independent Member – Trade Union

QSE: 19/06/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the meeting and gave a special welcome to Dr Navroz Masani, Clinical Director of the Specialist Services Clinical Board; Jessica Castle Director of Operations, Specialist Services and Paul Rogers Directorate Manager for the Artificial Limb and Appliances Service (ALAS). The Committee Chair noted that the meeting was not quorate and confirmed that in view of this any decisions made by the Committee would need to be ratified by the Board, through her Committee Chairs	**ACTION**

	report, when it met in July 2019. The Committee Chair also advised those present that she would need to leave part way through the meeting to attend the launch of the Joint Learning Disabilities Commissioning Strategy and so the Independent Member – Legal would Chair the remainder of the meeting. The Executive Director for Therapies and Health Science advised that as the Executive Lead for learning disabilities she would also like to leave the meeting to attend the launch if it was permissible.	
19/06/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/06/003	**DECLARATIONS OF INTEREST** The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declaration of interest was received and noted: ▪ Michael Imperato, Independent Member (Legal) declared a conflict of interest in respect of the Infected Blood Inquiry. The declaration was formally noted, and it was agreed that Michael Imperato would leave the meeting when agenda item 1.12 was discussed.	
19/06/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 16 APRIL 2019** The Committee reviewed the Minutes of the meeting held on 16 April 2019. **The Committee Resolved - that:** a) the minutes of the meeting held on 16 April 2019 be approved as a true and accurate record.	
19/06/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted that reports on Ophthalmology services and Car parking were on the meeting agenda. The following verbal updates were received in relation to the remaining items: **QSE19/04/025 – Items to be brought to the attention of the Board:** It was confirmed that the Annual Quality Statement and the key findings arising from the Annual Health and Care Standards assessment had been brought to the Board's attention through the Committee Chair's report presented at the May Board meeting. **QSE 19/04/020 – Endoscopy Decontamination Patient Notification Exercise:** It was confirmed that a report would be scheduled for the September meeting of the Committee. **QSE 19/02/010 – Gosport Independent Panel Report:** The Executive Nurse Director confirmed that a report would be brought to the September meeting of the Committee. **QSE 19/02/008 – PCIC Clinical Board Assurance Report:** The Director	PD RW

	of Capital, Estates and Facilities confirmed that the Business Case for the development of the Ely Hub had been developed. It was also noted that an interim solution to relocate staff was being put in place. **QSE 18/135 - Ombudsman Annual Letter**: The Assistant Director of Patient Experience confirmed that the Ombudsman's Annual Letters for 2017/18 and 2018/19 had been received and would be put on the agenda for the Committee meeting scheduled for September. **QSE 18/155 – CD&T Minutes:** The Director of Capital, Estates and Facilities confirmed that refurbishment works had commenced and a business case for the replacement of the Bone Marrow Transplant Unit was being developed. The Committee Chair requested that an update be put on the agenda for the Committee meeting scheduled for September. **The Committee Resolved – that**: a) the action log and the verbal updates be NOTED.	AH GW
19/06/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** The Committee Chair confirmed that Chair's Action had not been taken since the Committee meeting held in April 2019. In line with requirements set out in the UHB's Standing Orders, the Chair confirmed that the Committee had met in private following the public meeting held on 16 April 2019. It was noted that at the private meeting safeguarding, the recent Healthcare Inspectorate Wales' (HIW's) letter regarding the findings of the unannounced inspection of the Assessment and Emergency Units on the University Hospital of Wales site, and the UHB's response were discussed. The Executive Nurse Director confirmed that the UHB had submitted all the information requested to HIW and this information had been accepted along with the Improvement Plan. It was noted that the report would be published on 28 June 2019.	
19/06/007	**PATIENT STORY** The Chair invited the Clinical Director and Director Operations of the Specialist Services Board and the Directorate Manager for ALAS to start their presentation. The Director of Operations introduced the patient story explaining that the Specialist Clinical Board would like to take the Committee through the story of conjoined twins who had moved to Cardiff from Senegal, and tell the story of how, through the work of ALAS, they were given greater mobility and their quality of life improved. The Directorate Manager of ALAS explained that: • the twins were born in Senegal and given their disability their father had sought to find a specialist hospital somewhere in the World that would be able to separate the twins.	

- a paediatric surgeon in Great Ormond Street agreed to examine the twins but it was found that they could not be separated due to their complexities and heart issues.
- due to the girls needing specialist medical care the twins father sought asylum in the UK, and in 2018 the family moved to Cardiff.
- once settled in Cardiff the twins were referred to the Posture Mobility Service. The complexity of the twins condition and needs were outlined and it was noted that they included complex posture issues; life limiting conditions; heart defects; a fused pelvis and a central arm that was in a difficult position from a posture perspective.
- the twins needed specialist seating to help with their posture and to aid respiration. A full assessment was undertaken by the Posture and Mobility Service and using specialist equipment a suitable postural seat was developed.
- the seat was a success but due to the twins being constantly photographed and filmed when they were taken out, the father requested that the seat be rotated to give the girls some privacy. After some technical difficulties a way of rotating the seat was found but it was clear that solution was not suitable for the longer term.
- to help address the social issues and manage the reaction that members of the public had to the girls the ALAS team contacted social services, Ty Hafen and the BCC. The BCC produced a fascinating article on the twins with the idea that if the public had more information about them they would be less curious and more tolerant.
- the twins' postural needs are reviewed regularly to take account of their growth and any changes to their needs.

The Executive Nurse Director, stated that the Patient Story demonstrated how the UHB was able to provide bespoke services and highlighted the extent of the skills of its staff. The role that ALAS had played in seeking ways in which to drive down the stigma of the twins' disability was acknowledged and the importance role that all UHB staff had in this respect was emphasised.

The Executive Director of Therapies and Health Science advised the Committee that she had recently had the privilege of visiting a specialist school in Cardiff, and she had been impressed at the amount of specialist equipment that had been made available to the young people through ALAS. It was noted that ALAS was providing bespoke child friendly services too many young people and helping them fit into normal family life.

The Clinical Director advised the Committee that many of the adaptations and equipment issued by ALAS were invented and developed on the ALAS unit based on the Treforest site. The unique, innovative and specialised work of the ALAS team was emphasised.

The Executive Director of Public Health asked whether any of the inventions were patented and it was confirmed that some were, but the

	legal loopholes often meant that it was a difficult process that often outweighed the benefits. The Executive Director of Therapies and Health Science confirmed that arrangements were in place to ensure the best use of Research and Development. The Committee Chair confirmed that as Cardiff County Council's asylum lead the patient story was close to her heart, and stated she had been overwhelmed by the energy that the ALAS team had put into meeting the needs of the twins and their family. The Committee Chair asked a number of questions related to the quality of the service: • what is the frequency of review for the twins: it was confirmed that reviews were annual but the family could request a review at any time. • how well were the links with social care working: it was noted that relationships worked well but that challenges did arise due to some gaps in service provision The Executive Nurse Director asked if formal pressure damage assessments were undertaken by the team. In response, the Directorate Manager confirmed that the primary concern when undertaking any seating assessment was the management of pressure. It was confirmed that regular pressure assessments were undertaken and information on the signs of pressure damage to look for given to all service users and their families. It was also noted that a pressure care pathway was in place, with plans to roll the pathway out across all ALAS services. The Executive Nurse Director advised that the pressure damage assessment tool was changing and confirmed that she would contact the directorate manager to talk about this. The Committee Chair advised the Directorate Manager that she was happy to provide the ALAS service with support in her role as Chair of the Quality, Safety and Experience Committee as well as her Cabinet role with the County Council. It was noted that with improvements to neonatal services the UHB needed to be mindful of the growing demand for the services of ALAS and other specialities. Committee Members agreed that the Patient Story was an excellent example of where UHB services had gone the extra mile. The Clinical Board Director confirmed that the Posture Mobility Service was unique as it was the only service in the UK to have a team that included clinicians, nurses, health scientists, a factory, specialist workshop and a research facility. **The Committee resolved that:** **a)** the Patient Story be NOTED.	RW
19/06/008	**SPECIALIST CLINICAL BOARD ASSURANCE REPORT** The Director of Operations for the Specialist Services Clinical Board introduced the Assurance Report, which provided details of the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the previous 12-months.	

It was confirmed that the top five risks on the Clinical Board's risk register as at March 2019, were:

- Insufficient Critical Care capacity to meet demand.
- Haematology - Lack of isolation cubicles and appropriate filtration on Ward B4H.
- Neurosciences – Sustainability of services at Rookwood Hospital due to infrastructure issues.
- Neurosciences – Continuity of neurovascular service.
- Cardiac Surgery waiting list - ability to meet 36-week RTT, ability to treat urgent patients.

The discussions that followed focused on the capacity of the Critical Care Service. It was noted that:

- in 2018/19 six additional critical care beds had been commissioned through winter plan monies and that this money was likely to be recurrent. It was confirmed that the funding of the additional beds had relieved some of the capacity pressures, but further work was ongoing through a capital group and operational planning group.
- there was a plan to move the post anaesthetic care unit and free up a further six spaces on the main floor of the critical care facilitates.
- the need for further work in relation to the critical care infrastructure was confirmed and the recently reported findings of a review undertaken by the Royal College of Anaesthetists were outlined; It was noted that the findings highlighted by this review included infrastructure, workforce and relationship issues.
- several of the findings highlighted by the review were not for the Critical Care Service to address alone as they spanned a number of Clinical Boards, hence a UHB approach was required. It was noted that one such issue was care of the deteriorating patient across the two main hospitals.
- developments, such as the Major Trauma Centre, would have a further impact on the areas of concern highlighted by the review. The Critical Care services ability to cope with the predicted flu epidemic was also highlighted.
- the review team from the Royal College of Anaesthetists had noted that the Critical Care risk had been on the Clinical Board's risk register at a rating of 25 for some time, and had reported that the service had become accustomed to practices that were not acceptable, for example not reporting all incidents on DATIX, and was too accepting of certain types of risk.
- next steps in relation to the Royal College review, were to be discussed by Management Executive. It was noted that the Clinical Board had prepared responses to the review findings that were helpful and that responses had also been received from the Consultant Body in Critical Care and the Clinical Director within

anaesthetics.

- the Royal College of Anaesthetists would be undertaking a further visit in six months' time to review the UHB's response to their recommendations and had intimated that a referral to HIW may be made if the response was not felt to be sufficiently robust.
- during the period between the Royal College of Anaesthetists being invited to undertake the review and the findings being reported there had already been significant improvements made by the Clinical Board.

The Committee Chair asked for confirmation of the steps that the Clinical Board had taken to address the findings in relation to the normalisation of risk and the risk score having been 25 for such a long period of time. In response, the Clinical Director confirmed that all steps to mitigate the risk had been taken, and advised that short, medium, and long-term plans were in place and had been shared with Welsh Government.

The Executive Nurse Director stressed the important of incidents being reported through the formal process, as otherwise the Board was not sighted of the risks being managed at an operational level.

The Committee Chair confirmed that it was important to ensure that the Royal College of Anaesthetists report and the related improvement plan was brought to the Committee for discussion. It was noted that the Chief Executive Officer had made it clear that he wanted a robust improvement plan in place as soon as possible as some of the relationship and multi- disciplinary team issues would need a robust OD approach.

The Chief Operating Officer advised the Committee that the main issue was critical care capacity but improvements had been made over the previous 12-months as a result of the Chief Executive's negotiations with Welsh Government. It was noted that the UHB was fundamentally constrained by its estate.

The Committee Chair highlighted that the Clinical Director had raised concern in relation to the critical care services ability to respond to a major incident or flu epidemic and asked for the Chief Operating Officer's views on this. The Chief Operating Officer advised that there were very few critical care units in the UK with as many beds as the UHB and confirmed that there would be a networked response to any critical incident, and advised that contingencies were in place to respond to an epidemic, of for example the flu.

The Clinical Director stated that he recognised that contingencies were in place but noted that the recommended that the optimum occupancy rate for critical care beds was 75%, with most UK NHS organisations running at 85%. However, the UHB was running at occupancy levels of between 95% and 110% occupancy.

The Executive Nurse Director confirmed that the discussion highlighted the importance of there being a clear understanding of what the issues were and having a robust plan in place to address them in the short, medium and longer term.

It was noted that due to timing issues only one of the high-level risks

highlighted by the Clinical Board had been fully discussed. It was confirmed that issues in relation to haematology and Rookwood Hospital had been discussed by the Committee previously.

The Executive Nurse Director highlighted that the report referenced never events, incidents and other issues of important issues that the Committee needed to be made aware of and thanked the Clinical Board for its openness and transparency.

The Director of Operations advised the Committee that it was important that Members were aware of the issues in relation to the waiting times for cardiac surgery. It was noted that:

- cardiac Surgery was one of the areas where there was difficulty ensuring the right level of capacity on week days in order to maintain the number of cardiac surgery operations needed to eliminate the 36 week wait, and to reduce the overall volume of patients on the waiting list. It was confirmed that some of the risk was being mitigated by weekend working and that plans were in place to manage those patients on the waiting list and identify any patients at risk.
- while urgent patients were being seen there remained a bulk of routine patients who were having to wait much longer than they should. It was noted that plans were in place to avoid the UHB slipping back to the position it was in previously.

The Executive Nurse Director enquired as to how confident the Clinical Board was that things would improve. In response, the Director of Operations confirmed that the message was positive but there was a concern in relation to how much could realistically be done over the next 6-months to stop the situation from deteriorating further.

The Chief Operating Officer confirmed that the cardiac surgery wait had been escalated in line with the UHB's formal performance escalation processes. It was noted that the Chief Executive Officer and the Chief Operating officer were fully sighted of the issues and were meeting with the Clinical Board on a regular basis to discuss and seek a way forward on this matter.

The Committee Chair asked whether the Cardiac Surgery risk score should be higher. The Chief Operating Officer confirmed that the risk score would be reviewed outside of the meeting. It was agreed that if progress was not evident by the end of the calendar a paper focusing on cardiac surgery waiting times should be brought back to the Committee for discussion. **SC**

The Committee resolved that:

a) the Specialist Clinical Board's Assurance report and the progress made to date be NOTED.

b) the content of the Assurance Report be APPROVED, subject to the Royal College of Anaesthetists Report on Critical Care being brought to the September 2019 meeting of the Committee together with the improvement plan developed in response to the recommendations made.

c) if progress in relation to Cardiac Surgery waiting times was not

	evident by the end of the calendar year a paper should be brought back to the Committee for consideration.	
	The Committee Chair confirmed that as the meeting was not quorate the approval of the Assurance Report would need to be ratified, through her Committee Chair's report, by the Board when it met in July.	**SE**
	[The representatives of the Specialist Services Clinical Board left the meeting]	
19/06/009	**QUALITY AND SAFETY IMPROVEMENT FRAMEWORK** The Assistant Director for Patient Safety introduced the report confirming that it provided a high-level overview of the progress made in relation to the implementation of the Quality, Safety and Improvement Framework 2017 - 2020. It was noted that the UHB's Annual Quality Statement, due to be published on 25 July 2019, provided a summary of the progress made in 2018-19.	
	As part of discussions: • The Assistant Director of Patient Safety and Quality confirmed that work to develop the next strategy for the period 2021 to 2024 had started and it would be brought to the Committee in April 2020 for approval.	CE
	• The Independent Member – Legal asked for some background information in relation to 'Cyber bullying in young people' that had been highlighted as an area of focus in 2019 to 2022. In response, it was confirmed that this had been an area of concern highlighted by the work of the Mental Health Clinical Board. The Assistant Director of Patient Safety and Quality advised that responsibility for the delivery of a number of the actions set out in the Framework sat with specialist leads and Clinical Board and not the Patient Safety Team, therefore she did not have all the details in relation to why cyber bullying was an area of focus.	
	• The Executive Director of Public Health noted the importance of any work in relation to cyber bullying being linked to the UHB's Suicide Plan and the emotional mental health work that the Children and Women's Clinical Board were leading on as part of the UHB's integrated health and social care work.	
	• The Independent Member – Legal confirmed that 'cyber bullying' was a major issue and had featured as an important factor in a number of recent inquests. The need for the UHB to be ahead of the curve in relation to this matter was noted.	
	• funding for a mental health consultant nurse post had recently been agreed and that the post would have a particular focus on suicide issues.	
	• conversations regarding the issues aligned to male suicides and suicides in young people were taking place in partner organisations.	
	The Executive Nurse Director advised that the Quality and Safety Improvement Framework report demonstrated that a lot of work was being in relation to the quality and safety agenda. The importance of ensuring that the work was closely aligned to the UHB's Strategy was	

	acknowledged. **The Committee resolved that**: a) progress with implementation of year two of the Quality, Safety and Improvement framework, the main high-level achievements for 2018/2019 and areas for focus for 2019-20 be NOTED.	
19/06/010	**PATIENT EXPERIENCE FRAMEWORK AND IMPROVEMENT INDICATORS** The Assistant Director of Patient Experience introduced the report, which provided a high-level overview of progress in relation to the implementation of the refreshed Patient Experience Framework 2017 - 2020. As part of discussions it was confirmed that: • steps were being taken to ensure that patient experience was central to the delivery of the UHB's Strategy. • a key priority for the Patient Experience Team was ensuring that there was a clear governance framework around volunteers and carers and ensuring alignment across all strands of the work that the Team was leading on. It was also noted that there needed to be a focus on capturing the experiences of those groups of patients and service users that were less vocal and seldom heard. • the Putting Things Right Annual Report would be considered at the meeting scheduled for September. It was also confirmed that the Carers Report would come to the Committee for noting. • the Public Services Ombudsman for Wales had recently been granted new powers and a report outlining these would be prepared for the September meeting of the Committee. • the work that the Patient Experience Team had undertaken with the Clinical Boards was important and key to getting the approach to care and treatment right. The importance of putting patient experience at the centre of the conversations being held in relation to the transformation agenda. • the Executive Nurse Director would be meeting with the Chief Executive Officer and the UHB Chair to discuss a refresh of the mechanisms for bringing the patient voice to meetings of the Board. The Executive Director for Therapies and Health Science drew the Committee's attention to the fact that patients were less happy with the care and treatment provided over the weekend. It was agreed that there was a need to investigate the reasons for this. The Committee Chair suggested that consideration be given to Patient Safety Walkarounds being scheduled for the weekend. In response, the Executive Nurse Director confirmed that the Patient Safety Walkaround process was being refreshed and would be brought to a Board Development Session for discussion. The Assistant Director of Patient Experience confirmed that steps were in place to investigate and better understand the reasons for patients being less happy over the weekend. **The Committee resolved that**:	**AH** **AH** **RW**

	a) progress with implementation of the Patient Experience Framework and Improvement Indicators, the main high-level achievements for 2018/2019 and areas for focus for 2019-20 be NOTED.	
19/06/011	**ESSURE (ISSUES WITH THE FAILIURE OF THE PROCESS)** The Executive Nurse Director introduced the report, which provided an overview of a patient notification exercise that was undertaken when it became apparent that the outcomes of some patients who had undergone the ESSURE procedure (hysteroscopic sterilisation), were unclear. It was confirmed that the paper was being brought to the Committee to provide assurance that the ESSURE issue had been identified, fully investigated and necessary action taken. The Committee was advised that: • it had been identified that not all women who had undergone the ESSURE procedure had been checked to ensure that they were sterile. This issue escalated when one of the patients became pregnant. • 45 women had undergone the procedure and the UHB had been unable to contact or had not received feedback from only three of the 45 women. The UHB had taken all possible steps to contact and engage with the three women. • going forward all incidents where 'patient notification/recall' work was required would be brought to the Committee for scrutiny. • the lead clinician and Clinical Board had highlighted the issues with the ESSURE procedure, demonstrating openness and transparency It was noted that the UHB no longer performed the procedure and confirmed that all Clinical Board's had been reminded of the process to be followed when they wished to introduce new procedures. The Executive Director of Public Health advised the Committee that there were other patient notification exercises in the public health arena that would be appropriate to bring to the Committee for information. **The Committee resolved that**: a) the contents of the report and the outcome of the patient notification exercise be NOTED. *[Michael Imperato, Independent Member- Legal left the meeting prior to discussions in relation to the next item starting*] *It was noted that the Committee was the only Independent Member present to hear the next item.*	FK
19/06/012	**INFECTED BLODD INQUIRY UPDATE** The Executive Nurse Director confirmed that the paper provided the Committee with an update on the activity undertaken by the UHB to support and engage with the Infected Blood Inquiry.	

It was confirmed that a cohort of 150 patients predominately individuals under the care of the Haemophilia Centre had made enquiries and these individuals were being supported to review their medical records.

The Executive Nurse Director confirmed that:

- in general the UHB had been able to provide individuals with all of their records.
- as at May 2019, 81 individuals had approached the health board to request their records and as a result 84 Subject Access Requests (SAR) had been facilitated. It was noted that some individuals had up to 17 volumes of notes and so ensuring that they got access to the information that they need was a big exercise.
- in three cases it had been evident that medical records had been destroyed in line with the requirements of the Data Protection Act and in a further two cases it had not been possible to provide complete sets of medical records referencing all episodes of care; although records of all blood products administered to patients had been available and provided.
- the UHB had been in contact with the patients and their families and had provided help and support to them. It was confirmed that the UHB may still be able to provide some of the information that the patients and families required because of the testing arrangements. It was confirmed that the timing of testing was a very strong theme emerging form the inquiry.
- four days of hearings would be held in Cardiff during July 2019. It was confirmed that the majority of the infected or affected Welsh individuals called to give oral evidence would do so during this week. The Executive Nurse Director confirmed that she and the UHB Chair hoped to attend the hearings.
- the UHB had applied for Core Participant Status but the Solicitor to the Inquiry had requested further information to support the application.

The Executive Nurse Director advised that it was important that the Committee was made aware of the volume of work involved in relation to the Inquiry and the fact that there could be some reputational issues arising from the hearings because of the connection with the clinician who had been pivotal to this work.

The Committee Chair asked the Executive Nurse Director to ensure that staff involved in the inquiry work were properly support.

The Executive Nurse Director advised the Committee that the UHB was not disagreeing or challenging the views and opinions of the patients and families involved. The Committee Chair confirmed that she was content with this stance. (*to be ratified by the Board*)

SE

The Committee resolved that:

a) the approach being taken to respond to the Infected Blood Inquiry be NOTED.

[Michael Imperato, Independent Member- Legal re-joined the meeting]

The Committee Chair agreed to move the agenda around to

accommodate the need for certain individuals in attendance to leave to attend other meetings.

19/06/13 **OPHTHALMOLOGY REPORT**

The Chief Operating Officer introduced the item and welcomed Mike Bond, Director of Operations for the Surgical Clinical Board who led on the presentation. Committee Members were:

- reminded that around a year ago some work was undertaken to develop a plan for Ophthalmology as the volume of individuals requiring access to the service was a problem across Wales.
- advised that there was a high level of risk associated with long waits as an individual's eyesight could deteriorate quickly.
- informed that when steps were taken previously to develop an Ophthalmology Plan it had been difficult given the various groups and stakeholders with an interest. It was confirmed that a prioritised plan was developed based on discussions with a range of stakeholders and interested parties.
- provided an update on progress against the priorities set out in the Ophthalmology Plan (the Plan). It was confirmed that when developing the Plan a number of key factors had to be considered, such as:
  - the imbalance in capacity and demand.
  - service complexities.
  - sub speciality work.
  - high volume of work.
- informed that attempts to address the Ophthalmology waiting times had been made over several years with limited success.
- provided with an outline the steps taken by the UHB over the previous year to reduce the Ophthalmology wait, which included an overview of the areas that needed to be taken into consideration and the level of risk aligned to these, namely:
  - capacity and demand.
  - clinical leadership
  - recruitment and workforce
  - RTT
  - patient safety
- described the approach taken to develop and embed a community model and highlighted the importance of a clinically led approach was emphasised.
- confirmed that a Clinical Director was in post and was starting to provide sound clinical leadership, already resulting in good progress in relation to glaucoma.

In response to a question in relation to the approach taken by the

service to ensure there were no breaches of waiting time targets, it was confirmed that there had been a focus on managing capacity, the management of follow-up, additional resources, critical pathways and engagement. Communication with patients.

The Chief Operating Officer confirmed that while progress had been made there was more to do, and highlighted that to ensure further progress there needed to be a focus on:

- identifying the best way to ensure people were seen at the right time and in time
- ensuring clinicians decide the priority cases and not systems
- understanding and appropriately managing risks.

The need to move to an outcomes base approach to delivery was discussed.

The Executive Director for Therapies and Health Science confirmed that:

- she chaired a national group for eye care. It was also noted that each health board had been required to identify an executive lead for eye care in order that a local eye care group could be established.
- regional working was recognised as being needed and steps were being taken to regionalise ophthalmology. It was noted that opportunities for a regional approach to the treatment to cataracts was also being explored.
- the first pathway to go live with a regional approach was the glaucoma pathway.
- the technology to enable regional working would soon be in place but some operational preparations were needed to ensure a state of readiness.
- national data showed that the UHB was still the lowest discharger to primary care for cataracts. It was noted that there was a need to ensure that data reflected the local and tertiary situation separately.
- primary care optometrists were willing to pick up cataract follow-ups.

The Committee Chair confirmed that there was clear evidence of improvement and highlighted the importance of moving services out to the community as this was aligned to the transformation agenda.

The Executive Nurse Director asked that a copy of the presentation be sent to the UHB Chair. It was also agreed that a short update report, that included benchmarking data, whould be brought to the meeting of the Committee scheduled for December 2019.

The Committee resolved that:

a) the Ophthalmology presentation be NOTED. **SC**

b) a short update report, that included benchmarking data, should be brought to the meeting of the Committee scheduled for December 2019. **RW**

	The Executive Nurse Director confirmed that the work on the incident related to outsourcing was progressing well and a report would be taken to the Board in due course.	
9/06/014	**CAR PARKING UPDATE REPORT** The Director of Capital Estates and Facilities introduced the paper and outlined the improvements made to the park and ride facilities as a result of the Health Charity Board of Trustees agreeing to fund the first year costs of a number of initiatives. It was confirmed that: • the UHW the park and ride service operated until 11pm, with the bus running every ten minutes rather than every 20. • a new park and ride service would be introduced for UHL, in July subject to final contractual arrangements. • steps were being taken to introduce a shuttle minibus service that would run between UHW and UHL between 7am and 7pm. • parking at UHW continued to be an issue, and the amount of time for free parking was to be reduced to two hours due to the system being abused by staff. • a high volume of complaints regarding the issuing of car parking charge notices had been received. It was noted that Parking Eye had cancelled approximately 40% of the parking charge notices issued automatically as well as 20% of those issued by the onsite car parking attendants. The Executive Nurse Director confirmed that the information provided in the report demonstrated that issues and concerns raised by patients and staff had been considered and acted upon. The Committee Chair advised that there was further need to publicise the Park and Ride service and the steps taken to address issues raised by patients and staff. It was confirmed that avenues for publicising the service would be explored. The Executive Director of Public Health highlighted the importance of sustainable travel and reminded the Committee that the UHB had signed up to the Healthy Travel Charter. **The Committee resolved that:** a) the Car Parking update report be noted.	**GW**
19/06/015	**HTA CAPA PLAN CLOSURE LETTER** The Executive Director of Therapies and Health Science provided an overview of the report outlining the action plan that was in place, the monitoring mechanisms and the proposed Quality Led Governance approach. It was confirmed that: • since the paper had been drafted that the HTA had agreed to Tom Hockey taking on the role of Designated Individual (DI). • the remaining 'in progress' actions were in final stages of completion and included the transition to the new DI, final approval of the Service Level Agreement with the WIFM, and	

	completion of the database development for tissue management. • the CD&T Clinical Board was fully committed to on-going sustainability of the remedial actions delivered to ensure continued regulatory compliance in this service. • the Clinical Board have developed a Regulatory Compliance Dashboard, which is used to drive improvement through the Clinical Board Regulatory Compliance Group. • as the Licence Holder she would ensure close oversight of the situation. **The Committee Resolved that**: a) the closure of the HTA inspection findings, the action plans, the intended monitoring mechanism through CD&T governance structures and the proposed Quality Led Governance approach be NOTED. *The Committee Chair asked Michaels Imperato to Chair the meeting from this point as she had to leave for another meeting.*	
19/06/016	**POLICIES AND PROCEDURES FOR APPROVAL** The Director of Therapies and Health Science provided an overview of the policies and procedures that were being brought to the Committee for approval, these were the: • Ionising Radiation Risk Management Policy • Exposure of Patients to Ionising Radiation Procedure • Exposure of Staff and Members of the Public to Ionising Radiation Procedure • Radioactive Substances Risk Management Policy • Radioactive Substances Risk Management Procedure It was noted that the policies and procedures had been subject to review by the relevant professional groups **The Committee Resolved that:** a) due to the meeting not being quorate the approval of the policies and procedures would be referred to the Board for ratification in July.	**SE**
19/06/017	**STROKE REHABILITATION MODEL AND WORKFORCE** The Director of Therapies and Health Science introduced the report. It was confirmed that: • the Medicine Clinical Board was conducting a reconfiguration of its stroke services towards a Hyperacute Stroke Unit on the UHW site and acute rehabilitation at SRC, UHL. It was noted that this work involved redesigning the inpatient bed structure, enhancing community support to stroke patients and remodelling the multidisciplinary workforce with prudent use of resources across the stroke pathway.	

- the reconfiguration of services would result in the SRC caring for acute patients and not just those considered to be sub-acute and as a result the staffing model would need to be re-evaluated..
- immediate actions for SRC to implement included:
  - promotion of the rehabilitation ethos / last 1000 days / "get up get dressed get moving"
  - campaigns, ensuring that rehabilitation is "everyone's business".
  - Improved patient and carer education and communication; managing expectations.
  - improved goal setting with patients and their families.
  - reduction in the number of meetings which do not add value to individuals' rehabilitation experience.
- The longer term plan would need support from Medicine/CD&T Clinical Boards and Management Executive as it would include:
  - defining an operational therapy leadership role to ensure the delivery of a rehabilitation model.
  - development of nursing and therapy led beds
  - reconfiguration of stroke services.
  - reintroduction of the rehabilitation assistant role to work alongside both the nursing and therapy teams

It was noted that the stroke work had been started in response to concerns raised in relation to the quality of service**.** The Independent Member - Legal asked whether there were clear deadlines for the commencement and completion of the work outlined in the report.

The Executive Director of Therapies and Health Science confirmed that the Stroke Strategic Group was overseeing the work and a project plan with milestones and deadlines was in place. It was agreed that it would be helpful if an update could be brought back to the September meeting of the Committee to confirm the deadlines and the timeframes for delivery of the key pieces of work.

It was confirmed that the Model and Workforce Plan would need to be agreed by management Executive before they were brought back to the Committee.

The Independent Member – Legal asked whether more detailed priorities themes and priorities had been identified and developed as the ones contained in the paper were very high level and obvious. In response, the Executive Director of Therapies and Health Science confirmed that she would ask the project team to provide further information.

It was confirmed that the Hyperacute Stroke Unit was not resource neutral and so a decision by Management Executive would be needed. The Deputy Director of Finance advised that until the financial aspects of the development were confirmed it would be difficult to confirm timescales.

	The Executive Nurse Director confirmed that there had been a reduction in incidents and complaints related to the SRC and this was positive. **The Committee Resolved that:** a) the recommendations set out in the report be NOTED. b) a further update setting out deadlines, timeframes and further detail in relation to priorities be scheduled for the September meeting of the Committee. *[there was a five minute comfort break at this point in the meeting. The Executive Director of Therapies and Health Science left the meeting]*	FJ
19/06/018	**COMMITTEE EFFECTIVENESS REVIEW FEEDBACK** The Director of Corporate Governance confirmed that all Committees of the Board had been supported to undertake an effectiveness review, and provided an overview of the process and the action plan that had been developed in response to the findings of the self-assessment It was noted that the findings arising from the self-assessment process were fairly consistent and these were outlined. The Director of Corporate Governance confirmed that a common theme arising from the self-assessment process was the need to improve the committee administrative processes. In response to a question raised by the Executive Nurse Director, it was confirmed that there was no narrative to support the responses to the self-assessment. The Director of Corporate Governance confirmed that she would give further consideration to the suggestion that each Committee had an annual workshop to discuss its workplan and the operational issues related to it. The Executive Nurse Director advised that it was important that the Chair, Executive lead and Director of Corporate Governance discussed and agreed the work plan as it was important to align the work plan with reporting arrangements required by, for example Welsh Government. **The Committee resolved that**: a) the results of the Committee Effectiveness Review for 2019 be NOTED. b) the action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review be APPROVED (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate).*	
19/06/19	**HEALTH AND CARE STANDARDS SELF-ASSESSMENT** The Assistant Director of Patient Safety and Quality introduced the report and confirmed that as lot of information was contained in the paper, and that a high level of assurance was provided. It was confirmed that as specialist groups were owning the standards and embedding them, Clinical Boards had been asked to undertake a self-assessment against	

	only seven of the Health and Care Standards. Assistant Director of Patient Safety and Quality It was noted that each self-assessment was multi-factorial and considered a number of components relating to the individual standard. To reduce variation between Clinical Boards a scoring matrix had been developed for each standard with definitions aligned to four scores: • Getting Started • Progressing Towards the Standard • Meeting the Standard • Leading the Way It was confirmed that: • as the process was now working smoothly a self-assessment would be undertaken at the start of the year and an improvement plan developed, with an update brought to the Committee in December. This revised approach would replace the routine reporting to the Committee. • the work in relation to carers needed to be fully reflected in the Health and Care Standards self-assessments. • the UHB's Health and Care Standards process had been subject to review by Internal Audit and a rating of 'Reasonable' assurance achieved. **The Committee Resolved that:** a) The progress made against each of the Health and Care Standards be NOTED. b) the Corporate Priorities for 2019/20 be APPROVED. (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate*).	
19/06/020	**CWM TAF UHB MATERNITY – CARDIFF AND VALE LESSONS LEARNT** The Executive Nurse Director confirmed that following the presentation delivered to the Board in May it had been agreed that the detail of the self-assessment would be brought to the Committee for further consideration. The Executive Nurse Director advised that there continued to be a lack of clarity from Cwmtaf UHB in relation to the number of births that were expected to come to Cardiff. It was noted that the current figure was circa. 200 and that further conversations with Cwmtaf were being progressed. The importance of the service having a full understanding of the demands on it and the impact on planning was emphasised. It was confirmed that: • that the UHB's concerns in relation to the lack of clarity had been escalated to the South East Wales Regional Planning Group, Chaired by the Director General of NHS Wales.	

	• weekly 'exec to exec' meetings were taking place to discuss flow, patient safety and quality. • steps to secure additional consultant cover were progressing well. Two issues related to consultant workforce t were noted as being red in the self-assessment report, which needed to be urgently addressed. The Chief Operating Officer provided a summary of the progress made in relation to recruitment and confirmed that the Clinical Board should be able to progress at pace. • It was important that the UHB clearly articulated as what point it would be unable to safely mange the flow of patients from Cwmtaf was noted. The Independent Member – Legal confirmed that the UHB and not just Cwmtaf was subject to public scrutiny in relation to maternity services and therefore the UHB needed to be seen to do all that it could to ensure safe services. **The Committee Resolved that:** a) the current position of the UHB against the recommendations in the report be NOTED b) an improvement plan and progress update should be provided at the September 2019 Committee meeting with specific emphasis on the areas of non and partial compliance as well as an overview of the impact, in terms of patient flow to Cardiff and the Vale UHB and how this is being mitigated.	RW
19/06/021	**POINT OF CARE TESTING (POCT) ALERT** The Interim Executive Medical Director confirmed that: • WPOCT database continued to reveal several issues (mismatches) which prevent the flow of data into both WLIMS and WCP. It was confirmed that there had been a significant improvement in user compliance, with a reduction in incorrect use or manual entry of patient demographics. • he was confident that there were no patient safety issues but there were issues in relation to traceability of who did the POCT, when and where and these issues were in the main due to poor IT connectivity. • POCT was a process that cut across Clinical Boards and therefore the group overseeing was made up of representatives from across the UHB. The Interim Executive Medical Director confirmed that given this there was a need to make POCT a standing item on Clinical Boards Quality and Safety meetings. **The Committee Resolved that:** a) POCT should be part of the Quality and Safety review for each clinical board. b) POCT data should be clearly visible on a Business Intelligence dashboard to each clinical board and for the UHB.	

	c) The POCT group establish a task and finish group, which reports into the POCT group (which meets quarterly), to establish solutions for the IT/governance issues d) No new POCT devices would be introduced into the UHB until these problems had been solved e) An update be brought back to the December meeting of the Committee. (*it was confirmed that these resolutions would need to be ratified by the Board due to the meeting not being quorate*).	SE
19/06/22	**CLINICAL AUDIT PLAN** The Interim Executive Medical Director introduced the UHB's Clinical Audit Plan for 2019-20. It was noted: • that the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) was developed annually by Welsh Government and confirmed the list of National Audits and Outcome Reviews which all health boards and trusts were expected to participate in. • the UHB would take part in 36 national audits. • in February 2018, the Committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach, • Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. • a number of national audits were coordinated by the Patient Safety Team, but the team had no capacity to take on further work. • a number of diabetes audits had not been included in the plan; the Executive Director of Public Health confirmed that she would follow this up outside of the meeting **The Committee Resolved that:** a) the clinical audit plan for 2019-20 be APPROVED. (*it was confirmed that this would need to be ratified by the Board due to the meeting not being quorate).*	
19/06/023	**ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE** The following minutes from Clinical Board Quality Safety and Experience Sub Committees were noted: • Clinical Diagnostics and Therapeutics – March and April 2019 • Mental Health – May 2019	

	• Primary, Community and Intermediate Care – May 2019 • Specialist Services – March and April 2019 • Medicine – March 2019 • Surgery – March 2019 • Children and Women – March 2019	
19/06/024	**ANY OTHER URGENT BUSINESS** No items of urgent business were raised.	
19/06/025	**DATE OF THE NEXT MEETING OF THE QUALITY AND PATIENT SAFETY COMMITTEE:** It was confirmed that the next meeting of the Committee was scheduled to place on17 September 2019 at 9am, Woodlands House, Heath, Cardiff	