CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 17 SEPTEMBER 2019 COED Y BWL, WOODLAND HOUSE, HEATH, CARDIFF CF14 4TT

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:		
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Suzanne Hardacre	SH	Head of Midwifery and Gynaecology Nursing
Cath Heath	CH	Director of Nursing, Children and Women
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
Meriel Jennings	MJ	Clinical Board Director, Children and Women
Christopher Lewis	CL	Deputy Director of Finance
Paul Rogers	PR	Directorate Manager for the Artificial Limb and Appliances Service (ALAS)
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Glynis Mulford	GM	Secretariat
Observers:		
Mandy Rayani		Hywel Dda University Health Board
Joanne Wilson		Hywel Dda University Health Board
Apologies:		
Robert Chadwick	RC	Executive Director of Finance
Steve Allen	SA	Community Health Council

QSE 19/09/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting including colleagues from the Children and Women's Clinical Board. A special welcome was also extended to Joanne Wilson, Director of Corporate Governance and Mandy Rayani, Executive Nurse Director from Hywel Dda University Health Board who observed the meeting.	**ACTION**
QSE 19/09/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
QSE 19/09/003	**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: ▪ Fiona Jenkins, Executive Director of Therapies and Health Science declared a conflict of interest in respect of item 2.1 Diabetic Retinopathy as she Chaired the National Eye Health Delivery Group. The declaration was formally noted.	
QSE 19/09/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 18 JUNE 2019** The Committee reviewed the Minutes of the meeting held on 18 June 2019. **The Committee Resolved - that:** a) the minutes of the meeting held on 18 June 2019 be approved as a true and accurate record.	
QSE 19/09/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted the following updates: **QSE 19/06/007 – Patient Story – ALAS:** It was confirmed that the new pressure damage assessment tool had been implemented and was well received. Linda Jenkins was leading on the documentation and would be meeting with team for training on the use of new tool. **COMPLETE.** **QSE 19/06/014 – Car Parking Update Report:** The Park and Ride introduced on the UHL site over the summer months had been successful. **QSE 19/06/17 - Stroke Rehabilitation Model and Workforce:** The paper on the agenda demonstrated the progress which had been made to date. Members were informed that HIW had arrived on the SRC Unit on an unannounced visit (17.09.19) and would be reviewing the service over two days. **QSE 18/155 - Bone Marrow Transplant Unit:** The work to refurbish the unit was in progress and near completion. This would be clarified by the Executive Director of Planning at the December meeting. **The Committee Resolved – that**: a) the action log and the verbal updates be noted.	AH
QSE 19/09/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** The Committee Chair confirmed that there had not been any Chair's Action taken since the Committee meeting held in June 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 18 June 2019 where the Safeguarding Report was discussed.	

QSE 19/09/007	**PATIENT STORY – MY JOURNEY – COMPLEX MATERNITY CARE AND THE MULTI PROFESSIONAL TEAM WHO CARED FOR ME** The Chair invited the Clinical Board Director, Nurse Director and the Head of Midwifery for Children and Women's Services Board to present their story. The Story of Bethan and Mark's journey was read out to the Committee. The story demonstrated how up to 40 members of the Multi-Disciplinary Team (MDT) enabled a timely and effective approach into the care of how a low risk patient could suddenly become very ill. The following was highlighted with Bethan's treatment: Bethan was a low risk midwife led pregnancy until 32 weeks gestation when she suddenly became very unwell. After being reviewed by team she was a diagnosed with appendicitis. She had an MRI scan and consequently was diagnosed with a ruptured left kidney. The decision was made to deliver the baby by emergency caesarean. An epidural spinal combination was given to Bethan to remain awake and experience the birth of their first baby. She then underwent a procedure to place stents in both kidneys. The diagnosis was renal obstruction and hydronephrosis secondary to rabbit uterus which was extremely rare. Bethan received seven days of intravenous antibiotics and was cared for by the multidisciplinary team who were able to provide continuous care ensuring she had a positive experience after a worrying event. Arrangements were being made to meet for a debrief with the multi professional team where discussions around the incident and planning for the next pregnancy would take place. The key points in learning for the team were that women who were low risk may become very ill quite quickly. Skilled multi professional teams working and training together provided safe, effective and timely care even in most high risk and complicated circumstances. It showed that continuity of care by the right people in the right place could be achieved. The team also ensured that the couple were placed at the centre of care during their journey. A thank you and complimentary letter was received from Mark and Bethan which was read out citing the genuine care they received and thanking all individuals involved. The Chair stated the patient story was very moving and drew attention to the MDT's exceptional communication where it worked well. The Head of Midwifery expressed the importance of teams and how those involved had touched the family and the continuity of care and compassion was clearly expressed in the letter. On behalf of the Committee the Chair asked to send thanks and congratulate the team for their work. **The Committee resolved that:** **a)** The Patient Story be noted.

QSE 19/09/008	**CHILDREN AND WOMEN'S CLINICAL BOARD ASSURANCE REPORT** The Director of Nursing for Children and Women's Service Clinical Board provided an overview of the Assurance Report, which detailed the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the past 12 months. The following comments were made: Over the past year specialist CAMHS and cancer services had transitioned to the Children and Women Clinical Board. A summary of the aims of the quality, safety and patient experience was provided. **Staying Healthy:** The Safer Pregnancy Campaign was considered to be well embedded in the Clinical Board and promoted a healthy lifestyle for pregnant women where positive outcomes were seen. Detailed developments for 2019 were pointed out, this included the ChatHealth app for young people and children which would be developed further. Highlighted was concern over compliance rates of the 8, 12 and 16 week contacts required by the Healthy Child Wales Programme and in spring last year this was below the Wales average. A deep dive was undertaken and measures had been put in place to address the issue and the Committee could be reassured that compliance had improved quarterly since capturing the data. **Safe care:** There had been a considerable reduction of still birth rates since 2016. **Infection prevention and control:** Improvements had been made regarding health care acquired infections in comparison to last year and there had been no incidents of MRSA for almost two years. There were robust investigations of all incidents and these would be presented to the QSE Sub Committee. There had been further developments in paediatric surgery where the number of consultant paediatric surgeon posts had increased to seven. The services had been streamlined into specialties and the trainee rota had been fully recruited to. **Dignified care:** The launch of the Young Person Charter was at every bed space and in all outpatient clinics. There was further progress in delivering awareness sessions in conjunction with representatives from Unicef. Developments were underway for children admitted with mental health. **Individual care:** A significant amount of compliments continued to be received and management of concerns remained a key priority of the Clinical Board. Virtual reality was currently being trialled to support women's experience when given birth. As part of discussions the following was asked:	

	Regarding paediatric surgery work undertaken over the past two years what was the greatest learning in regard to the all incidents? The Clinical Board Director responded that the key was to understand the issues and treat people with respect, to work in 'real time' and not to postpone any actions but to listen and deal with concerns as quickly as possible. Also to recognise that there were complexities which may take time to work through. In regards to governance arrangements being changed it was stated that people had been reminded of their responsibility to report, to scrutinise and to be open and transparent. Training sessions had been put in place for all members of staff. Robust systems were in place to feed into QSE Sub Committee and issues had been escalated where appropriate. In response to the work undertaken by staff raising concerns, it was stated a pulse survey had been initiated and focus groups had been set up with staff side representatives and human resource colleagues. Attendance was increasing and night time visits had been undertaken. All of the information would be collated and an improvement plan developed. Work with staff continued as there was a need for solutions to come from staff themselves. A Neonatal Board would be set up and five themes had been identified. In addition, a Task and Finish Group would also be set up. It was highlighted that all staff members in the new unit were positive. Independent Member – Legal asked whether we were on track complying with the 8, 12 and 16 week contact for young people and children. It was stated that from a recent review the team considered they were back on track. The department did not have administration staff to input information and this information was not on the database. The review of the skill mix and the profile of some of the work with the health visiting team was currently underway. It was confirmed that the Young Person's Charter was enshrined fully. This would start with the C&W Clinical Board and subsequently be rolled out to embed throughout the Health Board. Work was being undertaken on this in the Emergency Unit. An update was requested for a future meeting detailing the steps taken.	C&WCB
	In regard to the repatriation of the CAMHS service, it was stated there was a plan in place and this would be presented at the next Board meeting. The specialist CAMHS external report was being reviewed which contained a good summary with actions from the Management Team. The CAMHS plan was very clear and by end of the month all long waiters would have been addressed with a new system in place. It was envisaged for additional staff to be in post by November. Independent Member – Trade Union asked whether there were any comparisons to be made over the past two years regarding incident reporting from staff? The Committee was assured there was a healthy reporting culture with an increase in the number of incidents being reported and a trigger list had also been developed. Weekly meetings were undertaken regarding Datix incidents to see whether further	SC

investigation was required and if necessary incidents were escalated.

In summary the Chair commented this was a comprehensive report and addressed taking responsibilities seriously it also highlighted that the culture of quality improvement had been embedded in the Clinical Board.

The Committee resolved that:

- The progress made by the Clinical Board to date be noted.
- The content of this report and the assurance given by the Specialist Services Clinical Board be approved.

QSE 19/09/009

YOUTH THEMATIC REVIEW

The Children and Women's Clinical Board Director presented the above all Wales Thematic Review stating not all of the actions were pertinent to Cardiff and Vale Health Board. It was recognised that children with mental health needs admitted to Noahs Ark Children's Hospital and cared for within the wards would be re-provided with a safe place to stay. The following comments were made:

In regards to the CAMH service the Medical Director asked what their three big concerns were from the external review? In response, it was stated the main concern was the structure and relationships across the teams and in future it would be important to work through and recognise the need for mutual respect. There were gaps around staffing and the service had evolved in ways of working that were considered to be ineffective and there would need to be assurance that the ways of working were fit for purpose. To review the skill mix and redress the culture would be the biggest challenge. This would need to be done without taking away individual confidence and self-assurance. There was a need to ensure staff were up to standard across specialist CAMHS and that they understood the framework. In addition it was essential to work on the single point of access. On a positive note they had successfully recruited into the Governance and Senior Nurse posts and had filled a number of outstanding vacancies.

The Committee resolved that:

a) The position outlined within the report in Appendix 1 be noted and the concerns raised be noted.

QSE 19/09/010

CWM TAF UHB MATERNITY – CARDIFF AND VALE LESSONS LEARNT

The Director of Nursing for Children and Women's Clinical Board stated the report and assurance framework had been reviewed and changes had been made since that time. The rag rated chart demonstrated that there was one red area left with the actions in place. The following comments were made:

Four consultants had been appointed in regard to the on-call service. Appropriate challenges from the midwifery team regarding a consultant presence on the labour wards had been received. Time had been spent obtaining agreement to change the job plan of consultants to include provision of evening cover . They were also contracted to be present on

weekends. The Clinical Board had been made aware of the lack of regular ward rounds on the ante natal unit and this would be audited to see that these ward rounds were taking place in a routine manner.

In terms of the ambers turning to green, the Executive Nurse Director confirmed that HIW would undertake an independent review shortly which would address the issues. HIW were aware of the local pressures to secure expected shifts within the services. Conversations were ongoing on a regional planning basis.

Independent Member – University, in reference to lean midwifery management and leadership, asked whether this was a quantitative issue i.e. not enough midwives in senior positions or a qualitative issue about how people approached leadership. In response it was stated that it was a combination of both and for a service of this size it would be expected for someone senior to be in a clinical governance role in order to have oversight of the assurances, in particular with changes in flow that would shortly be undertaken. There were two consultant midwives in place and from a strategic point of view strengthening the governance umbrella would be welcomed. An appointment to the deputy had been filled and conversations were underway with the Clinical Board about 'backfill ' to provide more resilience in the team.

In response to seeing a number of women coming from Cwm Taf to the UHB it was stated that the drift started in October 2018. When the Royal College of Gynaecologists published their report, requests for transfers increased significantly and triggered pressure on the Cardiff and Vale service in particular the difficulties with women unable to be seen in a timely manner. There had been discussions with Cwm Taf colleagues and this had settled down. The challenge remained as to what would happen come October 2019.

There was wider discussion on the robustness of the maternity services. The challenge for the service was around indecision, the lack of communication and the issue around the single point of access. The paediatric and maternity picture was similar and the lack of regional planning to some of the issues was the greatest challenge. The Health Board had been proactive around the over recruitment of midwives for future flow but the presumption of flow from other Health Boards had not been clarified. There was a structure in place but this was not based on the findings and the matter had been escalated from the CEO to the Director General of the NHS.

The Committee resolved that:

a) The current position of the UHB against the recommendations in the report be considered.
b) Progress had been made on the areas of non and partial compliance and the impact, in terms of patient flow to Cardiff and the Vale UHB and how this was being mitigated was agreed.

QSE 19/09/011

GOSPORT REVIEW

The Assistant Director of Quality and Safety introduced the report, and

stated there were three areas to provide assurance on, relating to anticipatory prescribing and what we had in place across the organisation, what we were doing in terms of mortality rates and trends in death certification. A high level of assurance could not be provided as there was still work to be undertaken on all three areas. The following comments were made:

Anticipatory Prescribing: An All Wales Framework was in place with an end of life care pathway. There was a national audit report on anticipatory prescribing practices and this confirmed the need to take forward an e-medicines code in anticipatory prescribing. In addition, there was a need to strengthen Cardiff and Vale local audit arrangements, provide more robust audits and look at how we monitor our commissioning services.

Mortality rates: It was recognised there was more to do in routine monitoring and reporting of mortality rates. Although regular reports were brought to the QSE Committee, early flags needed to be placed on the system.

Death certification: This would be addressed with the implementation of the Medical Examiner (ME) system. This had been agreed with the information team and revised with EMAT. Coding software would be introduced in death certification to analyse trends and themes.

The Medical Director provided an update on the Medical Examiner role and advised there would be an obligation to report all deaths within our Hospitals by April 2020 and all deaths within our Health Board by April 2021. There would be an office on both sites with an on-call service at weekends. The stage 1, 2 and 3 reviews and requirements were explained. The three outputs would be:

1. Back to the medical examiner;
2. Back to the service providing the care for the individual and
3. To the central governance unit to ensure thematic learning would be driven from this. If there was any high level of concern this would be put into the SI process.

The Medical Examiner Officer role had been appointed to; the position of the Medical Examiner post had not been filled as yet but a number of people had been trained on line.

The Executive Nurse Director stated the findings were more complex and from the Gosport Inquiry not all of the issues were known. It would therefore be helpful to understand the timeframes as the recommendations were being taken forward. It was considered helpful to provide an update at the next Committee meeting. CE

The Committee resolved that:

a) The contents of the report were considered and
b) Further action was required and had been identified for improvement.
c) Outside of the national audit to undertake a local audit of end of life cases analysing opiate use and whether it conformed to

national guidance.

QSE 19/09/012

OMBUDSMAN ANNUAL LETTER AND REPORT

The Assistant Director of Patient Experience confirmed the report was positive in relation to the number of complaints received from the Health Board. The number of investigations had reduced this year while more cases were upheld in whole or in part but fewer cases had been investigated. There were 10 public interest reports across Wales last year. Two of those reports were issued against our Health Board which had been reported to the Committee. One had been closed and awaited a closure letter on the second case. Clinical information provided from experts for the Ombudsman had been successfully challenged by the Health Board and had not been upheld.

The team was commended for the management of complaints through the system.

The Committee resolved that:

a) the findings of the Ombudsman's Annual Letter 2018/2019 be noted

QSE 19/09/13

PUTTING THINGS RIGHT ANNUAL REPORT

The Assistant Director of Patient Experience provided an overview of the report regarding the complaints system. The report demonstrated that although the concerns team was small it showed the work they did could make the process efficient. The Clinical Boards were engaged by having weekly tracking meetings to talk through their concerns. This had made a difference with sustained performance and did not compromise on quality.

In regards to car parking, feedback had been sent to Parking Eye and the parking office. Recently there had been favourable comments around Park and Ride and people found it much improved on the UHW site. Llandough was becoming an issue but this was around signage and the inability to contact anyone by phone.

The Committee was provided with the current claims position. Members were informed that the Health Board paid out claims under one £1m, if it exceeded this figure it went forward to Board. In the past these were very few but it was highlighted that in the future there would be a greater number of detailed claims going forward to our Board. The Executive Director of Nursing stated recently that a number of incidents had been reported retrospectively that had not been identified previously.

In regard to engaging the public with the Health Board, it was commented that Clinical Boards and Directorates needed to send compliments they received upwards. The new smiley face machines positioned around the hospital enabled users to leave compliments.

Members were advised that the General Medical Practice Indemnity came into effect on 1 April 2019 and the Health Board would be named as a defendant in a case. Training with Primary Care and GP services had been undertaken. More information would be known once the

practices started to engage with the Health Board around their concerns and claims. The Health Board would make the decision in relation to the complaints going forward. From a governance perspective this would provide more clarity to the Health Board of the undertakings in general practices. To provide assurance it was stated the Welsh Legal and Risk Pool service managed these claims. Concerns were raised that the number of concerns could escalate in 2-3 years' time. The Deputy Director of Finance advised that this was a national initiative and the National Assembly was behind the resource implications and should be deemed resource neutral.

The Committee resolved that:

a) the content of the Annual Putting Things Right report be noted

QSE 19/09/014

POLICIES AND PROCEDURES FOR APPROVAL

An overview of the policies and procedures were provided to the Committee for approval, these were the:

1. Parental Infusion Pumps Policy
2. Research Governance
3. Framework for the Management of Performance Concerns in General Medical Practitioners (GPs) on the Medical Performers List Wales

The Committee resolved that:

a) The policies and procedures be approved

QSE 19/09/015

DIABETIC RETINOPATHY – PATIENT RECALL

The Executive Nurse Director provided an overview of the report stating this was the final paper regarding the processes and systems that had been put in place. The following comments were made:

Welsh Government had asked the Health Board to host the Diabetic Retinopathy Service until 2015 when it was moved across to Public Health Wales. It was identified that there was no robust fail safe in place across the pathway. A considerable amount of work was undertaken and 2,848 patients had been identified as waiting longer than one year for an appointment and there was considerable concern that these patients may come into harm. Having gone through the process there was a cohort of 336 patients that needed to be seen immediately. Once seen a Root Cause Analysis was undertaken. 124 cases were referred back to their Local Health Boards. Of those 124, four patients were of concern and suffered mild / moderate harm. These went through the redress process. One patient was still in the redress process, two cases had settled and one patient declined any financial settlement.

The learning from this incident had been applied to other screening services.

The Chief Operating Officer joined the meeting at 10.45am

In response to lessons being learnt it was stated they had received one new incident of a patient that came to harm because they were delayed

	on the waiting list for eye care. At the last QSE Committee meeting there had been a detailed plan presented by the Chief Operating Officer (COO) on the issues of people waiting on the system. There was a need to enable plans previously presented be embedded into the service before any further updates. It was highlighted that one of the key messages and lessons learnt was the risk to people who did not attend screening. This would be shared with other Health Boards. **The Committee resolved that:** b) The level of work undertaken be noted.	
QSE 19/09/016	**CENTRALISATION OF ENDOSCOPY DECONTAMINATION** The Executive Director of Therapies and Health Sciences provided a verbal update advising all decontamination in the Health Board would be centralised to ensure they were clean and safe. There had been discussions with ME and a piece of work was being undertaken to develop an options appriasal. A meeting would be held with the group and shared services; the Committee would be kept informed as the work progressed. **The Committee resolved that:** a) The verbal update on the Centralisation of Endoscopy Decontamination be noted.	FJ
QSE 19/09/017	**UPDATE ON STROKE REHABILITATION MODEL AND WORKFORCE** The Director of Therapies and Health Science introduced the report on the Stroke Rehabilitation Centre (SRC). It was confirmed that: The rehab model and the current position was being reviewed. The Committee were advised that there would be ongoing service improvements looking at patient pathways. A Hyperacute Stroke Unit was being considered in the revised service model and would look at future demands for SRC which was likely to change by taking patients in an acute state. Out of 44 falls only one Serious Incident had been reported to WG with improvements being made on pressure damage reporting. There was good work on patient flow with reduced Length of Stay. In recent months the Deputy Head of Occupational Therapy had been reviewing the workforce model with the Senior Nurse and Lead Nurse. The Committee was assured that there was considerable work being undertaken to finalise the workforce plans to provide a model that was sustainable. The Executive Nurse Director explained to the Committee the concerns which had been raised by staff on the unit when she visited with the Chair. Patient Experience work was undertaken which reinforced the need for improvement. Very good assurance had been provided that progress was being made and the quality issues had improved considerably. The key was to have a workforce model that was different and it was this approach which was being progressed. When this model was completed a verbal update would be required at the December Committee.	FJ

	Independent Member – Legal asked although Length of Stay (LOS) had reduced was there a target to be achieved? The Executive Director of Therapies and Health Sciences replied that the SRC stratified their patients using an assessment tool which provided a range of services needed for that client. To ensure patients were in the appropriate place for the appropriate length of time they did not have a target to be achieved because of the different mix and range of patients. Benchmarking data was provided through a SNAP audit and would also benchmark against other organisations. **The Committee Resolved that:** Immediate actions for SRC to be implemented included: a) Revision of Multi-disciplinary documentation to enhance current processes and improve cross-professional and patient communication. b) Discussions with the Integrated Discharge Service and Primary Care about further support to the SRC rehabilitation model. c) Agreement for the Nursing and Therapy Leadership model to support the change in consultant model and to sustain the Quality Improvement Agenda.
QSE 19/09/018	**NATIONAL AUDIT UPATE** The Executive Medical Director provided an update on the National Audit and confirmed the following: The audit showed results over the past six months and how it aligned with the broader work of the national audit and how the organisations were working towards being compliant with all the national requirements. There were some audits which showed positive outcomes. It was acknowledged that there were some areas where improvements were needed. It was highlighted that outside the list, a pre alert relating to the hip fracture database, had shown concerns and was currently working through the data to take forward. The Chair commented on the National Audit of Dementia stating the report highlighted 42% of people over 70 with an unplanned admission had dementia. In response it was stated that it encompassed a whole range of cognitive impairment and many of the cases were unrelated to admission but it was acknowledged that this was a big issue. The Executive Nurse Director explained that when patients were admitted to hospital they become more confused and cognitively impaired and this was challenging for the nursing team in terms of managing the patient. The Enhanced Framework was embedded in Medicine Clinical Board and was being rolled out into Surgery and Specialist Clinical Boards. The real key was to avoid patients coming into a hospital setting and there was a need to get that message across to clinical teams. In regards to presenting a more detailed report, the Hip Fracture data was being worked through and would be escalated through the governance process. Also highlighted was the National Lung Cancer audit which was one of the main drivers for the Thoracic work and

Cancer Services.

The Committee Resolved that:

a) the assurance provided by participation in the National Audits and the headline results and associated quality improvement actions in place be noted and;
b) a detailed assurance report would be presented at a future meeting on the audits presented.

QSE 19/09/19

HEALTH INSPECTORATE WALES ACTIVITY UPDATE

The Assistant Director of Quality and Patient Safety provided an overview of HIW activity since April. The following comments were made:

It was expected for HIW to undertake an unannounced visit to the Maternity Services. Therefore a self-assessment had been completed. A self-assessment was also carried out for Specialist Services and the necessary evidence had been submitted. A further unannounced visit was anticipated in that area.

Unannounced visits had been undertaken in the Assessment Unit and Emergency Unit at the end of March and there had been some immediate assurance issues. Time had been taken to work through these with HIW. The main area of focus in the Assessment Unit was the lounge area and concerns had been raised relating to the quality, safety and patient experience. The Chief Operating Officer and Executive Nurse Director had a productive meeting with HIW and it had been acknowledged that some of the improvements which needed to be put in place would be medium to long term.

There were issues in terms of surgical flow and the improvement work centred on this area. Development of a Trauma Ambulatory Care Unit had been completed to address the flow in the lounge area and the extension of the Surgical Assessment Unit would be opened in November. The Clinical Board met on a weekly basis to monitor the plan.

The outcome of the unannounced visit to Mental Health services provided a positive report. There was a full action plan in place to address maintenance of the gardens. The Deputy Chief Executive attended the May 2019 Board meeting and provided a report on the performance throughout the year.

The Chair asked whether assurance had been received from a patient perspective. In response it was stated that over the past few month's smiley face machines had been placed in the area to capture feedback on a daily basis and as a result of this an increase in patients stating they had received a positive experience had been seen. The trend was improving and had picked up on themes around handover times. Volunteers were also providing feedback and the team were undertaking some bespoke patient experience activity.

Independent Member – Trade Union asked how did the work fit in with

	the Workforce Strategy on culture and behaviour and if this needed to be a priority for the staffing group on the Emergency and Assessment Units. It was stated that at an operational level there was good work between Human Resources and Emergency Unit colleagues. Recognition of behaviour being perceived in a particular way was necessary in order to change behaviour and further work was needed on this area. In regards to raising concerns at GP practices the Committee was informed that information was constantly being refreshed in GP surgeries and worked jointly with the Community Health Council (CHC) on this matter. The CHC had introduced a texting system which was working well. People were encouraged to raise issues promptly for an early resolution. **The Committee Resolved that:** a) The level of HIW activity across a broad range of services be noted. b) The appropriate processes were in place to address and monitor the recommendations.	
QSE 19/09/020	**HEALTH INSPECTORATE WALES PRIMARY CARE CONTRACTOR ACTIVITY** The Assistant Director of Quality and Patient Safety provided an update of HIW activity relating to Primary Care contracts relating to general medical services and dental services and explained the HIW process. The following comments were made: Since last years' report there had been five General Medical Inspectorate visits and two surgeries had been issued with immediate assurance letters. Both practices had implemented the systems and processes required to deal with the issues and these were being routinely monitored. More activity had been identified in General Dental Services with immediate assurance issues relating to storage of health care waste in a couple of practices HIW had visited. The Health Board had recently been advised of similar findings in other practices and was looking at this more robustly. The Primary Care Clinical Board was communicating with Primary Care colleagues on this. **The Committee Resolved that:** a) The ongoing monitoring and performance management systems and outcomes for Primary Care Dentists and GMS contractors be noted.	
QSE 19/09/021	**CARER MEASURES** The Assistant Director of Patient Experience presented a report on the Annual Carers Report for 2018/19 and the following comments were made: A meeting with Cardiff and the Vale Local Authorities was being arranged to discuss and agree how to support carers. the Report provided an overview of the objectives the Health Board must deliver.	

Also being reviewed was supporting carers in general practices and discharge from hospital planning. A pilot would be undertaken on the Llandough site and further discussions would be held with the Local Authorities and in particular with the Head of Integrated Care and the Discharge Team.

The work and schemes undertaken was maturing and there were champions within GP practices for recognising carers. Young carers in schools were inspiring and this was being acclaimed in schools and it was confirmed that the Sam Davies Ward in Barry Hospital had received a silver accreditation award recently.

The next phase of work was to focus on the recognition and number of carers in the Cardiff and Vale workforce. A survey would be distributed within the next few weeks. It was further stated that there was evidence that those in caring roles, as a profession, were often carers at home and there was a need to look at how they could be supported further.

Independent Member – Trade Union asked about the integrated approach and CRTs and the drive towards personalised planning that was not captured in the report. It was stated that the report focused on what had been undertaken with transitional funding and the comments made would be reviewed.

Independent Member – Legal asked how a carer gained access to carer support workers. It was explained carers had an assessment at the first point of contact which would put them in touch with the support and services they need.

The Committee Resolved that:

a) The ongoing work which was taking place be noted.

QSE 19/09/22

DELIVERY UNIT REPORT: IMPACT OF LONG WAITS

The Chief Operating Officer provided a report against the Delivery Unit Review regarding an increased number of patients across Wales waiting greater than 52 weeks. It was confirmed that:

The review comprised a three stage approach. Cardiff and Vale was aware of the position which was improving but more work was needed.

There were a number of recommendations which had been made and it was confirmed that these were routinely monitored by the Strategy and Delivery Committee. Action plans had been developed and the report set out actions to improve the position. The main action being pursued was not to have long waits for planned care. The Health Board was fixed on the strategy of removing long waits across all specialties. This was the year of compliance and the aim was to eliminate, not only over 52 week waits, but also over 36 week waits by the end of the financial year.

It was explained that they had moved from a volume problem to a target issue. In 2015/16 there was just under 1000 waiting more than a year.

	At the end of last year it was 150 and this figure now currently sat at 120. One hundred of these cases were in orthopaedics with complex surgery. A clinical risk based approach had been taken to clear areas where there was likely to be greater clinical risk. Orthopaedics had been dealt with later because it was deemed more complex and the clinical risk was not as great as in other areas. In response to the plan for IT and patients in the system it was stated that in all of the correspondence there was advice for patients to visit their GP if they continued to experience problems. There were also processes in place for GPs to expedite referrals. But the end point was to reach the target of 26 weeks. The pathways were explained and the Committee was advised that many were receiving treatment. There was a wider IT plan to use digital platforms to engage and empower users such as Patient Knows Best and PROMs. **The Committee Resolved that:** a) The findings and recommendations of the Delivery Unit's review of the impact of long waits for Planned Care on patients be noted b) The action plan developed in response to the recommendations be noted.	
QSE 19/09/023	**ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE** The Assistant Director of Quality and Safety stated she had observed there was a lack of medical engagement in the Clinical Board QSE Sub Committees. A meeting would be arranged to address the issues. 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	
QSE 19/09/024	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES** • The Ombudsman Letter. • The report for Putting Things Right. • The HIW Report in which the Assessment Unit received considerable attention. • The Carers Annual Report. **REVIEW OF MEETING** • The Chair would meet with the Lead Executive and Director of	

	Corporate Governance in relation to some of the papers. • A lot had been covered in a short space of time. • Independent Member – University would like to discuss some of the items with the Medical Director.	
QSE 19/09/025	**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 take place on 15 October 2019 at 9.00am, Medical Education Skills Suite, A2-B2 link corridor, UHW	