CONFIRMED MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON TUESDAY, 17 DECEMBER 2019 COED Y BWL, WOODLAND HOUSE

Present:		
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government
Gary Baxter	GB	Independent Member - University
Michael Imperato	MI	Independent Member – Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Stephen Allen	SA	South Glamorgan Community Health Council
Sue Bailey	SB	CD&T Clinical Board Director for Quality and Patient Experience
Mike Bond	MB	Director of Operations - Surgery
Karen Bonham	KB	Lead Speech & Language Therapist, Welsh Neuropsychiatry service
Nia Came	NC	Lead for Adult Speech & Language Therapy
Jessica Castle	JC	Director of Operations – Specialist Services
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Carys Fox	CF	Director of Nursing – Specialist Services
Angela Hughes	AH	Assistant Director of Patient Experience
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Alun Morgan	AM	Assistant Director of Therapies and Health Science
Hywel Pullen	HP	Assistant Director of Finance
Richard Skone	RS	Clinical Board Director Specialist Services
Matthew Temby	MT	Director of Operations – Clinical Diagnostics and Therapeutics
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Glynis Mulford	GM	Secretariat
Observers:		
Sian Passey	SP	Assistant Director of Nursing, Quality, Assurance, Safeguarding & Professional Regulation, Hywel Dda UHB
Adele Roberts		Head of Quality and Patient Care, WHSSC
Alena Ball		Senior Clinical Audit Coordinator
Apologies:		
Robert Chadwick	RC	Executive Director of Finance

QSE 19/12/001	**WELCOME AND INTRODUCTIONS** The Committee Chair welcomed everyone to the meeting.	**ACTION**
QSE 19/12/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
QSE 19/12/003	**DECLARATIONS OF INTEREST** There were no interests to declare.	
QSE 19/12/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 17 SEPTEMBER 2019 AND 15 OCTOBER 2019** The Committee reviewed the minutes of the meetings held on 17 September and 15 October 2019. **The Committee resolved that:** a) The minutes of the meetings held on 17 September and 15 October 2019 be approved as a true and accurate record.	
QSE 19/12/005	**ACTION LOG FROM 17 SEPTEMBER 2019 AND 15 OCTOBER 2019** The Committee reviewed the action log and noted the following updates: **19/09/008 – Children and Women's Clinical Board Assurance Report:** This item would be brought to a future meeting of the Committee as the Clinical Board was undertaking further work. **19/09/016 - Centralisation of Endoscopy Decontamination:** The Decontamination Committee was still reviewing the centralisation of endoscopy decontamination and an update would be brought to a future meeting of the Committee. **19/06/011 – Patient Notification Exercises: ESSURE (Issues with the failure of the process):** An item on Hepatitis C Patient Re-engagement was on the agenda for today. There was no further action needed. **COMPLETED.** **19/06/013 - Ophthalmology Report:** Work was being finalised and a report would be brought to a future meeting. **19/06/020 – Cwm Taf UHB Maternity – Cardiff and the Vale Lessons Learnt:** The Chief Operating Officer informed Members that it had been agreed with Cwm Taf and Aneurin Bevan UHBs that a further 200 patients would be referred over the course of this year. This was dependant on flows between Cwm Taf and Aneurin Bevan UHBs bringing the total to 400. There was also the potential for a further 180 patients to be directed to Cardiff and Vale UHB.	

	19/02/008 – PCIC Clinical Board Assurance Report: A report would be presented to Management Executives regarding the two mobile units that needed to be replaced. Action was being taken to address the issues and to provide the service in a different way with long and short term plans being drawn up. Decontamination equipment was being replaced with single use items and patients were being redirected elsewhere. **COMPLETED** **QSE 18/155 – CD&T Minutes - Bone Marrow Transplant Unit:** £1m had been spent to make improvements to the Bone Marrow Transplant Unit and work was due to be finished imminently. **COMPLETED** **The Committee resolved that:** 1. The action log and verbal updates be noted	
QSE 19/12/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No Chair's action had been taken since the last meeting.	
QSE 19/12/007	**PATIENT STORY - ELAINE** Nia Came and Karen Bonham from the Speech and Language Therapy Service presented the patient story on Elaine and shared the difficulties she encountered around her communication impairment. The Speech and Language Therapy (SLT) service, which is based at the Neuropsychiatry Unit in Hafan y Coed, was described. It is the only tertiary service NHS unit in Wales. A range of services are provided including an in and out patients day unit, rehabilitation and community services. The service supports people who have sustained moderate to severe cognitive emotional, behavioural and psychiatric difficulties arising from Acquired Brain Injury (ABI). The SLT service was engaged in a range of services to support service users and families and also provide assessment of communication difficulties. **Elaine's story** – Elaine was referred to the SLT service after four years of being at home without help. The service deals with the most vulnerable people within the population who suffer with pre-existing psychiatric issues. Elaine presented with dysphasia and dyspraxia. The SLT service was engaged to help Elaine to regain her confidence and find her new identity following her ABI. A short video was shown where Elaine shared her story. Elaine had written and produced the video and was currently editing the video with the support of the neuropsychiatry SLT service. It took Elaine 10 hours to complete the video. This was part of a series of videos that a small group of patients produced to help staff. A training package had been created by the patients and was delivered to staff. The project was designed to be challenging but the outcome measures demonstrated gains for all those involved and included improvements within individual communication skills, self-confidence, participation and wellbeing. The team found it a privilege to show the video.	

	The Chair invited comments and questions: In response to using technology options to interact from home so patients did not have to travel, it was stated this area was still in its infancy. Video conferencing was used for satellite clinics and in-reach services but currently this consisted of clinical and not therapy intervention and it was recognised that there was a need to do more. The Chair thanked the team and asked them to communicate to the rest of the team and Elaine how impressed the Committee were with the story. She added that what would be taken from the presentation was how it provided the person with purpose and showed partnership between all involved. The Executive Nurse Director commented that neuropsychiatry was looked at in the context of mental health and not as a therapeutic service. Further communication would be sent to Elaine and the service on behalf of the Committee. **CLINICAL BOARD ASSURANCE REPORT: CLINICAL DIAGNOSTICS AND THEAPEUTICS CLINICAL BOARD** Sue Bailey, Quality Lead for CD&T presented the report which provided assurance around the improved quality and care outcomes for patients. Matt Temby Director of Operations, updated the Committee regarding the work the Clinical Board had undertaken in collaboration with Public Health on the "Work Health, My Health". The initiative aimed to provide advice and information on simple steps to make small changes around being more active, eating and drinking healthily and improved wellbeing. The Clinical Board (CB) used its own resources and raised extra funds to look after the physical and mental wellbeing of its staff. A broad set of actions were put in place to help and drive forward some of the projects. The Executive Director for Public Health stated that the programme was an exemplar of how the system could be rolled out to other CBs and further praised the CB as being the flu vaccination lead with a 65% uptake. The Director of Operations confirmed that he supported the health and wellbeing of staff and in particular provided training opportunities for those who managed staff with health and wellbeing issues. The Chair invited questions and comments: The Executive Nurse Director asked if they could share their approach to regulation and compliance. In response it was stated there had been a real shift by inspectorates in raising the bar. Two main factors which impacted were senior management oversight and the timeliness of closing actions. In terms of oversight, the CB had developed a Regulatory Compliance Group and a dashboard was used in the system which allowed the CB to view how services were measuring. The new system in place saw improved metrics.	

	The Director of Operation confirmed that performance management and Q&S did not previously have a standard to measure QMS data underneath the dashboard. The dashboard provided intelligence to indicate where the problems and challenges were with some predictive nature. There had been a cultural shift in having a day to day visualisation of the dashboard, which encouraged services to make a change and drive improvements. The Chair asked if the data was available in 'real time'. It was stated the data was collated on a monthly basis but the CB would look at how this could be developed further. The Executive Director of Therapies and Health Sciences commented that the report provided a good breadth of what the CB undertook, the challenges it faced and how these would be addressed. It pulled a range of different services together and asked that assurance be provided to the Committee that cross Clinical Board working would be strengthened. The Director of Operations – Clinical Diagnostics and Therapeutics responded that this was developing well through the Director of Operations Forum. Each morning the team looked at how they could help another CB. Strong relationships had been developed through cross CB working. The central point would be to support CBs with pathway changes and how this could generate improvements to the whole system through the commissioning framework and joining events. Independent Member – University queried in regard to workforce, that there were a number of professions that were in shortage across the UK. How was recruitment and retention being managed? In response it was stated that some important work was undertaken with workforce planning principles and the change approach. There was a shift from relying on hard to recruit roles to using a different skill mix and support worker framework. Using staff differently had shown some elements of improvement. There was a need to provide and develop services so that people would want to come and work here. It was highlighted that HEIW could have a significant impact on recruitment as they would be training staff on a Wales only basis and could flag when recommissioning may deteriorate. It was recognised that incidents year on year had almost doubled in causing service disruption. It was explained that in the last 12 months there had been 13 business continuity events, some of which were outside of the CBs control. The committee were advised that the CB was working with the Business Continuity team and were assured that the CB had grown in sophistication in how to manage these events. The Assistant Director of Quality and Patient Safety highlighted that the CB had dealt with a number of challenging Serious Incidents and coordinated on some big issues. One of the biggest risks and frustrations was the failure to act on abnormal results and she was looking for an end to end solution from NWIS with a tracking system for requesting reporting. Had there been any progress? It was confirmed that work was being undertaken with NWIS to look at an alternative	

	solution so that radiologists could easily flag significant results quickly to a referrer via an electronic platform. The Executive Medical Director asked what were the biggest three quality risks faced by the CB and how would these would be highlighted in the report? In response it was stated there was concern regarding regulatory compliance, radiopharmacy and issues around the sustainability of ongoing estates issues and delays with turnaround times in the reporting of results and results notification. The Executive Medical Director commented on his concerns regarding the escalation process and what he considered should be in place locally. In addition, regarding the delays in reporting there were solutions based in transformation and QI. In regard to the IT situation it was pleasing to see that reporting was now aligned to the national reporting processes where our results could be viewed outside the Health Board, and showed we could work within the national agenda. The Chair thanked the team by being open in terms of responding to colleagues questions and acknowledged the challenges that the CB faced. **The Committee Resolved that:** a) the progress made by the Clinical Board to date and its planned actions be noted; b) the approach taken by the Clinical Board be approved; c) To note the areas to be addressed and some of the challenges faced by the Clinical Board	
QSE 19/12/008	**HEALTH CARE STANDARDS SELF ASSESSMENT PLAN AND PROGRESS UPDATE** The Assistant Director of Quality provided an overview of the report and confirmed that its purpose was to recognise the changed approach on self-assessment and the priorities that fall out of these. The following comments were made: • There had been alignment of Health and Care Standards to established groups and committees within the organisation and it was their responsibility to progress the actions throughout the year. The report was an update based on actions that each group was committed to deliver this year and evidence that most actions had been delivered. • There was a lack of resource in the Clinical Audit team and the Health Board were looking for solutions around this issue. • There was a consultation being undertaken in relation to the Health and Care Standards. Clarity was needed whether this was the main framework to underpin quality and safety within Health Boards and how it aligned with the Quality and Safety Bill. Currently, procedures did not align and would feedback comments to Welsh Government.	

	• Independent Member – Legal suggested the need to focus on issues we should be concerned about due to the amount of information presented. The Executive Nurse Director replied that the focus should centre on key areas of the standards and to monitor what needed to be progressed. Key indicators would be added following the self-assessment in order to demonstrate that we were seeing improvements in key areas over the year. • Independent Member – Legal raised that some of the reports came back each year and suggested that three or four key points be brought back to see how these had progressed. In response it was stated that a report was presented in April 2019 and an update provided six months later. The detail would be in those reports with the maturity of where we were against each standard and also that the Health Board would want to see an increase in maturity by April 2020. • The Executive Nurse Director confirmed that in the future she would bring to the Committee a report on an area of work that was not doing well and the action being taken to address the issue it would also include areas of good practice. **The Committee resolved that:** a) the progress made against the actions identified in each of the Health and Care Standards be noted.	RW
QSE 19/12/009	**POINT OF CARE TESTING** Executive Medical Director provided an overview of the Point of Care Testing report. He stated that there were a number of challenges in the department relating to a number of factors and there were a set of significant clinical processes that did not have the right structure and governance in place. Therefore the Committee was being informed and made aware of the challenges faced by the department and asked to provide support to the service on how to manage these issues. The report will also be taken to the next Board meeting. The Chair invited questions and comments: Independent Member – Trade Union commented that this was an opportunity for transformation using the technology available to the Health Board and stressed that the Health Board should not underestimate the concern around capacity and leadership issues. The need for a systematic approach was recognised. It was queried why the services had not been escalated to a committee. It was stated that POCT had been on the radar for a long time and became an acute problem because of the lack of succession planning which was explained. It was acknowledged that the current leader in POCT was excellent but there was a need for a stronger level of governance and leadership to be put in place. **The Committee resolved that:**	SW

	a) Clarification should be obtained regarding the governance reporting arrangements/ escalation route for the PoCT Group on an organisational level. b) Plans are to be put in place to ensure ongoing engagement from all Clinical Boards at the POCT Group. 1. a succession plan for a Head of Service/ Clinical Lead should be put in place. 2. Plans shall be put in place to secure sustained funding for the PoCT Dept. 3. Plans shall be put in place to source suitable premises for the PoCT Dept.	
QSE 19/12/010	**UPDATE ON STROKE REHABILITATION AND MODEL WORKFORCE** The Executive Director of Therapies and Health Science gave a verbal update on the Stroke Rehabilitation and Model Workforce. The following comments were made: • There were no longer any quality issues on the Stroke Rehabilitation Unit. • As part of their plans to move the unit forward the team had reviewed the staffing issues. Work had been undertaken with the lead nurse and lead therapist on the workforce model to move towards a rehab focused unit by using staff in different ways with a different skill mix. An initial meeting with the Medicine CB and CD&T CB would be undertaken and would be discussed in Stroke Strategy Group on Friday, 20 December. Assurance had also been provided by the HIW with a positive report. **The Committee resolved that:** a) The verbal update be noted	
QSE 19/12/011	**LOCAL CLINICAL AUDIT PLAN UPDATE** The Executive Medical Director stated the report provided a summary of the current audits on Tier 1 and Tier 2 national and local audit mandates for 2019/20. It was key to remember that there was no specific cycle and to note there were a number of audits in progress. **The Committee resolved that:** **a)** the progress being made against the 2019 / 20 Clinical Audit Plan and the overall clinical audit activity for 2018/19 be noted.	
QSE 19/12/012	**CANCER PEER REVIEW** The Executive Medical Director provided a report which summarised the Cancer Peer Review. It was highlighted that the lung report had been omitted from the report but had been received earlier that day. The Teenage and Young Adult report had not been submitted to the UHB but clinical teams were able to take forward actions to improve the service	

	based on verbal feedback. There were actions outstanding against previous reports but there were no concerns to highlight as a risk. **The Committee resolved that:** a) the contents of the report and the delayed action plans awaited from the Wales Cancer Network be noted. b) It be noted that the reports and action plans will be submitted to the next meeting.	
QSE 19/12/013	**INTERNAL INSPECTIONS** The Executive Nurse Director informed the Committee that 109 inspections had been carried out during 2019. There were no areas to be overly concerned about but it was recognised that there were some areas of practice that could be improved. There was learning to be had regarding the audit process itself and change would be introduced by using an electronic platform. An App had been designed to improve the quality and consistency of audit outcomes and the Health Board had started to see improvement following the introduction of the App. Information was being triangulated in a systematic way to inform the Health Board about the inspections. It was realised that more work was needed in this area. The themes that were coming out of inspections, complaints and Serious Incidents needed to be collated so that improvement could be measured and featured in the quality and safety feedback. It was requested that the App be shared with the Community Health Council. **The Committee resolved that:** a) the content of the paper be noted	RW
QSE 19/12/014	**PATIENT NOTIFICATION EXERCISES IN CARDIFF AND VALE OF GLAMORGAN POPULATIONS: HEPATITIS C VIRUS INFECTION RE-ENGAGEMENT PROJECT** The Executive Director of Public Health presented the report and informed Members that some patient notifications exercises (PNE) were led by Public Health Wales. It was explained that over 5000 individuals who had been diagnosed with hepatitis C, but for various reasons had never been linked to care or who had never received follow up investigation or treatment, had been identified through laboratory data searches in Wales. Those patients with an identified General Practitioner (GP) who had provided consent, were contacted and offered treatment as Phase 1 of an on-going re-engagement programme throughout Wales and directed by Welsh Government. The PNE carried out showed commitment to the World Health Organisation (WHO) goal to eliminate Hepatitis C by 2030. The measures outlined by the WHO had been fully complied with. There would be a phase 2 approach in finding patients who were not	

	registered with GPs or were in prison and had fully complied with the piece of work. **The Committee resolved that:** a) the progress made so far in this exercise be noted and support provided for on-going implementation	
QSE 19/12/015	**POLICIES FOR APPROVAL** An overview of the policies and procedures were provided to the Committee for approval, these were the: **1. Consent to Examination or Treatment Policy** **The Committee resolved that:** a) the Consent to Examination or Treatment Policy be approved; b) the full publication of the Consent to Examination or Treatment Policy in accordance with the UHB Publication Scheme be approved **2. Management of a Throat Pack Policy and Procedure** **The Committee resolved that:** a) the policy and procedure for the management of a Throat Pack be approved. b) the chairs action to approve the policy and procedure for the management of a Throat Pack be ratified. c) the full publication of the policy and procedure for the management of a Throat Pack in accordance with the UHB publication scheme be approved. **3. Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets** The Executive Director of Public Health introduced the policy, which had also been discussed at a recent Management Executive meeting. It was realised there was more work to be undertaken as it was not completely clear how the market would respond and there was a need to assess the impact in more detail. Therefore the policy would be brought back to the Committee at a later date. A communications plan would be put in place. There was wider discussion on affordability, getting the message right and sharing with the public what the policy was aiming to achieve. **The Committee resolved that:** a) Progress of the policy be noted b) A revised policy be brought back at a later date.	FK

QSE 19/12/016	**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE GUIDANCE** The Executive Medical Director informed the Committee that recently the National Institute for Health and Care Excellence Guidance (NICE) lead had undertaken a stock take of processes in Wales and reported that a well-documented system was in place at the Health Board. The NICE lead also flagged areas where other processes needed strengthening. No benchmarking had been undertaken with other HBs. In the future an all-Wales assessment would be undertaken to further strengthen processes. Technology appraisals were not currently being mandated but this would be addressed in the future. In the meantime, the Health Board should be measured against the process and work on this was currently being undertaken. In regard to CG192 Antenatal and post- mental health, the Executive Nurse Director asked that it be noted that when the Health Board met with Welsh Government on performance indicators, CG192 was an area where concerns were expressed by our staff that there was no post-natal psychology support in place. The Community Health Council queried in regard to NG80 - chronic asthma management, if the report was indicating that diagnostic testing would not be undertaken in primary care and that it was not part of QUAFF. In response it was stated that chronic asthma management was not in QUAFF and there had been a reduction in barometry testing across Wales. The Cardiff and Vale position was that GPs were doing much less barometry testing than they were and this had been raised as an issue. **The Committee resolved that:** a) The processes in place to consider NICE Guidance and the levels of implementation be noted	
QSE 19/12/017	**HEALTHCARE INSPECTORATE WALES ACTIVITY OVERVIEW** The Assistant Director of Quality and Patient Safety informed members that the outcome of an unannounced inspection by HIW to the Maternity Unit on 18 November reported with positive feedback. An immediate assurance issue had been identified with resuscitation trolleys and was rectified immediately. A safety notice was issued and the safety team completed a piece of work on this issue. Subject to discussion there would be better solutions across the Health Board. There were also positive outcomes with HIW visits to the Stroke Rehabilitation Centre and Rookwood Hospital. The Committee was made aware of the issues expressed by the Nurse Directors regarding the HIW template. It was deemed to be too bespoke in relation to the issues that arose from the Cwm Taf Review. This has been raised with Welsh Government.	

	The Committee resolved that: a) The level of HIW activity across a broad range of services be noted b) It be agreed that the appropriate processes are in place to address and monitor the recommendations made.	
QSE 19/12/018	**HEALTHCARE INSPECTORATE WALES PRIMARY CARE CONTRACTORS** The Assistant Director of Quality and Patient Safety informed members that the report focused on dental and surgery practices. There were two immediate assurance issues in terms of healthcare waste and a robust process was in place around this. Dental practice advisers would work with practices to address the concerns. There was a recurring trend with immediate assurance regarding DBS checks with non clinical staff. Discussions had been undertaken with HIW as their thresholds were higher than Shared Services. The Health Board did not require DBS checks for non clinical staff but this was being requested by HIW. Members were informed that primary care indemnity arrangements now came under the responsibility of the Health Board. The Health Board would therefore see more primary care issues coming through private providers. The Community Health Council will bring a paper to a future Committee relating to their visits to Primary Care Contractors. **The Committee resolved that:** a) the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors be noted b) they be assured that appropriate remedial actions are being taken by practices in relation to immediate assurance notifications; c) it be noted that there is a robust process in place within the Primary Care Team to manage the receipt of inspection reports and ensure review and follow up by the practice.	
QSE 19/12/019	**ITEMS RECEIVED FROM CLINICAL BOARDS QUALITY SAFETY AND EXPERIENCE COMMITTEE** Independent Member – Trade Union observed that the Mental Health Clinical Board was lacking in terms of minutes submitted to the Committee. It was confirmed that the CB had a different approach to minute taking but that the Executive Nurse Director would take the comments back to the CB. **The Committee resolved that:** a) The minutes of the Clinical Boards be noted	**RW**

QSE 19/12/020	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** Whilst there are no immediate concerns the audit finding that the retention rate had come up high may be referred to another committee or discussed externally to assure the committee that there were strong processes in place to resolve this and to show that due process would be observed.	
QSE 19/12/021	**REVIEW OF MEETING** The Committee Chair facilitated a review of the meeting. Members confirmed that: • There was openness and a very strong performance from the CD&T Clinical Board. Much work had been undertaken and the importance of triangulating processes was highlighted. • It was acknowledged by the Executive Nurse Director to be the most challenging meeting to collate and prepare papers. The processes were changing and she thanked everyone for their patience. The Chair invited the observers to provide comments: • It was observed that there was a good structure in place and it was recognised that although the Committee was on a journey it had found a balance between operational and strategic reporting. The strategic element came through strongly and the CBs were picking up on the operational elements. In addition, the patient story presentation was excellent.	
QSE 19/12/022	**DATE AND TIME OF NEXT MEETING** Thursday, 18 February 2020 at 9.00am Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff	