ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 7th June 2022 at 9.30am via Teams

Present:

Pippa Britton	- Vice Chair (Chair of Committee)
Shelley Bosson	- Independent Member
Louise Wright	- Independent Member
Paul Deneen	- Independent Member
Helen Sweetland	- Independent Member

In attendance:

Rani Mallison	- Director of Corporate Governance
Rhiannon Jones	- Director of Nursing
James Calvert	- Medical Director
Peter Carr	- Director of Therapies and Health Sciences
Alexandra Scott	- Assistant Director for Quality and Patient Safety
Danielle O'Leary	- Head of Corporate services, Risk and Assurance
Nathan Couch	- Audit Wales
Andrew Doughton	- Audit Wales
Jonathan Thomas	- Directorate Manager, Theatre Services
Martin Silcox	- Senior Practitioner, Theatre Services
Deb Jackson	- Assistant Director of Nursing
Emma Guscott	- Committee Secretariat

Observers:

Rhian Gard	- Principle Auditor, NWSSP
Tracey Partridge Wilson	- Assistant Director of Nursing, Quality, Safety & Patient Experience
Linda Alexander	- Deputy Director of Nursing
Gwawr Evans	- Scheduled Care Manager

Apologies:

Leanne Watkins	- Director of Operations
Glyn Jones	- Interim Chief Executive

1	**Preliminary Matters**
PQSO 0706/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance, noting the Director of Corporate Governance would be joining the meeting later.
PQSO 0706/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 0706/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 0706/04	**Draft Minutes of the Committee held on 5th April 2022** The minutes of the meeting held on the 5th April 2022 were agreed as a true and accurate record.
PQSO 0706/05	**Action Sheet of the Committee held on the 5th April 2022** The Committee reviewed those actions outstanding as recorded in the action log and noted the following: **'1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration-** *An update inclusive of a map of where the facilities are to be received following the review.'* Peter Carr, Director of Therapies & Health Sciences, informed the Committee that the review was being undertaken by the facilities division, with the aim for completion by July 2022. Action to remain with an update to come back to the Committee. **'2112/04 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration-** *Peter Carr informed members that the Health Board was not meeting NICE best practice model regarding a dedicated nutritional support team to include specialist nurses. A business case for a dedicated nutritional*

	support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.' Peter Carr informed the Committee that further discussions had taken place with Divisions to establish future implementation of NICE Guidance. Action to remain, with a detailed update to be provided at a later date. The Chair requested a timeline for the remaining outstanding actions, PQSO 0504/06.3 and 0504/06.4. **Action:** Rhiannon Jones, Director of Nursing, highlighted that the Action Log status' column did not follow the 'Agreed Actions' key. This would be updated and amended to reflect the agreed key in readiness for the next meeting. **Committee Secretariat**
2	**Items for Presentation and Discussion**
PQSO 0706/06	**Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response** Nathan Couch, Audit Wales, provided the Committee with an overview of the purpose of the Quality Governance Arrangements review and its findings. The review had taken place between June and October 2021. The purpose of the review was to determine if the Health Board's operational and corporate governance arrangements supported the delivery of high quality, safe and effective services. To assess this, Audit Wales focussed on the Scheduled Care Division and the General Surgery Directorate, reviewing organisational culture and behaviours, strategies, structures and processes, and information flows and reporting. Key messages from the review were that the Health Board had clear, articulated corporate arrangements for quality governance and key areas of quality and safety; however, further improvement was required at Divisional and Directorate level. As outlined in the report, eight recommendations were made during the review. The recommendations were summarised as: • Risk Management – strengthen the maintenance and oversight of the Divisional Risk Register • Clinical Audit – complete work on the organisational clinical audit strategy, policy, and plan • Values and Behaviours – undertake work to understand why some staff feel they are not treated fairly or given feedback when reporting errors/near-misses or incidents • Patient Experience – ensure there are systematic arrangements for collating and acting upon patient experience • Putting Things Right – ensure the policy is rapidly reviewed and updated

	• Quality and Safety Framework – complete a review of the Quality Assurance Framework and ensure coverage of operational flows • Resources to support governance – undertake an assessment of resources in place for quality and safety across Divisions and determine the capacity of staff to undertake their role effectively • Coverage of quality and safety matters – ensure operational meetings provide coverage for quality and safety alongside finance and performance. All recommendations had been agreed with the Health Board, appropriate actions outlined, alongside agreed completion dates and Executive ownership. Audit Wales thanked the Health Board for the engagement during the review, with a special thanks to Rachel Manley, Corporate Nursing Assistant and the Directorate nursing teams for their support. Shelley Bosson, Independent Member, referenced *'There is also a need to review the extent that operational staff and management have sufficient capacity to effectively support quality governance.'* (Audit Wales, pg. 5) and queried if this linked to job planning and requested assurance if improvements in job planning would therefore have a positive impact. Rhiannon Jones, Director of Nursing, responded that there were designated leads in each Division for quality and safety, and that a review of resources would be undertaken by Clinical Executives and divisional leads to assess any perceived infrastructure gaps. Paul Deneen, Independent Member, requested clarity on how the recommendations would be monitored. Rhiannon Jones indicated that these recommendations would be monitored through the Audit, Risk and Assurance Committee recommendation tracker and the Patient Quality, Safety and Outcomes Committee. It was agreed that a report highlighting progress against each recommendation to be presented to the Committee in October 2022. **Action: Rhiannon Jones/Linda Alexander** The Chair welcomed the report in October and requested a verbal update on progress against each recommendation at the next Committee meeting in August 2022. **Action: Rhiannon Jones/Linda Alexander** The Committee was assured that although the Audit Wales review focused on Scheduled Care, the results would be shared with all Divisions, along with an assessment of capacity and resources across

	all Divisions, to encourage organisational learning and promotion of best practice. Andrew Doughton, Audit Wales, informed members of planned work to produce a National Report scheduled to be published in Autumn 2022, which would address the following: • Key themes and messages taken from reviews across Wales. • National arrangements with Welsh Government (WG) and wider NHS partners. • Progress made against quality improvement, aligning with new Welsh Government legislation, relating to the Duty of Quality and Candour, which was due to be implemented in Spring 2023. The Committee **NOTED** the report for **ASSURANCE** and welcomed an update on progress in October 2022.
PQSO 0706/07	**Theatres Safety Programme Update** Rhiannon Jones, Director of Nursing, informed the Committee that the presentation on the Theatres Safety Programme related to concerns regarding an increase in 'Never Events' in surgical and theatres directorates. Marcus Silcox, Senior Practitioner in Theatre services, and Jonathan Thomas, Directorate Manager for Theatre services, provided an update on the work being undertaken in theatres and scheduled care, relating to theatre safety. The Committee was informed that a 'Never Event' was defined as "a preventable serious incident," and that national guidance and/or safety recommendations should be implemented by all health care providers to avoid such incidents occurring. Since July 2020 there had been 19 'Never Events' within the Health Board; 11 of which occurred in a theatre and within the theatre directorate. As a result of this, several initiatives had been implemented, including a Theatre Safety Group, and a Theatre Safety & Compliance programme, containing 23 workstreams, overseen by programme leads. The workstreams provided assurance through the Health Board by identifying areas of elevated risk and areas that required enhanced or ongoing support. As part of the presentation, the following key points were highlighted to the Committee: • The objective of all workstreams was to reduce the number of Serious Incidents and Never Events. • Through utilisation of audit tools, the Health Board would benchmark its practice against national recommendations and guidelines.

	• Robust processes in relation to incident management and organisational learning would provide the Health Board with an opportunity to produce constructive feedback and support to staff who used the DATIX system to report incidents. The Theatres Directorate was commended for excellent standards and practice during the Health Board's internal audit of Medicine Management, which was undertaken in May 2022. The Committee was informed that the report had determined a reasonable assurance level and would be presented to the Audit, Risk and Assurance Committee in line with due process. Paul Deneen, Independent Member, requested assurance around the following: • In relation to the numbers of patients who had utilised the Health Boards theatre services in comparison to the number of 'Never Events', whether the Health Board was an outlier in this area? Rhiannon Jones informed the Committee that the Health Board was an outlier in 2018/19, and this had triggered the workstreams being undertaken at present. Although there had been a recent spike, feedback from the Delivery Unit did not indicate that the health Board was currently an outlier, with the possibility that the spike could be linked to positive reporting due to the utilisation of the new 'Once for Wales' concerns management system and the revision of the Datix reporting systems. Jonathan Thomas informed the Committee that all patients were logged on the Ormis Theatre Management System. From 2019 to 2020, approximately 41,000 patients were treated in the Health Boards theatres. • Was there an appropriate level of communication and openness between medical professionals and patients in theatres? The Committee were informed that for each Never Event there was a robust process, with an open and transparent line of communication between staff and patients. It was discussed that there was room for improvement around communication across the Health Board, and that work was underway to address this. The Committee noted that some Clinical leads had raised concerns in relation to the increase in 'Never Events', in particular the patient misidentification incidents. Additional communication tools had been put in place to remind staff of the importance of following processes for patient identification to further improve outcomes and promote patient safety. Committee members supported the 'Human Factor Training' workstream as outlined in the presentation. Peter Carr, Director of Therapies and Health Sciences, discussed how theatre safety was a

	team responsibility and welcomed the multi-disciplinary approach, Peter Carr highlighted that the registered workforce in these areas is highly skilled, and that the Health Board had an obligation to provide a learning environment that promoted trust, regular mentoring and support of staff and highlighting training needs and gaps when appropriate. The Chair queried if well-being support for patients and staff was offered when 'Never Events' or Serious Incidents occurred. It was confirmed that each individual case was assessed and if further psychological support were deemed appropriate, a referral would be made for the patient concerned. A formal review process for staff was in place and signposting to well-being services formed an aspect of the template. James Calvert informed the Committee that patients and families are assigned a key link contact for support and that 'lay' summaries and glossaries are produced alongside reports to encourage transparency and enhance understanding. The Committee thanked Jonathan Thomas, Marcus Silcox and the teams for the excellent management response and presentation.
PQSO 0706/08	**Covid-19 Concerns and Claims: The National Framework & Investigative Process** Rhiannon Jones, Director of Nursing, supported by Deb Jackson, Assistant Director of Nursing, provided the Committee with an overview of the Covid-19 investigative framework. The Committee received a presentation of the Health Board's expectations. The following was discussed: • The Covid-19 investigative framework is a national framework. There was a Welsh Government requirement for all incidents of nosocomial (hospital acquired infections) Covid-19 to be investigated. Funding had been received across Health Boards in Wales to support a Covid-19 investigation team, with a two-year timeframe. • A three-stage, Executive led standardised approach for Covid-19 investigation was in place: o identification o assessment, and o investigation • The total number of health acquired incidents from February 2020 to April 2022 was noted as 2317, with the highest numbers recorded between December 2021, to April 2022 (wave 4). • There was a requirement for 15.2 whole time equivalent (WTE) multi-disciplinary staff to support the investigation. The recruitment process had commenced, with interviews held week

	commencing 30th May 2022. A Business and Performance manager had been successfully appointed and would be responsible for the appointment of remaining required staff. • It was noted that the Health Board would be providing additional support for staff and families during this process through a clinical psychologist. Louise Wright, Independent Member, queried if the investigations included staff who had contracted nosocomial Covid-19. Rhiannon Jones informed the Committee that this process was for patients only, however ongoing discussions had taken place and separate investigations would take place for staff members. Paul Deneen, Independent Member, queried the if the three-stage approach for Covid-19 investigation was an All-Wales approach. Deb Jackson responded that this was a National Framework followed throughout Wales. The committee was further advised that if probable harm was identified as part of the investigations, then legal teams would form part of the multidisciplinary scrutiny panel, following the Welsh Risk Pool process. Shelley Bosson, Independent Member, queried if the Health Board was an outlier in relation to anticipated challenges regarding recruitment. Required recruitment numbers varied across Health Boards and to ensure delivery of robust investigations within the two-year required timeframe, Aneurin Bevan University Health Board required a large, multidisciplinary team. Rhiannon Jones discussed that that the relevant number of clinical investigators had been recruited. There was a requirement for investigations to commence prior to all recruitment posts being filled, due to time restraints. Helen Sweetland, Independent member, queried if there had been additional funding given to support the investigation process. Rhiannon Jones informed the Committee that Welsh Government had provided additional funding of approximately £750,000 to support the investigative process. The Chair requested that regular updates on the investigation process and progress would be monitored through the Committee. Rhiannon Jones suggested that a report be presented in January 2023, with regular updates to the Committee to be included as part of the standing item, Patient Quality, Safety and Outcomes Report. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee thanked Deb Jackson for the overview, noting the challenges in relation to recruitment and acknowledged that investigations would commence in June 2022.

PQSO 0706/09	**Learning from Death Report** James Calvert, Medical Director, supported by Alexandra Scott, Assistant Director for Quality and Patient Safety provided the Committee with the report. James Calvert reminded the Committee that the Medical Examiner (ME) role was set up as a national recommendation taken from the Shipman Inquiry 2005, to provide independent scrutiny of deaths. The Committee was informed that by the end of 2022, there would be a statutory requirement for all deaths in Wales, in both primary and secondary care, to be subject to scrutiny by the ME. James Calvert discussed the report, noting it included contextual information of overall performance. Aneurin Bevan University Health Board had received 169 referrals from the ME between 1st December 2021 and the 1st May 2022. The Committee was informed that the Health Board's multidisciplinary Mortality Screening Panels regularly meet to assess all referrals from the ME. Medical Directors from across Wales had also met to discuss the ME service and highlighted how great value can be taken from identifying and themes/clusters. Alexandra Scott highlighted the mortality clusters that had been identified through mortality data. The data indicated that there might have been a correlation between the restart of some elective surgeries, however, Health Board mortality data that related to elective and emergency procedures showed the Health Board was in a good position against peers in Wales. Alexandra Scott informed the Committee that the National Emergency Laparotomy Audit (NELA) had previously identified Royal Gwent Hospital as a mortality rate outlier. Improved, real-time reporting through NELA, now showed the position had significantly improved, supported by the Health Board's Quality Improvement Programme. The Committee was informed of an additional theme that had been highlighted from the ME, with several referrals received for patients with Learning Disabilities cared for in acute hospital settings. As a result of this, a thematic review was underway. The Health Board had taken immediate action and the Learning Disability Steering Group had been reconvened, in order to monitor Health Board compliance with the 1000 Lives care package and promote a more collaborative approach to providing care. The Chair commented that the Committee was assured that recognised themes were being investigated and noted that work was underway to

	improve patient experience and care with all patients, particularly patients with Learning Disabilities (LD). The Committee requested assurance that the learning was shared throughout the Health Board to all staff in a patient care setting. Alexandra Scott informed the Committee that the Learning Disability Steering Group' terms of reference capture an evidence-based approach for caring for patients with a LD in acute settings, and that learning had been taken from the ME referrals. Rhiannon Jones, Director of Nursing, suggested that the issues raised by the ME in relation to LD patients highlighted the need for further monitoring of progress for improvement of patient care for individuals with a LD. A future update on the review of patient care for individuals with a Learning Disability to come back to the Committee. Chair to discuss request with Chris O'Connor outside of the meeting. **Action: Chris O'Connor/Chair/Secretariat** The Committee **NOTED** the report for **ASSURANCE**. The Committee acknowledged this was the final meeting for Alexandra Scott and thanked her for her contribution to quality and patient safety within the Health Board.
PQSO 0706/10	**Healthcare Inspectorate Wales (HIW) Unannounced Visit to the Grange University Hospital (November 2021)** Rhiannon Jones, Director of Nursing, provided an update report for assurance alongside an overview of the HIW unannounced visit findings. An update on progress against each recommendation was also included in the report. A letter had been received (included in papers) from HIW requesting an update on progress against the recommendations. The Committee was advised that this had been triggered by ongoing system pressures in Urgent Care. The Health Board had responded to the HIW letter, providing twenty-five pieces of evidence to support the implementation of the recommendations. The HIW visit took place over a three-day period, during which patients in Urgent and Emergency care for both adults and children were reviewed. Overall, HIW were not assured that all systems and processes in place were sufficient to ensure all patients were consistently receiving acceptable standards of safe an effective care, although the hard work of staff was recognised. It had been identified until the flow of patients had been addressed in the Emergency departments that the Health Board may find it difficult to address the recommendations made. The Health Board acknowledged that Urgent and Emergency care remained a priority and a current significant risk. HIW observed that staff were

	striving to provide safe and effective emergency care for patients within the busy units, although staff survey feedback indicated that some staff felt that they could not deliver the care they wanted to. Of the patients asked, 84% rated their experience as good or very good, notwithstanding significant issues with patient feedback on length of waiting times. The Committee were informed that the immediate assurance letter from HIW was received a few days after the visit, raising concerns around visibility of patients in waiting areas, infection control issues within the Covid corridor and insufficient Resuscitation trolley checks. The report outlined the immediate improvements made, and the Health Board response. This consisted of 12 recommendations and progress against each. HIW had also identified an additional 59 recommendations as part of the improvement plan. Based on the 71 recommendations, there were 112 actions. At the time of the meeting there were 15 actions outstanding, all of which would be completed by October 2022. A further update on the final response to HIW, progress and compliance against actions to come back to the October Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Chair requested information on the extra waiting space for the Emergency Department at the Grange University Hospital, as outlined in the report. Rhiannon Jones informed the Committee that this has been completed, however there were ongoing discussions and concern raised from clinical teams around the use of the space with current staff deficits. It was agreed that a further discussion to take place at the next Board development session. **Action: Rhiannon Jones/Rani Mallison** Shelley Bosson, Independent Member, queried why the infection control issue and signage issues outlined in the report were not factored into the new build. Rhiannon Jones informed the Committee that the infection control issue was due to system pressures and corridor areas being utilised to accommodate patients; corridor areas were not factored in for patient use in the initial design of the Grange University Hospital. The Health Board had recognised the need for a sink area and a request was in for a sink with the works and estates department prior to the HIW visit. Signage standards were followed, however on reflection the comments have been addressed. Shelley Bosson informed members of an upcoming meeting with Gareth Hughes, Divisional Director of Facilities, during which the concerns around signage would be raised and feedback would be provided to the Committee as part of the progress update at the next meeting. **Action: Secretariat**

	Paul Deneen, Independent Member, queried if staff feedback relating to the Grange University Hospital had improved. Rhiannon Jones informed the Committee that system pressures and recruitment issues continued to influence staff morale; however, progress had been made around nursing recruitment. In addition to this, a recent staff survey had been completed, the results of which would be shared with the People and Culture Committee in due course. **Action: Rhiannon Jones/Secretariat** Paul Deneen discussed the several hundred patients over capacity in hospitals who were awaiting care packages for discharge and the further pressure exerted on staff as a result. James Calvert, Medical Director, reiterated that staff were currently working under immense pressure, and highlighted that this was the case on a national level. The Committee were reminded that the data presented throughout the meeting showed improvements in outcomes for the Health Board, noting the requirement to focus on improvements but also noting the positive changes. The Committee noted the requirement for 'a whole system' approach to further improve patient care. The Committee thanked staff involved for their work and welcomed an update on the final response to HIW to be presented to the Committee at the October meeting.
PQSO 0706/11	**The Independent Review of Maternity Services at SATH (The Ockenden Review)** Rhiannon Jones, Director of Nursing, gave an overview of the final Ockenden Report, produced on the 30th of March 2022. The second, and final report identified several new themes intended for wider sharing across NHS England. The paper outlined the key points from the report and identified actions being taken in Wales to review the report and extract learning. The Chief Nursing Officer for Wales had written to each Health Board requesting an assessment of maternity services, to include relevant elements from the Ockenden Report, the previous review of maternity services conducted by HIW, and in addition, compliance with recommendations and actions from the Cwm Taf Morgannwg maternity review. The self-assessment would be rag rated, with a focus on areas that are red or amber. The Health Board has complied with the Welsh Government (WG) request and submitted a self-assessment. The self-assessment was executive led and involved multidisciplinary members of the Families and Therapies Division. No red rag rated areas were reported in the self-assessment, however, there were several amber areas flagged. The Health Board had requested guidance from WG

	regarding examples of evidence in relation to the amber areas. A report would be provided to the Committee at a future meeting, including the WG feedback to the Health Boards response. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee was informed that there was a national event planned for July, during which the Neonatal and maternity Board, WG and all Health Boards would review the collective finding from the self-assessments and plan the required improvement actions. The Committee was assured that the Health Board had undertaken the self-assessment and were reviewing services locally through the Health Board Maternity Services Assurance Group. It was agreed that a copy of the Health Board's self-assessment would be shared outside of the meeting. **Action: Rhiannon Jones/Linda Alexander** James Calvert highlighted the Health Board's positive culture and open approach to reporting that encouraged clinical staff to speak out when deemed necessary. Rhiannon Jones discussed an example of this when Health Board midwives formally reported their concerns, demonstrating the culture of an open approach to reporting, resulting in clinically driven decisive action. The Committee **NOTED** the report for **ASSURANCE**.
PQSO 0706/12	**Patient Quality and Safety Outcomes Report** Rhiannon Jones, Director of Nursing, provided an overview of the Outcomes report. Reporting within the Health Board continued to adopt a proportionate approach due to sustained challenges and therefore focussed on high-risk matters. The Committee's previous request of using arrows to demonstrate progress on the 'status at a glance' report, and the addition of a glossary at the end of the report had been fulfilled. The Committee was informed that two areas of concern continued to be 'red' RAG rating: Stroke Services and Urgent Care. Two additional red rated areas to note, were Never Events and Cancer Services. There has been an addition to the risk list which related to 'inter-site hospital transfers', falling under the 'safe care' category and currently rated as amber.

	Cancer performance had declined with challenges to manage backlog, compounded by increasing referrals. Cancer harm reviews have commenced to consider the impact of breaches in patients' care. In respect of Infection Prevention and Control there had been a reduction in the number of inpatients diagnosed with Covid with minimal outbreaks on hospital wards and a positive position in care homes. There had been an improvement in the rate in Colostrum Difficile (CDif), noting the occurrence remains above target, mirrored across Wales. Infection control teams were undertaking reviews to further understand this position. The report included options to implement a Child and Adolescent Mental Health crisis hub. A full report on this to come back to a future Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** A draft report had been received via Welsh Risk Pool, following their review of the Venous Thromboembolism. The Health Board was undertaking a review of the current position and action plan and an update would be submitted to Welsh Risk Pool by July 2022. It was agreed that an update would be presented to the August Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee was informed that the Urgent Care system remained under sustained and continued pressure. WG has published the requirements for '6 Goals for Urgent and Emergency Care' and an extraordinary meeting of Board members and Executives had been scheduled to discuss this and the Health Board response for June 2022. An ongoing review of the Urgent Care Transformation Board was in progress, and it had been proposed that the meeting would be redesigned to focus on the 6 goals. The system pressures had resulted in detrimental impact on patient experience, with some patient safety risks with lengthy delays on patient flow, together with delayed ambulance response times in the community. Positive improvements were discussed in Urgent and Emergency care, including previous risks identified in the Minor Injuries Units had eased, with increased staffing, fewer reported incidents a decrease in very unwell patients self-presenting. The Committee noted that an extraordinary meeting had been held in May 2022 with Executive leads, to create a plan for improvement for Urgent and Emergency Care. Whilst outcomes had improved, further work was required.

	Peter Carr, Director of Therapies and Health Science, informed the Committee of the current challenges within the Stroke pathway and how this linked to system pressures on the Urgent Care pathway Further progress had been made on protecting the Hyper Acute Stroke Unit (HASU) for stroke patients, noted as a previous challenge when the HASU was utilised to accommodate non-stroke patients. This will enable therapies colleagues to immediately assess patients on arrival at the Grange University Hospital. As part of the learning and improvement work for stroke services, the Health Board had invited an external organisation, 'Getting It Right First Time' (GIRFT) to review services. This review had taken place and the Health Board was awaiting a formal report containing recommendations. The full report and management response would come back to the Committee, **Action: Peter Carr/Secretariat** Additional work would be undertaken to review the provision of stroke services within current resource allocation against best practice. Expansion of the multidisciplinary teams wherever possible would be considered. ***Louise Wright, Independent Member, left the meeting.*** James Calvert, Medical Director, shared an update on cancer services with the Committee. The following key points were noted: • The Health Board was working towards improving the '62 days from referral to treatment' cancer pathway target. Some of the influencing factors were discussed, including staffing issues and a significant increase in referrals. • In comparison to pre-Covid data, there had been an overall increase in cancer referrals of 15-20%, increasing to 30% for some lower GI and Breast cancer services. • Delayed referrals, and patients were presenting with cancers at an advanced stage, had been exacerbated by Covid. To help combat this, the Health Board had introduced a programme called 'See the Signs', providing guidance on possible early signs of cancer to Primary Care teams and the public. • Single cancer pathways provide scans for patients on first point of contact with clinicians. This service had increased demand on cross sectional imaging, causing some delays in reporting, mirrored nationally. Wales's Radiology Academy has been proactive in increasing radiologist training to address increased demand. • The unavailability of sufficient outpatient appointments has also influenced cancer pathways. Work is underway at Directorate level to address this, noting that there has been a slight improvement due to the relaxation of the social distancing guidance.

	• Delays in histopathology, with 30% of samples not reported in time for the multidisciplinary (MDT) meetings. There is a current business case in development, seeking additional funding to improve the histopathology. • Improved metrics indicate clear visibility of cancer performance. Discussions had taken place at the Cancer Board, looking at innovative predictive modelling to help identify future peaks, allowing for forward planning around required resource based on demand. This is currently being piloted in Breast cancer services. • The Health Board had been successful in securing grant funding, looking at raising awareness and improving referral times for Ethnic Minority Groups and clients with Learning Disabilities. Shelley Bosson, Independent Member, requested assurance around the following: • Relating to Urgent and emergency care, had the ambulance delays and 'appendix B' incidents been completed. Rhiannon Jones informed the Committee that there were 6 outstanding 'Appendix B's', and a review was ongoing, alongside WAST, with a target for completion over the following month. It was noted that none of the 26 'Appendix B's' reviewed so far had met the criteria for a nationally reportable incident. An update on this to be covered in The Outcomes report at the next Committee meeting. **Action: Rhiannon Jones/Linda Alexander** • Requested a more detailed update on the current risk relating to Cancer services. An additional report to come back to the next Committee meeting. **Action: James Calvert/Secretariat** • Relating to Patient Reported Experience Measures, a timeframe for the procurement and installation of the Servica System. Rhiannon Jones informed the Committee that funding approval was with the Charitable Funds team and there were plans for rapid implementation, with further updates to come in Autumn 2022. The Committee **NOTED** the report for **ASSURANCE**. ***Rani Mallison, Director of Corporate Governance, left the meeting.***
PQSO 0706/13	**Operation Jasmine and the Coroner's Inquests- further reflection and learning** In December 2021, Care Inspectorate Wales, Caerphilly County Borough Council, the Health Board, and Social Care Wales worked in partnership to facilitate an online reflection and learning event on Operation Jasmine. As well as the multi-agency learning, the Health

	Board had considered further actions to ensure on-going improvements as a result of the inquests. Rhiannon Jones, Director of Nursing, provided an overview to the Committee of the Health Board's approach to continued organisational learning in respect of Operation Jasmine. The Health Board had produced an improvement plan, commencing work on the nine recommended actions for improvement, noting that the recommendation on the Standardised Reflection Tool had been completed. The recommendations had previously been approved by the Board in April 2022, with agreement for oversight via the Committee. The recommended actions were noted as: • "Lets not forget" – a schedule of awareness raising sessions • A standardised Quality Assurance Framework for commissioned work • A review of the Margaret Flynn Action Plan to assess progress • A review for the process of professional reflection • A strengthening of the patient and family voice with meaningful patient experience gathering • Education programmes – sessions on accountability, record keeping standards, raising concerns, reflective practice. • Review of Dignity and Essential Care Inspection (DECI)/Healthcare Associated Covid Infections (HCAI) processes across all areas • Consider safety tools (10 steps for safety) to heighten awareness and positioning of Quality and Patient Safety • Consider an approach of inter-Divisional reviews A further update on the progress of the improvement plan to be presented to the Committee in February 2022. **Action: Rhiannon Jones/Linda Alexander** The Committee **RECEIVED** the report for **ASSURANCE.**
PQSO 0706/14	**Patient Safety, Quality and Outcomes Committee Risk Report** Danielle O'Leary, Head of Corporate services, Risk and Assurance, presented the risk report to the Committee. The following key points were highlighted: • the continued and sustained challenge of the pandemic response continued to influence the risk environment. • The Committee was advised that work was being undertaken around the development and education around risk management, enhanced through the Health Board's Risk Management Community of Practice and would be monitored via the Audit, Risk and Assurance Committee as part of the Risk Management Strategy realisation plan.

	• A Board session around Risk Appetite had been planned for the for June 2022. • Work was underway to further improve assurance mechanisms to the Board on Health Board commissioned services. • The Committee was asked to note the de-escalation of risks, as referenced within the report. • Progress had been made in relation to the CAHMS risk profile (CRR028), and it was anticipated that an improved position would be reflected in the report at the next Committee meeting. Danielle O'Leary provided assurance to the Committee that areas outlined in the Outcomes Report, Urgent Care, Cancer, and Stroke services were reflected in the Corporate Risk Register. This was positive to note and provided a level of evidence that the thematic approach to risk management had started to embed across the Health Board as Operational 'themes' had been captured Corporately. The Committee risk profiles, and Corporate Risk Register would continue to inform the Committee workplan and all Committee priorities in the future. The Committee **NOTED** the report for **ASSURANCE**.
PQSO 0706/15	**Committee Priorities 2022/23** A presentation had been circulated to members of the Committee that outlined the Committee priorities for the next year. Committee members were invited to share comments with Rani Mallison, Director of Corporate Governance, outside of the meeting. It was agreed that this item would be re-scheduled for the next meeting. **Action: Rani Mallison/Secretariat**
3	**Items to be Received for Information**
PQSO 0706/16	**Highlight Assurance Reports:** **a) Maternity & Neonatal Services Assurance Group** The report was **RECEIVED** for **INFORMATION**. **b) Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chair's Report** The report was **RECEIVED** for **INFORMATION**.
PQSO 0706/17	**An overview of 'Enhanced Care': linking provision, cost, and outcome** The report was **RECIEVED** by the Committee.

PQSO 0706/18	**Internal Audit Report: Facilities (Care After Death) Report- Reasonable Assurance** The report was **RECIEVED** by the Committee.
4	**Other Matters**
PQSO 0706/19	**To Confirm any Key Risks and Issues for Reporting/Escalation to Board and/or other Committees** An oversight of wider maternity services, to include the future of Midwife led Units, to be discussed at Board level. **Action: Rhiannon Jones/Linda Alexander/Rani Mallison**
5	**Date of Next Meeting is Tuesday 16th August 2022 at 09:30 via Microsoft Teams**