CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'CONFIRMED' MINUTES OF THE MEETING OF THE QUALITY & SAFETY COMMITTEE, HELD ON 10 DECEMBER 2019 AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT:

Maria Thomas	-	(Chair) Health Board Vice Chair
Keiron Montague	-	Independent Member
James Hehir	-	Independent Member
Nicola Milligan	-	Independent Member
Dilys Jouvenat	-	Independent Member
Jayne Sadgrove	-	Independent Member

IN ATTENDANCE

Marcus Longley	-	Health Board Chair (In part)
Anne Phillimore	-	Director of Workforce & OD (Interim)
Eiri Jones	-	Programme Director
Gaynor Jones	-	Royal College of Nursing Convenor
Georgina Galletly	-	Director of Corporate Governance/Board Secretary (Interim)
Greg Dix	-	Director of Nursing, Midwifery and Patient Care
John Palmer	-	Chief Operating Officer
Kelechi Nnoaham	-	Director of Public Health
Mark Simons	-	Staff Side Health & Safety Representative
Nick Lyons	-	Medical Director
Rowena Myles	-	Cwm Taf Morgannwg Community Health Council
Sara Utley	-	Wales Audit Office
Clare Williams	-	Assistant Director of Planning & Partnerships (In part)
Jane O'Kane	-	Head of Nursing, Children & Young People & CAMHS (In part)
Emma Walters		Corporate Governance Officer/Committee Secretariat

PART 1. PRELIMINARY MATTERS

QSC/19/165 **PATIENT STORY**

Members received a Patient Story from Jess Jones. Maria Thomas welcomed Jess Jones and baby Cole to the meeting and advised of the importance Board Members understanding the positive and negative experiences of patients and added that she may be asked to attend Board at some point in the future to share her story.

In sharing her story with Members, Jess Jones advised of the difficulties she experienced whilst being pregnant with her first child 10 years ago.

Jess Jones advised of issues relating to lack of continuity of care from clinicians, she felt that staff had not appreciated the pain she was in during labour, she also felt moments of embarrassment and loneliness which had made her feel that she did not want any more children. Members **NOTED** that during her second pregnancy there was again no continuity of care, with Jess Jones seeing five different consultants and six different midwifes in which she had to explain to each of her previous experiences. Jess Jones advised that she felt that she could not build up a relationship with the consultants involved in her care and advised of lack of eye contact being experienced, and no introductions made to any other colleagues within the consulting area at the time. Members **NOTED** that she had not been advised of any other options as to which hospitals she could give birth at and advised that she eventually chose to give birth at the Princess of Wales Hospital which had been a fantastic experience.

Members expressed their disappointment and apologised for the negative experiences Jess Jones went through. Nick Lyons advised that he would follow-up the communication issues in this case. Members agreed that communication and engagement were key issues to be taken forward as part of the training and education agenda and the work being undertaken on values and behaviours.

A discussion was held as to the importance of the medical record and it was **NOTED** that there were different clinical systems in place at Princess of Wales Hospital which were in the process of being addressed. Members **NOTED** that access to data was being improved with medical records being digitised.

Members **NOTED** that at 36 weeks Jess Jones approached the reception desk distraught at her experience and was then introduced to Sarah Fox, Consultant Midwife who supported her through the rest of her care. Maria Thomas extended her thanks to Jess for sharing her story and advised that 'My Maternity, My Way' had now been established within the Health Board enabling patients to share their experiences of care received and advised that she would value Jess's input into this forum.

Jess Jones left the meeting at this point.

Nicola Milligan expressed concern that issues were still being experienced by patients 10 months on from the publication of the Joint report of the Royal College of Obstetricians & Gynaecologists and Royal College of Midwifes and questioned what was being done to address this.

Members **NOTED** that this would be an ongoing Board wide piece of work in relation to changing culture which was not limited to Maternity Services. Members agreed that it would be helpful if the story could be shared with clinicians and the Maternity Improvement Board.

QSC/19/166 **WELCOME AND INTRODUCTIONS**

Maria Thomas (Chair) **welcomed** everyone to the meeting, including Sara Utley, Wales Audit Office and Jane O'Kane who was attending the meeting on behalf of Alan Lawrie.

QSC/19/167 **APOLOGIES FOR ABSENCE**

Apologies for absence were **RECEIVED** from Alan Lawrie, Alison Davies, Chris Beadle, David Jenkins, Erica Hawes, Kevin Smith, Martin Gill, Liz Wilkinson and Paul Dalton.

QSC/19/168 **DECLARATIONS OF INTERESTS**

There were no additional interests declared.

QSC/19/169 **TO RECEIVE THE UNCONFIRMED MINUTES OF THE MEETING HELD ON 5 NOVEMBER 2019**

The minutes of the Quality, Safety & Risk Committee held on 5 November 2019 were **received** and **confirmed** as an accurate record of the meeting, subject to the following amendments:

Page 3, QSR/19/146 – Jayne Sadgrove said the statement made in the final bullet point could not be marked as 'completed' as this remained on the forward work programme;
Page 10, QSR/19/151, fifth bullet point to be amended to read 'the first Clinical Policies Group had been held with an upward report being presented to the December *Quality Improvement & Clinical Effectiveness sub-committee*';
Page 11, QSR/19/152, second sentence, third bullet point be amended to read 'newly named as '*My Maternity, My Way'.*

Members **RESOLVED** to:

- **APPROVE** the Minutes of the Quality, Safety & Risk Committee held on 5 November 2019 subject to the above amendments

QSC/19/170 **TO RECEIVE THE COMMITTEE ACTION LOG REVIEW MATTERS ARISING NOT CONTAINED WITHIN THE ACTION LOG**

Members **RECEIVED** and **NOTED** the Committee Action Log. The following key updates were provided:

- Page 1 QSR/18/11 – Occupational Health Skin Surveillance – Members **NOTED** that Anne Phillimore was the Executive Lead for this matter. Members **NOTED** that an update report would be presented at the January 2020 meeting **(action log updated and added to the forward work programme)**;
- Page 1 QSR/19/78 – Follow-Up Outpatients Not Booked – Members **NOTED** that an update report had been presented to the In-Committee Board meeting in November 2019 where assurance had been provided as to processes in place to address the issues including a further harm review. John Palmer advised that regular update reports would continue to be presented to the Committee. Members **NOTED** that this action would remain on the action log and that the timescale for completion was January 2020. Members advised that they would be happy to receive bi-monthly update reports on this matter, and **NOTED** that the position could also be closely monitored by the Quality Assurance and Quality Improvement & Clinical Effectiveness sub-committees **(action log and forward work programme updated);**
- Page 2, QSR/18/81 – Corporate Policy Sub-Group – Members **NOTED** that a recommendation was being made to December 2019 Management Board in relation to extending the timescales for existing policies. Members **NOTED** that an update would be presented to the January 2020 meeting;
- Page 2, QSR/18/88 – Peer Review Rapid Response to Acute Illness Learning Set – Nick Lyons advised that as a result of staff sickness, an update report would now be presented to the February 2020 meeting **(action log and forward work programme updated);**
- Page 2, QSR/19/48 – Medical Staffing in A&E – Members discussed the action and **AGREED** a further update report was required in relation to medical staffing issues and any associated risks. Members **AGREED** that the Quality Assurance Sub-Committee undertake a review of the performance dashboard to determine whether there were any quality issues associated with medical staffing issues **(action log updated and added to the forward work programme)**;

- Page 3, QSR/19/59 – Switchboard Issues – Members **NOTED** the ongoing issues in relation to accessing switchboard, with some calls taking up to 30 minutes to be answered. Members **NOTED** that it had been proposed that a review of the issues would be undertaken by the Quality Assurance Sub-Committee. Greg Dix advised that he would discuss this proposal outside of the meeting with John Palmer and Eiri Jones to determine whether the Quality Assurance Sub-Committee would be the right group to undertake the review. Members **NOTED** that the Welsh Language Team would need to be involved in switchboard discussions also **(action log updated);**
- Page 3, QSR/19/86 – Cancer Services Update – John Palmer advised that the Delivery Unit would be undertaking a review of front desk reporting in Radiology in preparation for the single cancer pathway becoming fully live after the shadow reporting period. Members **NOTED** that the Terms of Reference for the review would be presented to Management Board and it was hoped that a further update could be provided to the Committee at its February 2020 meeting **(action log update and added to the forward work programme);**
- Page 3, QSR/19/147 – Welsh Ambulance Services Trust (WAST) Patient Safety Presentation on Themes and Trends – Georgina Galletly confirmed that following Executive Team discussion this action was completed **(removed from the action log);**
- Page 3, QSR/19/131 – Delivery Unit Report Management and Review of Patient Safety Incidents and Concerns – Jayne Sadgrove advised that even though the Committee had received the report and action plan, there was further work required which would need to be monitored. Greg Dix advised that a commitment had been made to provide a quarterly update to the Committee and Members **NOTED** that this would be added to the forward work programme. Georgina Galletly advised of the need to develop robust monitoring arrangements for all reports **(action log updated and added to the forward work programme);**

Jayne Sadgrove stated that the action log did not reflect that totality of actions contained within the minutes and advised that the forward work programme did not fully correlate with the action log and meeting minutes. Georgina Galletly advised that work was being undertaken to address this and advised that monthly meetings were proving difficult to service in timely manner. Some suggestions were made as to how this might be addressed which would be considered further by the Board Secretary.

QSC/19/171 **TO REVIEW MATTERS ARISING NOT CONTAINED WITHIN THE COMMITTEE ACTION LOG**

There were no matters arising.

PART 2. ITEMS FOR APPROVAL/ENDORSEMENT

QSC/19/172 **TO RECEIVE AND APPROVE THE IONISING RADIATION PROTECTION POLICY**

John Palmer presented the report which was seeking approval from the Committee for the Ionising Radiation Protection Policy.

Jayne Sadgrove advised that it would have been helpful if some reference could have been made to Ionising Radiation (Medical Exposure) Regulations IR(ME)R in the executive summary and sought clarity as to whether an Equality Impact Assessment was required and had been completed. A discussion was held as to whether this policy should have been presented to the Clinical Policies Sub-Committee for approval. John Palmer advised that the previous governance route would have been through the Ionising Radiation Protection Committee but he was content to present the policy through the Clinical Policies Sub-Committee if required. Members **NOTED** that clarity would be required moving forward in relation to policy refresh and approval.

Members **RESOLVED** to: **APPROVE** the Policy.

QSC/19/173 **PATIENT STORIES – LISTENING TO AND LEARNING FROM PATIENTS AND STAFF**

Eiri Jones presented the report, the purpose of which was to propose for patient stories to be part of the Terms of Reference for the Quality & Safety Committee and to be a standing item on the agenda for each meeting. Members **NOTED** that a similar proposal would be presented to Board also.

Members **NOTED** that the report identified that there were a number of ways in which stories could be presented and that the process did not need to be complicated. The process would require some co-ordination and resource to support the function. Members **NOTED** the importance of providing feedback to patients who had shared their stories and the recording of specific actions that would need to be undertaken. Eiri Jones advised that if the proposal was supported an outline business case would be developed.

Following discussion, Members supported the proposal and advised of the need to ensure there was triangulation of data in place and of the need to ensure a consent process was in place. Members **NOTED** that consideration would also need to be given to equality and welsh language issues associated with patient stories also. It was also suggested that staff stories could also be presented to the Committee.

A discussion was held in relation to Community Health Council visit reports. Members **NOTED** that these reports were now being presented to the Patient Experience Sub-Committee which reported into the Quality & Safety Committee.

A suggestion was made that patient stories would need to be closely linked with the Committee's forward work plan and it was agreed that feedback would need to be provided to patients following presentation of such stories.

Members **RESOLVED** to:

- **NOTE** the report;
- **APPROVE** the proposal outlined in this paper in relation to establishing patient stories as a standing agenda item
- **SUPPORT** the proposal to resource the management of patient stories and to establish a patient stories library as a learning resource across the organisation, which would be provided by undertaking a redesign of roles.

QSC/19/174 **IMPLEMENTATION OF THE QUALITY & PATIENT SAFETY GOVERNANCE FRAMEWORK**

Eiri Jones presented the report the purpose of which provided an update on the actions taken to date (Month 5) to implement the current Quality & Patient Safety Governance Framework (April 2019) across the Health Board. It also provided information for discussion in relation to next steps once the current six month programme completes at the end of December 2019.

Members **NOTED** that the majority of actions were nearing completion and that the framework would be revised once the new operating model was implemented. Maria Thomas advised that progress seemed to have slowed during November and December 2019. Members **NOTED** that there had been challenges in relation to attending quality governance meetings which were not being held as frequently as they should have been and **NOTED** that there had been recent improvements in engagement. Members **NOTED** that work was being undertaken to improve links between Clinical Business meetings and Quality Governance.

Members **NOTED** that the Quality Dashboard had developed further and would be presented to the January 2020 meeting with inclusion of additional narrative. Greg Dix advised that work was also being undertaken to align the 22 quality indicators with the information contained within the quality dashboard. Members **NOTED** that informatics would be supporting the work in relation to the Quality Strategy and Sara Utley advised that she would welcome a discussion with Greg Dix and Eiri Jones regarding ideas she had in relation to the content of the dashboard.

A discussion was held in relation to the Terms of Reference for each of the four sub-committees. Members **NOTED** that the Terms of Reference for the Quality Improvement and Clinical Effectiveness Sub-Committee would be finalised later that week. Members **NOTED** that the Patient Experience Sub-Committee would now be held bi-monthly as opposed to quarterly and it was **NOTED** that reference to 'risk' would need to be removed from each of the Terms of Reference.

Members **NOTED** the upward reports from the Patient Experience and Quality Assurance Sub-Committees and the level of assurance the Committee had received from these reports.

Members **NOTED** that Eiri Jones would continue to work with the Health Board until the end of March 2020 and thanks were extended to her for the work undertaken to date.

Members **RESOLVED** to:

- **NOTE** the report;
- **APPROVE** the Terms of Reference for the Sub-Committees;
- **NOTE** the Sub-Committee upward reports.

QSC/19/175 **DELIVERY UNIT REPORT ALL WALES REVIEW OF PROGRESS TOWARDS DELIVERY OF EYE CARE MEASURES**

Members **RECEIVED** the report and **NOTED** that the report had also been presented to Management Board.

Members **RESOLVED** to:

- **NOTE** the Management Response and improvement plan.

QSC/19/175 **DELIVERY UNIT REPORT REVIEW OF OPHTHALMIC DIAGNOSTIC AND TREATMENT CENTRE**

John Palmer presented the report and advised that the report had also been presented to the Primary & Community Care Committee and Management Board, where assurance had been provided that most actions had been progressed.

Members **NOTED** that a long term plan was in the process of being developed for Ophthalmology, which included pathway redesign and cataract outsourcing. Members **NOTED** of the plans due to take effect from January 2020, which would enable five practitioners to undertake non-medical injections. Members **NOTED** that Cwm Taf Morgannwg were the only Health Board in Wales not to have these practitioners in place. A discussion was held as to the model to be adopted and John Palmer advised that he would be content to present the plan being proposed to the Committee in due course, following its discussion at Management Board.

Maria Thomas extended thanks to John Palmer for presenting the report, highlighted that some of the timescales within the action plan were now out of date and questioned when an updated action plan would be presented to the Committee. John Palmer advised that he would be happy to present an update to either the March or April 2020 meeting, subject to the plan being presented to Management Board first **(added to the action log and forward work programme).**

Members **RESOLVED** to:

- **NOTE** the Management Response and improvement plan.

QSC/19/176 **DELIVERY UNIT REPORT CARDIAC WAITING TIMES FOLLOW-UP**

John Palmer presented the report and advised that the review had focussed on the administration of the pathway, with a number of risks identified within the report, which could not be resolved until e-referral pathways and standard operating procedures were put into place, particularly at the Princess of Wales Hospital.

Members **NOTED** that management was discussing the necessary actions, and resources had been allocated from the Programme Management Office to support implementation.

Given the differences in the findings of the Delivery Unit and the Health Board's self-assessment, Maria Thomas said that further work would be required with revised timeframes identified within the plan.

John Palmer **AGREED** to seek confirmation as to when a further update could be provided to the Committee and advised that he hoped to present an update to the Committee by April 2020, following an update being provided to Management Board. Members **NOTED** that this would be added to the forward work programme **(added to the action log and forward work programme).**

Members **RESOLVED** to:

- **NOTE** the action plan and report;
- **RECEIVE** a further update on progress at a future meeting.

PART 3. GOVERNANCE, PERFORMANCE AND ASSURANCE

QSC/19/177 **HEALTHCARE INSPECTORATE WALES (HIW)/WALES AUDIT OFFICE (WAO) JOINT REVIEW INTO QUALITY GOVERNANCE**

Maria Thomas advised that concerns had been raised by Independent Members of the late submission of the report which had impacted on their ability to conduct scrutiny.

Kelechi Nnoaham extended apologies to Members for the late submission and advised that he wanted to ensure it had been presented through the correct governance processes which had resulted in the report being late.

Members **NOTED** that the report contained 14 recommendations for the Health Board to address and the Committee would recognise the weaknesses identified in the report in relation to quality governance systems and processes and each recommendation was being responded to directly which would take time. Kelechi Nnoaham advised that he would be happy to present the report to the January 2020 meeting and would welcome feedback from Members in the meantime **(added to the action log and forward work programme).**

Members **NOTED** that the management response would be discussed with HIW/WAO later that week and the final management response would be presented to January 2020 Board meeting for approval, following discussion at the January 2020 Quality & Safety Committee.

Members **NOTED** that a number of work-streams would need to be established to address the recommendations, each of which would be assigned to a Committee.

Members **RESOLVED** to:

- **NOTE** the report;
- **AGREE** to discuss further at the January 2020 meeting **(added to the action log and forward work programme).**

QSC/19/178 **MOTHERS AND BABIES: REDUCING RISK THROUGH AUDITS AND CONFIDENTIAL ENQUIRIES (MBRRACE) UK UPDATE REPORT**

Nick Lyons advised that the publication of the report had been delayed as a result of Purdah and advised that the report would be presented to a future meeting **(added to the action long and forward work programme).**

Members **RESOLVED** to: **NOTE** the oral update.

QSC/19/179 **NATIONAL MATERNITY AND PERINATAL AUDIT 2019**

Nick Lyons presented the report. Members **NOTED** that there were no particular issues within the report of which the Health Board was unaware and that the findings would need to be considered alongside the recommendations contained within the joint review undertaken by the Royal College of Obstetricians & Gynaecologists and Royal College of Midwifes. Members **NOTED** that a further discussion would be held at the Maternity Improvement Board.

Marcus Longley advised that the report indicated that there were no quality and safety implications associated with this and he was unclear as to how the Board could be provided with assurance of the significant issues. Nick Lyons advised that the issues highlighted were already being addressed through a number of action plans and there was concern as to who was owning the actions.

Members **NOTED** that a further discussion would need to be held as to where progress would get reported and **NOTED** that this would be discussed further by Nick Lyons and Greg Dix outside of the meeting.

Members **NOTED** that an update report would be presented to the February 2020 meeting, alongside an update on MBRACCE. Greg Dix advised that he would ask Jo Hilborne, Clinical Director to be in attendance to take part in the discussions **(added to the action log and forward work programme).**

Members **RESOLVED** to: **NOTE** the content of the report.

QSC/19/180 **MATERNITY IMPROVEMENT PROGRAMME**

Greg Dix presented Members with an oral update and advised that the second engagement event had been held with women and families on 28 November 2019 and was attended by approximately 30 women.

Members **NOTED** that 140 cases would be reviewed under the revised criteria and it had been agreed with the Independent Maternity Services Oversight Panel that correspondence would be sent to patients post the Christmas period. Members **NOTED** that six sets of medical records were being reviewed by the Clinical reviewers that week which was presenting a challenge in terms of the required redactions which had been made known to Mick Gianassi and would also be discussed further at the Maternity Improvement Board.

Members **NOTED** that there had been an improvement in the staffing position, with seven new midwifes recruited onto the Prince Charles Hospital site and no vacancies currently on the Princess of Wales and Royal Glamorgan Hospital sites. Nicola Milligan advised that although there were lots of staff working incredibly hard there was still some further work required to improve services.

Members **RESOLVED** to: **NOTE** the oral update provided.

QSC/19/181 **DIRECTORATE EXCEPTION REPORTS**

Anaesthetics, Critical Care & Theatres

John Palmer presented the report and highlighted the following key areas:

- Some follow-up work would be required with Health Education Improvement Wales (HEIW) in relation to discussions being held regarding service redesign opportunities, which may affect the medical staffing position;
- There were unplanned changes to the location of the Intensive Treatment Unit at Prince Charles Hospital as a result of Ground and First floor works being undertaken which would be challenging for operational teams;

Jayne Sadgrove made reference to 'single use only' laryngoscopes and advised that the dashboard indicated that issues were still being experienced with infections.

Members **NOTED** that this had been discussed at the previous Infection, Prevention & Control Committee and a plan to address this was in the process of being developed.

Maria Thomas expressed concern at the medical staffing position and advised that she felt the Committee had not been provided with assurance that this was being addressed. Members **NOTED** that discussions had been held with the Health Board's communication team and discussions had also been held with the Medical Director at HEIW in this respect.

James Hehir advised that during a recent visit to the Intensive Care Unit (ICU) at Prince Charles Hospital, patient flow was highlighted as an issue, with concerns raised that staff were being asked to help on other wards which meant their skills were not being fully utilised. Members **NOTED** that there were plans in place to try to address the position and assurance was provided that the less experienced nurses being placed into ICU had appropriate supervision arrangements in place.

Children & Young People

Jane O'Kane presented the report and highlighted the following key areas:

- There were insufficient staffing levels within the service with challenges being experienced in recruiting staff to Royal Glamorgan Hospital, which had led to an increase in the usage of bank and agency staff. Controls were in place and a range of alternative options were being considered, particularly in relation to the Paediatric medical staffing position;
- In relation to the Princess of Wales Hospital, the Health Board was NOTED to be managing a number of issues in relation to unfunded cots;
- Since the last report, there had been two serious incidents that had occurred at Ty Llidiard, with no harm experienced to either patient. There had been an additional five 'no surprises' matters reported to Welsh Government, one of which was in Child and Adolescent Mental Health Services (CAMHS). Work was being undertaken to ensure any lessons learnt were being shared amongst the Directorate;
- Winter pressures had exacerbated staffing issues across all three sites;
- A network review and assessment had been undertaken of the Neonatal Unit at PCH which identified gaps in provision. A report would be developed to identify how actions identified would be addressed;

- Positive external reviews had been undertaken by the Delivery Unit and QNICS;
- There had been a reduction in waiting lists in Primary and Secondary CAMHS as a result of work undertaken on job plans and waiting list initiatives;
- An engagement event for young people would be held in February 2020 to identify how young people wish to engage with the Health Board.

Keiron Montague expressed concern at the nurse staffing levels and shortage of Paediatric Doctors identified within the report and questioned whether the risk score reflected the position. Members **NOTED** that meetings had been held recently to discuss safe staffing and **NOTED** that a proposal was being developed for the Executive Team to consider. Nick Lyons advised that he would be happy to provide a further update to the Board at the next meeting and Members **NOTED** that the service remained incredibly fragile.

Members **NOTED** that the Princess of Wales Hospital had recently been awarded the Stage 3 Baby Friendly Initiative. Gaynor Jones welcomed the steps being taken to retain staff within the department.

Workforce

Anne Phillimore presented the report and advised that further work would need to be undertaken on the format of future reports to ensure that risks were being escalated. The following key updates were received:

- A number of concerns had been raised in relation to Resuscitation Services and a discussion had been held with Nick Lyons, Greg Dix and Georgina Galletly regarding governance processes and structures. Members **NOTED** that steps would now be taken to put an overarching Resuscitation Committee in place;
- An action plan was in place to address the Junior Doctor resuscitation compliance issues, with some additional support being deployed to address this;
- It was expected that there would be 150 overseas registered nurses in place within the organisation by the end of the financial year. An assessment of the position would be undertaken in February 2020 to determine whether additional recruitment needed to be undertaken;
- Work was being undertaken on exposure prone procedures with a plan in place to address;

- Concerns remained in relation to compliance against Welsh Language Standards which was a major risk to the organisation. Requests for exceptions had been submitted against a number of Standards some of which had been accepted.

Maria Thomas advised that future reports would need to clearly identify the risks that needed to be escalated to Board and Members **NOTED** that Georgina Galletly had offered her support to the Team in relation to the content of future reports.

Members **RESOLVED** to: **NOTE** the reports

QSC/19/182 **SAFEGUARDING AND PUBLIC PROTECTION SELF ASSESSMENT REPORT 2019**

Greg Dix presented the report and advised that the Safeguarding Annual Report would be presented to the February 2020 Quality & Safety Committee meeting **(added to the forward work programme).**

Members **RESOLVED** to: **NOTE** the report.

QSC/19/183 **INTEGRATED MEDIUM TERM PLAN (IMTP) 2020 – 2023 UPDATE**

Clare Williams presented the report which provided an update on progress made with the development of the IMTP 2020 – 2023. Members **NOTED** that the first draft of the Equality Impact Assessment (EQIA) was now available with Directorate level EQIA's on target to be presented to the Committee in the new year.

Members **NOTED** that Welsh Government had advised that they were content with the approach being taken and that engagement continued to be undertaken with stakeholders. Clare Williams advised that she would welcome comments in relation to the content of the IMTP from Committee members.

Members **RESOLVED** to: **NOTE** the update provided

QSR/19/184 **MORTALITY INDICATORS PROPOSED WAY FORWARD**

Nick Lyons presented the report which provided an update on the progress and development of the Universal Mortality Review within the Health Board, highlighting the learning from Mortality. The report also summarised the process and outcomes of mortality case note reviews of inpatient deaths.

Members **NOTED** that there were three stages within the mortality review process, with a proposal being made to focus more effort on stage 1 as opposed to stage 3. Members **NOTED** the report identified the key areas where improvement was required and it was **NOTED** that learning from mortality reviews needed to be embedded to ensure it was not an isolated process.

Members **NOTED** that Kelechi Nnoaham had offered to support the review of data being presented and an update on this review would be presented to the February 2020 meeting **(added to the forward work programme).** It was also suggested that a discussion could also be held at the Quality Governance & Learning Sub-Committee. Maria Thomas welcomed the suggested approach and requested that any issues identified were escalated to the Committee.

Members **RESOLVED** to: **NOTE** the report.

QSC/19/185 **MINUTES REPORTS FROM SUB GROUPS**

Members **RECEIVED** and **NOTED** the following:

Equality & Welsh Language Report

Dilys Jouvenat made reference to page four of the report and suggested that reference made to the extension of Standards 110 and 110A should read 30 November 2020 as opposed to 30 November 2019. James Hehir advised that he had previously raised concerns that Health Boards would be recruiting from a small pool of welsh speaking candidates.

Infection Prevention & Control

Jayne Sadgrove made reference to the discovery of Legionella at the Princess of Wales Hospital which had now been cleared. Members **NOTED** that random tests were now being undertaken and that the Water Safety Action Group were closely monitoring the position.

Members **RESOLVED** to: **NOTE** the updates provided.

QSC/19/186 **HEALTH BOARD ANNUAL PRESCRIBING REPORT**

Nick Lyons presented the report which highlighted that the Health Board was the seventh ranked Health Board in Wales with the highest opioid burden in Wales, with a small decrease in the last year. Members **NOTED** that the Health Board was also the highest prescriber of Antibiotics in Wales.

Members **RESOLVED** to: **NOTE** the report.

PART 4. ITEMS FOR INFORMATION

QSC/19/187 **PATIENT EXPERIENCE AND CONCERNS REPORT**

Members **RECEIVED** and **NOTED** the report.

QSC/19/188 **DIRECTORATE EXCEPTION REPORTS**

Members **RECEIVED** and **NOTED** the reports. Members requested that the Radiology Directorate Exception Report was presented to the January 2020 meeting as it was late in being submitted **(added to the forward work programme).**

QSC/19/189 **HEALTHCARE INSPECTORATE WALES ANNUAL REPORT**

Members **RECEIVED** and **NOTED** the report.

PART 5. OTHER MATTERS

QSC/19/190 **Any Other Business**

There was no other business to report.

QSC/19/191 **Forward Look**

Members **NOTED** that this would be reviewed further outside of the meeting. Members **NOTED** that a discussion would also be held in relation to the need to ensure the forward look triangulated with the action log and minutes.

QSC/19/192 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place at 9.00 a.m. on 14 January 2020.

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Maria K Thomas, Chair

Date……