AGENDA ITEM 5.1.6

Reporting Committee	**Quality & Safety Committee**
Chaired by	Maria K Thomas
Lead Executive Directors	Greg Dix Director of Nursing, Midwifery and Patient Services. Georgina Galletly, Interim Board Secretary
Author and contact details	Kathrine.davies2@wales.nhs.uk
Date of last meeting	14 January 2020

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Quality Safety & Risk Committee last met on the 14 January 2020, the agenda and papers are available on the following link: https://cwmtafmorgannwg.wales/how-we-work/quality-safety-risk-committee/

Patient Story

Brian Shilton, Health Visitor shared his story with the Committee with regard to the Dad's Baby Massage initiative. Members thanked Brian and were of the opinion that this was an excellent initiative and good to see services being offered outside of normal working hours and a great step forward. Members agreed that it would be good to see an evaluation of the take up of the service.

Management Response Regarding Healthcare Inspectorate Wales/Wales Audit Office Joint Review into Quality Governance

Members **received** the report and draft Management Response to the Joint Review. Members were advised that the draft response had been shared with Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) for initial feedback. Members **noted** that the response highlighted ten programmes of work that were ongoing within the organisation, all of which directly or indirectly touch on the issues highlighted in the review. Members **noted** that the Management Response would be monitored through the new Maturity Matrix to ensure that learning would be embedded across the organisation. Members **resolved** to **approve** the final draft response for onward submission to the Health Board at its meeting on the 30 January 2020.

Patient Experience and Patient Safety Report

Members **received** the report that was presented by Greg Dix. Members were advised that the report was in a new format and feedback would be welcomed.

Members **noted** that there had been a decline in the number of complaints received in November. Response times had also declined from 80% in

October to 67% currently. The Princess of Wales (POW) site had a consistent response rate of above 85%. The POW's unit's and service level governance structures were mature and the revised structures in the other units would help assist with the required changes in concerns management.

With regard to patient experience comments captured, it was **noted** that there had been some comments received from patients with regard to staff attitude on Wards 21 and 22 in the Royal Glamorgan Hospital (RGH) and timeliness of medication and pain relief in post-natal care. However, most comments being captured were rating the experience as high.

Members were advised that concerns with the quality of medical child protection assessments had been reported and there was ongoing improvement work to ensure required standards were met.

Members **noted** that two "Never Events" had been reported in Princess of Wales Hospital (POW), both relating to wrong site anaesthetic blocks and work was ongoing to identify any further required action following the immediate make safe actions put into place at the time. Five pressure ulcer incidents had also been reported.

Maternity Service Improvement Programme Update

Members **received** the report that was presented by Greg Dix. Members were advised that the next Independent Maternity Strategic Oversight Panel (IMSOP) Quarterly Report would be published by Welsh Government on the on 20 January 2020. IMSOP had validated 25 of the recommendations and had requested further information against the remaining recommendations. Members were advised that some actions would take longer to complete, however good progress had been made in the last few months.

Members **noted** that with regard to Safe and Effective Care, 10 metrics had been developed which were being monitored by Welsh Government on a weekly basis.

Members were advised that two Women and Families Engagement Events had been held which had been very well attended and received. The third event was planned for Bridgend in February.

Members **noted** that with regard to the clinical reviews, letters had been sent out to the first group of women and a helpline had been set up to provide support.

Members **resolved** to **note** the report.

Safe Storage of Medicines: Cupboards, Patient Safety Notice (PSN) Compliance

Members **received** the report that was presented by Alan Lawrie.

Members **noted** the update on the recent assessment undertaken in January 2020 with regards to compliance. Members were advised that a revised Welsh Government Guidance would shortly be published and a re-audit would be undertaken following this and brought back to the Committee. Members **resolved** to **note** the report.

Harm Review Process Implementation
Members **received** the report that was presented by Nick Lyons.

Members **noted** that the report outlined the work being progressed on the introduction of a systematic Harm Review process for patients who had been delayed or on the waiting list beyond recommended time standards in a number of areas across the organisation.

Members **noted** that a Waiting List Management Task and Finish Group has been established to take forward the response to the Delivery Unit (DU) review of waiting lists and it was suggested that the Harm Review Group reports into this as the outputs were part of the Organisational response. The work of the Task and Finish Group would be fed into the Quality Assurance Sub-Committee and operational processes. Members **noted** that the Task and Finish group have agreed a number of top priority areas to implement harm reviews which were outlined on page 3 of the report. Members **resolved** to **note** the report and receive an update in three months' time.

Directorate Exception Reports

The Committee **received, discussed** and **noted** four Directorate exception reports:

- Radiology
- Obstetrics & Gynaecology
- Surgery
- Medicine

The reports informed members of the common themes raised and risk and mitigating actions taken within/across the exception reports. Members were assured that actions were being taken where necessary to mitigate those risks. Members **resolved** to **note** the reports.

Emergency Medicine Medical Staffing
Members **received** the report that was presented by Nick Lyons. Members **noted** that the report highlighted the medical staffing issues facing the emergency departments in CTMUHB. The most significant risk being the Royal Glamorgan Hospital.

Members were advised that the Emergency Departments medical staffing needed to be looked at in the context of type of attendances expected in the future and a multidisciplinary approach to medical workforce planning

and training needed to be adopted. Members were advised that the Emergency Departments required specific ongoing support from the workforce team to support use of available e-roster systems. Members discussed current staffing levels and were advised that the organisation was doing everything possible with regard to recruitment which was extremely challenging.

Members **noted** that live performance data would now be more readily available with the introduction of Symphony, an Emergency Department focused patient administration system, due within the 2019/2020 financial year in the Royal Glamorgan Hospital and Prince Charles Hospital, however implementation was currently delayed for Princess of Wales Hospital.

Members **noted** that the proposed new service models would be presented to the January 2020 Board meeting. Members **resolved** to **note** the report.

Integrated Medium Term Plan 2020-2023 Development Update

Members **received** the report that was presented by Clare Williams. Members were advised that the working draft had been previously presented to the Board at its meeting November 2019 and Welsh Government for informal consideration.

Members **noted** that there were currently four risks ongoing in the development of the plan and that the organisation was doing everything they could to mitigate those risks. Members **resolved** to **note** the report.

Joint Review Being Undertaken by the Royal College of Surgeons and Royal College of Anaesthetists

Members **received** a verbal update from Nick Lyons. Members were advised that the review highlighted some long term issues at Princess of Wales and Prince Charles Hospital between staff groups with some issues going back for a number of year. Members **noted** that a draft action plan to the review was in the process of being developed and would be presented to the February 2020 meeting. Members **resolved** to **note** the verbal update.

Closure Report on the Implementation of the Quality & Patient Safety Governance Framework

Members **received** the report that was presented by Eiri Jones. Members were advised that the Framework had been developed over the last six months. The framework sets out the work over the next two to five years to change values and culture and foundations were now in place to move forward into the new phase of the proposed new Operating Model. Members **noted** that in terms of building a learning culture the majority of actions had been fully completed. There are some areas that will form part of the legacy and significant steps had been taken in regard to the patient experience work. Members **noted** that the revised framework was in the process of being finalised with work being undertaken to refresh the

Quality Impact Assessment within the IMTP process. Members **resolved** to **note** the report.

Patient Safety Quality Dashboard
Members **received** the report that was presented by Greg Dix. Members were advised that since the last Quality and Safety (Q&S) Committee, further work had been undertaken in partnership with the Performance and Information team in the Planning and Performance directorate to align the information available with the aim of providing assurance on the quality of care across the Health Board.

Members **noted** that the report provided data for the past 12 months and also included trends as a Statistical Process Control chart (SPC). The data was mainly taken from the Health Board's Datix system, with some further data from Myrddin (all-Wales system) and other national reporting systems.

Members were advised that further work was underway to improve data validation and some of the data had been correlated with information from the Delivery Unit in their Quality and Safety Assurance Report provided to the health boards. Members **resolved** to **note** the report.

Minutes/Report from Sub Groups
Members **received** and **noted** the reports from the following Sub Groups:

- Quality & Governance
- Quality Improvement
- Medicines Management

Healthcare Inspectorate Wales Review of Maternity Services
Members **received** and **noted** the report.

Forward Work Plan
Members **noted** that the Forward Work Plan would be discussed outside of the meeting.

Key risks and issues/matters of concern and any mitigating actions	
There were none	
Matters requiring Board level consideration and/or approval	
There were none	
Matters referred to or from other Committees	
There were none	
Date of next meeting	11 February 2020