





		Agenda Item	2.3 (ii)
Freedom of Information Status	Open		
Reporting Committee	Quality and Safety Committee		
Author	Leah Joseph, Corporate Governance Officer		
Chaired by	Martyn Waygood, Interim Vice Chair		
Lead Executive Director (s)	Gareth Howells, Director of Nursing and Patient Experience		
Date of last meeting	22 August 2019		

Summary of key matters considered by the committee and any related decisions made:

Neath Port Talbot Hospital Patient Staff Story – A patient story was received from a gentleman who had suffered an accident at home. He was treated at the Minor Injury Unit (MIU) at Neath Port Talbot Hospital. The staff completed a head assessment review and x-rays were taken. The patient commented that staff were thorough with their checks and that he was seen immediately on attending the unit. The patient was referred to the Ear, Nose and Throat department at Morriston hospital due to the injuries to his face. The patient praised the MIU staff for their care towards him.

The short film also outlined the past 12 months at the MIU in Neath Port Talbot hospital following an unannounced visit from the Healthcare Inspectorate Wales (HIW). The unit had received positive patient feedback via the friends and family tests. Kevin Randall introduced himself as the Lead Consultant Nurse at the Unit and provided information around the amount of patients that are treated at the Unit throughout the year.

Key risks and issues/matters of concern of which the board needs to be made aware:

Infection Control Report – Gareth Howells stated that there is work ongoing with prescribing in the community. The challenge is that the team was not in place to cover the community and he hoped that that a proposal of a dedicated team is supported by the Investments and Benefits Group (IBG).

Delegated action by the committee:

None.

Main sources of information received:

Neath Port Talbot Hospital Patient Staff Story – A patient story was received from a gentleman who had suffered an accident at home. He was treated at the Minor Injury Unit (MIU) at Neath Port Talbot Hospital. The staff completed a head assessment review and x-rays were taken. The patient commented that staff were thorough with their checks and that he was seen immediately on attending the unit. The patient was referred to the Ear, Nose and Throat department at Morriston hospital due to the injuries to his face. The patient praised the MIU staff for their care towards him.

Infection Control - An assurance report provided an update on prevalence, progress and actions for healthcare associated infections (HCAIs) within Swansea Bay University Health Board for the period 1 April – 31 May 2019;

Quality Impact Assessment – a standing item was to be added to the agenda advising of the outcome of the assessments of the savings schemes within the annual plan to ensure there are no adverse impact on quality and safety of care;

Maternity Services Update – a report was received in relation to the maternity services within the health board. The recent Health Inspectorate Wales (HIW) inspection feedback was positive, it was anticipated that the report will be finalized in the next few weeks.

Performance Report – Members received the performance report noting that it had also been considered in the Performance and Finance Committee. Members agreed that further work on developing the quality metrics was required and this would be picked up at the forthcoming development session for the Committee;

Primary Care Dashboard (PCS) – An update on progress to develop the PCS monthly performance statement was provided.

Patient Experience Report – A report information on Patient Feedback and Experience was received. A hybrid approach was mentioned and volunteers collecting the patient feedback was discussed.

Ward to Board Dashboard – Members received a presentation on the progress of the Dashboard since it's pilot launch in Neath Port Talbot Service Delivery Unit (NPT SDU).

Health and Care Standards Self-Assessment 2019/20 Report – Members received and supported the approach outlined in the report. Members noted that there would be some refinements to the process based on feedback from Internal Audit and that the Director of Nursing and Patient Experience would be taking these forward.

Quality and Safety Assurance Framework – Members received the draft Quality and Safety Assurance Framework, noting that this would be considered at the Committee Development Session in October. Members were invited to provide feedback on the draft framework.

Delivery Unit 90 Day Review Action Plan – a further update was received as to progress against the action plan following the NHS Wales Delivery Unit's 90 day review of the Intervention into Systems & Processes for the Management of Serious Incidents;

Internal Audit – a report setting out the findings of internal audit assignments. The report was noted.

External Inspections Report – the regular agenda item was received and discussed, noting that Health Inspectorate Wales had commenced a three day inspection in the period on Maternity Services as part of an all Wales Maternity Review. No immediate improvement notices were issued and the overall feedback was positive. Members also noted that the mortuary was inspected by the Human Tissue Authority. This inspection covered mortuary facilities at Morriston and satellite at Princess of Wales Hospital.

NHS Wales National Clinical Audit And Outcome Review Plan – a report providing an update in relation to the national clinical audit and outcome review plan was received and noted.

Highlights from sub-groups reporting into this committee:

- Clinical Senate Council
- Quality and Safety Forum

Matters referred to other committees:

None identified.

Date of next meeting 24 October 2019