ABM University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 5th April 2018
at 9am in meeting room six, Clinical Accommodation Building,
Morriston Hospital

Present
Maggie Berry, Independent Member (in the chair)
Martyn Waygood, Independent Member
Emma Woollett, Vice-Chair
Ceri Phillips, Independent Member

In Attendance
Angela Hopkins, Interim Director of Nursing and Patient Experience
Christine Morrell, Director of Therapies and Health Science
Sandra Husbands, Director of Public Health
Hamish Laing, Medical Director
Pam Wenger, Director of Corporate Governance
Paula O'Connor, Head of Internal Audit
Carol Moseley, Wales Audit Office
Nia Roberts, Healthcare Inspectorate Wales
Liz Stauber, Committee Services Manager
Rebecca Carlton, Service Director, Morriston Hospital (for minute 49/18)
Suzanne Holloway, Head of Quality and Safety, Morriston Hospital (for minute 49/18)
Mark Ramsey, Unit Medical Director, Morriston Hospital (for minute 49/18)
Judith Vincent, Clincal Director – Pharmacy (for minute 50/18)

Action

43/18 WELCOME AND APOLOGIES FOR ABSENCE

Maggie Berry welcomed everyone to the meeting.

Apologies for absence were received from ABM Community Health Council.

44/18 DECLARATIONS OF INTERESTS

Maggie Berry declared an interest in the dance for health programme highlighted within the patient experience report due to a family member's participation.

45/18 WORK PROGRAMME

The committee's work programme was **deferred** until the 2018-19 plan was established**.**

46/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 1st February 2018 were **received** and **confirmed** as a true and accurate record except to note the following amendments:

10/18 Children and Adolescent Mental Health Services (CAMHS) - paragraph one to read:

Emma Woollett stated that she found the report concerning as it did not appear to have a sense of urgency despite performance being very poor. Whilst she understood the challenges in performance managing a service provided by another health board and did not doubt there was considerable effort being put in, the paper did not provide assurance and there needed to be a plan of action going forward, which included trajectories.

22/18 Patient Experience Report - paragraph four to read

Martyn Waygood sought clarity as to why the committee had been asked to approve the claims policy and procedure. Pam Wenger advised that the health board's current process required policies to be approved by board committees however she *was* reviewing the process as part of her governance 'stock take'.

47/18 MATTERS ARISING NOT ON THE AGENDA

There were no matters arising not otherwise on the agenda.

48/18 ACTION LOG

The action log was **received** and **noted** with the following updates:

Action Point One

Angela Hopkins advised that she had provided feedback to the Welsh Risk Pool with regard to its annual report and the comments had been 'noted' however as it was an external agency's report, the health board was unable to influence the content. Pam Wenger advised that she was due to meet with a senior member of the Welsh Risk Pool and would reconfirm the issues. She undertook to write to the chair of the Welsh Risk Pool to raise the health board's concerns and to circulate a copy of the letter to the committee. **PW**

Action Point Two

Angela Hopkins confirmed that she had discussed the issues relating to child and adolescent mental health services with the Director of Nursing for Cwm Taf University Health Board.

Action Point Eight

Hamish Laing advised that the authorising engineer was reviewing the water policy and it was hoped that an update to the next meeting would confirm it had been approved.

Action Point 21

Emma Woollett noted the length of time it had taken for the committee to receive Singleton Hospital's letter following its June 2017 presentation to the committee and commented that an escalation process was required should actions not be completed in

a timely manner. Pam Wenger advised that this could be considered as part of the upcoming review of the committee's terms of reference. Angela Hopkins added that now the action log include dates, any issues could be escalated to the board via the committee chair's report.

49/18 MORRISTON HOSPITAL DELIVERY UNIT PATIENT STORY AND REPORT

Suzanne Holloway, Mark Ramsey and Rebecca Carlton were welcomed to the meeting.

(i) Patient Story

A patient story was received outlining the experience of an elderly emergency department patient who developed a pressure ulcer. The patient was a risk of developing bed sores as a result of other medical conditions and arrived at the hospital at 8.45am that morning, triaged within the department but due to lack of space, was put back on to the ambulance to wait. By lunchtime a cubicle was available and following the transfer of the patient into the department, a nurse identified red sore and the skin bundle was started. The patient was moved from a trolley to a hospital bed with an air mattress and was rolled into different positions however the patient requested to remain on his back. By the time he was transferred to a ward that evening, the patient had a grade two pressure ulcer. The learning from this case had been shared with staff and a number of actions already taken, including the purchase of additional air mattresses for the department, an increased frequency of checking the skin of patients and engagement with Welsh Ambulance Service NHS Trust (WAST) as to how patients in the back of vehicles could be monitored for skin damage.

In discussing the patient story, the following points were raised:

Suzanne Holloway advised that this patient's story was not a unique case and measures were being put in place to mitigate the problem which was exacerbated by the unscheduled care pressures. This included an assessment of each patient on arrival at the department and early interventions for any patient at risk of developing a pressure ulcer.

Martyn Waygood queried as to how the discussions with WAST were progressing. Suzanne Holloway responded that discussions were ongoing as to how to continue the skin bundle work should patients return to an ambulance but presently there was not an agreed protocol in place. She added that if there are patients at risk, the emergency department uses its own equipment to support them, for example placing air mattresses on the trolleys. Emma Woollett commented that it was important to consider the issue from the WAST point of view that if patients were loaded back onto an ambulance to wait it means they are unable to answer further calls.

Hamish Laing commended the unit on the work taken to date, adding that the committee chair had asked the Clinical Outcomes Group to review the outcomes associated with significant waits outside or within the emergency department and data for a number of measures was being collated, including pressure ulcers. He stated that some patients would develop ulcers as a result of emergency department waits which would not be identified until they had been admitted to a ward, which was also something that the audit would review. Rebecca Carlton responded that the unit was taking pressure ulcers very seriously and the issue was raised at all meetings, particularly at the unit's Quality and Safety Group at which it was made clear that such instances were a shared risk.

Hamish Laing commented that years ago, patients at risk of pressure ulcers were given a card to carry to advise medical staff and queried if this was still the case. Suzanne Holloway stated that these cards were no longer provided or carried but it was something for the unit to consider reintroducing.

Angela Hopkins stated that the engagement issues with WAST were not unique to ABMU and suggested that the health board write to its colleagues outlining the requirements as this would be of benefit across Wales as patients were delayed at a number of hospitals.

Unit Report

A report providing an update in relation to progress and performance for quality and safety for Morriston Hospital Delivery Unit was **received.**

In introducing the report, the team highlighted the following points:

- Morriston Hospital was in a unique position to deliver a full range of care services including secondary, tertiary, regional and supra regional however its ability to deliver was sometimes compromised, for example by winter pressures;
- The unit's cancer position was strong but there were challenges to maintaining elective performance;
- Partnership working with other services and organisations was key as there were a significant number of inpatients who did not need to be in Morriston Hospital but were awaiting care home beds, domiciliary care packages, transfer to another hospital, either within ABMU or another health board, or a rehabilitation centre;
- Providing timely care, particularly within cardiac or cancer services, was dependent on good patient flow;
- The unit was looking to work with Neath Port Talbot Hospital to develop an elective surgery pathway for specialist services however there were risk surrounding clinicians' confidence to work off-site following challenges at another hospital.

In discussing the report, the following points were raised:

Emma Woollett complimented the unit on it paper, adding that the health board needed to work towards the responsibility for patients residing with primary and community care with secondary care viewed as interventional. She stated that it was difficult to maintain performance during periods of high pressure and commended the unit on maintaining its position in relation to falls and *clostridium difficile.*

Emma Woollett sought clarity as to the risks in relation to TAVI (transcatheter aortic valve implantation) procedures. Mark Ramsey responded that demand was currently outweighing capacity and there was a substantial cohort of elderly patients. He added that it had been agreed with the Welsh Health Specialised Services Committee (WHSSC) to remodel the service to include a more detailed assessment by the referring hospital to support diagnosis and determine whether TAVI was an appropriate intervention as currently Morriston Hospital was relied upon to provide the diagnostics. Hamish Laing advised that the health board had commissioned an external review based on the outcomes of some patients while on the waiting list for the procedure. This was in its final draft and would be shared with the committee in due course.

Angela Hopkins asked for further details in relation to the additional unit for planned care procedures. Rebecca Carlton advised that a purpose built temporary unit had been installed on the site for patients suitable for day surgery which enabled some elective and cancer procedures to be protected during the unscheduled care pressures. Angela Hopkins added that the unit was locked at night which meant it could not be used as additional capacity thus ensuring day cases continued as planned.

Chris Morrell sought further details as to the unit's work in relation to the end-of-life pathway for patients wishing to die at home as it was making significant progress with rapid decision making. Suzanne Holloway advised that the intensive care unit was making this a focus and links had also been established with the bereavement service to support families.

Chris Morrell commented that she was working with the unit to develop a board-wide older person's strategy. She also commended the work to support patients to go home in timely manner through projects such as 'green to go ward'. Rebecca Carlton explained that the 'green to go ward' was a dedicated space for patients ready to be discharged. She added that a SAFER board round approach was also being taken which helped staff feel supported to discharge patients home when ready. Chris Morrell stated that Welsh Government was to launch its 'end PJ paralysis' campaign from Morriston Hospital as it was recognised that considerable work had been done on the site.

Hamish Laing stated that the unit had undertaken good work in immensely difficult circumstances and he was aware of the pressures

that colleagues were working under. He added that the executive team had met formally with Welsh Government to discuss the health board's performance in relation to healthcare acquired infections and the units would be asked to set individual targets.

Hamish Laing advised the committee that Hywel Dda University Health Board would be writing to ABMU to express concerns regarding patient flow for cardiac interventions but these were operational issues as opposed to clinical.

Maggie Berry advised that she had spent a Sunday shadowing staff at Morriston Hospital and it had been concerning the amount of patients who been transferred from other hospitals for treatment that could not be returned. Angela Hopkins responded that this demonstrated how the pressures were being replicated across the country. Maggie Berry added that the health and housing group was working with housing providers to consider temporary accommodation for patients medically fit for discharge awaiting residency elsewhere.

Several attendees drew on recent personal experiences of the health board's services noting the care and compassion with which they were treated. It also provided them with an opportunity to see the pressures from the front-line point of view and have empathy with both sides.

Resolved: The report be **noted.**

50/18 PHARMACY AND MEDICINES MANAGEMENT REPORT

Judith Vincent was welcomed to the meeting.

A report providing an update in relation to pharmacy and medicines management was **received.**

In introducing the report, Judith Vincent advised that workforce redesign was under consideration to provide opportunities to support quality and safety on wards via pharmacy technicians providing medicines administration.

In discussing the report, the following points were raised:

Angela Hopkins stated that she was grateful to Judith Vincent for the work being undertaken in relation to pharmacy technicians and discussions were ongoing with Swansea University as to how best to support this. She added that these staff were highly trained and could provide a prudent and timely response to some of the prescribing challenges in clinical areas.

Emma Woollett commented that the results for the pharmacy technician pilot were good but it was unclear from the report as to how the work would progress. Judith Vincent advised that further roll-out needed to be integrated into the workforce redesign programme. She added that she was undertaking discussions with Angela Hopkins in relation to nurse recruitment to determine how nursing

teams could be refocused to include a pharmacy technician to replace a nursing role where appropriate but in order for this progress, a plan and training needed to be established. Emma Woollett queried as to whether there was a date by which the programme was to be implemented. Angela Hopkins advised that nursing teams were under review to determine what resources were required to support the clinical areas as well as comply with the Nurse Staffing Act (Wales) 2016. She added that the unit nurse directors had been fully supportive of the pilot. Emma Woollett stated that if a pilot proved successful, it was important that a way was found to implement it more widely.

Emma Woollett noted that there was currently non-compliance with one of the 18 medication-related patient safety solutions. Chris Morrell advised that it had been escalated to her as the executive lead and she was seeking responses on a unit-by-unit basis to the Quality and Safety Forum. Emma Woollett asked that the committee receive an update at its next meeting. This was agreed. **CM**

Hamish Laing advised that there was significant evidence that electronic prescribing would improve compliance and performance in relation to patient safety and the health board was to be the first in Wales to take the system forward. He added funding had been secured and work was being undertaken to appoint leads and managers to start the work at Neath Port Talbot Hospital to inform the national programme.

Hamish Laing stated that he was grateful to Judith Vincent's support to challenge the prescription of antibiotics which were not in accordance with the policy. He added that Swansea University was looking to develop a school of pharmacy which would be useful for the progression of the pharmacy technician role.

Chris Morrell advised that work in relation to medicines management had been recognised by the National Institute for Health and Care Excellence (NICE) with several staff recognised as scholars. She queried if any of the related work had been evaluated. Judith Vincent advised that these details would be included in her next update to the committee.

Ceri Phillips noted that the pharmacy technician pilot had only been undertaken for five weeks, adding that this was a small amount of time of which to base workforce redesign. Judith Vincent advised that there was also UK-wide learning which the health board was using and it was recognised that not all pharmacy technicians would be able to undertake the role nor would all wards require it. She added that the wards and staff would be assessed for suitability. Hamish Laing commented that the health board had a tendency of undertaking pilots without a plan as to how roll-out more widely should they prove successful. He added that he would expect to see the role included within the units' annual plans.

Sandra Husbands commented that it would be useful in due course for the committee to receive a report which outlined the purpose of the pilot, the outcomes both positive and negative, and the plan going forward. Chris Morrell advised that a lot of this detail was to be picked up as part of the recovery and sustainability workforce redesign workstream and would be reported to the Workforce and Organisational Development Committee.

Resolved:

- The report be **noted.**
- Update be provided in relation to the non-compliance with one of the 18 medication-related patient safety solutions. **CM**

51/18 CATERING AND NUTRITION UPDATE

A report outlining an update in relation to catering and nutrition was **received.**

In discussing the report, the following points were raised:

Hamish Laing clarified that the definition of waste referred to within the report related to entire meals discarded not offered to patients and if all meal wastage was to be taken into account the figures would be higher.

Hamish Laing advised that in relation to the computerised catering system, the Public Accounts Committee had requested several updates and Welsh Government had offered 'invest to save' opportunities to develop the system but it as it was not a clinical system, it was yet to be developed by the NHS Wales Informatics Service.

Hamish Laing referred to the mobile 'app' referenced within the report and advised it had not been as successful as first hoped and as such, it was to be refreshed.

Christine Morrell commented that packing size was to be reviewed to reduce waste by providing fewer meals to wards and clinical areas so as to not over provide the quantity needed.

Martyn Waygood advised that Cardiff and Vale University Health Board had implemented a 'blue plate' system based on national research which made meals more attractive to patients. He added that it had been piloted on a couple of wards and rolled-out more widely using charitable funds. Chris Morrell responded that the blue plates system was something for the catering team to consider

Chris Morrell stated that in areas with ward hostesses, food wastage was lower as it enabled more interaction with patients during meal times. Angela Hopkins replied that there was inequitable provision of ward hostesses across the health board as the scheme was currently 'unfunded', therefore the areas in which the post was being undertaken were at financial risk. She added that a paper had been developed as to the costs benefits of the role, taking into account the

requirements of the Nurse Staffing Act (Wales) 2016, and undertook to bring a report to the next meeting. Chris Morrell advised that if ward hostesses were not rolled-out widely, nursing staff would need to undertake food hygiene training. Sandra Husbands commented that ward hostesses would not only support a reduction in food wastage but would also help to ensure patients were eating properly. **AH**

Sandra Husbands commented that food allergies were not referenced within the various training modules for nursing staff and this needed consideration.

Emma Woollett queried as to whether the health board had a volunteering strategy and if this could be adapted to support patients with eating. Chris Morrell advised that the health board's volunteering strategy was to be launched imminently and this had been discussed as part of its development.

Pam Wenger advised that the level of risk associated with not having ward hostesses was not included within the corporate risk register. Chris Morrell responded that a risk workshop was to take place in due course and could consider this.

Maggie Berry noted the reference to catering subsidiaries, adding that this would entail significant staff engagement.

Paula O'Connor stated that Princess of Wales Hospital's food hygiene rating had changed from five to three and queried the scores for the other hospital sites. Chris Morrell advised that it was isolated to Princess of Wales Hospital and related to training. Martyn Waygood advised that the Health and Safety Committee was set to become a board-level committee and could take forward food hygiene standards.

Emma Woollett commented that it was difficult to determine from the report what the big and little risks were in order to focus the committee's attention. Chris Morrell advised that more work was to be undertaken to determine the most effective way of reporting food standards.

Pam Wenger suggested that assurance be received at the next meeting in relation to the concerns raised. This was agreed. **CM**

Resolved:

- The report be **noted.**
- Report be received at the next meeting regarding the cost benefits of ward hostesses. **AH**
- Assurance be received at the next meeting in relation to the concerns raised. **CM**

52/18 STAYING HEALTHY

A report providing an update on a number of public health areas was **received.**

In introducing the report, Sandra Husbands highlighted the following points:

- Some progress had been made in relation to tobacco control to align the three 'stop smoking' services to enable service users to continue with the support after discharge or transfer;
- Uptake in relation to the influenza vaccine had been pleasing, particularly for children;
- School nurses had been nominated for an award for the work to encourage more children to receive the influenza vaccine as they had achieved the national target by Christmas 2018, which was the best performance in Wales;
- An improvement was required with regard to the uptake of the influenza vaccine by under 65s with chronic conditions;
- More work was required in relation to the measles, mumps and rubella vaccine given there was a current outbreak in south-east Wales.

In discussing the report, the following points were raised:

Emma Woollett stated that it was unclear from the report as to the health board's position in relation to obesity. Sandra Husbands responded that more work needed to be undertaken in relation to prevention and there was no clear obesity pathway for all four tiers, particular for tier three. She added that the health board did have a physical activity strategy which encouraged staff and service users to become healthier and a national obesity strategy was to be launched.

Hamish Laing advised that the health board previously commissioned 'We Predict' to model future insights using diabetes data, for which the costs in 10 years would be significantly higher. He added that if more could be done to reduce obesity levels, this would help reduce diabetes needs. Sandra Husbands concurred, adding that more work was needed within the community but it would take a long time for outcomes and change to occur.

Ceri Philips queried the potential impact of the new sugar tax. Sandra Husbands commented that it difficult to determine whether people would buy fewer fizzy drinks as a result as in other countries where it has been successful, tap water was not consumable whereas it was in the UK, therefore purchasing fizzy drinks was already undertaken by choice.

Martyn Waygood referenced a recent BBC programme regarding work undertaken in Amsterdam targeting childhood obesity for which the health service, local authorities and education services were working together to develop a healthy programme for children. Hamish Laing responded that as part of ARCH (A Regional Collaboration for Health) a number of the programme board visited Sweden where a wellbeing nursery was in development and a formal collaboration was now under consideration for the Llanelli wellbeing

village.

Martyn Waygood queried what actions were being taken to encourage people not to smoke on hospital sites. Sandra Husbands advised that while she and her public health team approached those smoking on hospital grounds, not all staff were comfortable doing so and it would be unfair to put them in such a position. She added that there needed to be a behavioural approach to encourage people to stop smoking at hospital sites.

Pam Wenger undertook to discuss with Sandra Husbands as to whether the board should receive a full report on obesity or whether this could be received by the committee. **PW**

Resolved:

- The report be **noted.**
- Discussion to be undertaken as to whether the board should receive a full report on obesity or whether this could be received by the committee **PW**

53/18 INFECTION CONTROL REPORT

A report providing an update in relation to infection control was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- Infection control was a targeted intervention area;
- A meeting had been undertaken with Welsh Government the previous day to discuss performance and challenges;
- Improvement priorities were to be established for a number of areas, such as falls and pressure ulcers, as these were other indicators of areas of concern;
- A three-year plan had been developed to enable gradual but sustained improvement;
- Trajectories were to be developed at unit level and hotspot areas indentified.

In discussing the report, the following points were raised:

Emma Woollett complimented the report.

Martyn Waygood noted that intense decontamination remained suspended and queried the reasons as to why. Angela Hopkins advised that some staff had significantly challenged the use of particular systems and had escalated this to the Health and Safety Executive, following which the decision was made to suspend the systems' use until the issues could be resolved. She added that the health board had escalated the situation to Welsh Government to determine the national view as all health boards used the systems but ABMU was the only one to receive such challenges and external

companies had been approached for help in the interim. Martyn Waygood responded that this would be another area for the Health and Safety Committee to consider.

Resolved: The report be **noted.**

54/18 QUALITY AND SAFETY DASHBOARD

The quality and safety performance dashboard was **received** and **withdrawn** from the agenda due errors within the report rendering the committee unable to scrutinise it fully.

55/18 PATIENT EXPERIENCE REPORT

A report providing an overview of progress relating to the delivery of the patient experience programme and performance against key outcome measures was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- The quality of responses was judged by the number of reopened complaints, for which the amount was reducing;
- Following a discussion at the March 2018 board meeting, a report would be received by the committee at its June 2018 meeting outlining the outcome of the seven recent never events.

In discussing the report, the following points were raised:

Emma Woollett commented that some of the report was duplicated by others on the agenda and she would have expected to see never events and serious incidents covered in a separate report as these differed from patient experience.

Hamish Laing stated that capturing patient experience also differed from just focusing on those who contacted the health board directly and there needed to be a way in which to capture patient experience on a larger scale, particularly a ‘free text’ option. He added that there needed to be a feeling amongst clinical staff that their patients would be asked to comment on their experience.

Chris Morrell commented that a trend analysis of things which contributed to issues was missing. She added that ‘near misses’ also needed to be considered as these did not need to be reported formally.

Pam Wenger advised that the board had undergone significant turnover of members and it had been those previously on the committee who developed the current format of the report. She added that it would seem sensible to have a separate report for serious incidents and never events. Angela Hopkins undertook to reformat the report and provide two separate papers for the June 2018 meeting

onwards. **AH**

Ceri Phillips commented that it was not just patient experience which needed to be captured but also outcomes. Hamish Laing advised that a report regarding patient reported outcome measures (PROMs) was to be received at the next meeting.

Martyn Waygood stated that having spoken to a number of patients, one of the biggest priorities for them was to feel warm and this should be included as a marker on the questionnaire.

Maggie Berry commented that the 'essence' of the report had been developed as issues had arisen from meetings and it was felt that learning from concerns needed to be considered as well as how good practice was being shared.

Chris Morrell commented that absolute numbers would be useful alongside percentages to show whether it was high or low number of patients for which the figures applied.

Pam Wenger advised that the board should be informed of the committee's plan to receive a separate report for never events and serious incidents as part of the committee chair's report to the May 2018 meeting. Angela Hopkins advised that the board's development session later that month, a presentation was to be received as to the concerns, complaints and feedback process which would provide members with an opportunity to ask questions. **PW/MB**

Resolved:

- The report be **noted.**
- Never events and serious incidents to be reported separate to the patient experience report going forward. **AH**
- Board to be informed of the committee's plan to receive a separate report for never events and serious incidents as part of the committee chair's report to the May 2018 meeting. **PW/MB**

56/18 HEALTH AND CARE STANDARDS ANNUAL REPORT

The health and care standards annual report for 2017-18 was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- Every health board was required to produce an annual report for its health and care standards process;
- It was proving challenging to maintain engagement throughout the year;
- Progress against each of the standards was included within the annual report.

In discussing the report, Ceri Phillips identified that the date on the report required updating from 2017 to 2018. Angela Hopkins

undertook to amend this. **AH**

Resolved:
- The report be **noted.**
- The date on the front of the report be amended. **AH**

57/18 15 STEP CHALLENGE

A report regarding the 15-Step Challenge was **received.**

In introducing the report, Maggie Berry highlighted the following points:

- The health board had been using NHS England's 15-step challenge process for a number of years;
- Visits were normally undertaken after a Quality and Safety Committee meeting;
- Independent members not part of the committee had asked to take part in the process and as such, the process was to be moved away from committee meetings to enable others to join;
- Hotspot areas to visit would be identified by the units to give a focus to the challenges.

In discussing the report, the following points were raised:

Hamish Laing noted that the new guidance presented to the committee under the agenda item related to non-ward environments, including community services, which was useful as these were areas not normally considered as part of 15-step challenges. He added that consideration was needed as to how the integrate the ward to board assurance framework within this as it was intended to be the in-depth process executive directors and non-officers use to review wards.

Pam Wenger stated that a 'walkaround' framework needed to be developed for board members to provide structure and opportunities for reflection. Angela Hopkins concurred and suggested that one executive take the lead so as to not have a fragmented approach. Hamish Laing undertook to bring a proposal to the committee in due course. **HL**

Maggie Berry queried the process for visits to GP practices. Hamish Laing advised that GP surgeries were private contractors but there was a dashboard available which could identify practices to visit.

Resolved:
- The report be **noted**.
- Framework for board walkarounds be developed. **HL**

58/18 QUALITY AND SAFETY COMMITTEE ANNUAL REPORT

The 2017-18 Quality and Safety Committee annual report.

In introducing the report, Angela Hopkins advised that the report was in draft form and invited comments to Alyson Charnock by 30th April **All**

2018 to enable the final version to be approved at the next meeting.

In discussing the report, Paula O'Connor queried how the committee would assess its effectiveness this year given its change in membership. Pam Wenger advised that the Audit Committee has postponed its assessment to allow committee members time to embed into the role and suggested that the Quality and Safety Committee do the same. This was agreed. **PW**

Resolved:

- The report be **noted**.
- Comments on the draft report be submitted to Alyson Charnock by 30th April 2018. **All**
- Assessment of committee's effectiveness be deferred for six months. **PW**

59/18 INTERNAL AUDIT REPORT

A report outlining the findings of internal audits was **received.**

In introducing the report, Paula O'Connor advised that health and safety remained a concern but the establishment of the new board-level committee would provide some traction.

In discussing the report, Pam Wenger advised that going forward, health and safety audits would be received by the Health and Safety Committee and the Quality and Safety Committee would therefore not have to manage this area.

Resolved: The report be **noted.**

60/18 CLINICAL OUTCOMES GROUP REPORT

A report providing an update from the clinical outcomes group was **received.**

In introducing the report, Hamish Laing highlighted the following points:

- The group remained an important factor in the assurance provided to the committee in relation to mandated audits and was also helpful in relation to benchmarking against peers;
- The number of actions not progressed was reducing as the units were moving more areas forward;
- Concerns had been raised with regard to unscheduled care performance that significant waits could impact on patients' outcomes and as such, a clinical audit was to be undertaken in this area. Meetings were already taking place to establish the measures and data to collect.

In discussing the report, Sandra Husbands commented that the analysis of outcomes of patients who incurred significant waits as part

of unscheduled care may be of interest on an all-Wales basis and it could be beneficial to discuss with Public Health Wales and WAST.

Resolved: The report be **noted.**

61/18 EXTERNAL INSPECTIONS REPORT

A report outlining the findings from external inspections was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- Three external inspections had been undertaken since the last report to the committee;
- Two non-compliance issues had been raised following an inspection at Princess of Wales Hospital regarding correspondence.

In discussing the report, the following points were raised:

Nia Roberts commented that there was no reference to correspondence received in relation to the cancer peer review. Angela Hopkins explained to the committee that Healthcare Inspectorate Wales had recently notified of a cancer peer review at Princess of Wales Hospital which focussed on clinical nurse specialists and the nursing team for inpatient gynaecology oncology. A response had been submitted to Healthcare Inspectorate Wales in regard to its findings and concerns and discussions were being undertaken with Cwm Taf University Health Board and external charities to determine the best way in which to support the service. Nia Roberts advised that there had been work ongoing since 2016 within the service of which the reviewers had not been informed and there were still some governance questions to address. She added that a response was still awaited in this respect. Angela Hopkins advised that clarification was being sought from Princess of Wales Hospital. Hamish Laing added that it had been a routine peer review but the health board had not been informed in advance in-line with normal protocal, which had led to reviewers not meeting with the staff who were aware of the ongoing work and the plan going forward.

Pam Wenger noted an inaccuracy within the report and clarified that the evidence requested in relation to the ‘KW’ review had not been submitted but would be by the deadline later that month.

Emma Woollett stated that it was unclear as to why the findings from the cancer peer review were not included within the report and queried as to whether this required further discussion by executives. Angela Hopkins responded that the report focussed on correspondence received however this should have been included given that it raised immediate concerns. She added that a second response was in progress and would be detailed in the next report to

the committee.

Emma Woollett noted that Princess of Wales Hospital was a prominent feature in a few areas of concern. Hamish Laing advised that the previous interim Chief Executive had supported the development of a performance framework to enable units to self-assess themselves against a number of domains which would support the escalation process. He added that he was meeting regularly with the unit medical director to discuss areas of concern.

Resolved: The report be **noted.**

62/18 ANALYSIS OF OMBUDSMAN CASES

A report providing an analysis of Ombudsman cases was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- As at the end of March 2018, the health board had 37 open Ombudsman cases;
- The backlog of complaints had substantially reduced to fewer than five within six months.

In discussing the report, Maggie Berry noted that a recurring theme of cases referred to the Ombudsman was communication and queried whether refreshing the patient advice and liaison service (PALS) would address this. Angela Hopkins responded that the Ombudsman had express concern that standard templates were not being applied to letters and key components, such as references to 'Putting Things Right', had not been included. She advised that a corporate template had now been established.

Resolved: The report be **noted.**

63/18 EMRTS CLINICAL GOVERNANCE

A report providing an update with regard to clinical governance for the Emergency Medical Retrieval and Transfer Service (EMRTS) was **received** and **noted.**

64/18 ANY OTHER BUSINESS

There was no further business and the meeting was closed.

65/18 NEXT MEETING

This was scheduled for 7th June 2018.

66/18 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.