



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board



		Agenda Item	3.4 (ii)
<b>Freedom of Information Status</b>	Open		
<b>Reporting Committee</b>	Quality and Safety Committee		
<b>Author</b>	Liz Stauber, Committee Services Manager		
<b>Chaired by</b>	Martyn Waygood, Independent Member		
<b>Lead Executive Director (s)</b>	Gareth Howells, Director of Nursing and Patient Experience		
<b>Date of last meeting</b>	21 February 2019		

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

- **Mental Health and Learning Disabilities Exception Report and Staff Story** – members received an update on quality and safety issues within the Mental Health and Learning Disabilities Unit. As part of the report, members heard that a new patient feedback method was being trialled as the traditional friends and family survey did not suit the service users.  
  
The unit also presented a staff story which outlined the impact of an inpatient's death on ward staff, particularly those who take their own lives. It was told from the point of view of a ward manager who was present at the meeting. The committee commended the ward manager on her bravery for providing the story and asked that it be shared more widely, so long as she was comfortable, in order for others to understand the affect such events have on staff.
- **Infection Control Report** - infection control remained a high focus, not just in terms of targeted intervention, but there was confidence that the improvement trajectory would be achieved.
- **Quality Impact Assessment (QIA) Process** – members of both the Quality and Safety and Performance and Finance Committees were present for a presentation providing assurance of the QIA process taken to test the schemes included within the annual plan for 2019-20.

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

- **Quality and Safety Performance Report** – members felt that the report in its current format did not provide the narrative it needed to effectively discharge its duty as it was based purely on performance. It was agreed that a proposal would be developed as to a more appropriate way to present the information to the committee.
- **NHS Wales Delivery Unit Long Waiting Patients** – the committee heard that the report had been commissioned on an all-Wales basis but there was an ABMU-specific report, for which the 12 recommendations had been accepted. The number of patients waiting more than 52 weeks for surgery had improved over the last four years but was

still too many. The majority of these were orthopaedic cases. There was no indication that any of the cases concerned were at risk of an emergency admission however there were clinical risks to consider, for example repeated diagnostic tests. The aspiration for the next year was to reduce the 1,300 cases to fewer than 1,000, but an improvement within orthopaedics would take two years. The action plan would be received at the next meeting.

- **External Inspections** – a report outlining the findings of recent external inspections was received, which included the action plan in response to the Healthcare Inspectorate Wales review of the Kris Wade case. Members felt it was critical that patients were treated equitably, regardless of their conditions or backgrounds and any concerns they raised taken seriously. The action plan was to be a standing agenda item.

#### Delegated action by the committee:

- **Quality and Safety Committee Work Programme 2019-20** – the committee approved its work programme for the coming year, subject to minor amendments.

#### Main sources of information received:

- **Safeguarding Report** – the bi-annual report outlining progress within the safeguarding service was received with no significant issues raised.
- **Internal Audit Update** – the findings of recent internal audits relating to quality and safety issues were noted;
- **Corporate Risk Register** – members received an update on the work to revise the corporate risk register.
- **Bridgend Boundary Update** – a verbal update was provided with regard to the quality and safety issues being considered by the transition workstream.

#### Highlights from sub-groups reporting into this committee:

- **Clinical Senate Council** – the committee received the first update from the clinical senate council;
- **Quality and Safety Forum** – the regular update from the forum was received with no significant issues raised.
- **Emergency Medical Retrieval and Transfer Service (EMRTS) Clinical Governance Report** – the regular report was received and noted.

#### Matters referred to other committees:

None identified.

**Date of next meeting**

19 April 2019