



Reporting Committee	Quality, Safety & Risk Committee
Chaired by	Maria K Thomas
Lead Executive Directors	Greg Dix Director of Nursing, Midwifery and Patient Services. Gwenan Roberts, Interim Board Secretary
Author and contact details	Kathrine.davies2@wales.nhs.uk
Date of last meeting	9 July 2019
Summary of key matters including achievements and progress considered by the Committee and any related decisions made.	
<p>The Quality Safety & Risk Committee last met on the 9 July 2019, the agenda and papers are available on the Health Board's website.</p> <p>The Patient Story – Experience of a patient's experience within the Mental Health service</p> <p>Members watched the video of a patient who expressed his positive experiences within the mental health service, and the benefits of the Expert Patient Programme course he had attended.</p> <p>Members agreed that it was good to hear experiences of community based programmes and noted that the impact of the service had been tracked by Welsh Government.</p> <p>Quality Safety and Risk Committee Annual Report</p> <p>Members received the draft Annual Report and following discussions agreed to forward comments to Gwenan Roberts, following which Maria Thomas would take Chair's action prior to submission of the report to the Board.</p> <p>Terms of Reference</p> <p>Members noted no significant change to the Terms of Reference. Following discussions around clarifying the distinction between Members and Attendees. Members noted and agreed that for effective governance, two Executive Directors should be in attendance, one of which should be a Clinical Director. Members noted the amendment to the frequency of meetings now being not less than 10 times per year.</p> <p>Self-Assessment questionnaire</p> <p>Members discussed the completion of the annual questionnaire, and agreed on responses. Members resolved to endorse the report for submission to the Board for approval subject to amendments, and to endorse the Terms of Reference for submission to the Board for approval.</p>	

Update Report on Legionella

The report was presented to members and **noted** that a strain of Legionella had been detected in eight outlets within the Princess of Wales Hospital.

Members were advised that on day one of the outbreak, key members of the Water Safety Group were brought together to address the issue. An external water specialist was brought into the Health Board to assist. Members **noted** that key tasks were carried out including:

- Completely draining the system overnight
- Disinfecting the system overnight
- Retests carried out with negative results being seen
- A request for a water risk assessment had been made

Members **noted** that constant temperature checks were being undertaken with samples being sent to Llandough Hospital for testing. Members **noted** that Legionella tests had come back negative, and assurance was provided that no Legionella had been detected in samples taken from patients. Members discussed escalation of concerns to Swansea Bay UHB.

Following discussion, Members resolved to: **Note** the report

- Advise that the Committee had been **assured** of regular monitoring and of negative samples as at the date of the meeting
- **Request** that Swansea Bay UHW were informed of the issues experienced
- **Request** that any further issues were escalated to Maria Thomas for Chair's action

Update on Maternity Services

Members **received** and **noted** the update report on maternity services from Greg Dix. Members **noted** that the Independent Oversight Panel had now been established, led by Mick Giannasi, and that the next business cycle was about to be held.

Members **noted** that the Quality and Governance Framework was now in place and had been shared with the Independent Oversight Panel, Healthcare Inspectorate Wales, and Welsh Government. Greg Dix advised that a significant increase in incidents being reported had been seen since the introduction of the framework.

Members **noted** that the Maternity Improvement Plan had been revised over the last four weeks, themes had been identified within the plan along with Executive leads for each area. Members **noted** that there were 140 actions within the plan with progress made outlined within the report. Members **noted** that the full risk register would be included within the report at the next meeting.

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In relation to Maternity assurance, the oversight panel had been very helpful in supporting the work to date and had recently spent some time in the organisation reviewing the 43 cases and the women who had contacted the Health Board since the publication of the Royal College report. Members **noted** that a member of the oversight panel would be developing a database to ensure all information was being captured.

Members **noted** that in relation to Directorate Structure, an increase in resourcing and capacity had been agreed and there would be a dedicated Team in place to support the programme. Members **noted** that a full time Programme Director and Programme Manager had been appointed.

Greg Dix advised that in relation to challenges and concerns raised by external partners, Members **noted** that he had attended the Rhondda Cynon Taf full council meeting, the Community Health Council (CHC) full council meeting and the CHC special council meeting to respond to questions raised in relation to Maternity.

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

Chairs Report

Members **noted** that Eiri Jones had joined the Health Board as a Programme Director and would be supporting Greg Dix in delivering the Quality and Governance Framework and Implementation plan.

Directorate Exception Reports

Members noted that a new style of Directorate Exception report had been developed and it was hoped that this would improve reporting moving forward.

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

- Obstetrics and Gynaecology
- Pathology
- Acute Medical Directorate
- General Surgery

The report informed members of the common themes raised, and mitigating actions taken within/across the exception reports.

Members **resolved** to **note** the reports.

Items Referred from/To Other Committee of the Board

Members **received** the following reports:

- Minutes of the Infection Prevention and Control Committee meeting held on 18 February 2019
- Update on Capital Issues at the Maternity Unit, Prince Charles Hospital
- Committee Referral from Finance, Performance & Workforce Committee – addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales – Welsh Health Circular WHC/2017/042

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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	5 August 2019