Agenda Item Number: 3.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 24 January 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Jayne Sadgrove	Vice Chair of the Health Board (Committee Chair)
James Hehir	Independent Member
Nicola Milligan	Independent Member
Dilys Jouvenat	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Dom Hurford	Executive Medical Director
Lauren Edwards	Executive Director of Therapies & Health Sciences
Gethin Hughes	Chief Operating Officer
Greg Dix	Executive Director of Nursing
Lydia Thomas	Head of Quality & Patient Safety
Claire O'Keefe	Head of Safeguarding
Karen Wright	Assistant Director of Policy, Governance and Compliance Assistant Director of Governance & Risk
Cally Hamblyn	Assistant Director of Concerns & Claims
Stephanie Muir	Head of Midwifery & Gynaecology (In part)
Sarah Fox	Medical Lead, Children and Families Care Group
Mohamed Elnasharty	Primary Care, Community and Mental Health - Care Group
Ana Llewellyn	Nurse Director Medical Lead, Unscheduled Care Group
Owen Weeks	Clinical Advisory Group Chair
Sally Bolt	Planned Care - Care Group Nurse Director
Carole Tookey Richard Hughes	Unscheduled Care – Care Group Nurse Director
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Chris Beadle	Head of Operational Health, Safety & Fire
Sarah Morgan-Jones	Volunteer Manager (In part)
Jenny Oliver	Governance & Patient Experience Manager
Paul Dalton	NWSSP Internal Audit Services
Gaynor Jones	Royal College of Nursing (RCN) Convenor
Sara Utley	Audit Wales
Rowena Myles	Cwm Taf Morgannwg Community Health Council
Rhys Jones	Healthcare Inspectorate Wales
Lisa Love-Gould	Clinical Director of Allied Health Professionals
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Observing:

Sophie Bassett	Lead Nurse, Mental Health Care Group (Observing)

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

In opening the meeting, J Sadgrove, Committee Chair provided a welcome to all those present, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted by the Committee Chair.

1.2 Apologies for Absence

Apologies for absence were received from:

- Carolyn Donoghue, Independent Member;
- Sallie Davies, Deputy Medical Director;
- Julie Denley, Deputy Chief Operating Officer;
- David Miller, Medical Lead, Primary & Community Care Group

1.3 Declarations of Interest

No interests were declared

2.0 SHARED LISTENING AND LEARING

2.1 Listening & Learning Story

S Morgan-Jones shared a presentation and video with Members which related to the Cariad Pet Therapy project that was being undertaken within the Health Board.

The Chair welcomed the presentation which had outlined the wonderful contribution this new service was making.

G Hughes queried whether in recognising the importance of services such as this for both patients and staff, any support was required from the Health Board to enable the service to be expanded more widely. S Morgan-Jones advised that sharing experiences via forums such as the Quality & Safety Committee would help and added that positive working relationships were established with the Communications Team who were helping the team to cascade information in relation to the project. Members noted that Cariad Pet Therapy were also providing excellent support. S Morgan-Jones advised that it would be welcomed if Members of the Committee could undertake a visit to the unit on a day when pet therapy volunteers were present, this suggestion was supported by Committee members.

The Chair extended her thanks to S Morgan-Jones for sharing the story and welcomed the suggestion made by G Dix for S Morgan-Jones to attend a future meeting to discuss the wider piece of work being undertaken in relation to the Volunteer Service.

Resolution: The Listening & Learning Story was **NOTED.**

Action: Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.

3 CONSENT AGENDA

3.0 For Approval/Noting

3.1.1 Unconfirmed Minutes of the Meeting held on the 15 November 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

3.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 17 November 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

3.1.3 Quality & Safety Committee Annual Cycle of Business

Resolution: The Quality & Safety Committee Annual Cycle of Business was **APPROVED.**

3.1.4 Quality & Safety Committee Terms of Reference

Resolution: The Quality & Safety Committee Terms of Reference were **APPROVED**.

3.2.1 Committee Action Log

Resolution: The Action Log was **NOTED**.

3.2.2 Quality & Safety Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED**.

3.2.3 Safeguarding Annual Report

Resolution: The Safeguarding Annual Report was **NOTED**.

3.2.4 Quality Governance – Regulatory Review Recommendations and Progress Updates

Resolution: The Report was **NOTED**.

3.2.5 Progress Report 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability

Resolution: The report was **NOTED**.

3.2.6 CTMUHB Nosocomial Covid-19 Incident Management Programme

Resolution: The report was **NOTED**.

4. MAIN AGENDA

4.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

5. GOVERNANCE

5.1 Organisational Risk Register – Risks Assigned to the Quality & Safety Committee

C Hamblyn presented the report and advised that Care Group Directors had now assigned all of the risks escalated to the Organisational Risk Register to the new Care Group model, and added that a workshop had been held with the Executive Team to commence a programme of work to review all risks within their portfolio focussing on the risk description, mitigation and control measures to ensure there is a consistent approach to risk methodology and scoring.

N Milligan made reference to risk 4148 and advised that it would be helpful to have an update against this risk given the last update was provided in August 2022 and sought clarity as to when the posts were likely to be filled to assist in addressing the backlog. G Dix advised that a discussion had been held in relation to the Deprivation of Liberty Service (DOLs) and some of the court of protection challenges and provided assurance that the risk would be updated to reflect the current position.

P Roseblade made reference to Risk 5276 which related to the failure to deliver the LINC programme, drawing attention to the reference to an extension of the contract. P Roseblade queried if an extension with the current supplier was possible as she understood this not to be the case. C Hamblyn advised that she would seek to confirm the position outside the meeting.

In relation to a query raised by P Roseblade in relation to Risk 5214, which related to Critical Care, which had not been updated since September last year, D Hurford advised that he was planning on combining the critical care risks into one overarching risk and added that a discussion would be taking place in February as to how Critical Care Services would be delivered moving forwards. D Hurford agreed to keep the Committee updated on progress.

In response to a query raised by P Roseblade in relation to Risk 4071 and any impact on waiting times that may arise from the pausing of the 104+ day harm review panels on two sites, G Hughes advised that he would confirm the position

on this outside the meeting as to whether the pausing of review panels would cause further delays.

In response to a comment made by P Roseblade in relation to risk 4013 which related to ophthalmology, G Hughes advised that as waiting times had not reduced as quickly as anticipated, additional funding had been secured from Welsh Government to enable the Health Board to undertake some further outsourcing by the end of March 2023. Members noted that this still remained the largest specialty in terms of long waits and noted that steps were being taken to source ongoing funding capacity for next year.

The Committee Chair made reference to Risk 3131 which related to the Mortuary service and noted that additional facilities were being provided. The Committee Chair sought clarity whether there was confidence that security and access control arrangements were in place. G Hughes confirmed that standardised processes were now in place. In relation to mortuary capacity, G Hughes confirmed that the new mortuary had recently opened at Prince Charles Hospital and added that significant support had been received from the Health Board's Funeral Director colleagues. Members noted that additional mortuary capacity had been purchased from Aneurin Bevan University Health Board between Christmas and New Year and it was hoped that the Health Board would no longer need to use this capacity from the 10 February. D Hurford also confirmed that the Coroner's office had reduced the number of post mortems the Health Board were required to undertake over the next year.

The Chair made reference to Risk 5254 which related to the Duty of Candour, and sought clarity as to how this would now be managed given the Invest to Save bid that was submitted being unsuccessful. G Dix advised that this would remain a risk and it was hoped that the recentralisation of the quality governance structure would help to support the mitigation of this risk moving forwards.

Resolution: The report was **NOTED**

Action: Responses to be sought from Executive Leads in relation to the queries raised in relation to Risks 4148; 5276; 5214; 4071 and 3131 and an update to be shared outside the meeting.

5.2 Update Report on Progress following Internal Audit on Concerns and Welsh Risk Pool Review of Claims/Redress/Inquests

S Muir presented the report which outlined the positive progress that had been made in relation to addressing the recommendations.

G Dix extended his thanks to S Muir and the Claims and Redress Team on the focus that had been placed on this piece of work and suggested that monitoring of progress would now be undertaken through local governance processes.

In response to a question raised by J Hehir as to how sustainable was the progress that had been made to date, S Muir advised that she was confident that improvements made would be sustainable as a result of the new operating model structures that are being implemented to support the care group quality governance model.

The Chair extended her thanks to S Muir and G Dix for presenting the report and confirmed that Committee members were content with progress being monitored through operational processes moving forwards.

Resolution: The report was **NOTED.**

5.2.1 Learning From Events Reports

S Muir presented the report which provided Members with an update on the work being undertaken to improve timely submission of Learning From Events (LFER) reports to the Welsh Risk Pool.

P Roseblade welcomed the report which she had found to be self-explanatory and noted the significant amount of work that had been undertaken in this area. In response to a query raised by P Roseblade in relation to the escalation process, S Muir confirmed that an escalation process was now in place with clarity as to where concerns needed to be escalated if Learning From Events forms were not being received.

In response to a question raised by P Roseblade as to what the financial risk was in regards to the submission of blank Learning From Events forms to the Welsh Risk Pool, S Muir advised that it was difficult to answer this question in terms of financial risk given the fluctuating values associated with each LFER submission.

In response to a query raised by J Hehir as to whether there were any deadlines that needed to be met for the amber deferred cases, S Muir advised that amber deferred cases were given a further six months to action following presentation to the amber panel.

The Chair welcomed the progress that had been made to date and advised that she was pleased to see that the system was working more effectively. The Chair sought clarity as to whether Members felt there was sufficient assurance and confidence in place for this to be monitored through operational processes or whether further assurance was required by Committee Members. G Dix suggested that it would be helpful if a further report could be presented to the Committee in three months for further oversight. Members received assurance that the position in relation to the submission of LFER's were also being monitored weekly at the Executive led patient safety meetings.

Resolution: The Report was **NOTED**.

Action: Progress report to be presented to the Committee in three months.

5.3 Datix Cymru Assurance Report

K Jenkins-Forrester presented the report. Members noted that incidents continued to be reported and themes and trends continued to be identified via the system. Members noted that a robust corporate audit programme was in the process of being developed and noted that a significant improvement in the quality of data being reported should be seen over the next few months.

The Committee Chair extended her thanks to K Jenkins-Forrester for presenting the report and noted that a further report on progress would be presented to the Committee within the next six months.

Resolution: The report was **NOTED**.

Action: Report on progress to be presented to the Committee within the next six months.

5.4 CTMUHB Quality & Safety Framework 2022-2025

L Thomas presented the report.

The Committee Chair welcomed the framework which was a significant piece of work and advised that the Committee would fully support the standardisation of documents and templates.

N Milligan made reference to the statement made on page 3 of the cover report which stated that 'the Committee can be assured that the organisation has in place a comprehensive framework for a Quality Management System'. N Milligan added that it would need to be acknowledged that the framework was now in place and that it was having a positive impact.

D Jouvenat commented that the Framework itself, particularly on page 13, was not very accessible to read with some of the colours used behind the font making it difficult to read. This was noted by L Thomas.

In response to a question raised by J Hehir as to what success would look like in 12 months and how success would be measured, G Dix advised that the Quality Governance Framework was the vehicle for the delivery of the Quality Strategy. G Dix added that ongoing discussions were being held with Welsh Government as to what the Health Board needed to achieve to improve its escalation status. Members noted that there would be tangible outcomes and measures that would fall out of the Quality Strategy and noted that there would also be an implementation plan which would be thoroughly socialised across the Health Board.

The Committee Chair welcomed the progress being made in this area.

Resolution: The Quality & Safety Framework was **ENDORSED FOR BOARD APPROVAL**.

6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

S Fox and M Elnasharty presented the report. The Committee Chair recognised the significant amount of information that had been included in the report.

N Milligan made reference to one of the questions used in the 'What we could have done Better? Section of the questionnaire and queried whether it would be more helpful to change one of the response options to 'Felt that they *sometimes* received sufficient info about unit facilities, visiting, support groups' to avoid confusion for those completing the questionnaire. S Fox agreed to feed this suggestion back to the team.

In response to a question raised by J Hehir as to whether there were any lessons that could be shared with the Committee today in relation to the severe incident that occurred in Prince Charles Hospital, S Fox advised that she was unable to share the exact make safes during this meeting but advised that she would be happy to provide feedback to the next Committee on any urgent make safes that have needed to be undertaken as a result of this incident. S Fox added that a robust review would be undertaken.

The Committee Chair advised that the report was discussed in detail at the Maternity & Neonatal Improvement Board and added that she was pleased to see that some of the areas discussed at that meeting would be taken forward. The Committee Chair advised that she was pleased to see that feedback being received was being considered and acted upon and formally congratulated the service for receiving their PROMPT training award.

Resolution: The report was **NOTED.**

Action: Feedback to be shared with the Team regarding the suggestion made by N Milligan to amend one of the response options within the questionnaire.

Action: Feedback to be provided to the next Committee in relation to the urgent make safes that had been put into place following the severe incident that occurred at Prince Charles Hospital.

6.2 Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

L Edwards presented the report and highlighted that the Welsh Health Specialised Services Committee had now formally de-escalated the Unit from Level 4 to Level 3 following a quality visit that was undertaken.

The Committee Chair welcomed the report and the progress that had been made and was pleased to see the connections with the Listening & Learning story that was shared earlier in the meeting.

D Jouvenat extended her congratulations to the service for achieving the de-escalation status and added that she recognised how hard the Unit had worked to achieve this position.

The Committee Chair welcomed the reports that had been received on the two services that were in external escalation and added that she had been in discussions with G Dix in relation to the services that were in internal escalation and how updates against these areas could be presented to the Committee moving forwards.

Resolution: The report was **NOTED.**

6.3 Quality Dashboard

L Thomas presented the report and highlighted the key matters for the attention of the Committee.

G Dix advised that the Health Board had recently attended the performance meeting with Welsh Government and the Delivery Unit where the Health Board was thanked for the work that had been undertaken in relation to delivery of the Patient Safety Notices. Members noted that the Delivery Unit also provided feedback in relation to the Nasogastric tube misplacement patient safety notice and noted that the Delivery Unit were now taking a refreshed approach in relation to the actual requirements that medics need to declare in relation to level of compliance.

G Dix advised that work continues to refine the Quality Dashboard report in light of the new Duty of Candour and Quality Governance Framework and added that he would welcome feedback from Committee Members as to what they would like to see included within the Quality Dashboard report.

In response to a question raised by N Milligan as to how the monthly patient safety newsletter was disseminated, L Thomas advised that the newsletter was shared with Heads of Department who then cascade to their Teams. Members noted that the Team were also in the process of establishing a learning repository which would be housed within SharePoint and would include themes, trends, action plans and improvement projects.

J Hehir welcomed the comprehensive report and made reference to the pressure damage incidents update contained on page 4 of the report and sought clarity as to when the community acquired pressure ulcer project was likely to commence and where the project would report into. L Thomas confirmed that the project had commenced. A Llewellyn added that a discussion had been held as to which forum the group would report into and it was agreed that the group would report into the Primary Care & Community Care Group Quality & Safety meeting. Members noted that an update on progress would be presented to the Committee as part of the Deep Dive into Community Services report.

P Roseblade made reference to page 3 of the cover report which referred to patient safety incidents which reads that 28 people had died as a result of patient safety incidents. K Jenkins-Forrester advised that within Datix Cymru, there was a severe or death category which these incidents would have been reported against, even though a death had not occurred. Members noted that these

incidents would undergo review to determine the level of harm that had occurred to the patient. D Hurford assured members that if the number of deaths had occurred as reported in this item then they would have been highlighted through the mortality review process which they were not and advised that he would highlight any areas of concerns with Members if they arose in future. Following discussion, it was agreed that a caveat would be included in the report to explain this moving forwards.

In response to a query raised by P Roseblade regarding the two falls referenced within the report being nationally reportable due to being unavoidable, L Thomas advised that this was a typographical error and advised that this should be avoidable as opposed to unavoidable.

P Roseblade advised that she could not reconcile the graphs to the narrative and asked for this to be addressed moving forwards. G Dix advised that as a result of the national policy changes, the content and format of the report would be reviewed moving forwards and added that he would be looking to test some data prototypes with Independent Members.

In response to a query raised by P Roseblade as to the potential reasons behind the reduction in patient falls, L Thomas advised that there had been an improvement made in the sharing of learning from patient falls.

R Hughes provided a verbal update in relation to the review that had been undertaken in relation to Emergency Care Incidents, particularly the incidents that had been deemed to be coded as severe and catastrophic incidents. Members noted that the review had identified that staff were concerned that pressures being seen within the department could result in death or injury of a patient and noted that some time had been spent with staff to work through alternatives for reporting of incidents. Members noted that the main areas of concern over the winter period related to falls and pressure sores and noted that the team had been asked to undertake a high level review of Quarter 3 data in order to gain an understanding of pressure ulcers and falls which would be classed as hospital acquired. Members agreed to receive a Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.

G Dix extended his thanks to R Hughes for commencing a review of the position and advised that whilst he had seen some fantastic compassionate care provided to patients, he still remained concerned in relation to the criticalness of the position and the lapses of care provided within the Emergency Departments. D Hurford advised that there were concerns in relation to the boarding of patients which was not the level of care that the Health Board wished to provide and added that an improvement had been seen in recent weeks in relation to ambulance red releases.

G Hughes advised Members that a letter had been written to the leaders of the three Local Authorities within Cwm Taf Morgannwg outlining the concerns in relation to the delays being experienced transferring patients out of hospital. Members noted that the response would be shared with Committee members

once received. D Hurford also extended his thanks to O Weeks, S Follows and R Hughes for the significant amount of work they had undertaken in this area.

The report was **NOTED**

Resolution:

Action: Caveat to be included within future reports in relation to the severe/death category for patient safety incidents to explain that an incident reported against this category had not necessarily resulted in the death of a patient.

Action: Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.

Action: Response from Local Authority Leaders to be shared with Committee members once received following the submission of a letter outlining the Health Board's concerns in relation to delays being experienced with the transfer of patients out of hospital.

6.4 Report from the Chief Operating Officer

G Hughes presented the report and highlighted the key matters for the attention of the Committee. Members noted that the 'go live' date of the navigation hub had recently been expedited which would enable Nursing Homes to contact the hub directly to identify whether there was a different response that could be provided to patients within the Community. Members noted that this was a significant development and noted that the Health Board were keen to encourage the ongoing uptake of this service.

P Roseblade made reference to the £3m investment that had been referred to for stroke services and sought clarity as to whether this was a bid or an investment. P Roseblade also sought clarity as to whether the action plan would be monitored through the Planning, Performance & Finance Committee or the Quality & Safety Committee. L Edwards confirmed that the Stroke Task & Finish Group had been tasked to scope out the gaps in services which would need further review and scrutiny in terms of risk stratification. L Edwards added that the resource currently in place was being utilised in different ways and the impact of this would be monitored. L Edwards advised that she would be happy to discuss this further with P Roseblade outside the meeting if it would be helpful. The Committee Chair advised that it was of her understanding that Stroke was an area that was overseen by the Quality & Safety Committee and in this respect would be happy for the Committee to monitor progress against the action plan.

P Roseblade advised that she was pleased to hear about the update provided that no red release of ambulances had been denied and added that she was disappointed to see that a six monthly update had been included in the report as opposed to a month by month summary. The Committee Chair also welcomed the positive improvement that had been made in relation to red release performance in January.

Resolution: The report was **NOTED.**

6.5 Monitoring & Reporting of Continuing Healthcare and Funded Nursing Care Activity

A Llewellyn presented the report and confirmed that she had met with P Roseblade following the last meeting to discuss the process further.

P Roseblade advised that she found the report to be very informative and welcomed the amendments that had been made to the report since the last meeting. P Roseblade clarified that whilst Audit & Risk Committee did monitor the action plan, this was undertaken by way of the Audit Recommendations Tracker.

Following discussion as to whether it would be helpful to receive further updates on this matter, it was agreed that it would be helpful if the Committee could be provided with an Annual Report, with regular reporting of any homes in escalation to be captured in the Quality Dashboard report.

Resolution: The report was **NOTED.**

Action: Annual Report to be presented to the Committee moving forwards with regular reporting of any homes in escalation to be captured in the Quality Dashboard report.

6.6 Deep Dive into Children and Adolescent Mental Health Service (CAMHS)

A Llewellyn presented Members with the report and highlighted the key matters for the attention of the Committee.

In response to a question raised by J Hehir as to whether the Committee should be concerned about anything contained within the report, A Llewellyn advised that she felt confident that oversight of any issues were being undertaken by the Team and advised that she would wish to highlight one risk which related to the Clinical Service Group Manager being successfully appointed into another role. Members noted that interim support had been secured whilst a substantive appointment was being made.

The Committee Chair expressed concern in relation to part 1 performance compared to performance within other Health Board's and also expressed concern in relation to care and treatment plan performance which was worsening and would inevitably affect the quality of care being provided. A Llewellyn advised that there were challenges across Wales in relation to Part 1 performance which was concerning. In relation to Care and Treatment Planning, A Llewelyn advised that an upward tick was being seen in this area and she anticipated the position would significantly improve by February/March 2023.

N Milligan commented that she was pleased to see the positive impact of the Schools In Reach Team. N Milligan expressed concern in relation to the 30% complaints response rate recorded for October 2022 and added that she was disappointed to read that further training to address this would not be undertaken until March 2023. A Llewellyn advised that this related to a small number of complaints and advised that whilst the Team were prioritising the

waiting list backlog they had committed to undertake a training session in March 2023.

In response to a query raised by the Committee Chair as to whether any further updates on CAMHS were required by the Committee, Members noted that from March 2023 onwards the Care Groups would be reporting their Quality & Safety Care Highlight reports to the Committee and noted that any areas which were of concern would be highlighted in the alert/escalate section of the report for further discussion. Members noted that it had also been agreed that each Care Group would present a Deep Dive on a specific area twice yearly.

Resolution: The report was **NOTED.**

6.7 Liberty Protection Safeguards Preparation

C O'Keefe presented the report and highlighted to Members that the implementation date had now been delayed from October 2023 to April 2024. Members noted that the full impact this would have on colleagues would not be known until the Code of Practice was received and noted that the Team were trying to prepare for the implementation of the Liberty Protection Safeguards by addressing the backlog of Deprivation of Liberties Standards applications.

Members noted that as a result of Welsh Government funding, the Health Board had been able to appoint two Best Interest Assessors and two additional members of staff to undertake training and awareness on this matter, which had resulted in an increase in referrals being seen.

In response to a question raised by J Hehir as to whether the delays in the guidance being issued by Welsh Government would impact on the ability to deliver the training on time, C O-Keefe advised that the Team were undertaking a benchmarking exercise and were working with colleagues within other Health Board's to understand the impact of any delays. Members noted that it may be necessary to share a further report later in the year with Committee Members on the progress being made.

Resolution: The report was **NOTED.**

Action: Report to be shared with Committee Members later in the year on progress being made in this area.

6.8 Child T – Child Practice Review

C O'Keefe presented the report and highlighted the key matters for the attention of the Committee. Members noted that an improvement plan was in place which could be shared with Members if required.

In response to a question raised by N Milligan as to what steps would be taken to help support staff in challenging senior staff if they feel uncomfortable with any decisions being made, C O'Keefe advised that steps were being taken to ensure access to support and supervision was available to all staff with opportunities to contact other teams and services for support.

D Hurford advised that in relation to Clinicians, communication had been issued reiterating their responsibilities and asking them to ensure they complete their training compliance.

J Hehir confirmed that this matter had been discussed at length at the Executive Safeguarding Board and added that he commended the work that had been undertaken to address the concerns highlighted within the report.

In response to a question raised by the Committee Chair as to whether the Committee needed to receive any further updates on this matter, D Hurford advised that assurances had been made through the Executive Safeguarding Board that the Committee would be regularly updated on this matter.

The Committee Chair advised that she agreed with the point made in relation to the difficulty for some staff in relation to raising concerns and advised of the importance of developing a culture that supports and enables staff to raise matters that were of concern.

Resolution: The report was **NOTED**.

7. ANY OTHER BUSINESS

There was no other business to report.

7.1 HIGHLIGHT REPORT TO BOARD

7.2 HOW DID WE DO IN THIS MEETING TODAY?

The Committee Chair advised that she would be happy to receive comments outside the meeting as to how Members felt the meeting went today. The Chair advised that further reflection was required as to the number of items contained on the agenda to ensure that items receive adequate discussion.

8. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 9:00am on Thursday 16 March 2023. An In Committee session would also be held on Monday 30 January 2023 at 4:00pm.