

**Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB)
Quality & Safety Committee held on the 22 March 2022 as a Virtual
Meeting via Microsoft Teams**

Members Present:

Jayne Sadgrove	Independent Member (Chair)
Dilys Jouvenat	Independent Member
James Hehir	Independent Member
Nicola Milligan	Independent Member

In Attendance:

Greg Dix	Executive Director of Nursing
Emrys Elias	Health Board Chair
Gareth Robinson	Chief Operating Officer (Interim) (In part)
Dom Hurford	Executive Medical Director (Interim)
Georgina Galletly	Director of Corporate Governance
Hywel Daniel	Executive Director for People (In part)
Julie Denley	Director of Primary, Community & Mental Health Services (In part)
Nicola Bresner	Healthcare Inspectorate Wales
Rhys Jones	Healthcare Inspectorate Wales
Ana Llewellyn	Nurse Director, Bridgend Integrated Locality Group
Carole Tookey	Nurse Director, Rhondda Taf Ely Integrated Locality Group
Sallie Davies	Deputy Medical Director
Sarah Fox	Maternity
Jo Hilborne	Maternity
Phil Lewis	Head of Nursing, Mental Health
Sharon O'Brien	Assistant Director of Nursing & People's Experience
Richard Hughes	Nurse Director, Merthyr & Cynon ILG
Gaynor Jones	RCN Convenor
Emily Howell	Audit Wales (Observing)
Febe Ashley	Welsh Government
Louise Mann	Assistant Director of Quality & Safety
Jane Armstrong	Clinical Director of Primary Care (In part)
Lauren Edwards	Deputy Director of Therapies & Health Sciences
Chris Beadle	Head of Operational Health, Safety & Fire Macmillan GP Facilitator (In part)
Emma Samways	Internal Audit
Rowena Myles	Cwm Taf Morgannwg Community Health Council
Wendy Herbert	Welsh Ambulance Services NHS Trust (In part)
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

In opening the meeting, the Chair provided a bilingual **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 Chair.

The Chair extended thanks to both F Jenkins and G Robinson who would both be leaving the Health Board in April for the support they had provided to the Committee over the last year and wished them well in the future.

1.2 Apologies for Absence

Apologies for absence were received from:

- Carolyn Donoghue, Independent Member;
- Patsy Roseblade, Independent Member;
- Fiona Jenkins, Interim Director of Therapies and Health Sciences.

1.3 Declarations of Interest

The Chair advised that C Donoghue asked for it to be recorded that she was Chair of the Welsh Wound Innovation Centre which would be relevant to the discussion held in relation to the report on the Community Acquired Pressure Ulcer Improvement Plan Briefing. G Dix declared that he was also a Member of the Welsh Wound Innovation Centre Board.

D Hurford declared that he was Chair of the Welsh Government Steering Group on Mortality Reviews. This declaration related to the Mortality Review and Mortality Indicators report.

2.0 CONSENT AGENDA

The Chair advised that there were a number of questions raised regarding consent agenda items which had not yet been responded to and advised that this clearly undermined the consent agenda process.

The Chair advised that a question had been raised in relation to agenda item 3.1.1 and two questions had been raised in relation to agenda item 3.2 and sought clarity as to whether a response could be provided in relation to these.

In relation to the question that had been raised in relation to the patient story, G Dix advised that the expectation was that any learning from patient stories was shared via the Integrated Locality Group communications structure. Members noted that the Listening & Learning Framework would be looking at how the sharing of learning could be strengthened. G Dix advised that from a

Cancer assurance perspective, he worked closely with G Robinson in relation to cancer assurance. G Dix advised that in summary, whilst there was learning that could be shared, the process was not as robust as it could be, however, he was hopeful that the listening and learning framework, alongside Committee members being presented with a revised patient story brief, should hopefully provide the Committee with some greater assurance.

In relation to the question raised in relation to the opening of the Gynaecology Day Assessment Unit, G Robinson advised that a response had now been provided. Members noted that it had now been confirmed that the final changes on the capital works should be agreed and signed off tomorrow which should enable a move to take place as early as next week. The Chair welcomed the update in relation to this.

In response to the question that had been raised in relation to Fire Officer resource, H Daniel advised that in relation to the immediate fire officer vacancy issues, this was being managed by redistributing the remaining four Fire Officers to undertake other duties to ensure the whole of the Health Board was being covered. H Daniel advised that in relation to the reason why there were staffing issues at present, one reason was as a result of the vacancies that were in place and the other reason was the need to have a sustainable financial plan from the Directorate to enable the vacancies to be signed off. Members noted that Fire Officer resource within the Health Board compared favourably to other Health Board resources.

G Jones advised that she had been made aware of the plans of the new location of the Gynaecology Assessment Unit following discussions with the Integrated Locality Group and added that she had also been provided with some information earlier in the week by the Committee Secretariat.

N Milligan advised that she had raised the question in relation to the sharing of learning from patient stories and added that if there was a desire to add purpose and meaning it would be helpful if Members had some form of communication at this meeting as to what was the outcome and what had been shared. The Chair thanked N Milligan for raising the question and noted that this would be considered further by the Director of Nursing.

The Chair advised that she would be referring to agenda item 3.2.10, Delivery Unit Dashboards, throughout the meeting.

3.0 SHARED LISTENING AND LEARNING

3.1 Patient Experience Story

W Herbert introduced the patient story which related to the experience of a patient who waited a length of time for an ambulance whilst in severe pain following an injury he sustained. Members noted that the Welsh Ambulance Services NHS Trust had met with the patient and noted that the patient was

keen for his story to be shared to enable lessons to be learnt from his experience.

G Robinson commented that patient stories were extremely helpful in constantly reminding the Health Board of the implications of every decision that was being made. Members noted that the overwhelming nature of the unscheduled care environment was causing issues for every site and every organisation and was a constant reminder of the individual impact decisions have on patients.

In response to a question raised by R Myles as to whether anything could have been done better given the situation the Welsh Ambulance Services Trust were in at the time, W Herbert advised that in terms of efficiencies and effectiveness, there would have been things that could have been done differently by both WAST and the NHS as a whole. Members noted that it was vitally important to ensure that resources were available to respond to patients and noted that work continued to be undertaken to try to address the imbalance.

In response to a question raised by R Myles as to whether there would have been patients who would have been classed as a higher priority than the patient the story related to, W Herbert confirmed that the patient had been categorised as an Amber 2 as his condition was not deemed to be life threatening and added that patients classed as red response would have been prioritised ahead of Amber 2 calls.

G Dix extended his thanks to W Herbert for sharing the story which was really difficult to hear. G Dix advised that this had made him consider the responsibilities from a system wide perspective and added that whilst the majority of Emergency Departments were overcrowded, there were also patients in their own homes waiting for an assessment. G Dix advised that as well as the Health Board's responsibility for patient safety within its Hospital settings, the Health Board also had responsibilities as a key strategic leader in terms of system wide risk which needed to be clearly articulated. G Dix concluded by saying that he would be very happy to write to the patient to thank him for sharing his story.

In response to a question raised by G Jones as to whether WAST had any plans to train and employ Advanced Paramedics who were able to treat patients at home, W Herbert confirmed that WAST had increased the Advanced Paramedic workforce in the last two years and added that WAST were looking to increase the numbers of Advanced Paramedics further. Members noted that in relation to this patient story, a Community First Responder did attend, however, they were not able to provide any pain relief. Members noted that support was now being provided to Community First Responders to enable them to provide some pain relief to patients waiting in the community for an ambulance for a period of time.

D Hurford advised that it was sometimes difficult to see what the risks were within the Community which were much bigger than imagined and added that it was evident that the model in place was not the correct model and consideration would need to be given to new ways of working moving forwards. D Hurford

advised that he would also be happy to write to the patient alongside G Dix to thank him for sharing his story.

The Chair extended her thanks to W Herbert for sharing the story.

Resolution: The patient story was **NOTED**.

3.0 For Approval

3.1.1 Unconfirmed Minutes of the Meeting held on the 18 January 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 9 February 2022

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

3.1.3 Health, Safety & Fire Sub Committee Highlight Report

Resolution: The Report was **APPROVED**.

3.2.1 Committee Action Log

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

3.2.2 Committee Annual Cycle of Business

Resolution: The Report was **NOTED**.

3.2.3 Quality & Safety Committee Forward Work Programme

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

3.2.4 Once for Wales (DATIXCYMRU) Implementation

Resolution: The Report was **NOTED**.

3.2.5 WHSSC Quality & Patient Safety Committee Chairs Report

Resolution: The Report was **NOTED**.

3.2.6 Covid 19 Closure Report – to include an update on the Vaccination Programme

Resolution: The report was **NOTED**.

3.2.7 Organ Donation Annual Report

Resolution: The report was **NOTED**.

3.2.8 Quality Governance – Regulatory Review Recommendations and Progress Update

Resolution: The report was **NOTED**.

3.2.9 National Clinical Audit Programme Update 2021/2022

Resolution: The report was **NOTED**.

3.2.10 Delivery Unit Quality & Safety Dashboard Reports

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 – Risk Assigned to the Quality & Safety Committee

G Galletly presented the report and advised that with the agreement of the Quality & Safety Committee and Audit & Risk Committee Chairs, the approach to presenting the Organisational Risk Register had been altered, and added that the Board would now receive the most up to date risk register which may mean that the Committees may, on occasion, be receiving the risk register after it has been presented to Board rather than prior to. Members noted that updates from the Rhondda Taf Ely (RTE) and Bridgend Integrated Locality Groups (ILG's) had not yet been included in the organisational risk register as risks continued to be queried and scrutinised at ILG level.

In response to a comment made by N Milligan in relation to Risk 3826, in which an update had not been provided against this risk since 27 September 2021, G Galletly advised that as highlighted earlier, an update had not been received from the Bridgend ILG in relation to their risks. A Llewellyn agreed to provide an adequate to Committee members regarding this risk outside the meeting.

N Milligan also commented on risk 4203 and advised that an update against this risk had not been provided since November 2021. N Milligan advised that recent information received from the RTE ILG indicated that the Health Board was losing Surgical Nurses to neighbouring Health Board's which had not been reflected in this risk.

N Milligan commented on Risk 4152 which had not been updated recently. N Milligan advised that recent information had been received advising that there was an 18-24 month wait for ultrasound scans which again had not been reflected in this risk and added that the Committee would need to be provided with more information on this. G Robinson advised that the RTE ILG were in the process of developing a report regarding the current position regarding Non Obstetric Ultrasound capacity issues and added that the Health Board was an outlier compared to other Health Board's which was concerning. G Robinson advised that the plans in place currently were not providing assurance that the situation was under control and advised that he would ask the ILG to include an update on this risk in their next report to Quality & Safety Committee as well as in the next iteration of the risk register.

The Chair extended her thanks to G Galletly for presenting the report and advised that the Committee had reviewed and considered the updates provided and looked forward to receiving an update on the queries raised.

Resolution: The report was **NOTED**.

Action: Update to be provided to Committee Members outside the meeting in relation to Risk 3826, which had not been updated since September 2021.

Action: Update in relation to Risk 4152 to be included in the next Rhondda Taf Ely ILG Quality & Safety Committee report and Risk Register update.

6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

G Dix introduced the report. S Fox and J Hilborne presented the proposed Maternity Service metrics that had been developed by the Team in the absence of a national core data set that the Health Board could benchmark against. Members noted that the metrics could be shared across Wales.

The Chair extended her thanks to S Fox and J Hilborne for presenting the benchmarking data and the Chair noted that the metrics identified would continue to evolve moving forwards.

The Chair made reference to two areas within the training compliance figures, one being PROMPT training which had seen some improvement in compliance, although it appeared that further improvement in compliance was required within the Merthyr & Cynon ILG which would need to be resolved. In relation to Gap and Grow, the Chair sought clarity as to how the uptake could be increased in relation to Clinicians undertaking this training. J Hilborne advised that she was unsure why compliance in this area had deteriorated and had not been notified of any issues regarding compliance. J Hilborne agreed to interrogate the data outside the meeting to determine whether the data was accurate. The Chair suggested that if the data was accurate, Clinicians would need to be reminded to complete this training.

The Chair made reference to the graphs contained on page 14 of the report which had been reported as percentages. The Chair suggested that given the different numbers of births for different areas, it may be more helpful to present the information in numbers as opposed to percentages.

In response to a comment made by the Chair in relation to the decrease in Lay involvement regarding My Maternity, My Way, S Fox advised that lay attendance had actually increased in January compared to December. J Hilborne advised that lay attendance had improved over the last couple of years as a result of the pandemic, which had made it easier for lay people to attend as a result of remote working, for example. Members noted that consideration was now being given to whether virtual meetings would continue or whether a more blended approach was required.

N Milligan extended her thanks to S Fox for ensuring that meetings with Trade Union partners went ahead regardless of events taking place within the organisation or how low the attendance had been as a result of other commitments being faced by staff.

S Davies advised that in relation to metrics within Neonatal services, Attain data would be a key metrics alongside the before 32 week gestation metric, which would be an area of focus over the next few months.

G Dix extended his thanks to the Team for their continued leadership in this area and advised that he was delighted to advise that S Fox had been successful in securing the Head of Midwifery role in Bridgend ILG. Members noted that Suzanne Hardacre, the new Director of Midwifery, would be commencing on 4 April 2022.

Resolution: The report was **NOTED**.

Action: Gap and Grow training compliance to be interrogated further outside the meeting to determine whether the data was accurate. If the data is accurate, Clinicians to be reminded that this training needed to be undertaken.

6.1.1 Delivery Unit Review of Open Incidents within Maternity & Neonatal Services

L Mann presented the report and advised that she was pleased to advise that despite all of the challenges faced all 72 historical Serious Incidents had been passed through the Quality Assurance panels, with a couple of incidents left that need to be amended prior to submission to the Delivery Unit. Members noted that work would now need to be undertaken in terms of providing feedback to women and their families as part of the Putting Things Right process which would need considerable resource to take this forward. L Mann extended her thanks to both the Delivery Unit and colleagues within Maternity & Neonates for the support provided.

In response to a question raised by the Chair as to how it could be ensured that all of this learning was sustained in order to avoid recurrence of further issues where possible, L Mann advised that with the exception of Covid, there hadn't been any new discoveries in terms of learning that had arisen from the investigations undertaken. Members noted that this linked with the development of the listening and learning framework and how learning was being shared within the Health Board as well as outside of the Health Board.

S Fox advised that each of the reports had a robust action plan against them which were in the process of being themed, with each theme being tracked. Members noted that the Team would be mirroring the same process that had been put into place by the Independent Maternity Services Oversight Panel (IMSOP) Clinical Review process which had been extremely robust.

S Davies added that the development of the action plans had improved and advised that the next steps would be to embed this work in order to develop a learning culture. Members noted that willingness amongst staff to learn and develop was in place which the Team would now be driving forward.

The Chair extended her thanks to L Mann for presenting the report and extended her thanks to colleagues for the hard work that had been undertaken during the process.

Resolution: The report was **NOTED**.

6.1.2 Neonatal Services Deep Dive Report

S Davies presented the report and advised that IMSOP commissioned a Deep Dive into Neonatal Services which was published in February 2022 and advised that this report provided an update on progress against that review.

The Chair advised that the following question had been raised by C Donoghue ahead of the meeting: *Good to see that progress had been made against the recommendations. I note on page 6 that it mentions continued investment being required to continue progress. How likely is this given what we know about the financial position and what happens if this is not provided.*

S Davies advised that IMSOP had recommended that investment was required in relation to the Nursing and Allied Health Professional workforce and added that a Business Case was in the process of being developed which would need to be considered further by the Health Board. S Davies advised that she felt that this was an important area to invest in and added that if investment was not made, the current workforce would need to be maximised and the service would need to work more smartly with the workforce currently in place.

In response to a question raised by G Jones as to whether the issues regarding the reluctance of some staff to rotate to the University Hospital of Wales had been resolved, S Davies confirmed that a decision had been made to use the

cohort of staff who had expressed an interest in rotating and it was hoped that this cohort of staff could share their learning with their colleagues.

The Chair extended her thanks to S Davies for presenting the report.

Resolution: The report was **NOTED**.

6.2 Quality Dashboard

L Mann presented the report and highlighted the key matters for the Committee's attention.

A discussion was held in relation to the Patient Safety Alerts and Patient Safety Notices, where Members noted that the Delivery Unit data in relation to Patient Safety Solutions was inaccurate and that the data was not being validated or checked for factual accuracy with the Health Board prior to the data being published. Members noted that work was being undertaken with the Delivery Unit in relation to the data anomalies.

L Mann advised that following a review of the data, the Health Board was non-compliant against 6 notices as opposed to the 9 that had been reported by the Delivery Unit.

The Chair extended her thanks to L Mann for the anomalies identified in relation to nationally reported incidents, and noted that in the period of June to December the Delivery Unit had identified 45 incidents compared to the Health Board reporting 27 incidents. L Mann advised that she would provide a further update to Members regarding the data validation exercise that would be undertaken. The Chair advised that she had flagged the anomalies in advance of the meeting and had requested an explanation against these and advised that she would prefer to have the Patient Safety Solutions data presented on the day as opposed to receiving a lagged report. The Chair advised that she had found the Delivery Unit Dashboards helpful and added that for the data to be useful there needed to be confidence that the right information was being reported.

The Chair welcomed the use and contribution of the Chaplaincy service which had made a significant difference to patient experience.

N Milligan made reference to the data reported on page 11 of the report in relation to inpatient falls, which stated that they were at the highest they had been for 12 months, however, the data reported on page 14 stated that there had been a decrease in numbers. N Milligan also advised that the numbers contained on page 14 of the report differed to the numbers reported on page 11. L Mann agreed to review the data outside the meeting. Members noted that D Bennion was leading a piece of work on patient falls and Members agreed to receive a spotlight report on patient falls at the next meeting.

The Chair advised that the following question had been raised by C Donoghue ahead of the meeting: *Page 15 of 32. Out of 72 incidents of pressure damage,*

only 12 have been identified as avoidable which seems surprising to me. I know there is a paper on this later on, but it would be good to know what criteria were used for this?

As per my point in the first paragraph, I note that IPC (page 17 of 32) relies on significant new investment.

In response to the question raised, L Mann advised that the Falls Scrutiny Panel make the decision as to whether pressure damage was avoidable/unavoidable and advised that the panel was supported by the Tissue Viability Nurses. L Mann added that she had not included too much detail within the report regarding avoidable/unavoidable pressure damage in the community and advised that this could be explored further by means of providing assurance. The Chair advised that a discussion would be held on the best way forward at the next agenda setting meeting.

Resolution: The report was **NOTED**.

Action: Review of the data reported on pages 11 and 14 of the report to be undertaken as the data reported seemed to differ.

Action: Spotlight report on Patient Falls to be presented to the next meeting.

Action: Discussion to be held at the next agenda setting meeting as to whether a report on avoidable/unavoidable pressure damage in the community needed to be presented to the Committee.

6.2.1 Community Acquired Pressure Ulcer Improvement Plan Briefing

L Mann presented the report. Members noted that the majority of pressure damage incidents reported were from within the Community and that work needed to be undertaken in relation to improving data capture.

The Chair welcomed the Stakeholder Analysis and noted that a significant amount of support had been provided by Quality Informatics colleagues who would be really beneficial in developing this work moving forwards.

In response to a question raised by D Jouvenat as to there being possible issues in relation to providing support to family members in preventing pressure damage, L Mann advised that this was an area that needed to be developed further within the strategy which was in the early stages of development. L Mann advised that there was hope that this would make a significant difference within the community.

N Milligan commented that whilst she was pleased to see that work was being undertaken to improve the position in the future, the report did not identify how improvements would be made for patients now, particularly the improvements required in relation to poor documentation and record keeping. N Milligan sought clarity whether any discussions had been held with the District Nurses

on how they felt the position could be improved. L Mann confirmed that District Nurses and Tissue Viability Nurses were involved in the Pressure Ulcer Group and would play a key role in the success of this piece of work.

In relation to poor documentation and record keeping, G Dix advised that he would not want the Committee to feel that interventions were not already being made. G Dix added that this new process would ensure that there would be an understanding as to the reasons why the issues keep reoccurring and what could be done collectively to properly enact the interventions to ensure sustainability of good pressure ulcer/skin integrity going forwards. Members noted that the application of the Quality Informatics methodology would be a slow process.

N Milligan advised that work needed to be undertaken on documentation, which was an area of concern also highlighted in the Neonatal Services review. G Dix advised that the implementation of the Digital Nursing Care record would support this and added that he had invited the Lead Informatics Nurse to a future meeting of the Committee to present on the work being undertaken regarding the digitisation of the Nursing Care Record and the release of time this had given Ward Managers back into practice.

In response to a comment made by R Myles in relation to the numbers of patients in receipt of District Nursing care compared to patients coming from Care Homes, L Mann advised that the District Nursing service were more likely to report in terms of incident reporting and added that the data was not very sensitive which was why it required further interrogation.

The Chair welcomed the focus that had been placed on this particular area and sought clarity as to when the Committee would be provided with a further update. L Mann advised that she would be happy to present a brief update to the next meeting alongside the Measurement Strategy which forms part of this work.

Resolution: The report was **NOTED**.

Action: Update to be provided to the next meeting in relation to the Community Acquired Pressure Ulcer Improvement Plan alongside the Measurement Strategy.

6.3. Report from Chief Operating Officer

G Robinson presented the report and highlighted three key areas for the Committee's attention which included the Pathology Improvement Plan, the 28 Hour Ambulance Wait and the Emergency Department Workforce Business Case which had now been approved utilising the recovery funding received from Welsh Government. Members noted that this had been approved in advance of the Integrated Medium Term Plan (IMTP) process. G Robinson extended his thanks to S O'Brien for the work she had undertaken in the development of this Business Case.

The Chair advised that the 28 hour ambulance wait was particularly striking given the story that was shared earlier which highlighted that the impact this has on the individual could be long lasting. In response to a question raised by N Milligan as to whether any follow up was undertaken with the patient when they got home, A Llewellyn advised that she would review the position outside the meeting and would provide a response. The Chair suggested that a follow up should be undertaken if this had not already been done.

Resolution: The report was **NOTED**.

Action: Review to be undertaken as to whether a follow up was carried out with the patient who waited 28 hours in an ambulance. Follow up to be undertaken if this had not already been undertaken.

6.4 INTEGRATED LOCALITY GROUP REPORTS

6.4.1 Merthyr & Cynon ILG Report

R Hughes presented the report and highlighted the key matters for the Committee's attention. Members noted that the ILG were awaiting receipt of the Delivery Unit Review of the Minor Injuries Unit at Ysbyty Cwm Cynon and noted that the ILG were in the process of accuracy checking the Healthcare Inspectorate Wales second visit report for the Emergency Department review.

The Chair shared the following comment that had been received from C Donoghue prior to the meeting: *Really good to see the Meaningful Care Matters Level 1 Award.*

In response to a question raised by G Jones as to whether a meeting had been planned with staff to discuss the reopening of the Minor Injuries Unit at Ysbyty Cwm Cynon, R Hughes advised that discussions were being held amongst the senior leadership team as to what level of service could be provided in a measured and balanced way. Members noted that once a plan had been developed then engagement would be undertaken with colleagues on the plans to re-open. G Jones expressed concern in relation to the re-opening of the unit if a full complement of staff was not in place.

Resolution: The update was **NOTED**.

6.4.2 Rhondda Taf Ely ILG Report

C Tookey presented the report and highlighted the key issues for the Committee's attention.

Resolution: The report was **NOTED**.

6.4.3 Bridgend ILG Report

A Llewellyn presented the report and highlighted the key matters for the Committee's attention.

Members noted that in relation to Complaints closure compliance, the ILG had not achieved compliance this month as a result of staff vacancies and staff absence. Members noted that compliance was unlikely to improve in the near future.

Members noted that the ILG had submitted the Regulation 28 response to the Coroner in relation to the M Jones inquest and A Llewellyn advised that she would be happy to provide the Committee with an update on this at a future meeting.

A Llewellyn reminded Members that they had previously expressed concern in relation to the Healthy Schools Programme and advised that she was happy to report that colleagues within the Clinical Service Group had made significant progress on Health Visitor Contact.

In response to concern raised by the Chair as to whether plans were in place in relation to CAMHS performance which appeared to be worsening, A Llewellyn advised that this has been an area of concern for some time and added that a number of actions had been taken to address the position, including the placing of CAMHS into enhanced monitoring and the creation of a CAMHS Clinical Service Group. Members noted that the CAMHS Clinical Services Group Operational Manager left in October with the post not being filled until January, which impacted on performance. A Llewellyn advised that the service had experienced a 30% increase in demand and added that a number of actions had been taken to try to address this, including waiting list initiatives and the implementation of single point of access for Parts 1 and 2 of the measure.

Members noted that work was being undertaken with GP Colleagues to try to prevent some of the referrals being made into the service and a review was being undertaken of CAPA to determine whether it was still fit for purpose. Members noted that the longest wait had now reduced to 12 weeks.

The Chair advised that she found the Care and Treatment Plan quality measure a particular area of concern. A Llewellyn advised that a discussion had been held with CAMHS colleagues to discuss this where it was agreed that a plan would be developed to address performance. A Llewellyn advised that she would be happy to provide an update on this matter at a future meeting if required.

The Chair advised that it would be helpful to have an update at the next meeting in relation to Neurodevelopmental Waiting Times. A Llewellyn advised that whilst she would be happy to provide an update, this was a complicated area as Merthyr & Cynon provide ND services for Cwm Taf Morgannwg, whilst Swansea Bay provide ND Services for Bridgend as part of a Service Level Agreement.

In response to a question raised by N Milligan as to whether the service was still utilising some of the Counselling Agencies that were in the system, A Llewellyn confirmed that counselling agencies were still being utilised.

G Robinson advised that as this was his last Quality & Safety Committee, he wanted to acknowledge the work of the ILG Nurses and other Senior Nurses who had made great achievements over the last six months, particularly the improvements that had been made at Prince Charles Hospital. G Robinson extended a particular thanks to S O'Brien for the work she had undertaken during her time as Interim ILG Nurse Director for Merthyr & Cynon. The Chair also extended thanks on behalf of the Committee for the work that had been undertaken.

Resolution: The Report was **NOTED**.

Action: Update to be provided to the next meeting in relation to Neurodevelopmental Waiting Times.

6.4.4 Primary Care Report

J Armstrong presented the report and highlighted the key matters for the attention of the Committee. Members noted that there were issues being experienced with shift fill in GP Out of Hours with discussions being held in relation to mitigating actions. Members noted that ongoing discussions were taking place at the Primary Care Board regarding GP practice sustainability.

Members received an update in relation to the Primary Care Optometry Pathway service which had been temporarily paused as a result of some administrative issues. Members noted that discussions were being held with Cardiff & Vale UHB in relation to the provision of clinical care and it was hoped the service would resume shortly. The Chair extended her thanks to J Armstrong for the update and advised that she was pleased to hear that lateral thinking was being undertaken regarding the reintroduction of the service.

The Chair noted the update provided in relation to the work being undertaken to engage with GP practices regarding service sustainability and sought clarity as to whether accelerated cluster development was offering potential solutions moving forwards. Members noted that there were opportunities within the cluster to strengthen the Multi-Disciplinary and Community Teams.

R Myles sought clarity in relation to the number of complaints that had been raised and whether there were any themes in relation to the complaints, for example, access to services. J Armstrong advised that the complaint level had remained pretty static over the last year and there had not been a significant increase. Members noted that the Primary Care Governance Manager mapped each concern to determine whether any themes or trends could be identified, with the most common theme being access to services and potential treatment. Members noted that as a result of the Independent Contractor status of the practices, a number of patients would usually submit their complaint to the

practice directly, with the Health Board only having sight of these via the Annual Practice visits that were routinely undertaken.

Resolution: The report was **NOTED**.

6.5 Healthcare Inspectorate Wales Mental Health Inspections

J Denley presented the report which provided an update in relation to two Healthcare Inspectorate Wales visits that had been undertaken within Mental Health, one of which was to Seren Ward which was a positive review. Members noted that there was further work to undertake in relation to improving staff training compliance and strengthening policies.

In response to a comment made by the Chair in relation to feedback that had previously been received from Healthcare Inspectorate Wales in relation to learning not being sustained or shared across the Health Board, P Lewis advised that mechanisms were now in place to share learning via the Post Graduate Question & Answer sessions. Members noted that a Senior Nurse Forum was also in place where learning could be shared, although meetings had not been held regularly during the Covid pandemic.

The Chair sought clarity as to how the Committee could be provided with assurance as to whether solutions and learning had been embedded. It was suggested that the Committee may find it helpful to receive a 6 monthly summary report of progress made against the audits that had been undertaken within the Mental Health Service to demonstrate that learning had been sustained.

G Galletly advised that one of the recommendations raised by Healthcare Inspectorate Wales/Audit Wales Joint Review related to the need to develop an Audit Tracker for Healthcare Inspectorate Wales recommendations which was in the process of being worked through to ensure information was being captured in a meaningful way.

The Chair extended her thanks to J Denley and P Lewis for presenting the report.

Resolution: The report was **NOTED**.

6.6 Mortality Indicators and Mortality Reviews

D Hurford presented the report which highlighted the significant progress being made in this area.

Resolution: The report was **NOTED**.

6.7 Infection, Prevention & Control Committee Highlight Report

G Dix presented the report.

Resolution: The Report was **NOTED**.

6.8 Preparedness for the Covid Inquiry

G Galletly presented Members with the report which provided the Committee with an overview as to how the Health Board was preparing for the Covid Inquiry. Members noted that a programme management approach was being taken and noted that a Working Group had been established to take this piece of work forward. Members noted that it was unlikely that there would be a Wales only Inquiry.

Resolution: The Report was and **NOTED**.
The Charter for Families Bereaved through Public Tragedy was **ENDORSED**.

6.9 Development of a Listening & Learning Framework

L Mann presented the report which had been developed following the internal and external audit reviews that had been undertaken which highlighted the need for greater clarity on how learning was being identified and captured within and outside of the organisation.

The Chair advised that the following comment had been received from C Donoghue ahead of the meeting: *Fully supportive of the Development of a Listening and Learning Framework. Principles all very clear. The detail of how these will be delivered will be key.*

Resolution: The Report was **NOTED**.

6.10 Internal Audit Review into Concerns

G Galletly presented the report which had been referred by the Audit & Risk Committee. G Galletly requested that Committee Members review the report and share any comments or questions they had in relation to the report. Members noted that a robust action plan was in place. Members agreed to receive a combined report at the next meeting on progress being made against the actions identified in the Internal Audit review and the review undertaken by the Welsh Risk Pool.

Resolution: The report was **NOTED**

Action: Report to be presented at the next meeting on progress being made against the actions identified in the Internal Audit Review and Welsh Risk Pool Review.

7. ANY OTHER BUSINESS

There was no other business to report.

8. HOW DID WE DO IN THIS MEETING TODAY?

The Chair advised that she would be happy to receive comments as to how Members felt the meeting went today outside the meeting.

9. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 9am on Tuesday 17 May 2022.

10. CLOSE OF MEETING

Unconfirmed