

QUALITY, SAFETY & EXPERIENCE SUB-COMMITTEE UPDATE REPORT

Date of last meeting: 12 September 2024

Quoracy: Met

Report by: Mr James Severs, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert¹ (may require discussion)

There were no matters to alert the Committee to.

Advise² (to monitor)

The Quality, Safety & Experience Sub-Committee wish to **advise** members of the Committee that:

- Despite there being process in place to ensure compliance with the **Medical Examiners (Wales) Regulations** which became statutory in September 2024, the Sub Committee remain concerned regarding the fragility in the service and have requested an action plan to clarify resource requirements, mitigations. QSESC will continue to monitor this service.
- Planning is underway to implement the **cook-freeze catering model** across the Health Board, starting with the acute sites which is being overseen by the Cook-Freeze Steering Group. An update was requested to the Senior Nurse Management Team meeting on the roll out plan.
- The Water Group is exploring sustainable provision of **free water provision for people attending Accident and Emergency (A&E)** units across the Health Board. An update was requested for the next meeting.

Assure³ (to note)

The Quality, Safety & Experience Sub-Committee wish to **assure** members of the Quality, Safety & Experience Committee that:

- A workshop will be arranged for Members of **QSESC** to explore opportunities to strengthen the current reporting and develop metrics to enable performance and outcome focussed updates from Directorates and also incorporate quality assurance for commissioned services which was highlighted during a **patient story**. The proposed date of the workshop is 14 October.

¹ There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

² There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

- Proactive actions are underway to ensure care of patients after death in response to the outcome of the **David Fuller Inquiry** ahead of the anticipated national roll out of improvement requirements from Welsh Government.
- National and local working groups have been established and action plans developed in readiness for the implementation of **Call for Concern** process and a six-month pilot has been agreed at Glangwili Hospital which will be monitored through the Resuscitation and Acute Deterioration group. An update on the pilot will be provided to QSESC in March 2025.
- A follow up meeting would be arranged between Hospital Heads of Nursing and the Heads of Estates and Facilities to understand the significant vacancies for Hotel Services staff at Bronglais Hospital and mitigations.

Written Control Documents

The Sub Committee approved the following Written Control Documents:

- The Human Tissue Authority Group terms of reference

Recommendation

The Quality, Safety & Experience Committee is asked to note the content of the report.