COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R PWYLLGOR/ QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 8 October 2024

Quoracy/ Cworwm: Met

Report by/ Adroddiad gan: Anna Lewis, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Committee wish to **alert** members of the Board to:

- There were no items to alert the Board to.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

QSEC wish to **advise** members of Board that:

- The risks associated with **Care Home Fragilities** relating to future demographic and capacity requirement projections need to be factored into the Health Board's strategic planning and that the Executive Team should agree how to take this forward to Board.

- There is currently a gap for **Upper Gastrointestinal (UGI)** representation on the Withybush Hospital (WGH) emergency medical rota, options are being considered to temporarily relocate the service until the implementation of the revised model as part of the Clinical Services Plan. The Committee suggested strengthening the data that is being captured on patient harm if the current arrangements continue.

- Further work was requested to improve the reliability of the data used for establishing nurse staffing levels, due to the current challenges with the Allocate system, which emerged during the Committee's scrutiny of the routine **Quality Assurance Report.** This report also provided a status report on outstanding Healthcare Inspectorate Wales (HIW) recommendations and, as a result of concerns raised by the Committee in respect of the pace of implementing these recommendations, further assurance was requested for the next meeting on whether there are effective systems in place to monitor and address outstanding recommendations.

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[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*.

Assure[3] (to note)/ Sicrhau (i nodi)

QSEC wish to **assure** members of Board that:

- Positive patient and staff feedback was shared at the meeting for the **Ceredigion Community Same Day Emergency Care and Outreach service** and the multi-disciplinary collaborative efforts to provide person-centred healthcare. The Committee suggested capturing outcome focussed data to help decision making for future strategic direction considerations.

- A workshop has been arranged on 19 November 2024 to review the Directorate reporting requirements for the **Quality Safety and Experience Sub Committee**, with Clinical Executive leadership.

- During the **Listening and Learning Sub Committee** update report, the Committee approved a revision to the Putting Things Right Regulations and for the timeframe of 2 working days for an early resolution to be increased to 10 working days, in advance of formal implementation of the new Regulations from 1 April 2025, with the expectation that the impact is monitored by the Sub Committee.

- Positive progress has been made in response to the Care Inspectorate Wales (CIW) recommendations following their inspection of the **Withybush Hospital Creche.** There is one action outstanding to develop a written control document and the Control Group will continue to meet until all actions are completed. Positive feedback has been received from CIW during their follow up visit.

- An appropriate response to the **Infected Blood Inquiry** has been undertaken, with ongoing robust testing and treatment pathways developed. Support will continue to be offered to individuals who may have been infected.

- The recent investment and developments in community nursing, which were shared during the **Community Nursing Annual Report 2023/24,** and the impact on workforce sustainability and quality and safety of patient care, was positively received by the Committee.

- During the **Medicines Management Operational Group** update, the Committee discussed the completion of Venous Thromboembolic Risk Assessments which continues to be poor, even though the prescribing of prophylaxis has generally improved. Discussion took place on current processes and the Committee requested an assurance report on systems in place for completion of Venous Thromboembolic Risk Assessments to be scheduled for Quality, Safety and Experience Sub-Committee in January 2025.

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

- With regard to the **Written Control Documents**, the Committee approved the Incident Reporting Procedure.

Review of Risks/ Adolygiad o Risgiau

Not applicable

Sharing of learning/ Rhannu dysgu

Not applicable

Recommendation/ Argymhelliad

The Board is asked to **note** the items the Committee is advising them of and **take assurance** from the items that the Committee is providing assurance on.

Agenda, papers and minutes are available on our website/ Mae agenda, papurau a chofnodion ar gael ar ein gwefan: Quality, Safety and Experience Committee