Meeting Date	**7th June 2018**	**Agenda Item**	**7a**
Report Title	***Quality and Safety Committee Annual Report***		
Report Author	Alyson Charnock, Corporate Matron Quality and Safety		
Report Sponsor	Maggie Berry, Chair and non-Officer Member		
Presented by	Maggie Berry, Chair and non-Officer Member		
Freedom of Information	Open		
Purpose of the Report	The appended report provides a summary of the work undertaken by the Committee over the past 12 months. It demonstrates that the Committee complied with its Terms of Reference.		

Key Issues	• The Committee received information in relation to a wide variety of Health Board matters in the 12-month period.
	• Throughout the year, improvements were made to the way such information was reported.
	• Amongst the key issues considered by the Committee during 2017/18 were the following:
	  ○ Health and Care Standards
	  ○ 15 Step Challenge Visits
	  ○ Patient Stories
	  ○ Quality Priorities		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • Note the contents of the Annual Report which provides assurance that the Quality and Safety Committee is complying with the Terms of Reference.

Quality and Safety Committee Annual Report

1. INTRODUCTION

The appended report provides a summary of the work undertaken by the Committee over the past 12 months. It demonstrates that the Committee complied with its Terms of Reference.

2. BACKGROUND

The Committee is a standing sub-committee of the Health Board. Its purpose is to provide:

- Evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- Assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The purpose of this paper is to seek the Quality and Safety Committee's approval of the attached Annual Report, which summarises the activity of the Quality and Safety Committee in the period 1st April 2017 to the 31st of March 2018.

In the year ahead the Committee will continue to focus on those matters that will strengthen our quality and safety arrangements and above all improve the experience of our patients.

It is recommended that the Quality and Safety Committee approves the content of the Annual Report and confirms that it is content for it to be submitted to the Board, for information, when it meets in July.

The Committee will continue to focus on this constant need to improve over the next 12 months.

3. GOVERNANCE AND RISK ISSUES

No matters addressed in this report carry a significantly increased level of risk for the Health Board.

4. FINANCIAL IMPLICATIONS

None.

5. RECOMMENDATION

Members of the Quality and Safety Committee are asked to:

- Note the contents of the Annual Report which provides assurance that the Quality and Safety Committee is complying with the Terms of Reference.

Abertawe Bro Morgannwg

University Health Board

Quality and Safety Committee

Annual Report

2017-18

Foreword

It gives me great pleasure to introduce the Quality and Safety Committee's Annual Report for 2017-2018. This report provides an overview of the work taken forward by the Committee during the last 12 months, and the steps taken to strengthen the Health Board's quality assurance, patient feedback and quality improvement arrangements.

The Health Board published its 3-year Quality Strategy in May 2015 where the following mission statement was declared:

"We will respect people's rights in all that we do. Wherever and by whom it is provided, care will be safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it could be."

The Health Board's Quality Strategy gives a clear direction to everyone who works for, or on behalf of, ABMU Health Board and demonstrates the importance placed on quality and the experiences of our patients.

During the year a number of key improvements were made to ensure that the Health Board, at all levels, had a citizen-centred approach, putting patients, patient safety and safeguarding above all other considerations. However, further work is still needed and the Health Board must continue to transform how it works if it is to always place people at the centre of the services it provides; and prevention, quality and transparency at the heart of the healthcare it delivers. This report therefore also provides a summary of the areas that the Committee will focus on over the next 12 months in order to support and scrutinise the developments and changes that are needed.

I am grateful to all of you who have contributed to the quality and safety agenda over the last 12 months. As the new Quality & Safety Committee Chair I would like to give very special thanks to Mr Paul Newman; Paul successfully Chaired this Committee for many years and helped prepare me for this new role. I would also like to thank the Health Board's executive leads for quality and safety during the last 12 months, Professor Hamish Laing, Professor Rory Farrelly, Mrs Christine Morrell and Professor

Angela Hopkins, all have provided support to ensure that the Committee always remains focused on the experiences of our patients and the outcomes of our services.

Maggie Berry

Chair, Quality and Safety Committee

1. Introduction to the report and Quality and Safety Committee

This report describes how the Quality & Safety Committee (the Committee) has complied with, and satisfied the requirements set out within its terms of reference over the period 1st April 2017 to 31st March 2018.

The Committee is a standing committee of the Health Board. Its purpose is to provide:

- evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare, in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The Committee revisited the Terms of Reference when it met in April 2017. A report outlining the committee's terms of reference for an annual review was received**.**

There was one addition to the Terms of Reference, the sub-committees be amended to include the Quality and Safety Forum.

The Committee is confident that, for the 2017/18 financial year, it fulfilled its purpose and duties, as identified within its Terms of Reference, ***Appendix 1***.

2. The 2017-18 Work Programme

The Committee's Terms of Reference refers to the importance of an annual work programme (***section 3.3***). This should be seen as a useful framework rather than a restrictive agenda. Therefore, flexibility was built into the annual work programme for 2016/17 to ensure that where the Committee identified a need for further assurance or information, relevant individuals could be required to attend the next meeting of the Committee to provide further information or assurance. The Committee agreed the work programme, ***Appendix 2***, in October 2017.

The Work Programme is on the Committee agenda as a standing item for review and is updated when required.
The Committees agenda is aligned to the Health and Care Standards. A review has taken place in April 2018 to capture the number of reports which were received against the relevant Health and Care Standards.

3. Frequency and Format of Committee Meetings

During 2017/18, the Committee met six times as scheduled and in line with the requirement set out in its terms of reference to meet at least bi-monthly.
The details of the Committee members and Executive directors who were in attendance at the meetings held during 2017/18 can be found in ***Appendix 3***.

Key to the efficient and effective discharge of the Committee's agenda is the quality of papers that it receives and therefore to this end at the start of the year clear requirements and expectations were set by the Chair that included:

- The need for those drafting papers to remember that the Committee's focus is on the Health Board's quality and safety agenda; papers therefore need to be open and transparent in terms of what the issues are, what action is being taken and when improvement can be expected.
- Papers needing to achieve a balance between highlighting good practice and learning as well as shining the light on areas where improvement is needed.

The need to improve the efficiency and effectiveness of meetings was also recognised by the Chair and Members and so it was agreed that during 2017/18 meetings would:

- be planned and organised to last no longer than 3 hours, plus a further 30 minutes for the "in committee" section;
- be held in different locations (Service Delivery Units and Headquarters) on a rotational basis so that the Committee has a greater presence across the Health Board;
- be held in the morning so that unannounced visits could be undertaken in the afternoon. During the year the '15 step challenge' methodology was used as the basis for these visits, ***Appendix 4***; and

- start with a patient story that, if possible, is related to the venue where the meeting is being held.

During the year, the Committee met in the following venues:

- Morriston Hospital (*April 2017*)
- Singleton Hospital (*June 2017)*
- Neath Port Talbot Hospital (*August 2017*)
- Princess of Wales Hospital (*October 2017*)
- Headquarters, Baglan (*December 2017*);
- Glanrhyd Hospital (*February 2018)*

The Committee also held 'in private' meetings to discuss incidents and Protection of Vulnerable Adults cases, although every effort was made to keep the private meetings to a minimum. Such meetings were only held to protect the confidentiality of patients', staff and the wider public interest.

4. Committee Reporting Arrangements

The minutes of the Quality and Safety Committee were routinely reported to the Board. In addition, the Chair of the Committee submitted regular reports to the Board as required by the standing orders of the Health Board. Reports to the Board highlighted key issues which the Committee considered needed to be brought to the Board's attention.

In order to ensure openness and transparency all minutes of Committee meetings and supporting papers were placed on the Health Board's Internet site.

5. Compliance with the Committee's Work Programme

The Committee received information in relation to a wide variety of Health Board matters in the 12-month period. Throughout the year, improvements were made to the way such information was reported.

Amongst the key issues considered by the Committee during 2017/18 were the following:

Health and Care Standard/ Key Issues Considered
1. Staying Healthy
• Staying Healthy Update
• Update and Big Fight Campaign (use of Antimicrobial Drugs)
• Catering and Nutrition Update
2. Safe Care
• Blood Glucometry Action Log Update
• Human Tissue Act Governance Report
• Safeguarding
• Infection Prevention and Control
• Health Board Female Genital Mutilation Policy
• Mental Health Desktop Review and Lesson Learned Report
• Influenza Immunisation Update
• Discharge Information Improvement Update
• Pharmacy and Medicines Management Report
3. Effective Care
• Delivery Units' performance presentation and patient stories
• Quality and Safety Dashboard
• Ward to Board Dashboard
• Mortality Reporting, dashboard and Mortality Reviews
• Reports from external review and regulatory bodies
• Internal Audit and Clinical Audit reports
• Annual Quality Statement
• Concerns and Claims annual report
• Health and Care standards annual scrutiny report
• Quality and Safety committee annual report, self-assessment and terms of reference
• Quality and Safety priorities
• Decontamination Action Plan Update
• Controlled Drugs accountable officer's annual report
• Report on Microbiology

• Quality and Safety Forum reports and sub-structure of the committee
• Welsh Government quality division feedback report
• Improving and Maintaining the environment and estates
• Thoracic Surgery Review
• Blood Glucometry
• Clinical coding
• Radiation Protection Committee Annual Report
4. Dignified Care
• Mixed Sex Ward Audit
• Older Peoples Agenda Position Update
• Coding Feasibility Study
• Patient Experience Report
5. Timely Care
• Wales Audit Office – Follow Up Not Booked Report
• Improvement in Management of gallstone disease
6. Individual Care
• Patient Feedback report
7. Workforce
• Individual Patient Funding requests policy
• Health and Safety polices, Safeguarding policies, policy for Controlled access/egress, Estates policies, Falls policy, 'Ask and Act' policy; Professional Abuse policy
• Ward to board assurance framework
• Maternity reporting structures
• Welsh Health Specialised Services Committee Quality and Safety key matters

An Internal Audit conducted into Clinical Governance has highlighted an opportunity for more effective management of the Quality and Safety Committee Work Programme, to include a colour-coded key which easily identifies and highlights reports received on time, late or that remain outstanding. This process was adopted as of June 2017.

6. Keeping a Patient Focus: Patient Stories

To support the drive to maintain the focus on the quality and safety of care the Quality and Safety Committee requested that Patient Stories be included in the annual Service Delivery Unit presentations to the Committee. The inclusion of Patient Stories has been more consistent than the previous year.

During 2017/18 the following stories were presented:

April 2017 – Morriston Hospital

The patient story focussed on a new pathway being piloted for non-weight bearing orthopaedic patients. Every Tuesday morning a meeting was held to discuss patients who were medically fit for discharge but were still in the hospital. One of the biggest causes was patients who had suffered a fracture and could not weight-bear for several weeks but live alone. As such, arrangements had been made for these patients to recuperate at a residential care home. The story compared two patients; one before the pilot who spent seven weeks in hospital and the other who was discharged straight from the emergency department to the residential home to recover. The first patient developed a hospital-acquired infection and missed her home life, whereas the other was in the residential home for nine weeks with her own room, access to social activities and maintained independence. The pilot had now ceased while additional funding was sought. There was also an opportunity to develop a similar pathway for patients who had confusion in addition to their fracture.

June 2017 – Singleton Hospital

The patient story focussed on a mother whose young son had passed away at Princess of Wales Hospital. She outlined her experience of spending time with her child at the mortuary, during which she felt that he had not been given the dignity and respect the family needed and communication from staff had not been forthcoming. The mum also felt that the condition from which her child died had not been properly explained to her and she did not understand what the term meant. The committee heard how the paediatric patient experience nurse had met with the mum to discuss her concerns as well the mortuary service

managers to develop ways to make the process more supportive of parents grieving the loss of a child. A bereavement leaflet had since been designed, as had a pamphlet to explain the condition from which the child died. In addition, a bespoke blanket was being made to cover children for viewings, as the adult covers were too big. A full action plan was in place to improve the experience for families and updates were consistently provided to the mother of the deceased child.

August 2017 – Neath Port Talbot Hospital

A report providing an update in relation to progress and performance for quality and safety in Neath Port Talbot Unit was **received.**

In introducing the report, the team highlighted the following points:

- An internal audit of the unit's governance had received a *reasonable assurance* rating
- Quarterly reports were received by the unit's management board in relation to its health and care standards action plan;
- A number of external visits to the various services had been undertaken and the learning from these as well as visits to other sites was being used to improve services and patient experience;
- The number of pressure ulcers resulting in harm had reduced by 50% and harm relating to falls was below the national average at 23%. Scrutiny panels had been established for both of these areas to monitor performance;
- Root cause analyses had been undertaken for incidents of c*lostridium difficile,* of which there had been two, and themes identified;
- Compliance with the spot the sick patient was 100%;
- Response rates to the friends and family test remained between 90% and 95%, with the exception of a 'dip' in May/June 2017, which was attributed to one patient using the form to access the wifi. The Patient Experience Advisory Service (PEAS) visited areas with low response rates;

- The unit had nine Bevan exemplar projects;

- The unit was implementing ‘John’s Campaign’ to enable carers to spend more time with their family members and was working with Aneurin Bevan University Health Board to share its learning;

- A re-enablement ward to avoid hospital associated de-conditioning and to facilitate earlier discharge had been established;

- The transfer of care advice and liaison service (TOCALS) was also promoting earlier discharge and reducing length of stay for patients;

- The operational hours had been revised for the Minor Injuries Unit , which had reduced the number of complaints as more staff were now available during opening hours;

- The Wales Fertility Institute had the highest number of concerns raised and the main theme was communication; as such patient stories were to be developed to inform new referrals.

October 2017 – Princess of Wales Hospital

A patient story was received outlining a family’s experience of their mother’s care at the hospital in 2013. The patient’s son explained that as his mother had vascular dementia, the family had put its trust in the hospital as it operated within the ‘Butterfly Scheme’, for hospitals where increased dementia awareness and dementia friendly environments had been developed. However, they found that their mother had not been showered, fed or given her insulin by staff and instead family members undertook such care. There were also issues of communication. Sadly, the patient had since passed away but the family asked that the Butterfly scheme be better implemented to improve patients and families’ experience.

December 2017 – Primary and Community Care

A patient story was received outlining the care of a terminally ill patient who was able to die at home. The patient’s husband explained that it was due to the care and support provided by the community nursing staff that this was possible. Every day the family felt valued and that the team was there for them during their hour of need to help the patient fulfil her wish to be at home for her final days.

The husband had written to the unit to express how much the team's support had meant.

In discussing the patient story, the following points were raised:

The Head of Nursing for Primary Care and Community Services advised the Committee that the story was very special to the unit and the team had been nominated by the family for a Patient Choice Award.

February 2018 – Mental Health and Learning Disabilities

A patient story was received outlining how a mental health service user benefitted from weekly activities at the health board's Ty Einon centre. The service user had spent time as an inpatient at Cefn Coed Hospital and could not praise the care enough. During that time she received medication and talked with psychiatrists. After discharge, she found she was on her own for long periods of time but a nurse visited her at home and suggested she attend the centre weekly, which she found to be 'wonderful'. Not only did it provide her with an opportunity to work with physiotherapists to improve her mobility but she had made a number of new friends with whom she could meet for coffee or go for meals. Also at the centre the service user was able to take part in crosswords and quizzes and her family was 'overjoyed' with how attending the centre had helped with her mental health. She felt that now if she suffered a bout of depression, it lasted a few days and her future seemed much brighter. In discussing the patient story, the following points were raised:

The Head of Nursing for Mental Health and Learning Disabilities commented that the story highlighted the importance of meaningful activity for mental health.

The Interim Director of Nursing and Patient Experience advised the Committee that the story was a good example of how loneliness can affect mental health and the centre gave opportunities for carers to do to the caring and provide families with respite.

7. Learning from complaints and incidents

At each Committee meeting, a report was received providing an overview of the complaints and incidents reported, the outcome of investigations and the lessons

learned. The Committee was also provided with regular updates on the work being taken forward to ensure timely, open and respectful responses to complaints and assurance that the Health Board's systems are designed to learn from concerns. During the year:

- Concerns & Redress Workshops have been held in the Health Board to promote consistency in terms of the management and investigation of concerns and promote “values” based responses.
- The management of complaints was reviewed and revised at a corporate level and within the Units, which has led to a gradual improvement in the timeliness of responses sent to complainants. As a result, the Health Board achieved the Welsh Government target of 80% of responses being sent to complainants within 30 working days in March and June 2017.
- Health Board wide Pressure Ulcer Strategy Group has been established to report to the Assurance & Learning Group with the aim of further reducing pressure ulcers by 10%.
- Health Board wide Falls Strategy Group has been established to report to the Assurance & Learning Group, with the aim of further reducing falls with harm by 10%
- Quality & Safety Forum has been established to support the work of the Quality & Safety Committee.

8. Quality Priorities for 2017-18

The Quality Priorities for the Health Board in 2017/are being continued from 2016/2017 to sustain improvements and three additional priorities have been agreed.

The three additional priorities are:

- Falls
- Pressure Ulcers
- Electronic Discharge

No	Priority	Description
1	PREMs and PROMs	Improving the way we collect and use Patient Reported Experience Measures (PREMs) and Patient Reported Outcomes Measures (PROMs)
2	Stroke Improvement	Improving our stroke services by reconfiguring the patient pathway
3	Spot the Sick Patient (NEWS)	Improving the way we identify and manage a patient whose condition deteriorates by spreading across all hospitals and wards the 'Spot the Sick Patient' initiative.
4	DNACPR Policy (NEWS)	Improving End of Life care by implementing the all-Wales Do Not Attempt Cardiopulmonary Resuscitation Policy
5	e-Prescribing	Reducing medication errors by implementing electronic prescribing and administration of medicines
6	The Big Fight	Spreading the 'Big Fight' campaign which targets antibiotic resistance and the incidence of *clostridium difficile* infections in primary care
7	Suicide Prevention	Improving risk assessment and support mechanisms to prevent those who are known to our mental health services from attempting or contemplating suicide
8	Falls	Improving the prevention of falls in hospital and community settings
9	Pressure Ulcers	Reducing avoidable harm by reducing the incidence of pressure ulcers across the Health Board but particularly in community settings
10	e-TOC	Sharing information accurately and in a timely fashion between clinical teams, particularly on discharge from hospital by compliance with our standard for an electronic discharge summary being sent.

9. Annual Quality Statement

In July 2017, the Health Board published its Annual Quality Statement (AQS) for 2016/17. The Committee oversaw the development of the AQS.

Work is underway for the AQS for the 2017/18 year, and this will outline the progress that has been made over the last 12-months in the 'looking back' and will further outline the areas for renewed or continued focus in the 'looking ahead'.

10. Health and Care Standards

The Health and Care Standards self-assessments from Service Delivery Units and Executive leads were monitored through the process executed by a Scrutiny Panel chaired by an Independent Member of the Board.

This panel met at the end of each quarter during the 2017/18 year, and finally on 9th April 2018, to reflect on the development of the 2017/18 process and to discuss the Executive scores for each standard.

The summary of the panel feedback on both the process and the Health and Care Standard Scores is summarised below;

- ✓ All standards need to be `live` during the year not just considered as part of a monthly or end of year exercise
- ✓ Action plans are sometimes duplicated with the same or similar information produced for different meetings.
- ✓ Executive leads have accountability for individual standards and will set objectives for Service Delivery Units to achieve progress against the Quality Priorities.
- ✓ There is a clear focus for each Service Delivery Unit to report progress against quality Priorities within the performance review process.
- ✓ The Panel felt that the Scrutiny process has matured over the last 12 months but that further work is required to facilitate Executive ownership of their standards and representation at the quarterly meeting of the panel.

- ✓ The process for 2018/2019 will now be embedded within the Performance review process and Service Delivery Units will need to continue to monitor progress against the objectives set by Executive leads and monitor performance via an action plan template.

11. 15 Step Challenge

Visible leadership is a key to the delivery of the quality and safety agenda. During the year, members of the Quality and Safety Committee undertook visits to the following clinical areas:

- Singleton Hospital (June 2017). Ward 2.
- Neath Port Talbot Hospital (August 2017). Ward E & Neuro-Rehabilitation Unit.
- Princess of Wales Hospital (October 2017). Ward 19 & Ward 20.
- Cwmavon Health Centre, Port Talbot (January 2018).
- Princess of Wales Hospital (February 2018). Ward 8.

Following these visits, feedback was provided to the wards and, where necessary, action plans put in place. These visits also provide front-line staff with the opportunity to engage directly with Board members.

Summaries of the 15-step activity in the past 12 months, as previously written in the Patient Experience Reports can be found in ***Appendix 4.***

12. Information Governance Arrangements

The Committees Terms of reference states in section 3.5 that;

"the Committee will receive reports through the Information Governance Committee relating to Quality and Safety issues, with the Audit Committee overseeing the overall Information Governance arrangements."

13. Self-assessment and Evaluation

In April 2017, Committee members took part in a self-assessment exercise coordinated by the Committee Services Manager. The purpose was to determine

its effectiveness and ability to discharge its role. The outcome enables training and development to be considered, in addition to changes to processes and procedures.

The generic survey template was integrated by internal audit, and finance colleagues in the SNAP survey system (a computer based software system that generates patient experience surveys and reports), and the link circulated via email following the committee meeting in February 2017. Reminders were sent prior to the closing date to encourage completion.

Of the eight invited responses for the Quality and Safety Committee, all eight were received; four non-officer members and four executive directors. This was the highest response rate to date of all board committees.

There was general agreement around several of the responses. There were a number of issues raised that may need further consideration by the committee. They are as follows:

(a) Adequate Administrative Support

While 50% of respondents agreed that the committee had adequate administration support, the remainder felt this was only partially true. Two also highlighted issues regarding the attendance of executive directors, noting that they are unable to attend each meeting or are only available for part of a meeting

(b) Adequate Induction and Ongoing Training

Feedback in response to this area was mixed; some agreed, others did not and some did not know how to answer. It was suggested that there was room for improvement and there could be more initial interaction with the members of the committee, as well as introductions to those leading the groups feeding into the committee.

(c) Assessment of Own Effectiveness

Seven of the eight responses agreed that the committee periodically assessed its own effectiveness with one comment stating that the chair and members were

also good at assessing effectiveness during meetings as well.

(d) Committee Meetings

Most of the responses agreed that the committee met sufficiently frequently to deal with planned matters and enough time was allowed for questions and answers. However, one person only partially agreed and another disagreed completely, with a comment suggesting that the agenda was not efficiently planned and items over ran, which did not allow for matters to be discussed nor breaks to be taken.

(e) Timing of Meetings

There was general agreement that committee meetings were scheduled prior to important decisions and the timing was discussed with all parties. One comment did note that the dates of the meetings were fixed throughout the year and it is impractical to arrange alternatives at short notice.

(f) Timeliness, Format and Content of Reports

Half of the responses were satisfied with the timeliness, format and content of the reports however the other half gave a mixed opinion, ranging from partially agreeing, disagreement and not knowing. One comment stated that the content of the reports has evolved and improved, while another noted that a review is sometimes useful.

(g) Robustness of Data

The majority of respondents either agreed or partially agreed that the committee reviewed the robustness of the data behind the reports and assurance received. However, it was noted that it would be impractical to systematically check all the data provided to the committee and that primarily, reports are accepted as presented with questions asked of the author at the meeting. It was stated that the committee has not taken the time to examine whether the data is presented in a way which gives assurance.

(h) General Comments

Within the free text section of the survey, it was stated that while the committee is very well chaired, the attendance by non-officer members was variable.

Another comment called for the timeliness of information to improve as typically the data is at least two months old, which impacts on the ability to gain assurance and the way in which decisions are made.

Concerns were raised as to the duration of the meetings and presentations, as one responder considered it was not conducive to examine and scrutinise quality and safety issues without a break.

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14. Key Areas of focus in 2018/19

In the year ahead the Committee will continue to focus on those matters that will strengthen our quality and safety arrangements and above all improve the experience of our patients. The Committee's 2018/19 work has been designed to ensure that:

- Patients and their families are always treated with dignity and respect.
- Those who access our services and buildings are safeguarded.
- The experiences of our patients are monitored and the feedback received is acted upon.
- When things go wrong they are put right in a way that is compassionate and timely.
- The Quality and Safety priorities set for 2018/19 are delivered.
- The visibility of the Committee members is increased, including conducting bi-monthly cross-site 15 step challenge.
- Robust Scrutiny arrangements are in place to monitor and support the Health and Care Standards across the Health Board.
- A mechanism for monitoring the Health Boards milestones and trajectories on Quality Priorities is introduced.

A copy of the work programme for 2018/19 is in ***Appendix 5***.

15. Conclusion

The above report provides a summary of the work undertaken by the Committee over the past 12 months. It demonstrates that the Committee has complied with its Terms of Reference.

Although much has been done, more still remains to be done if the quality and safety of the work undertaken by the Health Board is to be improved. The Committee will continue to focus on this constant need to improve over the next 12 months.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
					✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓
Quality, Safety and Patient Experience							
The purpose of the Quality & Safety Committee is to provide: ▪ evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and ▪ assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.							
Financial Implications							
None							
Legal Implications (including equality and diversity assessment)							
None							

Staffing Implications	
None	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
None	
Report History	This is an Annual Report. Previous versions of this report can be obtained from Corporate Administration.
Appendices	Appendix 1 – Quality and Safety Committee Terms of Reference Appendix 2 - Quality & Safety Committee Work Programme 2017/18 Appendix 3 - Attendance at 2017/18 Quality and Safety Committee Meetings Appendix 4 - Summary Reports of 2017/18 15 Step Challenge Visits Appendix 5 – Quality and Safety Committee Work Programme 2018/2019

Appendix 1

Quality & Safety Committee

Terms of Reference & Operating Arrangements

Reviewed in April 2017

1. INTRODUCTION

1.1 Abertawe Bro Morgannwg University Health Board's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

1.2 In line with standing orders (and the Health Board's scheme of delegation), the Board shall annually nominate a committee to be known as the Quality and Safety Committee. This committee's focus is on all aspects aimed at ensuring the quality and safety of healthcare, including activities traditionally referred to as "clinical governance". The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality & Safety Committee "the Committee" is to provide:

- evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of advice to the Board:

- oversee the initial development of the Health Board's strategies and plans for the development and delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;
- consider the implications for quality and safety arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (sub) Committees of the Board; and
- consider the implications for the Health Board's quality and safety arrangements from review/investigation reports and actions arising from the work of external regulators.

3.2 The Committee will, in respect of its assurance role, seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Health Board's activities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of quality and safety:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;
- the organisation, at all levels (locality/directorate/clinical team) has a citizen centred approach, putting patients, patient safety and safeguarding above all other considerations;
- the care planned or provided across the breadth of the organisation's functions (including locality/directorate/ clinical team and those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;
- the organisation, at all levels (locality/directorate/clinical team), has the right systems and processes in place to deliver, from a patient's perspective - efficient, effective, timely and safe services;
- the workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained;
- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;
- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;
- risks are actively identified and robustly managed at all levels of the organisation;
- decisions are based upon valid, accurate, complete and timely data and information;
- there is continuous improvement in the standard of quality and safety across the whole organisation – continuously monitored through the Health and Care Standards for Wales;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:
  - ✓ sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;
  - ✓ recommendations made by internal and external reviewers are

considered and acted upon on a timely basis; and

- ✓ lessons are learned from patient safety incidents, complaints and claims.

3.4 The Committee will advise the Board on the adoption of a set of key indicators of quality of care against which the Health Board's performance will be regularly assessed and reported on through Annual Reports.

3.5 The Committee will receive reports through the Information Governance Committee relating to quality and safety issues, with the Audit Committee overseeing the overall information governance arrangements.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.8 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Quality & Safety Committee.

3.9 The Committee will meet with Internal Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales) without the presence of officials on at least one occasion each year.

3.10 The Chair of the Quality & Safety Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.11 The Committee may, subject to the approval of the Health Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The following sub committees have been established:

- Health and Care Standards Scrutiny Panel

MEMBERSHIP

Members

3.12 Four members, comprising:

- Chair - Non Officer Member of the Board;
- Vice Chair - Non Officer Member of the Board; and
- Members - two other Non Officer Members of the Board.

The Committee may also co-opt additional independent “external" members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

3.13 In attendance - Executive Directors with responsibility for Quality and Safety.

The Chief Executive and other Executive Directors should attend from time to time as required by the Committee Chair

3.14 By invitation - The Committee Chair may extend invitations to attend committee meetings as required to the following:

- leads from localities/directorates/clinical teams;
- representatives of partnership organisations;
- public and patient involvement representatives; and
- Trade Union representatives

As well as others from within or outside the organisation who the Committee considers should attend, taking account of the matters under consideration at each meeting.

Secretariat

3.15 Secretary - As determined by the Board Secretary.

Member Appointments

3.16 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

3.17 Members terms of office will be reviewed annually by the Board Chairman. A member may resign or be removed by the Board.

3.18 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Health Board Chair and, where appropriate on the basis of advice from the Health Board's Workforce and Organisational Development Committee.

Support to Committee Members

3.19 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the Health Board's overall OD programme developed by the Director of Workforce & Organisational Development.

4. COMMITTEE MEETINGS

Quorum

4.1 At least two members must be present to ensure the quorum of the Committee, including either the Committee Chair or Vice Chair.

Frequency of Meetings

4.2 Meetings shall be held no less than bi-monthly, and otherwise as the Chair of the Committee deems necessary – consistent with the Health Board's annual plan of Board Business.

Withdrawal of Individuals in Attendance

4.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

5.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

5.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework. This will be achieved primarily through the Audit Committee.

5.3 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

6.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the Committee's assurance role relates to a joint or shared responsibility.

6.3 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers
-

8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Appendix 2

Quality & Safety Committee Work Programme 2017/18

Agenda Item	Apr 17	Jun 17	Aug 17	Oct 17	Dec 17	Feb 18	Apr 18	Jun 18	Aug 18	Oct 18
Preliminary Matters										
Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Work Programme	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the meeting held on 17th August 2017	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters arising not on the agenda	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action Log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Presentations/ Attendances										
Service Delivery Unit Update and Patient Story	MH	SH	NPT	PoW	PC&CC	MH&LD	MH	SH	NPT	PoW
Update on Big Fight Campaign	✓			✓					✓	
Pharmacy & Medicines	✓		✓		✓		✓		✓	

Management Report										
CD Accountable Officer Annual Report			✓						✓	
CAMHS			✓			✓			✓	
Primary and Community Care Quality and Safety Performance Measures	✓		✓		✓		✓		✓	
111 Pathfinder Project Update		✓						✓		

Agenda Item	**Apr 17**	**Jun 17**	**Aug 17**	**Oct 17**	**Dec 17**	**Feb 18**	**Apr 18**	**Jun 18**	**Aug 18**	**Oct 18**
Preliminary Matters										
Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Work Programme	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the meeting held on 17th August 2017	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters arising not on the agenda	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action Log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Presentations/ Attendances										

Service Delivery Unit Update and Patient Story	MH	SH	NPT	PoW	PC& CC	MH& LD	MH	SH	NPT	PoW
Update on Big Fight Campaign	✓			✓					✓	
Pharmacy & Medicines Management Report	✓		✓		✓		✓		✓	
CD Accountable Officer Annual Report			✓						✓	
CAMHS			✓			✓			✓	
Primary and Community Care Quality and Safety Performance Measures	✓		✓		✓		✓		✓	
111 Pathfinder Project Update		✓						✓		

Agenda Item	**Apr 17**	**Jun 17**	**Aug 17**	**Oct 17**	**Dec 17**	**Feb 18**	**Apr 18**	**Jun 18**	**Aug 18**	**Oct 18**
Staying Healthy										
Catering and Nutrition Update	✓						✓			
Staying Healthy (to include vaccination)		✓		✓		✓		✓		✓
Safe and Effective Care										
Quality & Safety	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Dashboard										
Blood Glucometry		✓	✓			✓		✓		
Infection Control Report		✓		✓		✓	✓	✓		✓
Decontaminati on Report		✓			✓			✓		
Radiation Protection Committee Annual Report					✓					
Quality and Safety Priorities Report			✓	✓						
Human Tissues Act Governance Annual Report						✓				
Safeguarding Report		✓				✓				
Themes Identified from Mortality Reviews					✓					
Clinical Audit Policy						✓				
Thoracic Surgery Review					✓					
Quality Division Feedback Report (HLI/CH)						✓				
Never Event report (HLI/AH)						✓				

Dignified and Individualised Care										
Pain Review paper					✓					
Older Peoples Report and Dashboard (6 monthly)	✓	✓	✓	✓	✓	✓				
Patient Experience Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Coding Feasibility Study				✓						
PROMS update							✓			
Timely Care										
Follow-Up Not Booked			✓			✓				
Improvement in Management of Gallstone Disease			✓							
Staff and Governance Arrangements										
Quality & Safety Committee Annual Report		✓								
Primary and Community Care Quality and Safety Performance Measures						✓				

Annual Quality and Safety Priorities Approval						✓				
Quality & Safety Committee Terms of Reference	✓									
Quality & Safety Committee Self Assessment	✓									
Annual Quality Statement		✓	✓							
Report from Quality & Safety Forum	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health and Care Standards Report	✓		✓	✓Q1			✓Q3/4			✓
Health and Care Standards Annual Audit Report							✓			
Patient Experience, Risk Management and Legal Services Annual Report										
15 Step Challenge Schedule and Proposal							✓			
Update from										

Internal and Clinical Audit Leads										
Internal Audit Report	✓	✓	✓	✓	✓	✓	✓			
Clinical Outcomes Group Report	✓	✓	✓	✓	✓	✓	✓			
External Review and Regulatory Bodies										
Welsh Audit Office Reports*	✓	✓	✓	✓	✓	✓	✓			
External Inspections Report*	✓	✓	✓	✓	✓	✓	✓			
External Review and Regulatory Bodies										
Welsh Government Healthcare Quality Divison Feedback Report			✓			✓				
Ombudsman's Annual Report		✓								
Welsh Risk Pool Annual Report						✓				
Ophthalmology Action Plan Update in response to HIW visit										
Analysis of							✓			

Ombudsman Cases										

***** Subject to reports being available following inspections/reviews.

Appendix 3

Attendance at 2017/18 Quality and Safety Committee Meetings:

Non Officers and Executive Directors

Quality and Safety Committee						
DATE	April 2017	June 2017	August 2017	October 2017	December 2017	February 2018
LOCATION	Morriston	Singleton	NPT	POWH	HQ	Cefn Coed
Non-Officer Committee Members Attendees						
Paul Newman (Chair until Aug 2017)	X	X	X			
Ceri Phillips			X	X	X	X
Maggie Berry (Chair from Oct 2017)	X	X	X	X	X	
Martyn Waygood (from Dec 2017)					X	X (Chair)
Chantal Patel		X	X	X	X	X
Emma Woolett (from December 2017)						X
Executive Officer Attendees						
Hamish Laing, Medical Director	X	X	X	X	X	X
Rory Farrelly, Director of Nursing and Patient Experience, Angela Hopkins from December 2017			X	X	X	X
Sara Hayes, Director of Public Health, Sandra Husbands from May 2017			X	X	X	X

Christine Morrell, Director of Therapies and Health Sciences	X	X	X	X	X	X

Appendix 4

Summary Reports of 2017/18 15 Step Challenge Visits

The 15 Steps Challenge is a series of toolkits developed by the NHS *(England)* Institute for Innovation and Improvement. They have co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders. And help look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like.

Each toolkit provides a series of questions and prompts that guide you to look at whether care environments are:

- Welcoming;
- Safe;
- Caring and involving; and
- Well-organised and calm.

The Quality & Safety Committee has adopted the 15 Steps Challenge methodology as part of its assurance framework. It helps the members gain an understanding of how patients and service users feel about the care provided and what gives them confidence. It also helps them understand and identify the key components of high quality care that are important to patients, services users and carers from their first contact with a care setting.

The 15 Steps Challenge visits are not intended to be a performance management or audit tool but a tool to help the Health Board continuously improve how it delivers services to patients and families.

Service Delivery Units develop action plans in relation to specific clinical area issues found as a result of 15 Step Challenge Visits.

April 2017

Cefn Coed Hospital

A 15 Step Challenge visit to Gwelfor Ward (Adult Mental Health Services) and Ysbryd Coed Unit (Older Peoples Mental Health Services) in Cefn Coed Hospital was undertaken in February 2017.

Action Points included:

Gwelfor

- Clean, tidy;
- Physical layout of the unit was not ideal and there were plans to address which would be actioned shortly;
- Large “goldfish” office at front was a barrier in ward – plans to address;
- Kitchen was not of sufficient size and layout for patients to use well- plans to address;
- There was an outside smoking area which was to be relocated;
- Men and women bedrooms were both on ward albeit in separate areas;
- An open boiling water tap was accessible in an area outside bedrooms - Health & Safety Hazard;
- Staffing – Ward Manager was open, but reasonably optimistic about challenges being faced. Appeared to be some tension but this may be a perception as did not get an opportunity to talk to any other staff apart from short introduction;
- Staff were busy on unit but level of patient engagement appeared minimal to moderate.
- Reported that there was still some way to go with staff PDR etc.

Ysbryd y Coed

- 3 wards visited in Unit, all clean, pleasant Wards which were well presented and designed;
- Staff were welcoming, all were keen to be introduced and be engaged. OT had come in particularly for visit. Culture felt far more open and welcoming. Ward Managers were very open and discussed successes and

some challenges across the ward in a highly professional and open manner.

- One of the Wards in particular had staff engaging in activities with patients and obvious strong positive patient focussed culture. There was a gradient of culture from ward to ward but all was positive. A comprehensive training and support programme has recently commenced across all 3 wards in Ysbryd y Coed to ensure consistent outcome focused, patient centred care is provided. Central to this is patient engagement with meaningful activities, which is being developed with the additional support of an Occupational Therapist and Support Workers.
- There were some “bar” areas in wards which were not used and these areas need to be repurposed in some way- plans were in place.

June 2017

A 15 Step Challenge visit was undertaken to Ward 2 and Ward 9, Singleton Hospital in June 2017.

The purpose of the visit was to understand what good quality care looks and feels like from a patient’s and relative’s perspective.

The visiting team noted positive interaction with patients and allied professionals on Ward 2. The ward sister was observed completing a pre-operative checklist in the patients preferred language, which was in Welsh. There was also good evidence of team working and interaction with student nurses allocated to the ward. Students that were spoken to by the visiting team were complimentary regarding their learning experience. They reported good support and mentorship, enjoying their placement.

In Ward 9, the nurse’s handover room was neat and the patient at a glance board explained how the daily Multi-disciplinary Team board round worked, daily tasks were allocated to ensure correct prioritisation depending on the needs of patients. The learning disability traffic light system was observed to be utilised on the ward. A patient with Learning Disabilities was on the ward at the time of the 15 step review. The disability traffic light document is a Transfer of Care document, and this can be used as an aide for the ward staff to understand the care needs of a patient

transferred from the Community setting into the acute setting. This approach supports a seamless transfer of care for patients with learning disabilities.

There were a number of issues identified during the visit and action points included as below:

Ward 2, Singleton Hospital

- Address information governance issues in relation to safe storage of patient notes. These were on display at the nurses' station and not locked away.
- Increase communication by better utilizing of icons and additional information on the Patient Status at a Glance Board.
- Consider informing patients of the planned plan of care on admission, as a result of a patient querying the rationale for being admitted early for theatre, later in the day.

Ward 9, Singleton Hospital

- Make area more welcoming – by repainting barriers outside entrance of the ward and landing area. Streamlining signage specific reference to Health Board values.
- Reorganise the 'know how we are doing' board and patient leaflets display to convey the safe care being provided.
- Explore the feasibility of using the wards WIFI system to install further call buzzers in the overflow area before the winter months.

These actions have been put into an action plan and are being monitored by the Singleton Hospital Delivery Unit's through their site leads and Assurance and Learning Group.

September 2017

A 15 Step Challenge visit was undertaken to the Neuro Rehabilitation Unit (NRU) and Ward E, Neath Port Talbot Hospital during September 2017.

The purpose of the visit was to understand what good quality care looks and feels like from a patient's and relative's perspective.

The visiting team noted that the Neuro Rehabilitation Ward was a lovely environment, calm and a good environment for the patients. The ward was commended for information governance, there were no notes accessible or seen lying around on the ward unsecured.

On Ward E, the visiting team commented on the positive patient feedback, staff and patients seemed happy and there was a very welcoming feel to the ward.

There were a number of issues identified during the visit and action points included:

Neuro Rehabilitation Unit, Neath Port Talbot Hospital

- Television found to be not working; this had been working prior to the visit – television repair as soon as possible.
- The ward was looking at working more closely with therapy and the health care support worker team by developing a more generic approach to rehabilitation and consider the work that has been ongoing with the Enabling ward and if any of this is transferable.
- Patients reported that they spent a long time on the unit for their rehabilitation and there were times where boredom does impact on mood. Considering the use of volunteers for activities to alleviate the boredom for some patients.

Ward E, Neath Port Talbot Hospital

- Outcome Measures: Director of Nursing and Patient Experience expressed a need to identify new/alternative quality outcome measures (different to the traditional ones) that reflect the new model of care.
- Friends & Family: highlighted the need to ask different questions to patients and families in order to generate rich, reliable and meaningful feedback; reflecting the enabling ethos and what it is that the ward does.
- Academic Development: fostering strong links with Swansea University with the aim of developing research collaboration such as PhD students undertaking a study.
- Workforce: identified a need to develop an effective rotational programme for Nurses across all our medical wards in order to enhance skills, share learning and improve the working experience and job satisfaction of staff.

- 3rd Sector Engagement: need to develop and foster strong links with Social Support Groups and networks in order to ensure that patients are prepared, able and fulfilled once “back out in the world” living their lives..
- Partnership Working: need to monitor the evolving interface with Community and Local Authority in terms of any challenges/blockages which might impact on outcomes or require support in order to ‘unlock’.

These actions have been put into an action plan and are being monitored by the Neath Port Talbot Hospital’s Delivery Unit’s Assurance and Learning Group.

October 2017

A 15 Step Challenge visit was undertaken to Wards 19 and 10 at the Princess of Wales Hospital during October 2017.

The purpose of the visit is to understand what good quality care looks and feels like from a patient’s and relative’s perspective.

The visiting team noted that the entrance corridor to Ward 19 was clean and bright. The notice boards were neat and up to date. Signage was bi-lingual and there were visible hand hygiene stations.

On Ward 10, the visiting team commented on staff being very welcoming and a calm atmosphere. It was noted that if the ward had Hostesses the provision of food would be delivered in a timely manner and wastage would be minimised. It was noted that there was poor space for manoeuvring beds in the corridor

There were a number of issues identified during the visit and action points included:

Ward 19

- Sign to be replaced on relatives room door.
- Signage to be reviewed throughout the ward
- Lockers to be provided to all staff – estates to either provide replacement keys or change locks on existing lockers.
- Poor lighting in treatment room – to contact estates to fit brighter bulbs.

- Floors in ward corridor, cubicles and bathrooms require repair – work is being completed in conjunction with refurbishment on Ward 20. Flooring is recorded on risk register.
- Limited storage for stock on ward – to review stock levels across the three COTE wards with a view to centralizing stock.

Ward 10

- Limited storage and equipment in corridors
- Inadequate bathroom facilities
- Poor lighting in Red and Green Bay's

These actions have been put into an action plan with timescales and are being monitored by the Princess of Wales Hospital's Assurance and Learning Group.

December 2017

Ward 6 Princess of Wales Hospital

A 15 Step Challenge visit was undertaken on Ward R at the Morriston Hospital on 15th December 2017 as the ward had been reported to the Committee as a Hotspot ward in December 2017.

The purpose of the visit was to understand what good quality care looks and feels like from a patient's and relative's perspective. There were a number of issues identified during the visit and action points included:

- Patient reported medication error.
- Non- compliant member of staff with medicines administration policy (signing for medication before meds being taken)
- Drugs key found in cupboard of medication room (Main door to room locked).
- Pain management – Patient report poor experience of pain management. Staff also highlight this as an issue.
- Discharge Planning - Poor documentation around discharge planning. This was also highlighted on the assurance visit last year.
- Communication **–** Most of the negative feedback reported in the patient feedback section relates to poor communication between staff and patients. This issue was not just related to ward nursing staff. For example, one patient

had been on the ward for three weeks and had their operation cancelled ten times. Another patient reported receiving information from one Doctor which had not been handed over to staff.

- Non-compliant staff with uniform policy.
- Doctors not compliant with bare below the elbow and dress code policy.
- Non-compliant member of staff with the correct procedure to dispose of PPE.
- Ward is cluttered with cleaning trolleys, linen trolley and equipment in walkways. Due to limited storage and need to provide more equipment & mobility aids needed due to nature of patients, this is a daily risk for ward.

Immediate feedback was provided to the Ward Manager on day of visit. The Unit Nurse Director was also given feedback on good practice observed and concerns. The full report has been presented to the Unit Nurse Director and Ward Manager. These actions have been put into an action plan with timescales and are being monitored by Morriston Hospital Delivery Unit's Quality and Safety Group.

Ward 7 Princess of Wales Hospital

Following the 15 Step Challenge visit to Ward 7 in the Princess of Wales Hospital in October, a number of immediate and longer term actions were identified for the Ward and management team with several issues in conjunction with the estates department, including:

- Poor and potentially hazardous flooring requires replacement
- Fire and Security notices to be easily seen and accessible
- Improvement plan to increase Friends and Family test compliance
- Racking requirement to organise storage areas

January 2018

A 15 Step Challenge visit was undertaken to Cwmavon Health Centre, Port Talbot on 11th January 2018.

General comments:

The centre is located in the middle of a housing estate and consists of a solid, well kept building originally built in the early 1970`s. The service has recently merged (April 2016) with a practice located further up the Afan Valley in Cymmer and now provides a service to approximately 6,000 patients. The practice has already implemented many changes to the original service provided to the local community, including a triage telephone service, nurse led minor illness clinics and a practice based pharmacist. There was evidence of user engagement and it is recognized that both the community and the practice staff found this challenging but there have been successes with some work identified as still to do. The environment is generally fit for purpose and is well kept and clean. The enthusiastic centre team understood the local community and were able to give a good account of what they aimed to achieve over the next few years.

Welcoming:

Action required	How, By Who and When?
Consider using boards to display themed information.	Centre Manager, September 2018
Plans underway to clear clutter within reception area, notes possibly being moved to off site location for storage.	Practice Manager September 2018

Entry to the building is via a wide, low silled doorway easily accessible to patients with mobility problems. The reception space is a large, well-lit area with good signposting, posters refer to the issue of privacy and ask people to stand away from the desk if someone is already being seen. The centre is shared with an independent practice which has a separate reception desk and shared accommodation. There is a good amount of current information for patients on various health issues and health promotion initiatives, the centre was promoting the `Flu` vaccine campaign with bunting and leaflets clearly visible.

Safe:

The centre is located in the middle of residential houses and is surrounded by a security fence. The staff report no security issues, they are aware of lone worker issues and were able to describe procedures to be taken if concerns were evident.

Equipment was stored appropriately and the corridors were free from clutter. The building was clean and was in good repair. The staff related some issues with poor lighting in the car park in winter but this isn't currently affecting the quality of the service provided.

Action required	How, By Who and When?
Secure funding to improve lighting (low priority)	Practice Manager

Caring and Involving:

The staff were extremely enthusiastic about the services the centre provides and there was a strong sense of teamwork. All the staff we spoke with were committed to the changes being made and there was clear direction and a sense of how the staff saw the centre improving services in the next few years. The centre team also mentioned that they felt they were fully engaged in the potential redesign of the building.

Staff told us there had been a number of patient engagement events which were poorly attended and they are finding the issue of patient consultation and engagement a continuing challenge. The centre has a suggestion box with poor uptake from the patients using the centre. There has been some uptake with the use of an Ipad to collect feedback using the Friends and Family surveys. There are plans to display performance information such as average time to seeing or talking with a health professional, average time to answer phones, patient satisfaction feedback etc. There is little uptake of the `My Health Online` system.

The team has developed a Patient Survey specific to their user group. This has been circulated for discussion and is part of the engagement strategy.

Action required	How, By Who and When?
To improve levels of patient feedback.	Apply to Charitable funds to purchase another Ipad. Consider alternative ways of engaging with patients, consider best practice elsewhere. Aim for improvement by September 2018.
To display performance related information in public areas.	Centre staff to agree quality measures, use boards or existing display areas to display information. Aim for implementation by September 2018.
Finalise and implement Patient Survey and display results. Action Plan development where necessary.	Centre staff to aim for implementation and action planning by September 2018.

Well Organised and Calm:

As mentioned previously, the centre has a team of enthusiastic staff who are fully engaged with the service changes that are being made. During the 15 Steps visit we were accompanied by the Clinical Director, a Senior Nurse, the Service Manager and the Practice Manager, all of whom were able to describe the service changes undertaken and those that are planned. The team were able to describe their roles and how they fit into the day-to-day business of the practice. The team described how they ulitise the rooms available and are looking to further develop the use of the centre, this requires some investment in infrastructure (IT points) and redesign of some key rooms (treatment room which was divided into two rooms needs to revert to one large room) to be able to offer more services to the community, such as minor operations etc. Possible funding streams are already being explored.

Conclusion:

It should be noted that the visit was conducted using standard 15 Steps methodology as a guide. The headings for feedback were used for consistency but the approach required to visit these types of units needs to be refined and we would welcome the opportunity to shape this revised methodology.

Appendix 5

Quality and Safety Committee Work Programme 2018-19

	Lead	April	June	August	October	December	February
Patient Story			**Singleton**				
Standard Items							
Minutes of the Previous Meeting	Director of Corporate Governance						
Action Log	Director of Corporate Governance						
Work Programme	Director of Corporate Governance						
3. Quality							
Annual Quality Statement	Director of Nursing and Patient Experience						
Ward to Board Dashboard	Director of Nursing and Patient Experience						
Quality Assurance Framework	Director of Nursing and Patient Experience						
4. Benchmarking, Learning and Quality Improvement							
Serious Incident and Never Events Report	Director of Nursing and Patient						

	Experience						
Nurse Staffing Act (Wales) 2016 Report	Director of Nursing and Patient Experience						
Staff Survey Results	Director Workforce and OD						
Infection Control Report	Director of Nursing and Patient Experience						
Staying Healthy	Director of Public Health						
Safeguarding Report	Director of Nursing and Patient Experience						
	Lead	**April**	**June**	**August**	**October**	**December**	**February**
Blood Glucometry Closure Report	Director of Nursing and Patient Experience						
NHS Wales Delivery Unit Serious Incident Report	Director of Nursing and Patient Experience						
5. Clinical and Service Quality Compliance and Performance							
Pharmacy and Medicines Management	Clinical Director for Medicines Management						

Quality and Safety Dashboard	Director of Nursing and Patient Experience						
Child and Adolescent Mental Health Services	Director of Strategy						
Patient Experience (to include complaints and concerns)	Director of Nursing and Patient Experience						
Older Person's Dashboard	Director of Therapies and Health Science						
6. Governance and Risk Management							
Terms of Reference	Director of Corporate Governance						
Committee Annual Report	Director of Corporate Governance						
Committee Self-Assessment	Director of Corporate Governance						
Unit Exception Report			Singleton				
Board Assurance Framework/Corporate Risk Register	Director of Corporate Governance						
Welsh Government Quality Division Feedback Report	Director of Nursing and Patient Experience						
Report from Quality and Safety Forum	Director of Therapies and Health Science						

Health and Care Standards Update	Director of Nursing and Patient Experience						
Internal Audit Update	Head of Internal Audit						
Clinical Outcomes Group Update	Medical Director			Annual Report			
External Audit Reports	Director of Nursing and Patient Experience						
Ombudsman's Annual Report	Director of Nursing and Patient Experience						
Welsh Risk Pool Annual Report	Director of Nursing and Patient Experience						
EMRTS Clinical Governance	Medical Director						
External Inspections	Director of Nursing and Patient Experience						