Swansea Bay University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 18th April 2019
at 9am in seminar room three, Morriston Hospital

Present
Martyn Waygood, Independent Member (in the chair)
Reena Owen, Independent Member
Maggie Berry, Independent Member

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Alastair Roeves, Deputy Medical Director (until minute 53/19)
Sandra Husbands, Director of Public Health
Chris Morrell, Deputy Director of Therapies and Health Science (until minute 48/19)
Paula O'Connor, Head of Internal Audit
Pam Wenger, Director of Corporate Governance
Liz Stauber, Committee Services Manager
Cathy Dowling, Assistant Director of Nursing and Patient Experience
Lee Joseph, Assistant Head of Concerns and Assurance
Jamie Kaijaks, Graduate Trainee
Carol Mosely, Wales Audit Office
Maria Thomas, Vice Chair , Cwm Taf University Health Board
Nicola Williams, Unit Nurse Director, Morriston Hospital (for minute 39/19)
Mark Ramsey, Unit Medical Director, Morriston Hospital (for minute 39/19)
Suzanne Holloway, Head of Quality and Safety, Morriston Hospital (for minute 39/19)
Clare Baker, Senior Matron, Burns and Plastic Surgery, Morriston Hospital (for minute 39/19)
Nicola Anthony, Quality and Safety Lead, Morriston Hospital (for minute 39/19)
Lisa Hinton, Assistant Director of Nursing and Patient Experience (infection control) (for minute 49/19)
Tammy Martin, Project Administrator, Corporate Nursing (for minute 51/19)
Jane Hopkins, NHS Wales Delivery Unit (for minute 53/19)
Stephen Jones, Deputy Unit Nurse Director, Mental Health and Learning Disabilities (for minute 53/19)

Minute		Action
39/19	**PATIENT STORY** Nicola Williams, Mark Ramsey, Suzanne Holloway, Clare Baker, and Nicola Anthony were welcomed to the meeting. A patient story was **received** outlining the experience of a young child with Down's syndrome who underwent treatment in the burns and plastic unit following a scalding. Members heard that due to her additional needs, the child rarely cried so it was difficult for the parents to gain the understanding of the nursing staff that when she did cry, it meant she was in significant pain. Having Down's syndrome meant that the patient's development was behind that of other children her age, this had an impact on the way in which she needed	

to be treated, and it would have been beneficial to have a nurse which specialised in learning disabilities available, particularly if an operation had been required. The family held the staff and treatment they received in high regard.

In discussing the report, the following points were raised:

Clare Baker advised that the video was used as part of psychology training and staff were also to be trained in Makaton, which used signs and symbols to help people communicate, and was favoured by the patient. Nicola Williams added that a learning disabilities nurse had also been recruited.

Martyn Waygood commented that while it was a positive story, there was some learning to be taken.

Gareth Howells noted the guilt felt by the patient's mum and queried as to whether the psychological support extended to families. Clare Baker responded that the burns service had its own psychologist who had spent time with the mum and child, and was available for families.

Maggie Berry advised that she had visited the burns unit some time ago and had been 'blown away' by the peaceful environment and equipment available to support patients to recover. She added she would recommend other independent members take the opportunity to visit.

Cathy Dowling commended the quality of the digital patient story, adding that it was a credit to the family in the way in which it had been portrayed.

Martyn Waygood queried if there was more that could be done in relation to psychological therapies. Christine Morrell advised that the head of service had transferred to Cwm Taf Morgannwg University Health Board as part of the boundary change and the psychological therapies group was reviewing the service in order to determine what it should look like for Swansea Bay University Health Board. Martyn Waygood stated that the committee would need an update on this in due course. Gareth Howells suggested an update be brought to the August 2019 meeting. This was agreed. **CW**

Resolved:

- The report be **noted.**
- Update be received at the August 2019 meeting as to the development of the psychological therapies service. **CW**

40/19 WELCOME AND APOLOGIES FOR ABSENCE

Martyn Waygood welcomed everyone to the meeting.

Apologies for absence were received from Richard Evans, Medical Director and Chris White, Chief Operating Officer/Director of Therapies and Health Science.

41/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

4219 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 6th December 2018 were **received** and **confirmed** as a true and accurate record, except to note the following amendments:

01/19 Quality Impact Assessment Process

Gareth Howells advised that panel membership comprised of clinical and non-clinical staff as well *as* a representative of the community health council.

08/19 Patient Story

Chris White concurred, adding that he and Richard Evans had spent time with the palliative care team in this regard, adding that there was also more to be done to help patients who wanted to die at home *to* be able to do this.

12/19 Infection Control Report

Richard *Evans* responded that the prescription of antibiotics was higher in ABMU than the majority of the UK, *health Boards and trusts,* therefore the clinical lead for medicines management was working with the clusters on education and awareness.

43/19 MATTERS ARISING NOT ON THE AGENDA

There were no matters arising not on the agenda.

44/19 ACTION LOG

The action log was **received** and **noted**.

45/19 WORK PROGRAMME 2019/20

The committee's work programme was **received** and **noted.**

46/19 CHANGE IN AGENDA ORDER

The agenda order be changed and items 5.7 and 6.1 be taken next.

47/19 CLINICAL SENATE COUNCIL REPORT

A report setting out the key discussions of the Clinical Senate Council was **received.**

In introducing the report, Alastair Roeves highlighted the following points:

- The recently established clinical senate council had met on two

occasions and membership included clinicians, doctors, nurses, midwives and therapies staff;

- It provided such staffing groups with the opportunity to make and endorse decisions rather than limiting it to a service unit focus;
- The clinical services plan had been discussed by the group;
- While the senate council met monthly, there were also plans to have a quarterly clinical senate forum which would have more of an aspirational feel to the discussions.

In discussing the report, the following points were raised:

Maggie Berry sought clarity as to whether the senate was working as it should. Alastair Roeves responded that it was and cited the challenge it had provided to the clinical services plan as an example of this. He added that it was a successor to the clinical outcome group, which focussed on national audits, and would ensure that actions, where relevant, would be taken.

Reena Owen noted the number of clinical staff involved with the clinical senate council, adding that they would have busy diaries. She queried as to whether there was sufficient participation. Alastair Roeves responded that the business of the senate needed to be built into 'business as usual'. He added that the organisation was to revert back to monthly half-day clinical audit session to which the senate would be aligned. Sandra Husbands commented that the senate had been established in response to the fact that clinicians did not feel they were sufficiently engaged. She added that the governance structures needed to be finalised. Martyn Waygood stated that it was critical staff were given the time to attend.

Resolved: The report be **noted.**

48/19 GP INDEMNITY

A report outlining changes to the GP indemnity process was **received.**

In introducing the report, Alastair Roeves highlighted the following points:

- Until 31st March 2019, GPs had been required to purchase their own insurance, with the exception of when working as a direct employee of the health board;
- It had been announced by NHS England that a GP indemnity scheme would be established and Wales followed suit;
- This came into fruition on 1st April 2019 but there was still some uncertainty as to all of the details;
- Now should a GP receive a letter in relation to the service provided, they were to contact the Welsh Risk Pool who would

provide advice and support, and the health board would become the defendant;

- Around 12 claims a year were expected and it was only once the first few had been received that a true understanding of the new process would be achieved.

In discussing the report, the following points were raised:

Cathy Dowling provided assurance that the claims team were aware of the changes and would be providing support, but consideration needed to be given as to the level of resources needed.

Martyn Waygood queried as to whether the changes would have an impact on patients. Alastair Roeves responded that practices were funded through the global fund and there would be less money allocated per patient. He added that the first to feel the impact would be the profit of private businesses.

Sandra Husbands commented that NHS Wales was developing opportunities for services to be provided within primary care, not just GP services, and queried if this would be accounted for. Alastair Roeves advised that it was in principle, if the GP practice was providing services on behalf of the health board but not if it was commissioned by a private company.

Resolved: The report be **noted.**

49/19 INFECTION CONTROL REPORT

Lisa Hinton was welcomed to the meeting.

A report providing an update in relation to infection control was **received.**

In introducing the report, Lisa Hinton highlighted the following points:

- The health board had delivered the reduction required in cases outlined as part of targeted intervention;
- Clostridium difficile cases had reduced by 40% in the last six months;
- A lack of decant facilities was making it challenging to clean ward areas;
- Significant work was being undertaken to standardise the information circulated to clinical areas as to how lessons were learned from infections;
- A number of infections originated in the community and consideration was needed as to how these should be managed and resourced.

In discussing the report, the following points were raised:

Reena Owen commented that when looking at the report, there

appeared to be a number of easy wins, for example, the insufficient cleaning hours at Singleton Hospital could be addressed through an invest to save bid. Gareth Howells responded that the units each worked to their own standards and discussions were needed at the infection control committee. Lisa Hinton added that cleaning was one of the basic actions which could be taken as part of reducing infections and there was much that could be done to improve in this area.

Alastair Roeves noted the inclusion of Bridgend data within the report and queried if the charts could focus on Swansea Bay University Health Board's position. Lisa Hinton responded that this was the end-of-year position and the charts for the next financial year would not include Bridgend information.

Martyn Waygood thanked Lisa Hinton for the report, adding that some of the trajectories were going in the right way, although there were also some peaks and troughs. He added that the report referred to the annual plan profile and queried as to whether the ambition should actually be no cases. He further stated that future iterations needed to include timescales. Gareth Howells responded that the improvement trajectory was set by Welsh Government but the organisation should have its own ambition to achieve zero cases. Lisa Hinton concurred, adding that the culture needed to change from one which accepted healthcare acquired infections occurring.

Resolved: The report be **noted.**

50/19 PATIENT EXPERIENCE REPORT

A report providing an update in relation to patient experience was **received.**

In introducing the report, Cathy Dowling highlighted the following points:

- The aspiration for the friends and family test was to achieve the top quartile and good progress had been made;
- Consideration was needed as to how to use feedback to drive change; as the patient voice was powerful;
- Work was continuing in relation to the serious incident toolkit and there had been positive progress with regard to complaints management;
- The organisation had a close working relationship with the Public Services Ombudsman and this was supporting better resolution in terms of responses.

In discussing the report, the following points were raised:

Reena Owen noted that one of the low scoring areas of the survey related to transport and car parking. She added that she had discussed these issues with the health board's chair, who was keen

to make progress in these areas. As such, a special board development session was to take place in May 2019.

Martyn Waygood queried whether there was a reason for the reduction in inpatient feedback. Cathy Dowling responded that seasonal pressures sometimes had an impact but hotspots were to be looked at to determine if there were any particular issues causing fewer patient feedback responses.

Martyn Waygood commented that it was important that the report outlined action being taken in areas where patient feedback was less positive, and more proactive action was needed, as the majority of the work being undertaken was reactive.

Martyn Waygood noted that the health board was not compliant with three patient safety notices and queried whether this needed to be escalated to the board. Gareth Howells advised that more detail was needed as to the reasons why as some of the issues may be out of the health board's control. Pam Wenger advised that it would be for the officers to provide assurance to the committee and its report to the board should state it had sought this assurance.

Resolved: The report be **noted.**

51/19 ANNUAL QUALITY STATEMENT

The draft annual quality statement for 2018-19 was **received.**

In introducing the report, Cathy Dowling highlighted the following points:

(i) Annual Quality Statement

- The annual quality statement was a 'live' draft and was being updated on a daily basis;
- The structure was set nationally which was a minor constraint;
- Internal audit feedback on the previous year's iteration had been incorporated into this year's version;
- There had also been more stakeholder involvement, particularly from the Stakeholder Reference Group, who identified the top 10 items to include;
- A 'plain English' version was to be produced as well as a digital one.

(ii) Health and Care Standards

- The quarterly scrutiny panels had been stood-down in 2017-18 on the basis that assurance should be provided as part of normal business;
- Lots of meeting agendas were now aligned to the standards;
- The units were currently undertaking their self-assessments

and Princess of Wales Hospital would be included for completeness.

In discussing the report, the following points were raised:

Reena Owen stated that the annual quality statement was well presented. She queried the targeted audience, adding that it would be good to include positive stories as well as areas for improvement. Cathy Dowling advised that historically, the document was presented at the annual general meeting but consideration was being given to holding roadshows, which would also be useful for feedback for next year's report. Reena Owen commented that another useful vehicle would be the partnership working arrangements, such as the partnership boards.

Pam Wenger advised that a different approach was to be taken this year in terms of the annual general meeting and the organisational annual report was going to have a more visual version as well.

Gareth Howells stated that the annual quality statement was a challenging but good piece of work and gave his thanks to Tammy Martin for the work she had undertaken to produce it. He added that traction on progress was needed and a demonstration of the direction the health board was travelling in, as the health board had a duty of candour.

Paula O'Connor commented that there were two aspects to be aware of from an internal audit perspective; the team had not yet had sight of the health and care standards assessment which was critical for the board to assess its maturity and close liaison had taken place with the corporate nursing team during the drafting of the annual quality statement. She added that it was important to note that the health and care standards and annual quality statement were separate pieces of work.

Martyn Waygood complimented the format of the annual quality statement, adding that he would meet with Cathy Dowling outside of the meeting to provide more specific feedback. **MW**

Paula O'Connor advised that the outcomes of the health and care standards process would be included in the head of internal audit opinion.

Sandra Husbands sought assurance that a simple Welsh version of the annual quality statement would be produced. Cathy Dowling advised that there would be.

Resolved:

- The report be **noted.**
- Martyn Waygood to meet with Cathy Dowling outside of the meeting to provide more specific feedback on the annual quality statement. **MW**

52/19 PERFORMANCE REPORT

The quality and safety performance report was **received.**

In discussing the report, the following points were raised:

Reena Owen highlighted that the health board had medically fit patients that it could not discharge as well as people waiting in the emergency departments for a bed. She queried as to why performance could not be better as other health boards managed it. Gareth Howells concurred, adding that it was not just a performance issue but a quality and safety one when looking at it from the patient perspective. He added that a whole system change was needed and this was an opportunity for Swansea Bay University Health Board to develop. Alastair Roeves stated that there were some health board services which supported patients returning to the community, however their capacity was currently filled with the work to prevent patients needing admissions in the first place. He added that the 'hospital to home' workstream was developing a comprehensive programme of interventions and work was ongoing to secure funding.

Martyn Waygood noted that unscheduled care remained an issue, adding that he and Pam Wenger has undertaken a walk around to the emergency department at Morriston Hospital to see some of the challenges. He added that the change in junior doctors twice a year had a significant impact on performance and there were also a number of gaps within the establishment, so until these were resolved, the situation would not improve.

Sandra Husband stated that while performance against the four-hour target remained 'red', it had improved since the previous year, and this needed to be acknowledged.

Maria Thomas commented that it was a lengthy report and the equivalent committee within Cwm Taf Morgannwg University Health Board focussed on five key priorities for quality and safety. Pam Wenger advised that the report was in development to create one which fully met the needs of the committee.

Martyn Waygood noted performance against discharge summaries and the variance across units. Alastair Roeves responded that it was linked to volume and a working group had been established to look into this.

Resolved: The report be **noted.**

53/19 NHS WALES DELIVERY UNIT 90 DAY-REVIEW

Jane Hopkins and Stephen Jones were welcomed to the meeting.

A report setting out the findings of the NHS Wales Delivery Unit 90-day review was **received.**

In introducing the report, the following points were highlighted:

- The Delivery Unit had undertaken a review of systems and

approaches in relation to serious incidents in 2017;

- The subsequent report highlighted a number of board-wide recommendations;
- A follow-up review had since been undertaken which had identified significant progress as well as areas of ongoing risk;
- The issues in relation theatres had been picked up elsewhere therefore a focus had been given to mental health and an action plan requested;
- The health board had been a significant outlier in 2018 with 10 never events reported;
- Not only was there learning from the incidents to be taken but also the process by which they were investigated. This now comprised those involved talking through their accounts to find solutions. This had started with theatres due to the never events and was currently in development for mental health, with a learning event taking place recently;
- A dedicated serious incidents investigation team was now in place.

In discussing the report, the following points were raised:

Stephen Jones advised that since the work within mental health to address the recommendations had taken place, the culture felt less defensive and more open and engaged. He added that there had been good progress against the action plan but more work was needed.

Martyn Waygood commented that the progress made for a good news story as it demonstrated how a serious situation could be improved.

Reena Owen stated it was an interesting report with a lot of detail for the committee to take on board in terms of governance arrangements. She queried if there were procedures in place for progress to be monitored. Pam Wenger responded that it needed to be kept on the committee's agenda for the next few months until assurance was taken that the recommendations had been addressed. Paula O'Connor added that the internal audit plan for 2019-20 included a review of mental health and learning disabilities which would take into account some of this work.

Cathy Dowling advised that work was also being undertaken in women and child health given some of the high-risk maternity cases seen by the service. The next to take on the work would be primary and community services.

Gareth Howells offered his thanks to the Delivery Unit for the review as it provided the beneficial role of a critical friend. He added it had been a significant piece of work to close down the 10 never events.

Resolved: The report be **noted.**

54/19 HIW KW ACTION PLAN

A report setting out progress against the action plan in response to the Healthcare Inspectorate Wales review of the Kris Wade incident was **received.**

In discussing the report, the following points were raised:

Paula O'Connor advised that the internal audit of mental health and learning disabilities would cover some of this work.

Pam Wenger stated that the workforce components were reported to the Workforce and Organisational Development (OD) Committee.

Martyn Waygood queried as to whether the information leaflet had been developed. Cathy Dowling responded that the next step was to engage the Stakeholder Reference Group.

Martyn Waygood noted there was no timescale included to provide feedback to Welsh Government on progress. Gareth Howells advised that a deadline had not been set.

Resolved: The report be **noted.**

55/19 QUALITY GOVERNANCE REVIEW

A report setting out the findings of the quality governance review was **received.**

In introducing the report, Pam Wenger highlighted the following points:

- Wales Audit Office's 2017 structured assessment had identified areas to improve in terms of quality governance, and the 2018 review had expanded on these;
- There were also quality governance issues to take into account in relation to the Kris Wade report;
- A specific piece of work was needed to determine how quality governance corporately aligned with that of the units and how sub-groups of the committee were providing it with assurance;
- An interim head of compliance had been appointed to take on some of this work;
- The first step had been to revise the terms of reference for the Quality and Safety Forum.

In discussing the report, the following points were raised:

Gareth Howells commented that he had recently chaired two meetings of the Quality and Safety Forum and while improvements had been made, there was still work to be done to make the

arrangements more robust.

Reena Owen stated that the report had been useful to give a better understanding of how the arrangements aligned but it was still unclear as to the process should the forum escalate an issue to the committee. Pam Wenger responded that the forum had an operational role while the committee was assurance-focussed.

Martyn Waygood highlighted typographical errors within the terms of reference for the Quality and Safety Forum to be addressed.

Resolved:

- The report be **noted.**
- The terms of reference be **agreed** subject to the amendment of the typographical errors. **GH**
- A review of the quality governance supporting structures in place, to include reviewing the terms of reference and reporting requirements, be **agreed.** **PW**

56/19 INTERNAL AUDIT UPDATE

A report outlining the findings of recent internal audits was **received.**

In introducing the report, Paula O'Connor stated that reviews had taken place since the last meeting within clinical audit and assurance and nursing quality assurance, both of which had limited assurance ratings.

In discussing the report, the following points were raised:

Gareth Howells advised that he had asked for the review of nursing quality assurance and the findings would be taken to the nursing and midwifery forum to progress the recommendations. He added that with matrons undertaking some of the operational detail, clinical components took second priority but quality needed to come first.

Reena Owen noted the ward to board assurance framework and raised a concern that the health board could be setting itself up to fail if it did not have the resources to undertake the work. Cathy Dowling responded that the health board had benchmarked itself against an NHS trust in the north Midlands and had also mirrored its approach against that of HIW inspections. She added that while Singleton Hospital had completely rolled out the framework, Morriston Hospital was struggling with the volume, but the aspiration was to be in a position to share the RAG (red, amber, green) ratings with the committee. Pam Wenger stated that a board assurance framework was to be developed during this financial year and a board development session with service users had taken place for them to share their experiences, which had been useful.

Resolved: The report be **noted.**

57/19 QUALITY AND SAFETY FORUM UPDATE

A report setting out the key discussions of the Quality and Safety Forum was **received.**

In introducing the report, Gareth Howells highlighted the following points:

- A 'summit' workshop was taking place the following week to discuss the format of the forum as the boundary change provided an opportune time to review;
- The report to the committee should improve as this work progressed;
- Ophthalmology needed to be kept under close scrutiny as the number of incidents relating to harm were not reducing.

In discussing the report, the following points were raised:

Paula O'Connor advised that the children's environment at the Morriston Hospital emergency department had also been raised at the recent meeting as a concern. Martyn Waygood concurred, adding that it had been a concern of his during his recent walk around the area. Gareth Howells advised the health board's youth board had been asked to visit the department one Saturday and their feedback reinforced this from a young person's view. He added that discussions were being undertaken as to how to use other paediatric assessment facilities more effectively as there were insufficient resources to manage the dedicated area within the emergency department.

Reena Owen sought clarity as to the process should the forum escalate an issue to the committee. Pam Wenger advised that she would expect the committee to ask the relevant team to provide a report with a plan to address the concerns.

Resolved: The report be **noted.**

58/19 EXTERNAL INSPECTIONS REPORT

A report outlining the findings of recent external inspections was **received.**

In introducing the report, Gareth Howells advised that as a result of the issues raised by HIW in relation to dental and primary care facilities, meetings were to take place between the two organisations for HIW to gain a better understanding of the operational service and for the services to understand more of how HIW worked.

In discussing the report, the following points were raised:

Reena Owen queried if the health board had plans in place to carry out its own audit of dental or primary care services. Paula O'Connor responded that internal audit did not have access to primary care contractors as they were independent. Gareth Howells advised that

the operational team undertook some inspections.

Maggie Berry provided assurance that the primary care and community services carried out its own audit and assurance of its premises, which included poorly performing services, and she participated in this process.

Martyn Waygood queried as to whether peer reviews were undertaken of primary care or dental practices for decontamination services, as this was a common theme, and whether feedback was submitted to the health board that they were compliant with the required standard. Gareth Howells advised that there was a process in place but in some instances, the practices had a differing view of its standards to HIW.

Resolved: The report be **noted.**

59/19 ITEMS TO REFER TO OTHER COMMITTEESS

There were no items to refer to other committees.

60/19 ANY OTHER BUSINESS

There was no further business and the meeting was closed.

61/19 NEXT MEETING

This was scheduled for 20th June 2019.

62/19 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.