Quality and Safety Committee Annual Report 2019-20

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1. Introduction

The Quality and Safety Committee was established in 2009 and its focus is on all aspects aimed at ensuring the quality and safety of healthcare, including activities traditionally referred to as 'clinical governance'.

During 2019-20, the committee met its responsibility by fulfilling its role as outlined in its terms of reference, and through the delivery of its work programme. The annual report summarises this.

2. Committee Structure

The membership of the Quality and Safety Committee during 2019-20 comprised:

Independent Members

- Martyn Waygood, independent member
- Maggie Berry, independent member
- Jackie Davies, independent member
- Reena Owen, independent member

Executive Directors

- Gareth Howells, Director of Nursing and Patient Experience
- Richard Evans, Medical Director
- Chris White, Director of Therapies and Health Science/Chief Operating Officer
- Keith Reid, Director of Public Health (from October 2019)
- Sandra Husbands, Director of Public Health (to October 2019)
- Sian Harrop-Griffiths, Director of Strategy

Meetings were also attended by the Director of Corporate Governance, representatives of internal and external audit, Community Health Council, Wales Audit Office and Healthcare Inspectorate Wales.

Committee support in terms of the circulation of the meeting papers and minute taking was undertaken by the corporate governance function to ensure continuity with other board committees. The secretary to the committee was Leah Joseph, corporate governance officer.

The terms of reference required the committee to meet bi-monthly, which was achieved and from January 2020, the committee met monthly.

3. Reports Received

During 2019-20, the following reports were received by the committee:

Patient/Staff Story

A patient story had been prepared which focussed on the learning from a never event or patient experience. The following stories were received:

<u>Lauren's Story</u>

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 who specialised in learning disabilities available, particularly if an operation had been required. The family held the staff and treatment they received in high regard.

Ante-natal Story

A patient story was received outlining the experience of a couple who had recently had their first baby at Singleton Hospital. For the delivery, the couple had use of the serenity suite, which had a birthing pool as well as a view of Mumbles, bed, sofa and tea/coffee facilities. All of this, in addition to music, helped to make the environment feel more relaxed. The new mother talked about how she had been able to have a water birth as planned and the midwife had helped her position herself so she could see her baby arrive. The care of the midwifery team was highly praised, as they ensured they provided the couple with all the information they would need during antenatal care, as well as waiting until the mother had been able to breastfeed and felt comfortable before moving her to the post-natal ward. While the new mother spoke of how happy she had been with her care, she did raise concern that the waiting area for scans was also used for gynaecology patients, which made her acutely aware that some women in the waiting room had issues with their fertility which made her feel uncomfortable.

Neath Port Talbot Hospital

A patient story was received from a gentleman who had suffered an accident at home. He was treated at the Minor Injury Unit (MIU) at Neath Port Talbot Hospital. The staff completed a head assessment review and x-rays were taken. The patient commented that staff were thorough with their checks and that he was seen immediately on attending the unit. The patient was referred to the Ear, Nose and Throat department at Morriston hospital due to the injuries to his face. The patient praised the MIU staff for their care towards him. The short film also outlined the past 12 months at the MIU in Neath Port Talbot hospital following an unannounced visit from the Healthcare Inspectorate Wales (HIW). The unit had received positive patient feedback via the friends and family surveys. Kevin Randall introduced himself as the Lead Consultant Nurse at the Unit and provided information around the amount of patients that are treated at the Unit throughout the year.

Swansea Bay University Health Board and Welsh Ambulance Service Trust

A patient story was received from Nicola, via a video recording, who recounted a recent experience when her mother suffered a fall at home. The short film outlined the difficulties that she faced. This included repetition of the information Nicola needed to provide in respect of her mother's fall, and the many calls Nicola had to make whilst her mother remained in pain. Nicola recalled how the attending paramedics were "brilliant", however they had to remain with her mother at the hospital for two and a half hours prior to handing her care over to the hospital staff.

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The following reports were received from April 2019:

- Annual Quality Statement

Members considered and approved the annual quality statement prior to its presentation to the health board's annual general meeting in July 2019. Comments and suggestions were provided to enhance the final version.

- Ward to Board Dashboard

As part of the development of the ward to board dashboard, the committee was provided with a demonstration of the system during its pilot roll-out at Neath Port Talbot Hospital. It had eight areas of focus: older people's standards; patient experience; falls; quality assurance framework; pressure ulcers; medicines, infections and safer staffing and the data was available to a wide range of staff.

- Primary Care Dashboard

The Primary Care Dashboard advised of a three phase programme. Phase one of the new measures was implemented in July 2019, with baseline information being introduced where possible. Phase two measures were expected for reporting by the end of Quarter 2 (October 2019), and the timeline for the roll-out of phase three measures was still to be agreed.

- Paediatric Acute and Emergency Department

Following the guidelines update of standards for children in emergency care settings, a single point of access pilot is underway. This proposal will enable the workforce to be shared, standards to be met, as well as help to recruit, retain staff and provide safe care.

- Suicide Prevention Plan

A report advised that a new suicide prevention plan was implemented with a pilot based in Swansea, alongside working with local people to understand how suicide rates can be decreased. The collaborative plans require Multi-agency working.

- Substance Misuse

An All Wales investigation was undertaken into an increased number of severe infections amongst people who inject drugs resulting in radical surgical intervention and /or ITU admissions during an 18 month period from November 2017 to April 2019. A final report described the investigation process and findings together with a series of recommendations. A report detailing the recommendations came to the committee.

- Screening foetal growth in line with gap and grow

A report was received detailing a national programme titled GAP/GROW which has been introduced, however the health board is not yet in full compliance. The report highlighted that local protocol for suspected growth issue screening is every four weeks, rather than three, however obstetric ultrasound scan use within the Health Board has increased significantly following the introduction of the All Wales care pathways in relation to altered foetal movements and implementation of GAP/GROW.

- Older People's Strategy

A presentation was received to the committee which outlined a collaborative partnership with the Local Authority. Three themes were highlighted following the partnership and these were 'hospital 2 home', 'keep me at home' and 'good hospital care'. 'Hospital 2 Home' went live in December 2019 and the ongoing commitment is to develop teams to provide a service and support using the resource already in place.

- National Maternity and Perinatal Audit

Following the National Maternal and Perinatal Audit that took place between 1 April 2016 and 31 March 2017, a report was produced which confirmed that Singleton Hospital had an outlier status for its elective caesarean section rates and third, and fourth degree perineal damage.

- Primary Care Peer Review

A report was received which provided an update of the action plan emerging from the All Wales process of peer review of Urgent Primary Care (UPC) Services and to note the project plan for the UPC Service in Swansea Bay UHB.

- Quality and Safety Risk Register

A report was received which informed the committee of the risks from the Health Board Risk Register assigned to the Committee.

- Healthcare Inspectorate Wales (HIW) action plan annual report 2018-19

The HIW annual plan was received for noting.

- Clinical Audit

A clinical audit update was received which provided the committee with assurance of participation in the mandated list of topics set out by the NHS Wales National Clinical Audit and Outcome Review Advisory Committee, and also summarised issues and exceptions.

- Draft Quality and Safety Assurance Framework

A draft version of the Quality and Safety Assurance Framework came to the committee for comments.

- Clinical Senate

A report was received detailing items considered by the Clinical Senate Council, including actions and decisions taken.

- General Practitioner indemnity

A report detailing the changes in the GP Indemnity Scheme with effect from 1st April 2019 was received. In May 2018, the Minister for Health and Social Services announced that the Welsh Government would introduce a state backed scheme to provide clinical negligence indemnity for providers of GP services in Wales. The scheme covers claims for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019 for NHS Work.

- Mortality Report

A report was received to provide the committee with assurance that the process is completed effectively and any learning shared. The process was broken down into three parts: Initial screening; Secondary review to identify any concerns and; thematic review to identify patterns/learning across a site.

- Unscheduled Care

The Health Board experienced unprecedented pressures in unscheduled care and 2019/20 has been a challenging year in terms of service delivery across the entire unscheduled care system. The Health Board has responded to these challenges through its consolidated unscheduled care action plan and more recently its winter plan. The report brought to the committee set out the current position, the actions being taken and the risk mitigation in place.

- Community Health Council

The report updated the Quality and Safety Committee on the Thematic and Monitoring reports received from the Health Board's Community Health Council, their status and any responses made by the Health Board.

- Health Care Standards

A report was received updating the Quality and Safety Committee on plans to undertake the annual self-assessment against the Health and Care Standards Framework for the 2019-2020 reporting period.

- Child and Adolescent Mental Health Services (CAMHS) action plan and report

The report provided the latest position and assurances in relation to Primary CAMHS (P-CAMHS), and progress against the recommendations made by the NHS Wales Delivery Unit review and access to Ty Llidiard, and the Welsh Health Specialised Services Committee Consultation.

- Notification to handover time lost report

A presentation was received from Wales Ambulance Services Trust (WAST) which detailed the amount and type of calls to 999 and 111, sickness rates, and that

clinicians now have the availability to work remotely to assist when there are peaks in demand.

- EMRTS Clinical Governance Report

The health board hosts the Emergency Medical Retrieval and Transfer Service (EMRTS) and a quarterly report outlining clinical governance issues was received. The report detailed expansion of the service and also collaboration work with Welsh Ambulance Service Trust (WAST) and commissioners to develop a plan to deliver a critical care inter-hospital ground-based transfer service.

- Child and Adolescent Mental Health Services (CAMHS)

Following concerns raised during 2017-28 as to CAMHS performance, a report was received by the committee outlining admissions of CAMHS patients to adult wards. In line with Welsh Government guidance, there was a designated bed on ward F, an adult mental health ward at Neath Port Talbot Hospital for emergencies. The bed was for short-term use when all other options for young people had been explored and there was no capacity at the specialist unit Ty Llidiard, commissioned from Cwm Taf Morgannwg University Health Board. One-to-one nursing care was provided due to the associated risks of the environment, however a business case was in development to centralise mental health services for adults and this would include an appropriate area for the CAMHS bed.

- Infection Control Report

The standing agenda item was received at each Quality and Safety Committee.. While an improvement was seen towards the latter half of the year with the number of cases drawing in-line with the trajectories, it was noted that the health board's ambition needed to be zero cases. Recruitment into domestic roles has proven to be problematic and further work will be required to fill these posts across the sites.

- Quality and Safety Committee Dashboard/Integrated Performance Report

At each Quality and Safety Committee an integrated performance report was received which confirmed metrics of falls, waiting lists, pressure ulcers, cancer treatment timescales and mortality reviews. Following a quality and safety workshop, committee members felt that there was too much information in order for it to be fully scrutinised. Following the workshop, the performance team undertook a review of the report to develop it into something more specific to the committee. This included adding a section which categorised areas into red, amber and green (RAG) system which received positive feedback from committee members.

- Health and Care Standards Annual Report

The organisation's health and care standards annual report was received and noted.

- Internal Audit Reports

Members received regular reports outlining the findings of recent internal audits and details of any relevant action plans.

- Quality and Safety Governance Group

A sub-group of the committee is the Quality and Safety Governance Group (previously titled Quality and Safety Forum) and a summary of the key issues from

each meeting is presented to the members. This group escalates area of concern and key issues to the Quality and Safety Committee.

- External Inspections Reports

Another standing item for the committee is a scrutiny of reports which detail the findings of external inspections. This created opportunities for members to seek assurances that any issues requiring immediate attention were addressed.

- Patient Experience

A quarterly report in relation to patient experience was received. It outlined the results of the friends and family surveys in order for members to challenge areas were being made.

- Safeguarding Report

A bi-annual report outlining work by the safeguarding service and committee was received.

- Delivery Unit 90 Day Review Action Plan

Following a review undertook by NHS Wales Delivery Unit, a 90 day action plan was presented to the committee in response to the recommendations. The Quality Assurance Framework was actioned and closed down.

- Quality Impact Assessment

As part of the work to develop the integrated medium term plan (IMTP), a quality impact assessment was established. All schemes were assessed at stage one for patient safety, patient experience, clinical quality and whole system. Those which had a risk score of more than eight proceeded to stage two, which was a full QIA reviewed by a panel, and they were either approved, declined or returned for further work. Regular reports were to be received by the committee as the process continued.

- Quality and Safety Governance Action Plan

Following a joint review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office of Cwm Taf Morgannwg University Health Board's governance arrangements, SBUHB have reviewed its own governance arrangements following guidance from Welsh Government. The action plan has been presented twice and is a work in progress.

- World Health Organisation Surgical Safety Checklist

The report provided assurance that the organisation's safety check procedures are adequate, are being used appropriately and evidenced by an audit process.

- Major Trauma Network Clinical Guidelines

A report was received which provided a brief with regards the clinical guidelines to be adopted to support the new South Wales Major Trauma Network once operational. Each participating Health Board must provide assurance to the Major Trauma Network Board that the guidelines will be embedded into clinical practice.

4. Conclusion

This report demonstrates that the committee fulfilled its responsibilities through the reports it had received during the year from various services and sources.