ABM University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 6th December 2018
at 9am in the Millennium Room, Baglan HQ

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

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Richard Evans, Medical Director (until minute 212/18)
Sandra Husbands, Director of Public Health
Christine Morrell, Deputy Director of Therapies and Health Science (for minute 209/18)
Chris White, Chief Operating Officer and Director of Therapies and Health Science (until minute 208/18)
Nia Roberts, Healthcare Inspectorate Wales
Paula O'Connor, Head of Internal Audit
Lynne Hamilton, Director of Finance (until minute 206/18)
Pam Wenger, Director of Corporate Governance
Liz Stauber, Committee Services Manager
Jason Crowl, Unit Nurse Director, Primary Care and Community Services (for minutes 195/18 and 196/18)
Anjula Mehta, Unit Medical Director, Primary Care and Community Services (for minutes 195/18 and 196/18)
Hazel Powell, Unit Nurse Director, Mental Health and Learning Disabilities (for minute 206/18)
Judith Vincent, Clinical Lead for Integrated Pharmacy (for minute 209/18)

Minute		Action
195/18	**PATIENT STORY**	

Jason Crowl and Anjula Mehta were welcomed to the meeting.

A patient story was **received** which outlined the experience of a new mum who was feeling socially isolated and anxious. Her health visitor referred her to the perinatal mental health service which was able to signpost to group sessions managed through a third-sector organisation. At the most recent visit, the health visitor had noted that the mum was like a 'new person', regularly attending playgroups. The early intervention work had prevented a mental health crisis which could have a long-term impact for both the mum and the child.

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

Chris White complimented the team on the story, adding that it was an encouraging patient outcome. He queried if there was any work undertaken during the ante-natal period to identify women at risk of developing mental health issues during or after pregnancy. Anjula

Mehta advised that if a woman had a history of mental health concerns a referral would be made as part of the antenatal clinic, but if it was a new concern, the health visitor had a scoring system to identify potential warning signs.

Martyn Waygood queried if such a case was resource intensive and if the service was equitable across the health board. Jason Crowl advised that there was nothing different or exceptional about this particular case to make it resource intensive. Gareth Howells added that while pregnancy was a natural 'condition', for some, there could be complications, and it was key to develop a way to pick up those who were developing social anxiety as part of 'business as usual'.

Reena Owen queried the method of funding and how widely the service was available. Jason Crowl commented that it was funded through grant money and managed through a range of third sector contracts. Reena Owen sought clarity as to whether it was available across all areas of the health board. Jason Crowl advised that there was one in Swansea and Carmarthen but not elsewhere. Maggie Berry stated that it was essential that such a service had parity as well as the capacity to deliver. Anjula Mehta commented that there was great reliance on the service as it was invaluable to those who used it.

196/18 PRIMARY CARE AND COMMUNITY SERVICES EXCEPTION REPORT

A report providing an update on quality and safety issues relating to primary care and community services was **received.**

In introducing the report, Jason Crowl highlighted the following points:

- The unit covered all patients within the health board area;
- The unit's assurance framework had been revised and included strengthened relationships with general medical and dental services;
- Learning had been taken from a number of audits, including changing the visiting cycles to contactors and the unit's strategic quality and safety meetings;
- A significant proportion of serious incidents related to the way in which pressure ulcers were reported, but the majority of these were 'inherited' by the unit as they existed before the patient transferred from another service;
- Work was ongoing to address the backlog of responses to incidents;
- Scrutiny panels had been established for pressure damage and falls were currently reported as the total occurrences, but this was to change to per 1,000 bed days;
- The number of infection control incidences was reducing and

action plans put in place to address concerns within care homes;

- Partnership working was taking place in Bridgend with the police and local authority to develop a 'hub' to manage safeguarding cases in the area through a dedicated resource;
- There were challenges with regard to deprivation of liberty safeguards (DoLS) performance and a dedicated team was to be recruited, with the management taken over by the unit;
- Patient flow was a key area of work with a number of initiatives such as the acute clinical care teams, 'end PJ paralysis' and the integrated care model at Morriston and Gorseinon hospitals;
- The unit recognised the gap in relation to end-of-life care and discussions were being undertaken as to how to address it;
- Primary care measures were in place;
- Changes in guidelines for general anaesthetic within dental services were being addressed by strengthening current arrangements and a task and finish group established;
- Healthcare Inspectorate Wales (HIW) had issued a non-compliance notice during a visit to a dental practice with a private patient element and as such, the unit was to recruit more dental assessors to revalidate the reassurance from its own inspections;
- The collection of patient experience feedback needed to be strengthened and consideration be given as to how the unit engaged with a wider group of users;
- As part of the 'you say, we did' campaign, staff as well as patients were asked to identify areas for improvement;
- Complaints performance dipped over the summer but an improvement was now evident, with a weekly review of cases being undertaken to make performance consistent;
- The unit had one managed practice with which it was working to develop a multi-disciplinary approach to make its workforce and services more sustainable;
- Work was being undertaken with partners within the justice service as part of the provision of healthcare for prisons;
- The national early warning score (NEWS) system was being implemented;
- A high number of staff within the unit continued to be nominated for national awards.

In discussing the report, the following points were raised:

Martyn Waygood sought clarity as to the fragility of GP services.

Anjula Mehta responded that a close eye was kept on all of the practices and several had been on the unit's radar for a while. She added that the management team was working with these practices to encourage them to consider where they wanted to be as a service and the kind of workforce they would need to achieve this. She added that the introduction of physician associates was also assisting and several practices were considering including the role within their establishment on a long-term basis.

Martyn Waygood noted that one of patients' concerns in relation to the managed practice was the telephone access system. Anjula Mehta advised that it had transpired that a significant amount of the patient cohort had raised concerns as they had wanted to be able to see their GP of choice. She added that all patients were responded to within the set timeframe upon contact via the telephone line and it was a board-wide process.

Chris White queried if there was a plan in place to address the backlog of incidents. Jason Crowl responded that a member of staff had been allocated just to focus on this and an interim governance lead appointed. Chris White advised that this would be followed-up through the monthly performance, quality and finance meetings.

Chris White stated that it was pleasing to see performance metrics had been established for the unit as this would give more traction. He added it was also useful to have the tracker in relation to the healthcare needs of those within the local private prison.

Chris White offered his thanks to the unit, particularly Jason Crowl, for the work in relation to patient flow and delayed transfers of care, which had improved, although there was still more work to be done.

Sandra Husbands commented that the managed practice had been identified as a complaints hotspot and a particular theme of appointments emerging. She queried if there was any intelligence as to why this was the case. Jason Crowl responded that it was based on the volume of complaints and the engagement with the community as this was disproportionate when compared with non-managed practices.

Reena Owen queried as to whether the number of complaints received by the unit was comparable with other health boards. Jason Crowl advised that the number of complaints was not significantly high in comparison with the number of patient contacts undertaken but the themes varied, such as access, communication and patient experience, and there were also complaints made when a patient disagreed with the doctor's opinion.

Reena Owen queried as to whether anything different was to be done by the unit to address the issues being raised in relation to communication. Jason Crowl stated that the unit was very much patient facing but it did not engage with its citizens enough. He added that it had a number of mobile device applications and questionnaires

available and it was working with colleagues within human resources to develop a culture of professional behaviours.

Lynne Hamilton sought assurance that the new process for managing DoLS was a board-wide process. Jason Crowl confirmed that it was, adding that the unit now had sole management responsibility for the discharge of the process and a board-wide performance dashboard was in development.

Richard Evans queried as to how the health board compared with others in terms of anti-biotic use within primary and community services and sought clarity if there was a 'disconnect' between any of the departments. Jason Crowl responded that the unit had a sub-group which monitored prescribing indicators but medicines management was an oversubscribed service. He added that the unit had given a focus to reminding clinicians as to the overall aim of reducing antibiotic prescribing.

Reena Owen asked whether there was a timeline for action in relation to the audit of the prescribing incentive scheme audit. Anjula Mehta advised that this was to be progressed as part of a six-month review.

Richard Evans sought further details as to the work in relation to end-of-life care. Jason Crowl responded that a review was being undertaken by the continuing healthcare team of the advanced directive to audit the number of plans available. He added that preliminary findings were demonstrating that not enough patients for whom it was appropriate had a plan in place and a concerted effort was needed to improve this to ensure patients' wishes were met.

Chris White queried as to whether there were plans in place to establish safeguarding hubs for Swansea and Neath Port Talbot. Jason Crowl responded that the success of the Bridgend hub would be used to consider whether ones for the other local authority areas would be relevant.

Pam Wenger complimented the unit on its report, adding that it demonstrated the breadth of the issues it was managing. She also acknowledged the unit's input into the refresh of the risk management process, noting that some of the risks on the unit's register relating to GP sustainability may need to be escalated to the corporate register.

Maggie Berry queried as to how the learning from external inspections was shared. Jason Crowl advised that meetings were held with medical and dental colleagues following such visits as it was essential that colleagues were held accountable and this included sharing the learning.

Maggie Berry noted that the unit used the patient advisory and liaison services for hospitals to support its hotspot areas and queried as to whether there were plans in place to establish a service of its own. Jason Crowl responded that it did not align with the structure of the unit at the moment to have one but consideration was to be given to

including it in a future model.

Resolved: The report be **noted.**

197/18 WELCOME AND APOLOGIES FOR ABSENCE

Maggie Berry welcomed everyone to the meeting, particularly Richard Evans who was attending his first meeting as Medical Director and Lynne Hamilton as an observer.

Apologies for absence were received from Ceri Phillips, Independent Member and Carol Moseley, Wales Audit Office.

198/18 DECLARATIONS OF INTERESTS

Maggie Berry declared an interest in any items relating to the Bridgend boundary transfer as a resident of the county borough.

199/18 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.

200/18 MATTERS ARISING NOT ON THE AGENDA

(i) 133/18 Quality and Safety Forum

Maggie Berry queried as to whether the issue relating to mortuary microphone had been resolved as it had been open for a significant period of time. Lynne Hamilton advised that she had spent two half-days visiting the mortuary services and the issue with the microphone had arisen during this. She added it was more complicated than just replacing it as specialist contractors were needed for the installation. Gareth Howells undertook to seek an update from the Deputy Director of Therapies and Health Science.

201/18 ACTION LOG

The action log was **received** and **noted** with the following updates:

(i) Action Point Three

Sandra Husbands commented that there was a need to determine which reports were to be received by the committee and those which should now be submitted to the forum. Gareth Howells concurred. Martyn Waygood advised that he and Maggie Berry were to meet the following week to discuss the work programmes for this committee and that of health and safety which would provide more clarity for future reporting.

202/18 WORK PROGRAMME

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

203/18 INFECTION CONTROL REPORT

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

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

- Infection control remained a high focus, not just in terms of targeted intervention, but from a patient safety perspective;
- There were three areas of focus; *e.coli*, *clostridium difficile* and *stauph.aureus bactaermia*;
- All three performance areas were all under the trajectory in October 2018 for the first time, which was thanks to the efforts of the unit nurse directors;
- Performance in November 2018 saw *stauph.aureus bactaermia* on trajectory, *clostridium difficile* remained under but *e.coli* had gone above trajectory.

In discussing the report, the following points were raised:

Reena Owen queried as to how the health board's performance compared with others. Gareth Howells responded that it was a false economy saying performance was within the trajectory as the organisation was the worst performer in Wales with regard to clostridium difficile however it was moving in the right direction and the health board needed to remain positive.

Martyn Waygood sought assurance that the decontamination process was to be reintroduced in January 2019. Gareth Howells confirmed that it was with a particular focus on clostridium difficile, as the recent outbreak at Morriston Hospital had led to the destruction of 80 mattresses.

Martyn Waygood queried the way in which the new test for clostridium difficile worked. Gareth Howells advised that it tested a sample of diarrhoea for the infection.

Martyn Waygood sought further details as to the compliance with care bundles. Gareth Howells commented that this was managed by the matrons who were reinforcing the message that the bundles of care reduced harm to patients.

Resolved: The report be **noted.**

204/18 NURSE STAFFING LEVELS

A report providing an update in relation to compliance with the Nurse Staffing Levels (Wales) Act 2016 was **received.**

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

- Significant progress had been made in relation to compliance with the act;
- Supervisors were no longer included in the establishment;
- A 26% uplift was in place which would also support sickness and training absences;
- The first uplift focus had been given to healthcare support workers (HCSWs) as the pool of registered nurses to take up posts was small, so using unregistered staff in different ways with support was an alternative;
- The key challenge was how to provide assurance to the board as to its compliance with the act;
- Paediatrics and community nursing were the next cohorts to be addressed;
- The internal group was meeting monthly to work though the requirements.

In discussing the report, the following points were raised:

Paula O'Connor queried as to where the Nurse Staffing Levels (Wales) Act 2016 group reported. Gareth Howells advised it was monitored through the workforce workstream.

Reena Owen queried the ability of HCSWs to undertake some of the duties required of registered nurses. Gareth Howells advised that within Wales, health boards had the ability to recruit HCSWs on either a band two, three or four, and this was an opportunity to see what they could do with support. He added they could not replace registered nurses but they could take on some of the duties.

Martyn Waygood commented that the issue of nurse vacancies was unlikely to be fully resolved. Gareth Howells advised that the health board had a deficit of around 500; 300 registered nurses and the rest HCSWs. He added that this was the lowest it had been for a while due to the recent graduation of student nurses. Chris White commented that the deficit was significant but there had been a major step forward due to turnover reducing and successful recruitment drives. Gareth Howells added that there should not be difficulties in recruiting HCSWs as these tended to be local people wanted to work locally and the health board had a good apprentice scheme.

Maggie Berry queried as to whether an allowance had been made within the integrated medium term plan (IMTP) for all wards to be reviewed. Gareth Howells advised that some had already received an uplift to make them safe and the rest were to be reviewed as well, but this needed to be a wider discussion with colleague from HR as well as finance.

Resolved: The report be **noted.**

205/18 CHANGE IN AGENDA ORDER

The agenda order be changed and item 3d be taken next.

206/18 QUALITY AND SAFETY INDICATORS FOR MENTAL HEALTH AND LEARNING DISABILITIES

Hazel Powell was welcomed to the meeting.

A report outlining the work to develop quality and safety indicators for mental health and learning disabilities services was **received.**

In introducing the report, Hazel Powell highlighted the following points:

- At its attendance at the committee earlier in the year, the unit had been tasked with developing quality and safety indicators;
- Not all acute performance indicators were relevant to the unit;
- A proposed list of indicators had been developed in discussion with the Director of Nursing and Patient Experience;
- It was also an opportunity to consider national benchmarking data to have something for the unit to measure itself against.

In discussing the report, the following points were raised:

Reena Owen queried as to whether any indicators focussed on patients' perception of the services. Hazel Powell advised that 15-step challenge visits were undertaken across the unit and the friends and family survey was also in use. She added that some of the national work was considering patient outcomes and this was an area in which the unit wanted to progress.

Sandra Husbands stated that it was pleasing that the unit was considering adopting more patient recorded outcome measures as it would be useful to incorporate some public health data as well.

Paula O'Connor advised that she had a number of queries and undertook to discuss these with Hazel Powell outside of the meeting. **PO'C**

Gareth Howells complimented the unit on its willingness to learn, adding that some of the work was groundbreaking as it was easy to determine if care was safe, it was what happened next to enhance it.

Chris White stated that the work was encouraging but queried as to how it would link to some of the risks identified within the unit. He added that waiting until the new financial year to implement the work seemed too long as the cohort of patient was one which was likely to try to harm themselves. Hazel Powell responded that the intention was to have a shadow reporting period between January and March 2019 to trial the metrics to identify whether others needed to be added in. Chris White advised that the metrics would be picked up as part of the monthly finance, quality and performance meetings.

Martyn Waygood queried as to whether there was an intention to consider any unlawful detentions. Hazel Powell confirmed that there was scope to include this.

Maggie Berry stated that some of the data was shown as a percentage and the rest as a figure. She stated that it would be useful for both to be used for all areas as a comparator. She also noted that HIW inspections were included, adding that it would be beneficial to incorporate other audits and inspections.

Resolved:

- The report be **noted.**
- Paula O'Connor to discuss the report further with Hazel Powell outside of the meeting. **PO'C**

207/18 DELIVERY UNIT UPDATE

A report providing an update against the review of serious incidents being undertaken by the NHS Wales Delivery Unit was **received.**

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

- The final report from the NHS Wales Delivery Unit had now been received. It was to be shared with the executive board first with an intention to circulate it to the committee prior to the next meeting, at which it would receive it formally;
- An action plan had been developed and this was included within the report on the agenda;
- There were some areas of risk which needed to be addressed urgently but there had also been some improvements;
- How learning was shared was key, as was the need for SMART action plans;
- It had been eight months since the most recent never event;
- The Mental Health and Learning Disabilities Unit needed to complete a robust root cause analysis process;
- Progress was moving in the right direction but it still needed to be kept under review.

Resolved: The report be **noted.**

208/18 CHRONIC PAIN REVIEW

Chris Morrell was welcomed to the meeting.

A report setting out the findings of an external review of the chronic pain service was **received.**

In introducing the report, Chris Morrell highlighted the following points:

- The review of the chronic pain service was undertaken some

time ago and focussed on its safety;

- The Director of Finance at the time was appointed as the executive lead and terms of reference were developed;
- The report gave assurance of the quality and safety of the service;
- All recommendations had been accepted and the primary care and community services unit was managing the action plan, which the committee had already received.

In discussing the report, the following points were raised:

Reena Owen queried as to whether the health board revisited services after such a review to ensure changes had been made. Chris Morrell advised that a revisit would be undertaken but only once the actions had been completed.

Martyn Waygood stated that it was a positive report which gave the health board the assurance that it needed. He queried the confidence that all actions would be addressed by the end of the financial year. Chris Morrell advised that this was the intention. Maggie Berry suggested that the committee receive an update in April 2019 providing confirmation that all actions had been addressed. This was agreed. **CW**

Resolved:

- The report be **noted.**
- Further update be received in April 2019. **CW**

209/18 PHARMACY AND MEDICINES MANAGEMENT

Judith Vincent was welcomed to the meeting.

A report outlining an update from pharmacy and medicines management was **received.**

In introducing the report, Judith Vincent highlighted the following points:

- There was a correction to the primary care anti-biotic prescribing reduction as the national reporting mechanism had changed, which meant it no longer met the 5% target and had reduced to 0.5%;
- The impending Bridgend boundary change would have a negative impact on resources;
- To improve anti-microbial stewardship, consideration needed to be given to recruiting a consultant pharmacist, particularly in light of the impact that the Big Fight campaign had during its existence. However it had not resulted in substantial behaviour changes.

In discussing the report, the following points were raised:

Gareth Howells commented that he fully supported the case for a

consultant pharmacist and the next step in the improvement of anti-biotic prescribing would be a concerted effort within primary care and community services, which needed a degree of support.

Reena Owen stated that she found the report concerning given the volume of work which was required. She queried as to whether it was as simple as continually reinforcing the messages with regard to anti-biotic prescribing. Judith Vincent responded that at the start of her career, one of the first engagement efforts she had been party to was around anti-mircobial prescribing and it was not just the mindset of clinicians which needed to change, it was also that of the public. Reena Owen stated that in which case, consideration needed to be given to involving the media in the work. Pam Wenger responded that as part of the transformation funds, the health board had additional monies to invest in communications resources for primary care so she would relay this suggestion to the head of communications. **PW**

Richard Evans advised that he was also fully supportive of the case for the consultant pharmacist as a resource was needed to drive through the messages. He added that the majority of the traction was needed within hospitals to stop people from prescribing anti-biotics unnecessarily, particularly junior doctors.

Maggie Berry queried as to whether more recent data was available and queried as to whether an additional consultant was needed at this time. Judith Vincent advised that it was provided three months in arrears.

Richard Evans commented that there were challenges with anti-microbial prescribing within Swansea but the consultant microbiologist currently seconded from Cardiff was helping to address these. However there was a risk he would be returning to his substantive role.

Martyn Waygood stated that the health board's performance was not improving as well as others. Judith Vincent responded that its starting position was higher than others.

Resolved:

- The report be **noted.**
- Pam Wenger to relay the suggestion to raise awareness of anti-biotic prescribing through the media to the head of communication. **PW**
- The proposal to recruit a consultant pharmacist be supported. **JV**

210/18 QUALITY AND SAFETY INTEGRATED PERFORMANCE REPORT

The monthly integrated performance report was **received.**

In discussing the report, the following points were raised:

Pam Wenger advised that the report in its current format was received by three committees as well as the board itself and

consideration was needed as to how to avoid duplication. She suggested that the executive directors develop a proposal as to the way in which to present performance data to the committee. This was agreed. **PW**

Gareth Howells stated that the report included a considerable amount of information and not necessarily all of it was required by the committee in order to discharge its duty effectively. He added that the link between performance and quality was not being made and that was the narrative which the committee needed to be given, which may require separate reports.

Reena Owen commented that some of the performance charts were too small to read on a tablet.

Paula O'Connor advised that internal audit had previously made some recommendations as to what needed to be included within the performance report and not all of this had been addressed, as such she would be happy to offer further advice to the executive directors to develop a new version of the report that will address the audit recommendations that were made.

Reena Owen queried as to whether there was a legal requirement for the committee to receive such information on a regular basis. Gareth Howells responded that while it was not a legal requirement, it was key for the committee in order for it to provide assurances that services were safe.

Maggie Berry stated that was important for the committee to know the good/bad elements of performance, risks, priorities and themes, and how these related to quality and safety. Gareth Howells concurred, adding that the health board had quality priorities and should be reporting progress against them, and the main role of the committee was to scrutinise the quality and safety elements of the risk register.

Maggie Berry sought clarity as to the issue in relation to authorising annual leave for medical staff. Richard Evans explained that this related to the popular holiday periods and how groups of consultants agreed between them as to who would take what leave, rather than leave it to the clinical director to determine.

Maggie Berry queried as to whether the quality improvement leads were now in place. Richard Evans advised that they were for Morriston and Neath Port Talbot hospitals, as well as mental health and learning disabilities, but Singleton Hospital had been unable to appoint to the post. He added that the roles were intended to strengthen clinical leadership.

Maggie Berry referenced the theatre efficiencies work and queried if plans were in place to make improvements. Gareth Howells commented that this area of performance was a risk to the health board and the committee would need to be given assurance as to the improvements as the work progressed.

Resolved:

- The report be **noted.**
- Proposal be developed as to the more appropriate way in which to provide quality and safety performance data. **PW**

211/18 CHANGE IN AGENDA ORDER

The agenda order be changed and item 5c be taken next.

212/18 CLINICAL OUTCOME GROUP UPDATE

A report providing an update in relation to clinical audit was **received.**

In introducing the report, Richard Evans highlighted the following points:

- The work of the clinical outcome group was to be absorbed by the clinical senate council, which was meeting for the first time later in December 2018;
- The contribution of the health board to national audits was variable due to the challenging requirements for resources;
- The national clinical audit programme work for the upcoming year was to be discussed by the clinical senate council in order for consideration to be given as to how to integrate this into other health board work and to deliver the IMTP.

In discussing the report, the following points were raised:

Maggie Berry stated that as the chair of the Quality and Safety Committee, she would attend the clinical outcome group as an observer and queried if this would also apply to the clinical senate council. Pam Wenger responded that it was important that independent members were kept separate from operational details in order to provide the right level of scrutiny as part of the assurance progress. She added that she would seek the advice the health board Chair. **PW**

Martyn Waygood sought clarity as to the consequences of not engaging fully with national audits. Richard Evans advised that there were no consequences as such and there were ways in which the health board could mitigate the issues.

Martyn Waygood queried whether scrutiny was undertaken by the Medical Director of proposed local audits to determine the value. Richard Evans advised that the decision had been made to revert back to a half a day per month for clinical audit sessions for units to undertake the work in the timely way.

Resolved:

- The report be **noted.**
- Confirmation be sought from the health board Chair as to whether it was appropriate for the chair of the Quality and Safety Committee to attend the clinical senate council as an **PW**

observer.

213/18 PATIENT EXPERIENCE

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

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

- Friends and family feedback remained consistent at 95% of people happy to recommend the health board's service;
- The patient experience work programme was included in the report;
- The number of complaints received had increased;
- There was non-compliance with two patient safety alerts;
- A patient experience forum was to be developed.

In discussing the report, the following points were raised:

Reena Owen referenced the feedback in relation to food and drink, particularly in relation to the elderly, and queried if the health board's figures were comparable with others. Gareth Howells undertook to clarify the health board's position as mealtimes should be protected but there were differing views as to how to achieve this. **GH**

Martyn Waygood commented that generally the overall picture was good with positive feedback around 93% or above, but there were pockets where the results were considerably lower. Gareth Howells concurred, adding that 31% was the target so there was a detailed piece of work he needed to undertake.

Martyn Waygood noted the intention to introduce more technology into the process to capture patient experience, providing that there were charitable funds for which bids could be submitted.

Nia Roberts noted that a common theme within complaints received by all the units was communications and queried the opportunity for shared learning. Gareth Howells advised that each unit had a quality and safety forum at which all complaints were discussed and he would expect such feedback to be discussed within the meetings.

Martyn Waygood noted that mental health and learning disabilities services was an outlier in terms of feedback. Gareth Howells concurred, adding that staff had been asked if they would recommend their services, the results of which had been fascinating. He undertook to bring a formal plan for patient experience to the April 2019 meeting. Martyn Waygood stated that it would be useful to have something specific in relation to the mental health and learning disabilities performance. Paula O'Connor undertook to discuss this with the service director as she could recall there being a specific reason as to why. **GH** **DR/HP**

Resolved:

- The report be **noted.**
- Clarity be sought as to the health board's position in relation to food and drink performance in comparison with others. **GH**
- Formal plan for patient experience be received in April 2019. **GH**
- Clarity be sought for the reason as to why mental health and learning disabilities was an outlier in terms of family and friends feedback. **DR/HP**

214/18 INTERNAL AUDIT UPDATE

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

In introducing the report, Paula O'Connor stated that the format of report had changed as the Audit Committee chair had sought assurance that the information provided to the Audit Committee flowed to the relevant board committee. She added that the key reports for the committee to consider were: mortality reviews (follow-up); delayed follow-ups; Morriston Unit governance.

In discussing the reports, the following points were raised:

Gareth Howells referenced the limited assurance rating for mortality reviews, stating that the outcome of the reviews needed to be considered somewhere in order to be of meaning and to determine if harm was being caused to patients. Paula O'Connor concurred, adding that the stage one performance was positive, it was stage two which was proving challenging, and the decision to use clinicians on restricted duties to clear the backlog was not having an impact.

Martyn Waygood stated that it was pleasing to see the reasonable assurance rating in relation to Morriston Hospital but noted the outstanding risks. Paula O'Connor responded that significant work was being undertaken to strengthen the health board's risk register.

Pam Wenger advised that she was taking a committee referral log through the upcoming Chairman's Advisory Group to inform each what they were doing as well as refer issues to other committees.

Resolved: The report be **noted.**

214/18 CORPORATE RISK REGISTER (QUALITY AND SAFETY RISKS)

A report providing an update in relation to the development of a corporate risk register was **received.**

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

- The report had previously been received by the Audit Committee;
- It demonstrated the direction of travel for the refreshed

corporate risk register;

- Part of the new process included establishing executive leads and relevant board committees to which to report for accountability;
- This committee would receive updates against the quality and safety risks;
- It was a work in progress and the executive board would receive the first iteration of the populated revised register;
- A risk management process had been developed to ensure consistency of scoring.

In discussing the report, the following points were raised:

Reena Owen complimented the format of the new register and queried as to whether it would feed into other plans. Pam Wenger advised that was the intention and the highest risks should be the ones on which there was focus and be part of core business.

Martyn Waygood stated that he also liked the format as it provided clarity as to the challenges.

Resolved: The report be **noted.**

215/18 QUALITY AND SAFETY FORUM

A report providing an update from the quality and safety forum was **received.**

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

- The report provided a precis of the discussion at the recent meeting of the forum;
- One of the main areas the forum wished to escalate to the committee was the use of lap straps for patients at risk of falling, which was not best practice;
- A formal update had been given in relation to pre-emptive beds;
- HIW had undertaken a review at Morriston Hospital in relation to venous thromboembolism (VTE) and consideration needed to be given as to how patients were given medication.

In discussing the report, the following points were raised:

Martyn Waygood noted that a number of posts were vacant in relation to decontamination and queried if succession planning was taken into consideration. Gareth Howells responded that considerable work was being undertaken to centralise the service and the required posts were quite specialist.

Maggie Berry queried as to the progress in relation to developing a

quality hub. Gareth Howells advised that the work had slowed down to compensate the impending boundary change. Maggie Berry suggested that an update be provided to the August 2019 meeting. This was agreed. **GH**

Maggie Berry stated that it was essential that the units attended the forum and this message needed to be relayed to those who continued to miss meetings. Gareth Howells undertook to relay this message. **GH**

Resolved:

- The report be **noted.**
- Update be provided in August 2019 as to the development of a quality hub.
- Message be relayed to the units that it was imperative that they attended all meetings.

216/18 EXTERNAL INSPECTIONS

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

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

- Two recent visits had been undertaken by HIW; one to the minor injury unit (MIU) at Neath Port Talbot Hospital and theatres wards (A and B) at Morriston Hospital with regard to VTE;
- It was hoped the visit to Morriston Hospital would support the work in relation to fractured neck of femurs for which there were weekly meetings;
- The findings of the MIU visit had been disappointing, particularly as similar issues had been identified at Singleton Hospital earlier in the year and lessons had not been learned. A development review was in process.

In discussing the report, the following points were raised:

Nia Roberts advised that with regard to the VTE review at Morriston Hospital, similar issues were being identified across Wales and the various organisations were working in different ways. She added that it was really positive to hear of the work being undertaken.

Nia Roberts stated that a visit had taken place that week to a GP practice for which an immediate assessment notice had been issued, with the main issue relating to the defibrillator. It was battery operated but the battery had been removed and staff had been unable to demonstrate how it had worked. She added that it had been an announced visit, so the practice had time to prepare, and there had also been issues with the resuscitation equipment. Gareth Howells advised that an internal inspection scheme had since been established. Nia Roberts responded that it was pleasing to hear such action was being taken.

Martyn Waygood commented that it would be useful to include within the review of the MIU the alignment of the service to that of the out-of-hours to provide the opportunity for inter-service referrals. He added that currently those attending MIU, but for whom out-of-hours was more appropriate, had to phone the services themselves for an appointment despite them being positioned near to each other within the hospital site. Gareth Howells concurred, adding that the various unscheduled care services across the health boards did not work in a consistent way and this needed to be addressed. Reena Owen stated that it would be useful to include the ambulance service in the discussion.

Resolved: The report be **noted.**

217/18 ANY OTHER BUSINESS

(i) Departures

Maggie Berry advised that this was Nia Roberts's final meeting as she was to take up a post with Welsh Government. She thanked her for her support to the committee.

Maggie Berry informed the committee that she was to step down as chair and be replaced by Martyn Waygood, while she was to take over the chair of the Health and Safety Committee. Pamela Wenger thanked Maggie Berry for her work to develop the committee during her time as chair.

There was no further business and the meeting was closed.

218/18 NEXT MEETING

This was scheduled for 21st February 2019.

219/18 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.