ABM University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 2nd August 2018
at 9am in the board room, Neath Port Talbot Hospital

Present
Maggie Berry, Independent Member (in the chair)
Martyn Waygood, Independent Member
Ceri Phillips, Independent Member

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Christine Morrell, Director of Therapies and Health Science
Push Mangat, Interim Medical Director
Paula O'Connor, Head of Internal Audit
Neil Thomas, Internal Audit
Pam Wenger, Director of Corporate Governance
Charlotte Higgins, Graduate Management Trainee
Liz Stauber, Committee Services Manager
Julie Hopkins, NHS Wales Delivery Unit
Jane Williams, NHS Wales Delivery Unit
Lesley Jenkins, Unit Nurse Director, Neath Port Talbot Hospital Delivery Unit (for minute 118/18)
Angharad Higgins, Quality, Safety and Improvement Manager, Neath Port Talbot Hospital Delivery Unit (for minute 118/18)
Lee Morgan, Head of Information (for minute 125/18)

Minute		Action
118/18	**PATIENT STORY**	

Lesley Jenkins and Angharad Higgins were welcomed to the meeting.

A patient story was received which outlined the impact of a pressure ulcer for an elderly gentleman. Following surgery, a moisture lesion had been identified and advice sought from a tissue viability nurse, which included a change in mattress and regular repositioning. The pressure ulcer developed after the patient spent a long period of time in the day room, sat in the same chair without pressure release or skin integrity checks, and as a result, the scrutiny panel had deemed it avoidable. Senior staff had since met with the patient and explained that it would be addressed through redress, with which the patient was content, as if he had been given advice as to what to do while sat in the chair, he would have taken it.

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

Lesley Jenkins advised that unit was undertaking significant work around pressure ulcers and each occurrence was scrutinised by a dedicated panel, which had seen a 75% improvement. She added that the pressure ulcer policy was to be revised to take into account the improvement work implemented and causation factor fields had

also been added to Datix.

Angharad Higgins stated that training was being provided for all clinical staff on the ward, as often when patients had capacity, it was assumed that they would know what to do to avoid pressure ulcers. She added that the ward had gone 17 months without a bed sore but then reported a handful in a short period of time for a cohort of patients of similar age. Lesley Jenkins informed the committee that the culture within the unit had changed, and the ward had been 'horrified' at the occurrence of a pressure ulcer. She added that Neath Port Talbot Unit have developed a short video encouraging people to 'move a little more' to remind everyone to move every half an hour.

Chris Morrell noted that the unit hosted therapies staff for the health board and queried how the improvement work was being communicated to them. Lesley Jenkins advised that therapies staff were engaged with the scrutiny panels which were board-wide.

Sandra Husbands asked whether a Welsh version of the 'move a little more' video was available. Lesley Jenkins responded that a strategic group had been established which was considering the communication of the video and this would be included within its remit.

Gareth Howells stated that it was critical that patients with capacity were given ownership in order to help themselves avoid pressure ulcers; without the knowledge or advice, they were unable to do so.

Martyn Waygood sought clarity as to the engagement of district nurses as pressure ulcers were also an issue for community and care home services. Lesley Jenkins advised that the service was part of the scrutiny panels.

Pam Wenger noted the planned launch of the 'move a little more' campaign and queried as to whether the communications team had been involved. Lesley Jenkins responded that the launch was to be tied in with the national campaign launch in November 2018.

119/18 WELCOME AND APOLOGIES FOR ABSENCE

Maggie Berry welcomed everyone to the meeting, particularly Gareth Howells who had joined the organisation as Director of Nursing and Patient Experience.

There were no apologies for absence.

120/18 DECLARATIONS OF INTERESTS

There were no declarations of interest.

121/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 7th June 2018 were **received** and

confirmed as a true and accurate record.

123/18 MATTERS ARISING NOT ON THE AGENDA

There were no matters arising.

124/18 ACTION LOG

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

(i) Action Point Two

Martyn Waygood advised that he was meeting with the head of support services the following week to discuss blue plate scheme.

(ii) Action Point Three

Pam Wenger advised that she had met with the health board's contact for the Welsh Risk Pool and discussed the concerns raised by the committee with regard to its annual report. She added they had provided assurance that the report was not intended for the public domain.

(iii) Action Point Four

Gareth Howells advised that he would be keen for the committee to receive an update before February 2019 in relation to performance measures for mental health and learning disabilities and undertook to bring something to the next meeting. **GH**

125/18 WORK PROGRAMME

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

In discussing the work programme, Pam Wenger advised that she was to undertake a planning session with Maggie Berry and Gareth Howells to develop the work programme for the committee. She added that this time would also be spent considering the reports received by the committee to ensure they provided the required assurance.

Resolved: The work programme be **noted.**

126/18 WARD TO BOARD DASHBOARD

Lee Morgan was welcomed to the meeting.

A verbal update on the ward to board assurance framework was **received.**

In introducing the report, Lee Morgan highlighted the following points:

- The roll-out was continuing at Neath Port Talbot Hospital and meetings undertaken with ward managers to check that the system worked;
- As well as ward staff, the system was being used by site and

department managers, from whom feedback had positive;

- Widespread usage was not quite where it needed to be, but it was hoped this would increase once confidence grew;
- Agreement had been received for Singleton Services Delivery Unit to be the next unit for implementation;
- A promotional video was to be developed to outline the benefits of the system.

In discussing the report, the following points were raised:

Gareth Howells commented that understanding patient experience was a significant challenge for the health board, particularly how to assure the board and partners that what was being done was right. He added that the dashboard would provide that visibility and enable concerns to be escalated.

Maggie Berry advised that the demonstration received at the previous meeting had sparked an enthusiasm for what could be achieved, and it was pleasing to know that staff felt the same. She added that once it was fully operational, it could be an opportunity to share it on an all-Wales basis.

Pam Wenger stated that she was in the process of developing a board assurance framework for which the dashboard would be beneficial.

Gareth Howells commented that the long-term objective for the health board was to provide more care out in the community, rather than hospital-based, and how this was made accessible to these services would be the challenge. Maggie Berry concurred, adding that it was important that everyone accepted that it was one organisation.

Resolved: The report be **noted.**

127/18 INFECTION CONTROL REPORT

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

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

- Performance against the *clostridium difficile* trajectory for the quarter was over by six cases and the s*taphylococcus aureus* by 10. *E.coli* was one case above the trajectory;
- It was important that tolerance for the performance did not become the norm and a return to ‘basics’ was needed;
- Consideration was needed as to how to implement controls to address the issues;
- Work was needed with ward staff to ensure daily checks were undertaken;
- Nurses needed to be empowered to just focus on nursing.

In discussing the report, the following points were raised:

Martyn Waygood noted that the Welsh Government targets were 'not achievable' by the following year, and queried as to whether plans were in place, as this appeared to be defeatist. Gareth Howells responded that the target had been set for performance, but it was more about patient care, and the health board should actually be targeting zero tolerance. He added that there were no cost or time reasons as to why healthcare acquired infections could not be eradicated, it was more about mindset.

Push Mangat stated that the way in which such situations were accepted needed to change, for example, the number of days between never events were counted but the occurrences should be years apart. He added that those who delivered care needed to own the issues in order to improve.

Ceri Phillips commented that 'zero tolerance' had become diluted in a number of areas across the health board, not just in areas in which patient care was provided. He added that many patients who contracted *clostridium difficile* had been in hospital for too long, and this was preventing the admission of others, so there was a whole system issue, and it should not just be the Director of Nursing and Patient Experience managing it, rather the whole executive team. Gareth Howells concurred, adding that all the executives were as responsible for finance as the Director of Finance and operationally as the Chief Operating Officer, so the same should be said for quality and safety.

Sandra Husbands commented that clinical staff needed to accept that pressure ulcers were preventable in order for the mindset to change and as such, the same was required for healthcare acquired infections in order to have engagement with the action plan, for example switching from intravenous (IV) antibiotics to oral when appropriate. Martyn Waygood queried as to whether there were significant numbers of cases where IV antibiotics were continued unnecessarily. Sandra Husbands responded that patients were given a cannula on admission as routine should there be a suspicion of infection or sepsis, however once a diagnosis had been made that it was not sepsis, oral antibiotics should be prescribed instead. She added that this did not happen as frequently as it should.

Maggie Berry queried whether infection rates were aligned with the hotspot areas identified as part of the Nurse Staffing Levels (Wales) Act 2016 as needing increased establishments. Gareth Howells advised that the health board had 23 wards to which the act applied but not all were hotspots in terms of infection control. Pam Wenger added that a mechanism needed to be identified to provide the committee with assurance in regard to hotspot areas and quality issues.

Martyn Waygood sought an update on the recruitment of an assistant

director of nursing with responsibility for infection control. Gareth Howells advised that the interviews were scheduled for later that month.

Maggie Berry queried the contribution of pre-emptive beds to infection control issues. Gareth Howells advised that such measures should only be undertaken when absolutely necessary as it added additional pressures to the wards. He added it needed to be done on a risk-based approach and length of stay needed to be addressed as a priority in response, but capacity was needed to do this.

Resolved: The report be **noted.**

128/18 STAYING HEALTHY

The staying healthy report was **received.**

In introducing the report, Sandra Husbands highlighted the following points:

- A management response had been completed following an internal audit of immunisations and vaccinations, which had raised concerns as to the structures in place;
- Issues had been raised as to the terms of reference for some of the strategic task and finish groups established to oversee immunisations and vaccinations, as well as the reporting mechanisms.

In discussing the report, the following points were raised:

Neil Thomas advised that there was one final comment to address in relation to internal audit after which the final report would be issued. Pam Wenger advised that the summary of the report would be presented to the Audit Committee in due course in line with standard governance procedures.

Maggie Berry stated that was important to have an oversight as to the risks and that anything significant should be on the risk register in order to mitigate any issues.

Resolved:

- The report be **noted.**
- The actions being undertaken to address the 18 recommendations detailed in the appendix as the senior management response to the report be **endorsed.** **SH**

129/18 TUBERCULOSIS REPORT

A report providing an update in relation to tuberculosis was **received** and **noted.**

130/18 QUALITY AND SAFETY COMMITTEE DASHBOARD

The quality and safety committee dashboard was **received.**

In introducing the report, Gareth Howells and Push Mangat highlighted the following points:

- Performance against the national early warning scores (NEWS) was 96.5% against a target of 100% and action was being taken in a number of areas to triangulate hotspots as well as an analysis as to whether the service pressures were preventing the observations being taken;
- Falls had increased by a rate of 10 and for every one which resulted in a fractured head of femur this had a cost of £15k, an increased length of stay and a mortality rate of 60%, so the falls group needed to be seen as a priority;
- Pressure ulcers had decreased compared with this time the previous year but a focus needed to be given to community cases;
- Work was continuing to address the backlog of stage two mortality reviews through a consultant on non-clinical duties.

In discussing the report, the following points were raised:

Martyn Waygood sought confirmation that hi-lo beds had been purchased to address the issue of falls following a successful bid to the Charitable Funds Committee. Gareth Howells undertook to clarify this. **GH**

Pam Wenger advised that a new monthly performance report had been developed and this would be received by the committee going forward in lieu of the scorecards.

Chris Morrell commented that in relation to serious incidents, it would be interesting to see the reporting trend over 12 months to determine if it was increasing or reducing as there needed to be a strong culture of reporting and so low numbers were not necessarily the best outcome. Sandra Husbands concurred, adding that identifying themes and system issues was also important.

Maggie Berry stated that it was important that never events and serious incidents were reviewed to ensure lessons were learned and more recent occurrences were not repeats which could have been avoided.

Pam Wenger queried whether an internal audit was scheduled of serious incidents. Neil Thomas responded that there was one planned for Datix but not serious incidents due to the external scrutiny being undertaken by the NHS Wales Delivery Unit.

Maggie Berry noted that 1,700 staff at Morriston Hospital had undertaken sepsis training and queried if this was to be made available elsewhere. Push Mangat advised that the leads for sepsis were based in Morriston Hospital and had wanted to update the training for staff, so had arranged a pilot. He added the success of this would be reviewed to determine if it was to be more widely rolled-out.

Maggie Berry referenced the three-part national pilot that the Mental

Health and Learning Disabilities Unit was participating in with relation to mortality reviews and queried if there were any results available. Pam Wenger responded that the unit was piloting it on behalf of Wales and results were yet to be collated.

Maggie Berry noted the intention to complete the stage two mortality review backlog by May 2018. Push Mangat advised that in order for this to be achieved it needed to be included in job plans to provide doctors with the time to complete them. Chris Morrell added that the work would also align with the incoming medical examiner role.

Maggie Berry commented that a reporting tool in relation to safeguarding children was due for completion by December 2018 and asked that assurance be given to the February 2019 meeting that this had been achieved. Gareth Howells advised that concerns were reported via Datix but not necessarily referred to the safeguarding team and the system would address that.

Martyn Waygood noted that 83% of complaints received a response within 30 days, which was above the Welsh Government target, but there were some outliers, so the overall result should not mask the fact that there were issues. Chris Morrell advised that some of the complaints, particularly relating to cancer or paediatrics, were complex, and required a longer period of time to investigate. She added that a significant focus had been given to the quality of responses, which also took time.

Pam Wenger queried whether it would be useful for the committee to receive a report specifically in relation to complaints performance. Gareth Howells responded that it would be useful to have that context. **GH**

Sandra Husbands stated that from the view of a complainant, if they are advised that they will receive a response within 30 days, it is frustrating for them when this was delayed without explanation and perhaps a standard acknowledgment should not be sent but rather a tailored one which outlined a more manageable timescale.

Ceri Phillips advised that a risks report had been received by the Workforce and Organisational Development (OD) Committee which outlined the insufficient numbers of staff available to manage complaints. Pam Wenger added that this was to be developed further for the board to consider.

Maggie Berry sought clarification as to where the hand hygiene figures had been derived as compliance had deteriorated. Gareth Howells undertook to clarify this as a scheme was now in place for external peer reviews. **GH**

Resolved:

- The report be **noted.**
- Clarification be sought that the hi-lo beds had been purchased to address the issue of falls following a successful bid to the Charitable Funds Committee. **GH**
- A report outlining complaints performance be received at the **GH**

next meeting.

- Clarification be sought as to where the hand hygiene figures had been derived. **GH**

131/18 PATIENT EXPERIENCE

The patient experience report was **received.**

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

- Completion of the family and friends survey had fallen and was deemed a good indicator as to how patient care was viewed;
- The number of feedback forms received was high but the reason for the deterioration needed to be investigated;
- A review by Healthcare Inspectorate Wales (HIW) had identified areas for improvement, but also that staff seemed kind and compassionate;
- 321 complaints had been received during the reporting period, which was a significant number, with a large proportion from assembly members in relation to performance and waiting times;
- Discussions had been undertaken with the Public Services Ombudsman as to how best to use the service;
- Sharing the learning from complaints needed to be a key piece of work moving forward to improve patient care;
- A way of recording informal compliments, such as thank you cards, needed to be developed.

In discussing the report, the following points were raised:

Pam Wenger complimented the report, adding that it was important to provide such feedback to the team. Martyn Waygood concurred, adding that overall, the message was pretty positive.

Martyn Waygood stated that in relation to the all-Wales questionnaire, one overarching theme appeared to be insufficient help with feeding and drinking, but it was not clear if this question had only been asked to those who required assistance. Gareth Howells undertook to clarify this as it was a clear indicator of the care provided. **GH**

Maggie Berry sought an update in regard to the three outstanding patient safety alerts. Chris Morrell advised in relation to 007, one response was awaited from the units before it could be closed. Push Mangat stated that with regard to 008, further discussions were required with the multidisciplinary team as to the process for placing a nasogastric tube before a response could be provided to Welsh Government. Pam Wenger advised feedback was needed on 030. Jane Williams added that there were several elements to the alert and one related to the use of metal cabinets rather than wooden and as it was not financially viable for health boards to replace all, metal ones

would be installed as part of capital projects.

Resolved:

- The report be **noted.**
- Clarification be sought as to whether the all-Wales questionnaire section regarding assistance with food and drink section was only asked to those who required it. **GH**
- The standard operating procedure for managing patient stories be **approved**. **GH**

132/18 CHANGE IN AGENDA ORDER

Resolved: The agenda order be changed and item 6c be taken next.

133/18 QUALITY AND SAFETY FORUM

A report providing an update from the Quality and Safety Forum was **received.**

In introducing the report, Chris Morrell advised that the forum had considered three clinical policies but the main area of discussion had focussed on whether approval should be within its remit.

In discussing the report, the following points were raised:

Pam Wenger advised that a similar discussion had taken place at the Audit Committee in relation to approval of policies as the 'policy on policies' delegated approval of such documents to board committees. She added this was unchanged for the time being, but she would be looking to develop a more robust process for the future.

Maggie Berry queried whether the broken microphone in the mortuary gallery was preventing students from observing. Chris Morrell advised that it was in the process of being repaired.

Resolved: The report be **noted.**

134/18 NEATH PORT TALBOT DELIVERY UNIT EXCEPTION REPORT

The exception report from Neath Port Talbot Delivery Unit was **received.**

In discussing the report, the following points were raised:

Pam Wenger advised that the committee needed to work to a position whereby it received an exception report from all the units at every meeting, which had been considered in detail by the forum first. Chris Morrell responded that this was currently being reviewed.

Maggie Berry complimented the initiative of the unit to use the Patient Advisory and Liaison Service (PALS) to support patients to complete the friends and family questionnaires in their own home. She added that she was working with the Interim Deputy Director of Nursing and Patient Experience to ensure the various PALS teams were working

consistently, and how best to develop the service for mental health and learning disabilities and primary and community care.

Chris Morrell stated that the health board had a number of quality priorities which differed to those outlined within the report. She added that work was required to determine what was measurable for the board-wide priorities.

Martyn Waygood noted that a large proportion of the complaints received by the unit related to the minor injury unit (MIU), particularly about staff attitude and the information provided to patients as to the scope of the service. He queried if there was a possibility of the MIU signposting patients to a more relevant service if not appropriate for there, for example GP out-of-hours. Sandra Husbands responded that the unscheduled care service at the unit was misunderstood by service users and this needed to be more widely discussed by the unscheduled care board. Gareth Howells concurred and undertook to discuss this further with the unit. **GH**

Maggie Berry referenced the data breach highlighted within the paper, adding that the learning needed to be shared more widely. Pam Wenger advised that such instances were discussed at the information governance board.

Resolved:

- The report be **noted.**
- Discussions relating to the MIU be raised with the unit. **GH**

135/18 CLINICAL OUTCOMES GROUP – CLINICAL AUDIT ANNUAL REPORT

The clinical audit annual report was **received.**

In introducing the report, Push Mangat highlighted the following points:

- The committee received a regular update in relation to the clinical outcomes group's activity but this was a summary of the past year;
- Alongside the national audits, some patient safety reviews were also undertaken;
- Primary care had its own audit process for GPs which did not align with health board processes and discussions were needed with the unit medical director to determine to where these were reported.

In discussing the report, the following points were raised:

Maggie Berry advised that she attended the clinical outcomes group as an observer and her biggest concern was the lack of attendance by the delivery units. She queried whether this would improve if more of a focus was given to local audits and if this would encourage better completion rates of such work. Push Mangat responded that local audits were reported to the units as it would be difficult to manage

these corporately given the resources available.

Chris Morrell stated that the membership of the clinical outcomes group was predominantly medical while nursing staff attended the assurance and learning group. She added that the group needed to expand its membership more widely and consideration needed to be given to it reporting to the Quality and Safety Forum. Push Mangat advised that other professionals were included within the group's terms of reference and were welcome to attend.

Sandra Husbands commented that expanding the scope and participation of the group was the right course of action to take but it was also important that staff viewed the group as a priority and as a way to learn from different specialities. She added that while the corporate team should not be responsible for local audits, they should still be reported to the clinical outcomes group, as it would ensure that they were undertaken for the right reasons and were completed.

Resolved: The report be **noted.**

136/18 EXTERNAL INSPECTIONS

A report providing an update in relation to external inspections was **received.**

In discussing the report, the following points were raised:

Nia Roberts advised that HIW was still awaiting a report or correspondence in relation to the MIU at Neath Port Talbot Hospital. Pam Wenger asked that she be sent a copy of the original letter from HIW in order to follow-this up. **NR**

Pam Wenger stated that there were a variety of ways in which to capture the results and recommendations of external reviews and she was working to develop something for the health board. Carol Moseley added that she had shared an example with Pam Wenger which enabled recommendations to be allocated to the relevant board committees for monitoring.

Martyn Waygood commented that it was pleasing to see that the recent external reviews at Cefn Coed Hospital had found the care to be good but assurance was needed that the concerns raised would be addressed. Gareth Howells advised that in his first few weeks, he had spent time at the mental health facilities at Glanrhyd Hospital and felt more assured by these than those at Cefn Coed Hospital. He added there was a lot of good work at the hospital, but it needed to be of the same standard as others.

Resolved:

- The report be **noted**.
- A copy of the original HIW letter sent in relation to the MIU at Neath Port Talbot Hospital be provided in order for a response to be followed-up. **NR**

137/18 RATIFICATION OF CLINICAL POLICIES

A report seeking ratification of clinical policies was **received.**

In introducing the report, Pam Wenger advised that it was putting forward the three policies considered by the Quality and Safety Forum for approval and a proposal that the forum be able to approve policies going forward for the committee to ratify in order to separate operational business from assurance was being considered.

In discussing the report, the following points were raised:

Sandra Husbands commented that on occasion, people referred to procedures as policies and clarity was needed as to the purpose of such documents. She added that the pressure ulcer policy appeared to be more procedural. Paula O'Connor advised that the policy was upfront with the corresponding procedure behind it to make searching easier.

Resolved:

- The report be **noted.**
- The following policies be **approved:** **GH**
  - policy for the prevention and management of pressure ulcers
  - clinical policy for the insertion and maintenance of nasogastric (or orogastric) feeding (and draining) tubes in adults
  - policy and procedure for the prevention and management of adult inpatient falls clinical policies for approval by the committee

138/18 QUALITY AND SAFETY COMMITTEE TERMS OF REFERENCE

The committee's terms of reference were **received.**

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

- Following the NHS Wales Delivery Unit review of serious incidents, the committee's membership had been widened to include the Chief Operating Officer;
- The Director of Finance was attending the next meeting to observe.

Resolved:

- The report be **noted.**
- The revised terms of reference be **approved.** **GH**

139/18 NURSE STAFFING LEVELS (WALES) ACT 2018

A report providing an update in relation to the Nurse Staffing Levels (Wales) Act 2018 was **received** and **noted.**

140/18 ANY OTHER BUSINESS

(i) Medical Director

Push Mangat advised that he would be leaving the organisation the following month to take up a new post with Health Education and Improvement Wales. He added that until a substantive Medical Director was appointed, three interim deputies had been appointed who would share responsibilities for board committees. Maggie Berry thanked Push Mangat, on behalf of the health board, for his hard work and commitment to the committee.

141/18 NEXT MEETING

This was scheduled for 4th October 2018.

142/18 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.