Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
27th September 2022
at 1.30pm via Microsoft Teams

Present
Steve Spill, Vice-Chair (in the chair)
Jackie Davies, Independent Member
Patricia Price, Independent Member

In Attendance
Christine Morrell, Director of Therapies and Health Science
Gareth Howells, Director of Nursing and Patient Experience
Richard Evans, Medical Director
Hazel Lloyd, Acting Director of Corporate Governance
Hazel Powell, Deputy Director of Nursing
Scott Howe, Healthcare Inspectorate Wales (until 232/22)
Michelle Walters, Healthcare Inspectorate Wales
Ross Hughes, Internal Audit
Liz Stauber, Head of Corporate Governance
Kimberly Hampton-Evans, Care After Death Service Manager (minute 227/22)
Mark Ramsey, Service Group Medical Director, Morriston Hospital (from minute 227/22 to 230/22)
Kate Hannam, Service Group Director, Morriston Hospital (from minute 227/22 to 230/22)
Martin Bevan, Service Group Medical Director, Singleton and Neath Port Talbot (for minutes 229/22 and 230/22)
Delyth Davies, Head of Nursing - Infection Prevention and Control (for minutes 229/22 and 230/22)
Anjula Mehta, Service Group Medical Director, Primary, Community and Therapies (for minutes 229/22 and 230/22)
Emily Davies, Head of Nursing, Primary, Community and Therapies (for minutes 229/22 and 230/22)
Deb Lewis, Deputy Chief Operating Officer (minute 231/22)
Meghann Protheroe, Head of Performance (minute 232/22))

Minute No.		Action
221/22	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting. Apologies for absence had been received from Reena Owen, Independent Member, Maggie Berry, Independent Member, Inese Robotham, Chief Operating Officer,	

	Siân Harrop-Griffiths, Director of Strategy and Sue Evans, Community Health Council.	
222/22	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
223/22	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 23rd August 2022 were **received** and **confirmed** as a true and accurate record.	
224/22	**MATTERS ARISING**	
	There were no matters arising not otherwise on the agenda.	
225/22	**ACTION LOG**	
	The action log was **received** and **noted**.	
226/22	**WORK PROGRAMME 2022-23**	
	The work programme was **received** and **noted.**	
227/22	**PATIENT STORY: CARE AFTER DEATH TEAM**	
	A presentation setting out the work of the care after death team, including the stories of three families supported by the service, was **received.** In introducing the presentation, Kimberly Hampton-Evans highlighted the following points: - The care after death team was a new service, established in preparation for the expected high number of deaths due to the pandemic, with the aim of support patients' families; - It was also in response to the requirements of the medical examiners' service; - The business case had been approved in 2021 for the full team which had since been appointed; - Welsh Government had developed a framework for the delivery of bereavement care but the health board was already in advance of this; - The service was available seven days a week;	

- Families were proactively contacted when patients died in hospital;
- Referrals could also be received for unexpected deaths in the community;
- The offer of support from the service was dual purpose – practical, to go through all the things families needed to do in response to a death and emotional to discuss what support was available;
- Contact was a combination of face-to-face, telephone call, video calls and a condolence care was also sent;
- Support was also available for staff for personal bereavements, patient bereavements or to support families;
- Three patient stories were shared, all of which had very different needs, and demonstrated how adaptable the service needed to be to support everyone who needed it
- Since 1st October 2021, 1,963 families of inpatients had been supported;
- 308 referrals for unexpected deaths in the community had been received since March 2022;
- Two staff debriefs had taken place – one for a patient's death and the other for a staff member;
- 12 members of staff had been supported by the service to date;
- The service was the only one of its kind in Wales and the health board was leading the way.

In discussing the presentation, the following points were raised:

Steve Spill showed an interest in the professional backgrounds of the team. Kimberly Hampton-Evans responded that it varied from a funeral services, occupational health, mortuary and NHS patient affairs. In-house training was provided around the counselling provision the service could provide as it was not a counselling service. The support it provided was immediate and preventative when people needed to avoid it turning into something more traumatic. It was important people understood that grief was not a mental illness and everyone would be affected at some point.

Christine Morrell stated that that the service was a great addition to the health board and put it in a good position with Welsh Government's national framework, being set as an exemplar on which to provide such a service. A significant amount of work had been undertaken to ensure the service met the needs of the medical examiner and was ready to take on primary care, which was the next phase. The team had achieved a significant amount in the last year, which was a good news story for the health board.

Gareth Howells commented that the progress of the team had been phenomenal. When a loved ones died, relatives were rarely able to think clearly, so it was beneficial to have such a service to guide them through it. It was important that the scope of the service covered the breadth of the health board, with momentum gained in the emergency department.

	Hazel Powell advised that such a service normalised grief and bereavement, which was a positive. On behalf of the committee, Steve Spill thanked Kimberly Hampton-Evans and the team for all that it did to support the bereaved. It was a fantastic and unique service.	
Resolved	The patient story was **noted.**	
228/22	**SERVICE GROUP HIGHLIGHT REPORT – MORRISTON HOSPITAL**	
	The highlight report from Morriston Hospital was **received**. In introducing the report, Mark Ramsey highlighted the following points: – A lot of the quality and safety issues at Morriston Hospital related to urgent and emergency care and ambulance waiting times as well as overcrowding in the emergency department; – There were also links with infection control and the high numbers of clinically optimised patients; – The operational pressures meant it was challenging to get urgent, planned care cases treated and a significant amount of the complaints received by the service group related to waiting times, with a high number referring to the Public Services Ombudsman; – Good patient feedback was being received, achieving 84%, but this needed to improve as the service group usually achieved more than 90%; – The medical examiner service had been rolled out across the site except for the intensive care unit; – Two never events had been reported and investigations were underway; – The Datix legacy system had been closed; – The service group had completed its scrutiny process for the health and care standards and the only change in scores had been a decrease in dignified care from four to three due to overcrowding and patients being too close together; – Complaint numbers had increased by 40%, 73% of which were responded to within the required 30 days (national target was 75%), however the level of resources had not increased which made it challenging; – Work was ongoing with an external company to pilot specialist technology to support the reduction in healthcare acquired infections and a feasibility study was to take place on wards A and B;	

	– A stronger framework had been put in place around clinical audit which included a digital structure; – The acute medical services redesign programme was now in the implementation phase; – E-prescribing was being rolled out with the exception of the emergency department and intensive care unit; – SIGNAL version three implementation had been delayed but work was continuing with the electronic nursing documents system; – A number of external visits had taken place including the Royal College of Surgeons and Healthcare Inspectorate Wales, the reports for which were being considered and action plans developed; In discussing the report, the following points were raised: Anne-Louise Ferguson stated that patients/families tended to refer to the Public Services Ombudsman when they were unhappy with the response they received to a complaint. She queried if there was any indication as to what families were discontent in terms of the health board's responses. Mark Ramsey responded it tended to relate to waiting times for surgery as, given the significant operational pressures at Morriston Hospital, the service group was unable to give an indication as to when patient may receive their procedure. Anne-Louise Ferguson advised that it was important that all responses to the Public Services Ombudsman were consistent in this regard to ensure some patients did not have further causes for complaint. Hazel Lloyd provided assurance that the health board regularly met with the Public Services Ombudsman, part of which included reviewing themes from complaints and also briefing the regulator on the organisation's short, medium and long-term plans. She added that while a number of complaints were being referred to Public Services Ombudsman, not all were being investigated. Steve Spill noted that Morriston Hospital had the highest level of healthcare acquired infections and sought an update on its eight-week rapid improvement plan. Mark Ramsey responded that a significant amount of work was being undertaken within the service group. It had been identified that rapid reviews were not being undertaken consistently when infections were reported so a system was now in place whereby the consultant in charge of the patient's care was informed and involved in the improvement plan from the outset. All documents relating to the case were also made available so all the information was in one place. *Staph.auerus* infections were the ones over which there was the most control as many related to devices inserted into patients, such as a cannula or venflon. A targeted piece of work had been undertaken with renal services and progress made in terms of arteriovenous (AV) fistulas. Focus was also been given across all services to ensure cannula bundles were being completed on a daily basis. If all basic standards were met, this should lead to a reduction in	

	cases. *Clostridum.difficile* was more difficult to target and each one had to be reviewed to determine if was avoidable, as not all were and the service group needed to do all it could to prevent those that were. Healthcare acquired infections were heavily scrutinised within the service group now and the Chief Executive was due to visits the wards with the highest incident numbers in early October 2022 to see how engaged the clinical teams were with the work needed.	
Resolved:	- The service group highlight report from Morriston Hospital be **noted.**	
229/22	**UPDATE ON HEALTH BOARD'S INFECTION CONTROL PLAN**	
	A report providing an update on the health board's infection control plan was **received.** In introducing the report, Delyth Davies highlighted the following points: - The current position was not where it needed to be but a reduction in *clostridium difficile* and *e.coli* cases had been evident. There had also been a small reduction in *staph.aureus* cases but *klebsiella* was on the increase; - The rise in *klebsiella* cases was potentially linked to an increase in hepato-biliary disease; - A peak of *clostridium difficile* cases had been seen during the summer but the position was better this month; - No *e.coli* or *klebsiella* cases had been reported in Morriston Hospital during September 2022; - A rapid improvement plan was in place for Morriston Hospital which included standardising the scrutiny process; - The intelligence available was being refined to understand which cases were avoidable/unavoidable to enable an improved focus on the themes and activities which would affect a change; - A digital dashboard was under development with a view to a testable version being available in December 2022. In discussing the report, the following points were raised: Gareth Howells queried the two key areas on which traction was needed. Delyth Davies responded that reviews of invasive devices needed to be 'smarter' as when these were removed in a timely way, the risk of infection was reduced. She added that training attendance remained challenging and there also needed to improved clinical attendance at ward level for the rapid reviews. It was important people understood their responsibilities as improving the position was in the health board's gift.	

	Jackie Davies asked whether workforce constraints had an impact on infection rates. Delyth Davies advised that some of the wards covered by rapid improvement plans were heavily reliant on temporary staff and this did make a difference. She added that it meant that fewer staff were attending the basic training which reduced the skill-level on wards. Patricia Price queried whether there was confidence that the sufficient quality data was available to put actions into place. Delyth Davies responded that progress was being made in this area and the infection control team was monitoring things to develop an idea of trends, but it was not easy at a ward level, and not all would be linked to clinical infections, as some would be acquired in the community by patients living in other health board areas admitted to Morriston Hospital emergency department. Patricia Price queried if it was possible for infection control training to be monitored through the electronic staff record (ESR). Delyth Davies responded that manual training lists had had to be created to demonstrate improvement. Gareth Howells suggested that the issue be referred to the Workforce and OD Committee as this was a critical part of the business intelligence. This was agreed. Richard Evans commented that while the infection control was being refreshed, it was becoming more apparent that while environment was a factor in infection rates, there was also a level of best practice that should be expected and these were more measurable. Mark Ramsey agreed, adding that there were simple things which all staff should be doing, such as hand hygiene requirements and checking cannula bundles, as standard.	**SS/LS**
Resolved:	- The report be **noted;** - The challenges around infection control training on ESR be referred to the Workforce and OD Committee.	**SS/LS**
230/22	**SERVICE GROUPS' INFECTION CONTROL PLANS**	
	Progress reports on two of the services groups' infection controls plans were **received.** **(i) Singleton and Neath Port Talbot** In introducing the report from Singleton and Neath Port Talbot Service Group, Martin Bevan highlighted the following points: - In Neath Port Talbot Hospital, there has been a reduction in *clostridium difficile* and *e.coli* cases, an increase in *klebisiella* and *staph.aureus* and *pseudomonas* had remained unchanged; - However there had been a rise in all infections at Singleton Hospital;	

- Fortnightly scrutiny panels were in place which included ward staff;
- The service group had launched its infection control plan in May 2022 and presented it to a physicians' meeting the following month;
- A high-level of scrutiny was in place for *clostridium difficile,* with a bi-weekly meeting of cases presented by the clinician/lead nurse to the service group medical and nurse directors. This was an opportunity to deep dive for learning but the frequency may increase due to the time needed for each case;
- More engagement was needed from medical staff;
- Training compliance with level two infection control training was low as many clinical staff were unaware they were required to complete it;
- There was an issue with reporting hand hygiene performance and compliance was higher than shown, but there was room for improvement;

In discussing the report, the following points were raised:

Steve Spill queried why clinical staff were unaware of the requirement to complete level two infection control training. Delyth Davies responded that the national framework made level one training mandatory for all staff and this was managed through ESR. However, clinical staff were also required to complete level two, but the ESR system did differentiate between those who needed level two and those who did not, there was no prompt for those who should be completing it.

Steve Spill commented that there was a significant difference in case numbers between the two hospitals within the service group. He added that there was also a massive difference in the environment of the two sites but queried if there was any learning which could be taken from Neath Port Talbot Hospital. Martin Bevan responded that Singleton Hospital treated a number of patients with chemotherapy which left them highly vulnerable to infection, plus there were no acute patients at Neath Port Talbot Hospital, which also impacted the numbers as did the overcrowding in Singleton Hospital. Delyth Davies added that Neath Port Talbot Hospital had a higher proportion of single rooms and all multi-bed rooms had an ensuite, with the maximum occupancy of any these rooms being four.

(ii) **Primary, Community and Therapies**

In introducing the report, Anjula Mehta highlighted the following points:

- The current position within the service group was an improvements, with reductions seen in *clostridium difficile, e.coli* and *staph.aureus;*

	- A shift in focus has been given resulting in a 26% reduction in *e.coli* cases and the same attention was to be given to *clostridium difficile;* - Education and training was a key part of the improvement work and this was to be shared with independent contractors with a visiting programme in place for high-risk areas; - A task and finish group, led by the clinical lead for infection prevention and control, was rolling out best practice for urinary tract infections (UTIs) treatment and prevention; - Scrutiny panels were in place for *clostridium difficile* cases and deep dives undertaken to identify common themes. Consideration was now needed as to how to feed these back and provide targeted support for care homes though a supportive discussion; - Data was improving; - Resources were being reviewed to consider the pace at which the improvement work was being delivered; - Clinical engagement continued to be a challenge, as did current operational pressures and estates. In discussing the report, the following points were raised: Anne-Louise Ferguson queried if it was difficult to keep staff training current given the high turnover. Anjula Mehta commented that turnover was particularly high within care homes and there was little opportunity to provide sufficient training before some recruits moved on and there was also a high level of agency staff. In addition, GPs relied on locums which often meant some things were done differently. Steve Spill referenced the collaborative approach between the service group and central infection control team and sought further details. Emily Davies responded that the infection control team had provide a temporary dedicated resource for primary and community care and mental health services, and supporting with care homes was part of this remit when notifications were received of an infection within one to draw out any learning for the scrutiny panel. It was important not to just educate staff but to communicate through all services to see reductions. Delyth Davies added that while the infection control team was content to provide additional support for the care homes, this did reduce the number of resources available to acute services, but there was confidence that the work would yield results. It was also hoped that a process could be built to provide GPs with all the information required should a patient contract a healthcare acquired infection before they were discharged, especially if returning to a care home, to reduce the transmission.	
Resolved:	The services groups' infection control plans update be **noted.**	

231/22	**CLINICALLY OPTIMISED PATIENTS**	
	A report providing an update on the clinically optimised patients position was **received.** In introducing the report, Deb Lewis highlighted the following points: - At the time of the meeting, there were currently 315 clinically optimised patients across the sites, the majority of which were in Morriston Hospital, closely followed by Singleton Hospital; - To date, 236 transitional care home beds had been used, with 51 currently occupied; - Reducing the number was a key priority for the Chief Executive through the acute medical services redesign (AMSR) programme; - Colleagues from the Welsh Ambulance Service NHS Trust (WAST) had been reviewing the call stack for a number of months and this continued to have a positive impact but the process of signposting more appropriate alternative services to the emergency department needed to become more automatic; - A home visiting scheme was in development with WAST and a proposal had also been submitted to Welsh Government for the same day emergency care centre (SDEC) so patients could be reviewed at home and if necessary conveyed to the SDEC/older person's assessment service to reduce the number of lost hours in the system; - An in-reach service was being implemented for the virtual wards, which were in all eight clusters now, which identified patients waiting in the emergency department who could be better supported by a virtual ward at home rather than a hospital admission. It was currently seeing between six to eight patients a day through this route; - An increased focus was being given to clinically optimised patients rated either red or amber, with PSDA (plan, do, study, act) cycles commencing in August 2022 for four weeks. These were to be extended for a further four weeks. Weekly meetings took place for both patient groups to increase the numbers being discharged; - A more comprehensive plan was being developed to share with the Management Board and each service group had been asked to nominate a lead to attend the meetings; - A flow-chart to set out the discharge process was in development to assist more junior ward managers; - Proposals were to be developed for a central discharge team rather than training every ward manager as to how to complete	

	the process for complex patients. This would also provide a single point of contact for care homes and local authorities; In discussing the report, the following points were raised: Steve Spill queried the current status of the health board's relationship with the local authorities. Deb Lewis responded that engagement through the weekly meetings was good but the challenge was understanding what was the responsibility of a local authority and what sat with the health board. A manual was to be drafted to clearly define the roles and maintain the good working relationship. Gareth Howells stated that 315 clinically optimised patients was the equivalent of 10 wards and consideration was needed as to the key things the organisation needed to do to reduce the numbers. If the high numbers were addressed, this could potentially be a game-changer for the organisation. Deb Lewis concurred, adding that a communications package was in development to share with patients at the front door to set out the process should they need care packages on discharge, rather than waiting until closer to the time to have the difficult discussions.	
Resolved:	The report be **noted.**	
232/22	**QUALITY AND SAFTEY PERFORMANCE REPORT**	
	The quality and safety performance report was received. In introducing the report, Meghann Protheroe highlighted the following points: - There were currently 217 cases of Covid within the hospitals, which was a reducing from July 2022; - Staff Covid sickness had reduced to 1%; - Performance against the four-hour urgent and emergency care target had improved but the 12-hour wait deteriorated; - The urgent and emergency care trajectories were on target with work on the pathways ongoing; - No new never events had been reported; - There had been increase in the number of patients waiting more than 26 weeks for a new outpatient appointment but a reduction in the 36-week, 52-week and 104-week waits and activity plans had been shared with Welsh Government; - The number of people waiting more than eight weeks for diagnostics had increased whereas there had been a reduction in those waiting more than 14-weeks for therapies; - Performance against the single cancer pathway had improved to 56% but was still below trajectory and there had been a slight increase in the number of backlog cases; - Patient feedback had decreased slightly in terms of those who would recommend health board services and there had been an	

	increase in the number of complaints in May, which was the latest data available; - Access to adult mental health services and child and adolescent mental health services continued to meet the targets but neuro-developmental services performance had deteriorated slightly. In discussing the report, Gareth Howells stated that patients were waiting a significant amount of time waiting either in the back of an ambulance or on a trolley for an admission into the emergency department which was leading to pressure ulcers. It was important make the link with when the harm occurs, and pressure ulcers would be a priority for 2023-24.	
Resolved:	The report be **noted.**	
233/22	**EXECUTIVE SUMMARY OF THE PATIENT SAFETY GROUP**	
	A report providing the executive summary from the recent meeting of the Patient Safety Group was **received.** In introducing the report, Hazel Lloyd highlighted the following points: - The terms of reference for the group had been agreed and subsequently ratified by the Management Board; - The group had received a update on the quality summit; - The sub-groups of the group did not meet in August 2022 and neither did the Quality Priorities Programme Board as it was not quorate; - The need for a quality dashboard had been discussed and this was in development; - A programme of activities had taken place in September 2022 for the quality priorities to recognise associated national days, such as falls prevention day although some had been delayed to October 2022 following the death of Her Majesty, the Queen; In discussing the report, the following points were raised: Steve Spill queried how well the new arrangements were working. Hazel Powell responded that there was still work that needed to be done to reach a level of 'business as usual' but the groups were 'bedding in' nicely. Gareth Howells added that there had been a real positive discussion at the last meeting and it was also pleasing to see the sub-groups developing. The gap which now needed to be addressed was to replicate the arrangements within the service groups to ensure a degree of robustness from ward to board. Momentum was gathering around the quality strategy and this had been discussed within the group in advance of it being received at the September 2022 board meeting. Steve Spill sought assurance as to the confidence that the group would be able to identify potential issues early on. Gareth Howells responded	

	that confidence was increasing but there was still more work needed on a divisional level. However it should be noted that within a short space of year, the amount information on which the executive team was sighted had now increased. Hazel Powell concurred and cited as an example the recent Healthcare Inspectorate Wales (HIW) review of another health board's emergency department. The group had taken the opportunity to review an assessment of Morriston Hospital's emergency department against the recommendations made as a self-assurance programme to ensure confidence in responding to safety risks.	
Resolved:	The report be **noted.**	
234/22	**CLINICAL OUTCOMES AND EFFECTIVENESS**	
	A report providing an update on the clinical outcomes and effectiveness work was **received.** In introducing the report, Richard Evans highlighted the following points: - This was the mid-year review of clinical outcomes and effectiveness; - The clinical audit plan had been refreshed and different activities applied across the health board; - Focus had also been given to national guidance as well as NICE (National Institute for Clinical Excellence) guidance, with a self-assessment process undertaken to ensure compliance; - Work was being undertaken to determine what statistics were held around mortality, with the informatics team developing a dashboard to better understand the information available. In discussing the report, the following points were raised: Anne-Louise Ferguson noted the list of themes identified by the medical examiner reviews and queried how these could be captured and used to develop learning. Richard Evans responded that the mortality group collated the information for the service groups to consider and develop actions plans as appropriate. Casenotes were also reviewed to determine where the health board was an outlier for mortality to see trends and themes. Data accuracy still needed to be improved and the coding process needed to be reviewed to make sure the right information was being recorded. Communication was a common theme but it was a complicated one as it was challenging to know if the communication was the issue as was the cause of death or the family has concerns over the communications process with it. Christine Morrell added that there was also a regular panel meeting aligned with the medical examiner process which ensured all the necessary arrangements were triangulated for example complaints data and care after death services. Hazel Lloyd confirmed that the concerns team was also a part of that group and as part of the refresh of the quality	

	management arrangements, a patient congress had been established to ensure communication was at the heart of everything. Pat Price queried the types of these emerging from the medical examiner reviews. Richard Evans advised that these would vary as the majority were undertaken by GPs who would have particular questions for specialist surgeries as these were areas with which they were unfamiliar. Generally they identified areas in which treatment could have been improved.	
Resolved:	The update in relation to external reviews and the health board responses to issues raised be **noted.**	
235/22	**2021-22 ANNUAL LETTER FROM THE OMBUDSMAN**	
	The 2021-22 annual letter from the Public Service Ombudsman was **received.** In introducing the report, Hazel Lloyd highlighted the following points: - There had been an increase in the number of cases referred to the Public Services Ombudsman and being investigated. However only 11 had been upheld in the last year; - The learning from each of the cases could be reviewed at a future patient safety congress; - Work continued to improve communications training; - There appeared to be an increase in the number of referrals due to the way in which complaints had been handled therefore the training around complaints handling was also to be increased. In discussing the report, Gareth Howells stated that the health board continuously worked hard to maintain a positive relationship with the Public Services Ombudsman, who continued to provide training and regular catch-up meetings.	
Resolved:	- The report was **noted**.	
236/22	**WHSSC JOINT COMMITTEE KEY ISSUES REPORT**	
	The WHSSC joint committee key issues report was **received** and **noted.**	
237/22	**ITEMS TO REFER TO OTHER COMMITTEES**	
	(i) Infection Control Training	

	Members agreed to refer the concerns around compliance with infection control training and the issues surrounding ESR to the Workforce and OD Committee.	
238/22	**ANY OTHER BUSINESS**	
	There was no further business and the meeting was closed.	
239/22	**DATE OF NEXT MEETING**	
	The date of the next meeting was confirmed as 25th October 2022.	