Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
22nd February 2022
at 1.30pm via Microsoft Teams

Present
Steve Spill, Vice Chair (in the chair)
Reena Owen, Independent Member

In Attendance
Gareth Howells, Interim Director of Nursing and Patient Experience
Richard Evans, Medical Director
Siân Harrop-Griffiths, Director of Strategy
Chris Scott, Internal Audit
Paul Stuart Davies, Assistant Director of Nursing
Michelle Walters, Healthcare Inspectorate Wales
Sue Evans, Community Health Council
Alison Clarke, Assistant Director of Therapies and Health Science
Liz Stauber, Head of Corporate Governance
Georgia Pennells, Corporate Governance Administrator (until minute 32/22)
Steve Jones, Service Group Nurse Director, Mental Health and Learning Disabilities (for minutes 22/22 and 23/22)
Delyth Davies, Head of Nursing for Infection, Prevention and Control (for minute 30/22)
Darren Griffiths, Director of Finance (for minute 31/22)
Lesley Jenkins, Service Group Nurse Director, Singleton and Neath Port Talbot (for minute 32/22)
Jane Phillips, Group Head of Quality Improvement (for minute 32/22)
Vicki Burridge, Head of Nursing, Children's Services (for minute 32/22)
Kate Hannam, Service Group Director, Morriston (for minute 33/22)
Rebecca Davies, Matron, Morriston Hospital (for minute 33/22)
Neil Thomas, Assistant Head of Risk and Assurance (for minute 34/22)

Minute No.		Action
22/22	**PATIENT STORY: MENTAL HEALTH AND LEARNING DISABILITIES**	
	A story was **received** which set out the way in which Dechrau Newydd, the dialectical behaviour therapy (DBT) team**,** had adapted its way of working in response to the pandemic. The team work with people with mental health conditions prone to self-harm and/or suicidal thoughts to help them manage their emotions. There were 16 patients under the team's care at the start of the pandemic, all of whom had to move to a	

	telephone service at short notice, which was challenging and hard to motivate. The team quickly developed virtual group sessions for which good feedback was received. There were challenges to this when a service user did not want to participate or abusive to others within the group. In this instance, they were removed from the virtual session and had a one-to-one call to work through what was causing the behaviour. The team checked in with one another regularly, as it was a difficult role to work in given the challenging behaviours of the service users. This had an emotional affect on staff, and all were encouraged to take time-out during the day for breaks. In discussing the patient story, the following points were raised: Steve Spill queried what a standard DBT session comprised. Steve Jones advised that it differed between each one as the team adapted to meet the needs of the service users. There was even variation as to whether sessions were held indoor or outdoor, as walking therapy proved to be beneficial for some. There was now a mix of virtual and face-to-face sessions taking place. Gareth Howells commended the adaptability of the health board's teams during the pandemic and queried whether there had been any change in service user outcomes due to virtual working. Steve Jones responded that it was still early days as the first year had been a significant learning curve to regulate the process and understand the needs of service users. It was a difficult arena in which to work as some service users were non-verbal and there were also the softer sides to the therapy to provide. Work now needed to commence to develop indicators to measure the impact of the work. Reena Owen asked whether there was support in place for the families of services users. Steve Jones advised that this was often an area which was underplayed as many did not realise the impact such behaviours had on loved ones. There were carers' forums and networks available, but the core business for the team and the service group was the individuals, and any inclusion of families had to be with their permission. The team was excellent at drawing in the family network as this was key to service users' safety.	
Resolved	The patient story was **noted.**	
23/22	**SERVICE GROUP HIGHLIGHT REPORT – MENTAL HEALTH AND LEARNING DISABILITIES**	
	The highlight report from the Mental Health and Learning Disabilities Service Group was **received**. In introducing the report, Steve Jones highlighted the following points: - The backlog of serious incidents had been addressed with one case remaining from the 120 recorded in December 2020;	

- Training had been provided to investigators, resulting in improved reports;
- Now that the backlog had been addressed, the staff recruited to undertake the work would be asked to focus on other high-risk areas, such as Public Sector Ombudsman cases;
- The number of court of protection cases was having a significant impact on staff resources as many were learning disability service users who were already subject to a deprivation of liberty safeguard. A review of additional resource needed was to be undertaken;
- Work continued to implement the Welsh Communuity Clinical Information System (WCCIS) but this did have some challenges;
- The anti-ligature work was ongoing but had been delayed by six weeks due to staff availability. Assurance had been provided from Cwm Taf Morgannwg University Health Board as to the Glanrhyd Hospital site in which some Swansea Bay services were provided;
- Progress was being made against the five quality priorities set out in the annual plan 2021-22:
    - The service group was the host for the suicide prevention workstream and a lead had been appointed, who was already making progress;
    - It had been recognised that staff could also be patients and consideration was being given to the work needed to reduce their risk of suicide, especially as this had been intensified by the pandemic;
    - Funding had been secured through an arts grant to create a self-help group for suicide prevention;
    - The number of falls within the service were too high, but the majority were related to those within older person's mental health services with diminished cognitive functions. A commitment had been made to reduce these by 20% with a focus being given to improving the environment, such as lighting;
    - The service group was in a good position with healthcare acquired infections (HCAIs) and had no reported cases, but there were some staff still to complete the training;
    - Cases of sepsis were rare but the National Early Warning System (NEWS) was used to identify patients deteriorating;
    - End-of-life care required some improvements and work was taking place to identify champions across the services;

	• Using mental health improvement funds, the service group created its own patient feedback team and the increase in responses had been phenomenal; • The temporary closure of one of the wards at Tonna Hospital had gone smoothly with all staff redeployed to other services, and patients transferred to another appropriate ward or site. In discussing the report, the following points were raised: Reena Owen stated that historically, the health board's suicide rates had been quite high and queried if there was learning from other organisations that could be taken. She also asked how the service group linked in with prison services to support people upon release. Steve Jones advised that previously, the rates in Neath Port Talbot had been the higher ones and both local authority areas were now in-line with national parameters. He added that in order for prevention work to be successful, it needed to be a collaborative approach. There was a multi-agency rapid response to suicide group, which also looked at the impact on those who survived their attempts, to take forward learning from incidents. Prisons would be included in this and had links to secondary care services as well as an in-reach team. Reena Owen sought further details as to the service provision at Tonna Hospital. Steve Jones responded that there were two older person wards, an integrated autism service, mum and baby unit as well as community and outpatient teams. He added that there was also outside space for patients to use, including a sensory garden. Steve Spill noted that the health board had a statutory requirement to only report to Welsh Government the deaths of service users where the health board was not a contributing factor. He queried if the investigators were independent enough from clinical staff to make this judgement. Steve Jones confirmed that they were, adding that there was a range of expertise in the team and the findings from investigations were then reviewed by other senior clinicians as a sense check. The clinical teams were committed to learning from incidents, whether the findings be good or bad. Gareth Howells added that he signed off all the reports and there were definite signs that the investigations were more patient centred, focused on outcomes and action, but written in a way that was kind. Steve Spill recognised the low HCAI rates and queried if there was any learning that could be taken by the other service groups. Steve Jones responded that infection prevention and control had been a priority of the service group initially as patients were rarely physically unwell and when they were, they were most likely transferred to an acute site for treatment. As such, all staff had undergone rigorous training so best practice now embedded. In addition, outbreaks were investigated quickly to identify the source and reduce the risk of further exposure.	
Resolved:	The report be **noted**	

24/22	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting, noting apologies for absence had been received from Christine Morrell, Director of Therapies and Health Science and Maggie Berry, Independent Member.	
25/22	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
26/22	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 25th January 2022 were **received** and **confirmed** as a true and accurate record.	
27/22	**MATTERS ARISING**	
	There were no items raised.	
28/22	**ACTION LOG**	
	The action log was **received** and **noted**, with an action taken for the section on 'actions included within reports' to be reviewded.	**LS**
29/22	**WORK PROGRAMME**	
	The work programme was **received** and **noted.**	
30/22	**INFECTION PREVENTION AND CONTROL AND RECRUITMENT AND RETENTION UPDATE**	
	A report providing an update in relation to infection, prevention and control was **received**. In introducing the report, Delyth Davies highlighted the following points: - The service had been feeling the impact of the Omicron variant of Covid-19 during January 2022, with outbreaks on 13 wards at Morriston Hospital and three within mental health; - It remained difficult to close wards completely in response to outbreaks due to operational pressures, therefore risk-based mitigation strategies were being used to admit people with co-morbidities safely; - The uptake of the flu vaccine offer had not improved but only 21 cases had been identified per month;	

	- HCAI levels were currently under the expected trajectory, which was promising, and there was cautious optimism this would remain the case for the rest of the month; - An analysis of cases across the service groups had been undertaken and five wards at Morriston Hospital identified for a more focussed piece of work; - Work was continuing to progress the business case for a sustainable vaccination and immunisation service; - A primary care lead was now in place for infection control; - Recruitment to the vacant posts within the team was ongoing, with interviews currently taking place; - A meeting had taken place the previous week to confirm the action needed following the recent 'state of the nation' review, setting out clear expectations of the service groups; - Morriston Hospital was holding its first infection control committee meeting in February 2022 to scrutinise each of the reported cases, the findings of which would be presented to the Director of Nursing and Patient Experience and the Medical Director; - A significant amount of invasive devices were used within secondary care and the service groups had been tasked with improving the position; - There was an intention to launch an infection prevention and control charter within 2022-23 as well as strengthen digital intelligence to be able to evidence any improvements. In discussing the report, the following points were raised: Reena Owen empathised with the challenges faced by the team but sought assurance that improvements were being made as a result of the 'state of the nation' work, as the expected completion date was the end of February 2022. Gareth Howells stated that this was a fair challenge but the service groups were starting to take ownership of the concerns, with each one establishing an infection control committee. The meeting the previous week had gone over the action plan in significant detail and a progress update would be included in the next report to the committee, as well as an overview of the plans. These were to be scrutinised on a weekly basis by the clinical executive directors. Steve Spill queried if the business case to expand the vaccination and immunisation service would help to stabilise it. Richard Evans advised that people classed as clinically vulnerable had now received letters inviting them for a fourth booster for Covid-19 and the offer of a first dose was to be extended to all children in the five to 11 age group. The plan from September 2022 would be for anyone over the age of 75 or clinically vulnerable to receive an annual vaccine, barring any significant new variants. Gareth Howells advised that the Director of Public Health was leading on the vision for the business case and suggested he be asked to provide an update at the next meeting. This was agreed.	**KR**
Resolved:	- The report be **noted**;	

	- Update be provided at the next meeting around the business case for vaccinations and immunisations.	**KR**
31/22	**QUALITY AND SAFETY PERFORMANCE REPORT**	
	The quality and safety performance report was **received.** In introducing the report, Darren Griffiths highlighted the following points: - The latest peak of Covid-19 occurred in December 2021 and started to recover towards the end of January 2022; - There were currently 75 inpatients with the virus and 170 recovering; - The number of staff isolating had reduced to 300; - The eight minute release time for red ambulances remained under the 65% target and was currently 55%; - One hour ambulances delays for January 2022 had been 735 and February 2022 appeared to be on a similar track; - Four-hour emergency department waits remained stable at 72%; - 12-hour waits had been 1,142 cases against a trajectory of 739; - The number of clinically optimised patients was broadly unchanged at 276; - An increase in community pressure ulcers had been evident; - The current elective waiting list stood at at just over 86k cases; - Elective surgery rates were now at 95% of pre-Covid performance; - Podiatry waiting times were increasing and a substantive report was to be shared with the Performance and Finance Committee; - Performance against the single cancer pathway was 45% (target was 65%) but the backlog had reduced from 683 to 583 In discussing the report, the following points were raised: Reena Owen queried whether the increase in pressure ulcer cases was linked to the number of clinically optimised patients. Gareth Howells advised that the tissue viability team has been commissioned to review the cases but the hike had been within the community, so was not connected to clinically optimised patients. He undertook to provide an update on progress at the next meeting. Steve Spill noted that patient experience rates were generally good and sought assurance that the full story was being captured. Gareth Howells responded that across his NHS experience, patients were generally pleased with the services they received. There were services which did not work as well as they should but this was often in a way that patients did not know about. He added that the Quality and Safety Governance Group structure was currently under review and was due to have a designated patient experience group in its sub-structure. This would provide the forum to ensure patients were genuinely happy with the care they were receiving as there was a culture in Wales of people just accepting poor experience. Reena Owen concurred, adding that as the	**GH**

	NHS was free at the point of access, there was an immense gratitude for any services received. However, there was evidence that services were starting to improve and this needed to be a continued focus.	
Resolved:	- The report be **noted.** - Update be provided at the next meeting as to progress with the community pressure ulcer review.	**GH**
32/22	**EXTERNAL REVIEW OF THE CHILDREN'S COMMUNITY NURSING SERVICE UPDATE REPORT**	
	A report providing an update against the recommendations from an external review of the children's community nursing service was **received.** In introducing the report, Jane Phillips and Vicki Burridge highlighted the following points: - A number of immediate actions were identified and addressed while the review was in progress; - The report had been discussed with all staff within the service; - Not all the families involved wanted to receive feedback but those who did had been spoken with; - The families were ones with children with complex needs and for whom time was precious, so it was important the service was right for them; - There were currently some challenges around staff availability; - A patient and family task and finish engagement workstream had been established with an external specialist commissioned to ensure the service was what the families needed; - A continuing healthcare workshop was to take place with stakeholders; - Peer feedback and how to share lessons on an all-Wales basis was being considered; - A wider piece of work around where in the health board structure children's service should be placed was being undertaken with the Chief Executive; - Since the report had been written, there had been a challenge around the availability of healthcare support workers, with around 50% leaving the team – these had been replaced through rotational secondments within general paediatrics. The recruitment process was also being accelerated. In discussing the report, the following points were raised: Steve Spill noted that engagement was better within the registered workforce rather than the unregistered and queried if this was a risk. Vicki Burridge responded that they had been seen as a team working in isolation and lone workers at night so registered nurses had been introduced by way of support. Healthcare support workers delivered the	

	majority of the care and knew the children better than the more senior nurses, so they were being included much more in the developments of care packages. A recent study day had been well received and on the whole, staff engagement was improving. Steve Spill queried if there were ever shifts which were not filled. Vicki Burridge advised there were occasions when shifts were not filled and there were contingency plans in place as well as an auditable record provided to the service team. Families and carers did have to fill the gaps but were given an additional night of respite when more staff were available. Reena Owen sought clarity as to why the health board waiting for an all-Wales agreed peer review rather than just approach another organisation. Jane Phillips responded that the aim was to share good practice within continuing healthcare across Wales to get the best out of the review.	
Resolved:	- The report be **noted;** - A further update be received in April 2022.	**JW**
33/22	**CLINICALLY OPTIMISED PATIENTS**	
	A report on the position of clinically optimised patients from a quality and safety perspective was **received.** In introducing the report, Kate Hannam and Rebecca Davies highlighted the following points: - At the point of drafting the report, there had been 105 clinically optimised patients in Morriston Hospital, with varying reasons; - The way in which such patients were coded differed – green patients had all assessments completed and were awaiting a package of care/residential home placement or rehabilitation bed on another site. Amber patients were awaiting a form of assessment but it was noted that these did not necessarily need to take place at Morriston Hospital; - Around a third of incidents logged on Datix relating to clinically optimised patients had resulted in harm as well as a number of pressure ulcers reported; - There were also some behavioural incidences linked to longer lengths of stay as patient generally became more anxious; - Hospital sites were not the right place for patients to be once they were fit enough to return home as they were at risk of deconditioning and a deterioration in quality of life due to less contact with families; - Consideration was being given to commissioning additional capacity to identify what patients were awaiting discharge to move them through the system; - A causation event had been held with frontline staff to discuss	

	what could be done differently and some suggestions had been reinstating therapists at board rounds, active rehabilitation, for example, not patients not eating in the bed in which they slept and actively escalating complex cases; - The discharge team currently comprised one discharge liaison nurse and this was to be increased, as well as expanded to include flow co-ordinators, as a central hub; - Frontline staff felt that the discharge pathways were too complex, as there were six, and it was challenging for ward staff to know which to use. This would now be co-ordinated through the central discharge team as a trial to make it more simple and streamlined. In discussing the report, the following points were raised: Steve Spill queried if there was anymore which could be done to help patients be discharged more quickly. Kate Hannam responded that the Chief Executive had facilitated a discussion around the blockages within continuing healthcare to determine if there was anything different that the health board could do. There were currently no big health and social care groups within Swansea which could work together and pool resources and families were relied upon to 'top-up' funding. She added that currently, the community teams would not accept a single referral from hospital teams and there was insufficient capacity to make multiple referrals in a timely manner. Rebecca Evans stated that patients' needs were becoming more complex which had led to multiple pathways being in place. Ward staff did not know which one to use for each patient so having a central hub would address this. Reena Owen commented that it was important this protocol included patients and families to ensure their voices were heard when decisions were being made. Alison Clarke stated that it was pleasing to see initiatives such as the last 1,000 days of life, SAFER bundle and PJ Paralysis being re-implemented but it was important that everyone was aware this was their responsibility to ensure these were successful. Gareth Howells commended the service group for its work to question systems which had been in place for a number of years. The work to address the number of clinically optimised patients was critical as it would create more available beds each day which would optimise patient quality and safety, as well as performance. Kate Hannam concurred, adding that while there were capacity constraints within provider services, there were opportunities for improvement within the health board. However, the only way the work would be sustained would be if it became part of the culture, which was why initiatives were being implemented to put patients at the centre. There was confidence within the service group that it could deliver an improvement. Steve Spill suggested that an update be received in June 2022 from all service groups as to the work to reduce the number of clinically optimised patients. This was agreed.	**IR**

Resolved:	- The report was **noted.** - An update be received in June 2022 from all service groups as to the work to reduce the number of clinically optimised patients.	**IR**
34/22	**HEALTH BOARD RISK REGISTER**	
	A report setting out the health board risk register was received. In introducing the report, Neil Thomas highlighted the following points: - The health board risk register was last received by the board in November 2021 and the committee in December 2021; - It was in the process of being refreshed for the next quarter and the changes since the last iteration were highlighted; - Of the 41 risks on the register, 14 were assigned to the committee and of these, 11 were at or above the current risk appetite of 20; - There had been no new quality and safety risks recorded but one relating to the burns service had been added for the Performance and Finance Committee; - The risk around nosocomial infections had increased from 16 to 20 while the entry for midwifery staff availability had decreased from 20 to 16 as more returned to work; - The mitigating actions for a number of the quality and safety risks had been updated and it was hoped that a reduction in score would be evident in due course; - The Chief Executive reviewed all risks on the register to ensure progress was being made. In discussing the report, Steve Spill noted the risk appetite had been increased from 16 to 20 at the start of the pandemic and queried if there was a view as to when it would be decreased. Neil Thomas responded that there was a board session taking place on 24th February 2022 to discuss the future risk appetite.	
Resolved:	- The report be **noted;** - The mitigating actions to manage the risk assigned to the Quality and Safety Committee be **endorsed.**	
35/22	**QUALITY AND SAFETY FRAMEWORK FINAL INTERNAL AUDIT REPORT**	
Resolved:	The quality and safety framework final internal audit report was **received.** In discussing the report, the following points were raised: Steve Spill stated that the limited assurance rating for the audit was concerning for the committee given it was responsible for quality and	

	safety. He queried the current position of the framework as it had not been progressed since it was introduced in 2019. Gareth Howells responded that Covid-19 had erased a lot of the processes that had been in place so the report was a true reflection of the current position. Both Audit Wales and internal audit had identified similar themes in recent reviews of quality governance and two away sessions had been arranged with the senior leadership team, to be led by an external facilitator. This would support the creation of a quality management system. Richard Evans commented that this was an opportunity for the health board to get its quality governance right, particularly in terms of accountability. Reena Owen noted that a report from the Quality and Safety Governance group was not included within the meeting's agenda and queried if this was a cause for concern given the findings of the report. Paul Davies responded that there had been a small window of time between the group's January and March 2022 meetings so the February 2022 one had been stood-down as there would be little to report in-between. He added the dates for the rest of the year had been reviewed and reissued so they were more in-line with the committee's schedule. Reena Owen stated that quoracy and service group attendance had been issues for the group and asked whether this was to be addressed. Paul Davies advised that the level of representative of the service groups was the critical area to address to ensure the right people were in attendance and the new dates had been shared with these. He added work was being undertaken around the group itself to ensure the right assurance mechanisms were in place.	
Resolved:	- The report be **noted.**	
36/22	**CONTROLLED DRUGS GOVERNANCE FINAL INTERNAL AUDIT REPORT**	
	The controlled drugs governance final internal audit report was **received** and **noted.**	
37/22	**NEXT STEPS FOR PHARMACIES IN THE CONTENT OF THE POPULATION HEALTH STRATEGY**	
	A report on the potential next steps for pharmacies, in the context of the population health strategy was **received** and **noted.**	
38/22	**ITEMS TO REFER TO OTHER COMMITTEES**	
	There were no items referred to other committees.	

39/22	**ANY OTHER BUSINESS**	
	There were no items raised.	
40/22	**DATE OF NEXT MEETING**	
	The date of the next meeting was confirmed as 29th March 2022.	