ABM University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 21st February 2019
at 9am in the Millennium Room, Baglan HQ

Present
Martyn Waygood, Independent Member (in the chair)
Reena Owen, Independent Member
Emma Woollett, Vice-Chair (via Skype for minute 01/19)

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Richard Evans, Medical Director (from minute 08/19)
Sandra Husbands, Director of Public Health
Chris White, Chief Operating Officer and Director of Therapies and Health Science (until minute 14/19)
Jane Dale, Healthcare Inspectorate Wales
Paula O'Connor, Head of Internal Audit
Pam Wenger, Director of Corporate Governance
Liz Stauber, Committee Services Manager
Malcolm Lewis, Associate Board Member
Emrys Davies, Independent Member, Welsh Ambulance Service NHS Trust
James Hehir, Independent Member, Cwm Taf University Health Board
Charlotte Higgins, Programme Management Lead (for minute 01/19)
Siân Harrop-Griffiths, Director of Strategy (for minute 01/19)
Steve Jones, Deputy Unit Nurse Director, Mental Health and Learning Disabilities (for minute 08/19 and 09/19)
Rhonwen Parry, Head of Psychology and Therapies (for minute 08/19 and 09/19)
Andrea Davies, Clinical Psychologist (for minute 08/19)
Simone Richards, Ward 14 Manager, Caswell Clinic (for minute 08/19)
Nicola Edwards, Head of Safeguarding (for minute 13/19)
Darren Griffiths, Associate Director – Performance (for minute 19/19)

Minute		**Action**
01/19	**QUALITY IMPACT ASSESSMENT PROCESS**	

Charlotte Higgins was welcomed to the meeting.

A report and presentation setting out the quality impact assessment (QIA) for the integrated medium term plan (IMTP) was **received.**

In introducing the report, Charlotte Higgins highlighted the following points:

- QIA was common practice in NHS England and had been introduced in ABMU as part of the IMTP planning process;
- All schemes were assessed at stage one for patient safety, patient experience, clinical quality and whole system. Those which had a risk score of more than eight proceeded to stage two, which was a full QIA reviewed by a panel, and they were either approved, declined or returned for further work;

- A QIA panel had taken place in February 2019 to consider category A and B schemes;
- Neath Port Talbot Hospital did not have any schemes requiring a full QIA and therefore brought others to the panel to test the robustness of the process;
- The next panel meeting had been scheduled for March 2019, which would re-review any category A and B schemes sent back for amendments as well as the category C schemes;
- Risk scores would be cross-referenced with the risk register;
- Quarterly updates would be provided to the Quality and Safety Committee.

In discussing the report, the following points were raised:

Sandra Husbands queried as to how assurance could be taken that the schemes deemed not needing the full QIA had been appropriately scored and the mitigating actions were correct. Gareth Howells advised that the panel was also scrutinising some of the schemes which only required completion of stage one to check the robustness of the process.

Reena Owen stated that she was in support of the process but queried as to who was on the panel and whether it included consideration of patient experience. She sought clarity as to where the process integrated into the governance arrangements. Gareth Howells advised that panel membership comprised of clinical and non-clinical staff as well a representative of the community health council. He added that in terms of governance, it was important that the committee had sight of the work being undertaken, and it would be useful to include patients and families to really consider the impact of the schemes on their experience.

Malcolm Lewis commented that the process required a significant amount of work by the units and queried if they had the capacity to address this. Charlotte Higgins advised that a full engagement process was undertaken with the units before the process commenced in order to provide support for the first reviews. She added that the majority of feedback received had been positive.

Chris White stated that the health board now needed to move towards more cross-unit and cross-boundary working. Siân Harrop-Griffiths concurred, adding that engaging service directors and their teams in such processes would encourage the challenge needed in order to develop the plans required to establish the right services.

Siân Harrop-Griffiths commented that it would be useful for the QIA to be an evolving process and integrate with others, for example, equality impact assessments, rather than undertaking multiple assessments. She added that it was important that all the work was focussed on developing one plan, including workforce, finance,

performance and quality.

Emma Woollett sought clarity as to who from the units had been involved in the initial assessment of the schemes prior to panel submission and whether it extended to doctors and other senior clinical/nursing staff. Gareth Howells confirmed that matrons, clinical staff and service managers had been involved but not necessarily front-line staff.

James Hehir commented that it was an interesting piece of work and it was pleasing to see that the community health council had been involved in order to keep a focus on a patient-centred service.

Reena Owen queried the intention to quality assure the process. Gareth Howells responded that it was constantly being reviewed as it progressed. Siân Harrop-Griffiths added that it aligned with the performance framework in development in order to have a holistic view of what was being achieved. Paula O'Connor advised that as part of the 2019-20 internal audit of the annual plan, the QIA process would be reviewed.

Chris White commented that the QIA process aimed to identify potential adverse effects of change as a result of the schemes, but the positive outcomes also needed to be considered.

Resolved: The report be **noted.**

02/19 CHANGE IN AGENDA ORDER

Resolved: The agenda order be changed and items 3.1, 3.2, 3.3, 3.4 and 3.5 be taken next.

03/19 WELCOME AND APOLOGIES FOR ABSENCE

Martyn Waygood welcomed everyone to the meeting.

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

04/19 DECLARATIONS OF INTERESTS

There were no declarations of interest.

05/19 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, except to note the following amendment:

<u>196/18 Primary Care and Community Services Exception Report</u>

Richard Evans queried as to how the health board compared with others in terms of *antibiotic* use within primary and community services and sought clarity if there was a 'disconnect' between any of

the departments.

06/19 MATTERS ARISING NOT ON THE AGENDA

There were no matters arising not on the agenda.

07/19 ACTION LOG

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

(i) Action Point Three

Gareth Howells advised that the friends and family test did not ask about food and hydration but there was an all-Wales question which asked if patients had been aided with food and drink, for which the health board's performance was in the 80%s. He added that consideration was being given as to how to provide regular updates to the committee on this as it was important that members were sighted on progress.

(ii) Action Point Nine

Paula O'Connor advised that she had met with members of the senior management team for mental health and learning disabilities to discuss further developing key performance indicators that included both mental health, learning disabilities and community, and this was still a work in progress.

08/19 PATIENT STORY

Steve Jones, Rhonwen Parry, Andrea Davies and Simone Richards were welcomed to the meeting.

A staff story was **received** which outlined the impact of an inpatient's death on ward staff, particularly those who take their own lives. It was told from the point of view of ward manager, Simone Richards, who outlined the need to be strong for her team, who would have built up a relationship with the patient, as well as their family. One of the most challenging elements was building a timeline in the lead up to the death to determine the facts, as it was important to ensure staff did not feel they were being blamed. As a ward manager, a range of feelings were felt; grief for the patient, for the family and for staff who had to continue caring for other patients. The team at Caswell Clinic was close-knit, which was important, as staff could support each other, but it would be beneficial to have more support from outside the unit during such times, and to tell staff it was okay not to feel okay.

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

Martyn Waygood thanked Simone Richards for her story, adding that it was brave for her to tell it.

Gareth Howells stated that it never ceased to amaze him what health board staff experienced and it was inherently brave of Simone

Richards to share her story. He added that it was okay for ward managers not to be brave all the time and that it was important that they were supported as well. Simone Richards responded that it was not until she recorded the story that she realised how affected she had been by such incidents and she hoped by sharing it, it would help others.

Chris White complimented the story, adding that it was heartwarming to know that such staff were working for the organisation and it was important that the message was shared more widely amongst senior teams of all professional groups, providing that Simone Richards was comfortable with that. He queried staff access to clinical psychology and whether there was an automatic referral in such situations. Andrea Davies advised that clinical psychologists were part of the team and were also affected by inpatient deaths. She added that while support was available, it often took a while for patients to realise that they needed it. Rhonwen Parry stated that it was important staff had space off-site to reflect, and this concept needed to be more widely available across all services.

Sandra Husbands suggested that the story be shared with the suicide prevention workshop taking place the following month. Rhonwen Parry responded that she would discuss this further with the organisers.

Gareth Howells commented that it was important that the health board had a general plan in relation to end-of-life care as patients died in all parts of the organisation, and it was important staff had the right support. Chris White concurred, adding that he and Richard Evans had spent time with the palliative care team in this regard, adding that there was also more to be done to help patients who wanted to die at home be able to do this. Emrys Davies advised that the WAST non-emergency transport team was developing a process in this regard and could provide assistance in the future.

09/19 **MENTAL HEALTH AND LEARNING DISABILITIES UNIT EXCEPTION REPORT**

A report providing an update on quality and safety issues relating to mental health and learning disabilities services was **received.**

In introducing the report, Steve Jones highlighted the following points:

- A serious incident group had been developed over the past 12 months as the nature of the services meant a significant number were reported therefore systems needed to be robust;
- An investigation team was to be appointed to the following week;
- 15-step challenges and spot checks were to be implemented to monitor quality and safety of clinical areas;
- The majority of the unit's estate was old and as such the

environment needed constant investment;

- The 5x5 patient experience survey model was being piloted as the friends and family version did not suit the patient type;
- The unit was 100% compliant with the response rate to complaints;
- Further work was being undertaken to develop key performance indicators that included both mental health, learning disabilities and community.

In discussing the report, the following points were raised:

Reena Owen noted the need to develop the infrastructure in order to provide the telephone element of the 5x5 survey and queried the reason as to why. Steve Jones advised that as the survey was to be undertaken on a board-wide basis for mental health and learning disabilities, it would require someone on the phone on a daily basis.

Reena Owen sought clarity as to how the unit compared with other health boards in terms of the number of complaints received. Gareth Howells responded that the health board did not formally compare itself with other health boards but did liaise with Cardiff and Vale University Health Board as the services were similar, and the numbers were comparable.

Sandra Husbands commented that the 5x5 method was a good way in which to get a sense of what patients needed however the majority of the questions were treatment focussed and people needed to be asked about the breadth of their experience. She added that consideration could be given to the system being rolled out to other units. Steve Jones concurred, adding that this was something the unit would take into consideration.

Jane Dale stated that it was pleasing to see the quality indicators in development, adding that comparative data on a national scale was challenging as services differed across sites.

Pam Wenger commented that units should be asked to include in their reports actions taken and lessons learned from complaints investigations.

Martyn Waygood noted that a number of deaths of patients in the community had been under investigation for a significant amount of time. Steve Jones advised that this was because external agencies, such as the coroner, were involved, therefore the health board could not close the investigation.

Martyn Waygood sought further details restraint of violent or aggressive patients. Steve Jones responded that the unit did what it could to reduce the risk to patients and staff and was part of the national group to stop the use of restraints. He added that support for staff was in place should incidents of violence and aggression occur, including debriefs and periods of refection to consider the reasons

why restraints were used.

Gareth Howells stated that he had been impressed by the unit's willingness to review, take on messages and take action in order to develop and improve.

James Hehir commented that the unit's approach to peer review was to be commended but it would be useful for the risk register to expand on open entries to outline if and how they were being addressed. Pam Wenger advised that the board's risk management process was under revision.

Resolved: The report be **noted.**

10/19 WORK PROGRAMME 2018/19

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

11/19 WORK PROGRAMME 2019/20

A report setting out a proposed committee work programme for 2019-20 was **received** and **approved,** subject to the agreed minor amendments.

12/19 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:

- Progress was being made;
- *Clostridium.difficile* had seen a major reduction but challenges remained within primary care;
- Care bundles were in place to reduce the risk of *stauph.aureus* and *e.coli;*
- A big focus had been given to matron leadership;
- A decontamination review was undertaken in quarter three and a decontamination nurse had been appointed;
- Only one formal outbreak of flu had been reported.

In discussing the report, the following points were raised:

Reena Owen queried whether there was confidence that the targets set would be delivered. Gareth Howells advised that there was.

Reena Owen asked whether there was any feedback from the decontamination review. Gareth Howells responded that general feedback related to the adherence to standard operating procedures, which was always a risk. Reena Owen sought confirmation that the health board would retain the decontamination nurse following the

Bridgend boundary change. Gareth Howells confirmed that it would.

Chris White commented that the level of flu cases seen last year had not been evident this year, which was positive, and a focus needed to be given to isolating any cases which presented at the front door.

Martyn Waygood queried as to whether the improvement trajectory was ambitious enough. Gareth Howells advised that it was the one set as part of targeted intervention and while the health board could applaud itself for achieving it, it was still the worst performer in Wales, and this needed to be addressed. He added that there needed to be an aspiration towards no cases. Richard Evans concurred, adding that antibiotic prescribing within the community needed to be addressed.

Martyn Waygood noted the delay in re-establishing the ultra-violet cleaning system as well as concerns raised as to the lack of decant facilities to enable wards to be cleaned. Gareth Howells advised that capacity was a challenge at this time of year and work was being undertaken to establish ways to clean wards which could not be completely decanted. He added that these challenges needed to be a key piece of work for the summer.

Malcolm Lewis queried if the data could identify the GP practices with the highest antibiotic prescribing rates. Richard Lewis responded that the prescription of antibiotics was higher in ABMU than the majority of the UK, therefore the clinical lead for medicines management was working with the clusters on education and awareness.

Martyn Waygood noted the different processes and systems in place across the sites and queried as to why consistency could not be achieved. Gareth Howells advised that the establishment of the new organisation from April 2019 was an opportunity to address this.

Resolved: The report be **noted.**

13/19 SAFEGUARDING REPORT

Nicola Edwards was welcomed to the meeting.

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

In introducing the report, Nicola Edwards highlighted the following points:

- The safeguarding team had undergone a number of changes but all posts were now filled;
- Going forward, there would be changes to the way in which children's cases were reported and work was ongoing in relation to child sexual exploitation;
- Scenario-based safeguarding training was to be developed.

In discussing the report, the following points were raised:

Reena Owen noted the lack of compliance with training and queried whether the units had been tasked with developing improvement plans. Nicola Edwards responded that there was an e-training package available but there were some challenges in getting compliance data from the electronic staff record (ESR). She added that the units had been asked to consider the training they needed for their staff in order to tailor the scenario-based training. Gareth Howells advised that discussions were being undertaken at the Workforce and Organisational Development (OD) Committee in relation to the requirements of statutory and mandatory training.

Chris White advised that partnership discussions were being undertaken with colleagues within the police as to how to take assurance within the community in relation to safeguarding.

Pam Wenger commented that it was a detailed report which would be helpful to be received twice a year with exception reports received as and when issues arose, but the committee would be expecting an update at every meeting as to the progress against the action plan in response to the action plan for the Healthcare Inspectorate Wales (HIW) review of the Kris Wade case.

Martyn Waygood stated that the child referral case numbers appeared low. Gareth Howells responded that school nurses and health visitors were quality assuring referrals but not all of them were received by the safeguarding team so it was reliant on the local authorities.

Martyn Waygood commented that compliance with deprivation of liberty safeguards (DoLS) had halved since the same period the previous year. Nicola Edwards advised that clinical areas were finding it challenging to release staff repeatedly to complete training therefore consideration was being given to creating a day of safeguarding training to reduce the amount of times staff needed time away from the ward or department.

Resolved: The report be **noted.**

14/19 QUALITY AND SAFETY INTEGRATED PERFORMANCE REPORT

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

In discussing the report, the following points were raised:

Martyn Waygood advised that the current format of the performance report did not meet the needs of the committee and he would be discussing with the executive directors who attended the committee ways in which it could be developed.

Gareth Howells advised that work was being undertaken to monitor falls per 1,000 bed days to be comparable with other organisations. He added that there had been increased incidences of falls and

pressure ulcers, particularly in the community, and a focus was needed on this as well as avoidability. He added that responsibility was key and a concordance framework was needed with external providers of care, such as care homes.

Pam Wenger stated it was important to have a quality dashboard and a performance framework was in development which would aid this.

Reena Owen commented that some of the performance issues, such as 12-hour waits for unscheduled care and 52 week waits for planned care, would have a negative impact on patient experience. She queried whether the health board was doing all it could to address the issues. Gareth Howells responded that the 'drumbeat' of the health board needed to be quality and safety, and even those classed as performance targets, such as unscheduled care waits, were quality targets. He stated that changing the narrative was key. Pam Wenger concurred, adding that if quality issues were addressed, this would help with performance and finance.

Reena Owen stated that it would be useful to see comparative data for other organisations. Pam Wenger responded that this was a valid point and could be considered as part of the discussions on the next iteration of the report.

Richard Evans commented that there was a risk of getting lost in the data if too much was available and also provided a challenge as to what to do with it.

Paula O'Connor advised that quality and safety committees faced a challenge nationally in terms of agendas and papers, so the challenges were not unique to the health board. She added that the health and care standards needed to be taken into consideration when developing a new report style.

Resolved: The report be **noted.**

15/19 INTERNAL AUDIT UPDATE

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

In introducing the report, Paula O'Connor advised that since the last meeting, one final report had been issued with a quality and safety link which was a follow-up of pressure ulcers and while progress had been made since the original audit, there was still work to be done.

Resolved: The report be **noted.**

16/19 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 approach to risk management and the risk register was being refreshed;
- Progress had been reported to the Audit Committee and would be taken to the board in March 2019;
- Risks would be assigned to the relevant board committees for assurance to be sought.

In discussing the report, the following points were raised:

Gareth Howells commented that the revised process would be a culture change and a significant amount of work was being undertaken to engage the units.

Reena Owen commented that some of the risks assigned to the Workforce and OD Committee also had quality implications. She stated that it would be important to ensure that nothing 'fell through the gaps'. Pam Wenger advised that as part of the Chairman's Advisory Group, the chairs of each committee had the opportunity to raise any universal issues they thought others should be aware. In addition, a section had been added to all committee agendas to encourage members to consider items to refer to other committees.

Martyn Waygood suggested that he discuss the rationale for some of the allocations to the committee with Pam Wenger, as not all were necessarily appropriate for its remit. This was agreed. **MW**

Paula O'Connor advised that an internal audit had been undertaken of the risk process, which had some recommendations for consideration, including reconciling the content of the units' registers with that of the health board.

Resolved:

- The report be **noted.**
- Rationale for some of the allocations to the committee with be discussed with Pam Wenger. **MW**

17/19 QUALITY AND SAFETY FORUM

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

In introducing the report, Gareth Howells stated that two forums had taken place since the last meeting, both of which he had chaired, and while it was making progress, there was still more work to be done to improve its effectiveness.

In discussing the report, the following points were raised:

Paula O'Connor commented that she had attended one of the meetings and it had been evident that the forum was now identifying areas of escalation for the committee.

Reena Owen stated that it was unclear as to what role the committee

was required to play should an issue be escalated. Gareth Howells advised that for such issues, leads would be identified within the units to take responsibility for any actions and action plans would need to be discussed at the forum for assurance to be provided to the committee. Richard Evans added that he, Pam Wenger and Gareth Howells were in the process of discussing what was received by the forum.

Resolved: The report be **noted.**

18/18 CHANGE IN AGENDA ORDER

The agenda order be changed and item 6.8 be taken next.

19/19 NHS WALES DELIVERY UNIT LONG WAITING PATIENTS

Darren Griffiths was welcomed to the meeting.

A report outlining the findings and recommendations of an NHS Wales Delivery Unit review of long waiting patients was **received.**

In introducing the report, Darren Griffiths highlighted the following points:

- The report had been commissioned on an all-Wales basis but there was an ABMU-specific report, for which the 12 recommendations had been accepted;
- The number of patients waiting more than 52 weeks for surgery had improved over the last four years but was still too many. The majority of these were orthopaedic cases;
- An action plan was now in development;
- Several themes had been identified, including cross-clinical practices, complaints, risk and co-production;
- There was no indication that any of the cases concerned were at risk of an emergency admission however there were clinical risks to consider, for example repeated diagnostic tests;
- The aspiration for the next year was to reduce the 1,300 cases to fewer than 1,000, but an improvement within orthopaedics would take two years.

In discussing the report, the following points were raised:

Sandra Husbands complimented the report, stating that it clearly set out the key risks and recommendations, as well as what could be learned. She queried if factors outside of the recommendations had been considered, such as digital technology, as the first outpatient appointment did not necessarily need to be face-to-face. Darren Griffiths responded that while digital technology was an area which needed focus, the challenge was not around the time patients had to wait for an outpatient appointment, rather the time between the

appointment and surgery.

Reena Owen stated that having to wait 52 weeks for a procedure was poor patient experience and queried as to whether patients were communicated with regularly to keep them apprised of the situation. Darren Griffiths advised that those waiting for that length of time were the least clinically urgent and the quality of communication differed across specialties, but patients were kept informed as to the planned care performance. Jane Dale commented that often patients sought updates from the GPs so it was important that they were also apprised.

Gareth Howells stated that he really liked the report as it made the link between performance and quality, taking into account the affect such a wait could have on a patient.

Martyn Waygood commented that it was encouraging to see the ambition to reduce the waiting list but the work was still reactive and the health board needed to become more proactive.

Resolved: The report be **noted.**

20/19 EXTERNAL INSPECTIONS

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

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

- External inspections had taken place of a GP practice and dental surgery, both of which had resulted in immediate action notices;
- An action plan had been developed in response to the HIW review of the Kris Wade case which was appended.

In discussing the report, the following points were raised:

Pam Wenger referenced the Kris Wade action plan, adding that the workforce and quality and safety elements needed to be separated in order for the relevant committees to monitor progress effectively.

Sandra Husbands noted that this was not the first immediate action notice for a primary care facility relating to resuscitation equipment, adding that it was vital that such issues were addressed.

Sandra Husbands referenced the Kris Wade action plan, stating that it was critical that patients were treated equitably, regardless of their conditions or backgrounds and any concerns they raised taken seriously.

Resolved: The report be **noted.**

21/19 EMRTS CLINICAL GOVERNANCE REPORT

A report outlining the clinical governance update from the Emergency Medical Retrieval and Transfer Service (EMRTS) was **received** and **noted.**

22/19 CLINICAL SENATE COUNCIL REPORT

A report providing an update from the clinical senate council was **received** and **noted.**

23/19 BRIDGEND BOUNDARY UPDATE

A verbal update with regard to the quality and safety issues being considered as part of the Bridgend boundary change was **received.**

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

- There was a well developed workstream for quality and safety with sub-groups within both organisations and robust action logs;
- A quality summit was to take place in March 2019;
- The main risks related to safeguarding, compliance with national audits, safer staffing and decontamination;
- Around 30 staff had were transferring to Cwm Taf University Health Board between the medical and nursing directorates;
- There would still be work to do after 1st April 2019 to complete the transfer as well as restructure the new health board.

24/19 ITEMS TO REFER TO OTHER COMMITTEESS

There were no items to refer to other committees.

25/19 ANY OTHER BUSINESS

There was no further business and the meeting was closed.

26/19 NEXT MEETING

This was scheduled for 18th April 2019.

27/19 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.