ABM University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 1st February 2018
at 9am in the meeting room, Angelton Clinic

Present
Martyn Waygood, Independent Member (in the chair)
Emma Woollett, Vice-Chair
Chantal Patel, Independent Member (until minute 20/18)
Ceri Phillips, Independent Member (until minute 20/18)

In Attendance
Angela Hopkins, Interim Director of Nursing and Patient Experience
Christine Morrell, Director of Therapies and Health Science
Sandra Husbands, Director of Public Health (from minute 07/18)
Hamish Laing, Medical Director (until minute 27/18)
Pam Wenger, Director of Corporate Governance
Liz Stauber, Committee Services Manager
Dai Roberts, Service Director, Mental Health and Learning Disabilities (for minute 07/18)
Hazel Powell, Unit Nurse Director, Mental Health and Learning Disabilities (for minute 07/18)
Richard Maggs, Unit Medical Director, Mental Health and Learning Disabilities (for minute 07/18)
Joanne Abbott-Davies, Assistant Director of Strategy (for minute 10/18)

Action

01/18 WELCOME AND APOLOGIES FOR ABSENCE

Martyn Waygood welcomed everyone to the meeting, noting that he was chairing the meeting in the absence of Maggie Berry. He also thanked Emma Woollett for attending to ensure the committee was quorate.

Apologies for absence were received from Maggie Berry, Independent Member; Sue Evans, ABM Community Health Council; Nia Roberts, Healthcare Inspectorate Wales and Carol Moseley, Wales Audit Office.

02/18 DECLARATIONS OF INTERESTS

There were no declarations of interest.

03/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 7th December were **received** and **confirmed** as a true and accurate record.

04/18 MATTERS ARISING NOT ON THE AGENDA

There were no matters arising not otherwise on the agenda.

05/18 **ACTION LOG**

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

(i) Action Point One – Quality in Primary Care Indications

Chris Morrell advised that the chronic pain review report had been received by the Quality and Safety Forum the previous week and would be received by the committee at its next meeting.

(ii) Singleton Hospital Delivery Unit Presentation

Angela Hopkins stated that given the length of time which had passed since the request for the letter, the response was under review to ensure it was robust, and would be circulated following the meeting.

(iii) Estates Updates

Hamish Laing informed the committee that a revised water policy had been submitted to the authorising engineer and once they were in agreement, the policy could be finalised and published.

06/18 **WORK PROGRAMME**

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

In discussing the work programme, the following points were raised:

Chris Morrell advised that now that the work in relation to older persons had progressed, it was not necessary for the committee to receive a report at every meeting, and suggested it be received twice a year. This was agreed. **CM**

Pam Wenger commented that a number of the reports contained a significant amount of detail and as she was currently undertaking a governance review, this was an opportune time to review the work programme. She added that a presentation was to be received at the February 2018 board development session to review committee arrangements.

07/18 **MENTAL HEALTH AND LEARNING DISABILITIES DELIVERY UNIT PATIENT STORY AND REPORT**

Dai Roberts, Hazel Powell and Richard Maggs were welcomed to the meeting.

(i) Patient Story

A patient story was received outlining how a mental health service user benefitted from weekly activities at the health board's Ty Einon centre. The service user had spent time as an inpatient at Cefn Coed Hospital and could not praise the care enough. During that time she received medication and talked with psychiatrists. After discharge, she found she was on her own for long periods of time but a nurse visited her at home and suggested she attend the centre weekly,

which she found to be ‘wonderful’. Not only did it provide her with an opportunity to work with physiotherapists to improve her mobility but she had made a number of new friends with whom she could meet for coffee or go for meals. Also at the centre the service user was able to take part in crosswords and quizzes and her family was ‘overjoyed’ with how attending the centre had helped with her mental health. She felt that now if she suffered a bout of depression, it lasted a few days and her future seemed much brighter.

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

Hazel Powell commented that the story highlighted the importance of meaningful activity for mental health.

Angela Hopkins stated that the story was a good example of how loneliness can affect mental health and the centre gave opportunities for carers to do to the caring and provide families with respite. She noted that the service user had referenced seeing ‘a lot’ of psychiatrists and queried whether this had an impact on continuity of care. Richard Maggs responded that the model of care had changed and to support service users to return to the community in a timely way, they saw the clinicians who were available as and when required, which often meant sessions with different doctors. He added if the same psychiatrist was to work with a service user throughout their treatment then it would take longer for them to be medically fit for discharge.

Hamish Laing commented that it was a lovely story and asked whether there were arrangements in place with the third sector to support service users in-between their weekly visits to the centre. Hazel Powell confirmed that there were and the service user used to attend the centre more often before these arrangements took over. Emma Woollett added that the story highlighted the importance of community mental health services.

Hamish Laing advised that the health board had run a time-limited programme with a local authority which enabled mental health service users to ‘bank’ time credits to be used within a number of community activities such as the gym and cinema. The initiative had now ceased but its projects like this that would benefit the service user and those with similar needs.

Martyn Waygood noted that the service user had been offered ‘electric’ treatment and while she had not been concerned about having it, her husband had been wary given the side effects during previous sessions. As such, she had not received the treatment. He asked whether it was appropriate for families to influence patients’ decisions as to whether to have a particular treatment. Richard Maggs advised that electro-convulsive therapy was not a standalone treatment and would have been provided in addition to others. He added that while families were consulted on patients’ treatments, the service did have powers to displace their views and decisions if it was

felt that it would be detrimental the patient. Hamish Laing commented that as the husband had reminded her about her memory loss following the previous treatment, it was reasonable to think that he was making her aware of an experience that she had forgotten.

(ii) Unit Report

A report providing an update in relation to progress and performance for quality and safety for Mental Health and Learning Disabilities Delivery Unit was **received.**

In introducing the report, the team highlighted the following points:

- It had been two years since Hazel Powell had taken up post and during that time a significant amount of work had been undertaken to improve the governance of the unit and to integrate with the rest of the health board;
- While an improvement in the uptake of the flu vaccine had been evident, more work was required;
- One of the next focuses for the unit was to enhance leadership;
- Environmental issues needed to be considered in the context of the financial challenges;
- Workshops were to be undertaken with staff in relation to patient experience and while the number of responses to the family and friends test had increased, there was still room for improvement;
- Significant work was being undertaken in relation to mortality reviews as well as to improve the scrutiny of serious incidents and suicides;
- The unit was now taking a quality improvement approach to developing services;
- A process was being established to better the investigation model for suicides which included working towards one reporting template and establishing a way for learning to be cascaded to staff;
- Work had been undertaken with mid-level managers to ensure they had the right skills for their role and knew how to balance priorities.

In discussing the report, the following points were raised:

Chantal Patel commented that there had been issues with some of the venues selected for Hospital Managers Powers of Discharge review meetings as not all had been suitable, which meant the meetings did not go ahead and deadlines were missed. She added that there were also challenges with the completion of the statutory care plans and she would have expected these risks as well as those surrounding Deprivation of Liberty Safeguards (DoLS) to have been

referenced within the report. Dai Roberts responded that any issues relating to the Mental Health Act were received by the Mental Health and Capacity Act Legislation Committee or the unit's operational group, and DoLS were also reviewed by the Safeguarding Committee.

Ceri Phillips sought further details as to the timescales for the quality improvement work. Hazel Powell advised that she and Richard Maggs co-chaired the implementation group and a review of progress was to be undertaken in May 2018. She added it was a long-term piece of work to be completed in 12-month cycles but it was important that it demonstrated outcomes.

Ceri Phillips noted that three areas had been identified as a focus for the quality improvement programme and sought assurance that once the work moved to other areas, these would still be kept under review to ensure performance did not deteriorate. Dai Roberts responded that the unit had a locality approach therefore the relevant managers were on the site for which they were responsible on a daily basis. He added that these would be accountable for performance with the unit's triumvirate overseeing the full process to identify issues before they escalated.

Angela Hopkins informed the committee that there had been a significant drive to improve compliance with immediate life support training as this had been area of great risk. She added there was now a clear plan in place to improve compliance and commended the unit for its work.

Emma Woollett noted that the quality and safety measures within the report were those used within acute settings, adding consideration should be given to establishing measures specific to mental health and learning disabilities. **DR**

Hamish Laing complimented the team on its report, adding that real progress was evident. He stated that there was an international improvement network for mental health and it would be useful for the health board to become a member as it would identify a raft of quality and safety measures for the unit to consider using but also an opportunity for it to share its own good practice. He added that he had met with a colleague working within east London with whom he had discussed the benefits of the network. Hazel Powell advised that unit representatives were attending the network's conference in April 2018 and contact had already been established with colleagues within east London. Hamish Laing advised that the 'Q Network' was seeking additional members and to date, the health board only had one representative.

Martyn Waygood sought details as to how the unit was managing its risk of nursing vacancies. Hazel Powell responded that there were some hotspots and as such, a task and finish group had been established to focus on recruitment and retention. She added that the

unit was participating within the health board's recruitment fayres and a bespoke preceptorship programme was in development to support newly qualified staff. Dai Roberts commented that while services were safe, they were also traditional, which was not appealing to those seeking employment therefore it was hoped that service changes would help increase recruitment.

Resolved:

- The report be **noted.**
- Performance measures to be reviewed. **DR**

08/18 CHANGE IN AGENDA ORDER

Agenda order be changed and item 3.1 be taken next.

09/18 STAYING HEALTHY

A report providing an update on a number of public health areas was **received.**

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

- Providing support to mental health patients wishing to stop smoking was proving challenging however Caswell Clinic was now a smoke-free environment with staff supporting each other as well as patients;
- Progress had been made in relation to some childhood vaccinations but there were some gaps within the measles, mumps and rubella vaccine for mid-teens for which a plan had been developed;
- Uptake of the flu vaccine had been high for those over the age of 65 and children, and work was to be undertaken with the primary care clusters to address the remaining at risk groups;
- The health board's tobacco group required a fora into which to report;
- A significant amount of detail was included in the report and consideration was required as to whether it was more beneficial for the committee to receive reports focusing on particular topics.

In discussing the report, the following points were raised:

Emma Woollett stated that it was a significant achievement for Caswell Clinic to be smoke-free as a mental health unit. Sandra Husbands concurred, adding that there was much learning to be taken for other models of care.

Chantal Patel noted that the uptake of the flu vaccine varied for each cluster and asked whether there were reasons as to why some practices had a higher rate. Sandra Husbands advised that work was

ongoing within the clusters to establish which actions had worked for them to increase uptake of the vaccination but the easier it was made for members of the public to access the vaccination, the more likely they would be to receive it.

Pam Wenger suggested that as the tobacco group had an operational focus, it would be more appropriate for it to report to the Quality and Safety Committee forum and updates be included as part of the forum's regular update to the committee. This was agreed. **SH**

Pam Wenger undertook to work with Sandra Husbands outside of the meeting to determine what reports needed to be received by the committee in order to seek assurance and the items which could be received by the Quality and Safety Forum. **PW**

Martyn Waygood referenced the 'Healthy City' programme, adding that he felt that there was a danger that some momentum could potentially be lost. Joanne Abbott-Davies advised that discussions were currently being undertaken as to whether the PSBs for Swansea and Neath Port Talbot should be aligned which would be an opportunity to reinvigorate the process.

Resolved:

- The report be **noted.**
- Tobacco group to report to the Quality and Safety Forum. **SH**
- Pam Wenger to discuss with Sandra Husbands future reporting arrangements. **PW**
- The direction of travel for immunisation be **supported**. **SH**

10/18 ASSURANCE REPORT: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Joanne Abbott-Davies was welcomed to the meeting.

A report providing an update with regard to child and adolescent mental health services (CAMHS) was **received.**

In introducing the report, Joanne Abbott-Davies highlighted the following points:

- The CAMHS service was provided by Cwm Taf University Health Board and as such, it had been challenging to engage colleagues within ABMU with the issues;
- There needed to be clear ownership not only within the health board but also within local authorities, both social services and education;
- Work had been undertaken by ABMU with local authorities to identify alternative models of care so the reliance was not completely on specialist CAMHS;
- The position had improved in the last 12 months and regular performance reports were received from Cwm Taf University

Health Board;

- Cardiff and Vale University Health Board had given notice to Cwm Taf University Health Board that it intended to repatriate specialist CAMHS services and this approach was to be monitored by the ABMU to determine whether to undertake similar action;
- A delivery plan had been established;
- Integrated care funding was to be invested in a liaison post as a single point of contact for the local authorities to seek advice.

In discussing the report, the following points were raised:

Chantal Patel commented that some GPs felt that they were outside of the CAMHS communications channels and therefore were unclear of other services to direct patients to if their referrals were returned as unsuitable for specialist CAMHS services. Joanne Abbott-Davies advised that she had attended a number of local medical committee meetings to discuss the delivery plan along with the lead GP for liaison and both had left contact details should any members have queries. She added that consideration was being given to developing a proposal for voluntary sector input for low level counselling and support.

Ceri Phillips noted that some services had already been repatriated and stated that it was difficult to see how the system could be coherent if divided between health boards. Joanne Abbott-Davies responded that the health board did not want to consider repatriating specialist services until it had agreed with social services and education colleagues as to the preferred models of care. She added that consideration also needed to be given as to the capacity to manage such specialist services.

Angela Hopkins noted that any CAMHS-related safeguarding events which occurred in the health board's emergency departments were recorded by Cwm Taf University Health Board and therefore ABMU was unsighted. Hamish Laing commented that there should be arrangements in place for all regional services that any incidents were to be reported on Datix by the hosting organisation and shared with the relevant partnering health board. He added that the Welsh patient administration system enabled clinicians across Wales to upload letters and test results which could then be accessed by colleagues when appropriate. Joanne Abbott-Davies advised that neither of these options was currently being undertaken by the Cwm Taf University Health Board therefore ABMU was unsighted on the information. Pam Wenger advised that this was a clinical governance issue and undertook to write to Cwm Taf University Health Board in this regard. **AH**

Emma Woollett added that the details also needed to be included within the health board's risk register. Angela Hopkins concurred and suggested Joanne Abbott-Davies progress this with the corporate lead for the risk register. This was agreed. **JAD/AH**

Emma Woollett stated that she found the report concerning as it did not appear to have a sense of urgency despite performance being very poor. Whilst she understood the challenges in performance managing a service provided by another health board and did not doubt there was considerable effort being put in, the paper did not provide assurance and there needed to be a plan of action going forward, which included trajectories, and while she did not doubt there was considerable work being undertaken, there was no assurance being provided.

Hamish Laing commented that the Welsh Health Specialised Services Committee (WHSSC) had commissioned a consultation regarding inpatient CAMHS and the health board's response was its opportunity to influence the process.

Angela Hopkins sought details as to the processes in place for primary care CAMHS, such as school nursing, in order to prevent children from needing specialist services. Joanne Abbott-Davies advised that the school nursing team did not feel sufficiently empowered or skilled to take forward some of the work. Angela Hopkins stated that this also needed to be incorporated into the entry on the risk register. **JAD/AH**

Hamish Laing queried the services in place for young people who fulfilled the criteria for specialist CAMHS but not inpatient care. Joanne Abbott-Davies responded that this was an issue as they would still require a 'place of safety' and the health board only had one option, Hillside, but this required a court order and would need to be considered as part of DoLS. Hamish Laing advised that the WHSSC consultation was an opportunity to address the 'mismatch' between specialist CAMHS and inpatient CAMHS criteria.

Angela Hopkins noted that there were occasions where young people requiring inpatient support had been given a bed on an adult ward and queried as to how many patients were in facilities outside of the health board area. Joanne Abbott-Davies advised that Ward F at Neath Port Talbot Hospital had been used as a 'one-off' for a young person requiring inpatient care but this had now become the custom for those who did not meet the criteria for the specialist CAMHS inpatient unit. She added that a piece of work had recently been commissioned to identify the patients at facilities out of the area to assess if their placements were still adequate and whether there was a way in which they could be treated closer to home.

Emma Woollett advised that the all-Wales vice-chairs' group was developing a national position paper on CAHMS which might help at a strategic level. However, there remained the question of how, as a health board, it could improve the way in which it manage the service and its performance. She commented that it appeared as though a complex set of clinical services were being managed through an SLA, which did not appear to be working very well. Angela Hopkins concurred and agreed to support Joanne Abbot Davies in preparing

an action plan for improvement that would be presented at the next meeting. **JAD/AH**

Resolved:

- The report be **noted.**
- Letter to be written to Cwm Taf University Health Board regarding non-reporting of incidents/tests/letters via all-Wales systems. **AH**
- Issues outlined during the discussion to be included within the corporate risk register. **JAD/AH**
- An action plan be received at the next meeting dealing with performance issues and the coherence of the service. **JAD/AH**

11/18 QUALITY AND SAFETY PRIORITIES REPORT

A report providing an update in relation to the quality and safety priorities was **received.**

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

- The quality strategy was due to be refreshed and as such, a workshop had taken place with clinical leads and the quality improvement team;
- A refresh of the quality assurance process and priorities was also to be undertaken;
- Discussions were being undertaken with regard to establishing a quality improvement 'hub' to align principles with key areas;
- One priority had been identified as healthcare acquired infections and investment had been agreed for clinical leads in each of the units to have sessions for this and quality improvement;

In discussing the report, the following points were raised:

Ceri Phillips stated that the way in which the health board collected and used patient recorded outcome measures (PROMs) needed to improve as they were the way in which the health board could evidence that it was contributing to the health of the population. Hamish Laing advised that the health board had ambitions to undertake PROMs on a large scale but had received a request to be part of the national PROMs programme which was not working at the pace that the health board wished to, but a lead for the work had been appointed within ABMU. He added that ABMU and Hywel Dda University Health Board had been asked to work together as leads for value-based healthcare and this was an opportunity to accelerate some of the PROMs work and requests for funding had been submitted to Welsh Government. In addition, work was being undertaken with the International Consortium for Health Outcomes Measurement (ICHOM) to use some of its datasets, including the PROM for lung cancer and it was proposed to use six more. Ceri

Phillips responded that the work sounded encouraging as recording PROMs was not a complex process as the units could collect the data via a simple questionnaire which could be input into the national data collection system EQ-5D or Albatross. Hamish Laing stated that the health board was actively participating in PROMs but just not at a significant pace and undertook to bring an update to the next meeting which included details of the value-based healthcare work. **HL**

Emma Woollett noted the intention for the following year's priorities to focus on targeted intervention areas, which she understood and agreed with, however, she urged that this should not allow attention to be detracted from other quality and safety challenges such as falls and pressure ulcers. Chris Morrell advised that areas such as those would be indicators within each priority and would still be reported as part of the quality and safety dashboard. Hamish Laing added that each performance area would have a number of measures and the health board's quality network would develop driver diagrams to encourage ideas.

Resolved:

- The report be **noted.**
- Report providing an update in relation to PROMs and value-based healthcare be received at the next meeting. **HL**

12/18 QUALITY AND SAFETY DASHBOARD

A report providing an update on the performance of units against key measures was **received.**

In discussing the report, the following points were raised:

Chantal Patel noted that Neath Port Talbot Hospital's performance in relation to discharge summaries had dipped and queried the reasons. Hamish Laing responded that there were a number of wards within the hospital which were managed by Princess of Wales Unit and as such, the consultants were not on site on a daily basis to sign-off the summaries. He added that it was difficult to separate these from the performance of Neath Port Talbot Unit but also as the numbers of discharge summaries requiring completion by Neath Port Talbot Hospital was small, if the unit did miss one deadline, it would have a greater affect on its performance.

Chantal Patel queried if there was any data which highlighted that patients were at risk of readmission if discharged without a summary. Hamish Laing advised that the risk was very small, as GPs had alternative ways of seeking the information, such as contacting the hospital or accessing the patient's secondary care record via the Welsh Clinical Portal. He added the biggest risk area related to changes within medications and this should be mitigated by the implementation of electronic prescribing, which was to start at Neath Port Talbot Hospital later in the year.

Martyn Waygood referenced the six month discharge improvement

programme at Morriston Hospital, adding that a significant improvement had not been evident. Hamish Laing commented that reports were now available at individual consultant levels and there were several specific clinical areas which were under a targeted intervention focus. He added that he was meeting with the clinical leads for these areas to make clear the need for the summaries to be completed in a timely manner and to encourage the use of the wider clinical team to complete the paperwork where appropriate.

Martyn Waygood stated that the clinical coding team needed to be congratulated for the way in which it had improved and maintained its performance.

Martyn Waygood sought details as to the work being undertaken to improve falls and whether there were opportunities to do more through bids to the Charitable Funds Committee. Angela Hopkins advised that a number of areas were under consideration such as flooring, footwear and the layout of wards, particularly in times of high pressure when extra beds were added to wards. She added that a falls group had been established to scrutinise falls and develop indicators, and funding through charitable funds was something to consider. Hamish Laing commented that the flooring on some of the wards at Morriston and Princess of Wales hospitals had been replaced which was not only having an impact on falls but it was also improving infection rates. He added that a number of patients were given compression socks but there was no evidence that they were of benefit and as such, consideration was being given to using slipper socks instead.

Chantal Patel stated it was difficult to see from the performance data the benefits of activities being undertaken. Angela Hopkins responded that consideration needed to be given as to how interventions and actions undertaken could be demonstrated on performance charts and graphs to show the impact. **AH**

Resolved:

- The report be **noted.**
- Consideration be given as to how interventions and actions undertaken could be demonstrated on performance charts and graphs to show the impact. **AH**

13/18 CHANGE IN AGENDA ORDER

Resolved: The agenda order be changed and items 4.6, 7.1 and 8.1 be taken next.

14/18 DISCHARGE INFORMATION IMPROVEMENT

A report regarding the improvement of discharge information was **received.**

In introducing the report, Hamish Laing highlighted the following

points:

- A sustained improvement had been seen in relation to completing discharge summaries for when the patient left hospital however it was not at the required pace;
- A formal collaboration had been established with the Royal College of Physicians in London and a memorandum of understanding signed as part of digital healthcare.

In discussing the report, Martyn Waygood stated that the general improvement was encouraging, particularly within mental health services.

Resolved: The report be **noted.**

15/18 MANAGEMENT OF MEDICAL DEVICES POLICY

A report seeking the endorsement of the medical devices policy was **received.**

In introducing the report, Hamish Laing highlighted the following points:

- The policy had been updated following a *limited assurance* internal audit report;
- If the revised policy was ratified, the service would be ready for a re-audit;
- The policy had already been approved by the Medical Devices Committee.

In discussing the report, the following points were raised:

Ceri Phillips noted that medical devices were to be subject to more stringent evaluations in the future and queried as to whether the policy took this into account. Hamish Laing responded that this was reflected by the way in which the policy aligned with others. He added that the all-Wales health technology committee had sought assessments of certain areas and this had been referred to the head of medical electronics to consider.

Hamish Laing stated that as more web-enabled devices were being produced, correct disposal of items was critical. He added that a significant amount tended to be sent to developing countries and as such care needed to be taken to ensure that were correctly ‘wiped’.

Resolved:

- The report be **noted**.
- The management of medical devices policy be **ratified.** **HL**

16/18 CLINICAL OUTCOMES GROUP REPORT

A report providing an update from the clinical outcomes group was **received.**

In introducing the report, Hamish Laing highlighted the following points:

- The clinical outcomes group received reports following national mandated audits;
- At its meetings, the relevant clinicians were invited to discuss the findings and actions to be taken;
- Welsh Government had developed a pro-forma for health boards to report findings of national audits to provide assurance but the process was under review as some of the timelines were challenging;
- Key findings from national audits would be included within the annual quality statement;
- A revised clinical audit policy was appended for approval, which if ratified would enable a re-audit to take place following a recent *limited assurance* rating.

In discussing the report, the following points were raised:

Emma Woollett queried as to whether a record was kept of audits started but not completed. Hamish Laing advised that the health board had placed its clinical audit focus on the national mandated programme rather than local audits. He added that local clinical audits were undertaken by junior doctors but often not completed as they moved on to new rotations and as such, a new approach was being taken whereby audits were undertaken by departments to improve learning based on issues identified.

Emma Woollett asked if there were discussions undertaken should a doctor wish to undertake a local clinical audit outside of the health board's priorities. Sandra Husbands advised that the clinical audit policy outlined the process should anyone wish to undertake a local audit, which included seeking approval and addressing health board priorities.

Emma Woollett queried as to whether the Audit Committee received updates in relation to clinical audits. Hamish Laing advised that the Audit Committee oversaw the clinical audit process whereas the detailed audits were received by the Quality and Safety Committee.

Resolved:

- The report be **noted.**
- Clinical audit policy be **ratified.**

17/18 BLOOD GLUCOMETRY ACTION LOG UPDATE

A report updating on progress against the action log in response to the blood glucometry review was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- As the author of the original review, it was pleasing to see a number of the actions had been completed;
- 15 action still required addressing, the majority of which could now be marked as 'complete' following the approval of the police disclosure policy by the Audit Committee;
- A further update would be brought to the April 2018 meeting.

Resolved: The report be **noted.**

18/18 INFECTION CONTROL REPORT

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

In introducing the report, Angela Hopkins highlighted the following points:

- The overarching message was that the health board's performance in relation to infection was unacceptable;
- An internal profile of the current position was to be established in order to set internal targets and this would also be shared with Welsh Government;
- Welsh Government required an improved position by autumn 2018;
- An anti-microbial procedure had now been approved;
- Investment was to be made into quality improvement infection prevention leads for each unit;
- An increase in leadership was to be established as well as an internal escalation framework;
- The vacant assistant director of nursing post for infection control was to be recruited to.

In discussing the report, the following points were raised:

Chantal Patel queried as to how informed frontline staff were as to their responsibilities for infection control. Angela Hopkins advised that Princess of Wales Hospital was a prime example as to how targeted intervention focus was of benefit as they had developed a decant area to enable deep cleaning to be undertaken in clinical areas. She added that peer review of hand hygiene was being undertaken with colleagues in Hywel Dda and Cwm Taf university health boards and the focus was on quality improvement rather than control to support a culture change.

Emma Woollett welcomed the approaches being taken, adding that having a focus and a relatively small number of actions was key, but it was also important to keep in mind that change did take time. Chantal Patel concurred, stating that significant improvements would not be evident overnight and cited an example which had been shared with

her of a nurse just using new gloves in between patients rather than handwashing. Angela Hopkins responded that leadership was vital in these instances and ward managers not only needed to be role models to their teams but also be provided with the time and support to do so.

Martyn Waygood sought more details as to the reduction in acid suppression therapies. Angela Hopkins advised that this related to proton pump inhibitors which were used for people who had developed gastric symptoms but were a leading risk for *clostridium difficile.*

Martyn Waygood noted the imminent retirement of two senior infection control nurses and queried the work to develop the skills of other members of the team to take over the responsibilities. Angela Hopkins advised that the two senior nurses were leaving on a 'retire and return' basis and would be working together on a part-time basis to succession plan the team for the future.

Pam Wenger noted that an infection control update was received at every other meeting and suggested that it be received at every meeting due its high risk profile. This was agreed.

Resolved:

- The report be **noted.**
- Frequency of the report's receipt by the committee be changed to every meeting. **AH**
- The proposal for the delivery units to adopt the key focused improvement priorities be **supported.** **AH**

19/18 SAFEGUARDING REPORT

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

In introducing the report, Angela Hopkins highlighted the following points:

- The report was received bi-annually by the committee and she would be reviewing the content prior to the next iteration;
- Currently there was no risk register for safeguarding and as such, one was to be developed;
- Compliance with safeguarding training was low due to difficulties in releasing staff but actions to improve were being considered;
- Discussions were being undertaken to develop one referral form for all local authority services;
- The risk of nursing young people on adult wards for mental health services continued to be an issue and a risk assessment was to be developed to inform actions;

- Work was ongoing to increase the amount of people able to sign-off DoLs forms to reduce the number of breaches and best interest assessor training was now in progress.

In discussing the report, the following points were raised:

Chantal Patel stated that the quality of DoLs reports needed to be consistent as well as staff trained to identify those who may be applicable. She added that while no legal cases had been brought for breaches to date, courts were likely to become more stringent. Angela Hopkins stated that staff needed to understand that DoLs was not just the responsibility of the corporate safeguarding team rather everyone needed to be aware of how to raise such issues.

Martyn Waygood noted that no cases of female genital mutilation had been reported in Wales and queried as to how the health board would be made of aware of such instances. Angela Hopkins advised that reports would have been received from social services or the police, unless the person was under the care of an ABMU GP or hospital.

Martyn Waygood stated that is was pleasing to see that work was ongoing with IT to develop a robust procedure for collating data to develop a safeguarding dashboard.

Pam Wenger reminded the committee that reports were to be published on the health board's website and as such, authors needed to be mindful of the information being put in the public domain.

Resolved: The report be **noted.**

20/18 NEVER EVENT UPDATE REPORT

A report detailing themes identified following a number of 'never events' was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- The report highlighted the incidents classed as 'never events' in Wales as two new areas had been added;
- The various royal societies were considering if those in relation to spinal surgery should still be included;
- A review was also being undertaken as to whether incidents relating to incorrect lenses for cataract surgery should be amended;
- In the recent seven weeks, four 'never events' had occurred, all of which were reported to Welsh Government and strategy meetings arranged to identify actions;
- A reflective practice workshop had taken place to determine how best to share learning from such incidents as often people's assumptions as to why they had occurred differed;

- The NHS Wales Delivery Unit had been asked to continue the work with units to evaluate 'never events' and publish the results Wales-wide.

In discussing the report, the following points were raised:

Emma Woollett referenced the 'never events' in relation to the World Health Organisation (WHO) checklist and noted that a theme identified was that a locum was present. She added that this was not a reason or a theme, rather the issue was the training provided to a temporary member of staff and this was what required mitigating.

Hamish Laing advised that the list of 'never events' was one developed by NHS England who had updated it that day to remove several incidents, which included three of the four reported by ABMU recently. He added it was unclear as to whether Wales would make similar amendments. In addition, while consideration was being given to removing spinal surgery from the list, the Royal College was to identify a more appropriate measure to include. Emma Woollett stated 'never events' were a key assurance mechanism but it was important to differentiate between whether the correct procedure had been followed or whether it was just unfortunate that an error had occurred.

Resolved: The report be **noted.**

21/18 OLDER PEOPLE'S AGENDA POSITION PAPER

A report providing an update in relation to the work to capture the experience of older people was **received** and **noted.**

22/18 PATIENT EXPERIENCE REPORT

A report providing an overview of progress relating to the delivery of the patient experience programme and performance against key outcome measures was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- Behaviour and communication needed to be at the forefront for staff in order to deliver good patient experience, especially during times of extreme service pressure;
- The number of patients who would recommend the emergency department service had decreased but it was important to view this in the context that January 2018 was a period of high demand;
- Both Healthcare Inspectorate Wales (HIW) and ABM Community Health Council (CHC) had undertaken visits to the emergency departments and while there had been recommendations, overall the feedback had been positive;

In discussing the report, the following points were raised:

Martyn Waygood referenced the recent 15-step challenge to a Cwmavon GP surgery, adding that it had been well-run practice in which the staff were enthusiastic and happy to engage.

Martyn Waygood noted the ABMU arts in health's team's dance for health project and advised the committee that a bid had recently been approved for funding from charitable funds. Angela Hopkins commented that not only did dancing assist older patients with physical issues such as co-ordination, but such activities were a solution for loneliness.

Hamish Laing stated that the narrative within the report needed consideration as the statistics were reported to two decimal points and any slight change was considered movement, which was not really the case.

Martyn Waygood sought clarity as to why the committee had been asked to approve the claims policy and procedure. Pam Wenger advised that the health board's current process required policies to be approved by board committees however she reviewing the process as part of her governance 'stock take'.

Resolved:

- The report be **noted.**
- The 'Putting Things Right' policy be **approved.** **AH**
- The claims policy and procedure be **approved** **AH**

23/18 QUALITY AND SAFETY FORUM UPDATE

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

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

- The actions taken following a naso-gastric tube never event had been discussed;
- A new European Union safety regulation for radiation was to become law in February 2018 which outlined standards for protection of workers, public and patients against exposure to ionising radiation.

In discussing the report, Martyn Waygood noted that only Singleton and Morriston units had attended the recent forum meeting. Chris Morrell advised that there had been some issues in relation to attendance and as such, the reporting process for units to various fora needed to be established. Pam Wenger added that she was discussing such arrangements with the head of internal audit.

Resolved: The report be **noted**.

24/18 NHS WALES PRIOR APPROVAL POLICY

A report seeking approval of the all-Wales prior approval policy was **received** and **ratified.** **SH**

25/18 CHANGE IN AGENDA ORDER

Agenda order be changed and item 11 be taken next.

26/18 ANY OTHER BUSINESS

(i) Princess of Wales Hospital Enhanced Monitoring

Hamish Laing advised the committee that following the 'Trusted to Care' review, Princess of Wales Hospital had been placed in 'enhanced monitoring' status by the General Medical Council in relation to the knowledge provided to junior doctors. He added that work had been undertaken to address this, and as such, the health board's Chairman had received a letter to advise that this status had now been lifted.

27/18 EXTERNAL INSPECTIONS REPORT

A report detailing a summary of external inspections and letters received from inspectorates/regulators was **withdrawn** from the agenda.

28/18 WELSH RISK POOL ANNUAL REPORT

The annual report from the Welsh Risk Pool was **received.**

In discussing the report, the following points were raised:

Emma Woollett noted that the report did not provide a sufficient level of detail for the committee to seek assurance in relation to the health board. Angela Hopkins concurred, adding that it would be more beneficial for the report to outline a position statement for each organisation under each section.

Martyn Waygood raised concern with regard to the way in which case studies were written as not only were they potentially identifiable but the language used was significantly informal. Sandra Husbands concurred, adding that there was a lack of serious examples and adherence to public duty.

Emma Woollett queried if there was an opportunity for the health board to comment on the report. Pam Wenger undertook to write to the Welsh Risk Pool. Angela Hopkins added that she would also discuss it with the health board's legal liaison within the service. **PW/AH**

Resolved:

- The report be **noted.**
- Feedback be provided to the Welsh Risk Pool in relation to the content of the report. **PW/AH**

29/18 **QUALITY DIVISION FEEDBACK REPORT**

The Welsh Government quality division feedback report was **received.**

In introducing the report, Angela Hopkins highlighted the following points:

- She was due to meet with the Public Services Ombudsman to support good relations however the organisation had been complimentary with regard to the way in which overdue complaints responses had been managed in the previous year;
- Feedback had been provided to the corporate nursing team in relation to the way the graphs were presented to ensure more assurance could be taken from future reports.

In discussing the report, the following points were raised:

Martyn Waygood queried as to whether the number of open and overdue serious incidents was something of concern. Angela Hopkins advised that she had met with the quality department of Welsh Government regarding the number and while actions were to be taken to close the reports quickly this would not be to the detriment of the quality. She added that Welsh Government was pleased with the health board's reporting approach but wanted outstanding incidents closed.

Emma Woollett queried as to how some of the learning was to be taken forward. Angela Hopkins advised that newsletters were now being produced in response to serious incidents. She added that there were pockets of good practice and this needed to be reflected within future reports.

Resolved: The report be **noted.**

30/18 **ANY OTHER BUSINESS**

There was no further business and the meeting was closed.

31/18 **NEXT MEETING**

This was scheduled for 5th April 2018.

32/18 **MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.**