Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
25th October 2022
at 1.30pm via Microsoft Teams

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

In Attendance
Anne-Louise Ferguson, Board Advisor (Legal)
Christine Morrell, Director of Therapies and Health Science
Gareth Howells, Director of Nursing and Patient Experience
Richard Evans, Executive Medical Director
Hazel Lloyd, Director of Corporate Governance
Hazel Powell, Deputy Director of Nursing and Patient Experience
Scott Howe, Healthcare Inspectorate Wales
Chris Scott, Internal Audit
Sue Evans, Community Health Council
Liz Stauber, Head of Corporate Governance
Steve Jones, Service Group Nurse Director, Mental Health and Learning Disabilities (until minute 249/22)
Delyth Davies, Head of Infection, Prevention and Control (minute 249/22)
Kate Hannam, Service Group Director, Morriston Hospital (minute 250/22)
Sue Morgan, Consultant in End-of-Life Care (minute 251/22)
Meghann Protheroe, Head of Performance (minute 252/22)
Sue Ford, Head of Patient Experience, Legal and Risk (minute 253/22)
Rhys Howell, Pharmaceutical Advisor (minute 255/22)
Karen Gronert, Head of Nursing, Primary Care (minute 256/22)
Neil Thomas, Deputy Head of Risk (minute 257/22)
Andrea Bradley, Network Manager, Major Trauma Network Operational Delivery Network (minute 258/22)
Lorraine Hay, Clinical Lead, Major Trauma Network Operational Delivery Network (minute 258/22)

Minute No.		Action
240/22	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting. Apologies for absence had been received from Patricia Price, Independent Member and Sian Harrop-Griffiths, Director of Strategy.	

241/22	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
242/22	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 27th September 2022 were **received** and **confirmed** as a true and accurate record, expect to note Anne-Louise Ferguson was present.	
243/22	**MATTERS ARISING**	
	There were no matters arising not otherwise on the agenda.	
244/22	**ACTION LOG**	
	The action log was **received**, with the following updates **noted**: **(i) Action Point One – Infection Control Training** Steve Spill advised that the issue relating to infection control training on ESR (electronic staff record) had been referred to the Workforce and OD Committee and a response was now awaited. **(ii) Action Point Four – Virtual Ward Visit** Steve Spill advised that the visit for independent members to a virtual ward had now been arranged.	
245/22	**WORK PROGRAMME 2022-23**	
	The work programme was **received** and **noted.**	
246/22	**CHANGE IN AGENDA ORDER**	
Resolved:	Agenda order be changed and item 2.2 be taken next.	
247/22	**SERVICE GROUP HIGHLIGHT REPORT – MENTAL HEALTH AND LEARNING DISABILITIES**	
	The highlight report from Mental Health and Learning Disabilities was **received**. In introducing the report, Steve Jones highlighted the following points:	

	- Serious incidents relating to Ward F were being managed through the serious incidents groups and work was ongoing to reduce the backlog; - The ward was similar to the emergency department in terms of level of activity and risk; - Previously the doors of the ward had been actively open but due to the high risk of those detained under the Mental Health Act 1983 absconding. As the policy was for the door to be open with the ability to lock, benchmarking was being undertaken with similar units across the UK as parity in approach was needed; - The number of healthcare acquired infections within the service group remained at zero and this was being constantly monitored. The action plan was being reviewed to determine why the good performance to identify learning that could be shared; - The service group was managing outbreaks of Covid; - There had been an increase in the reporting of the falls due staff not being aware of the need to report long-bone fractures. This had now been done retrospectively and caused a spike. The situation was being monitored to ensure this was the reason for the increase; - Patient feedback continued to be good therefore an external review was to be commissioned to talk with those actually using the services to get a feel for what the feedback was really like. In discussing the report, the following points were raised: Steve Spill queried the medium to long-term plan for acute adult mental health services given the development plans for Neath Port Talbot Hospital. Steve Jones responded that the matter had been subject to numerous discussions and an outline business case had been developed for the service to be located at Cefn Coed Hospital in the next five years. Reena Owen sought clarity as to whether the staffing levels for Ward F at Neath Port Talbot Hospital were sufficient. Steve Jones responded investment had been made and the ratio of staff to patients was correct however for some patients, this could be too much staffing as it created a busier environment which was a trigger for some mental health conditions and consideration was needed how to find the right balance. Reena Owen advised she was part of the health board's sepsis group which would benefit from representation from the Mental Health and Learning Disabilities Service Group. Steve Jones concurred, adding that arrangements had been and a representative was to be on the group going forward. Reena Owen referenced the numbers of suicides and queried if the organisation was in a position of understanding the implications and how to improve. Steve Jones responded that this was an ongoing process and action plans were in development. The backlog of reviews needed	

	to be completed first to identify themes in order for a whole service response. He added that the service group was an active partner of the national untoward incident steering group which provided data from across Wales for comparison and this would provide an opportunity nationally to develop improvement plans as well. Hazel Powell reflected that the Ward F had been the location of three serious incidents in the last few months, the severity of which would have affected the staff greatly. She commended Steve Jones and the senior management team for the way in which the ward staff had been supported as just one of these events could have causes staff to have wanted to leave their roles.	
Resolved:	The service group highlight report from Mental Health and Learning Disabilities be **noted.**	
248/22	**PATIENT STORY: MENTAL HEALTH AND LEARNING DISABILITIES**	
	A story setting out the role Clyne Ward at Cefn Coed Hospital was **received.** It set out that the female acute adult ward had been established as an assessment and treatment facility but now just provided treatment, focusing on a recovery model. Activities were one of the main sources of treatment plan, for example pumpkin picking, visiting farms and a party for the Queen's jubilee. The ward was currently decorated for Hallowe'en. There was a focus on wellbeing, with sessions provided on smoking cessation and sexual health, but more support was needed from the voluntary sector. Staff were in the process of being trained to undertake smear tests as often the patients were more comfortable with someone familiar. Memberships were available for patients who wanted to exercise with discounted rates so they could continue once back in the community. The family rooms had been improved to provide space for relatives to visit but this was the only space available. Patients could not be taken from the ward and there was little outdoor space available. There was no formal rehabilitation service available (there was for male patients) and as such, a service had to be paid for away from home which was leading to a delay. The goals for the ward were to improve outdoor spaces, focus on use of occupational therapy space and a sub for recovery. The service was looking forward to be a part of the new build.	
Resolved	- The patient story was **noted.**	
249/22	**INFECTION, PREVENTATION AND CONTROL REPORT INCLUDING OVERARCHING IMPROVEMENT PLAN**	
	A report providing an update on the health board's infection control plan, including overarching improvement plan, was **received.**	

	In introducing the report, Delyth Davies highlighted the following points: - Reductions were still evident for *clostridium difficile* and *e.coli* but increases in cases for *staph.aureus, pseudomonas* and *klebsiella*; - The percentage of the *staph.aureus* increase had levelled off; - A reduction in *klebsiella* cases had been evident in primary care but the increase in others areas was linked to the rise of hepato-biliary disease in the community for those with gall bladder issues; - A rise in *clostridium difficile* cases was likely due to the increase in Covid-19 prevalence; - The intensive care unit at Morriston Hospital had not reported a case of *staph.aureus, e.coli or klebsiella* since April 2022. In discussing the report, the following points were raised: Anne-Louise Ferguson queried the wellbeing of staff trying to reduce the number of healthcare acquired infections, as this would be challenging given the lack of decant facilities. Delyth Davies provided assurance that staff morale was monitored as keeping momentum was key. The infection control team visited the wards regularly to recognise the achievements which were being made as it was challenging. Progress was slow but this was in the midst of staff shortages. Regular meetings were taking place with staff to confirm that it was okay if the starting position was low as the purpose was for improvements to be made. Reena Owen stated that she was encouraged by the progress but noted that the programme lead for Morriston Hospital's repaid improvement programme had not yet been released. She sought assurance that this would be resolved. Gareth Howells advised that the member of staff currently managed the emergency department which was currently the bigger risk but there were plans to provide backfill for this post, so the person would be released in the next few weeks. He added that Delyth Davies was currently providing the additional support needed for the rapid improvement plan. Reena Owen noted that the recent recruitment for a Director of Infection, Prevention and Control had not been successful and queried the next steps. Richard Evans responded that external advice on the content of the job description had been sought and the relevant changes made ready to go back out to advert. There was no other such post in Wales so the job needed to be appealing to those working within NHS England. If that round of recruitment proved unsuccessful, consideration would be given to a recruitment agency or another reformation of the role.	
Resolved:	The report be **noted.**	
250/22	**UPDATE ON HIW IMMEDIATE IMPROVEMENT NOTICE AT MORRISTON EMERGENCY DEPARTMENT**	

A report setting out progress against the Healthcare Inspectorate Wales (HIW) immediate improvement notice at Morriston emergency department was **received.**

In introducing the update, Kate Hannam highlighted the following points:

- Part of the inspection included talking with staff and patients, observations and a questionnaire for staff to discover what it felt like to work there;
- An immediate improvement notice had been issued relating to time sensitive areas, particularly the delay to triage chest pains;
- An action plan had been submitted to and accepted by HIW and there was an expectation it would be completed by 22nd December 2022;
- The full report from the visit was yet to be received and the action plan would be extended should there be further areas to address;
- Despite the pressures in the department, feedback had been given that staff were compassionate and patients spoke positively about their care, but did raise the issue of waiting. Links with the bereavement services were held as an exemplar;
- There were a number of wellbeing champions within the department and there was a commitment to protecting the wellbeing of staff;
- Weekly meetings were taking place to progress the action plan.

In discussing the update, the following points were raised:

Reena Owen stated that she understood the pressure the staff were under and it was encouraging the immediate improvement notice did not find more areas of concern. She sought an explanation as to what the actions relating to walking through to find additional capacity and intentional rounding meant. Kate Hannam responded that one of the biggest constraints of the department was physical space in which doctors could observe a patient prior to discharge. The team had now walked through the department and identified areas which could be segregated off and used to extend triage and observation options. Intentional rounding was undertaken by medics or nursed every few hours with a checklist of areas to check each patient, such as observations taken, hydration and medication as one of the areas of concern had been access to food, but there was no evidence of this being a daily issue. Gareth Howells added that it was a way of ensuring ‘eyes on’ the patient being looked after and speaking to them of every few hours.

Reena Owen queried the extent to which additional capacity had been identified. Kate Hannam advised that one additional area to cordon off had been allocated but the waiting area had also been ‘zoned’ and those waiting for a bed cohorted in this area for a nurse to care for and observe.

	Kate Hannam advised the committee that following the release of a HIW review of another health board's emergency department, Gareth Howells had asked Morriston Hospital to review itself against the recommendations to assess its own position. This had been an opportunity to show HIW the action that already been taken and the willingness to learn from others.	
Resolved:	The update be **noted.**	
251/22	**PROGRESS REORT ON THE END-OF-LIFE QUALITY PRIORITY**	
	A progress report on the end-of-life quality priority was **received.** In discussing the progress report, the following points were raised: Anne-Louise Ferguson commented that patients were not routinely asked about power of attorney or their end-of-life wishes and more training was needed for staff to understand that talking about death was a good thing. She queried if there had been any examination of why staff were reluctant to discuss it, as often there was an element of heroism and wishing they could cure the patient. Sue Morgan responded that doctors had a tendency to want to keep patients alive for as long as possible, and this may not always be in-line with the wishes of a patient. Sometimes trying to keep people alive did not always add quality to their life. The last 12 months of a person's life were so important and this needed to be a core part of medical and nursing training. Reena Owen queried if there were barriers within the system which meant it difficult to discharge patients home when they were dying. Sue Morgan responded that the bigger challenge was recognising and acknowledging that the person was dying rather than the resources to enable them to return home. Christine Morell stated that the highest percentage of people who died in one of the health board's hospitals did so in the emergency department. Work needed to be done to make sure this was not because they were waiting for a bed elsewhere. She added that death needed to be normalised and that was the 'Care After Death' team had been called that as it needed to be as much a part of business as living. Richard Evans concurred, adding that reviews were being undertaken of those who died in the emergency department to determine if they had been expected to die or it was a case of having waited too long to be admitted. A lot of cases were the frail elderly, some of whom had advanced care plans and should not have been conveyed to hospital. Adequate services in the community were needed to avoid this. He added that one of the service group medical directors convening a group around surgery as the right decision was not always to operate and there needed to be consideration as to what the right intervention for the best interests of the patient in the last few days of their life. Finally work was ongoing with residential and nursing homes around DNACPR (do	

	not attempt CPR) decisions to ensure plans were in place for anyone who had signed these documents.	
Resolved:	The progress report be **noted.**	
252/22	**QUALITY AND SAFTEY PERFORMANCE REPORT**	
	The quality and safety performance report was **received.** In introducing the report, Meghann Protheroe highlighted the following points: - Focus was being given to reducing length of stay and admission avoidance to improve urgent and emergency care; - The numbers of clinically optimised patients continued to be high and a focus piece of work was being undertaken to address this to improve patient flow; - Healthcare acquired infection numbers were below the Welsh Government trajectory with the exception of *e.coli* and detailed work was taking place at each individual service group level; - Reductions had been reported for those waiting more than 24, 36, 52 and 104 weeks for planned care treatment. In discussing the report, the following points were raised: Darren Griffiths advised that overbooking was now in place to manage some of the backlog within outpatients and performance was currently ahead of trajectory. While it was though that this would continue, a watchful eye would be needed around Christmas time as it was likely that numbers would start to breach as a result of delayed referrals during the second wave of Covid-19, and demand and capacity plans may have to change. Planned care remained an area for which the health board continued to be in enhanced monitoring with Welsh Government. Reena Owen queried whether there were arrangements in place to support patients on pathways with particularly long waiting lists. Inese Robotham responded that signposting was in place for a number of specialities for available support services however, the waiting lists were so long, it was often unclear the condition of the patient until they were seen in clinic. Validation would help relieve some of this pressure. Gareth Howells noted that number of reported falls, adding that it was another of the health board's quality priorities and it would be beneficial for the committee to receive a 'deep dive' on the improvement work, which included a 'mini-summit'.	
Resolved:	The report be **noted.**	
253/22	**QUARTERLY PATIENT EXPERIENCE REPORT**	

	The quarterly patient experience report was **received.** In discussing the report, the following points were raised: Steve Spill queried the way in which a complaint was processed through the health board's systems and whether the Public Services Ombudsman was able to extract from records. Sue Ford advised that every response to a complaint sent by the health board included a paragraph which explained how a complainant could contact the Public Services Ombudsman. Some preferred to come directly back to the health board if they were not satisfied with the response whereas others contacted the Public Services Ombudsman instead. If someone did refer to the Public Services Ombudsman, it was not always to the knowledge of the health board and a full investigation could be undertaken before the organisation was informed, after which, there would be 20 days in which the health board would need to respond. Reena Owen queried referenced a recent workshop on complaints responses and queried if there was any further work that could be undertaken internally. Susan Ford responded that complaints required a formal response and a meeting was always offered as part of this with the clinical team. The gold standard would be to move towards offering a meeting as soon as the complaint was received.	
Resolved:	The report be **noted.**	
254/22	**EXECUTIVE SUMMARY OF THE PATIENT SAFETY GROUP**	
	A report providing the executive summary from the recent meeting of the Patient Safety Group was **received.** In discussing the report, the following points were raised: Reena Owen referenced the work undertaken following a HIW inspection of an emergency department within another health board and queried the purpose. Hazel Powell responded that on the back of that report, the Gareth Howells had asked for the health board to self-asses itself against the recommendations for learning and improvement. This had put its service in a good position for when HIW came to review it. Steve Spill commented that given all the changes to the quality governance system, it would be useful to have a diagram which outlined the structure. Hazel Powell undertook to provide this. Steve Spill referenced the issues raised during external reviews such as of the prison and emergency department and queried why these were not spotted earlier. Hazel Powell advised that the work around the quality management system would enable problems to be identified early on rather than rely on external regulators. Gareth Howells concurred, adding that it was important to systemise the information from ward to board to ensure no surprises.	**HP**

	Richard Evans stated that services were being challenged to develop quality indicators to demonstrate services were of a high quality. Christine Morrell added work was in progress to standardise peer and external reviews as the audit process was vital. Gareth Howells commented that a significant amount of work was being undertaken to digitize the quality work and suggested this be shared at a future meeting. This was agreed.	**MJ/GH**
Resolved:	- The report be **noted.** - Diagram be provided of the quality governance structure; - Demonstration of the quality digital dashboard be provided.	**HP** **GH/MJ**
255/22	**CONTROLLED DRUGS GOVERNANCE AND ASSURANCE PROGRESS REPORT**	
	The controlled drugs governance and assurance progress report was **received** and **noted.**	
256/22	**ONGOING TASKS, ACTIONS AND IMPROVEMENT PLAN SURROUNDING HMP SWANSEA FOLLOWING THE HIW REVIEW**	
	A report detailing ongoing tasks, actions and improvement plan surrounding HMP Swansea following the HIW review was **received.** In introducing the report, Karen Gronert highlighted the following points: - A significant amount of the action plan had been completed but two of the recommendations could only be addressed through a successful bid for additional resources; - Swansea prison had 250 cells which were often used for two patients, doubling the demand for healthcare but no such flex in the staffing provision; - An implementation group was in place to focus on the a health delivery plan. In discussing the report, the following points were raised: Reena Owen queried if there was an absolute set standard for nursing numbers and it was the responsibility of the health board to meet this. Karen Gronert responded that benchmarking was being undertaken to determine the optimum number as the service was not covered by the Nurse Staffing Levels (Wales) Act 2016. It was the health board's obligation to provide nursing care and work was ongoing within the service group to identify additional monies. Reena Owen sought clarity as to how the partnership groups within the prison governance system aligned with that of the health board. Karen Gronert responded that this was a work in progress to align the two structures and the wellbeing plans and delivery frameworks for the	

	prison improvements would be shared within the health board's structures for approval. Reena Own sought assurance that the health promotion was a critical part of the prison healthcare. Karen Gronert responded that there would be specific priorities for substance misuse, mental health wellbeing, nutrition and smoking, amongst others.	
Resolved:	The report be **noted**.	
257/22	**QUALITY AND SAFETY RISK REGISTER**	
	The quality and safety risk register was **received** and **noted.**	
258/22	**Q1 SOUTH WALES MAJOR TRAUMA NETWORK CLINICAL GOVERNANCE REPORT**	
	The quarter one South Wales Major Trauma Network clinical governance report was **received.** In discussing the report, the following points were raised: Reena Owen queried if the original data analysis on resources prior to implementation had accounted for potential significant influxes of trauma. Lorraine Hay confirmed that robust modelling had taken place but levels were above what had been anticipated however the pathways were still moving smoothly. The service was well resourced but could always benefit from more. Robust governance processes were also in place.	
Resolved:	The report be **noted**.	
259/22	**ITEMS TO REFER TO OTHER COMMITTEES**	
	There were no items to refer to other committees.	
260/22	**ANY OTHER BUSINESS**	
	There was no further business and the meeting was closed.	
261/22	**DATE OF NEXT MEETING**	
	The date of the next meeting was confirmed as 22nd November 2022.	