Swansea Bay University LHB
Quality and Safety Committee
Unconfirmed minutes of the meeting held on 20th June 2019
at 9am in the board room, Singleton Hospital

Present
Martyn Waygood, Independent Member (in the chair)
Reena Owen, Independent Member
Maggie Berry, Independent Member

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Alastair Roeves, Deputy Medical Director
Chris Morrell, Deputy Director of Therapies and Health Science (for minute 88/19)
Alison Clarke, Assistant Director of Therapies and Health Science
Paula O'Connor, Head of Internal Audit
Carol Moseley, Wales Audit Office
Jane Dale, Healthcare Inspectorate Wales
Liz Stauber, Corporate Governance Manager
Jacqui Maunder, Interim Head of Compliance
Sue Jose, Acting Head of Midwifery (for minute 74/19)
Lee Joseph, Assistant Head of Concerns and Assurance (for minute 87/19)
Kath Hart, Head of Nursing for Neath Port Talbot, Mental Health and Learning Disabilities Unit (for minute 86/19)

Minute		**Action**
74/19	**PATIENT STORY**	

Sue Jose was welcomed to the meeting.

A patient story was received outlining the experience of a couple who had recently had their first baby at Singleton Hospital. For the delivery, the couple had use of the serenity suite, which had a birthing pool as well as a view of Mumbles, bed, sofa and tea/coffee facilities. All of this, in addition to music, helped to make the environment feel more relaxed. The new mother talked about how she had been able to have a water birth as planned and the midwife had helped her position herself so she could see her baby arrive. The care of the midwifery team was highly praised, as they ensured they provided the couple with all the information they would need during ante-natal care, as well as waiting until the mother had been able to breastfeed and felt comfortable before moving her to the post-natal ward. While the new mother spoke of how happy she had been with her care, she did raise concern that the waiting area for scans was also used for gynaecology patients, which made her acutely aware that some women in the waiting room had issues with their fertility which made her feel uncomfortable.

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

Sue Jose advised that a significant amount of investment had been made in order to make it a more comfortable environment for patients, which would enhance the dignity and care.

Reena Owen queried if the unit had sufficient capacity for all patients to use a birthing pool. Sue Jose responded that not all women would be able to use one as some had high-risk pregnancies. She added that a second pool room was now available which provided more capacity in the midwife-led unit and there were plans to include one on the consultant-led area as part of the refurbishment plans.

Reena Owen sought clarity as to whether any changes could be made to the waiting areas for scans to enable obstetric appointments to be separate from gynaecology. Sue Jose advised that work was being undertaken to determine the most appropriate place for gynaecology appointments to take place at Singleton Hospital but it was critical that the right environment was identified. She added that a capital bid had been submitted to improve the current waiting area and turn it into a 'café' style to draw less attention to women being called for appointments.

Gareth Howells stated that feedback had been provided to Welsh Government following the external review of maternity services at Cwm Taf Morgannwg University Health Board and no major concerns had been identified. However, there was now a plan to centralise the management of maternity services within one unit, rather than having it devolved across two. Sue Jose added that having one management structure would help unlock potential within women's services and she was now a member of the quality and safety forum to represent service users' voices.

Alison Clarke noted that the patient had had to wait almost an hour for her appointments and queried if there was a particular reason. Sue Jose responded that there was a tendency to overbook clinics for obstetricians and there was to be a focus on validating whether all the patients waiting for an appointment needed to see a consultant. She added that scanning capacity was a challenge and was on the risk register, but consideration was being given to ultrasound training for midwifes to undertake growth scans in the third trimester.

Martyn Waygood advised that he had recently undertaken a visit to the maternity services where the attitude from staff had been excellent and it was an impressive unit, despite the current refurbishment work.

Resolved: The patient story be **noted.**

75/19 WELCOME AND APOLOGIES FOR ABSENCE

Martyn Waygood welcomed everyone to the meeting.

Apologies for absence were received from Chris White, Chief Operating Officer/Director of Therapies and Health Science; Pam

Wenger, Director of Corporate Governance and Richard Evans, Medical Director.

76/19 DECLARATIONS OF INTEREST

There were no declarations of interest.

77/19 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 18th April 2019 were **received** and **confirmed** as a true and accurate record, except to note the following typographical error:

53/19 NHS Wales Delivery Unit 90 Day Review

The issues in relation *to* theatres had been picked up elsewhere therefore a focus had been given to mental health and an action plan requested.

78/19 MATTERS ARISING NOT ON THE AGENDA

(i) 48/19 GP Indemnity

Maggie Berry queried whether the Primary Care and Community Services Unit would now become more involved in the complaints process following the change in guidelines. Alastair Roeves commented that this was the case, however the unit should be more involved than it currently was .

(ii) 49/19 Infection Control Report

Reena Owen stated that the cleaning hours remained a risk in the iteration of the infection control report on the current agenda, adding that it was a basic function and an 'easy win' in terms of reducing infections. Gareth Howells responded that while it was clear what action needed to be taken, it would require investment, and currently solutions were unit-based rather than board-wide.

(iii) 51/19 Annual Quality Statement

Martyn Waygood queried if the issues relating to the health and care standards had been resolved. Paula O'Connor advised that the information was taken to the April 2019 board development session. Gareth Howells added that he planned to re-establish the quarterly review process through an internal panel with an independent member lead.

(iv) 58/19 External Inspections Report

Martyn Waygood raised the issues of differing opinions of standards between dental practices and external inspectors. Gareth Howells responded that this was not a local issue but it was still something that the health board needed to address, and a summit was to be arranged.

79/19 **ACTION LOG**

The action log was **received** and **noted**.

80/19 **WORK PROGRAMME 2019/20**

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

81/19 **CHANGE IN AGENDA ORDER**

Resolved: The agenda order be changed and item 3.2 be taken next.

82/19 **SAFEGUARDING REPORT**

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

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

- A local and national safeguarding agenda was in development;
- The Mental Health Legislation Committee had received a robust update in relation to deprivation of liberty safeguards (DoLS);
- Confirmation had been received from the local crime commissioner that it would fund GP domestic abuse training for 12 months;
- Compliance with safeguarding training was increasing;
- Work was progressing with Swansea prison with regard to suicide prevention.

In discussing the report, the following points were raised:

Reena Owen sought assurance that the risk in relation to DoLS was improving. Gareth Howells advised that it was, adding that two assessors had been appointed and a review was being undertaken as to how people detained under the Mental Health Act in acute areas were supported. He added that the unit nurse director for primary care and community services had been identified as the lead and DoLS was also to move into the remit of the safeguarding team.

Reena Owen queried compliance with training for the Wellbeing of Future Generations Act. Gareth Howells advised that there was a plan in place with the safeguarding committee but the challenge was with the higher level safeguarding training, which was based on role requirements, and was difficult to identify where it was needed.

Maggie Berry queried as to whether a robust data analysis process was in place. Gareth Howells responded that while it was improving, better use of the data could be made. Martyn Waygood asked that an update be provided. **GH**

Maggie Berry sought clarity as to the next internal audit review of DoLS. Paula O'Connor advised that it had been delayed until July 2019 to enable the best interest assessors time to make progress in their roles.

Martyn Waygood noted that mental health services and Morriston Hospital were outliers in terms of the cases of abuse. Gareth Howells responded that these were the main entry point to the health board and saw a high number of vulnerable patients. He added that some of the cases related to issues in the community, such as pressure ulcers, and were not necessarily the fault of health board staff.

Resolved:

- The report be **noted.**
- Update be provided on the improved use of data. **GH**

83/19 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:

- Concerns had been raised by the infection control committee as to insufficient microbiology support;
- While good progress was being made to improve performance, a zero tolerance to any infection cases was required;
- A bid had been submitted to the investment and benefits group to expand the infection control team;
- Further support was needed within primary and community care as 40%-50% of cases originated within these services;
- Scoping was being undertaken to appropriately implement ultra-violet cleaning;
- Occupancy rates proved a challenge to infection control as the additional beds open were not only a risk but prevented decant facilities from being available.

In discussing the report, the following points were raised:

Reena Owen stated that cleaning was one of the basic functions for infection control, adding that it needed to be right. Gareth Howells stated that it would be worthwhile the independent members spending time with the infection control team. This was agreed and Gareth Howells undertook to make the arrangements. **GH**

Reena Owen queried the action being taken to improve compliance with training in clinical area. Alastair Roeves responded that it was improving but needed to be at a quicker pace, and there were also plans to extend training into care homes.

Reena Owen referenced recent food safety issues in NHS England

and queried whether the committee needed assurance on such issues. Gareth Howells advised that the health board had undertaken a review to ensure that such concerns were not relevant but food safety was something that needed to be considered. Martyn Waygood concurred, adding that the Health and Safety Committee would be including food safety as part of its work programme.

Alison Clarke advised that 'champions' had been assigned in areas of therapies and health science to support training compliance as well as requirements that mandatory and statutory training be completed prior to study leave being agreed for other courses.

Martyn Waygood noted that ultra-violet cleaning was not available in Neath Port Talbot and Singleton hospitals, only Morriston Hospital, and sought clarity as to why. Gareth Howells responded that the impact that it had needed to be understood before it could be extended more widely, plus there were insufficient decant facilities in order to undertake the process adequately.

Martyn Waygood sought further details as to the plans to improve the availability of decant facilities. Gareth Howells advised that due to the current operational pressures, all the additional capacity beds were still open, which made it more difficult to decant wards. He added that alternative options needed to be considered outside of the norm in order to have the space.

Martyn Waygood noted that there had been an improvement in *clostridium difficile* cases at Morriston Hospital but a deterioration in *e.coli* at Singleton Hospital. Gareth Howells commented that it was useful to have the breakdown by unit and Singleton Hospital had been asked to undertake a deep dive to determine the issue. Martyn Waygood asked that an update be provided on due course. **GH**

Resolved:

- The report be **noted.**
- Update be provided on the Singleton Hospital deep dive. **GH**

84/19 QUALITY IMPACT ASSESSMENT

A report providing an update in relation to the quality impact assessments for the annual plan was **received.**

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

- The process was in place to ensure that none of the savings schemes as part of the financial plan would impact on the quality and safety of patient care;
- The report outlined the progress to date;
- It was the first time that the health board had used the process so it was being continually tested.

In discussing the report, Reena Owen noted that a number of

schemes were categorised as 'red' and had risks associated. She queried as to how assurance could be taken that they were the right things to do as savings should not be made at the expense of patient care. Members needed to know how services would be provided if any of the items within the schemes were removed. Gareth Howells advised that this was why the process was integral as it ensured that quality of care was not compromised. He added that this report would now be a standing item in order for the committee to monitor progress. Alastair Roeves stated that the fact that the report was highlighting the same risks as the independent members demonstrated that the process was working.

Resolved: The report be **noted.**

85/19 PERFORMANCE REPORT

The quality and safety committee performance report was **received.**

In discussing the report, the following points were raised:

Martyn Waygood advised that he had attended the Quality and Safety Committee at Cwm Taf Morgannwg University Health Board during which four performance report options had been presented. He added that he had shared these with the performance team at Swansea Bay University Health Board as it was developing an appropriate report for this committee.

Maggie Berry informed the committee that the Performance and Finance Committee dissected the figures in detail so it was the role of the Quality and Safety Committee to consider the quality and safety of the services. Martyn Waygood concurred, adding that the current presentation of the report did not enable members to do this. Reena Owen commented that there was insufficient information in relation to population health and wellbeing.

Gareth Howells stated that a new quality governance framework was in development to make the arrangements within the units and under the committee more robust.

Reena Owen commented that there was no noticeable improvement in theatre usage and queried the improvement plan. Gareth Howells responded that it was similar to that of maternity and would be brought under the management of one unit. He added that this was a clear quality indicator and progress needed to be carefully monitored.

Martyn Waygood stated that while a lot of information was provided, there was not as much narrative. Gareth Howells concurred, adding that so much focus could not be given to the figures so that sight was lost on what was happening. Martyn Waygood suggested that he organise a discussion with the relevant staff to develop the report further. This was agreed. **MW**

Maggie Berry noted the underperformance in the fertility service,

adding it would be beneficial to see a report on it. Gareth Howells suggested that the committee invite the unit to discuss it further. This was agreed. **RE**

Martyn Waygood stated that the profile for mortality reviews was no longer recorded and it was unclear as to why. Paula O'Connor advised that mortality reviews was an area in the audit plan for this year following a previous limited assurance rating. Alastair Roeves added that the Medical Director was progressing the improvement work in this area.

Reena Owen stated that it would be interesting to receive a report in relation to the work to improve discharges for medically fit patients. Gareth Howells responded that a significant amount of work had been undertaken in relation to the older people's strategy and suggested the committee receive an update. This was agreed.

Resolved:

- The report be **noted.**
- Meeting be arranged to discuss the development of the performance report. **MW**
- Report be received on the underperformance within the fertility service. **RE**
- Update be received on the work of the older people's strategy. **GH**

86/19 ADMISSION OF CAMHS PATIENTS TO ADULT MENTAL HEALTH WARD

Kath Hart was welcomed to the meeting.

A report outlining admissions of child and adolescent mental health service (CAMHS) patients to adult wards was **received.**

In introducing the report, Kath Hart highlighted the following points:

- There was a designated CAMHS bed on ward F, an adult mental health ward, at Neath Port Talbot Hospital for emergencies in line with Welsh Government guidance;
- It was for short-term use when all other options for young people had been explored and there was no capacity at the specialist unit Ty Llidiard, commissioned from Cwm Taf Morgannwg University Health Board;
- One-to-one nursing care was provided due to the associated risks of the environment;
- A business case was in development to centralise mental health services for adults and this would include an appropriate area for the CAMHS bed;
- Anyone below the age of 16 was admitted to a paediatric ward.

In discussing the report, the following points were raised:

Maggie Berry stated that the numbers of young people needing such services would only increase and queried if there was potential to meet the needs within the organisation. Kath Hart responded that specialist CAMHS services were commissioned from Cwm Taf Morgannwg University Health Board and the capital bid would only cover the emergency bed provision as opposed to the full service.

Maggie Berry commented that as the service was commissioned, it was difficult for the health board to have a 'strong grip' as it did not have the complete intelligence it needed to make informed decisions. Gareth Howells responded that the Mental Health and Learning Disabilities Unit provided significant support to any young patients on ward F but it should not be a common occurrence as it was not the right environment for them. He added that assurance was needed that the pathway worked as there was a risk of there being capacity at Ty Llidiard but patients still admitted to ward F. Data should be available from the Welsh Health Specialised Services Committee (WHSSC).

Martyn Waygood undertook to discuss the issue further with the health board's vice-chair. **MW**

Resolved:

- The report be **noted.**
- Martyn Waygood to discuss the issue further with the health board's vice-chair **MW**

87/19 DU 90 DAY REVIEW ACTION PLAN

Lee Joseph was welcomed to the meeting.

A report outlining progress against the action plan following the NHS Wales Delivery Unit's 90 day review was **received.**

In introducing the report, Lee Joseph highlighted the following points:

- Only six of the recommendations remained open;
- The ward to board dashboard was on target for completion in September 2019 with the quality assurance framework the last element to be populated;
- Work was ongoing with the Mental Health and Learning Disabilities Unit following the change in reporting of deaths as serious incidents as well as to understand why some service users did not access treatment when they needed it;
- The approach for investigating serious incidents had changed to incorporate the views of the multi-disciplinary team;
- Work had commenced to establish a quality hub which would look at areas of good practice as well as those in need of improvement.Examples had been researched of English NHS trusts where such programmes were already in place.

In discussing the report, the following points were raised:

Reena Owen noted that should concerns result in significant learning briefs, these were shared with the Quality and Safety Forum. She added that this should also be the case with achievements. Gareth Howells concurred, adding that attendance had now improved at the forum so this was an opportune time to do this. He stated that the vast majority of what the health board did, it did well, and how this was shared more widely needed to be considered.

Reena Owen referenced the need for a 'stronger connectivity' for independent members and queried as to how this could be achieved. Gareth Howells responded that the visits undertaken by board members to sites was a key part of this and needed a more formal structure. He added it was also achieved by gaining assurance through the committees.

Maggie Berry noted that the committee had received a presentation on the ward to board dashboard the previous year, suggesting the committee received an update on progress. This was received. **CW**

Resolved:

- The report be **noted.**
- Update be received on the ward to board dashboard. **CW**

88/19 INTERNAL AUDIT: INTERIM HTA REPORT

Chris Morrell was welcomed to the meeting.

A report setting out the findings of an interim internal audit of Human Tissue Authority (HTA) services was **received.**

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

- The HTA was to inspect the health board later in June 2019;
- A full audit had been undertaken by the services in advance against the standards, for which there had been some shortfalls, and an action plan was in place;
- Areas in which other health boards had been criticised had been reviewed to address any similar issues within Swansea Bay University Health Board;
- A follow-up internal audit had been postponed to the autumn due to the HTA visit.

In discussing the report, the following points were raised:

Reena Owen queried if there was anything proactive that the HTA would expect the committee to be doing. Chris Morrell responded that the health board followed the HTA's guidance as to good governance which included regular reports to the Quality and Safety Forum. She added any issues would then be escalated up to the committee via the forum's report. Paula O'Connor added that there was also a governance section within the self-assessment which the health

board would have completed.

Maggie Berry sought further details as to the service level agreement with Cwm Taf Morgannwg University Health Board in relation to the mortuary services. Chris Morrell responded that the health board was continuing to manage the service while colleagues addressed matters raised during its own HTA inspection.

Resolved: The report be **noted.**

89/19 EXTERNAL INSPECTIONS

A report setting out the findings of recent external inspections was **received.**

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

- Two inspections of dental surgeries had been undertaken which had raised issues with emergency equipment and action plans were being managed by the Primary Care and Community Services Unit;
- Healthcare Inspectorate Wales (HIW) was to review all maternity services in Wales following the issues at Cwm Taf Morgannwg University Health Board;
- Plans were in place for the summit with HIW to discuss the challenges relating to inspections in primary care and dental services.

Resolved: The report be **noted.**

90/19 CLINICAL SENATE COUNCIL REPORT

A report setting out the discussions of the recent clinical senate council was **received.**

In introducing the report, Alastair Roeves highlighted the following points:

- The senate had met in May 2019 and the main agenda item had been value-based healthcare;
- A presentation had also been received from the NHS Wales Financial Delivery Unit on the role of value and efficiency;
- The list of national audits for the year had been received in April 2019 and a formal plan to address this would be presented to the next meeting.

In discussing the report, Maggie Berry stated it was encouraging to see the progress being made but noted the emphasis on national audits, querying whether local audits would also be considered. Alastair Roeves advised that local audits would be part of the plan but

with an aim to rationalise the number to ensure they were completed.

Resolved: The report be **noted.**

91/19 COMMITTEE ANNUAL REPORT

The committee's annual report was **received** and **approved.**

92/19 COMMITTEE TERMS OF REFERENCE

The committee's revised terms of reference were **received** and **approved,** subject to minor changes.

93/19 NHS WALES NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN

A report providing an update in relation to the national clinical audit and outcome review plan was **received** and **noted.**

94/19 ITEMS TO REFER TO OTHER COMMITTEESS

There were no items to refer to other committees further to what was agreed earlier in the meeting.

95/19 ANY OTHER BUSINESS

(i) Charitable Funds Committee

Martyn Waygood advised that the Charitable Funds Committee was to focus its approval of bids on improving hospital environments, of which the committee should be aware. Maggie Berry stated that this should also extend to facilities outside of hospitals as well.

There was no further business and the meeting was closed.

96/19 NEXT MEETING

This was scheduled for 22nd August 2019.

97/19 MOTION TO EXCLUDE THE PRESS AND PUBLIC IN ACCORDANCE WITH SECTION 1(2) PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960.