GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe | Swansea Bay University Health Board

Swansea Bay University Health Board
Unconfirmed
Minutes of the Meeting of the
Special Quality and Safety Committee
Monday, 15th May 2023 at 1pm
via Microsoft Teams

Present
Steve Spill, Vice-Chair (in the chair)
Reena Owen, Independent Member
Anne-Louise Ferguson, Independent Member
Nicola Matthews, Independent Member

In Attendance
Gareth Howells, Director of Nursing and Patient Experience
Alison Clarke, Deputy Director of Therapies and Health Science
Richard Evans, Executive Medical Director
Hazel Powell, Deputy Director of Nursing
Mitchell Parker, Health Inspectorate Wales
Elizabeth Stauber, Head of Corporate Governance
Claire Mulcahy, Corporate Governance Manager
Heidi Maggs, Lead Service Manager Laboratory Medicine
Sue Evans, Llais Wales
Felicity Quance, Audit and Assurance Services
Angharad Higgins, Head of Quality and Safety, Corporate Nursing
Sharron Price, Interim Nurse Director, Neath Port Talbot and Singleton Service Group
Jayne Hopkins, Head of Quality and Safety and Risk, Neath Port Talbot and Singleton Service Group

Minute No.		Action
57/23	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	Apologies for absence had been received from Christine Morrell, Director of Therapies and Health Science and Hazel Lloyd, Director of Corporate Governance. Heidi Maggs was welcomed to the meeting, she was in attendance on behalf of Christine Morrell. Steve Spill explained that due to the postponement of the April 2023 Committee due to nationwide IT issues, this special committee had been held to receive the Patient Story and Highlight Report from the Neath Port Talbot and Singleton Service Group.	

58/23	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
59/23	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 28th March 2023 were **received** and **confirmed** as a true and accurate record.	
60/23	**MATTERS ARISING**	
	There were no items raised.	
61/23	**ACTION LOG**	
	The action log was **received** and was **noted.**	
62/23	**PATIENT STORY: CAROL'S STORY**	
	A patient story titled 'Carol's Story' was **received.** - Sharron Price informed that this story provided an insight into the experience of one of our younger patients (and a member of staff) and the impact of the illness and delays in treatment has had on her; - Carol is a healthcare assistant working for the Swansea Bay University Health Board. In 2019, she was admitted to hospital following severe pain due to her endometriosis. She was given strong medications but was not offered surgery at that time; - She was put onto the waiting list on the 19th July 2019 but no surgery dates could be offered. Her pain was continuous and she would attempt to manage this with many medications just to be able to work; - There was some days where the pain was so bad, she was unable to work or would need to leave shifts on the ward and she felt guilty for this; - She felt neglected by the health board, as a staff member helping patients she was not being helped; - On the 14th September 2021 she was given a date for her surgery. She felt very grateful for this and now feels like a different person living without pain. In discussing the patient story, the following points were raised:	

	Sharron Price commented that the video illustrated the impacts of our treatment waits and the pandemic has had on our patients. Reena Owen commented that she found the video very upsetting and reflected on her own experiences of endometriosis. She queried the current position of the gynaecology waiting lists and whether there were better solutions in place for patients while they were waiting. Sharron Price undertook to gain the information on the waiting lists and relay to members outside of committee. In terms of better solutions, she advised that a nurse specialist had been employed to support patients on that pathway, as well as appointment slots within colorectal which some patients require as part of this illness.	**SP**
Resolved:	- Sharron Price undertook to gain the information on the gynaecology waiting lists and relay to members outside of committee. - The patient story was **noted.**	**SP**
63/23	**SERVICE GROUP HIGHLIGHT REPORT: NEATH PORT TALBOT AND SINGLETON SERVICE GROUP**	
	A report was **received.** In presenting the report Sharron Price highlighted the following points: - **Nurse Staffing gaps within Singleton Hospital**; since (AMSR) there has been a challenge to get below 100 beds on the retained temporary wards at Singleton and this has impacted significantly on staffing levels. It currently has a risk rating of 25 on the risk register. There are daily staff risk assessments. In order to mitigate, a high level of temporary staff utilized through bank, agency and off contract. There is work underway to potentially use unregistered staff to cover the gap. A proposal was presented to Bed De-commissioning Board to release some beds. Currently down to 90 beds and the plan is de-commission further. - **Human Fertilization and Embryology Authority Inspection;** the Human Fertilisation and Embryology Authority (HFEA) inspection for Welsh Fertility Institute (WFI), Neath Port Talbot Hospital was undertaken on 18th January 2023. There were 7 major non-conformances noted at time of inspection. A gold command group has been set up to implement the action plan. - **Critical Midwifery Staffing Level;** staffing levels continue to be a challenge resulting in the suspension of home-births and closure of the Birthing Centre at Neath Port Talbot Hospital. A midwifery	

	Transformation Board has been developed and work is progressing in this area. - **Health Inspectorate Wales – (HIW) Paediatric Services;** a full inspection took place in January 2023 and the improvement plan had been accepted. - **Cancer Wait Times and Chair Capacity;** there was work to do on pathways two and three and a review of pathways for all breach patients is now in place following appointment of the (Systemic Anti-Cancer Therapy) SACT Quality Improvement practitioner; During discussion, the following points were raised: Anne-Louise Ferguson referenced the need to look at unqualified staff to cover the vacancies in the system, she highlighted that the International Educated Nurses were not yet working on the wards until full training and registration was received. She queried whether this staff group could be utiliised to support the gaps in the system. Gareth Howells responded that discussion was currently underway in regards to whether it was practical for them to work on bank. Concerns have been raised as it was important for these staff members to acclimatize fully and concentrate on gaining the OCSE (Objective Structured Clinical Examination). Steve Spill queried whether the clinically optimized patients in the system needed the care of registered nurse staff or was it possible for this to be provided by unregistered workforce. Sharron Price informed that the majority of these patients were frail and elderly, with a number of co-morbidities. There were a number of risks with them being in the hospital setting; falls and infection which would require medical intervention. The hospital was not a homely environment and those patients become deconditioned therefore they do require the care of the registered workforce. Reena Owen referenced the phlebotomy survey and provision. She advised that she had received feedback that communities were unhappy with the current provision and were having difficulty getting appointments and results being processed in a timely manner. She queried the results of the survey and whether these could be received at committee as discussion on the future of the service. Sharron Price informed that improvement work had taken place in four areas and undertook to seek further details and provide to Independent Members outside of committee. Sue Evans advised that an engagement document for phlebotomy was awaited following the survey. This would go through a wider engagement exercise in June 2023. Heidi Maggs informed that there was a national shortage of phlebotomy specialist staff and difficulty to recruit. The night shift pattern for this staff group required more experienced staff members with at least two	**SP**

	to three years experience. The health board undertakes significant training for this group and has become a training laboratory but there are challenges with retained these staff following training. Gareth Howells informed members that mechanisms were in place via the Workforce, OD and Digital Committee Work Programme, to have oversight of staffing levels for those are outside of the NSA and assurance could be sought via this committee. Steve Spill undertook to refer the issue of staff deficiencies across many areas within the NPTSSG, to the Workforce, OD and Digital Committee. During a recent Independent Member visit to the Neonatal Unit in Singleton, it was evident that the accommodation for parents was poor and needed an upgrade. Reena Owen informed that there was a discussion on the use of charitable funds monies to do this and sought assurance that this was being actioned. Sharron Price informed that significant work in Singleton was taking place surrounding the cladding and she would need to explore the issue of this accommodation further with colleagues. Jayne Hopkins assured that work was underway and this avenue, as well as others, were being explored in the service group. Once the refurbishment took place, the plan was to do patient story and bring back to committee. Anne-Louise Ferguson raised concerns around the maternity staffing issues and queried the pace on the re-opening of the Birth Centre at Neath Port Talbot and the home-birth pathway. Sharron Price advised of the commitment on getting those open, there had been very little choice in their closure due to staffing levels. The aim was to look at re-opening in late Autumn but there needed to be a re-design of the workforce in order for these pathways to be safety re-opened. Steve Spill commented that workforce was a running theme through all the risks, he queried whether there are specific reasons for this or are they systematic issues. Sharron Price advised that there were national shortages of nursing and midwifery staff as well as other professional groups in healthcare. In terms of the NPTSSG, the medical re-design did impact on staff levels with a lot of staff movement into other posts in the service group and across the health board. There is difficulty in gaining substantive employees on the temporary wards as the posts are less attractive due to being temporary. In terms of midwifery staffing, the health board has been engaging with midwifes and students on their views and how the health board could attract others to work with us. Reena Owen commented that the health board appeared to have an issue with the retention of staff members we had been trained here and sought assurance on what the health board does to address this. Steve Spill undertook to refer this to Workforce, OD and Digital Committee.	**SS**

Resolved:	- Sharron Price to provide further details on the improvement work and provision in Phlebotomy and provide to Independent Members outside of committee - Steve Spill to refer the issue of staff deficiencies across many areas within the NPTSSG, to the Workforce, OD and Digital Committee. - Assurance sought on the issue of retention of staff members we had trained and on what the health board does to address this. To be referred to Workforce, OD and Digital Committee. - The report be **noted.**	**SP** **SS** **SS**
64/23	**TO RECEIVE THE QUARTERLY PATIENT EXPERIENCE REPORT**	
	The quarterly patient experience report was **received.** Reena Owen queried how the new volunteers at the emergency department were assisting and it was informed that they were providing food and drink and other personal assistance to the waiting patients.	
Resolved:	The report be **noted.**	
65/23	**TO RECEIVE AN UPDATE ON THE IMPLEMENTATION OF THE DUTY OF CANDOUR AND QUALITY**	
	A report on the implementation of the Duty of Candour and Quality was **received.** Angharad Higgins highlighted the following points; - Both Duties were implemented on the 1st April 2023 and going forward, all decisions made would be quality driven. - The Duty of Candour promotes a culture of openness, learning and improving. - There was both local and national work underway; - There was work to do on the training needs for both Duties which would require specialist training; - A communication plan was being developed to support messages regarding quality across the organisation. In discussion, the following points were raised;	

	Reena Owen commented on the amount of work that would be required to collate all the information and queried whether we would see a much larger annual report due to this. Angharad Higgins advised that there was additional work, especially with the Duty of Candour and the need to evidence that decisions are quality driven. This would be system wide, whatever the role, all staff had a responsibility for quality. A report would be available at the end of the financial year via a new version of the healthcare standards and there would now be twelve standards to report under.	
	A report was **received** and **noted**	
66/23	**ITEMS TO REFER TO OTHER COMMITTEES**	
	The following are to be referred to other committees; - The issue of staff deficiencies across many areas within the NPTSSG, be referred to the Workforce, OD and Digital Committee. - Assurance sought from the Workforce, OD and Digital Committee, on the issue of retention of staff members trained within the health board and what is being done to ensure they remain with us.	
67/23	**ANY OTHER BUSINESS**	
	There was no further business, and the meeting was closed.	