	Agenda Item	2.3 (ii)

Freedom of Information Status	Open
Reporting Committee	Quality and Safety Committee
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Chaired by	Steve Spill, Vice Chair
Lead Executive Director (s)	Gareth Howells, Director of Nursing and Patient Experience
Date of last meeting	22 November 2022

Summary of key matters considered by the committee and any related decisions made:

Patient Story: *'Alone in a Foreign Land'*

The story set out the experience of a patient on medical ward following sudden sight loss. She had been admitted late at night without any additional clothing so a nightclothes were found, but her bed was unmade. She suffered severe pain when the nursing staff put on the lights above her were switched on. While one team used the lights on the opposite side of the ward, the information was not passed onto the new shift to do the same, resulting in the patient feeling ignored. She was discharged not knowing what had caused her sight loss or what would happen next, other than occupational therapy would be in touch. After six weeks, she had an appointment with ophthalmology at which she was informed she had been registered blind and would eventually lose her sight completely, something she for which she was unprepared.

Service Group Highlight Report: Singleton and Neath Port Talbot

Critical midwifery staffing levels has led to continuing with centralised services to maintain safe staffing levels and effective business continuity, with no home births. The service group received a positive external review of maternity and neonatal services in relation to our governance arrangements and the leadership to ensure the safety of mothers and babies. Clinical support currently being provided by Morriston emergency department medical Team via red phone to the minor injury unit due to staff unavailability on an ad hoc daily basis for case discussions and X-ray reviews. Consultants are also providing half-day sessions at the unit. Healthcare Inspectorate Wales (HIW) is satisfied with an improvement plan submitted in September for Singleton hospital radiotherapy centre.

Matters raised by members:

- *Concerns around faulty equipment;*
- *Support provided to cancer patients between diagnosis and treatment starting;*
- *Succession planning for paediatric neurology following retirements;*

- *Actions to improve midwifery staffing and reopen the birth centre at Neath Port Talbot Hospital;*

Preparedness for the Duty of Candour

The report set out the new legislation which became law on 1st June 2020 and will be implemented from 1st April 2023. It created two new duties – the Duty of Candour and Duty of Quality which are out for consultation now. The Health Board had reviewed its position and developed an action plan which was agreed by the Management Board and within the report it sets out key areas for policy development and education and reporting.

Matters raised by members:

- *The risk of the Duty of Candour trigger more clinical negligence claims.*

Key risks and issues/matters of concern of which the board needs to be made aware:

Infection, Prevention and Control Report Including Updates from Service Groups

The progress against the tier one infections continues to demonstrate reductions in *c.difficile, e.coli, klebsiella bacteraemia* although the reductions are slight. The Morriston improvement plan continues to make some progress. The IPC matron will be seconded as Programme Improvement Lead for 3 months or until such time that the appointed candidate is able to take up the post. Backfill arrangements were in place. Improvement in training in Morriston has continued. Highlighted wards who have caught up with training – will say that Nursing staff making strong improvements with compliance with their training. Some wards have had many days without cases of infection and continue to be the same.

Matters raised by members:

- *Action being taken on the wards not making as much progress.*

Allocation of Funds to Support Long Waiters

Recurrent monies have been secured to provide a GP lifestyle model in GP clusters, also an orthopaedic pre-habilitation scheme plus the pilot with the ONKO digital platform. There have been some delays due to fitting the service model around the funding requirements. The GP lifestyle model commenced in October in the Llwchwr Cluster and has seen 20 patients to date. Once established, and the initial pilot evaluated, the potential to widen the scope geographically will be considered across all clusters. The Rapid Diagnostic Centre has seen 37 patients to date.

Matters raised by members:

- *Validation of waiting lists to ensure all still require treatment;*
- *Benefit of physiotherapy prior to orthopaedic surgery and the time taken to offer patients pre-habilitation;*

Deep Dive on Quality Priorities: Falls

Falls prevention has been made one of the health board's top 5 quality priorities as it is the highest rate of incidents in the health board and it is 2nd leading cause of accidents in the home. Over last 3 year reported falls incidents have decreased from an average of 213 in 2019 down to 180 in 2022. Since April this year an increase in people over 65 falling has been seen, becoming the most at risk group presenting to front door services. The pandemic had produced a rise in falls where people had long periods of being inactive. When a patient is in hospital there are complex pathways to allow a smooth transition home – all increasing length of stay and risk of falls in the hospital setting.

Matters raised by members:

- *Vast opportunities to focus on falls in the community prevention;*

- *Consideration of adaptations in hospitals with a lot of frail elderly patients and hard floors.*

Maternity and Neonatal Network Review of Swansea Bay Services

A letter was received by the Health Board on 22nd February expressing concerns that the maternity services failed to identify learning related to a particular case. It was decided to ask the maternity and neonatal network to review of the governance process and the structure of the service. This took place on 24th and 25th August and the framework they used to review the service included four key points: risk management, safety, patient service user involvement, data, clerical effectiveness, clinical audit, quality improvement and workforce and training. The review panel concluded that that health board delivers a culture of patient safety and prioritises opportunities for improvement through reflecting on data and lessons learned through adverse events.

Matters raised by members:

- *Assurance that the reviewers were independent to the health board;*
- *The good practice of having a consultant run informal CTG reviews using a read from the previous nightshift as a short-teaching session;*
- *Importance of keeping a close eye on staff and families given the challenges faced by the services.*

Delegated action by the committee

None taken.

Main sources of information received:

- Quality and Safety performance report;
- Summary of recent external inspections;

Highlights from sub-groups reporting into this committee:

Quality and Safety of Patient Services Group

The monthly report was received for assurance.

Matters referred to other committees:

There were no matters referred.

Date of next meeting	20 December 2022