Service Groups' Highlight Report for Quality and Safety Committee

Meeting Date:	29th March 2022
Service Group:	Neath Port Talbot & Singleton Service Group
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Summary of Quality and Safety issues since last report to the Committee (Reporting period: January 2022 to March 2022

This paper provides the Quality and Safety Committee with an update on matters of Quality and Safety overseen by the Service Group. This is the second report of the newly formed Neath Port Talbot and Singleton Service Group.

- **Key Quality and Safety Issues**

The Service Group has faced significant staffing challenges due to unplanned staff absence resulting from COVID-19 related sickness, shielding and self-isolation, alongside other current absences. This risk has been coupled with pressure staffing additional surge capacity in adult, paediatric and neonatal services. Staff unavailability increased significantly during the height of wave 4 of the COVID-19 pandemic.

- **SACT**

Update on the Systematic Anti-Cancer Therapy (SACT) capacity and the impact on patient experience and outcomes

Waiting Times for SACT treatment remains on risk register below is summary of actions being taken forward by the service to mitigate the risk as noted on risk register.

Unacceptable delays in access to SACT treatment in chemotherapy day unit.- Risk ID 1834 (HBR 66), Risk Score = 20

Mitigation & Action *Summary*

Actions complete

Review of Chemotherapy Delivery Unit by Improvement Science practitioner completed in 2020, resulted in change to booking processes to streamline booking process and deferral.

Additional funding agreed to support increase in nursing establishment. Agreed and in place.

Review of scheduling by staff to ensure that all chairs are used appropriately**. Additional scheduling staff appointed. provisional start date May 22**

Daily scrutinising process in place to micro-manage individual cases, deferrals etc**. This will be liked to new QI SACT practitioner post appointed to in March 2022 awaiting start date. The post holder will be responsible for establishing efficient, effective and equitable pathways for SACT treatment with a focus on quality improvement to improve patient access for SACT treatments and compliance with performance metrics**.

Actions ongoing

- Business case approved to increase provision of intravenous therapy at home (Sept 2021) phase 1 expansion of pharmacy team. **2/3 of staffing recruited to start dates planned for Qtr 1**
- Explored option of moving further treatments to community service. **Model agreed Dec 2021.**
- Business Case for phase 2 home care expansion based on moving further treatments to community service. **Paper with CEO for comments, prior to going to BCAG**
- Paper to support extended day working very Saturday also included in above and with **CEO for comments**
- Business Case to relocate CDU and increase chairs. Is still in draft format, due to delays in AMSR project case now not due to be **finalised until August 2022**. Increase in PTS capacity to deliver this extra work will need to form part of this case.

Continue to monitor patient experience via friends and family and under our PTR procedures.

We also now monitoring our waiting times against new SACT metrics. The new metrics are linked to treatment intent and are described below

<u>Intent of treatment list has been reduced and defined as per CRUK SACT consent forms</u>

- **Curative** - to give the best possible chance of being cured
- **Palliative/Disease Control** - the aim is not to cure but to control or shrink the disease. The aim is to improve both quality of life and survival
- **Adjuvant** - therapy given after surgery to reduce the risk of the cancer coming back
- **Neo-Adjuvant** - therapy given before surgery/radiotherapy to shrink the cancer, allow radical treatment and reduce the risk of the cancer coming back
- **Obtain or maintain remission** (for Haematology Only)
- **Not known**

Urgency of Treatment needs to be allocated according to intent:

Emergency/Priority 1 - emergency (within 48 hours)

Urgent/Priority 2 - within 14 days (for Curative, Palliative/Disease Control, Haematology remission and Neoadjuvant intent)

Routine/Priority 3 - within 21 days (for adjuvant intent)

Definitions for Metrics:

- **Time to SACT** - defined as the time in calendar days that it takes a patient from the date of 'Decision to Treat' for SACT to the start of SACT.
    - **The date of 'Decision to Treat' with SACT is the date a consultation took place with the patient and agrees a treatment plan.** *There has already been a lot of discussion about variation in timing of consent across Wales but the Cancer standards define the **decision to treat** is when the patient **agrees to treatment not necessarily date of consent**. In Swansea, this is often taken at first consultation if patient agrees to proceed as they have 2 further opportunities for confirmation of consent at pre-assessment and then on day of chemotherapy (confirmed by competent chemotherapy nurse as per national Chemotherapy Board Guidelines).*
    - **The start of SACT is the date the first treatment is delivered**.

These new measures give us a very different process for booking our SACT regimes and as service, the team has quickly adapted their processes to allow as to start reporting this new measure. Previously we reported average waiting times for all starting first cycle of SACT. So this new way of reporting is welcomed and supported fully by team

Cancer Waiting times are noted below

Priority & wait		Oct-21		Nov-21		Dec-21		Jan-22		Feb-22	
P1	Treatments started	0		0		0		2		0	
	Within target	0	NA	0	NA	0	NA	0	0.00%	0	NA
	Breached (outside of Target)	0	NA	0	NA	0	NA	2	100.00%	0	NA
P2	Treatments started	7		11		10		10		8	
	Within target	1	14.29%	2	18.18%	0	0.00%	1	10.00%	4	50%
	Breached (outside of Target)	6	85.71%	9	81.82%	10	100.0%	9	90.00%	4	50.00%
P3	Treatments started	29		43		56		35		40	
	Within target	14	48.28%	22	51.16%	26	46.43%	14	40.00%	19	47.50%
	Breached (outside of Target)	15	51.72%	21	48.84%	30	53.57%	21	60.00%	21	52.50%

This performance metric is included in our Cancer Performance report we send to WG and Management Board and internally via governance arrangements with NPTSSG where Oncology services sit.

Challenges, Risks, Mitigation and Action being taken relating to Quality and Safety issues noted above (what, by when, by who and expected impact)

Key quality and safety issues, risks, mitigation and actions being taken are summarised in Table 1:

Table 1.

Challenges & Risks	Mitigation & Action *Summary*	Expected Impact	Lead & When
Health & Care Standard 2.0 - Safe Care			
Deficit of qualified Haematology and Blood Transfusion staff within the HB Laboratory Medicine Services. **Risk ID 2809** **Risk Score = 25**	• Employ locum BMS staff with transfusion experience • Offer overtime to staff to 'fill the gaps' in shift rotas • Commence training lower grade staff (band 4's) to undertake less technical duties which will free up qualified staff to participate in shift system. • Employed a Transfusion Tutor to begin cross training Biochemistry staff in Blood Transfusion. – • Train staff to work alone OoHs on all hospital site to improve service resilience • Recruit analysts with Haematology/Blood Transfusion experience.	• Stabilised workforce • All shifts covered on all sites	Estimated April 2022 Lead – Divisional Manager-Clinical Diagnostics &Therapeutics
Critical midwifery staffing levels **Risk ID 2788** **Risk Score = 20**	• Phase 3 Implementation of RCOG/RCM guidance to Centralise Services • Home birth service has been reintroduced on a case by case basis where community staffing can facilitate • Freestanding Midwifery Unit has been temporarily suspended • Community services have been centralised to maximise available resources • Ongoing response to COVID pandemic has posed • Further recruitment campaign for Band 6 Midwives - interviews first week of April 1st 2022.	• Challenges in women's choice in place of birth • Safe midwifery staffing of centralised services • Safe care	Estimated April 2022 in line with RCOG/RCM Guidance Lead: Group Nurse Director (GND) & Head of Midwifery
Risk of failure to sustain safe service provision for the CCN team due to shortage of experienced qualified nurses and HCSWs in the agreed establishment to meet the required number of shifts in agreed packages of care, exacerbated by high levels of unplanned absence. **Risk ID 2709** **Risk Score= 20**	• Recruitment campaign • Organisational Development plan and programme being developed by the Health Board OD team to support and develop the new team • Paediatric nurses from the general wards have transferred into the community to support • Interim Lead Nurse for Continuing care appointed with an additional responsibility to operationally manage the CCN team, being supported by the HON • Senior management support available – with the HON providing professional leadership (was previously the interim Dep Head and Head of Nursing)	• Delivery of services to provide agreed packages of care • Positive user experience • Continuing care guidance standards are met • Staff are confident in providing community services • Community activity levels are	Estimated May 2022 Lead: GND & Head of Nursing C&YP

	• Head of Nursing offering meetings with staff • All of the community nursing team offered feedback from the external review and will now be involved in the implementation of the Improvement plan. • Staff have been directed to wellbeing services including Guardian services • Lead roles identified within the team to support ongoing service delivery and support the transformation programme • Clinical supervision made available to the registered staff • Healthcare support workers have been supported by the registered nurses and the practice development nurse. • Support from workforce colleagues for senior managers to manage registered staff who are subject to any alleged conduct concerns. • NPTSSG Group Directors offering support and meeting with the team	managed by the team • No further staff leave the service • Positive feedback from families	
Non Compliance with Nurse Staffing Levels Act Wales (2016) **Risk ID1759** **Risk Score = 20**	• Risk rating increased to 25 on January 7th 2022 and reduced to 20 on the 14th February 2022 • Mitigation summary attached (**appendix 2**):	• All reasonable steps have been taken to provide safe staffing • Robust recruitment and retention plan	Daily safe staffing risk assessment Lead - GND
Reduced nurse staff levels in Neonatal services **Risk ID 853** **Score = 20**	• Daily acuity assessment of the neonatal unit • Pre-authorisation for escalation to off-contract agencies to mitigate staffing shortfalls • Overseas recruitment of 4 nurses • Recruitment and retention plan	• Service remains open to Neonatal Network • Safe neonatal staffing against daily acuity	Daily safe staffing and staff Lead – Head of Childrens Nursing
Sonography scanning capacity constraints resulting in significant challenges achieving the National GAP & Grow standards **Risk 1605** **Risk Score = 20**	• 2 midwives completed sonography training in January 2022 and currently on preceptorship programme. • Lead sonographer trainer recruited to support midwifery sonography training. • Incident reporting if unable to meet standards have been completed in this reporting period • 2 further midwives have commenced their ultrasound training. • Staff have been trained in Gap and Grow Ultrasound scanner machine on order for delivery before 31st March 2022. Plan for preceptorship midwifery sonographers to provide service from April 2022.	• Partial compliance with GAP and Grow standards • Approved Business Case to train further midwives	Estimated April 2022 Lead – Head of Midwifery
Failure to find suitable candidate for substantive Named Doctor for Safeguarding Children	Community Consultants supporting cover of role • Corporate Safeguarding team supporting peer review of cases • Active recruitment campaign	• Role redesigned to Speciality grade Doctor to support successful recruitment	Estimated April 2022 Lead – Divisional Manager C&YP

Risk 2426 **Risk Score = 20**	• Developing a speciality grade Doctor role job description • Named Doctor post currently out to advert, closes 21/3/22.	• Safeguarded children and young people	
The inpatient unit in Tŷ Olwen had been able to provide in-patient care for those with palliative and end of life care needs who also require NIV. **Risk ID 2820 Risk Score =** 20	• The service has been in consultation with colleagues within the Morriston Hospital Respiratory team to provide IP care (when required) on ward J with in-reach liaison palliative care. Further development of process to allow admission of patients with palliative care needs, with NIV, who require in-patient care direct to appropriate ward area without requiring initial ED transfer and with additional specialist palliative care nursing / medical support.	• All reasonable steps have been taken to provide safe patient care and keep staff protected	Lead – Divisional Manager Cancer services
Health & Care Standard Standard 6.3 - Listening and Learning from Feedback			
Reduction in performance in the Service Group's concerns (complaints and incidents) compliance with PTR 30 working day target and the management of overdue incidents due to staff sickness (both Q&S teams and matron teams) and staffing shortages (clinical), increasing numbers of AM enquiries	• Deputy Head of Nursing holds weekly meetings with team to monitor and improve compliance • Reduction in sickness in both nursing and Quality, Safety and Risk teams • Successful recruitment to both teams • Group Nurse Director exploring means to safely close historical overdue no harm incidents • Quality, Safety and Risk team support the service Divisions by running monthly (more frequently on request) Datix concerns reports to assist with improving compliance • Implementation of Divisional level Quality, Safety and Risk groups	• 80% performance compliance • Timely investigations completed to allow for timely patient feedback and early learning • Shared learning integrated into practice • Performance scorecard to be provided weekly to HONS / HOM	Estimated December 2021 Lead – GND & Group Head of QSR

Serious Incidents and Never Events

There are 20 confirmed Serious Incidents (SI's) currently under investigation. This is an improved position since the start of this reporting period (April 2021) when the Service Group reported 47 SI's under investigation. Of the 16 SI's 3 are being investigated by the Serious Incident Team and 5 are fractured neck of femur following falls incidents. There were no Never Events reported by the Service Group in this reporting period and the last date the former Delivery Units reported a Never Event was 02/10/2020.

Progress Against Annual Plan Quality and Safety Priorities 2021/22 (as applicable) Quality Priorities: reduction in healthcare acquired infections; improving end-of-life care; sepsis; suicide prevention; and reducing injurious falls.

HB Quality Priority – Reducing Injurious Falls

Whilst there is not an evident reduction in the overall falls data, there have been several individual patients at Neath Port Talbot Hospital (NPTH) where the Memory Impairment Advice Team (MIAT) has assessed and advised the ward team on interventional approaches which has reduced falls. This has included specific advice on the impact of footwear, lighting, the environment and a person's abilities (mobility, vision etc.) on falls and advice on strategies to prevent falls as much as possible. There have been a number of patients who had experienced multiple falls and following assessment and intervention did not fall again during the admission.

MIAT also provides advice on positive risk taking i.e. encouraging patients to be more mobile and engaged throughout the day with the aim to reduce avoidable deconditioning in hospital. The Occupational Therapist (OT) completing Personal Activities of Daily Living (PADLs) has been extremely valuable in maximising patient's potential, where it has been identified that some patients who were nursed in bed were able to have a wash in the armchair and sit out for longer periods of the day.

Post Falls Management Working Group

The Service Group is actively involved in developing a health board wide approach to the management of injurious falls as part of the Quality Priority Work. This includes the Hot Debrief tool now embedded within NPTH and being rolled out at Singleton Hospital. The quality improvement methodology has been shared with Morriston Service Group as part of the collaborative approach to quality improvement across the health board.

Monthly Falls Scrutiny Panels continue to be held within the Division of Medicine and there has been an improvement in timely review and scrutiny of serious incident to ensure learning is integrated into practice as soon as possible.

Reducing Health Acquired Infection

During the reporting period there has been significant challenge staffing wards to the planned roster which has been further compounded with the requirement to maintain and additional surge capacity during wave 4 of the pandemic. This has meant increased staff unavailability and reliance on temporary staffing which has impacted audit compliance with the expected standards of infection prevention and control.

The Matrons Monthly audits have continued with themes around Infection Prevention Control practices in particular compliance with commode cleaning and PPE compliance, NEWS chart completion compliance and it has been noted that risk assessments contained within WNCR has demonstrated an overall improvement in standards of documentation.

Key Achievements

- NPT sustained a 0 incidence of C-Diff infection during the period.
- Continued progress on historic incidents.

- Vaccinated 80 patients at Neath Port Talbot Site and 71 on the Singleton site
- RSV surge cases continue to be managed within capacity. Increase in community cases has not been reflected in the numbers of cases seen at Morriston
- IPC level 2 training within Adult Ward areas has shown improvement
- Maternity Services have reported no COVID-19 outbreaks during this period.

Areas for improvement

- PPE compliance (identified on RAG audits)
- Mandatory training compliance across all areas
- Compliance with completing VIP scores and catheter bundles
- ANTT principles and training across all services.

Actions

- Medicine Division to identify leads for catheter and VIP score bundles
- Identification of Leads for Bug Stop and VIP score across adult service areas

Maternity Services completed a "How To" guide for ANTT online training which has been sent to their teams.

Clostridium Difficile

The CDI position at Singleton Hospital has improved during this period although there have been 12 cases reported.

NPT has had no reported cases during the reporting period.

There are currently 16 incidents relating to C-Difficile with outstanding investigations, 4 of these sit within the Singleton Assessment Unit and the remainder sit within the Division of Medicine. This is an improvement from the previous reporting period with the weekly panels ensuring learning from current events takes place.

Ward E and Ward 4 outbreaks closed.

The CDI improvement plan has been completed and will be implemented through the Divisional and Service Group Infection Control meetings.

Standard Infection Control Precautions Training – Total Service Group

There continues to be low levels of IPC training compliance in particular in level 2, ANTT and Hand Hygiene. Most ward areas have compliance in excess of 60 % with Ward 3, NRU and Ward C scoring red and require further work.

There have been no outbreaks for neonatal services during the period of September to December, there have been 3 RCAs, 2 are under investigation and the 3rd has been reported as appropriate use of longline, sited at first attempt, removed on day 6 of life due to high temperature and antibiotics given.

A number of incidental positive results for RSV, through routine COVID swabs for patients for Ward 12, was deemed a cause for concern therefore the IPC policy guidelines were applied. In total, 8 patients tested positive to RSV from 6th – 14th October 2021. All of the affected patients were either cohorted or isolated in cubicles as appropriate. Limited service disruption was observed over this period.

The in-patient vaccination programme continues in-line with national roll out. COVID booster vaccinations were successfully completed seeing both hospital sites offering booster vaccinations to all eligible patients in the last 2 weeks of 2021. The programme continues.

There have been COVID-19 outbreaks within the reporting period with Ward 7 (stroke and orthogeriatric rehabilitation) and Ward E reporting outbreaks in December 2021, SAU has also reported COVID-19 outbreak with links notes between the unit and other outbreaks on the Singleton site.

Sepsis

- Radar group established chaired by Lead ANP and DHON for Cancer;
- NEWS (Cymru) chart implemented and Audit programme planned;
- Acute Deterioration and Sepsis of the older person included into Clinical Frailty training programmes;
- BEACH training being rolled out for HCA's across the service group;
- 100% compliance with Recognition of the Deteriorating Patient (HCS data).

Sepsis group has been established in general paediatrics to coordinate and drive the work of the All Wales Paediatrics Sepsis group in relation to having a quality improvement MDT approach to the early recognition and management of sepsis with the aim of improving patient outcomes and reducing mortality currently associated with sepsis.

Improving end of life care

The Service Group End of Life Care (EOLC) quality priority performance measures are;

- Individualised plan of care in place addressing end of life care needs for patients where death was recognised
- Increase number of patients for whom there is timely discussion/ early discussion regarding EOLC
- Increase proportion of patients who die at home, compared with those who die in hospital

Suicide prevention

The Head of Nursing (Adults), Deputy Head of Children's Nursing and the Perinatal Mental Health Specialist midwife represent the Service group on the health board on the Suicide Prevention Group. Good progress has been made to train staff in wellbeing, Trauma Risk Management (TRiM) and Resuscitation Emergency Assessment Clinical Teaching (REACT);

- 3 TRiM practitioners trained
- All Matrons within Adult Services trained with REACT
- 2 wellbeing champions supported per ward
- Ligature risk assessment work planned to expand to non-ward areas and public areas
- 5 Staff members identified to attend Suicide Prevention Training
- Clinical supervisor in neonatal services nominated for TRiM training.

The Service Group has 3 additional quality and safety priorities:

Service Group Priority – Prevention of Health Acquired Pressure Damage (HAPU)

	Q2	Q3	% change
Singleton Hospital	46	35	-23.9%
NPTH	7	4	-42.9%

The Service group has maintained a sustained decrease in pressure ulcers over the last two quarters. There continues to be an enhanced focus on investigating and scrutinising hospital acquired pressure ulcers at the sites and the sharing of learning from the incidents.

Service Group Priority - Effective care of patients with memory impairment

The Memory Impairment Advice Team (MIAT) commenced on 1st June 2021 at Neath Port Talbot hospital in response to concerns that the approaches to care for older people within our hospitals at times increased the incidences of expressive behaviour and did not allow for individualised care plans for those who may have cognitive impairment.

A six month evaluation of the MIAT pilot has been conducted and the full report is within Appendix 1.

Progress Against Health and Care Standards 2021/22

Senior managers presented the Service Group's Health and Care Standards Self-Assessment to the mid-year scrutiny panel on 24th November 2021. The panel appreciated the challenging operational demands on the Service Group due to the on-going effects of the COVID-19 pandemic and how this is affecting both progress against the standards and the self-assessment process. The panel feedback included the following;

The panel feedback letter to the Service Group stated the following;

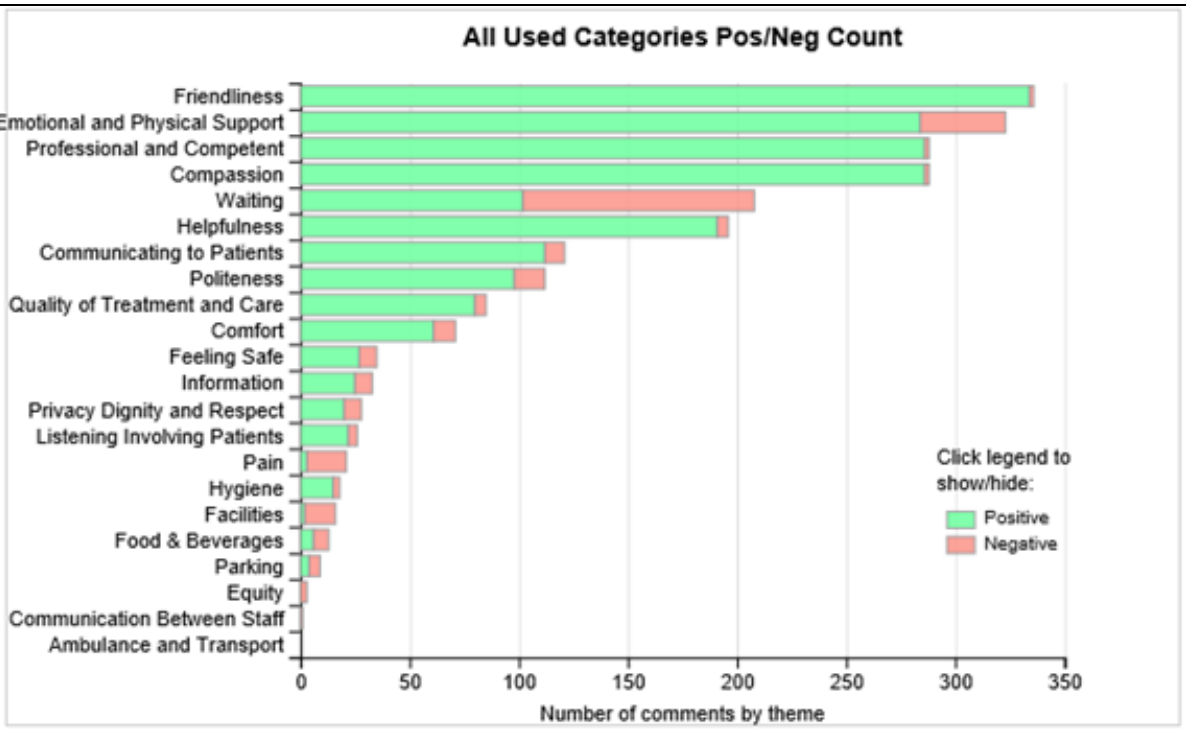
- The excellent presentation and discussions provided a clear statement of the service group's position with regard to the standards, it also served to highlight areas of good practice, innovation and areas of concern and risk;
- You described how service pressures meant that there were gaps within the submission and some services were not included. You outlined work to develop a more inclusive approach to the self-assessment process, which will make future submissions more reflective of the breadth of specialties within the group;
- The panel welcomed the evident medical engagement in the process and commend the service group for this;
- Inclusion of Patient Reported Outcomes (PROMS) from innovations such as the Memory Impairment Team would strengthen future submissions;
- Whilst Therapy Services do not sit within this service group, their role to support patients, in particular with regard to discharge planning, should be reflected;
- Reference to the role of volunteers within the group would be welcome in future submissions;
- In general, the submission included considerable evidence from some service, in particular Maternity, but others, including Medicine and Children's Services were not included in such detail
- The panel felt that your presentation of the self-assessment and the subsequent discussions demonstrated clear linkages between the standards and structures within the group.

The Service Group Medical Director and Nurse Director attended a further scrutiny panel on February 16th 2022 and confirmed Quarter 4 self-assessments and evidence is being uploaded to the system.

Patient Experience Update

For the month of February, there were 1,549 Friends and Family survey returns with overall score of 94%.

The heat map below showing F&F scores; when asked the question 'Overall, how was your experience of our service'.



Below are some of the positive feedback received;

Corridor 4&5 OPD

Not having been to hospital for some time I was a little worried about my visit with all the restrictions going on. However, all the staff were professional and helpful from the time I arrived until I left from the voluntary gentleman at the entrance to the admin staff, nurses and doctors I felt safe throughout my visit.

Clinic B1

The ladies in Clinic B1 are such lovely people. I was nervous about the procedure but they kept me chatting and calmed me down a lot. I was so grateful to them and enjoyed a lovely cuppa after my procedure was over.

Endoscopy Unit

All staff were friendly very assuring the procedure was fully explained in good detail and treated with dignity at all times.

Pre-assessment

Excellent staff, clear concise explanation.

Dermatology

Very quick and very well organised.

Patient experience data collected is summarised in the table below

Results by Service Group

Service Group	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	93.6%	3.9%	1580	1292	187	35	24	37	5
NPT & Singleton Group	93.6%	3.9%	1580	1292	187	35	24	37	5

Results for Children & Young People Divison

Total	**93.9%**	**2.0%**	**49**	**40**	**6**	2	**0**	**1**	**0**
Children's Centre	**100.0%**	**0.0%**	**19**	15	4	0	0	0	**0**

Results for maternity services

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	**90.5%**	**4.8%**	**63**	**51**	**6**	3	**0**	**3**	**0**
Antenatal Clinic	**88.9%**	**6.7%**	**45**	36	4	2	0	3	**0**
Labour Ward - CDS	**100.0 %**	**0.0%**	**4**	4	0	0	0	0	**0**
Midwife Led Unit	**100.0 %**	**0.0%**	**1**	0	1	0	0	0	**0**
Ward 20 (Postnatal)	**92.3%**	**0.0%**	**13**	11	1	1	0	0	**0**

Any Other Issues to Bring to the Attention of the Committee

Quality Assurance Audits – Adult Services

Due to wave 4 of COVID-19 and numerous ward outbreaks it has been difficult to completed the planned QAF unannounced audits. These have recommenced in February 2022.

Quality Assurance Audits- Paediatric and Neonatal Services

Matron assurance audits have been completed in general paediatrics where themes continue to be environmentally challenging with storage issues, compliance with infection control for High dependency care this being carried out in two separate areas.

Health Inspectorate Wales – HIW

Following HIW Review in January 2020 of Paediatric Services in Morriston Hospital, the Division for Children & Young People have submitted an updated action plan. There are two outstanding actions which have not been completed. Firstly, the call bell upgrade which is on the risk register as due to the age of the Morriston Hospital building full revamp of the call service for all wards is required. The Adolescent Area has not progressed due to potential identified area being used for adult capacity surge.

Safeguarding

- **Adult Services**

There are a number of outstanding Professional Concerns, all undergoing appropriate processes. There are a number of areas of risk in terms of safeguarding within adult services, this includes safe staffing levels and risks to patient safety as a result of challenges in reaching required compliance with safeguarding training across all staff groups. 2 Safeguarding audits have been completed within this period with no significant areas of concerns noted (Ward C and NRU).

Childrens Community Nursing Service External Review

The Divisional Childrens Community Service Improvement Meeting has been established to coordinate and manage the actions within the Childrens Community Nursing Improvement plan which was developed following the outcome of the external review. The division will ensure progress is made in implementing the recommendations and then reporting progress to the Health Board Quality and Safety Committee via the Neath Port Talbot & Singleton Service Improvement group. The Children & Young People Division will provide assurance to NPTSSG Service Group senior management team that the recommendations are delivered within the appropriate timescales with measurable outcomes and also escalate when actions cannot be delivered. Work streams from this has been developed, workforce task and finish group, the data task and finish group and patient / parent engagement task and finish group. All groups will ensure the delivery of the actions associated with each group within the appropriate timescales with measurable outcomes.

Childrens and Adolescent Mental Health

The current design of Children and Young People's ward space at Morriston Hospital is not optimum. The environment does not meet the standards required to provide high quality care, and is not designed to suit the range of ages that Children and Young People's services support. A need to re-evaluate the appropriateness of the service's environment has been highlighted. Therefore, work is being carried out jointly with adult services at Morriston, Research has been conducted into;

- The current situation and environment at Morriston Hospital;
- National Guidelines and recommendations of providing quality care in appropriate settings;
- Examples of good practice.

The aim of this work is to give an overview of this research and propose recommendations for consideration for environment for adolescent.

This period has seen an increase in-patient admitted to the paediatric unit with Mental Health issues.

Risk Assurance Training

All Divisions have completed bespoke risk assurance training by the corporate risk team. The training was well attended and well received. We recognise subsequent training is required on the Datix Risk module. During March the Quality, Safety & Risk team have been providing training for all Divisions.

Quarterly Stillbirth review – Maternity services

Reporting period 1st January 2022 to 11th March 2022.

From the Maternity and Neonatal performance board meeting in June/July 2021, a plan was made to present the review of stillbirths to the Quality and Safety group. Maternity services are experiencing a delay in finalising the stillbirth reports due to National delays in obtaining post-mortem results. This is due to post mortem examinations having to be referred externally to Cardiff for fetal pathology examination where there is only one fetal pathologist currently working. These delays have been escalated to the Maternity and Neonatal Network and the Bereavement Midwife is emailing Cardiff every 2 weeks for updates.

There have been 5 stillbirths in Maternity services since January 2022.

Table to correlate age of mother and gestation of stillbirth.

AGE of mother	24 - 27+6	28 - 31+6	32 - 36+6	37 - 41+6	Total
Under 20					**0**
20-25		1		1	**2**
25-29					**0**
30-34	1		1		**2**
35-39		1			**1**
40 or greater					0
Total	**1**	**2**	**1**	**1**	**5**

- 4 out of 5 women were booked for Consultant Led Care and received serial ultrasound scans in pregnancy.
- 2 out of 5 women disclosed mental health at booking.
- 2 out of 5 women disclosed smoking at booking.
- 4 out of 5 women gave birth to a baby with a birth weight centile less than the 10th centile.
- 3 out of 5 women had a BMI over 30.

Recommendations

Members are asked to note the report.

Appendices

Appendix 1 - MIAT report
Appendix 2 - Mitigation Summary regarding non Compliance with Nurse Staffing Levels Act Wales