Meeting Date	**24 November 2020**	**Agenda Item**	**4.1**
Report Title	**Quality and Safety Governance Group Report**		
Report Author	Lee Joseph, Deputy Head Quality and Safety		
Report Sponsor	Christine Williams Interim Director of Nursing & Patient Experience Cathy Dowling Deputy Director of Nursing and Patient Experience		
Presented by	Nigel Downes Head of Quality and Safety		
Freedom of Information	Open		
Purpose of the Report	To provide the Committee with an update from the Quality and Safety Governance Group		
Key Issues	This paper provides the QSC with an update on matters of Q&S overseen by the QSGG during Covid-19. The paper provides a formal route of escalation to QSC from QSGG where necessary.		

Specific Action Required *(please choose one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐

Recommendations	Members are asked to: • **Note this report** • **Note matters for escalation**

Quality and Safety Governance Group Report

1. INTRODUCTION

This report provides the Quality and Safety Committee with an information report from Quality and Safety Governance Group. This report outlines the key Quality and Safety areas discussed at the Quality and Safety Governance Group on **23 October 2020**. Please note that the format has changed to reflect how QSGG is currently dividing the agenda into Covid-19 and general Q&S.

2. BACKGROUND

The Quality and Safety Governance Group (QSGG) was constituted to provide an operational focus and to strengthen the organisational flow of information to the Quality and Safety Committee.

3. GOVERNANCE AND RISK ISSUES

QSGG agenda has been amended during Covid-19 to reflect a more concise approach.

Agenda template is not currently mapped against Health and Care standards themes as per previous/normal processes.

4. FINANCIAL IMPLICATIONS

None from this report

5. UPDATE REPORT

Part A	Covid-19
Patient Safety Issue	Patient Safety Issue – Neonatal Ventilators The group were advised about the national issue with neonatal ventilators. The group were advised of service plans to replace the fleet of ventilators due to age and how the patient safety notice has accelerated the timescales. Procurement will be involved with purchasing of new ventilators with possible plans of law suit to the original supplier. MHRA and BA safety notices have been implemented and WHSSC will be informed of the situation. The group asked for the matter to be brought back to QSGG once the situation has been resolved and

	recommended the matter also be discussed at the Senior Leadership Team meeting.
Revised Never Event Improvement Plan	The group were informed a working group had met in September to review and update the previous Corporately held Never Event action plan. The revised Never Event Improvement Plan 2020/21 has been circulated to the working group members and QSGG membership for final comment to ensure timescales and ownership of actions are accurate and realistic The Group were happy to agree the draft improvement plan which will be presented to QSC.
Annual Quality Statement (AQS) 2019-2020 Final Submission	The group were informed the final AQS was submitted to Welsh Government. It was acknowledged this year's submission had been challenging due to Covid and timescales surrounding the production. The Chair thanked everyone involved and praised the work that had taken place for everyone involved. It was acknowledged that the without the hard work of the HB staff that produced the document, submission would not have been possible.
A1	**Infection Control**
	The group discussed the report. The group were advised of a 75% increase on Tier 1 target from last year, but no clear picture on how this has occurred but acknowledged this was not just within SB UHB, but throughout all HB's across Wales. More positively, was the standing down of targeted intervention status, moving to enhanced monitoring. Chair highlighted the issue around CV-19 cluster outbreaks with a focus on Morriston Hospital, highlighting there was tight management around this with the implementation of daily outbreak control meetings now in place. Early learning was highlighting staff behaviours, with a need to re-inforce the message to staff around staff social distancing. The group were advised that recent blanket testing showed 14 positives - the learning being that all patients coming into the hospital are potential sources of infection and should be managed accordingly.
A2	**PPE**
	The group received the updated paper.

	The local position of PPE is very positive, and nationally stocks are in-line with the winter plan. Some models of FFP3 masks which have been in limited supply, such 8833, may soon be made available again. PPE central stores has now been re-located to the Bay Field Hospital and the temporary infrastructure at HQ removed.
A3	**Safeguarding**
	The group received and discussed papers. Further concerns were raised that the Safeguarding Team are not being copied in to all safeguarding reports submitted to local authority. It was agreed that the matter would be raised at the November Safeguarding Committee. The group were advised that Safeguarding training has been re-commenced in virtual format and is going well.
A5	**Putting things Right:** **Incidents, Concerns, Claims, Inquests, Risk**
	The group received and discussed papers. The group were advised that Patient Experience has gone up to 93% of patients recommending Health Board through friends and family, and that the Patient Experience Team has won a Penna award. The number of reported SI's has increased following the WG decision to revert back to the pre-covid reporting criteria. HIW have published their work programme for the next quarter. Service Groups have been informed accordingly. Group members were advised to raise any concerns with HL or a member of her team. The group were informed that the Datix alert module is now in use.
Part B	**General Q&S**
B1	**Morriston Service Delivery Unit** SH reported by exception to the group. Congratulations was given to the PALS Team for their excellent work during Covid. No separate issues raised.
B2	**Singleton Service Delivery Unit** Group discussed the exception report.

	No separate issues raised. **Maternity Services Group** • CTG training is running well • Cluster CV-19 infection outbreak within service was caused by staff to staff transmission, no mothers or babies were infected. • A report on stillbirth reviews would be brought to next month's group meeting. **Children's Services** • Head of Midwifery is currently seconded to Interim Head of Children's services. • It was noted that no Neonate concerns have been raised within the last 9 months. The need to share excellent practice was discussed. • Group advised of plans to trial Perspex pods within the next few weeks. • Questionnaires of patient experience on ward during COVID to be trialled, plus feedback on pre-assessment service changes, 50 have been sent out, feedback at next meeting. Chair praised the excellent work taking place regarding midwifery ultrasound, with this work finally coming to resolution.
B3	**Neath Port Talbot Service Delivery Unit** The group discussed the exception report. • Confirmation that SI's have been dealt with in exactly the same way during the COVID period was given to the group. • Regular Weekly Scrutiny reviews of incidents are taking place. • Communication bulletin has gone out in regard to Laundry arrangements. • Ongoing concern of engaging with families and reassuring them now that visiting has been suspended again, making it manageable for the ward staff. • Meeting with MIU in preparation for HIW inspection.
B4	**Primary Care and Community Services** The group discussed the exception report. No separate issues raised. Thanks given to the IPCT team for their recent and on-going support
B5	**Mental Health and Learning Disabilities Service Delivery Unit**

	The group received the exception report. • The group were advised of plans to recruit 2 additional investigators to help manage SI investigation workload. • ECT clinics were suspended due to lack of anaesthetist cover - service set to resume on 16/11/20. • Visiting rules have been clarified, outdoor visiting facilities are currently being arranged. • Caswell clinic HIW review went well. • To address concerns from citizens around visiting, PALS and patient feedback forums are actively promoting the visiting arrangements. Looking at a more digital proactive service for families to keep them informed.
B6	**Director of Therapies and Health Sciences** The group received the exception report. • Update on care after death centre; Currently advertising for the managers post where this service will be held in Morriston Hospital. Need to confirm local governance reporting structures but reporting will be via QSGG. Chair acknowledged this service will be of a huge benefit to grieving families.
	For Noting
B7	Referring Registrants to the Nursing & Midwifery Council
	Any Other Business
B8	QSGG Meeting dates and reporting schedule for 2021 distributed amongst group HIW Letter to be circulated with next month's papers Next QSGG 19 November 2020.

6 Maternity Services – Increase in stillbirths

It was highlighted in the October Q&S Committee that there had been an increase in the number of stillbirths between January and June 2020. Therefore, a comparison of the reportable cases with the same period in 2019 was undertaken and is noted as:

Reportable cases	Jan – June 30th 2020	Jan - June 30th 2019
Intrauterine deaths (stillbirths)	**11**	**9**
Rate of stillbirth / 1000 live births	**6.2%**	**5.2%**

6.1 Action Taken

6.2 A Safer Pregnancy Message from Jane Philips (Head of Midwifery) was released on the HB Social Media on 7 September 2020 and is noted below:

As the Head of Midwifery I feel it is important we share this message with you in relation to our review of the stillbirths which have occurred from January to June 2020 and the important actions you can take to reduce your risks of your baby being stillborn. Unfortunately, we know that every day in the UK 10 babies are stillborn.

This year a higher number of women who have suffered a stillbirth have been smokers (all smoking different amounts) it is really important you stop smoking completely during pregnancy. We will offer every woman who smokes a referral to the Stop smoking services who can help you get the right support, and if you are in hospital we can also organise for you to have nicotine replacement therapy during your stay and for your you to take home with you. Please ask your midwife about referral to Stop smoking services – it is never too late to stop and it could help to keep your baby safe.

We have also seen an increase in the number of women suffering stillbirth who have a high BMI (overweight). It is essential you aim to maintain a healthy weight gain and even weight loss during your pregnancy, you can do this by eating healthy food and taking regular exercise (This doesn't have to be running a marathon, even regular walks can help if you are not normally very active). please speak to your midwife who will provide you with a personalised weight target and signpost you for further support.

Remember: We are here for you! Even during COVID-19 it is still really important that you let us know if you have any concerns at all about yours or your baby's wellbeing. Maternity services are a 24/7 service and it is always the right time to call if you need us!

More information is available from…………..what about the Tommy's website

https://www.tommys.org/pregnancy-information/symptom-checker/i-just-think-something-wrong/always-ask-about-our-safer-pregnancy-campaign

6.3 Stillbirth reviews are also being finalised and on completion a thematic report will be submitted to QSGG.

7 RECOMMENDATION

The Quality and Safety Committee is asked to:

1. Note report
2. For the Committee to review the report and highlight any areas of improvement they require of the Group to support current review and development.

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☐
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
This paper provides a summary from the Quality & Safety Governance Group.		
Financial Implications		
None		
Legal Implications (including equality and diversity assessment)		
None		
Staffing Implications		

None	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
None	
Report History	N/A
Appendices	Nil