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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



		Agenda Item	2.4 (ii)
Freedom of Information Status		Open	
Reporting Committee	Quality and Safety Committee		
Author	Liz Stauber, Head of Corporate Governance		
Chaired by	Steve Spill, Vice Chair		
Lead Executive Director (s)	Gareth Howells, Executive Director of Nursing and Patient Experience (Interim)		
Date of last meeting	24 January 2023		

Matters to Draw to the Attention of the Board (particularly areas relating to risk or quality)

- Infection Prevention and Control**

Key Matters Raised by Members for Board Attention: the health board would not achieve its 2022-23 infection reduction expectations, except for *e.coli*. There had been pockets of improvement in primary care and Neath Port Talbot Hospital which could provide system-wide learning.

Other Areas of Discussion: acute respiratory diseases, including Covid-19, had started to reduce but were still present and a potential transmission risk. The Morrison Hospital improvement programme was progressing well and infection scrutiny panels within the site were meeting weekly to go through cases. With more advanced medicine came more equipment which was making wards more cluttered.

Other Areas of Discussion

- Patient Story**

A patient story was received setting out a patient's experience of the emergency department when attending with chest pains. She set out her long wait without any communication after her initial tests in which time she witnessed patients in the waiting room who were unwell, some of whom were waiting for a bed or being assessed in front of others. Small changes could improve efficiencies in queue management, communication, waiting room management, privacy and dignity. Staff presenting the story explained the efforts being made to make the waiting room more visually safe with the sicker patients in front of staff to be kept under observation. Discussions were also taking place with medical staff whereby if patients nearby and could safely go home and return the next day for tests to avoid waiting in the department, this should be considered.

- Service Group Highlight Report – Morrison Hospital**

Work was coming to an end to align the service group's quality governance structure to that of the corporate. 11 serious incidents had been reported since the last report to the committee and one never event. A programme of improvements for healthcare acquired infections had been instigated with an improvement lead in place until the end of March 2023. The acute medical unit had opened on 5th December to provide an alternative patient

flow to the emergency department. An increase in patients attending the hospital with pressure damage had been evident possibly because they were sitting in one room, not keeping mobile, trying to stay warm due to the cost of living crisis.

- **Maternity Self-Assessments Against Recent Reviews of NHS Trusts**

A self-assessment was undertaken of the findings of two reports published by NHS England in 2022 regarding failing maternity services - Ockenden (March 2022) and East Kent (October 2022). Of the 78 recommendations, 56 were green for the health board, 16 amber and five red (two of which needed national responses). Recruitment remained a national concern and the health board had an ongoing recruitment campaign. Maternity services met every 24 hours to plan for the next 24 hours and the review the previous day.

- **Quality and Safety Performance Report**

Unscheduled care performance shows the percentage of red calls responded to within 8 minutes has increased in January, and there was a reduction in the handovers over 1 hour. Performance against the four hour target for January was 74% against the target which is an 8% improvement on December's performance. Clinically Optimised performance continues to report high numbers across the sites, there were recent reductions over the last few months, however average figures have increased in January to 284. Cancer performance remained under the outlined trajectory and the reported performance has reduced to 48% from 54% in November 2022. Patient experience has seen a slight improvement with regards to patient and family satisfaction, improving to 92%, and there has been an increase in the number of surveys which were completed.

- **Preparedness for Duty of Candour**

The Duty of Candour would be 'live' from April 2023 and the national Implementation Board would be providing training to organisations in advance of this date. Service groups were working to determine how the Duty would work in practice. Promotional information had been received from Welsh Government and the communications team was developing a plan to share the information more widely through an internal communications campaign and training.

- **Update on External Inspections**

Unannounced visits had been undertaken by Healthcare Inspectorate Wales to Bryn Afon, mental health and learning disabilities and paediatrics at Morriston Hospital as well as a planned inspection to radiology for which one area of improvement had been identified.

- **Learning of the Management of the Tuberculosis Outbreak**

The report was in response to an external review of an outbreak of tuberculosis that happened in Hywel Dda University Health Board (Llywnhendy in Carmarthen). There has been a cluster of cases there for over a decade, all linked to the same outbreak, with 30 active cases and 300 not active but at risk. Due the scale of the duration, an external review had been undertaken of the response by Hywel Dda and the recommendations considered by Swansea Bay for learning should an outbreak occur in its areas. There was a risk the current screening resources were insufficient as the numbers of refugees from Ukraine requiring screening was increasing the burden.

- **Mortality Review Plan**

Mortality was a key performance indicator for quality. Metrics had been identified as well as an approach to reducing the numbers. The Medical Examiner service would be mandated

from April 2023, run centrally by the NHS Wales Shared Services Partnership to get independent scrutiny of any death not referred to the coroner. The health board has a well-established process to undertake medical examiner reviews with the creation of dashboards for crude and condition specific mortality ratios.

- **Health Board Risk Register**

There were 16 risks allocated to the committee, eight of which have a score of 20 and one a score of 25. Following a discussion at the Mental Health Legislation Committee, the risk for Deprivation of Liberty Safeguards (DoLS) would likely increase from 15 to 20. The maternity risks were currently being reviewed with foetal monitoring likely to increase to 20 and induction of labour decrease to 15.

Decisions Made for Approval by the Board

No decisions were made requiring board approval.

Updates Received from Sub-Groups

- **Quality and Safety of Patient Service Group**

The summary of the recent Quality and Safety Patient Service Group was received and noted. Members raised concern as to the challenges to release staff to attend statutory and mandatory training and the level required to be completed needed to be reviewed. This was referred to the Workforce and OD Committee.

Matters Referred to Other Committees

The challenges to release staff to complete statutory and mandatory training was referred to the Workforce and OD Committee.

Date of next meeting	23 February 2023
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