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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



Agenda Item	2.2 (ii)
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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, Interim Director of Nursing and Patient Experience
Date of last meeting	25 October 2022

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

Patient Story: ‘Clyne Ward’

A story setting out the role Clyne Ward at Cefn Coed Hospital was received. It set out that the female acute adult ward had been established as an assessment and treatment facility but now just provided treatment, focusing on a recovery model. Activities were one of the main sources of treatment plan, for example pumpkin picking, visiting farms and a party for the Queen’s jubilee. The ward was currently decorated for Hallowe’en.

The family rooms had been improved to provide space for relatives to visit but this was the only space available. Patients could not be taken from the ward and there was little outdoor space available. There was no formal rehabilitation service available (there was for male patients) and as such, a service had to be paid for away from home which was leading to a delay. The goals for the ward were to improve outdoor spaces, focus on use of occupational therapy space and a sub for recovery.

Service Group Highlight Report: Mental Health and Learning Disabilities

Serious incidents relating to Ward F were being managed through the serious incidents groups and work was ongoing to reduce the backlog. The number of healthcare acquired infections within the service group remained at zero and this was being constantly monitored. The action plan was being reviewed to determine why the good performance to identify learning that could be shared. The service group was managing outbreaks of Covid. There had been an increase in the reporting of the falls due staff not being aware of the need to report long-bone fractures. This had now been done retrospectively and caused a spike. The situation was being monitored to ensure this was the reason for the increase. Patient feedback continued to be good therefore an external review was to be commissioned to talk with those actually using the services to get a feel for what the feedback was really like.

Matters raised by members:

- *Long-term plan for acute adult mental health services;*
- *Understanding of the implications of the high numbers of suicide.*

Progress on the End-of-Life Quality Priority

Members heard that 1% of the population died each year, three quarters of whom could be predicted given their chronic condition. The report and presentation set out the five priorities of the dying person to ensure their last few months of life were right. Patients and families needed to understand the prognosis to be able to prepare. Swansea bay was an outlier in terms of the number of patients who died in hospital. A significant amount of work was being undertaken to change the culture within the health board as often the important conversations to be had with families were left until the final hours, which was too late.

Matters raised by members:

- *The barriers to discharging patients in time to die at home should that be their wish;*
- *Reviews of patients who died in the emergency department to determine if their death had been expected and whether they really needed to be conveyed to hospital;*
- *Plans to identify patients for whom surgery was the wrong intervention given their prognosis;*
- *Ongoing work with residential and nursing homes around DNACPR (do not attempt CPR) decisions to ensure plans were in place for anyone who had signed these documents.*

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

Reductions were still evident for *clostridium difficile* and *e.coli* but increases in cases for *staph.aureus*, *pseudomonas* and *klebsiella*. The percentage of the *staph.aureus* increase had levelled off. A reduction in *klebsiella* cases had been evident in primary care but the increase in others areas was linked to the rise of hepato-biliary disease in the community for those with gall bladder issues. A rise in *clostridium difficile* cases was likely due to the increase in Covid-19 prevalence. The intensive care unit at Morriston Hospital had not reported a case of *staph.aureus*, *e.coli* or *klebsiella* since April 2022.

Matters raised by members:

- *Wellbeing of staff trying to manage infection control levels;*
- *Release of the dedicated resource for the Morriston rapid improvement plan;*
- *Recruitment of a Director of Infection Prevention and Control.*

HIW Immediate Improvement Notice at Morriston Hospital

Following an unannounced inspection of the emergency department at Morriston Hospital by Healthcare Inspectorate Wales, an immediate improvement notice was received. Part of the inspection included talking with staff and patients, observations and a questionnaire for staff to discover what it felt like to work there. The immediate improvement notice had been issued relating to time sensitive areas, particularly the delay to triage chest pains. An action plan had been submitted to and accepted by HIW and there was an expectation it would be completed by 22nd December 2022. The full report from the visit was yet to be received and the action plan would be extended should there be further areas to address. Despite the pressures in the department, feedback had been given that staff were compassionate and patients spoke positively about their care, but did raise the issue of waiting. Links with the bereavement services were held as an exemplar. There were a number of wellbeing champions within the department and there was a commitment to protecting the wellbeing of staff. Weekly meetings were taking place to progress the action plan.

Matters raised by members:

- *Additional capacity identified by staff to triage and observe patients.*

Delegated action by the committee

None taken.

Main sources of information received:

- Integrated Performance Report;
- Quarterly Patient Experience Report;
- Controlled Drugs and Assurance Progress Report;
- Ongoing Tasks, Actions and Improvement Plan Surrounding HMP Swansea Following the HIW Review
- Risk Register;
- Quarter One South Wales Major Trauma Network Clinical Governance Report

Highlights from sub-groups reporting into this committee:

Patient Services Group

The monthly report was received for assurance.

Matters referred to other committees:

There were no matters referred.

Date of next meeting

22 November 2022