Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
Tuesday 23rd February 2023
at 1.30pm via Microsoft Teams

Present
Steve Spill, Vice-Chair (in the chair)
Reena Owen, Independent Member

In Attendance
Anne-Louise Ferguson, Board Advisor (Legal)
Gareth Howells, Director of Nursing and Patient Experience
Darren Griffiths, Director of Finance and Performance
Hazel Lloyd, Director of Corporate Governance
Richard Evans, Executive Medical Director
Deb Lewis, Interim Chief Operating Officer
Anjula Mehta, Deputy Medical Director
Liz Stauber, Head of Corporate Governance
Delyth Davies, Head of Nursing Infection Prevention and Control (for minute 28/23)
Karen Thomas, ED Matron (for minute 26/23)
Ceri Matthews, Interim Group Director Morriston (from minute 26/23)
Emma Mitchell, Interim Head of Nursing for Medicine, and Emergency care (for minute 26/23)
Clare Baker, Deputy Head of Quality and Safety
Sheena Morgan, Quality Improvement Manager
Michelle-Louise Walters, Health Inspectorate Wales
Neil Thomas, Assistant Head of Risk and Assurance (from minute 32/23)

Minute No.		Action
19/23	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting. Apologies for absence had been received from Chris Morell, Director of Therapies and Health Science, Sian Harrop-Griffiths, Director of Strategy, Maggie Berry, Independent Member, and Pat Price, Independent Member.	
20/23	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
21/23	**MINUTES OF THE PREVIOUS MEETING**	

	The minutes of the main meeting held on 24th January 2023 were **received** and **confirmed** as a true and accurate record.	
22/23	**MATTERS ARISING**	
	There were no items raised.	
24/23	**ACTION LOG**	
	The action log was **received** and was **noted.**	
25/23	**WORK PROGRAMME 2022-23**	
	The work programme was **received** and **noted.**	
26/23	**PATIENT STORY: EMERGENCY CARE MORRISTON HOSPITAL**	
	A patient story was **received.** - The patient (Karen) experienced chest pains and was advised by her GP to attend Morriston Emergency Department (ED). She arrived at the ED at 10.30am. - She was triaged by a nurse about 40 minutes after she arrived, and her blood pressure was found to be high. She went back to the waiting room. - She had an Electrocardiogram (ECG) and a blood test after another 30 minutes, then returned to the waiting room. - Karen stated that she received no further communication, had no idea what was happening and did not know how long the blood results would take or if her ECG was normal. - She went on to say that the waiting room was full and she felt really unsafe. - Water was available in the waiting room and at some point, a student nurse came round offering sandwiches because people had waited so long. - Karen stated she felt sad because of the lack of privacy and dignity for a patient who was being provided with walking aids. - Karen stated that the chairs in ED were incredibly uncomfortable. - Karen emphasised she was sharing her story – not making a complaint. The care she received from staff was kind, compassionate and apologetic. The waiting room was full of patients with multiple ambulances waiting outside. She stated	

	the ED waiting room is “really dangerous” and the lack of privacy and dignity really bothered her. Patients were being called but due to the noise could not hear the names clearly and the patients may have left the waiting room to go to the toilet or to go outside for a cigarette. - She felt that efficiencies in queue management, communication, waiting room management, privacy and dignity could be made. She also felt that small changes could improve both patient and staff experience. - Karen emphasised again that staff were kind, compassionate and apologetic in extremely difficult circumstances. In discussing the patient story, the following points were raised: Karen Thomas outlined the learnings from the patient story and the actions that will be taken as follows: - Two areas are being looked at – the waiting area which Karen referenced as dangerous and unsafe – is a known problem. Physically there is no space to expand, and patients are frequently accompanied by more than one friend or family member, which adds to the overcrowding. - Efforts are being made to try to make the waiting area more visually safe by creating colour coded areas – red, amber, and green – so more urgent patients are directly in front of staff. - More comfortable seating will be provided, and there will be provision for USB ports to prevent wires from causing a tripping hazard. Having a television in the waiting room is being considered but there must be a happy medium because some patients welcome watching TV programmes while others prefer a quieter environment. Volunteers are now allowed back in ED and the Red Cross will be able to aid with hydration and nutrition. - There is a one way mirror in enabling staff to see the waiting area and can monitor patients. - Dignity and privacy have been looked at and it is considered too much of a risk to separate off a room in case of patient collapse. - Staff will always endeavour to make the waiting room as safe as it can be in difficult circumstances. - Karen Thomas stated It was very nice to hear that Karen considered the staff provided compassionate and accurate care, going on to say that she felt staff wellbeing was an issue. - At the end of summer last year, a wellbeing garden for staff and a Cwtch corner was opened to give staff a chance to compose themselves after a difficult experience e.g. in case of paediatric death. - She described excellent wellbeing support for staff with signposting to get accurate support. - She acknowledged that more improvements are needed.	

	Deb Lewis felt that Karen had provided a balanced view on what was good and what was not so good from her experience in ED. She referenced an examples of patients who stay all night then go home and questioned if they could have gone home earlier and slept in their own bed. She queried if these cases are reviewed or discussed and who made that call to send them home. Karen Thomas said that conversations are being held with the medical team that if the patient lives locally and has support at home if they could go home and come back the next day. She stated this was particularly appropriate for trauma and orthopaedic patients if an MRI is needed because an appointment could be given for the next day. She mentioned that perhaps this is not being done due to fear of potential litigation or simply because it has not previously been done. She felt that collaborative care may be something to re-explore. Emma Mitchell stated work is ongoing with NHS Elect around same day emergency care (SDEC) and a case review has been done to see where there are gaps in the service to avoid long waits in ED or admission, alongside AMU/AMSR and community colleagues. Deb Lewis queried if there is a directory of services that can be accessed quickly. Emma Mitchell stated that information is needed because ED doctors and staff will not know all the services available, and that information is needed. Gareth Howells stated that all roads lead to ED and the lights never go out. He went on to say that capacity must be created to prevent an ED waiting room that is full of people who should not be there. He went on to say there is a wider picture of how to deflate the pressure, so ED is not a holding area for patients waiting for beds. He stated discussions are taking place about how to create capacity to take that pressure away. Steve Spill queried if it is known that patients are going to have to wait for hours, could they sit in their cars if they are guaranteed they will not miss their slot thus having a more comfortable seat. Or perhaps go home if they live locally without missing their place. There are things can be done to prevent sitting in chairs all those hours. Reena Owen stated she is keen to look at best practice in ED and queried if it is possible to have a nicer environment and a different method of calling patients for a better patient experience. She further queried if Swansea Bay University Health Board (SBUHB) has looked at what other health boards are doing in this respect. Emma Mitchell confirmed that SBUHB does benchmark and look at other health boards. She stated work is ongoing with north Bristol colleagues to discuss ED pathways and SBUHB is always looking elsewhere for guidance and are looking at Cardiff to see if anything can be learned about offloads with the next step being that the team visits Cardiff and bring back learning.	

	Ceri Matthews stated that the Minor Injury Unit (MIU) at Neath is now part of the Morriston Service Group and that what Steve Spill is suggesting is in practice there with patients sitting in their cars with an estimated appointment time. Steve Spill stated that he recently visited MIU and the service was brilliant. He went on to thank the Morriston team for their work in ED.	
Resolved:	The patient story was **noted.**	
27/23	**SERVICE GROUP HIGHLIGHT REPORT: MORRISTON HOSPITAL**	
	A report was **received.** In presenting the report Ceri Matthews highlighted the following points: - The reporting period covers 01/10/2022 to 31/12/2022. - The Health Board is reaching the conclusion of its review and implementation of a revised governance structure to support the delivery of the Quality, Safety & Patient Experience (QS&PE) agenda. - Work is ongoing work with corporate colleagues with regards to the dashboard. - In terms of patient safety and experience, the report indicates a higher than average reporting of Serious Incidents during this period, but this is linked to the national guidance that came out from Welsh Government in July 2022. The change in reporting process, where the 7 day window to establish the degree of harm caused is being enforced. - Once harm is established (routinely in conjunction with the Medical Examiner and/or His Majesty's Coroner), there is an approximate 50% downgrade rate, which reflects observed historical levels. Any incident that may be considered a Serious Incident has to be reported within 7 days and with some we are not able to make that definition clearly without further investigation. - Eleven serious Incidents were reported during that period but nearly 50% of them were downgraded so there is not really an increase in Serious Incident reporting. - One Never Event was reported during that period, which involved a wrong-sided block being administered intra-operatively. The patient was not harmed as a result of the event and immediate action was taken with Theatres to mitigate any future occurrence. - There has been a continued increase in the number of patients admitted to hospital in poor physical health and with pre-existing pressure damage. This post COVID-19 increase in presentation has meant an increase in the challenges related	

to further skin deterioration whilst in hospital. Deterioration of skin integrity is emerging as a future priority.

- Health care acquired pressure damage will be a quality priority and funding is being sought for funding and appointing a tissue viability nurse.
- Reducing Healthcare Acquired Infections continues to be a priority with focus around improving patient safety and reducing harm events to our patients. A programme of improvements has been instigated with an improvement lead in place until the end of March which has enabled significant improvement to be made.
- Through case presentations and weekly MDT reviews better understanding of those infections that were avoidable and those that were not has been gained with learnings taken back to ward staff.
- 40% of *aureous Bactereum* are line related and these must be within our influence to reduce. Reduction in numbers in Jan but slight increase in Feb. Compliance with cannula insertion needs to improve and we have implemented the insertion bundles into the ED and Theatre.
- Chlorhexidine washcloths are part of improvement programme and we have seen inconsistencies in the application of these washcloths, one reason for which is we are experiencing a temporary workforce so are constantly reminding staff to use these washcloths.
- A new initiative “Team Tuesday” is being introduced from 7th March when the Deputy Heads of Nursing, the Head of Nursing and myself will work on a ward in Morriston for a morning shift then regroup to discuss what we saw and feel when we are out on the ward what did we need to address and what common themes are coming through.
- A full report was published mid-October regarding the Health Inspectorate Wales unannounced audit into the ED at Morriston. The Health Board has since provided a progress report on implementation of immediate actions and a full action plan in December. We are on target for compliance within timescale for the actions, and the action plan is monitored via ED governance structure and Morriston Quality and Safety and Patient Experience Group.
- The Acute Medical Unit opened 5th Dec with planned period of service transition from legacy patient pathways from Singleton.
- Patient experience feedback from the CIVICA system (December 2022) shows 84% of patients surveyed (1,355) rate SBUHB’s services as good or very good.
- The Patient Advisory Liaison Service (PALS)is being looked at to proactively obtain real time patient and relatives’ feedback from service users.
- Negative feedback includes patient reported pain and observed prevalence of failure to administer medicine

management. This is being looked at to see if there is any correlation.

- 139 complaints were received during this period with 77% responses sent within 30 days target.
- There is a continuing challenge in terms of capacity for both planned and emergency care along with workforce challenges in areas other than nursing.
- As a result of student streamlining and international recruitment the vacancy position at Morriston is improving and the 1st cohort of 27 nurses are arriving today from India with a planned visit to Dublin end of March for further recruitment.
- Quality priorities for Quarter 4 include: to reduce harm events by reducing HAC infections; launch of Baywatch falls prevention initiative; to look at sepsis improvement and use new scoring to identify acutely unwell and deteriorating patients on ward.

In discussing the report, the following points were raised:

Anne-Louise Ferguson sought further information regarding the admission of patients with poorer health with existing pressure damage querying the reasons for patients having poorer health than previously and if it was due to lack of GP or District Nurse involvement or perhaps a reluctance to come into hospital.

Ceri Matthews explained patients' poorer health is due to a combination of factors. Many patients coming in are elderly and frail and have skin damage when they arrive. Because of their poor physical health their skin will continue to deteriorate during periods of admission.

Anne-Louise Ferguson queried if there is an impact on longer length of stay when patients come in with existing pressure damage.

Gareth Howells stated that the Pressure Ulcer Group has been asked to look at that and this and that these patients are not known to any part of the service previously. He went on to say that many patients are coming in with moisture lesions and grade 2 damage, possibly because they are sitting in one room, not mobile, keeping warm because of the cost of living crisis. This is also being looked at by the Pressure Ulcer Improvement Group are looking at this. Also, it is becoming clear that patients will not access services or call an ambulance because they are aware of long wait times. He went on to say that the public health outcome of that is enormous.

Steve Spill queried if public health messaging about pressure ulcers caused by sitting or lying for long periods of time should be increased because members of the public might not be aware of that.

Alison Clarke stated that children and young people will have grown during the Covid pandemic and may need new types of chairs, physiotherapy, or rehab – so changes in numbers of pressure ulcers might be seen because of that.

	Ceri Matthews thanked Alison Clarke and stated these patients can be contacted and informed. Steve Spill sought clarification how the process of downgrading serious incidents works. Ceri Matthews explained if an incident comes through, and it looks like it meets the definition of significant harm or death a report is made because it cannot always be determined immediately if there has been significant harm or death from the incident, so we are required to complete the form. Often, they are downgraded following investigation and/or by the Medical Examiner's (ME) service. Steve Spill commented that he noted the Mental Capacity Act and Deprivation of Liberty Standards training is not being rolled out as much as we would like. He queried if there isa plan to get that back on track. Ceri Matthews confirmed there are trajectory plans for improvement by each division which are being monitored through various committees and performance reviews. Steve Spill sought clarification about the patient who should have had a spinal block on the right side, but it was on the left side. Ceri Matthews explained a spinal block was put on the wrong side of the patient in preparation for surgery in the anaesthetic room. No harm came to the patient and actions have been taken to prevent this from happening in the future.	
Resolved:	- The report be **noted.** - Update on pressure ulcers to be brought to this Committee in due course.	**GH**
28/23	**INFECTION PREVENTION AND CONTROL REPORT INCLUDING OVERARCHING IMPROVEMENT PLAN**	
	A report was **received.** In presenting the report Delyth Davies highlighted the following points: - It is anticipated the Health Board will not achieve the 2022/23 infection reduction expectations for anything other than E-coli bacteraemia. - There are pockets of reduction in the Primary Care and Therapies group following work with GP practices reviewing patients with urinary tract infections. - There has been an 87% reduction in E-coli bacteraemia in NPT. This is being looked at to see what can be shared with other service groups. - Acute respiratory illnesses peaked in the middle of December and tailed off in the middle of January. Cases of influenza have	

dropped, Covid cases are also down but are an ever present force causing disruption on our wards with potential transmission events.

- The Morriston Improvement Project is still progressing well which Joanne Walters, Infection Prevention and Control (IPC) Matron has been leading. Her secondment ends in March.
- Infection scrutiny panels within the service group meet weekly to go through cases, identify themes and take appropriate action.
- Primary Care have a new electronic system to provide feedback from GPs regarding significant event analysis which will feed into their regular scrutiny meetings.

In discussing the report, the following points were raised:

Reena Owen stated that it is clear that a lot of work has been done but the proof of the pudding is results which are not being seen yet. She went on to say that on recent visits she observed that there is a major issue regarding cluttered wards and inadequate storage space which may impact cleaning and may be a factor in hospital acquired infections. However, on a couple of occasions has seen absolutely superb storage, organisation, and clean, uncluttered wards. She commented if this can be done in some places, could it be done on all wards and if best practice is being spread from ward to ward.

Delyth Davies replied that on regular walkarounds she could think of one ward which seems busy and cluttered and another that is calm and uncluttered. She explained that sometimes this is due to the type of ward. On an admissions ward, with multiple teams and ward rounds going on it can look very busy and cluttered. She went on to say that the more advanced medicine becomes the more cluttered the wards become with new equipment which is a challenge in buildings that were not designed to hold all the equipment now used. Uncluttered wards are not achievable everywhere depending on they ward function and equipment used but like for like wards can be compared and good practice shared.

Steve Spill queried if Joanne Walters will be replaced in the role she is doing at Morriston, and if it is the best use of her time to bring her back to your team or to leave her in position at Morriston.

Delyth Davies stated if she looks at it from Morriston's perspective, because the most vulnerable and acutely ill patients go there, she can see the momentum Joanne is building and the impact that is having. From a Health Board perspective if there is not a replacement she should stay there. From the team's perspective, she should come back.

Gareth Howells stated that if Joanne goes back to the team she should be replaced because the work she is currently doing is important.

Resolved:	- The report was **noted.** - The proposed actions related to the overarching Infection Improvement Plan were **agreed.**	
29/23	**MATERNITY SELF-ASSESSMENTS AGAINST RECENT REVIEWS OF NHS TRUSTS**	
	A report was **received.** In presenting the report Catherine Harris highlighted the following points: - This paper provides an update on maternity services self-assessment against recent National reviews following two reports published by NHS England in 2022 regarding failing maternity services - Ockenden (March 2022) and East Kent (October 2022). - Following publication of the East Ockenden report the Maternity and Neo-Natal Network developed an assurance framework for Health Board to self-assess against and this was submitted by 27th May. - A national meeting hosted jointly by Welsh Government and the Wales Maternity and Neonatal Network for maternity service clinical leaders took place on 7th July to consider national priorities for investment. A second national meeting of clinical leaders took place on 6th September 2022. - It was agreed to develop national actions. There has been no feedback back from these events. - The initial self-assessment is unchanged. There were 78 recommendations, of which 56 are green, 16 are amber, and 5 red (2 of which require national responses). - The Maternity Service multidisciplinary team plan to convene at end of this month to undertake an updated self-assessment of the framework by the end of February 2023. - The recommendations identified in the report, are predominantly directed at national professional bodies and service providers including education institutes and will be incorporated into the Mat-Neo SSP work stream. - Whilst there is no national self-assessment tool a baseline assessment tool using the key recommendations and key actions has been developed by the service group for additional assurance. - The benchmark exercise has not been completed due to service pressures and is planned for completion by the end of February 2023. - Each health board had a Maternity-Neonatal site visit on 19th Jan and whilst there has been no official feedback unofficial	

	feedback is that it was very positive and feel there is strong leadership and teamworking within our mat services. - A Safety Champion has been appointed and commenced in November. During discussion, the following points were raised: Anne-Louise Ferguson sought more information about the problems and difficulties on recruitment of midwives and the impact it is having on being able to do anything towards meeting the demands of these reports and what is needed. Catherine Harris explained that recruiting is a national problem. The Health Board currently has 13.45 whole time equivalent (wte) vacancies in the community service. There is also a high level of maternity leave currently of 18 wte. Regarding our senior leadership unfortunately our previous head of midwifery was off for approximately 7 months we have not been able to meet as a team to look at the work we need to do to assure ourselves against these reports. We have had an external review from the Maternity and Neonatal Network which provided the Health Board with assurance around our governance process so although we have staffing issues we now have our leadership and I am interim Head of Maternity (HOM) at the moment. And we are going out for a deputy head and will be interviewing for that next week so we will have our management structure back. Still got ongoing recruitment programme and we are slowly getting staff in but has had a huge impact on us to do our day to day work. Anne-Louise Ferguson queried how morale is kept up recognizing us is an enormous task to get the service to where it needs to be and feel progress has been made. Catherine Harris confirmed there have been tough times and staff. She stated staff morale is OK currently and there is focus on their wellbeing through engagement, communication, and regular meetings. Gareth Howells stated one of the biggest actions taken is the closure of the NPT birthing unit enabling and centralizing staff to ensure numbers are available to provide the care required. He gave assurance to the Committee that Maternity Services meet on daily basis and review the previous 24 hours and plan for the next 24 hours to identify any risks or gaps and ensure there are13 midwives on per shift. Michelle-Louise Walters (HIW) sought clarification regarding plans to reopen the NPT birthing centre. Gareth Howells stated the decision to close the Neath Port Talbot birthing centre was based on safety. If the staff required are not available, then it cannot reopen and that decision is supported by our Management Board and Chief Executive. There is a plan, which is being scrutinized by Welsh Government, but we cannot put a	

	timescale on it due to lack of staff and as a first step the community service must be reinstated first. The Board is aware how politically challenging this is but the Birthing Centre has got to be safe.	
Resolved:	The report be **noted.**	
30/23	**QUALITY AND SAFETY PERFORMANCE REPORT**	
	A report was **received.** In presenting the report, Darren Griffiths highlighted the following points: - There was a reduction in the number of Covid positive cases reported in January to 230 cases, which is a reduction from 395 cases recorded in December. Subsequently, the percentage of staff absence due to Covid specifically decreased in January, reducing from 1.1% to 0.5%. - 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. As outlined in the paper, actions continue to be implemented to support pathway improvement at the front door and work is progressing with the recent implementation of the Acute Medical Service Redesign - Performance against the four hour target for January was 74% against the target which is an 8% improvement on December's performance. Following the implementation of the AMSR programme, a predicted improvement in performance can be seen in most unscheduled care measures for January. - The remaining unscheduled care measures still remain slightly above trajectory, however they have shown a marked improvement, with the 12- hour target showing a reduction in numbers waiting to 1,089 in January. - 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. - Infection prevention Control performance was above the outlined Welsh Government trajectories in all areas apart from E. coli. This continues to be a focussed area for the Health Board for improvement and Service Group focussed recovery plans are continuing to be implemented and are seeing some improvements. - Ten Nationally reportable incidents were reported NRI's in January, with 3 of those being in Morriston Hospital, 2 in MH&LD and 5 in Singleton Hospital. - We reported no new never events in January	

	- Planned care performance, we have seen an increase in the number of patients waiting over 26 weeks. The number waiting over 36 weeks and 52 weeks have continued to decrease. We continue to see a consistent reduction in the number of patients waiting over 104 weeks on page 33 and we are outperforming the recovery trajectory. We also continue to outperform the submitted trajectory for the number of patients waiting over 52 weeks at stage 1 - Updated trajectories are currently being developed which will provide our position for the end of this financial year and going into the next financial year also. - The number of patients waiting over 8 weeks for diagnostics, has increased in January to 6,829 patients waiting and the numbers waiting specifically for Endoscopy has increased. You will note we remain above the submitted Welsh Government trajectory, however actions have been implemented to reduce the over 8 week position which include administrative validation (over 60 patients have already been removed since implementing), along with an increase in endoscopist sessions which will increase weekly capacity. - The number of patients waiting over 14 weeks for therapies has decreased to 194 patients waiting over 14 weeks which is a noticeable improvement on previous months. We continue to see slightly larger numbers in areas like speech and language therapy and dietetics. As I have outlined previously, the service are aware of their current performance and are managing it closely in their monthly service group meetings. - Cancer performance, we remain under our outlined trajectory for SCP performance, and the reported performance has reduced to 48% from 54% in November 2022. Our backlog figures remain noticeably above the outlined trajectory; however a consistent reduction has been seen following focussed intervention and I can report that currently the backlog figures sit at 470. Updated backlog trajectories are currently being developed for the next financial year which will be formally improved at the end of the month. - The number of patients waiting for follow-up has risen slightly. As previously mentioned we now have an internal validation team working on validation and work has begun with HBSUK in certain services. - Our patient experience has seen a slight improvement with regards to patient and family satisfaction, improving to 92%, and we have seen an increase in the number of surveys which were completed. - Adult mental health and CAMHS performance, both of which are meeting the key WG target areas for access to emergency services and NDD performance was reported as 37% against the 80% target. During discussion, the following points were raised:	

	Reena Owen sought clarification around the numbers awaiting follow up appointments. She went on to say that Welsh Government was employing someone to do work on this, but the numbers do not seem to be going down but appear rather to be going up. Deb Lewis stated the traction expected with the WG scheme is slower than anticipated. There are a number of schemes to tackle the follow up outpatient appointment backlog in particular. Whilst WG has given us funding to review backlogs of follow ups it has not been received yet so there will be limited improvement this financial year but hopefully will see more going forward. Work is starting internally with enhanced monitoring how to move patients on to a patient initiated follow up pathway and an See on Symptom (SOS) pathway where patients contact us when they need to be seen rather than being on a waiting list. Anne-Louise Ferguson then queried cancer numbers stating there are a lot of people waiting over 104 days. She sought clarification if these patients are kept informed. Deb Lewis explained that the length of pathway is longer than we would want it to be, but something is happening with the patient all the time and there is constant communication between the patient and the clinical teams from the minute a referral is received. The longest waits are waits for surgery, particularly at Morriston, so pts with more complex needs and needing a higher level of care than we can provide at Singleton have longer waits e.g., colorectal. However, patients receive a diagnosis or a non-diagnoses within the first 4 weeks. At all stages we communicate with patients, so they know what is going on. Some of that wait is patient initiated so they can have time to process the diagnosis.	
Resolved:	- The report be **noted.**	
31/23	**EXECUTIVE SUMMARY OF THE QUALITY AND SAFETY OF PATIENT SERVICES GROUP**	
	A report was **received.** In introducing the report, Clare Baker highlighted the following key points: - Terms of Reference (TOR) have been reviewed for the Quality and Safety Group (QSG), Patient and Stakeholder Experience Group (PSEG) and Patient Safety and Compliance Group (PSC) and now have standardised terms of reference for all groups. - There are 8 Quality and Safety risks above 20 in a number of areas including infection control, safeguarding, delaying	

induction of labour, midwifery levels and HMP Swansea. Updates from risk managers will be reported through future meetings.

- The Quality Strategy has been presented to Board and approved with a launch date of 2nd March at NPT.
- An implementation plan will be developed to deliver the strategy, and this will be progressed through QSG sub-groups.
- Patient and Stakeholder Experience Group update – a focus session on PROMS was held in the last meeting, how we include PROMS in our reporting will be progressed by the Patient Feedback Team.
- An update on how we communicate with patient waiting for our care was received and the group will take forward commitments within the Quality Strategy to improve how we communicate with patients whilst they are waiting for services.
- Patient Safety and Compliance Group - issues for escalation were reported by Morriston Service Group.
- Reporting of pressure damage and a concern regarding potential duplication, this will be taken forward through the Pressure Ulcer Prevention Strategic Group (PUPSG).
- No assurance audits were undertaken in the month. Tool under development for paediatric areas. Unannounced audits planned for February.
- The increased risks within unscheduled care, in particular through the Emergency Department (ED), the service group risk register reflects this, the risk is in relation to the acuity of patients attending the ED along with the demand on the department. Action against this is reported through the Risk Management Group.
- The positive work in delivering the Health Inspectorate Wales (HIW) ED action plan was noted.
- Issues reporting of pressure ulcers – potentially related to the new Datix Cymru so is being looked at.
- Assurance visit didn't take place – digital one in Jan and Feb also did a paediatric assurance audit tool and try it in March.
- ED – increased risk in ED relating to acuity of pts attending and demand on the department.
- Clinical Outcomes Effectiveness Group - discussions relating to leadless pacemakers and left atrial appendage occlusion were held and will be pursued through the group medical directors.
- The Safeguarding Report notes an increase in number of attempted hangings in November, but this had not been the case in December.
- Quality Improvement programme - the sepsis did not report into the group and are doing a separate report.
- Quality Priorities Programme Board - Issues for Escalation from service groups (which have not been raised within QSG sub-groups):

- Mental Health and Learning Disabilities (MHLD)
- On-going serious incident which is currently at pre-inquest stage
- Patient absconding incident under investigation
- Potential Information Governance breach and reputational issue due to previous patient recently self-publishing book referring to their time in our care
- Staffing pressures being across the service
- Primary Care, Community and Therapies – reports a new risk within Sexual Health services due to their software company entering into liquidation. The service group are putting appropriate mitigation in place.
- Morriston – work is ongoing work with Welsh Ambulance Services NHS Trust (WAST) in relation to off-load issues. This is reflected in the service group risk register.
- NPTS – no issues were raised.
- Quality Priorities:
- There is a high risk to delivery of the Falls Prevention priority due to the problems with the interface between ward metrics and DATIX, meaning that ward level falls incident data is not readily available. This is an all-Wales issues, which is also affecting other areas of patient safety. Progress has been made with informatics to build a local work around for short term use – this remains in progress. Project with nursing homes with safe care collaborative.
- End of Life Care (EOLC): discussions being held to identify mitigation to risk regarding digital intelligence and recording of EOLC planning:
- Falls risk being progressed as part of national discussions regarding Once for Wales
- Meeting arranged with Digital Intelligence regarding recording of discussions relation to EOLC
- Suicide Prevention - Meeting sought with workforce and OD regarding sustaining Suicide Prevention training in the longer term

In discussing the report, the following points were raised:

Reena Owen – one of the concerns raised at last RADAR group was quality priorities around sepsis in that training places are being wasted by staff booking places then not turning up. Perhaps it could be taken up in one of these groups that if we are not fully utilising training places, they could be sold to other health boards.

Clare Baker stated she would take that back to and see how we can look at offering training places out to other health boards.

Anne-Louise Ferguson stated that while she was aware there is a problem with digital with EOLC, there is a target of 95% of relevant staff to be trained in end of life care, and presumably be able to

	cascade down to junior staff. However, the report states that in various organisations only tiny percentages are booked on to EOLC training. She queried if the training being promoted. Gareth Howells stated training is a consistent area of discussion, with mandatory training in 12 distinct areas, staff also have to undertake training around plus priorities e.g., Sepsis and EOLC. There is a wider piece of work being done to look at training aligning with priorities. Reena Owen agreed that all training should be reviewed. She went on to say that independent members are asked to attend many courses on ESR and need to set aside a whole day to work through the system, which course completion not being shown. Clare Baker gave assurance that the issues around ESR have been raised and escalated. She went on to say that efforts are being made to have priority training status converted to mandatory and statutory training.	
Resolved:	- The summary be **noted.** - Referral to the Workforce and OD Committee to review staff training to reduce courses that are not crucial to their job role.	
32/23	**UPDATE ON THE PREPAREDNESS FOR DUTY OF CANDOUR**	
	An update was **received.** In presenting the report Neil Thomas highlighted the following points: - Duty of Candour training is being delivered by the National Implementation Board which is supporting organisations and reporting to Welsh Government. - The Health Board is awaiting national training materials which is expected to be received by 28th February. This is being mitigated by local awareness sessions initially to senior members responsible for delivering Duty of Candour. - Service Groups are being engages with to look at how to make Duty of Candour work in practice. - The reporting mechanism is Datix Cymru. - Primary Care is responsible to the Health Board for end of year contractors and is contractually responsible to notify us when duty of candour is triggered. - Welsh Government will ensure staff and public awareness materials / leaflets will be available through an accessible platform (SharePoint). Draft awareness leaflets were shared with the health board on 12th January 2023. Feedback has been provided and further information is awaited. - To mitigate any risk around staff awareness, the health board's communication team plan to share information about the Duty of Candour widely.	

	- An internal communications campaign and training to increase general awareness of the Duty and highlight what this means for staff is being undertaken by the implementation lead - The implementation lead met with representatives from all four service groups on 13th January 2023 to discuss the implementation of the Duty of Candour, including the background and the process should an incident be reported as more than minimal harm. - The implementation lead is meeting with all divisions within service groups to discuss the implementation of the duty of candour via a presentation and question and answer session. Meetings also to be arranged with other stakeholders, such as, estates, portering, volunteers, staff side, chaplaincy, etc. - Arrangements are also in place to present an awareness session around the process with the Executive Board, SBUHB Community Health Council. - The health board's commissioning team are aware of and considering their contracts with providers in relation to the Duty of Candour. Contracts will need to be reviewed to consider the regulations. In discussing the report, the following points were raised: Reena Owens commented that she has looked at implementation of Duty of Candour in detail and it is clear there are major financial implications to the Health Board. She then sought clarification how the Citizens Voice body is going to overlap with the Community Health Council (CHC). Gareth Howells explained Citizens Voice is replacing the CHC, which is being dissolved locally. Elizabeth Stauber informed the Committee indepenent members would receive a briefing on how Citizens Voice will affect the Health Board in April 2023 and how it would align with the Health Board. Steve Spill commented that all CHC people are moving across to the new organisation. He added that the Board had a one hour presentation from Shared Services about the Duty of Candour at a development session.	
Resolved:	The report be **noted.**	
33/23	**UPDATE REPORT ON EXTERNAL INSPECTIONS**	
	An update report on external inspections was **received.** In presenting the report Neil Thomas raised the following points: - A correction to the report: The first bullet on the front page states there have been no new inspections undertaken by HIW since the last QSC report. This is incorrect and is	

	corrected by the third bullet point which states: "Unannounced inspections have been undertaken at two further services". These took place in January at Bryn Afon MHLD and Paediatric Services at Morriston and we are awaiting reports. - Since the report was written the planned inspection in Morriston radiology was completed with verbal feedback provided with one area of improvement indicated. A full report will follow in 4-6 weeks. - HM Inspectorate of Prisons has commenced an inspection at Swansea this week. HIW will join them next week. - New Final reports - Previously had draft findings of the Morriston ED review and have now received the final report. - Update on the Improvement Plan for Dan Danino ward at Morriston has been received. - Reviews – HMP progress review went to partnership board in December and is currently going through PCT Governance groups. - Update on the National Review of Mental Health Crisis Prevention has been received. - HIW requested a progress report regarding actions to address recommendations resulting from their review of Ophthalmic services. 6 Ophthalmology Services. An update was sent to them in January 2023. In discussing the report, the following points were raised: Alison Clarke reported she was present at the Radiology inspection. Several issues were identified including low compliance of face to face resuscitation training and face to face Manual Handling Training within radiography. However verbal feedback was received highly commending all other areas. The formal written reports is awaited.	
Resolved:	The update report be **noted.**	
34/23	**LEARNING OF THE MANAGEMENT OF THE TUBERCULOSIS OUTBREAK**	
	A report was **received.** In presenting the report Richard Evans highlighted the following points: - The report is in response to an external review of an outbreak of TB that happened in Hywel Dda Health Board (Llywnhendy in Carmarthen). There has been a cluster of cases there for over a decade, all linked to the same outbreak.	

	- There are 30 cases of active TB and 300 cases of late TB, cases that are not currently active but are at risk of TB breaking through and becoming active infection at a later date. - Associated with that is screening of contacts – over 600 individual contacts of someone who has had TB plus over 2000 members of the wider community. Due to scale and duration, there has been an external review to look at response of Hywel Dda HB. - It is difficult to manage outbreaks of TB, which is a fairly low prevalence disease in UK, but when outbreak happens resource in management and screening related is significant. - A small core team that delivers treatment is adequate then additional resource is significant for screening. - The recommendations made to Hywel Dda regarding the outbreak have been reviewed and an assessment made as to what the indications would be for SBUHB should an outbreak occur. - There is a risk that current level of resource available for TB screening is inadequate and the requirement for screening Ukrainian refugees is added to the burden on what is already being done. - The Committee is being asked to approve the recommendations in the report and that the Regional Health Protection Forum be invited to develop a local plan for the management of TB which will be supported by a business case identifying the resource required to deliver a sustainable service by the Health Board. Steve Spill sought further information regarding the Regional Health Forum. Richard Evans explained that the Regional Health Forum sits under the Executive Director of Public Health and stretches into the wider community. Steve Spill queried if 29 cases over a decade represents a virulent outbreak of TB. Richard Evans explained that TB is an issue is that grumbles on in the community but does not go away. He went on to say that if effective screening is not carried out there are 300 people who might develop it later. TB not pleasant as it is a lung infection and where it goes outside the lungs it can cause meningitis. A major concern is exposure to antibiotics encouraging resistance which is particularly problematic in TB. Reena Owen queried if the Health Board has enough people and funding for an adequate response. She also queried if there would be	

	a regional response to a TB outbreak and if Public Health Wales and all local authorities would be involved in a response. Richard Evans stated the amount of resource needed would be modest and would need to be managed within the resources we already have in conjunction with Hywel Dda, then assess for the following year's finances if there needs to be a significant investment.	
Resolved:	- The report be **noted** - Recommendations were **agreed.**	
35/23	**MORTALITY REVIEW PLAN**	
	A report was **received.** In presenting the report Raj Krishnan highlighted the following points: - The paper explains how data on mortality is captured and reviewed by the Health Board and proposes a new process for reviewing and learning from deaths, the mortality review process, and the development of a mortality reduction programme. - Mortality has been identified as a key performance indicator for quality by the Health Board. - The paper outlines the metrics for the indicator, the governance structure, and the approach to reducing mortality in the health board. It was emphasised that the numbers need to be looked at in context. - The Medical Examiner (ME) service will be mandated from April 2023. In Wales, the ME is run centrally by the Shared Services partnership. This helps to get an independent scrutiny of all the deaths that are not directly referred to the coroner. - The clinical team will identify the cause of the death and is expected to complete the Medical Certificate of Cause of Death (MCCD). The MCCD will not be registered by the Registrar until the ME has reviewed the cause of death with the clinical team. The ME will then proceed to undertake a review of the notes and contact the bereaved family or representative to identify any concerns. If there are concerns identified, then the case is referred to the HB for a further review. The below chart (Figure 2) demonstrates the return undertaken by the ME over the last nine months for each HB in Wales. - The Health Board has a lot of data but is information poor, so triangulating is needed. A dashboard is being created for this purpose and mortality reduction programme data will be triangulated on a monthly basis. - SBUHB has a well-established process to undertake the Medical Examiner reviews. The creation of dashboards for crude and condition specific mortality ratio will enable the Health Board to monitor its mortality across different clinical	

	areas, triangulate the various data sources to identify variation. - There are no financial implications identified for this plan. The programme will be utilising existing resources to implement this. In discussing the report, the following points were raised: Anne-Louise Ferguson queried what is being put in place to resolve the issue of making data more meaningful to clinical care. Raj Krishnan explained that at the moment it is not possible to relate mortality index to quality of care due to different data sets and delays. The work is to identify avoidable deaths and if there are, to ascertain if there is a problem with access, delivery, or quality of care. He admitted there is a problem with coding at present. Anne-Louise Ferguson queried if this work would make a difference in the long term. Raj Krishnan explained that in England the ME service is run by individual health boards. In Wales it is run by Shared Services and that in his opinion it cannot be bettered. Reena Owen stated that she found report useful and reassuring in terms of process for Secondary Care. She acknowledged that Primary Care process has yet to be resolved. She queried if a regular report be brough back to Quality and Safety Committee. Raj Krishnan confirmed that the Mortality Review Plan goes to 2 groups and will be reported back to this Committee if there are concerns. Richard Evans stated that a lot of work has been done in short space of time and it has had a great impact. It is a pragmatic way of reporting data and does not rely on system that will take time to be fixed.	
Resolved:	- The report be **noted.** - The outcomes and actions be **agreed.**	
36/23	**HEALTH BOARD RISK REGISTER**	
	An update report was **received.** In presenting the report Neil Thomas highlighted the following points: - The January Risk Register summarises 16 risks allocated to the Quality and Safety Committee, 8 have a score of 20 and one scores 25. Other committees' risks are reported where there is relevance to this committee.	

	- Management Board will be reviewing the Risk Register next week and it is going to the board in March. There will be some changes to risk scores. - Following discussion at the Mental Health Legislative Committee the Deprivation of Liberty Safeguards (DoLS) risk will be increasing from 15 to probably 20. The maternity risks are being comprehensively reviewed within the service and 2 of those are likely to be changing: Fetal monitoring risk likely to be increased to 20. Induction of labour risk is likely to decrease from 20 to 15. This may be reviewed due to changes to legislation. In discussing the report, the following points were raised: Reena Owen queried the deprivation of liberty safeguards and sought clarification around the implications of delay in the assessments for patients. Neil Thomas explained there is a risk to the Health Board is if there are no legal documents supporting the reasons for depriving the liberty of patients. If timescales are not met there could be financial claims against the Health Board as well as reputational damage. Reena Owen sought clarification of the rights of patients to defend against their loss of liberty without these assessments being done. She went on to ask if a DoLs has been applied to a person in the street, what redress that person has. Steve Spill explained in that situation the person has a full legal right to sue the Health Board. The Mental Health Legislation Committee insisted the risk be increased due to concerns about DoLs exposure. Reena Owen queried the effect on the patient. Michelle Louise Walters explained that DoLs application are open to litigation and scrutiny. Whilst capacity is assumed there is a need to remove certain parts of their liberty in the best interests of the patient. If you deprive any person of liberty it must be justified in the decision making. Gareth Howells commented that the risk is around only having 2 DoLs assessors and that depriving a patient of liberty is always about having justifiable reasons. Anne-Louise Ferguson explained how DoLs works in practice. She gave the example of an elderly patient who is on a ward, has a bad infection, is hallucinating and wants to go home yet needs to be kept safe and needs to be detained so the least restrictive option is applied. For example, someone might sit next to the bed and stop them running away. As soon as that phase is reduced it is expected that a clinician would assess to see if it is a temporary alleviation or permanent. Then if it is decided the patient was wrongfully detained and there is no proper documentation, they may be able to seek compensation for wrongful detention	

Resolved:	- The report be **noted.**	
37/23	**ITEMS TO REFER TO OTHER COMMITTEES**	
	- The following items to be referred to other committees: - To identify non-crucial training courses (minute 31/23) to be referred to Workforce and OD Committee. - ESR issues relating to completed courses not appearing on the system (minute 31/23) to be referred Workforce and OD Committee.	
38/23	**ANY OTHER BUSINESS**	
	There was no further business, and the meeting was closed.	