Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
22nd November 2022
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)
Maggie Berry
Christine Morrell, Director of Therapies and Health Science
Gareth Howells, Director of Nursing and Patient Experience
Richard Evans, Executive Medical Director
Hazel Lloyd, Director of Corporate Governance
Hazel Powell, Deputy Director of Nursing and Patient Experience
Scott Howe, Healthcare Inspectorate Wales
Chris Scott, Internal Audit
Sue Evans, Community Health Council
Liz Stauber, Head of Corporate Governance
Steve Jones, Service Group Nurse Director, Mental Health and Learning Disabilities (until minute 249/22)
Delyth Davies, Head of Infection, Prevention and Control
Kate Hannam, Service Group Director, Morriston Hospital
Sue Morgan, Consultant in End-of-Life Care
Meghann Protheroe, Head of Performance (minute 271/22)
Sue Ford, Head of Patient Experience, Legal and Risk
Karen Gronert, Head of Nursing, Primary Care
Andrea Bradley, Network Manager, Major Trauma Network Operational Delivery Network
Lorraine Hay, Clinical Lead, Major Trauma Network Operational Delivery Network
Jayne Hopkins, Head of Quality and Safety, Singleton Hospital (minute 269/22)
Martin Bevan, Group Medical Director Singleton and Neath Port Talbot Hospitals.
Angharad Higgins, Deputy Head of Quality and Safety (minute 272/22)
Michelle Davies, Head of Strategic Planning (minute 273/22)
Neil Thomas, Assistant Head of Risk and Assurance (minute 274/22)
Catherine Harris, Deputy Head of Midwifery (minute 277/22)

Minute No.		Action
262/22	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	

	The chair welcomed everyone to the meeting. Apologies for absence had been received from Patricia Price (Independent Member).	
263/22	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
264/22	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 25th October 2022 were **received** and **confirmed** as a true and accurate record, except to note apologies were received from Maggie Berry.	
265/22	**MATTERS ARISING**	
	There were no matters arising not otherwise on the agenda.	
266/22	**ACTION LOG**	
	The action log was **received**, with the following updates **noted**: **(i) Action Point One – Demonstration of Digital Dashboard:** Steve Spill advised that a demonstration of the Quality Digital Dashboard would take place in January 2023. **(ii) Action Point Two – Diagram of Governance Structure:** A diagram of the Quality Governance Structure has been drawn up. Gareth Howells informed the meeting that the diagram will go through a task and finish group at the end of the week and will be shared with members of this Quality and Safety Committee after that meeting. **(iii) Action Point Three – Performance Report on Waiting List Management with information about Pre-habilitation:** A performance report on what is being done in terms of Quality and Safety for patient safety will be presented today. Information will be given in today's presentation about patient pre-habilitation with a full report given in December. **(iv) Action Point Six – Succession Planning** Reena Owen stated that whilst she has received emails relating to succession planning in light of no General Paediatrics Consultants supporting cardiology, she has not yet received the answers she	

	requires. Action point to be put back on the open items on the Action Log and chased up.	
267/22	**WORK PROGRAMME 2022-23**	
	The work programme was **received** and **noted.**	
268/22	**PATIENT STORY: ALONE IN A FOREIGN LAND**	
	A story setting out the experience of a patient experiencing unexplained sight loss who was admitted on a medical ward was **received.** In introducing the patient story, Jayne Hopkins advised it told, through a series of videos, a patient's experiences on a medical ward after being admitted for investigation of her sudden sight loss and how she felt being a patient with visual impairment. She had been admitted on to a ward late at night and had not been expecting to be admitted so did not bring any nightclothes with her. There were few staff on the ward and the patient had difficulty finding someone to ask for something to wear in bed, which was unmade, and she had to make herself. As it was a Bank Holiday, was 4-5 days before she saw a doctor to talk to about her visual impairment. Despite experiencing severe pain when exposed to bright light,she was put on a ward with lots of windows with no blinds. One team of nurses were very thoughtful, and she was put into an alcove with very little light coming at her. At night lights were put on for nurses to dispense medication and take observations. On one occasion she was sleeping and was woken up by severe pain when the light was put on. The same night duty nurses who had put her in an alcove solved that problem by only turning on the lights on the opposite side of the ward. This information was not passed on at shift change and when she informed the staff on the new shift what the other team had done, she felt she was ignored, and the lights were switched on. The patient went out into the corridor and found a dark space where she sat on the floor near stored furniture until they had switched the lights off. She then found her way back to bed. She felt that the approach to her situation was mostly thoughtless and careless and on the last day prior to discharge a doctor told her that they still did not know what was causing her sight loss. She went home with no idea what was going to happen next apart from being told that someone from Occupational Therapy was going to call the following day to see if she needed any support. About 6 weeks after discharge she had an appointment with Ophthalmology. She was completely unprepared for being given a piece of paper stating that she was now registered blind and would eventually lose her sight. In discussing the report, the following points were raised:	

	Steve Spill queried if any learnings had been achieved from the experience. Jayne Hopkins informed the meeting that learning is still ongoing, and she had had several meetings with the matron from that area to find out why this lady had come to the ward, why her bed had not been made and basic supplies not available. It became apparent that she was admitted during a Covid wave on to an area used for extra capacity, which explained why she was on a bay with no alcoves. It was stressed that this was an explanation, not an excuse. Alison Clarke queried if Linda's predicament has been shared with the Disability Reference Group as they have a strong sector membership for the visually impaired and have materials that can be distributed across wards. Jayne Hopkins was unaware if this had happened. Reena Owen queried how much support was available for the as she clearly needed someone to hold her hand – not nursing staff but perhaps a third sector organization – as the loss of her sight must have been very frightening. She also queried if there could have been support for the Ophthalmology outpatient appointment. Gareth Howell explained that as the patient story related to an admission during a Covid wave that people from voluntary sectors were not allowed on the wards during that time. He went on to say that the situations patients and staff found themselves in during Covid were heartbreaking but that did not absolve the Health Board of its responsibility with this lady, who clearly did not receive great care. Maggie Berry queried why one night team provided a solution for the patient not to hurt her eyes and have more rest, and then the next night team ignored her even when she explained how the previous night team had helped by only turning on lights one side of the ward. She also queried where the information would have been recorded by the problem-solving night team and suggested that if that information had been in the notes the new night team may have accommodated the request about the lights. Gareth Howells explained that at the height of the Covid wave, wards being staffed by bank and agency nurses, that unfortunately things may have been missed. Maggie Berry went on to express concern that after discharge, at the ophthalmology appointment, the patient had no support when she was told she was going to lose her sight. Jayne Hopkins informed the meeting that she has received excellent support from the RNIB Eye Care Liaison Nurse who works within the Health Board and who was able to signpost support. Unfortunately, there was a delay in being linked up with the patient, so the Matron is getting information up on the general medical wards about this excellent resource. Anne-Louise Morgan queried if the patient will be kept updated of the outcome of her Patient Story as if she knows her story has made a positive difference it may give her some closure. Jayne Hopkins stated that she is in 4 weekly direct contact with Linda who has given consent to share her story widely and is keen to get feedback on	

	where her story is being shared and how it is being received at ward level. **ACTION: update be received as part of the service group's next highlight report as to the learning taken from the story.**	**JWo**
Resolved:	The Patient Story was **noted.**	
269/22	**SERVICE GROUP HIGHLIGHT REPORT – NEATH PORT TALBOT HOSPITAL/SINGLETON HOSPITAL**	
	A Service Group highlight report for Neath Port Talbot Hospital and Singleton Hospital was **received.** In introducing the report, Jayne Hopkins highlighted the following points: - Critical midwifery staffing levels has led to continuing with centralised services to maintain safe staffing levels and effective business continuity, with no home births; - Received a positive external review of maternity and neonatal services in relation to our governance arrangements and the leadership to ensure the safety of mothers and babies. - Clinical support currently being provided by Morriston emergency department medical Team via red phone to the minor injury unit due to staff unavailability on an ad hoc daily basis for case discussions and X-ray reviews. Consultants are also providing half-day sessions at the unit; - 20 confirmed serious incidents under investigation for the service group – of the 20 - 11 relate to inpatient falls 3 obstetric care 1 is a pressure ulcer 1 access to service and 4 relating to ongoing monitoring and provision of care. - 2300 Friends and Family survey returns with positive feedback received in September for Singleton Outpatient Department, MIU, X-ray staff and Dermatology - Poor patient feedback was received regarding access to phlebotomy services including the fairly new booking system; poor choice of birth around home birthing service being suspended; and long waiting times for cancer services. - HIW is satisfied with an improvement plan submitted in September for Singleton hospital radiotherapy centre. In discussing the report, the following points were raised: Anne-Louise Morgan expressed concern regarding the risk of prolonged neutropenia and possible death mentioned in the report if the faulty Sahara machine is used. She commented that there is a big risk to the hospital in running such a machine. She queried what plans are in place as it is known that funding is not available to replace the machine. Jayne Hopkins informed the committee that the Sahara machine is not currently being used to thaw stem cells and	

	stated that until a new machine is secured a water bath is being used for the purpose – which is a safe method. Additionally, conversations are being held with Cardiff and the Vale regarding possible joint working and to explore if it is viable to secure a new machine across both Health Boards with a view to joint working. Anne-Louise Morgan further queried if the Sahara machine was out of commission, so it is not possible to use. Jayne Hopkins stated she would contact Ward 11 after the meeting and check on the machine status immediately after the meeting. **ACTION: Jayne Hopkins to get confirm if the Sahara machine is completely out of commission.** Anne-Louise Morgan queried if any support offered to cancer patients between referral and diagnosis or delays between diagnosis and treatment, bearing in mind current long wait times. She went on to say that there is pre-treatment for orthopaedic patients and wondered if there is any support available to allay the fears of cancer patients who are on long wait lists. Martin Bevan could not provide information on any specific measures that are in place but believed that patient who are on pathways are getting treatment in the required times. Anne-Louise Morgan stated that the report says that 6 weeks delays have previously been observed in chemotherapy delivery unit but there are plans to make chairs more used so that there are not gaps. She expressed concern that patients are being left in limbo. Richard Evans clarified that the information in the report was historic and currently no patients on that pathway are waiting more than 2 weeks.Anne-Louise Morgan requested that future report be amended to show the current waiting times. **ACTION: Future Service Groups' Highlight Report for Quality and Safety Committee report to be amended to show cancer wait times have reduced and long wait times are historic.** Reena Owen expressed concern about Paediatric Neurology as the consultant has retired and no one is in post. She commented that the Health Board has had plenty of time to replace the consultant as she has given notice of her intention to retire and had been working part-time for the last 4 years. She queried how patients are getting help now that there is no Paediatric Neurology Service in SBUHB. Richard Evans informed the meeting that the consultant had retired a few months ago and filling her post has been on the agenda. He explained that the challenge has been that paediatric neurology is a very small speciality and to secure that specialist expertise a cohort of patients was required. He went on to explain that another challenge is that high calibre paediatric neurologists would want to work in a big centre for paediatric neurology rather than a unit delivering mainly general paediatrics.	

	Reena Owen then queried that given the national shortage of midwives if any in-house training for midwifery was taking place. Gareth Howells stated that staffing challenges remain an area of high risk despite recruitment of overseas support. He stated that the Health Board was looking at alternatives to midwives by redeveloping the role of Band 3 Birthing Assistants and Band 4 Health Care Assistants/Nurse Practitioner roles. He informed the meeting that Lesley Jenkins (Unit Nurse Director) has been released from her role a couple of days each week to focus specifically on staffing in Midwifery and that it is planned to open the Birthing Centre early in the New Year. He commented that at the moment all Maternity is in Singleton, which is a very acute unit, and many families do not require that level of support. **Action – update be provided in January meeting regarding plans to reopen the Birthing Centre and actions around Midwifery staffing.** Maggie Berry expressed concern that a case of FGM was missed commenting this was the first time she had seen such a case being missed in board papers. She also expressed concern around poor take up of safeguarding training.Gareth Howell stated an update from the Safeguarding Team on training numbers in Maternity Services would be given in January. **ACTION: Update be received in January from Safeguarding Team on training numbers in Maternity Services.** Maggie Owen queried whether Compassion Fatigue training is going to be a statutory or mandatory option within ESR. Gareth Howells stated that he would find out how the Compassion Fatigue training is being rolled out and would contact Workforce and OD for further information and bring an update back. **ACTION: Gareth Howells to contact Workforce and OD to find out how Compassion Fatigue Training is being rolled out and update meeting in January.**	
Resolved:	The service group highlight report from Neath Port Talbot and Singleton Service Group was **noted.**	
270/22	**INFECTION, PREVENTATION AND CONTROL REPORT INCLUDING OVERARCHING IMPROVEMENT PLAN**	
	A report providing an update on the health board's infection control plan, including overarching improvement plan was **received.** In introducing the report, Delyth Davies highlighted the following points:	

- The progress against the Tier 1 infections continues to demonstrate reductions in *c.difficile, e.coli, klebsiella bacteraemia* although the reductions are slight.
- We continue to see an increase in *staph.aureus bacteraemia, pseudomonas bacteraemia – pseudomonas* particularly appears to have very high increase compared to this time last year. Although figures are very small there are no common themes and there does not appear to be one or 2 sources and infections seem to be quite spread out.
- The Morriston improvement plan continues to make some progress. The IPC matron will be seconded as Programme Improvement Lead for 3 months or until such time that the appointed candidate is able to take up the post. Backfill arrangements were in place;
- Improvement in training in Morriston has continued. Highlighted wards who have caught up with training – will say that Nursing staff making strong improvements with compliance with their training.
- Have moved forward on use of chlorhexidine washcloths in Morriston. There had been delay in getting them procurement but now in place in Rapid Improvement Wards and subject to continue discussion on how they may improve and be applicable to some of our patient groups areas.
- Some wards have had many days without cases of infection and continue to be the same.
- Unable to show live digital dashboard for infections so have given an indication of what that will look like. We will be able to go into each Tier 1 infections and drill down to overview from Health Board perspective and wards and give breakdown of trends and will have distribution of which wards have highest incidents live way to keep focus on where needs improvement.

In discussing the report, the following points were raised:

Reena Owen queried what was being done on wards with low infection rates that also needs to be done on other wards that are not making as much progress. She went on to say that she has been on a couple of infection control visits recently to Morriston and Neath Port Talbot Hospitals that there seemed to be a major issue with storage with some wards overstocking and ending up with boxes in corridors and on floors preventing and interfering with cleaning. She wondered if storage facilities could be looked at in order to ensure boxes are appropriately stored which would enable better cleaning and therefore infection control. Gareth Howells stated that despite doing all the right things and so much excellent work being done, the focus was still on getting the number of infections down.

Resolved:	The report be **noted.**	
271/22	**QUALITY AND SAFETY PERFORMANCE REPORT**	
	A report providing an update on Quality and Safety Performance was **received.** In introducing the report Meghann Protheroe highlighted the following points: - There has been a slight reduction in positive Covid cases with 171 new cases recorded in October compared with 218 in September. - Staff absences due to Covid marginally increased in October from 0.8 % to 0.9%. - In October the number of red calls increased by 25%. The number of red calls responded to within 8 minutes saw a slight increase to 50.3%; the number of green calls increased by 15% and the number of amber calls increased by 6%. - In October there were 739 ambulance to hospital handovers taking over 1 hour – of which 722 were attributed to Morriston Hospital and 17 attributed to Singleton Hospital. - Actions continue to be implemented to support pathway improvement at the front door and work is progressing with implementation of AMSR. - The Health Board's performance against the 4 hour target wait time is for October deteriorated from 72.7% in September to 70.56% in October. - Performance against the 12-hour wait has declined further and it is currently performing above the outlined trajectory. The number of patients waiting over 12-hours in ED increased to 1622 in October from 1470 in September. - Continuing to report high numbers across sites in October with an average of 306 clinically optimized patients being reported. The Deputy Chief Operating Officer (Deb Lewis) is doing a piece of focused work to improve this position as it is recognized that continued high COP numbers is having an impact on patient flow. - There were 9 Nationally Reportable Incidents in October – 2 in Morriston, 2 in Singleton and NPT. 3 in Primary Care and 2 in Mental Health and LD. - Planned care performance - the number of patients waiting over 26 weeks for a first outpatient appointment is still a challenge. October 2022 saw an in month reduction of 7% in the number of patients waiting over 26 weeks for an outpatient	

appointment. Orthopaedics has the largest proportion of patients waiting over 26 weeks for an outpatient appointment closely followed by Ophthalmology and ENT. The number of attendances has remained steady in recent months despite the impact of the recent Covid wave.

- The number of patients waiting longer than 36 weeks from referral to treatment has increased every month since the first wave of Covid 19 in March 2020. In October 2022 there were 36121 patients waiting over 36 weeks (a 2.6% in-month reduction from September 2022) of which 26147 were waiting over 52 weeks.
- In October 2022 there were 10090 patients waiting over 104 weeks for treatment, which is a 5% reduction from September 2022. There has been a consistent reduction of patient waiting over 104 weeks outperforming the recovery trajectory.
- The number of patients waiting over 8 weeks for diagnostics decreased in October to 5833 patients. The number of patients waiting for endoscopy decreased slightly and we are slightly over the submitted trajectory. An Endoscopy plan is being developed and focused work in on long term recruitment to support improvement actions currently underway.
- We do remain under the outlined trajectory for single cancer pathway performance however reported performance has increased to 57% from 55% in September. Backlog figures do remain above the outlined trajectory but are beginning to decrease slowly following focused intervention and our Chief Executive Officer is also focusing on supporting the cancer backlog position and is meeting with Urology, Breast and Colorectal Departments to develop and implement a recovery plan.
- The number of patients waiting for a follow up appointment has risen slightly in October to 141,643. A new internal SBUHB validation team has been created and have recently started validation work. Alongside this, Welsh Government has facilitated a pan-Wales contract with HBSUK to undertake more in-depth validation which focuses on direct contact with patients and a more ‘clinical-triage’ approach.
- The Health Board Friends & Family patient satisfaction level in October 2022 was 90% and 4,358 surveys were completed.
- We have seen a reduction in complaints received. In August 2022 the Health Board received 124 formal complaints which is a 23% reduction on the number seen in July 2022.
- Adult Mental Health and CAMHS performance are both meeting key Welsh Government target areas.

	- Emergency services and NDD performance has deteriorated in September reporting 36% against a target of 80%. Maggie Berry queried about Stage 2 Mortality Reviews asking if these are firmly embedded within the new structure and if it is working sufficiently. Richard Evans advised that Dr Raj Krishnan has just started full time as his deputy and is going to make recommendations around learning from death reviews. **Action: Deputy Medical Director to report to this committee regarding mortality reviews once he settles in his new role.** Maggie Berry queried the number of clinically optimised patients, and the care home beds available to the Health Board. She also queried the average length of stay in the care home beds as a step-down option. She commented on the detrimental effect the increasing numbers of clinically optimised patients were having on the service, citing cancelled operations on the day of surgery due to lack of beds. Gareth Howell stated that length of stay in transitional beds was not being monitored automatically adding that it was not planned to transfer patients into a transitional bed only for them to have extended stays of 4 – 5 months with people not getting through. He advised that focused work was being done with ASMR which is going live on 5th December to reduce centre stays and improve discharges to manage flow through the service.	
Resolved:	The report was **noted.**	
272/22	**EXECUTIVE SUMMARY OF THE QUALITY AND SAFETY OF PATIENT SERVICES GROUP**	
	A report providing an Executive Summary of the Quality and Safety of Patient Services Group was **received.** In introducing the report Hazel Powell highlighted the following key points: - Mental Health and Learning Disabilities conducted an internal review against the findings of the Panorama programme on care in Manchester. An action plan was developed to address any gaps in assurance. This includes a programme of peer quality walkabouts which have been taking place. - Healthcare Inspectorate Wales visited the Emergency Department and we have had confirmation from HIW that they are assured by our actions following their immediate assurance issues and the service groups are working on the rest of the actions and report 75% completion of immediate action.	

	- Review of structures is ongoing in primary, community and therapies to reflect corporate arrangements. - HMP HIW review – report to QSC (Quality and Safety Committee) and Management Board this month and on target to achieve timescale within the plan. - Engagement on the quality improvement training review was commenced with members asked to consider how the training provision can be improved in order to increase the application of QI across the Health Board. In discussing the report, the following points were raised: Richard Evans informed the meeting that there had been 2 Never Events directly linked to Morriston theatres in a period of 10 days, which caused concerns regarding variability in completion of WHO checklists in theatres generally. He advised that he sent a direct email to all consultants stating that the WHO checklist was mandatory. Feedback from clinicians suggested some modification to the list as the process at theatres for elective procedures might be different to the process in emergency theatres. As a result he has requested that a group be convened to look at any modifications needed to checklists for standard and emergency procedures around governance and discipline to be put in place as soon as possible. Reena Owen expressed concern that the escalation pathway needed to go through service groups and requested assurance that if there were major issues that they went straight to the patient safety group or came to the Quality and Safety Committee. Hazel Powell gave assurance that urgent issues can be escalated to the patient safety group or other relevant group directly and apologised that this was not made clear in the report. Angharad Higgins advised that a number of “dawn raids” had been done as well as announced audits emphasising that work was being done to work out ways to complete unannounced audits in the community, HMP Swansea and other areas that are not ward based.	
Resolved:	The Executive Summary be **noted.**	
273/22	**UPDATE ON ALLOCATION OF FUNDS TO SUPPORT LONG WAITERS**	
	A report providing an update on allocation of funds to support long waiters was **received.** In introducing the report Michelle Davies highlighted the following points:	

- Recurrent monies have been secured to provide a GP lifestyle model in GP clusters, also an orthopaedic pre-habilitation scheme plus the pilot with the ONKO digital platform.
- There have been some delays due to fitting the service model around the funding requirements. There were also some digital requirements for patients to flow between primary and secondary care.
- The GP lifestyle model commenced in October in the Llwchwr Cluster and has seen 20 patients to date. Once established, and the initial pilot evaluated, the potential to widen the scope geographically will be considered across all clusters.
- The Rapid Diagnostic Centre has seen 37 patients to date.
- We will be developing PROMS and PREMS outcome measures for all those schemes so we will be able to measure value for the Health Board and for individuals.
- The Orthopaedic Prehab model offers a broad range of support options.
- Funding has been secured from the Value Based Health Investment available to the Health Board with final approval of the Business Case confirmed in September.
- We have also received money from the Red Cross to provide a service to patients that is now live.
- Physiotherapy have been working with Pro-Mapp to create the IT system for 12 months and have already piloted it. Starting with the longest waiters, the first surveys will be sent out to patients in 300-400 batches. The plan is that all patient's access stage 1 support over the next 2-3 months.
- By end of financial year those who are appropriate and eligible for Red Cross support will have received that referral.
- Then we will be working on Stage 2 (advanced support) which relies on staff recruitment to offer face to face support. 80% of the Prehab budget is spent on stage 2 which will become operational once recruitment is complete. Given recruitment timescales, this is likely to be the end of February/beginning of March.

In discussing the report, the following points were raised:

Maggie Berry queried if validation of the waiting lists was being undertaken to ascertain if there are people on the lists who do not or no longer need support. Michelle Davies confirmed that validation is a priority area within Health Board.

Reena Owens stated that she had spoken with nurses on an orthopaedic elective ward who confirmed how necessary physiotherapy is prior to elective surgery for better patient outcomes and expressed concern regarding the length of time it has taken for pre-habilitation to be offered to patients on waiting lists.

Michelle Davies gave assurance that the delays were due to having to secure funding and put digital processes in place to support the service. She felt that now those processes were in place the

	numbers will increase adding that a pre-hab to rehab steering group was being set up to put some governance in place and to escalate any challenges or delays in the system. **AGENDA POINT: Michelle Davies to come back in April 2023 with an update on numbers and to report how validation of waiting lists is being undertaken.**	
Resolved:	The report be **noted.**	
274/22	**REPORT ON EXTERNAL INSPECTIONS TO INCLUDE UPDATE ON PROGRESS AGAINST THE HIW IMMEDIATE IMPROVEMENT FOR MORRISTON EMERGENCY DEPARTMENT**	
	A report providing an update on external inspections to include an update on progress against the HIW immediate improvement for Morriston Emergency Department was **received.** In introducing the report Neil Thomas highlighted the following points: - HIW inspections have taken place in Morriston Emergency Department and Dan Danino Ward. The report in respect of Dan Danino Ward has been finalised by HIW and action agreed. Following the inspection at ED Morriston, immediate improvements were required which have been agreed with HIW. - No immediate improvements required in Dan Danino. Improvement plan for that was submitted and accepted. - For ED an immediate improvement plan was required, has been submitted and has been accepted by HIW. - This is an update on progress which is going through Morriston quality and safety governance processes within the timescale we submitted papers for this meeting. The draft report has been received subsequent to the immediate improvement plan. - Since writing this report the improvement plan has been put together and submitted to HIW so just waiting for agreement on actions included as part of that. - Additionally HIW have asked for updates on progress against 2 – one of the LD units and the report they did on IR(ME)R compliance they did at Singleton within Singleton radiotherapy. Both of those have been provided to HIW and have been accepted. - MHLD service group are due to receive a comprehensive progress update within their internal mechanism shortly. Will bring back a fuller update to the next meeting. - Open actions have been refreshed for last HIW maternity review. And are targeted for completion by March 2023 – there are 15 of them. One was previously closed but it further attention has been indicated which is PROMPT training which	

	has suffered due to the midwifery staffing levels. The service has informed us that training has resumed. - It has been agreed there would be one coordinated response for Wales for the ambulance handover reviews and we have obtained that action plan for EASC. Since then EASC have sought information from Health Boards in October to inform their next update. Service director at Morriston coordinated that response which has been forwarded to colleagues there to consolidate. In discussing the report, the following points were raised: Steve Spill requested clarification about HIW reviews of sub-contractors (e.g., dental practices). He queried who had oversight of responsibility for sub-contractors. Neil Thomas advised the HIW is responsible for sub-contractors and for putting issues right when identified. He confirmed that it is not the Health Board's responsibility, but that HIW would keep the Health Board informed of issues. Steve Spill then requested clarification regarding Dan Danino ward at Morriston Hospital, which is a cardiology ward, and if we have learned everything we can from the report. Neil Thomas stated that the Dan Danino ward inspection was a significant event and that HIW was happy with the response to their recommendations. He went on to say that the process is if there are any immediate improvements, we learn about those very quickly after a visit. For this visit we had the draft report and as part of that we identify any issues and also develop an improvement plan which we return to HIW who respond to us to indicate if it's not satisfactory and they were happy to accept what we provided and it's now for the service to implement.	
Resolved:	The report be **noted.**	
275/22	**REPORT OUTLINING THE HEALTH BOARD'S PREPAREDNESS FOR THE DUTY OF CANDOUR**	
	A report outlining the Health Board's preparedness for the Dury of Candour was **received.** In introducing the report Hazel Lloyd highlighted the following points: - This report sets out the new legislation which became law on 1st June 2020 and will be implemented from 1st April 2023. - The legislation creates two new duties – the duty of candour and duty of quality which are out for consultation now. - Meanwhile the Health Board has reviewed its position and has developed an action plan which was agreed by the	

	Management Board and within the report it sets out key areas for policy development and education and reporting. - It's important to note that resource might be an issue so we have set up an implementation group to oversee that and report up to the Quality and Safety group as well; - In terms of duty of candour there already is a duty on professionals to be open and transparent but what this duty does is flip the requirement to contact patients or relatives at the start of a process where we think something has happened before we start the investigations whereas now requirements are that we do the investigations then contact families if there is an issue in care. In discussing the report, the following points were raised: Anne Louise Morgan commented that the duty of candour is an incredibly difficult tightrope, and foresaw that it will trigger more payouts for negligence and claims going on to say that the Duty of Candour is fine in principle but awkward in practice because sometimes there is a fine line between a good outcome and an unexpected outcome. Hazel Lloyd stated that these are some of the issues needed to be worked through and why the implementation group has been set up. Sara Utley informed the meeting that consultation on duty of candour is still open until 13th December. She invited members to comments. Hazel Lloyd added that whilst consultation for Duty of Candour closes on 13th December, consultation for Duty of Quality closes on 17th January.	
Resolved:	The report be **noted** and establishment of a start and finish group for implementation was **agreed.**	
276/22	**Deep Dive on Quality Priorities: Falls**	
	A report providing a deep dive on quality priorities: falls, was **received.** In introducing the report Eleri D'arcy highlighted the following points: - Falls prevention has been made one of the Health Board's top 5 quality priorities as it is the highest rate of incidents in the Health Board and it is 2nd leading cause of accidents in the home. - Falls cost the NHS about £2.3 billion annually - Over last 3 year reported falls incidents have decreased from an average of 213 in 2019 down to 180 in 2022.	

- Falls per 1000 bed days – since April this year we have reduced from 5.6 to 4.3 against a national average of 6.6.
- All this is around a background of falls in the community increasing.
- Since April this year we can see an increase in people over 65 so our most at risk group presenting to front door services.
- The number of serious injuries resulting from a fall in each group is increasing at a very similar rate.
- We have a system with more at risk people, more frailty in our hospitals yet we are managing to reduce the number of inpatient falls albeit slowly.
- 22 pts coming to severe harm in our care is 22 too many.
- Set a new target to reduce falls of 10%;
- Colleagues at the Welsh Ambulance Service are under immense pressure and response to non-critical emergencies is increasing and often waits of several hours, sometimes days. Once fallen if unable to get up we are seeing more and more long lies where a person remains on the floor for over an hour. Prognosis for recovery reduces as the wait increases;
- The pandemic has produced a rise in falls where people had long periods of being inactive. In hospitals we are seeing staff in crisis with increased use of agency staff, increased waiting times at the front door, lack of bed availability. When a patient is in hospital there are complex pathways to allow a smooth transition home – all increasing length of stay and risk of falls in the hospital setting.

Reena Owen commented that is was good to hear that so much work was being done and that some reductions have been seen. She queried how much do GPs check with people in terms of falls when they come in for regular blood pressure checks. Eleri D'arcy assured the meeting that GPs are now well engaged with the task force and find ways to report in to us so we can develop those pathways.

Steve Spill queried the figure of £2.5 billion cost for falls nationally. Eleri D'arcy confirmed that figure related to pan-UK community and inpatient.

Steve Spill commented that prevention of falls is the Health Board's quality priority and queried if we focusing as much on falls outside hospitals in the community. Eleri D'arcy stated that there is a vast opportunity to prevent falls in the community adding that historically we have a better foundation in our inpatients and that her personal clinical work is around prevention in the community.

Steve Spill commented that there are a lot of frail old people in Gorseinon where there are very hard floors. He queried if there were any adaptations that could be affected so if they do fall it would be

	less catastrophic mentioning rubber floor coverings such as in gyms – which can be cleaned effectively. Eleri D'arcy stated there is a lot of evidence around different adaptations about the use of falls sensors and more digitally advanced sensors. Looking at adaptations and environments to make sure it's as safe as possible. **ACTION – further update on progress be reported in six months.**	
	Quality Priority Update on Falls Prevention was **received** and **noted.**	
277/22	**MATERNITY AND NEONATAL NETWORK REVIEW OF SBUHB MATERNITY SERVICES**	
	A report on the Maternity and Neonatal Network review of SBUHB Maternity Services was **received.** In introducing the report Catherine Harris highlighted the following points: - A letter was received by the Health Board on 22nd February expressing concerns that the Maternity Services failed to identify learning related to a particular case. - In the response letter to the Chief Executive the Executive Nurse Director and Executive Medical Director it required external assurance of the governance process within maternity services. - It was decided to ask the Maternity and Neonatal Network to come into our service to perform a review of our governance process system and the structure of the service. - They came in on 24th and 25th August and the framework they used to review the service included 4 key points: risk management, safety, patient service user involvement, data, clerical effectiveness, clinical audit, quality improvement and workforce and training. - The review panel concluded that that Health Board delivers a culture of patient safety and prioritises opportunities for improvement through reflecting on data and lessons learned through adverse events. - The panel were satisfied with the multiple examples of multi-disciplinary team working and the perinatal approach to service delivery. - They were also assured that the Health Board was committed to ensuring that the voices of the service users are heard, and they highlighted and commended the Health Board on the development of the HIE review tool incorporating parents voices. - They did highlight they were unable to meet some key members of the leadership team during the review because of sickness.	

	- There was some learning from the review for which we have drafted an action plan. Steve Spill queried if the Wales Maternity and Neonatal network was an independent organisation. Gareth Howells advised that there are a number of networks in Wales and confirmed that the Wales Maternity and Neonatal Network is independent providing a link between all the maternity services in Health Boards, going on to say that there is a cardiac network, children's services network, all there to provide oversight. The people who conducted the review were from Betsi Cadwaladr and had no link with SBUHB prior to the review. Anna Louise Morgan commented on the regular informal CTG review held weekly, after a nightshift and run by a consultant who would have worked the previous nightshift who would choose a CTG from that shift to review and would host a short teaching session. The panel were very impressed by the commitment and dedication of the consultant to teaching and offering alternative learning sessions as well as reflecting on cases which did not necessarily have a poor or adverse outcome, but to look at every case as an opportunity to learn – that sounds fantastically good practice. That is kind of ground breaking reviews and could be picked out as an incident of really good practice. Catherine Harris reported positive feedback from consultants about what's in place and other Health Boards are looking to implement same. Gareth Howells pointed out that it is important to mention challenges the service has and keep a close eye on the impact that is having on our staff and families. We review ourselves against other health boards so we can check where we are and keep on top of it, but this brings external eyes on things to give us assurance. **ACTION – progress report be received in January 2023.**	
Resolved:	The report be **noted.**	
278/22	**ITEMS TO REFER TO OTHER COMMITTEES**	
	There were no items to refer to other committees.	
279/22	**ANY OTHER BUSINESS**	
	There was no further business and the meeting was closed. 1550.	
280/22	**DATE OF NEXT MEETING**	
	The date of the next meeting was confirmed as 20th December 2022.	