Swansea Bay University Health Board

Unconfirmed
Minutes of the Meeting of the Quality and Safety Committee
26th October 2021
at 1.30pm via Microsoft Teams

Present
Steve Spill, Vice Chair (in the chair)
Maggie Berry, Independent Member
Martyn Waygood, Independent Member
Reena Owen, Independent Member

In Attendance
Gareth Howells, Interim Director of Nursing and Patient Experience
Nigel Downes, Head of Quality and Safety
Richard Evans, Medical Director
Keith Reid, Director of Public Health
Liz Stauber, Head of Corporate Governance
Darren Griffiths, Director of Finance (from minute 243/21 to 246/21)
Kirsty Lagdon, Healthcare Inspectorate Wales
Delyth Davies, Head of Nursing – Infection, Prevention and Control (to minute 243/21)
Leah Joseph, Corporate Governance Officer
Lesley Jenkins, Group Nurse Director (from minute 243/21 to 244/21)
Melanie Llewelyn, Interim Deputy Head of Midwifery (from minute 243/21 to 244/21)
Neil Thomas, Assistant Head of Risk and Assurance (from minute 248/21 to 249/21)
Susan Ford, Patient Feedback Manager (from minute 249/21 to 250/21)
Delyth Brushett, Audit Wales
Meghann Protheroe, Head of Performance
David Roberts, Service Director for Mental Health and Learning Disabilities (to minute 242/21)
Stephen Jones, Nurse Director for Mental Health and Learning Disabilities (to minute 242/21)
Alison Clarke, Assistant Director of Therapies and Health Science (from minute 250/21)
Pam Wenger, Director of Corporate Governance (from minute 244/21)

Minute No.		Action
234/21	**PATIENT STORY: FRANCES' STORY**	
	Steve Spill welcomed David Roberts and Stephen Jones to the meeting.	

	A story was **received** which set out Frances' experience of being hospitalised after contracting COVID-19. Although the story was not able to be played fully due to technical issues, Stephen Jones highlighted that the story had been created in the last 12 months and consent had been provided by Frances to share her story. When Frances contracted COVID-19 she was living in supported accommodation but subsequently was admitted to the Princess of Wales Hospital in Bridgend. Following admission Frances was ventilated and spent six weeks in the intensive therapy unit. Frances has down's syndrome and was well known to the liaison nurse which created elements of trust. The patient advice liaison service were incredibly helpful throughout her admission. Stephen Jones agreed to share the story outside of the meeting.	**SJ**
Resolved:	- The patient story to be shared outside of the meeting. - The patient story was **noted.**	**SJ**
235/21	**CHANGE IN AGENDA ORDER**	
Resolved	Items 2.1 to be taken with 2.2, 2.3, 2.4, 2.5, 2.6 and 1.2 following.	
236/21	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting. The following apologies were noted: Keith Lloyd, Independent Member; Scott Howe, Healthcare Inspectorate Wales; Victoria Davies, Community Health Council; Wendy Lloyd-Davies, Community Health Council; Siân Harrop-Griffiths, Director of Strategy; Christine Morrell, Interim Director of Therapies and Health Science.	
237/21	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
238/21	**MINUTES OF THE PREVIOUS MEETING**	
Resolved:	The minutes of the main meeting held on 28th September 2021 were **received** and **confirmed** as a true and accurate record.	
239/21	**MATTERS ARISING**	
	There were no items raised.	
240/21	**ACTION LOG**	

	The action log was **received.** i. 219/21 Community Health Council Reports Maggie Berry requested that there is an allocated time at November's meeting to discuss Community Health Council orthopaedics report.	
Resolved:	The action log was **noted.**	
241/21	**WORK PROGRAMME 2021/22**	
Resolved:	The work programme was **received** and **noted.**	
242/21	**UNIT HIGHLIGHT REPORT – MENTAL HEALTH AND LEARNING DISABILITIES**	
	The Mental Health Learning Disabilities highlight report was **received**. In introducing the report, Stephen Jones highlighted the following points: - The clinical audit programme had been promoted to increase the volume of audits, and 'drop in' sessions had been supported by clinical audit to guide and advise potential audit teams; - MHLD have undertaken focused work to improve local standards as a consequence of the 2018 Welsh Government delivery unit national review of the quality of care and treatment plans. Further action plans were created and improvements were made. Reporting mechanisms are via the Quality and Safety Governance Group (QSGG) and Mental Health Legislation Committee; - The service group developed a strategy to ensure that staff have opportunities to review data collected via incidents, complaints, serious incident reviews and patient feedback; - Lunch and learn events were developed to ensure that learning opportunities were available across the teams; - The serious incident (SI) review backlog remains a risk for the service group. In order to manage the backlog and continued volume of reported incidents requiring review, the service group agreed additional funding to expand the SI review team from 1.00 whole time equivalent (wte) to 3.2 wte. The appointments commenced from March 2021; - Good progress was made in managing the risk surrounding valproate prescribing in females of childbearing potential; - Court of protection cases are complex and there are challenges that were not historically foreseeable;	

	- Individual root cause analysis reviews are ongoing following a small number of falls resulting in a fractured neck of femur; - The infection, prevention and control team have provided tremendous support to the MHLD team when managing COVID-19 outbreaks; - In the reporting period of 1st October 2020 to 1st October 2021, the child and adolescent mental health service (CAMHS) emergency bed was utilised eight times and remains a risk. In discussing the report, the following points were raised: Gareth Howells noted that progress was good and reflected that it was positive to hear from the team. Delyth Davies commented that an excellent response was received from the MHLD team surrounding the COVID-19 outbreaks. Reena Owen was pleased to see the patient experience feedback, and queried whether carer's feedback was also included. Stephen Jones advised that feedback is actively encouraged from carers. Reena Owen highlighted that 'train the trainers' was important and would give a wider scope for staff. Stephen Jones advised that 'train the trainers' was more cost effective and would continue to be adopted for benefit and efficiency. Reena Owen recounted a negative personal experience when visiting Cefn Coed Hospital in the COVID-19 pandemic, and noted that many MHLD patients benefit from visits. Stephen Jones advised that visiting is actively monitored on a weekly basis and there was a booking system in place for visitation appointments to manage and balance the risk. Martyn Waygood voiced concerns in redemption to compliance in safeguarding training, and highlighted assurance concerns regarding the low return on family and friends feedback in September 2021. He requested assurance that there would be a work stream around the court of protection cases as credibility and support for staff to give evidence was important. Maggie Berry liked the presentation of the report along with the appendices. She queried whether there was a deadline to review the historical SI cases. Stephen Jones advised there was an expectation that the 2019/20 cases would be reviewed by the end of the year calendar year, however there was no deadline to review 2020/21 cases. Maggie Berry queried whether there was a need for additional resource to manage the court of protection cases. Stephen Jones advised that the service group was actively discussing with the team to ascertain workforce requirements. Maggie Berry queried if there was a health and care standards monitoring mechanism in place. Stephen Jones advised that there was a mechanism in place for good governance.	**SJ**

	Maggie Berry queried if there was a solution following the increased utilisation of the CAMHS bed on ward F at Neath Port Talbot Hospital. David Roberts advised that there was no solution to date, however a regional solution would be required. Steve Spill highlighted that the Chief Executive had been in discussions for a possible regional solution which would be supported by other Health Boards.	
Resolved:	- Assurance be provided to Martyn Waygood around friends and family feedback and that there would be a work stream around the court of protection cases. - The MHLD highlight report and appendices were **noted.**	**SJ**
243/21	**INFECTION PREVENTION AND CONTROL AND ALL WALES POSITION**	
	A report providing an update in relation to infection, prevention and control (IPC) and IPC all Wales position was **received**. In introducing the report, Delyth Davies highlighted the following points: - Swansea Bay University Health Board (SBUHB) continued to have the highest incidence of infection for the majority of the tier 1 key infections. Further analysis was undertaken to show comparisons with other Welsh acute Health Boards; - The incidence of C. difficile was above the infection reduction monthly goals. The cumulative rate of increase, year-on-year, has slowed since July 2021, when the increase was 17%. This had reduced to a 5% increase by the end of September 2021; - In September 2021, there were six localised outbreaks of COVID-19, with COVID-19 incidence in community healthcare settings and social care settings continuing to impact significantly on service provision; - The lack of decant facilities compromised effectiveness of the cleaning/ decontamination programme. Provision of decant facilities would enable plans to upgrade mechanical ventilation and single room accommodation to standards set in national guidance; - The COVID-19 vaccination programmes are progressing well; - This year approximately 50,000 children in primary and secondary school across SBUHB will be offered the vaccination by the school nursing team; - The primary care flu-planning group is focussing on improving uptake in the two and three year olds, which only saw a marginal increase in the 2020-21 flu season; - The immunisation team has one substantive immunisation and vaccination lead for SBUHB, and one temporary secondment	

	Band 7 immunisation co-ordinator. The secondment has been extended until 31st December 2021. The business case to expand the immunisation team is in the final stages of review before submission to the Board; - Welsh Government published their targets on 28th September 2021, however SBUHB had been working towards the same standards for the past two years. - It was identified that there has been a reduction in the scrutiny of C. difficile cases which was linked to pressures at Morriston Hospital, however improvements have been made since this was identified. In discussing the report, the following points were raised: Martyn Waygood commented that the figures reported are highlighting infection issues in the community and queried if there was anything the community needed to be doing. Delyth Davies advised that there was a lack of national clarity regarding the exposure of infections and in a local basis screening is being undertaken, however an all Wales picture was needed for context as exposures could be due to a number of factors such as the food chain or agriculture. Martyn Waygood queried if there was any learning to be shared from Aneurin Bevan University Health Board (ABUHB). Delyth Davies advised that ABUHB has a hospital that holds predominately single rooms along with the availability of decant for deep cleans to take place. She advised that without the decanting facilities, infections would remain a challenge for SBUHB. Reena Owen queried the position on hand hygiene prior to eating and drinking. Delyth Davies advised that work had been undertaken previously and hand wipes were provided to patients prior to eating and drinking. The improvement is unsustained and there had been an increase in the number of temporary staff. Feedback surrounding hand hygiene is continually requested on friends and family forms, and constant messaging continues to be shared with staff. Martyn Waygood felt frustrated that patients were leaving clinical wards to meet with relatives outside of the hospital environment, and queried the advice given to manage the situation. Delyth Davies advised that messaging is provided to patients on admission and relatives also receive the same messaging. There are challenges when patients leave the site which can be frustrating for staff, however this cannot be policed. Gareth Howells noted that mask wearing is decreasing even though there is a high prevalence of COVID-19 in the community, and stated that patients cannot be detained.	
Resolved:	The progress against healthcare associated infection priorities up to 30th September 2021 was **noted.**	

244/21	**MATERNITY SERVICES' CRITICAL STAFFING LEVELS**	
	Steve Spill welcomed Lesley Jenkins and Melanie Llewellyn to the meeting. A report providing an update in relation to Maternity Services' Critical Staffing Levels was **received**. In introducing the report, Lesley Jenkins highlighted the following points: - In July 2021, midwifery absence reached critical levels due to unplanned staffing absences which increased staff unavailability to 30% and a 'no surprises' notification was submitted to Welsh Government on 9th July 2021; - Home births were temporarily discontinued and community services have been centralised to maximise available resources; - On 15th September 2021, due to increased unavailability of community midwives who could co-ordinate and lead the specialist service in the freestanding midwifery unit (FMU) at Neath Port Talbot Hospital, Welsh Government was updated of the action taken to temporarily suspend services at the FMU; - The ongoing response to the COVID-19 pandemic has posed challenges in women's choice in place of birth; - The risk rating in relation to critical midwifery staffing was escalated from 20 to 25 on the risk register; - The obstetric unit aims to have 13 midwives on every shift which provides staffing for the labour ward, the alongside midwifery unit, antenatal assessment unit, antenatal and postnatal wards. During the period from the 9th July 2021 to the 13th October 2021 there were 126 shifts that fell below the required staffing levels; - As staff availability improves, a recovery plan will be developed in accordance with the midwifery staff that become available. It was projected that the timeline of recruitment of new band 6 midwives, commencement of band 5 newly registered midwives and the completion of preceptorship programmes for band 5 graduate midwives from the 2020 university cohort would improve staff availability and skill mix by the beginning of December 2021. In discussing the report, the following points were raised: Reena Owen endorsed the handling of the critical staffing levels, but queried whether any negative feedback or levels of understanding had been received. Lesley Jenkins advised that there had been a mixture of understanding and frustration, with communication having been circulated via social media to manage expectations and answer questions. Melanie Llewellyn highlighted that social media had allowed the team to contact women and families to explain the position.	

	Maggie Berry and Martyn Waygood endorsed the actions taken to mitigate the risks. Martyn Waygood queried if there were adverse consequences of the risks. Lesley Jenkins advised that 'red flags' are reviewed on a day-to-day basis. The delays are thematic in terms of inductions, medication and there had been one SI investigation. Gareth Howells was pleased with the National Institute for Health are Care Excellence (NICE) framework. He advised that Birthrate Plus provided workforce assurances and SBUHB is currently compliant, however it needs be monitored regularly. Steve Spill queried the proportion of women that request home births. Melanie Llewelyn advised that there are 12 to 15 home births per month and 18 to 23 midwifery unit led births per month.	
Resolved:	- The ongoing risk mitigation measures were **endorsed.** - The report was **noted.**	
245/21	**OLDER PEOPLE'S CHARTER NEXT STEPS**	
	A verbal update surrounding the next steps of the Older People's Charter was **received**. In introducing the update, Gareth Howells highlighted that the historical older people's charter was not currently operational and he was due to meet with Maggie Berry to discuss the next steps of reviewing the 'trusted to care' actions from the Andrews report. In discussing the report, the following points were raised: Maggie Berry welcomed the opportunity to discuss the item further with Gareth Howells outside of the meeting. She advised monitoring against the charter is important. Gareth Howells agreed to bring an update back to the Quality and Safety Committee once the detail has been agreed.	**GH**
Resolved:	- An update to be brought back to Quality and Safety Committee once the detail has been agreed. - The verbal updated was **noted.**	**GH**
246/21	**QUALITY AND SAFETY PERFORMANCE REPORT**	
	The Quality and Safety Performance Report was **received.** In introducing the report, Darren Griffiths highlighted the following points: - The 'harm from overwhelmed NHS and social services' quadrant to be updated to reflect a red status in November's performance report;	

	- In September 2021, there were an additional 12,839 positive cases recorded bringing the cumulative total to 54,189 in SBUHB area since March 2020. There are currently 72 COVID-19 positive and 46 recovering patients occupying beds across sites; - The percentage of staff sickness absence due to COVID-19 slightly increased from 1.7% in August 2021 to 3.2% in September 2021; - Ambulance response times for September decreased to 50.4% dropping further below the 65% target, which is indicative of the pressures at Emergency Department (ED) and within primary care; - In September 2021, there were 642 ambulance to hospital handovers taking over one hour. This is a significant deterioration from 410 in September 2020 and an in-month decrease of 84 from August 2021. In September 2021, 622 handovers over one hour were attributed to Morriston Hospital and 20 were attributed to Singleton Hospital. The number of handover hours lost over 15 minutes significantly increased from 1,100 in September 2020 to 2,467 in September 2021; - The current ED four hour performance figures for September 2021 are sitting at 72.2%, which is currently tracking above the outlined trajectory; - In September 2021, there were on average 272 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's hospitals, with 250 patients occupying a bed to date; - In September 2021, SBUHB reported five Serious Incident's (SI) and no Never Events were reported; - Falls reported via Datix for SBUHB was 207 in September 2021. This is 5.8% less than September 2020 where 219 falls were recorded; - The number of patients waiting over 26 weeks for a first outpatient appointment is still a challenge, and September 2021 saw a slight in-month increase in the number of patients waiting over 26 weeks for an outpatient appointment. The number of breaches increased from 23,444 in August 2021 to 23,997 in September 2021; - In September 2021, there was an increase in the number of patients waiting over 8 weeks for specified diagnostics. It increased from 5,523 in August 2021 to 5,732 in September 2021; - In September 2021 there were 191 patients waiting over 14 weeks for speech and language therapy. The figure to date is 151;	

	- 27% of Neurodevelopment disorder patients received a diagnostic assessment within 26 weeks in August 2021 against a target of 80%. A follow-up report is being taken through November's Performance and Finance Committee.	
Resolved:	The current Health Board performance against key measures and targets was **noted.**	
247/21	**CHANGE IN AGENDA ORDER**	
Resolved:	Item 4.3 to be taken with 5.1, 5.2 and 4.2 following.	
248/21	**HEALTH AND CARE STANDARDS SELF-ASSESSMENT 2021/22**	
	A report on health and care standards self-assessment 2021-22 was **received.** In introducing the report, Nigel Downes highlighted the following points: - The health and care standards team meet monthly and the corporate team are involved with data collection; - Scrutiny panel meetings are being held and Independent Member attendance was welcomed. In discussing the report, the following points were raised: Reena Owen found the report helpful and was happier with this year's self-assessment outcome. She stated that the self-assessment could help provide assurance around scoring and gives improvement opportunities for service groups. Steve Spill advised he would be unable to attend the scrutiny panel meeting on 24th November 2021 and requested another Independent Member attended on his behalf. Maggie Berry and Reena Owens undertook to confirm their availability to Nigel Downes.	
Resolved:	– An Independent Member to attend the scrutiny panel meeting on 24th November 2021. – The report was **noted.** – The proposed approach to undertaking the annual self-assessment against the Health and Care standards framework for 2021-2022 was **approved.**	**MB/RO**
249/21	**HEALTH BOARD RISK REGISTER**	
	The Health Board risk register (HBRR) was **received.**	

	In introducing the report, Neil Thomas highlighted the following points: - The HBRR was last presented to the full Board in July 2021 and it has been shared with executive director's to update where appropriate. The register reflected revisions made up to mid-October 2021, and was endorsed at Management Board on 20th October 2021; - SBUHB continues to operate at the increased risk appetite level of 20 as determined at the outset of the pandemic; - The HBRR currently contains 39 risks, of which 15 of these are assigned to the Quality & Safety Committee for oversight. 10 are at or above the Health Board's current risk appetite score of 20; - The COVID-19 risk register is managed within the COVID-19 Gold Command structure. It has not been included in recent reports as its operational risk scores were below SBUHB's current appetite of 20. In recent weeks, scores have risen for two risks to meet this threshold; COV004 COVID-related sickness absence; and COV009a workforce shortages. In discussing the report, the following points were raised: Steve Spill highlighted that risk 67 relating to risk target breaches for radiotherapy has was reduced from 25 to 15. He queried where the outsourced patients are now receiving treatment. Keith Reid advised that the patients have been outsourced to the Rutherford Centre. Reena Owen queried if risk 63 relating to screening for foetal growth was contributing to a greater risk and whether the figure should be reconsidered. Gareth Howells advised that he has discussed the risk with the service group as they have yet to mitigate the risk, and although there were no immediate plans the risk would continue to be monitored. Reena Owen suggested that the item is added to the committee action log. Pam Wenger reflected that the next Health Board meeting is scheduled for 25th November 2021 and an update could be provided then. Steve Spill requested that an update on the position of the screening for foetal growth assessment in line with gap-grow be scheduled for December 2021. Steve Spill queried the process if committee members are no assured on the risks relating to the risk register. Pam Wenger advised that if the committee did not have the assurance it required, the executive director could be asked to review the risks by the chair of the committee.	**GH**
Resolved:	- Update on the position of the screening for foetal growth assessment in line with gap-grow be scheduled for December 2021. - The updates to the Health Board Risk Register (HBRR) relating to risks assigned to the Quality and Safety Committee were **noted.**	**GH**

250/21	**OMBUDSMAN ANNUAL REPORT**	
	The Ombudsman's Annual Report was **received**. In introducing the report, Susan Ford highlighted the following: - There was a decrease in the number of cases referred to the Ombudsman during the reported period of 2020/21 (79) compared to 2019/20 (91); - There was a decrease in the number of complaints which proceeded to investigation 2019/20 (31) when compared to 2020/21 (25); - There had been a slight increase in complaints regarding clinical treatment in hospital compared to 2019/20; - There had been a 50% decrease in complaints regarding complaint handling compared to the previous year; - Concerns Assurance Manager would be taking a lead in terms of ensuring timely responses are sent to the Ombudsman; - A training programme was in place to share the learning from Ombudsman cases and findings following the concerns, redress and assurance group (CRAG) following a review of closed complaint responses; - Complaints standards training would be provided by the Ombudsman. In discussing the report, the following points were raised: Steve Spill queried the responsibility and influence of the Health Board when Ombudsman investigations were ongoing. Susan Ford advised that the Ombudsman informs the Health Board at the beginning of an investigation and the outcome of an investigation. Steve Spill queried the placement of the concerns manager. Susan Ford stated that the concerns manager role was a part of the patient experience team. Steve Spill queried if there had been a deep dive into the output of monthly redress cases. Susan Ford advised that the redress assurance group has been running for some time and deep dives took place with service groups on a monthly basis. Workshops have been held to share the learning between service groups which have been useful and a report has been shared with QSGG. Pam Wenger highlighted that the reporting mechanism fed through QSGG and it would be helpful for Nigel Downes to include a report in November's QSGG report as an appendix with a focus on concerns management. Reena Owen highlighted that communication remained a concern for SBUHB and contacting the Ombudsman is often the last resort for patients and relatives. Susan Ford advised that CRAG focusses on	**ND**

	transparency and dialogue is ongoing with the Ombudsman to support the team in communications. Pam Wenger advised that as the report has been considered by the Quality and Safety Committee, the report will go through Board on 25th November 2021, however a response is required from SBUHB by 15th November 2021.	
Resolved:	- The next iteration of the QSGG report to include the deep dive on the output of monthly redress cases and a focus on concerns management. - The actions taken to improve complaint management and learn from Ombudsman cases were **approved.** - The contents of the report and actions being taken to improve complaint management and learn from the Ombudsman cases were **noted.**	**ND**
251/21	**PUBLIC HEALTH SERVICE OMBUDSMAN PUBLIC REPORT**	
	A verbal update surrounding the public health service Ombudsman public report following a complaint within upper (gastrointestinal) GI services was **received.** In introducing the update, Richard Evans highlighted the following points: - The public health service Ombudsman public report related to a complaint in a previous report surrounding upper GI endoscopy; - The patient and relatives were not properly informed of the prognosis and the patient deteriorated quite rapidly; - Most of the Ombudsman recommendations had been completed; - One of the recommendations was for advanced communication training be provided to all GI staff. This would be quite broad and needed to be commissioned on a bespoke basis; - The Medical Director has contacted the Ombudsman to advise of two options. The first would be to limit the training to GI cancer. The second would be to broaden the requirements and work through the detail with a pragmatic approach. - SBUHB awaits a response from the Ombudsman.	
Resolved:	The verbal update was **noted.**	
252/21	**WELSH HEALTH CIRCULAR QUALITY AND SAFETY FRAMEWORK**	

	A report on Welsh Health Circular (WHC) quality and safety framework was **received.** In introducing the report, Nigel Downes highlighted the following points: - The WHC was issued on 17th September 2021 and it contained a letter from the Deputy Chief Medical Officer introducing the quality and safety framework for Wales; - The framework replaced the Welsh Government quality delivery plan; - The framework contained a series of 15 actions for local or national response; - An update report will be brought to December's Quality and Safety Committee. In discussing the report, the following points were raised: Reena Owen queried if the quality management system was accredited. Nigel Downes advised that national works were ongoing and more information would be provided as the process progressed. Maggie Berry queried the resource planning structure. Nigel Downes advised that coupled with annual priorities, a future infrastructure would be needed and would be picked up in due course. Pam Wenger advised that Welsh Government began work a few weeks ago and there was an expectation to have implemented a group as processes become clearer. Resources will be considered under the requirements of 'the Act' and she suggested that the committee had regular updates throughout the next 6 to 12 month period. Nigel Downes suggested a report is received in December 2021, with additional reporting timescales being confirmed in due course.	**ND**
Resolved:	- Update report on the Welsh Health Circular quality and safety framework be received in December 2021. - The report was **noted.**	**ND**
253/21	**QUALITY AND SAFETY GOVERNANCE GROUP**	
	A key issues report from the Quality and Safety Governance Group (QSGG) was **received.** In introducing the report, Nigel Downes highlighted the following points: - The last QSGG meeting took place on 5th October 2021; - At Morriston Hospital, avoidable harm to patients as a consequence of excessive access waiting times across all categories of patient had a current local risk score 25. Mitigating	

	actions have been taken which included recruitment of 15 members of staff into ED; - Actions have been taken to manage the nursing deficit at Morriston Hospital which includes a review of bed availability; - In the children's service, five premature babies had pressure damage to their nasal areas receiving continuous positive airway pressure. Following a review and the involvement of the equipment manufacturer, new humidifiers have been installed. In discussing the report, the following points were raised: Martyn Waygood queried the long-term effects on the babies. Nigel Downes advised that he had been informed there were no long-lasting injuries to the babies. Martyn Waygood noted the good outcome for the general practitioners to complete sustainability matrix. Nigel Downes advised that an update report is being taken through November's QSGG meeting.	
Resolved:	The key issues highlight report was **noted.**	
254/21	**ITEMS TO REFER TO OTHER COMMITTEES**	
	There were no items to refer to other committees.	
255/21	**ANY OTHER BUSINESS**	
	There were no items raised.	
256/21	**DATE OF NEXT MEETING**	
	The date of the next meeting was confirmed as 23rd November 2021.	