Swansea Bay University Health Board

Confirmed

Minutes of the Meeting of the Quality and Safety Committee
Tuesday 24th January 2023
at 1.30pm via Microsoft Teams

Present

Steve Spill, Vice-Chair (in the chair)
Reena Owen, Independent Member
Maggie Berry, Independent Member
Pat Price, Independent Member

In Attendance

Anne-Louise Ferguson, Board Advisor (Legal)
Gareth Howells, Director of Nursing and Patient Experience
Hazel Lloyd, Director of Corporate Governance
Christine Morrell, Director of Therapies and Health Science
Richard Evans, Executive Medical Director
Karl Bishop, Dental Director (for minute 7/23)
Anjula Mehta, Deputy Medical Director (for minute 7/23)
Liz Stauber, Head of Corporate Governance
Angharad Higgins, Head of Quality and Safety
Delyth Davies, Head of Nursing Infection Prevention and Control (for minute 9/23)
Andrew Letters, Interim Matron Infection Prevention and Control (for minute 9/23)
Nicola Lewis, Interim Matron Infection Prevention and Control (for minute 9/23)
Lesley Jenkins, Group Nurse Director NPTSSG (for minute 14/23)
Vicki Burridge, Head of Nursing, Morriston (for minute 14/23)
Jane Phillips, Quality Improvement Lead (for minute 14/23)
Andrea Bradley, Network Manager for South Wales Major Trauma Centre (for minute 15/23)

Dr Luke Jones, Designated Education Clinical Lead Officer (DECLO) (for minute 16/23)

Minute No.		Action
1/23	**WELCOME / INTRODUCTORY REMARKS AND APOLOGIES**	
	The chair welcomed everyone to the meeting. Apologies for absence had been received from Hazel Powell, Deputy Director of Nursing, Sian Harrop-Griffiths, Director of Strategy, Tanya Spriggs, Nurse Director Primary, Community and Therapies, Brian Owen, Group Director Primary, Community and Therapies, and Inese Robotham, Chief Operating Officer.	

2/23	**DECLARATION OF INTERESTS**	
	There were no declarations of interest.	
3/23	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the main meeting held on 20th December 2022 were **received** and **confirmed** as a true and accurate record with one point of accuracy reported: - Anne-Louise Ferguson pointed out that on Page 4, line 2 of the last paragraph, the word 'distilled' should read 'disseminated'.	
4/23	**MATTERS ARISING**	
	There were no items raised.	
5/23	**ACTION LOG**	
	The action log was **received** and was **noted.**	
6/23	**WORK PROGRAMME 2022-23**	
	The work programme was **received** and **noted.**	
7/23	**PATIENT STORY: FRACTURE DISCHARGE**	
	A patient story was **received.** Angela Mehta introduced the patient story. Norma was admitted after a fall and a diagnosis of urinary tract infection was made at the time of admission. During admission the virtual ward looked at what Norma's needs would be to facilitate an early discharge as she had lost confidence during her inpatient stay and her mobility was significantly reduced. At the time of discharge several needs were identified including occupational therapy, medication review, pain management and nursing support in the community. The main issues were physiotherapy for mobility and regaining confidence after her fall. Family support was given as well as there was significant concern about the patient's confusion and wandering outside the home. Discharge was in December, and she was kept on the virtual ward for a period of time to address her needs.	

	In discussing the patient story, the following points were raised: Anne-Louise Ferguson commented that when the patient went home there were still lots of outstanding needs which needed to be addressed to prevent re-admission. She emphasised that it is important to be side by side with patients to evaluate and explore their needs as they arise as there may be needs that are not apparent at time of discharge to avoid re-admission. Reena Owen commented that Norma's patient story highlighted the importance of getting patients out of hospital quickly, and the benefits gained by doing so. She added that keeping clinically optimised patients in hospital beds for long stays can result in them losing condition because patients cannot walk very far or exercise in other ways. She went on to say that being out of environment is also not good for those suffering with dementia and emphasised that virtual wards appear to be an excellent approach in terms of discharging patients as quickly as possible for their good. Anjula Mehta agreed that the ability to recuperate and recover is better at home because of familiarity, networks plus improved mental health and being encouraged to do things, stating that this is the feedback she is receiving from the virtual wards team.	
Resolved:	The patient story was **noted.**	
8/23	**SERVICE GROUP HIGHLIGHT REPORT: PRIMARY, COMMUNITY AND THERAPY SERVICES**	
	A highlight report of the Primary, Community and Therapy Services (PCTG) Service Group was **received.** In presenting the report the Karl Bishop highlighted the following points: - PCTG currently have 949 open incidents on Datix Cymru. - Of the 12 severe harm incidents, 9 relate to pressure ulcers, which are awaiting scrutiny panel, and the others did not require national reporting. - Nationally reportable incidents - pressure ulcers. The move to Datix Cymru in April 2022 resulted in a temporary failure locally to pick up pressure ulcer incidents categorised as grade 3 and above. This led to a backlog of cases for investigation when the error was identified in September 2022. - There are currently 16 pressure ulcer incidents that possibly require national reporting dependent on outcome of scrutiny panel. There is ongoing work with the clinical teams to work through the backlog of cases for scrutiny panel in quarter 4,	

with dedicated roles appointed to undertake investigation and support the process.

- Incident Performance - the service group successfully closed all incidents on Datix Web by end of August 2022.
- Open incidents on Datix Cymru are increasing and require a focus to support services to undertake timely investigation and closure. Incident performance will be included in the monthly reporting through the new quality and safety structures from January 2023.
- Top five themes for Concerns include issues with treatment, access to services, medications and prescriptions, delay in appointments and staff attitude.
- Concerns Performance - PCTG are currently at 71% compliance with performance standard for responding to complainants within 30 working days. This is due to an increase in the numbers of complaints and enquiries being received, and annual leave over the summer months. Quality and Safety structures within the service group are currently under review.
- Mortality Reviews - PCTG has responded to the introduction of the mortality review process this year with development of service standard operating procedures and processes, centrally coordinated and monitored by the governance team. A process of learning from feedback has also been developed, with findings shared within PCTG and with relevant contracted/commissioned services. A learning event for mortality reviews in planned for quarter 4.
- Clinical audit - audiology completed a trial of NICE guidance within the new Audit Management and Tracking system.
- A Clinical Audit Task and Finish Group has been formed and will meet in December to develop the next audit plan and develop the process for planning, approval, monitoring and reporting of audits. The Clinical Audit group will report to the Clinical Outcomes Group.
- An adapted ward assurance audit is being developed for HMP Swansea.
- HMP Prison Partnership Board - 27 out of 29 actions have been resolved. 2 outstanding due to infrastructure prison board responsibility.
- An assurance audit to Gorseinon Hospital is planned over the coming weeks.
- An internal Audit on safe management of Controlled Drugs was largely positive. Actions in Q3 are to demonstrate activity against key recommendations. Mitigations includes adding Controlled Drug internal pharmacy audits in HMP, GPOOH and

Gorseinon to the Health Board dashboard. A template has been devised to track and monitor progress of internal Audit recommendations within agreed timescales. PCTG Plan discussed and agreed with HB Accountable Officer

- PCTG is applying for 2 new controlled drugs for community dental services – the application is going forward now.
- Quality and safety structures are being reassessed to comply with corporate reporting and legislative requirements and going to board for final sign off.
- There is some concern around duty of candour in PCTG.
- 2 GMS contracts handed back due to retirement and unable to recruit. Welsh Government have issued guidance. There may be a flurry of practices changing back to old style practices, and we are engaging and supporting as far as possible.
- Infection prevention and control (IPC) remains a challenge. Focus is on looking for common elements targeting antimicrobials. Compared to report figures the has been an improvement in C. difficile but other figures remaining stagnant.
- 9 Health Board staff (community staff nurses and district nurses) and 8 care home staff attended the recent End of Life Champion Day for Primary and Community Care staff.

In discussing the report, the following points were raised:

Anne-Louise Ferguson requested clarification if “access to services” in the top 5 themes for concerns described referrals or people not being able to see therapists or receive treatment. Karl Bishop confirmed it was the wider definition of access and included patients complaining about waiting lists for referrals, outpatient appointments, getting an appointment with the GP, etc.

Anne-Louise Ferguson queried if end of life training was mandatory as the numbers attending training did not appear to be very high. Karl Bishop explained that the numbers given in the report were a snapshot of that one individual training session, not of the whole programme. He went on to explain that end of life care is part of current medical staff training. Angharad Higgins explained that end of life care projects are taken forward through the Safe Care Collaborative and reduce conveyance from care homes into hospitals and having poor quality of life. There is an ongoing training programme to get end of life champions into each of the services.

Anne-Louise Ferguson queried how success of end-of-life care initiatives could be measured. Angharad Higgins stated she is working closely with the Medical Examiner around end-of-life care and work is ongoing around that.

Pat Price raised several queries regarding pressure ulcers, including if incidents were severe or moderate and if the numbers reported

	included residential homes which were known hot spots. She also sought clarification regarding leads for duty of candour, and if new posts had been created or duty of candour work would be added to current workloads. Karl Bishop was unable to provide information regarding the national average relating to pressure ulcers and went on to say that the Pressure Ulcer Group would have that information including pressure ulcers within the community, coming from secondary care where they have been discharged and is part of their package. Gareth Howells informed the Committee that the health board has better reporting of pressure ulcers now and skin damage is being reported at a much earlier stage - hence the high numbers. A deep dive is being undertaken for pressure damage work by the Improvement Group, but it is not improving. The Long-Term Care team reviews care homes monthly and when there is a challenging situation the Health Board Safeguarding Team gets involved and district nursing teams tend to get involved earlier. He confirmed that pressure ulcers present a challenge and offered to bring an update back to this Committee at a future date. Angharad Higgins explained that work was ongoing across all service groups regarding pressure ulcers, and it was recognized that more improvements needed to be made including additional training for staff. Regarding Duty of Candour Gareth Howells explained that leads would be existing members of staff and there was concern around increased workloads. Anne-Louise Ferguson commented that she went on a Learning Disability visit, and it would be good to see annual health checks for people with Learning Disabilities and would be interested to know if GPs offer them routinely, and if so what the take up is. However, this information was not available. Reena Owen stated that she would support initiating a PCTG RADAR Group to feed into the health board RADAR Group adding that she is on the health board RADAR Group which has not, as yet, had representation from this service group. She went on to say that it is important there is representation from PCTG at RADAR meetings. The next meeting is 2nd February. Maggie Berry expressed concern regarding implementation of duty of candour. She went on to say that we are aware of the impact on health board itself – but wondered about contractors – opticians, dentists, GPs, and queried if the health board is planning to support independent contractors as well? Karl Bishop stated that nationally there has always been a duty of candour but the challenge now will be formal reporting. Work is ongoing but it is not clear as yet how reporting will be affected. From a GDS point of view we do not know. The Welsh Government is looking at it as well. Anjula Mehta stated that from a professional perspective duty of candour has always been applied and it is now about aligning it with	

	existing processes. The thinking nationally would be to align it in the current reporting process e.g. DATIX or existing systems in use within the Health Board rather than creating new system. She agreed that the Health Board will have to support contracted services with education and training going forward. Maggie Berry commented that there are increasing pressures on contractors, citing the GP resignations/retirement. She queried if there are concerns that this is something that will increase with the coming changes in contracts and if the health board must prepare itself for more intervention and support. Karl Bishop confirmed that sustainability work within GMS has been going on for some time and the Primary Care team are continually engaging as early as possible with practices they think are struggling. However, retirement, recruitment, locum roles etc., is a national problem resulting from a changed environment where contractors no longer want their own practice but are happy to have a salaried role. We are seeing it with GDS but have had no contract hand backs this year. There is a degree of concern around what will be happening in the future and the Primary Care Team have asked for an assessment of the risks to pre-empt as much as possible. Anjula Mehta clarified that the GMS position is that 2 resignations have been received from practices – one in Swansea and one in Neath Port Talbot. She went on to say that both are single handed practices, and the resignations were anticipated as there was no succession planning, adding that the business model of single-handed practice not sustainable – both GPs had been planning their retirement and wanted to improve work life balance. Both doctors would be retained within workforce in Health Board positions. Steve Spill commented that he has handled a couple of GP hand back situations and both the Community Health Council (CHC) and the patient population is represented adding that the Health Board has a process for these situations. Richard Evans wished to make a point to Karl Bishop commented that it is a great idea to establish a clinical audit group for Primary Care. He went on to say that it has been that lots of clinical audit plans have been developed, however within service groups such plans are usually for completion within a year, and we are finding that a lot of them are dropping off due to lack of capacity. He stated that service groups will be asked to prioritise by quarter as it is easier to manage completion within a quarter rather than waiting for year end.	
Resolved:	- The report be **noted.** - Update on pressure ulcers to be brought to this Committee in due course.	**GH**

9/23	**INFECTION, PREVENTION AND CONTROL REPORT INCLUDING OVERARCHING IMPROVEMENT PLAN**	
	A report was **received.** In presenting the report Delyth Davies highlighted the following points: - By the end of December, we had exceeded the annual target for most infections except e-coli, which may still be achieved. - There was a year-on-year reduction in *C. difficile* and *E. coli* bacteraemia. The incidence per 100,000 population of *Staph. aureus* bacteraemia and *Pseudomonas aeruginosa* bacteraemia remains the highest in Wales, and the second highest for both *Klebsiella spp*. bacteraemia and *C. difficile*. - The graphs in Appendix 2 attached to the report showing incidence/1000 admissions provide an alternative view on Health Board performance, comparing the incidence of these infections in SBUHB's acute hospitals with other acute hospitals in Wales. - Numbers of acute respiratory infections have been unprecedented – we have never had a year when these numbers of acute respiratory infections occurring at the same time presenting significant demand for services plus increased staff absences which will have had a knock-on effect on the AMSR due to staff shortages as a result. - The three cases of *C. difficile* on Singleton's Ward 3, reported to the Committee in December, were confirmed to be unrelated. Whole Genome Sequencing for these cases indicated three separate genomes; as a result, a transmission event has been excluded. - The overarching infection improvement plan to end of quarter 3 has shown some achievements in the rapid review of infection cases across all service groups. - Rapid improvement wards are participating in undertaking point prevalence of peripheral vascular devices and urinary catheters. Reported compliance with insertion and maintenance bundles has improved, particularly in relation to urinary catheters and there has been an improvement in compliance with peripheral vascular device maintenance bundles. - Not much progress has been made on surveillance of some of the more common infections such as catheter related urinary tract infections, hospital acquired pneumonias, surgical site infections etc and we are looking for a different model of how we can deliver that.	

- There were no suitable applicants for the second time for the Director of Infection Prevention & Control post. Consideration is being given to alternative models for a way forward.

- The digital dashboard is progressing slower than anticipated. Validation of the data continues, to confirm that the data is correctly mapped to hospital and primary care and community locations, and that infection onset type definitions are correctly identified by application of specified national criteria.

- A small number of inconsistencies have been identified and referred back to the Digital Intelligence team for investigation and rectification. On reflection, the work to identify the onset type and the location of attribution has been significantly more complex than originally anticipated. Accuracy of the data is critical. Completion of validation remains on track for the end of January.

- The challenge over the next few months will be increase in c-diff. ARI activity continues to be high across the Health Board and has resulted in outbreaks in several wards/units. This situation will continue to be monitored, but increased influenza and COVID cases circulating in the community impacts on hospital admissions, staff sickness and potential clusters of inpatient transmission. In previous years, the Health Board has seen an increase in the numbers of *C. difficile* cases approximately 8 to 12 weeks after the peak of the respiratory viruses. There are several studies on the co-seasonality of *C. difficile* and influenza, pneumonia and other respiratory viruses, with one study estimating that there could be an impact on *C. difficile* for up to 6 months due to antimicrobial prescribing having an effect on gut flora.

In discussing the report, the following points were raised:

Gareth Howell stated that the real challenge now is in community and primary care as 50% of infections appear to be emanating or being managed there. Additionally, any infection in a care home is attributed to the Health Board and this was raised this with Welsh Government as to how we report. Avoidability needs to be looked at and internal reviews are giving us good data if infections are avoidable or not. Going forward we will continue to report all infections, but the narrative will change.

Steve Spill observed that it appears good progress was being made but has now halted for the reasons described. He queried if this is a blip in the earlier progress e.g., infection after acute respiratory diseases can last or be recorded several months after an illness. Delyth Davies replied that this is a likely scenario with C. difficile. She explained that in the past high seasonal influenzas have taken us into

	middle of year with high numbers of C. difficile. We are now seeing high levels of Covid, flu and other acute respiratory infections, with patients sometimes having more than one infection concurrently. Other health boards are also having challenges. At the moment Cardiff and Vale are not but this may be linked to different times in waves with flu. Aneurin Bevan and Hywel Dda are seeing increases. C. difficile occurs because we give antibiotics for other infections. Bacteraemias will occur because there is a pre-existing infection. Last 2 months there have been particularly challenges for sites with AMSR. We may see further increases in infection in Morriston and Singleton infection rates come down. Steve Spill queried if the service groups meeting with the CEO went ahead in December to present a summary of the improvement work that has taken place and learning to date and Morriston Directors were asked to provide the CEO with a summary of the Service Groups aspirations with time scales during January 2023. Delyth Davies reported that a meeting took place early in December and at that point all the influenzas and respiratory infections hit us. Since then Morriston has been struggling to provide service provision at the front door and achieving flow so the meeting described has been delayed. Gareth Howells stated that a meeting took place with the CEO regarding stage 2 of AMSR. He went on to say that he meets with Richard Evans, Delyth and the service groups every 2 weeks to go through actions and performance work is ongoing.	
Resolved:	- The report was **noted.** - The proposed actions related to the overarching Infection Improvement Plan were **agreed.**	
10/23	**QUALITY AND SAFETY PERFORMANCE REPORT**	
	A report providing an update on Quality and Safety Performance was **received.** In presenting the report, Darren Griffiths highlighted the following points: - In November 2022 there were 171 confirmed cases of Covid-19 with 395 confirmed cases in December 2022 with 27 Covid positive patients in beds today. - The percentage of staff sickness absence due to Covid-19 in December has increased from 0.9% in November to 1.1% in December 2022. - Red ambulance response times (responded to within 8 minutes) were as low as 40.6% in December, down from 45.5% in November 2022. - There was a reduction in ambulances waiting over an hour.	

- For urgent and emergency care, the four-hour target was at 64.13% from 70.41% in November 2022.
- 12 hour waits in ED increased to 1636 in December 2022, increased from 1,456 in November 2022.
- Clinically optimised patients (COPS) averaged 251 in beds in December (283 today).
- In November 2022 there were 114 cases of pressure ulcers; 45 of which were community acquired and 69 hospitals acquired.
- There were 8 nationally reportable incidents (NRI) in December 2022.
- 184 inpatient falls were reported in December 2022.
- Planned care – There has been a steady reduction in patients waiting over 6 months and the number of patients waiting over 36 weeks are well within trajectory.
- The number of patients waiting for an outpatient appointment over 36 weeks is well within trajectory; 52 weeks well within trajectory and the number of patients waiting over 104 weeks is reducing considerably. This is probably the best rate of improvement in Wales.
- Lots of demand is coming through for cancer patients, which has been prioritised. Patients awaiting specified diagnostics increased to 6607 in December from 5627 in November.
- Cancer – the backlog peaked at about 600 in December (535 today) again much higher than we would want, and the 4 main tumour sites contributing to that are Lower Gastrointestinal (GI), Gynaecology, Upper GI and Urology.
- There is a long way to go to improve follow up appointments. But numbers are starting to stabilise.
- There were 3569 Friend & Family surveys done in December, with high levels of satisfaction.
- Complaints – 140 formal complaints were received in October 2022 with responses out almost within target levels.
- Adult MH services are delivering very good access in line with target levels with some improvement in CAMHS access. Neurodevelopment remains a challenge at 38%.

In discussing the report, the following points were raised:

Pat Price queried if there is any explanation behind the significant drop in prompt surgery for fractured neck of femur, which has deteriorated significantly down to 24.6%, also theatre utilisation which has dropped to 59% - a 15% deterioration. Richard Evans stated that the numbers given for fractured neck of femur data comes from the National Hip Fracture data base and went on to say that our performance on fractured neck of femur is better than it was two and a half years ago. He explained that delays in treatment are due to the time to an orthopaedic bed and time to surgery, which relates to capacity issues. Looking at the National Hip Fracture database the

	time to an orthopaedic bed has nosedived and we are in line with other health boards nationally. When we come out of this period of Covid and flu and some of the capacity issues resulting from these are resolved, we will get back on track. Reena Owen queried if the surgery is done within a certain time are there are better patient outcomes and if there is statistical evidence that the sooner surgery takes place the better the outcome. Richard Evans confirmed that everything contributes to a favourable outcome including being in the right bed in the right place with a team that understands the condition. He went on to say that the current UK average of admission to a specialist bed is at 6% so it is a challenge for everyone. Maggie Berry requested that the number of readmissions be presented in numbers rather than percentages on future reports and sought clarification on the reasons for readmissions and to what area. She went on to say that a figure of just under 20% has been given for readmissions of patients who must have been clinically optimised, who then returned so quickly after being medically fit for discharge. Maggie Berry then sought assurance that best use is being made of existing theatres, citing 2nd theatre utilisation rates and the fact agreement has been requested for new theatres at Singleton. Darren Griffiths agreed that we must use theatres as effectively as possible. He went on to say that Singleton will be used as a short stay site for cancer surgery which would potentially decommission theatres at Morriston to be repurposed. Anne-Louise Ferguson commented that it was heart-warming that patients are still recognising they are receiving good care despite the significant pressures staff are under currently.	
Resolved:	- The report be **noted.** - Numbers not percentages be given in future reports for readmissions together with a breakdown of reasons for readmission and to which area.	**DG**
11/23	**EXECUTIVE SUMMARY OF THE QUALITY AND SAFETY OF PATIENT SERVICES GROUP**	
	A summary of the Quality and Safety of Patient Services Group was **received.** In introducing the report, Angharad Higgins highlighted the following key points: - December's meeting did not go ahead as it coincided with the WAST industrial action, business was conducted by circulating	

	papers. No issues arose that required chair's actions and no issues requiring escalation raised by service groups. - The final draft quality strategy was circulated for comments then presented to Quality and Safety Committee on 20.12.22. It is going to Board this Thursday to be followed by launch early in March 2023. - Service groups were asked to review the complaints sign-off process to increase timeliness of responses - There is a reduction in reopened concerns within Morriston Service Group - Patient satisfaction reported through Friends and Family test has increased by 1% to 91% in November, compared to 90% in October - Volunteer Services are to report into this group in future. - Increased diligence regarding sharing learning from Learning From Events to be built into reporting processes - Actions were summarised and are all on track. During discussion the following points were raised Reena Owen stated she would find it useful to look at the terms of reference (TOR) for each group as she is not clear which group is looking at what issues. She expressed concern that the same people are going to the same groups from the service areas and if they differentiate between what the groups are doing. She went on to say that she is still struggling with acronyms and requested that the full descriptor be used initially otherwise a lot of time is spent looking them up. Angharad Higgins apologised for using an acronym without first using the full descriptor. She gave assurance to the Committee that different work is undertaken by each group with work programmes in place. An internal audit is imminent to review the system and ensure it works properly. Steve Spill commented that the quality strategy will be delivered in an upcoming meeting so the description of the quality management system being implemented will cover some of those missing structures. He admitted that, like Reena Owen, he found it difficult to envisage how the structure of the quality management system builds up from all the different parts of the Health Board to this Committee.	
Resolved:	The summary be **noted.**	
12/23	**QUARTERLY PATIENT EXPERIENCE REPORT**	
	The quarterly patient experience report was **received.** In presenting the report Hazel Lloyd highlighted the following points:	

	- We have developed a monthly Children and family's feedback report, this will be shared monthly with Childrens services managers. It has been very well received and having the data in one place has really helped the team to focus on actions they need to undertake. - A regular patient experience report for the prison service has been developed and there has been some increase in negative feedback which be included in the report, describing what the issues are and what has been done about it. - Complaints performance – generally the numbers are the same. Trying to get back up to the 75% target – 71% for October. It is reassuring that complaints are at the level prior to the pandemic. Some organisations have doubled their numbers of complaints and ours are pretty much level. - The team have started to look at themes (communications, appointments, clinical treatment, assessments and admissions) and triangulate them with patient experience. For example, communications highlighted general surgery for Quarter 3 complaints, but there are 51 positive feedback forms for general surgery. In the case of clinical treatment issues around outpatients, feedback confirms the complaints we have received e.g., waiting times. This information is taken back to the service groups and actions can be decided upon. In discussing the report, the following points were raised: Reena Owen commented that triangulation is useful to bring together what is being seen in different areas. When we, as independent members, go on visits we can use this information in questioning to get further information. Hazel Lloyd stated the team have done a lot of work and still have a lot of ideas how they can strengthen the report. Steve Spill commented that in terms of dealing with the issues the top theme is always communication. Anne-Louise Ferguson explained that communication should be easy but is clearly not and that communication involved the patient listening, understanding and remembering what has been said.	
Resolved:	The report be **noted.**	
13/23	**UPDATE REPORT ON CAMHS**	
	An update report on CAMHS was **received.** In presenting the report Nerissa Vaughan highlighted the following points: - Risks are materializing but whilst there is a lot of work yet to be done the transfer is going ahead.	

	- The key risks are around workforce and ICT. The workforce risk is a significant risk going forward. There are vacancies but the situation has improved since February 2022 with vacancies reducing from 44% to 18% but there are a couple of crucial risk areas. - Nursing is almost fully established and is about 6 posts away from being fully established. Residual agency staff will disappear as recruitment continues. - The more worrying workforce areas are around medical and therapies. Therapies have been without a leader, but the post has been filled recently. - Medical staffing is reliant on quite a big agency workforce. The main issue is the Cwm Taf Morgannwg (CTM) pay levels are much higher than Swansea Bay University Health Board's (SBUHB) pay levels. Negotiations are taking place, but it does represent a risk. - The Transfer of Undertakings (Protection of Employment) (TUPE) process almost and ended on 18th January. Formal feedback has not yet been received but informally we have been told there is nothing worrying coming out of that exercise and we can start bringing staff over from 1st April. - Another key concern around workforce is the reliance on agency staff to deliver critical services, and this will continue to be an issue post transfer. - The other major risk area is ICT to do with hardware. This paper went through Management Board last week and there was approval for the capital requirements to support the new equipment required. The hardware used by CTM uses Thin terminal, which has no brain works like a keyboard attached to a device. It will not talk to any SBUHB systems so new hardware compatible with SBUHB systems will be purchased. - It was hoped that data migration from CTM to SBUHB would be a simple electronic transfer but will have to be done manually. There are 3000 patient files to be transferred and is a much bigger piece of work than anticipated. In addition there are paper patient files to be transferred over. - Negotiation around the residual SLA to cover on-call is underway but will not be complete until the end of February. This may represent a risk if CTM press for an increased cost as they are currently absorbing locum costs to cover the rota. No indication has been made by CTM as of yet that they will pursue this – but it may materialise during the course of the negotiation. - Nerissa Vaughan emphasized that lack of governance processes within the service is a key risk and has caused several problems as issues are appearing as work continues	

	around the transfer and will continue to be risk going forward. The service has been working in a very isolated and as it moves into Mental Health structures it is anticipated that further issues will be revealed. - At the moment we are handling the risks thrown up by the transfer, and more work will be needed post transfer. In discussing the report, the following points were highlighted: Steve Spill sought clarification on the on-call service and if it will be a service commissioned by CTM. Nerissa Vaughan explained the on-call service will be the same arrangement as now under the current Service Level Agreement (SLA) with on call staff rota including CTM, Cardiff and SBUHB and will cover the entire area. The risk is that CTM pays a higher rate to locums. The arrangement will remain the same as now and the risk is CTM will charge more for it. Steve Spill queried if the rota could be staffed entirely by SBUHB. Nerissa Vaughan stated that there were not enough staff in SBUHB able to fill the rota but once it is moved into the Mental Health Group it would be sensible to review the rota to see if a joint adult Mental Health and CAMHS could be covered. Steve Spill sought clarification on how CAHMS would be developed once the transfer is complete. Nerissa Vaughan pointed out that the paper describes the transfer of CAMHS to SBUHB with the associated risks only. Further updates will be given as work continues.	
Resolved:	The update report be **noted.**	
14/23	**QUARTERLY CHILDREN'S COMMUNITY NURSING REPORT**	
	The report was **received.** In presenting the report Jane Phillips highlighted the following points: - The Head of Nursing for Children & Young People commenced in post in January 2022. - Funding now supported by the Health Board for key posts to be put into place and the recruitment process has started for a nurse assessor for Childrens' Continuing Care (Band 7) and a Childrens' Nurse (Band 6) for out of hours until 12 midnight to ensure the care provided by the Health Care Support Workers is in line with the individual care plans. Recruiting is also underway for a Deputy Head of Nursing Post (Band 8b). - Of the 30 recommendations made by the external reviewers there are now only 2 key red areas. - On red area is the need to transform complex care and there has been some movement in developing multi-agency	

pathways and assurance work around the Childrens Continuing Care element of the complex health needs. A meeting was held yesterday, and a plan is in place for vanguard training in February which will hopefully see some good traction for pathways for continuing care and the funding linked to that.

- Welsh Government guidelines are being followed for Childrens' Continuing Care.
- The follow up review by 2 external reviewers has commenced. All background work is being done before going out to see families. Letters to all the families involved in the 2021 review are going out this week plus one new family.
- Reviewers will be asking families how they would like to engage with us and how they would like us to engage with them. These are busy families, and it is difficult to get their feedback exacerbated by the fact that previously they felt they were not listened to so did not bother to raise feedback.
- Early feedback from the follow up reviewers, families and staff will be included in the next quarterly report.
- A patient story about one of the families in Continuing Care and a member of staff who joined the team as the review concluded is being worked on.
- Due to insufficient levels of Health Care Support Workers (HCSW's) at Band 3 and 4 available to support care packages there was a risk of delays in care packages being commenced. Additionally, short and long term absences of the team could result in increased cost to the Health Board to support care packages by using external and private care providers to meet the needs.

In discussing the report, the following points were raised:

Lesley Jenkins reported positive news around funding for recruitment which allows the workforce action to be closed down and the risk moved to amber. Steve Spill commented that he had noticed a low take up of training by health care assistants – not nurses. He stressed the importance of training and sought clarification on how it was ensured that staff are getting the training they need.

Gareth Howells informed the Committee that a version of this report is going to Board this week – with a patient story and staff experience. He commended Lesley Jenkins, Jane Phillips and Vicki Burridge on the progress made and the hard work they have put into Childrens' Continuing Care and considering the dire situation previously.

Pat Price queried that given the history and the remaining high level of reticence of families to engage and give feedback if there is a strategy to encourage more feedback moving forward. Jane Philips informed the Committee that several measures have been taken

	including a parent and patient feedback group, external support analysing previous engagement attempts and current engagement activities, monthly newsletters sent out to families and qualified staff meeting families monthly. Additionally, families are reminded that there is a QR code for feedback. The team has learned that no news does not mean good news and feedback is being received but not through formal channels. Vicki Burridge responded to Steve Spill's query about HCSW training. She explained that the specific patient training they already receive is not captured in the report. Regarding the training mentioned in this report, we can now release staff in small numbers (8-10) more frequent training sessions and are now up to nearly 100% attendance. This will continue on annual basis. Steve Spill queried the number of staff including nurses and HCSWs. Vicki Burridge stated there are 45 HCSWs and 6 registered nurses in the team. Steve Spill congratulated the team on the progress they have achieved to date.	
Resolved:	The report be **noted.**	
15/23	**Q2 SOUTH WALES MAJOR TRAUMA NETWORK CLINICAL GOVERNANCE REPORT**	
	A governance report for the South Wales Major Trauma Network was **received.** In presenting the report Andrea Bradley highlighted the following points. - The information given in the report is for Quarter 2 as the TARN quality data presented is 6 months behind. - There continues to be a high number of patients accessing the Major Trauma Centre in Cardiff, 87% of which are due to road traffic accidents and falls. 20% of patients discharged from the MTC required repatriation to their local Health Board hospital - There were 69 trauma related incidents (TRiDS) in this quarter including delayed repatriation, pathway awareness and clinical issues. - There are some governance risks including Major Trauma ITCU capacity at Cardiff. - 3 ICU beds at Cardiff were commissioned as part of the South Wales Major Trauma Network (SWTN) however, due to various demand in the Major Trauma Centre intensive care unit (MTC ICU) capacity transfers have taken place. These require investigation regarding the requirement for MTC	

	rehabilitation requirements post patient ICU admission. Evaluation is ongoing led by the Operational Delivery Network (ODN). - The ODN has started benchmarking across other MTNs around 2 tier trauma team activations. - There have been12 Trauma desk occurrence desk log entries including no contact with trauma desk, no trauma desk cover, TTL phone line down. - There have been 10 GREATix reports including nominations for teamwork, support, leadership, and communication. In discussing the report, the following points were raised: Reena Owen sought clarification how repatriation of patients to their own health board hospitals is negotiated as all health boards are short of acute beds. Andrea Bradley explained that the SWTN has a repatriation policy which is monitored by Welsh Government. She went on to say that for a patient to be sent to the Cardiff trauma centre, there has to be space so details of patients ready to be repatriated are entered on a database and the hospital notified within 24 hours. If the patient is not repatriated after 48 hours the situation is escalated and the Chief Executive Officer of the health board is notified if the patient is not moved. She emphasised that teamwork and communication is key. Reena Owen commented that there must be a great deal of negotiation. Andrea Bradley agreed about the levels of negotiation required and went on to say that building relationships, having conversations and mutual respect were vital stating that she has experience from both sides, and she has had to learn how to be respectful but forceful. Steve Spill queried how many patients does the SWTN have at any one time. Andrea Bradley reported that 3 to 4 patients are being repatriated daily and 495 patients were treated in MTC from the 1st July to 30th September. She added that hyper acute rehabilitation is vital and by having that the patient makes a quicker recovery that is more sustained with a better outcome.	
Resolved:	The report was **noted.**	
16/23	**ADDITIONAL LEARNING NEEDS ACT**	
	An update report on the Additional Learning Needs and Education Tribunal (Wales) Act 2018 was **received.** In presenting the report Dr Luke Jones highlighted the following points:	

	- The report provides an update regarding Health Board's activity in relation to the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (hereafter, the ALN Act) and articulates key quality and safety opportunities, risks and mitigating actions. - SBUHB's Additional Learning Needs (ALN) Operational Group has developed a workplan to support ALN implementation in the 2022/23 school year. - A Senior Project Manager is now in post (currently fixed term to March 2023) to support the workplan. . - The ALN Operational Group now has local authority representation. - There have been significant challenges implementing the workplan due to service-related demands on Operational Group members. This has led to delays in some areas and no progress in other areas - A steering group meeting took place this morning during which the working plan has been supported as the right way forward. - Work is underway, with the support of Informatics colleagues, to develop improved mechanisms for the capture of data relating to statutory compliance. - Risks around dissatisfaction leading to complaints, education tribunal and judicial review. - In the Health Board's scheme of prioritisation in the IMTP, the resource requirements associated with the ALN Act are captured at Tier 3. On this basis, and given the relatively early stage of implementation, it has been agreed by the Steering Group that at this stage it would not be appropriate to produce a business case associated with the demand / capacity implications of the Act. - This means that the financial implications of the Act at this stage are limited to the risk of legal challenge and consequent financial impact on the Health Board. However, the 'cost' of this position is the risks as set out at section 3 of this paper, which cannot be fully mitigated. During discussion the following points were raised: Steve Spill queried if an education tribunal is congregated, who would be "in the dock." Dr Luke Jones stated the Local Authority would be "in the dock" with the health board as supporting witness and partner as the plan owned by either education or the Local authority. He went on to say that a tribunal can only recommend outcomes to health boards, but Education can be ordered to put measures in place. If recommendations are made to the health board and we do not	

	comply, Local Authority can be ordered to put them in place which could damage collaboration going forward. Steve Spill queried what actions the health board could take to become more compliant with the Act. Dr Luke Jones emphasised that working to improve the health board's data systems to enhance ownership within service groups would result in improvement, but full compliance will largely be how we are going to meet demand capacity and how we are meeting requirements of the act. He added that it will be challenging to be completely compliant with competing demands within the health board with limited resources to meet those demands. Christine Morrell informed the Committee that ALN is in early days of implementation and a better overview is being obtained through the steering group. She added that it is early days with data validation and national definitions need to be looked at. She said our numbers in some areas look different to other health boards and we may be calculating numbers differently. She went on to say that ALN was originally reporting directly to the Quality and Safety Committee but will now be reporting through the Patient Compliance Group via Quality and Safety to go through validation routes for internal scrutiny and questioning and support. Going forward it is necessary to drill down on the services needed and the general capacity of It is around the general capacity of our children's services including CAMHS and other therapy services such as speech and language services. Some services will be able to comply 100% but speech and language services will struggle because they always receive the highest number of requests with the most extensive assessments needed. Pat price queried if we are not monitoring the statutory 6 weeks compliance if we monitor waiting times to deliver info or services. Dr Luke Jones stated we do need to know how far off we are because from a patient quality perspective this is creating a delay in the patient receiving treatment or services. However, it is unclear at the moment how long that wait is, and there is variation nationally how this data is being captured. Christine Morrell added that as the steering board was this morning the outcome should come through the Quality and Safety pathway and will not need to come to this group as a standalone but come through Patient Safety Scrutiny Group.	
Resolved:	- The report be **noted.**	
17/23	**ITEMS TO REFER TO OTHER COMMITTEES**	
	There were no items to refer to other committees.	
18/23	**ANY OTHER BUSINESS**	

	There was no further business, and the meeting was closed.	