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	Agenda Item	2.4 (iii)

Freedom of Information Status	Open
Reporting Committee	Quality and Safety Committee
Author	Leah Joseph, Corporate Governance Manager
Chaired by	Steve Spill, Vice Chair
Lead Executive Director (s)	Gareth Howells, Interim Director of Nursing and Patient Experience
Date of last meeting	22 February 2022

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

Patient Story: *DBT service, Dechrau Newydd* the dialectical behaviour therapy (DBT) team

A story was received which set out the way in which Dechrau Newydd, the dialectical behaviour therapy (DBT) team**,** had adapted its way of working in response to the pandemic. The team work with people with mental health conditions prone to self-harm and/or suicidal thoughts to help them manage their emotions.

Service Group Highlight Report: Mental Health and Learning Disabilities (MHLD)

The highlight report was received for noting. It was highlighted that the backlog of serious incidents had been addressed with one case remaining from the 120 recorded in December 2020. Training had been provided to investigators, resulting in improved reports. The number of court of protection cases was having a significant impact on staff resources, as many were learning disability service users who were already subject to a deprivation of liberty safeguard. A review of additional resource needed was to be undertaken. Work continued to implement the Welsh Communuity Clinical Information System (WCCIS) but this did have some challenges. The anti-ligature work was ongoing but had been delayed by six weeks due to staff availability. Assurance had been provided from Cwm Taf Morgannwg University Health Board as to the Glanrhyd Hospital site in which some Swansea Bay services were provided.

Matters raised by members:

- *The Health Board's suicide rates and possible opportunities for learning;*
- *Service provision at Tonna Hospital;*
- *Reporting deaths of service users to Welsh Government where the Health Board was not a contributing factor;*
- *The low healthcare acquired infection (HCAI) rates in MHLD.*

Key risks and issues/matters of concern of which the board needs to be made aware:

Infection Prevention and Control Report (IPC)

The substantive report was received for assurance. The service had been feeling the impact of the Omicron variant of Covid-19 during January 2022, with outbreaks on 13 wards at Morriston Hospital and three within mental health. It remained difficult to close wards completely in response to outbreaks due to operational pressures, therefore risk-based

mitigation strategies were being used to admit people with co-morbidities safely. The uptake of the flu vaccine offer had not improved but only 21 cases had been identified per month. HCAI levels were currently under the expected trajectory, which was promising, and there was cautious optimism this would remain the case for the rest of the month. An analysis of cases across the service groups had been undertaken and five wards at Morriston Hospital identified for a more focussed piece of work. Work was continuing to progress the business case for a sustainable vaccination and immunisation service. Recruitment to the vacant posts within the team was ongoing, with interviews currently taking place. A meeting had taken place the previous week to confirm the action needed following the recent 'state of the nation' review, setting out clear expectations of the service groups. Morriston Hospital was holding its first infection control committee meeting in February 2022 to scrutinise each of the reported cases, the findings of which would be presented to the Director of Nursing and Patient Experience and the Medical Director. A significant amount of invasive devices were used within secondary care and the service groups had been tasked with improving the position. There was an intention to launch an infection prevention and control charter within 2022-23 as well as strengthen digital intelligence to be able to evidence any improvements.

External review of the children's community nursing service

A report was received for assurance. A number of immediate actions were identified and addressed while the review was in progress. The report had been discussed with all staff within the service. Not all the families involved wanted to receive feedback but those who did had been spoken with. The families were ones with children with complex needs and for whom time was precious, so it was important the service was right for them. There were currently some challenges around staff availability. A patient and family task and finish engagement workstream had been established with an external specialist commissioned to ensure the service was what the families needed. A continuing healthcare workshop was to take place with stakeholders. Peer feedback and how to share lessons on an all-Wales basis was being considered. A wider piece of work around where in the health board structure children's service should be placed was being undertaken with the Chief Executive. Since the report had been written, there had been a challenge around the availability of healthcare support workers, with around 50% leaving the team – these had been replaced through rotational secondments within general paediatrics. The recruitment process was also being accelerated.

Matters raised by members:

- *Engagement differences between registered and unregistered staff;*
- *Shift allocation.*

Delegated action by the committee:

None taken.

Main sources of information received:

Performance Report – A year-end report was received which presented the four quadrants of harm and data in respect of COVID-19, fractured neck of femur, theatre utilisation, unscheduled care, planned care, cancer performance and stroke metrics. The report was received for assurance.

Matters raised by members:

- *Increase in pressure ulcers;*
- Patient experience rates were generally good

Health Board Risk Register was received for assurance. This report is received bi-monthly.

Clinically optimised patients from a quality and safety perspective report was received for assurance.
At the point of drafting the report, there had been 105 clinically optimised patients in Morriston Hospital, with varying reasons. The way in which such patients were coded differed – green patients had all assessments completed and were awaiting a package of care/residential home placement or rehabilitation bed on another site. Amber patients were awaiting a form of assessment but it was noted that these did not necessarily need to take place at Morriston Hospital. Around a third of incidents logged on Datix relating to clinically optimised patients had resulted in harm as well as a number of pressure ulcers reported. There were also some behavioural incidences linked to longer lengths of stay as patient generally became more anxious. Hospital sites were not the right place for patients to be once they were fit enough to return home as they were at risk of deconditioning and a deterioration in quality of life due to less contact with families. Consideration was being given to commissioning additional capacity to identify what patients were awaiting discharge to move them through the system;. A causation event had been held with frontline staff to discuss what could be done differently and some suggestions had been reinstating therapists at board rounds, active rehabilitation, for example, not patients not eating in the bed in which they slept and actively escalating complex cases. The discharge team currently comprised one discharge liaison nurse and this was to be increased, as well as expanded to include flow co-ordinators, as a central hub; Frontline staff felt that the discharge pathways were too complex, as there were six, and it was challenging for ward staff to know which to use. This would now be co-ordinated through the central discharge team as a trial to make it more simple and streamlined

Quality and Safety Framework Final Internal Audit Report was received for noting.

Controlled Drugs Governance Final Internal Audit Report was received for noting.

Potential next steps for pharmacies, in the context of the population health strategy was received for noting.

Highlights from sub-groups reporting into this committee:
None received.
Matters referred to other committees:
None identified.

Date of next meeting	29 March 2022