Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**9th August 2022**

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

1.0 Mother & Baby Serious Untoward Incident Feedback

An informative presentation was received from Aneurin Bevan University Health Board (ABUHB) on the learning and reflections following a Serious Untoward Incident relating to a Mother and Baby Unit placement that occurred in December 2019. This had been shared with the South Wales Mother and Baby Unit for shared learning in terms of the importance of communication and care and treatment plans for home leave.

2.0 Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer & Blood**

The Committee was pleased to receive the formal notification that the Neuroendocrine Tumour (NET) Service in Cardiff & Vale University Health Board (CVUHB) had received UK ENET's accreditation. The team were congratulated on their achievement.

- **Cardiac**

The Committee was informed of the improving position in Swansea Bay University Health Board (SBUHB) cardiac services. The level of escalation will be considered once the invited services review report has been received and reviewed by the commissioning team.

- **Neurosciences**

An update was provided on the Artificial Limb Service. It was agreed that it would be beneficial to request an update on patient outcome as part of future work with the service.

- **Women & Children**

An update was provided to the committee regarding Paediatric Surgery, which continued to be monitored with the Clinical Board at CVUHB and through Service Level Agreements (SLA) meetings. It was noted that the SiTREP meetings had been reinstated as a result of ongoing pressures on neonatal cot capacity. This was primarily as a result of workforce issues. Concern was raised regarding the progress in setting up the Welsh Government Maternity & Neonatal Safety programme which would oversee the work. The Committee was made aware of a letter from Welsh Government (WG), dated 14th July, that had been sent to the Neonatal network and copied to WHSSC highlighting growing concerns around neonatal intensive care cot capacity across south Wales. A paper outlining the extent of these issues over the past six months across Wales had been requested, which will be signed off by the EDoN prior to submission to WG. An update regarding the neonatal transport positon was provided to the committee and it was agreed that the neonatal update report submitted to Joint Committee would be shared after the meeting.

- **Intestinal Failure (IF)– Home Parenteral Nutrition**

A verbal update was provided to the committee and a detailed report was requested for the next meeting.

- **Mental Health & Vulnerable Groups**

The committee was provided with a summary of the services in escalation and Members received a presentation from the Cwm Taf Morgannwg University Health Board (CTMUHB) Exec Lead on the progress made at Ty Llidiard, which is currently in Escalation Level 4. It was noted that good progress has been made against the service improvement plan and a further update was requested at the next meeting to ensure a sustained improvement.

Members received a presentation on the recommendations and findings of a coroner's inquest that took place on 22nd February 2022. This was as a result of a serious untoward incident at Arnold Lodge Women's Enhanced Medium Secure Service in July 2018. Whilst no Regulation 28 was issued, a Quality Improvement Plan was put in place that is monitored by Mental Health Specialised Commissioning NHS England Midlands Region. The committee was assured that a joint meeting involving National Collaborative Commissioning Unit (NCCU), WHSSC Health Board and NHS England took place immediately following the inquest and an in-depth Ward Review was undertaken on the 16th June, which will be considered by the commissioning team once published. There were no Welsh placements currently with the NHS provider.

Members were provided with an update regarding service provision for Welsh patients with Eating Disorders. Negotiations with NHS England continue and it is planned that the 'gatekeepers' will visit the two potential units and develop a seamless pathway for patients. This will be an interim arrangement and long-term plans will be considered as part of the Mental Health Strategy. Assurance has been

sought that current patients in Cotswold House will continue with their treatment and be unaffected by any changes to the contract.

The members were provided with an update on the new model and Early Adopter services for the Gender Identity Development Service (GIDS) patients that NHS England announced on 29th July. Dr Cass recommended new regional centres be led by specialist children's hospitals, which are hoped will be operational by Spring 2023. Once operational, these services will take over clinical responsibility for all GIDS patients and those on the waiting list. The London-based service will be formed as a partnership between Great Ormond Street Hospital for Children and Evelina London Children's Hospital, with specialist mental health support provided by South London and Maudsley NHS Foundation Trust. The North West-based service will be formed as a partnership between Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital, who both provide specialist Children and Young People's Mental Health services.

3.0 Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated.

- **CRAF Risk Assurance Framework**

Members noted a new risk relating to neonatal cots and were provided with an updated positon regarding the WHSSC Individual Patient Funding Panel Terms of Reference position and noted the progress made.

- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**

The committee was updated regarding the unannounced inspection that HIW undertook on Hillview Independent Hospital on 15-17 November 2021 and published their report on July 8 2022. Regis Healthcare Ltd is registered to provide an independent hospital for Children and Adolescent Mental Health patients at Hillview Hospital based in Ebbw Vale. The improvement plan will be overseen as part of the NCCU Framework.

The CQC undertook an unannounced inspection of St Mary's Hospital (Elysium Healthcare) focusing on Cavendish and Leo wards on the 21st and 22nd July. This was as a result of recent concerning restraint episodes and the death of a NHS England patient. The commissioning team report will consider the findings once published and WHSSC are a member of the Quality Assurance Board which will oversee the improvement plan.

- **Incident and Concerns report**

A concern was raised by a parent of a child regarding care at Hillview. This is being managed through the NCCU and legal advice has been sought. A copy of the response has been received. The same individual recently featured in a media article and an alternative placement is being actively sought.

- **Policy Group Report**

Received for assurance.

4.0 Items for information:

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 July 2022,
- Welsh Health Circular – Never Events,
- Welsh Health Circular - National Clinical Audit and Outcome Review Plan,
- Draft Development Day Agenda,
- QPS Distribution List; and
- QPS Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation (Appendix 1 attached)

Matters requiring Committee level consideration and/or approval

There were no specific issues requiring escalation to the committee.

Matters referred to other Committees

None were noted.

Confirmed minutes for the meeting are available upon request

Date of next scheduled meeting:	11th October 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician. • Bed panel data submitted electronically. • NCCU undertook Annual Review on 29th June 2022 report yet to be published.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 20th July. • Improvement Board established to oversee delivery of an integrated improvement plan. • Emergency SOP has been fully implemented. • Successful recruitment to posts created under a revised nursing workforce model. • All new therapy posts have been advertised and will be completed by end of August. • A new consultant has been appointed to lead the medical staff complement which now includes a further consultant post and a physicians associate grade post. • Completion of a 4C's engagement process.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Next escalation meeting proposed July 20th but has been postponed due to lack of IGL availability however written update provided as alternative • Staff proposal approved by BDGB, to increase resilience • Work ongoing to address issues in HMP YOI • Consultant Psychiatrist job description remains with College for approval	

7/15

7/15

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	Continued six weekly meetings in place to receive and monitor against the improvement plan. Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged. Escalation level will be reviewed –	

					discussion planned for September 2022 – on provision of six months of data following delivery of GIRFT recommendations and the submission to WHSSC of the recent Royal College of Surgeons of England (RCS England) Invited Service Review report.	

9/15

9/15

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
July 2021 April 2022 (from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of continued failure to provide the GIRFT improvement plan and HEIW report the service was re- escalated in April 2022. • Level 3 meetings were held in June and July, and subsequent meetings will be held at six-weekly intervals. • These Executive level escalation meetings supersede bi- monthly meetings previously instituted for	

					monitoring purposes. • The service has now provided the requested GIRFT improvement plan and HEIW report (and action plan), and is has been agreed that WHSSC develop de-escalation criteria based on the recommendations in the GIRFT report and action plans.	

11/15

11/15

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • Escalation monitoring meeting arranged for 12th August 2022. • The current timeline	

12/15

12/15

					for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.	

13/15

13/15

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 03.08.2022	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to produce a business case of sufficient quality in a timely manner for	• The next escalation monitoring meeting is arranged for 23rd September 2022. • PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service.	

				replacement of the scanner.		

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position