Health and Social Services Group
Integrated Quality, Planning and Delivery Meeting
Swansea Bay UHB

Llywodraeth Cymru
Welsh Government

Minutes of meeting
24 March 2023

Name	**Organisation/Job Title**	
Redacted s40(2) – WG1	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG2	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG9	Welsh Government	Redacted s40(2)
Redacted s40(2) – HB8	Health Board	Redacted s40(2)
Redacted s40(2) – WG4	Welsh Government	Redacted s40(2)
Redacted s40(2) – HB1	Health Board	Redacted s40(2)
Redacted s40(2) – HB2	Health Board	Redacted s40(2)
Redacted s40(2) – HB7	Health Board	Redacted s40(2)
Redacted s40(2) – WG5	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG10	Welsh Government	Redacted s40(2)
Redacted s40(2) – DU7	Delivery Unit	Redacted s40(2)
Redacted s40(2) – DU8	Delivery Unit	Redacted s40(2)
Redacted s40(2) – DU5	Delivery Unit	Redacted s40(2)
Redacted s40(2) – HB4	Health Board	Redacted s40(2)
Redacted s40(2) – HB9	Health Board	Redacted s40(2)
Redacted s40(2) – HB10	Health Board	Redacted s40(2)
Redacted s40(2) – DU9	Delivery Unit	Redacted s40(2)
Redacted s40(2) – WG6	Welsh Government	Redacted s40(2)
Redacted s40(2) – DU10	Delivery Unit	Redacted s40(2)
Redacted s40(2) – WG8	Welsh Government	Redacted s40(2)
Redacted s40(2) – FDU1	FDU	Redacted s40(2)
Apologies		
Redacted s40(2) – DU2	Delivery Unit	Redacted s40(2)
Redacted s40(2) – DU3	Delivery Unit	Redacted s40(2)
Redacted s40(2) – WG11	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG3	Welsh Government	Redacted s40(2)

1. **Welcome and introductions.**

<Redacted s40(2) – WG1> welcomed all to the IQPD meeting, the Enhanced Monitoring meeting would be chaired by <Redacted s40(2) – WG2> once the IQPD meeting had finished. The agenda was re-arranged as follows:

2. **Stroke**

<Redacted s40(2) – HB7> advised the main challenge for the service was access to the acute stroke unit. There were no ring-fenced beds available due to the emergency pressures, yet the thrombolysis rates were reasonably good compared to all Wales performance. The team had been enhanced with advanced nurse practitioners. Access to CT was an issue, a pilot with WAST where patients would go direct to CT would commence shortly.

A business case has been developed by <Redacted s40(2)> to recruit a neurologist with experience in stroke in conjunction with Hywel Dda Health Board as part of developing the comprehensive regional stroke centre, which would be based on the Morriston site.

<Redacted s40(2) – HB7> confirmed the regional stroke centre would be included in both Hywel Dda and Swansea Bay IMTP's and modelled around the previous HASU with information from the Delivery Unit.

<Redacted s40(2) – WG1> acknowledged the issues around resources in terms of people and beds, but the population of Swansea were currently not receiving a good stroke service. There was a need for clarity on when standards would start to improve within the IMTP's.

3. **Quality and Safety**

<Redacted s40(2)- HB4> explained a major review of the quality and governance structures had been carried out across the health board. The infection prevention and control action plan identified:

- Similar trajectories as for 22/23.
- Fortnightly Executive scrutiny panels continued.
- Currently undertook a clinical review of each individual case of Tier 1 infections to identify lessons learnt and if any infections were avoidable/unavoidable.
- Work continued with the National Infection, Prevention and Control work-stream to ensure there was consistency across the organisation re testing regimes, and reporting – especially around avoid ability.
- Developing a specific DIPC role/Nurse Consultant.
- A renewed focus on reducing antimicrobial prescribing.
- Implemented the universal use of Chlorhexidine washes.
- A focus on reducing the number of infections in areas of highest incidence and ensure the clinical leaders in those areas were aware of their role and responsibilities in HCAI reduction.
- Maintaining compliance with training (across all professions).

- Ensuring clinical areas were clean and mattress checks for example were taking place, and clinical areas were decluttered.
- Ensuring and evidencing that the appropriate bundles of care were fully implemented (e.g., over 40% of our Bacteraemia's are line associated).
- Being clear about Service Delivery Group specific areas of action – e.g., Care Homes, Oncology, Acute Admission areas.

There were 87 nationally reportable incidents between April 2022 and February 2023. Of the 87 reported, 39 were attributed to patient accidents / falls which had reduced by 25% compared to the previous year. There were 17 pressure ulcers.

1,913 complaints had been received between April 2022 and February 2023 with the main issue around communication, clinical assessment being the next most popular.

In relation to patient safety alerts, there were four outstanding.

- PSN052 Risk of death and severe harm from superabsorbent polymer gel granules. Services looking to remove use in all but essential areas. Risk assessments to be recorded for exceptions. Expected timescale for compliance revised to end of May 2023.
- PSN065 The safe use of ultrasound gel to reduce infection risk. Deadline for completion 28th March 2023, when this will be closed.
- PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients. Recently received and disseminated internally.

A new alert PSA015 Safe Use of Oxygen Cylinders in Areas Without Medical Gas Pipeline Systems. Was not compliant yet. Risk assessments were being collated to develop action plans to address. No significant issues identified to date – main issue relates to storage of cylinders.

Progress towards compliance was overseen by health board's Patient Safety & Compliance Group.

In terms of patient and service user feedback:

- Routine data collection was received through a range of methods when people touch our services e.g., Q-codes, texts, paper etc.
- Health board wide use of the "Friends and Family" test – consistently over 90% satisfaction.
- PALS presence on all sites and in specific areas like ED where they can support and act immediately on feedback where appropriate.
- Bespoke surveys in ED ran by the Patient Experience Team.
- CHC Assurance and HIW visits also provide specific patient feedback which leads to improvement.
- A robust system of recording and sharing digital patient stories is in place across the whole Health Board.
- Action plans are fed into and monitored by the individual Service Delivery Groups and the Health Board wide Patient Experience Group as appropriate e.g., the recent Guardian feedback relating to our AMU has led to a robust action plan including the purchasing of recliner chairs for patients who may be unfit to sit in the ED overnight.

Swansea Bay was the only health board in Wales to develop a Maternity Voices Partnership and made fantastic progress in 2022 in establishing and developing this – key areas of improvement include:

- Supporting the further development of the organisations “Milk Bank” and supporting a focus on infant feeding with an event being planned for Service Users and Providers in April 2023 to meet and discuss potential solutions to issues raised.
- Reviewing information leaflets and revising these as co-produced Decision Aids that contain Information Service Users and their families tell the partnership they want.
- Developed a Service charter for both Service Users and Providers.
- Mental health support with the aspiration to support the development and introduction of a mental health tool kit for all Service Users.
- A focus on recruiting members from minority groups.
- Focus on ensuring Service Users and their families feel heard and properly consulted and informed consent obtained during their maternity experience. This will include promotion of the BRAIN acronym to both Service Users and providers for decision-making.
- Growing Service User Representative community will be an absolute priority focus for the partnership in 2023.
- The voices Log continues to grow with rich feedback, insights and suggested solutions and look forward to all the rich insights and suggestions it will bring in 2023.

On maternity, <Redacted s40(2) – HB4> advised:

- Workforce capacity was still a challenge and remains on a risk rating of 25.
- NPH Birthing Unit and home births remain suspended to mitigate staffing risks.
- The alongside midwifery pathway remains open in Singleton Hospital.
- A workforce observation paper was being presented to Management Board on the 15th of April 2023, followed with a paper to propose a new workforce model in community.
- Currently have an interim head of Midwifery in place, with interviews for the interim Deputy Head of Midwifery role taking place on 24th of March.
- The 8a Lead Midwife for Intrapartum Care has been appointed.
- The 0.6 WTE 8a Workforce Transformation Midwife has been appointed and started this week with a priority to support the Maternity Care Assistant (MCA) workstream.
- The Midwifery Support Worker JD & PS has been rewritten, and 25 candidates are being interviewed next week, with the aim for recruiting at least 10 trainees.
- Participating fully in the MatneoSSP National Programme and leading the development of the Neonatal Transport ODN, final sign off from WHSCC agreed.

<Redacted s40(2) – DU7> acknowledged the good work being carried out across the organisation and the development and engagement towards the quality strategy. It was good to hear about the drop-in sessions for the duty of candour and duty of quality for colleagues.

In terms of the healthcare infections, the policy change from 1st April will include all covid 19 investigations, plus the duty of candour will increase the requirement to convert more patient safety incidents and investigations. There was some national work being carried out and a task and finish group had been set up from the Healthcare Profession Delivery Board to look at what the appropriate methodology and tools required.

<Redacted s40(2) – WG10> reported an internal policy deep dive had taken place on maternity outcomes at the organisation. It was determined that maternity outcomes were broadly within the range expected, therefore no further action would be taken in relation to maternity services. <Redacted s40(2) – WG10> raised concerns with the number of medical examiner referrals back to the organisation, which was 39%, the second highest in Wales. <Redacted s40(2) – HB4> confirmed it was on the radar, with one of the two new deputy medical directors leading on this and was in dialogue with the medical examiners on improving the processes currently in place. <Redacted s40(2) -HB10> explained the community element was being developed on the new process of how deaths would need to be reported. Learning has been welcomed from the pilots held across Wales in relation to the medical examiners in terms of the component around the mortality reviews. There was good communication into services as well into general practice to take on any actions which came out of the reviews. The process was robust in terms of governance.

4. Winter Planning

<Redacted s40(2) – HB1> explained the main element of the plan over winter was the implementation of the AMSR programme and the centralization of the medical take at Morriston hospital during December and January which concluded in February. Embedding the new model into the hospital footprint and diverting the flow from the front door and ED into the hospital was the focus. There was a focus on improving the SDEC model with Service Improvement support. There were too many patients in the bedded assessment area which needed to be diverted into the SDEC.

Same day care for surgery was a new unit above the medicine model for the surgical pathway which would increase bed capacity to pull the surgical patients through into that assessment unit and away from the ED. From a planning perspective, <Redacted s40(2) – HB1> was looking to extend the opening hours of the SDEC, virtual wards and same day care for surgery. Extending the pharmacies opening hours was an issue as needed to ensure pharmacy hours were aligned from a demand perspective.

On AMSR, <Redacted s40(2) – WG9> queried what measures were being monitored? <Redacted s40(2) – HB1> advised the UC Programme Board key measure were focused on reducing the ambulance handovers and the number of ambulance lost hours, reducing the 12-hour waits in ED and improving on the four hours in the first instance, then would look at the overall length of stay and the number of discharges. Workstreams would be aligned to each of the key measures which linked into the Six Goals programme.

<Redacted s40(2) – HB1> advised the next UC Programme Board was on 4th April and had asked teams ahead of the meeting to develop a plan of work for discussion with more succinct measures and clear actions.

Action: <Redacted s40(2)- HB1> to forward a copy of the UC Programme Board plan to <Redacted s40(2)- WG1>.

<Redacted s40(2) – HB10> saw real opportunity for SDEC, not only to assess but look to discharge patients to the liaison teams in REACH. Work was being developed on the discharge processes in starting to plan a discharge at the time of admission with criteria led discharge.

5. **Mental Health**

<Redacted s40(2) – HB1> explained that from a performance viewpoint, all the measures were where they expected them to be now. Adult mental health services were achieving targets across the patch except for psychological therapy which was due to some sickness absence within the team and would improve over the next few months.

<Redacted s40(2) – DU5> flagged some areas of concern around part 2 care and treatment planning being below targets consistently for the year which equated to around 160 / 170 people without a care and treatment plan per month.

Secondly, was around part 1b even though the target was achieved the actual number of interventions was particularly low with only 30 interventions commenced compared to 1,500 across Wales in January.

Action: <Redacted s40(2) – DU5> to forward a summary of Mental Health performance to <Redacted s40(2) – HB1>.

6. **Fracture Neck of Femur**

<Redacted s40(2) – HB1> acknowledged there were issues regarding prompt surgery which was predominantly due to the delays at the front end of the pathway. Additional trauma operating had been secured at Morriston to ensure there was enough capacity in the system along with ring fenced fracture neck of femur bed for those patients. Return to original residence was another area of concern and would be key focus for the organisation going forward.

7. **AOB**

Date of next meeting: 21 April 2023 11:30 – 13:30

Action Log			
Area	**Action**	**Owner**	**Update**
Winter Planning	<Redacted s40(2) – HB1> to forward a copy of the UC Programme Board	Health Board	

	plan to <Redacted s40(2) – WG1>.		
Mental Health	<Redacted s40(2) – DU5> to forward a summary of Mental Health performance to <Redacted s40(2) – HB1>.	Delivery Unit	