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

Llywodraeth Cymru
Welsh Government

Minutes of meeting
17 November 2022

Name	**Organisation/Job Title**	
Redacted s40(2) – WG1	Welsh Government	Redacted s40(2) – (Chair)
Redacted s40(2) – WG2	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG9	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG3	Welsh Government	Redacted s40(2)
Redacted s40(2) – WG10	Welsh Government	Redacted s40(2)
Redacted s40(2) – HB1	Health Board	Redacted s40(2)
Redacted s40(2) – HB13	Health Board	Redacted s40(2)
Redacted s40(2) – DU6	Delivery Unit	Redacted s40(2)
Redacted s40(2) – WG5	Welsh Government	Redacted s40(2) – (Secretariat)
Redacted s40(2) – DU3	Delivery Unit	Redacted s40(2)
Redacted s40(2) – DU4	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) – HB6	Health Board	Redacted s40(2)
Redacted s40(2) – HB40	Health Board	Redacted s40(2)
Redacted s40(2) – WG25	Welsh Government	Redacted s40(2)
Apologies		
Redacted s40(2) – HB1	Health Board	Redacted s40(2)
Redacted s40(2) – WG4	Welsh Government	Redacted s40(2)

1. Welcome and introductions

<Redacted s40(2) – WG1> welcomed all to the meeting and explained that the meeting would focus on Quality and Safety issues as Planned / Elective Care, Urgent and Emergency Care, Cancer, CAMHS and Neurodevelopment had been discussed at the Enhanced Monitoring meeting earlier the same day

2. Quality and Safety

Infection Prevention and Control

<Redacted s40(2) – HB4> gave an overview on IP&C and noted that whilst they were the worst performing organisation in Wales, that over the last 12 months a real concerted effort in terms of reducing infection rates had been taken.

The Health Board had seen a 6% reduction in C.Diff compared to the 2% increase across Wales. S.Aureus had seen a 2% increase for the Health Board compared to

an 8% increase across Wales. E.Coli had reduced by 15% at the Health Board compared to a 4% reduction across Wales. Klebsiella also reduced by 5% compared to an 8% increase across Wales.

C.Diff peaked to 22 cases in October of which 12 occurred at Morriston hospital associated to 10 different wards. There was no evidence of outbreaks to date. Genome sequencing results were due. Previously there were hotspots in three or four wards. Morriston hospital had been put on an enhanced improvement programme to focus on these areas of incidents. The improvement plan was reported monthly to the Quality and Safety Committee, which then goes to the Executive Board each month. Each service group had an Infection Control Committee. Scrutiny panels reviewed each C.Diff case.

All the management board undertake IP&C walkabouts across the three sites. Morriston service delivery group attended Singleton hospital, Singleton team went to Morriston hospital and some of the mental health team went to Neath Port Talbot hospital. Positive feedback had been received.

Cleanliness had been raised as an issue in some of areas and particularly in some shower areas, along with the general environment. Rapid improvement works had commenced in these areas. Patients admitted to Morriston have Chlorhexidine wash cloths along with an auxiliary and groin wash.

Antimicrobial stewardship work continued in secondary and primary care with a targeted focus on the highest primary care prescribers had resulted in a marked reduction in 4C prescribing. The approach was being extended to the next level of high prescribing clusters.

Challenges remain with service pressures, occupancy, acuity, and complexity of patients – particularly in Morriston hospital. Staffing challenges continue which impacts risk. Unfortunately, pseudomonas aeruginosa bacteraemia continued to increase. There were no issues relating to water safety.

<Redacted s40(2) – DU6> was pleased with the refresh approach to the quality priorities and progress in relation to the actions and queried how did the surveillance data identify the hotspot wards. <Redacted s40(2) – HB4> recognised some green shoots had started to be seen across all HCAI's and noted all Health Boards across Wales were seeing an increase in C.Diff and further work on an all Wales basis was required on prescribing.

In relation to the nosocomial investigation work, <Redacted s40(2) – DU6> queried if the learning was translated into the healthcare improvement plan. An oversight and feedback session had been carried out on the lessons learned with the Executive Board.

<Redacted s40(2) – WG10> welcomed the update on HCAI, and improvements made and welcomed the increased scrutiny and accountability for clinical areas for performance which in turn would drive improvement systematically across all the organisations. She highlighted the reporting of the nosocomial investigation work and noted that the Health Board had only reported 33 investigations as completed to

date. <Redacted s40(2) – HB4> was working with <Redacted s40(2) – DU6> on improving the process.

Action: <Redacted s40(2) – DU6> to meet with <Redacted s40(2) – HB4> for some qualitative feedback in relation to the nosocomial investigations.

National reported incidents
<Redacted s40(2) – HB40> advised the patient safety investigation incident team (PSIIT) were working with the Delivery Unit in terms of standardising the approach for investigations and rolling the process out across Wales.

The PSIIT were rolling out a new training programme on 5 December to include:

- Duty of Candour
- Incident Awareness Session
- Severity of Harm Training – categorising incidents
- 72 Hour Rapid Review Training
- Specialist Lead Training

PSIIT had presented learning from NRI and NE at the patient safety congress in October and were initiating a QI project with the Morriston Service Group for themes and trends. The PSIIT share point page was now live.

One NRI was not closed in May

Complaints
<Redacted s40(2) – HB40> anticipated September's compliance against the 30-day target would be around 75%. Sickness within the team and service groups had predominantly been the issue in not meeting the target. Levels of compliance were starting to return to normal. A complaint investigation toolkit was being developed and would be shared through all Wales complaint network and monthly newsletters would be published highlight themes from learning. Communication had been identified as the top theme. The corporate team were rolling out communication training and worked closely with the public service ombudsman. The Ombudsman had noticed the increase in complaints around June / July which related to the long waits in orthopaedics. The Ombudsman was made aware of the Health Board's plan in terms of managing these and because of which, had decided not to investigate those cases.

<Redacted s40(2) – HB40> gave a comprehensive update on a complex complaint received in 2019 which had significant press coverage. Following the investigation, a Regulation 24 response would be issued. The SI had been shared with the Welsh Government. As part of the mediation agreement, it was agreed that the Health Board undertake a review of the complaint handling around the concerns raised by the family, which was completed in February.

3. **AOB**

There was no other business recorded.

Action Log			
Area	**Action**	**Owner**	**Update**
Quality and Safety	<Redacted s40(2) – DU6> to meet with <Redacted s40(2) – HB4> for some qualitative feedback in relation to the nosocomial investigations.	Delivery Unit	