

**Health Social Care and Early Years Group  
Welsh Government**

Integrated Quality, Planning and Delivery Meeting  
Hywel Dda University Health Board  
**Note of meeting: 9 September 2024**



Llywodraeth Cymru  
Welsh Government

**1. Welcome, introduction and apologies.**

Members were welcomed and apologies noted.

**2. Notes and actions of last meeting**

The notes and actions of the last meeting were agreed.

**3. Quality and Safety**

August complaints 30-working day compliance was 64.96%. A focussed approach was carried out during the month and 141 complaints, 40 early resolutions and 143 enquiries were responded to. To improve the complaints / concerns performance, a workshop was scheduled for the end of October for senior managers, heads of nursing and other key individuals across the health board. PSOW, medical examiner, and colleagues from the Welsh Risk Pool would be invited to talk about complaint / concerns management process. A tender for a compassionate care training package had been issued aimed at frontline staff. An expert clinical reviewer training package for consultants and senior nurses was also being sought.

120 complaints were closed last week, and work continued on the reducing the backlog which was affecting the 30-day performance.

One external report from the Ombudsman highlighted the issue of prolonged handover delays outside the emergency department. The following actions were being taken to address the situation:

- Daily conference calls – all ambulance waits discussed and plans put in place, boarding protocol (putting patients onto wards based on confirmed discharges) enacted on a daily basis to reduce overcrowding in ED.
- Live real time operational dashboard to support operational staff in understanding the overall system situation and pressures and providing forecasting information to help mitigate pressures before they occur.
- National 6 goals program policy goal 5 relates to safe hospital care. We have a dedicated workstream working directly with front line staff using national resources to help improve our patient flow.
- Discharge strategy group, including a review of the role of the DLN resource and supporting discharge planning being the role of the ward manager allowing specialist resource to be focussed on complex individuals.

- All patients with a LoS > 21, 50 & 100 days reported weekly to Exec Team, all localities have escalation processes in place to reduce these numbers. Over 21 days was for example 479 on 1st April and is now 426. The reduction in those with the longer length of stays is a greater reduction; >50 days 352 in April down to 90 > 100 days 165 down to 73.
- Pathways of care Delays managed through a regional delivery group, 237 delays recorded in April and 203 recorded in August, forms part of the Home First approach.

In relation to NRIs, the health board was making some improvement on those patient safety incidents open more than 90 days and had a plan to address the backlog. Of the 13, 749 patient safety incidents reported, 9, 631 had been closed. 1.5% were closed as moderate, severe or catastrophic harm.

There were 34 overdue HIW inspections actions which were reported in the quality assurance report to the Safety Experience Committee. Some inspections actions were overdue since 2022 which had been transferred to a MAC tracker. Assurances and appropriate evidence were being sought before those overdue inspections were closed.

An immediate assurance letter had been issued following a recent unannounced HIW inspection of Bryngolau MHLN ward. An action plan related to estates and ligature assessments was being produced and a response would be submitted to HIW by the end of this week.

The Health and Social Care Quality and Engagement Act annual report would be submitted to the board in September / October setting out how the health board was meeting the duty of quality and duty of candour requirements.

Consistent themes identified through the NRIs include communication and timely management. Duty of candour theme was in relation to communication. Information from the walk arounds would be including in the action plans. Maternity themes were shared with the Listening and Learning Subcommittee and incorporated into the learning framework and will be presented by to the Quality and Safety Experience Committee and listening and Learning Committee in October 2024.

### **Infection Prevention and Control**

C Diff performance had deteriorated across Wales with Hywel Dda reporting the worst performance. Hospital acquired infections was not achieving the TI de-escalation plan. Some improvement was made in July and August. A review of GP

treatments was underway due to the number of community acquired infections being reported.

S Aureus peaked in March and June, no consistency in the reduction plan of no more than two cases a month. There were seven hospital onset E Coli cases reported in July.

In July the number of beds days lost to infection control was 71 which include four norovirus outbreaks. A review of CDI treatment identified 24 patients in 2023 / 24 had a relapse, seven of which had fidaxomicin for their initial CDI.

In relation to HCAs, monthly scrutiny meetings for each of the sites take place to drill down and scrutinise each of the hospital and some of community onset cases. Any learning is disseminated across each of the sites and discussed at the IPC locality and governance meetings. A report is shared with and discussed at the Quality and Safety Committee.

With regards to the secondary care deep cleaning programme, the health board advised two sites would be cleaned during quarter three and four. Wards would be decanted and deep cleaned followed by a UVC machine and HPV tracing. A new cleaning policy and guide had been developed for each discharge or infection outbreak. Sites with no decant facilities, bays would be emptied in turn. The rolling cleaning programme across all sites would be dependent on winter bed pressures and outbreaks.

#### **4. Maternity and neonatal**



2.0 IQPD - Maternity  
and Neonatal Review

Challenges remain around some of the unfilled vacancies due to maternity leave which was being backfilled with temporary fixed term contracts. There were eight WTE community midwifery posts out to advert. Maternity medical consultant workforce was compliant, with one local consultant post due to be advertised shortly at Glangwili / Bronglais hospital. There were some vacancies within the paediatric medical workforce. The health board advised 9 streamliners would be joining the teams.

**Action: Health board agreed to forward information on the split between QIS and non-QIS vacancy rates.**

Neonatal nursing BAPM QIS deficits were mitigated by bank staff in the first instance, then agency staff. There were two agency staff who worked regularly within the unit which ensured the maintenance of service delivery.

As part of the HIW immediate assurances around the anaesthetic programme, the health board acknowledged it was an ongoing action which was being prioritised as improvements had been made in the area from the additional courses provided.

MDT training compliance PROMPT programme for 2024 / 25 had recently been approved both locally and nationally and will commence during September 2024.

In relation to MDT training compliance for fetal surveillance, a new IFS Welsh Risk Pool programme had formally commenced in May 2024.

The health board was implementing mandatory training for NLS / BLS as compliance was below required levels. The programme was reviewed in 2023 / 24 and compliance had increased to 96%. From a neonatal perspective, compliance is 85% for all staff, four staff nurses were booked to complete the training in November 2024.

**Action: Health board to provide compliance rate for trained QIS staff and non-trained QIS staff in future updates.**

For paediatric consultant compliance, the next NLS courses were scheduled for November 2024, teams also accessed training courses in Swansea Bay UHB.

Instances, complaints, concerns and IPC by month of occurrence remained relatively consistent. There were nine NRI's reported in 2023, three had been reported to date in 2024. There was a robust governance framework in place which supported open and honest culture of reporting complaints. There was a slight increase in the number of complaints across maternity services between July and August, some may trigger duty of candour.

In relation to MBRRACE / PMRT 2024, the health board advised there were two stillbirths, one late fetal loss and two neonatal deaths. The neonatal death was not included in the MBRRACE data as baby died in a tertiary unit. A joint collaborative review was underway with the tertiary unit.

**Action: Health board agreed to share a copy of the HIW maternity inspection report at Bronglais 2020.**

**Action: Health board agreed to provide an update on the status of any actions within National Maternity report.**

The health board confirmed they had transitional care provision with SCBU services for the last 12 months and had seen a significant reduction in the number of babies admitted to special care.

## **5. Impact of value and efficiency programmes of work**



3.0 IQPD Value and Efficiency Sep24.ppt

The health board gave an update on the progress against outputs from each of the five national workstreams. An update on the outputs was provided to executive teams in June and the Welsh Government on 30 August 2024.

In relation to diabetes and from a clinical perspective the health board will work with the team to consider what the improvement plan needs to look like to improve the quality and the experience of care and the performance.

From an orthopaedic perspective, the voice of the patient would be considered in all the decision-making processes and considered for any intervention along with evaluation of the outcomes that is paramount to the patient.

The health board has developed a business case for a fracture liaison service and were in the process of implementing the service. A clinical lead and nursing staff had been appointed; administrative staff would be recruited imminently. Patient reported outcomes measures data would be collected over the next few months and long-term management of patients identified through the fracture liaison service would be periodically reviewed by the service for any ongoing treatment.

consumes a significant amount of bed days within the organisation. The health board had several early accurate diagnostic and rapid intervention processes in place with regard to cardiovascular disease. PROM and PREM results have shown a 92% reduction in the time taken for a referral of a patient with heart failure to the point of treatment. This could reduce the amount of acute heart failure admissions over a 12-month period potentially resulting in around £1.4 million worth of reduced admissions and readmissions for acute heart failure patients into the system.

**Action: Health board agreed to provide data to show improvements made within cardiovascular pathway to the Welsh Government.**

A Bevan exemplar project was undertaken focusing on advanced care planning for end-of-life care and the avoidance of overtreatment. Domiciliary visits were also undertaken to administer drugs.

## 6. Mental health



4.0 - IQPD Mental health Position at Ju

In July 2024, adult mental health performance for part 1a is 98.1% and part 1b is 95.7%. 440 (73.7%) patients out of 597 were waiting less than 26 weeks to start psychological therapy in the Integrated psychological Therapies Service. 157 (26.3%) were waiting more than 26 weeks.

CAMHS July 2024 position for part 1a is 97.0% and part 1b is 81.0%. 540 (16.3%) patients out of 3,305 were waiting less than 26 weeks to start a neurodevelopment assessment for ASD. 2,765 (83.7%) were waiting more than 26 weeks.

## 7. Any other business

No other business was discussed.

## 8. Date of next meeting

29 October 2024, 9:00 – 10:30

## Action log

| Action   | Responsible  | Update  |
|--|--------------|---------|
| Health board agreed to forward information on the split between QIS and non-QIS vacancy rates.                       | Health Board |         |
| Health board to provide compliance rate for trained QIS staff and non-trained QIS staff in future updates.           | Health Board | Ongoing |
| Health board agreed to share a copy of the HIW maternity inspection report at Bronglais 2020.                        | Health Board |         |
| Health board agreed to provide an update on the status of any actions within National Maternity report.              | Health Board |         |
| Health board agreed to provide data to show improvements made within cardiovascular pathway to the Welsh Government. | Health Board |         |

## Attendance

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| <b>List of attendees and noted apologies</b> |
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| <b>NHS Executive</b> | <b>Welsh Government</b>    | <b>HDUHB</b>      |
|----------------------|----------------------------|-------------------|
| Brett Denning        | Jeremy Griffith (Chair)    | Lee Davies        |
| James Davis          | Olivia Shorrocks           | Angela Lodwick    |
| Gareth Lee           | Martyn Rees                | Keith Jones       |
| Kathryn Barley       | Gaynor Evans (Secretariat) | Frances Howells   |
| Lee Joseph           | Hannah Williams            | James Severs      |
|                      | Caroline Lewis             | Cathie Steele     |
|                      | Brent Shurn                | Cerian Llewelyn   |
|                      |                            | Huw Thomas        |
|                      |                            | Lisa Humphreys    |
|                      |                            | Mandi Chesterman  |
|                      |                            | Mark Bowling      |
|                      |                            | Sara Davies       |
|                      |                            | Simon Mansfield   |
|                      |                            | Peter Skitt       |
| <b>Apologies</b>     |                            |                   |
| Dave Semmens         | Emma Coles                 | Louise O'Connor   |
|                      | Richard Desir              | Lisa Gostling     |
|                      | Aled Brown                 | Mark Henwood      |
|                      | Karen Jewell               | Liz Carroll       |
|                      |                            | Olwen Morgan      |
|                      |                            | Andrew Carruthers |
|                      |                            | Sharon Daniel     |