Experience, Quality and Safety Committee

02 July 2020, 10:00 to 12:00

Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and apologies

Oral

Chair

1.2. Declarations of interest

Oral

Chair

1.3. Minutes of the previous meeting held on 4 June 2020 for approval

Attached

Chair

EQS_Item_1.3_Unconfirmed Minutes_4_June.pdf (9 pages)

1.4. Matters arising from previous minutes

Oral

Chair

1.5. Committee Action Log

Attached

Chair

EQS_Item_1.5_EQS Action Log_2020-21_Jul20.pdf (7 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. Clinical Quality Framework: Implementation Plan

Presentation

Chief Executive

3. ITEMS FOR DISCUSSION

3.1. Mortality Reporting

Attached

Medical Director

EQS_Item_3.1_Mortality Review Paper.pdf (8 pages)

3.2. Clinical Audit Programme

Attached

Medical Director

EQS_Item_3.2_Clinical Audit Programme Plan Update Paper.pdf (18 pages)

3.3. Once For Wales Complaints Management System (DATIX) Implementation Update

Attached

Director of Finance and IT

EQS_Item_3.3_Once For Wales Complaints Management System (DATIX) Implementation Update.pdf (4 pages)

4. ITEMS FOR INFORMATION

There are no items for inclusion in this section

5. OTHER MATTERS

5.1. Items to be brought to the attention of the Board and other Committees

5.1.1. Any other urgent business

5.1.2. Date of next meeting:

Thursday 7 July 2020, 10am.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 4 JUNE 2020 VIA SKYPE MEETING

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Vivienne Harpwood	PTHB Chair
Owen James	Independent Member
Frances Gerrard	Independent Member
Susan Newport	Independent member

In Attendance:

Carol Shillabeer	Chief Executive
Alison Davies	Director of Nursing and Midwifery
Julie Rowles	Director of Workforce, OD and Support Services
Stuart Bourne	Director of Public Health
Wyn Parry	Medical Director
Claire Madsen	Director of Therapies and Health Sciences
Rani Mallison	Board Secretary
Wendy Morgan	Assistant Director of Quality and Safety

Apologies for absence:

Katrina Rowlands	Assistant Director of Nursing

Committee Support:

Stella Parry	Committee Secretary

EQS/20/10	**WELCOME AND APOLOGIES FOR ABSENCE** The Vice-Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/20/11	**DECLARATIONS OF INTERESTS**

	No interests were declared.
EQS/20/12	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 16 APRIL 2020** The minutes of the previous meeting held on 16 April 2020 were AGREED as being a true and accurate record.
EQS/20/13	**MATTERS ARISING** No matters arising were declared.
EQS/20/14	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. It was noted that those action assigned Priority 2 and 3 would be due for completion in a later quarter. EQS/19/89: It was noted that as this action had been allocated a Priority 3. The Chief Executive assured the Committee that as new ways of working are implemented mechanisms will be put in place to ensure safety. A paper is due to be received by the Board on 27 July 2020 and could be reported to this Committee for further assurance. EQS/19/75: The Committee noted that the National Ophthalmology Audit (Adult Cataract Surgery) was on hold due to COVID-19. EQS/19/74: The Board Secretary reported an increase in the demand on the Information Governance Service, it was agreed that a report on Information Governance would be brought forward to the next meeting of the Committee. EQS/19/73: It was agreed that a report regarding Health and Safety would be brought forward to the next meeting of the Committee. EQS/19/73: This action would be reviewed under the report due to be presented for action EQS/19/73. EQS/19/72: It was confirmed that this action had been allocated Priority 1 status. The first meeting of the Mortality Review Group is due to be held on 18th June 2020. A report regarding the first 5 months of 2020 and the last quarter of 2019/20 would be presented to the Committee at the next meeting. The Chief Executive recognised that there had been a delay in relation to this action and it was agreed that an additional meeting would be arranged for early July 2020 to review the Mortality Report. EQS/19/71: The Director of Nursing assured the Committee that the Maternity Assurance Framework was being managed through the 2 weekly Maternity Matters group. It was noted that Maternity Assurance would be discussed in

	more detail In-Committee and the Board Secretary expressed that Maternity Assurance would be included on the EQS Committee workplan for 2020/21. EQS/19/68: The Assistant Director of Quality and Safety noted that a report of Putting Things Right would be available shortly. It was agreed that this report would be considered at the meeting to be held in early July. EQS/19/22: The Chief Executive report that the Discretionary Capital Programme was to be assessed in light of COVID-19 by the Board. A revision of the programme would be reported to the Committee in due course.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/15	**CLINICAL QUALITY FRAMEWORK: IMPLEMENTATION PLAN** The Chief Executive introduced the plan, although the plan had been presented for approval the Committee was asked to note that the plan was a draft. The plan has been discussed at the Quality Governance Group and Executive Committee following the approval of the Clinical Quality Framework by the Board on 25th January 2020. Timeframes within the plan were due to be evaluated and reprioritised in light of COVID-19 by the Executive Team week commencing 8th June 2020. The Director of Nursing reported that the plan proved a comprehensive plan for implementation. Executive resource had been identified as well as timelines and reporting mechanisms. The Chief Executive noted the importance of the document and welcomed and feedback from members post meeting. The Committee was assured that work identified within the plan was being taken forward and would not be paused whilst approval was pending. It was AGREED that the item would return to the meeting of the Committee to be scheduled for early July for approval.
ITEMS FOR DISCUSSION	
EQS/20/16	**CONCERNS & SERIOUS INCIDENTS REPORT** The Director of Nursing presented the report which provided an overview of the current position in managing concerns and serious incidents. The report outlined a quality based robust approach to concerns and serious incidents. It was noted that area of work is tied to the Clinical Quality Framework Implementation Plan.

	Meetings are to be held regularly with teams to undertake 'deep dives' and will be centred on quality and assurance. Owen James queried who would be responsible for determining the robustness of the approach and how feedback is provided for those who reported the incident. It was noted that Director of Nursing would be the quality assurer and that investigations are clinically led with clear ownership and involvement of key stakeholders. Item could also be escalated to the Chief Executive if required. The Director of Nursing reported that the incident report will receive feedback if not involved with the investigation. The Datix One for Wales system will enable feedback further. Trish Buchan noted that concerns regarding access, attitudes and behaviour had been raised previously and queried how this is monitored in terms of hotspots and the effectiveness of Sage and Thyme. It was agreed that further reports would include themes, trends, lessons learned and impact analysis. The Director of Workforce and OD suggested that complaints should be considered in light of the Just Culture work undertaken. Frances Gerrard questioned how PTHB performance compares with other Health Boards. It was noted that the data can be made available however when Once for Wales is implemented this will provide clearer comparators as currently reporting is subject to individual interpretation. The Vice Chair thanked the Director of Nursing for the report and noted that a clear direction for the future had been provided.
EQS/20/17	**SHREWSBURY AND TELFORD HOSPITALS NHS TRUST** The Director of Nursing presented the item. It was noted that Shrewsbury and Telford Hospitals NHS Trust (SaTH) is the main provider of services for patients who reside in North Powys. 3 reports had been commissioned in 2019 by the Care Quality Commission (CQC). Weekly meetings with SaTH has been implemented ad contingency plans established. The Chief Executive noted that a meeting via phone had been held with the SaTH Chief Executive and that PTHB had been invited to attend their Gold meeting however it was felt that PTHB would be content with a representative attending SaTH Silver Command at present. SaTH have committed to the Commissioning Assurance Framework and a meeting held between the Chief Executive and the CCG's confirmed that any concerns would be escalated directly to the Chief Executive. A further meeting with SaTH is due to be held on 10th June 2020.

	Trish Buchan raised that a number of concerning reports had been received by the Committee regarding SaTH and queried at what point PTHB would consider reviewing other options. The Chief Executive reported that there had been system wide issues at SaTH which the SaTH Chief Executive and CCG are to address, this will assist in improving quality and safety. It was noted that the SaTH pathway is well established and other potential options for North Powys residents also present complex challenges. The Assistant Director of Quality and Safety raised that patient experience surveys have now been established for patients who utilise the pathway. Frances Gerrard queried whether PTHB are receiving updates regarding each area of concern raised within the CQC report. It was reported that regular updates are received and it was expressed that these could be shared with Committee members. The Chief Executive assured members that the CQC and NHS Improvement are actively involved with SaTH and that risk summits are held regularly. At no point have the regulators expressed that SaTH is unsafe for patients. The Vice Chair noted the areas of concern and expressed thanks for update amongst COVID-19 pressures.

EQS/20/18	**ORGANISATIONAL QUALITY GOVERNANCE ACTIONS**
	
	The Board Secretary provided the following overview of the Self Assessments undertaken during 2019/20 by PTHB:
	
	• PTHB Self-assessment against recommendations arising from RCOG/RCM Independent Review into Maternity Services at Cwm Taf University Health Board, undertaken in June 2019
	  ○ 21 areas assessed – 0 low level assurance, 9 medium level assurance and 12 high level assurance
	  ○ Improvement actions required in respect of the 9 medium level assurance areas relate to: Information analysis and intelligence reporting; Clinical Quality Review Meetings with 15 NHS providers; Concerns management; Risk management; Clinical Audit and Board development
	
	• PTHB Self-assessment against WG's Quality Governance Arrangements, undertaken in December 2019
	  ○ 14 areas assessed – 3 low level assurance, 10 medium level assurance and 1 high level assurance

	○ Improvement actions required in respect of the 3 low level assurance areas relate to: Clinical Audit; DATIX; and Concerns management The Board Secretary provided an update regarding the RAG status of each action identified within the assessments. Trish Buchan noted TOR 3 secure medical process and queried whether 2 external obstructions were on the review process for PTHB. The Chief Executive confirmed that there had been in the past however this was not currently in place. The Medical Director assured the Committee that the process was under review and would be continue to be reviewed during the COVID-19 period. Trish Buchan expressed concerns regarding Datix. The Chief Executive noted significant concern regarding the current Datix system, the Head of Information is now the lead for Datix and the Once for Wales system. The Chief Executive confirmed that the Director of Finance and IT could be invited to attend the next meeting of the Committee to provide an update. Owen James queried whether PTHB will be expected to provide Welsh Government with updates regarding the actions. The Board Secretary that they would not at present however Audit Wales were due to undertake work in this area and PTHB will need to be able to demonstrate work undertaken. The actions within the presentation will also inform Committee workplans for 2020/21.
EQS/20/19	**CLINICAL AUDIT PROGRAMME** The Medical Director presented the item and noted that the PTHB clinical audit programme requires further improvement, as recognised by Welsh Audit Office and through two "limited assurance" internal audits. The updated plan allows for planning, reprioritisation, service improvement and a reduction in the number of audits to achieve focus of shared learning. The strategy had been reviewed and endorsed by the Clinical Leadership group and the Quality Governance Group. An emphasis on Mental Health and Women and Children's was underway in line with NICE guidelines. The Director of Workforce and OD raised concerns that a number of dates in Appendix 2 were 'To be confirmed'. The Medical Director reported that the plan is risk based and a number of the TBC's were due to COVID-19, a number of the audits may now have confirmed dates in the time since the report was written.

	The Vice Chair also expressed concerns regarding the lack of confirmed date and suggested the approval of the plan should be considered only when the dates are completed. It was AGREED that pending the provision of dates for all audits the item would be considered for approval at the next meeting of the Committee. The Committee would receive regular updates on progress thereafter.
EQS/20/20	**SAFEGUARDING UPDATE** The Director of Nursing provided the Committee with an update which presented the achievements made since the last report and the identified next steps. Trish Buchan expressed her thanks for the strategic approach and queried how progress would be tracked. It was reported that the Strategy and Operational group is due to review it's Terms of Reference and that this item would be tracked via the group. The Director of Nursing suggested that reports could be reported to this Committee or the Quality Governance Group if requested. Frances Gerrard requested an update on the levels of abuse reported due to the redeployment of Health Visitors and School Nurses. The Director of Nursing summarised the Four Harms approach and noted that initially a reduction in referrals was reported, however it is unclear whether this is directly attributable to Health Visitors and School Nurses. It was confirmed that the number of referrals had started to revert. The Vice Chair thanked the Director of Nursing and expressed ambition to further focus on the area going forward.
EQS/20/21	**INFECTION PREVENTION AND CONTROL UPDATE** The Director of Nursing presented an update regarding Infection Prevention and Control and noted that the area is in a transition period in regards of workforce and therefore there is an opportunity to refocus the area going forward. The Director of Nursing noted that there is an understanding of areas for improvement and a realistic trajectory is to be developed.
EQS/20/22	**RISK ASSESSMENT: TRANSMISSION OF COVID-19 IN THE WORKPLACE** An overview of the work undertaken to minimise the risk of transmission of COVID-19 within the workplace was provided. It was noted that there has been a multifaceted approach including infection prevention and control and PPE. The COVID-19 Gold Group was due to review the RIDDOR approach on 5th June 2020. A Social Distancing

	Working Group had been established and would be supporting the reintroduction of services under the review of new guidance received. A risk assessment had been produced in March 2020 in relation to Black and Minority Ethnicity (BAME) staff. The same approach would now be undertaken for all staff deemed at risk. The Vice Chair queried the health board would manage staff that had not recorded their ethnicity. It was assured that this is part of an ongoing process of communications to ensure staff ethnicity recording. Owen James noted that anecdotal theme shad been emerging regarding BAME staff in the media and queried whether any BAME staff were working on the front line in PTHB. The Director of workforce and OD confirmed that no at risk staff were working on the front line. The Vice Chair noted that the approach seems comprehensive and that the approach provided assurance. It was reported that staff are allocated placement dependent upon their risk score, this has been done for BAME staff and is to be rolled out for all staff. Owen James requested the outcomes of the risk assessment in terms of the adjustments made. It was agreed that the item could return to the Committee for further discussion at a future meeting.
EQS/20/23	**SUPPORT TO CARE HOMES DURING COVID-19** The Director of Nursing provided an update in relation to the activities undertaken with Powys County Council to best support Care Homes in Powys during the COVID-19 pandemic. The area has been fast paces with a myriad of changes coming in to place during a short period of time. Section 33 arrangements are to be reviewed and reintroduced in the near future. The Vice Chair recognised the importance for balance and reach as a health board and noted that PTHB must be clear on where it is obliged to step in and retract should a care home crisis occur. The Chief Executive noted that the need for clarification of roles and responsibilities in regards to care homes has received recognition at Welsh Government level. Work is to be undertaken to clarify, what support the health board would provide voluntarily and the financial implications. It was noted that this work should be considered not just for Care Homes but broader closed setting environments. Susan Newport requested assurance that agency nurses are not rotating between establishments. The Director of Workforce and OD reported that PTHB are not supplying agency nurses. Any agency nurses working in care homes

	would do so under the care homes IPC guidance. It was confirmed that further work is to be undertaken regarding IPC standards and training in care homes. The Director of Nursing confirmed that there have been significant work on nursing assessments for homes and that a number of care homes a part of wider IPC networks. The Vice Chair raised the importance of tracking financial contributions. The Chief Executive assured that this would be shared with the Board. It was requested that a verbal update be provided at the next meeting of the Committee.
ITEMS FOR INFORMATION	
There were no items for inclusion in this section	
OTHER MATTERS	
EQS/20/24	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be reported.
EQS/20/25	**ANY OTHER URGENT BUSINESS** The Board Secretary reported that the Quality and Engagement Bill had received Royal Assent and is now the Health and Social Care Quality and Engagement Wales Act 2020. The Act will be implemented over a period of 2 years and includes the implementation of duty of candour and the establishment of an All Wales Citizens Voice Body.
EQS/20/26	**DATE OF THE NEXT MEETING** 2nd July 2020, 10:00am – 12:00pm, Board Room, Glasbury House, Bronllys Hospital

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Arising from Meetings of the Experience, Quality & Safety Committee (2019/20)					
EQS/19/89	4 February 2020	Information regarding how PTHB receive assurance that visiting clinicians are compliant with training will be circulated with Committee Members.	Assistant Director of Quality & Safety	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q4, 2020/21 (priority 3).	
EQS/19/76	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

EQS/19/75	3 December 2019	The Item Clinical Audit Plan & Update on Progress is requested to return to the Committee within a short timescale	Medical Director	02 July 2020 Included as a substantive item on the agenda. 04 June 2020 The item was reviewed by the Committee and it was agreed that a further iteration would be presented to the Committee on 2 July 2020. 16 April 2020 The Committee agreed that in light of COVID-19, that some elements of clinical audit would need to be a priority and others deferred. It was agreed that a Clinical Audit Plan would come forward to the Committee on 4th June 2020. 04 February 2020 It was agreed that the item would return to the next meeting of EQS on 2 April 2020.	

EQS/19/75	3 December 2019	Discussion around the National Ophthalmology Audit (Adult Cataract Surgery) will take place at QGG.	Medical Director	04 June 2020 The Medical Director confirmed that the audit had been placed on hold due to COVID-19. 16 April 2020 It was agreed that this audit would be considered when developing the Clinical Audit Plan.	
EQS/19/74	3 December 2019	Future Information Governance Quality reports will include further analysis and benchmarking	Board Secretary	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	
EQS/19/73	3 December 2019	A Health and Safety Report Update will be brought to the Committee in the next 6 months	Board Secretary/Director of Workforce & OD	16 April 2020 Some areas would be considered COVID-19 Priority 1, update reports would continue to be received. Scheduled for 30 July 2020 meeting.	
EQS/19/73	3 December 2019	The 'Heat Maps' reported to the LPF will be provided to this Committee at the next Health & safety Update report	Director of Workforce & OD	16 April 2020 To be included in Health & Safety Updates, as above.	

EQS/19/72	3 December 2019	From January 2020 quarterly in-patient mortality reviews will take place, a Q3 review will be brought to the Committee on 4 February 2020	Medical Director	<u>2 July 2020</u> Included as a substantive item on the agenda. <u>4 June 2020</u> It was agreed that this item would be reviewed by the Committee on 2 July 2020. <u>16 April 2020</u> The Committee agreed that in light of COVID-19, this action would need to be a priority for Q1, 2020/21 (priority 1). <u>04 February 2020</u> Q3 information would be available end of March and a substantive item brought to Committee April 2020	

EQS/19/71	3 December 2019	The Committee will continue to monitor the Maternity Assurance Framework periodically	Director of Nursing & Midwifery	16 April 2020 HIW had stood down the regulatory inspection of Maternity Services in Powys, however, PTHB were in regular contact with commissioned services providers and were monitoring provided services.	
EQS/19/68	3 December 2019	An Annual "Putting Things Right" Report will be brought forward to this Committee in June 2020	Assistant Director of Quality & Safety	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3-4, 2020/21 (priority 3).	

EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be confirmed at the next meeting	Assistant Director of Estates and Property	<u>16 April 2020</u> It was confirmed that due to pressure on the Estates Department as a result of COVID-19, this item would be deferred to Q3, 2020/21 (Priority 3). A further assessment would be made by the Board when reviewing the Capital Programme for 2020/21. <u>03 December 2019</u> The immediate improvement work identified in the HIW report is now complete however it is recognized that further work is required. This item is currently being assessed by the Capital Control Group and the mechanism of prioritization which will be brought to the Board on 29 January 2020 along with the Capital Programme for sign-off. <u>10 October 2019</u> There is an ongoing	

				discussion with Welsh Government around potential further capital funding to support refurbishment work at the hospital, which would include The Hazels and other adjacent houses; timescale not agreed. In the meantime, work has been undertaken to upgrade a toilet in The Hazels but it is recognised further work is required.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

Experience Quality and Safety Committee	**Date of Meeting: 2nd July 2020**
Subject :	Mortality Review (Hospital Deaths)
Approved and Presented by:	Wyn Parry Medical Director
Prepared by:	Amanda Edwards Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	

PURPOSE:

This purpose of this paper is to provide an update to EQ&S on the mortality review process implemented across the Health Board together with actions that are being taken to show improvement.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to note and approve the content of this paper.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✓	✗	✗

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper provides an update on the mortality review process implemented across the Health Board together with an update on a number of actions we are taking to improve our learning from deaths processes.

During the period under review; October 2019 to May 2020 there have been 540 deaths of Powys residents in hospitals. These deaths occurred in Powys community hospitals and in acute units in neighbouring Health Boards and NHS Trusts.

The PTHB approach to case review has been developed with the aim of ensuring a standardised format and process. This will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning. The learning from mortality case review will be used to drive service improvement and offer assurance to our patients, stakeholders and the Board that the causes and contributory factors of all deaths have been considered and appropriately responded to.

DETAILED BACKGROUND AND ASSESSMENT:

Background

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. The NHS continues to evolve and our staff continue to work hard to deliver safe, high quality care in line with our values. Unfortunately, there are occasions when patients experience a lesser quality of care which is often due to system issues and or challenges. In order to identify when death has been associated with care that might have been better, there is a requirement to undertake mortality reviews to highlight what could have been done better and how services need to change in order to improve and prevent recurrence. Ideally, every death should be reviewed; even those where there is no doubt that the care provided during the final illness was of the highest quality. Reviews and investigations need to be clear, transparent, repeatable, consistent and robust are only useful for learning purposes if their findings are shared and acted upon.

Our culture focuses on supporting staff to be confident in identifying what can be improved upon by openly and honestly reviewing the care/care pathways that the patient has been on. In doing so, we seek to improve future patient care and support of our staff. Furthermore, any emerging themes/trends that are identified must be shared across the organisation and actions taken to ensure that they are appropriately

reviewed and acted upon. To enable us to learn from deaths of our patients, we require a clear and robust governance process.
The aim of this review process is to learn specific lessons and to develop and improve future care provision provided both by our internal PTHB services and those we commission across Wales and England, to minimise the risk that this could occur again. Any emerging themes/trends that are identified will be shared across the organisation and actions taken to ensure that they are appropriately reviewed and acted upon. Learning from a review of the care provided to patients who die should be integral to our clinical governance and quality improvement work.

Data Quality

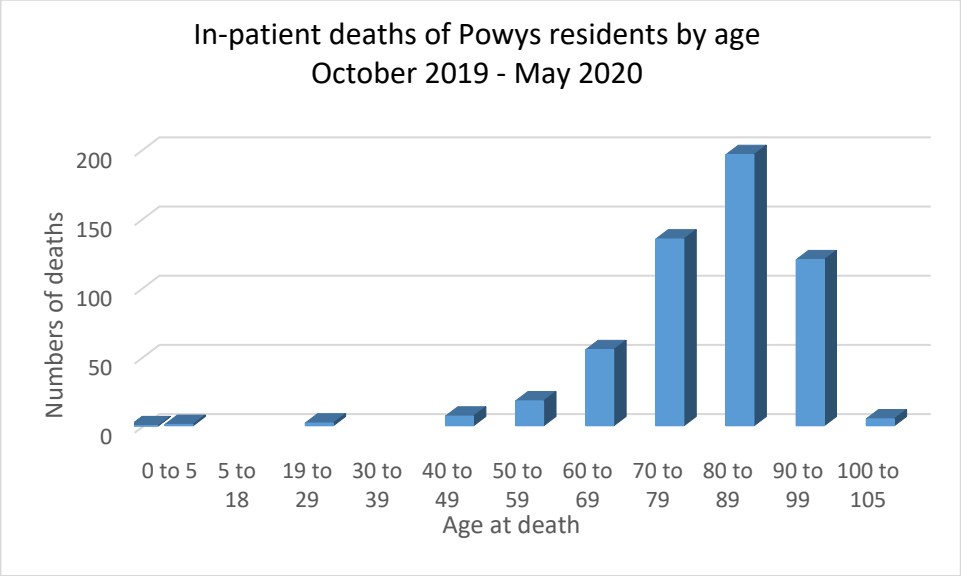
Mortality reviews are only as effective as the quality of information that can be gathered. For the greater part of the time, data quality from routinely available data sources and from individual case notes is of a high quality. However, at times, the information quality is not as good as it should be. Commenting on data quality must be an integral part of the review process and will allow us to continue to strengthen our review process. Within this mortality review, we have been working with Registrar data which can shed light on some of the mortality review process. However, it is clear that, at present, the Powys system needs to evolve further and and pace in order to generate the extra clarity that we need to inform service change and innovation.

It is essential that PTHB is able to monitor the Summary Hospital Level Mortality Indicator for its main English DGHs published on NHS Digital (as was previously the case). The relevant director should escalate this matter to NWIS.

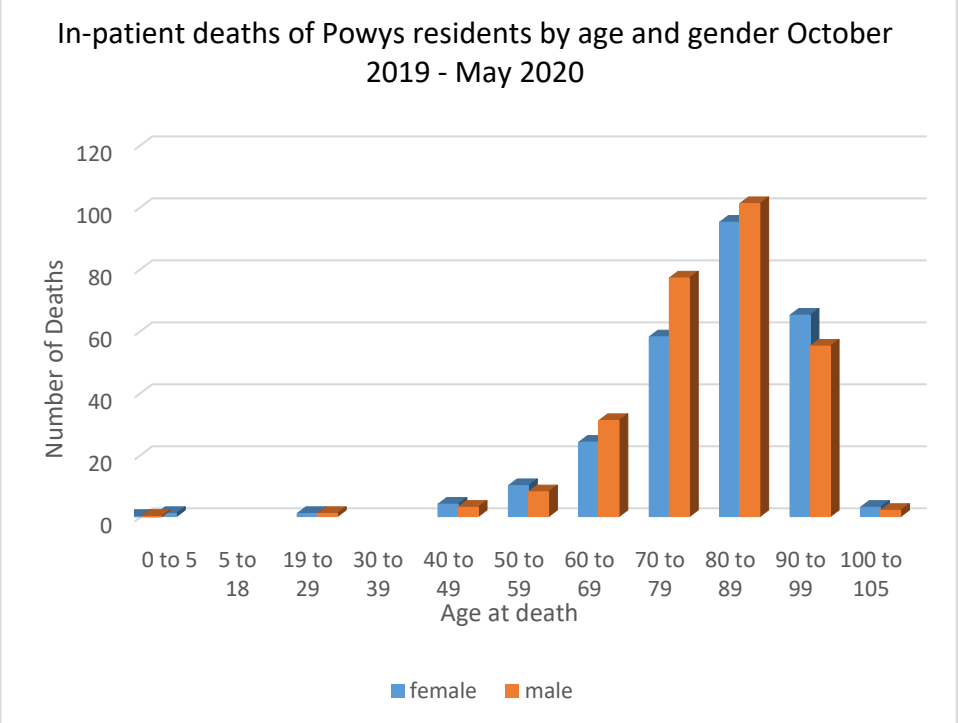
Death Powys Residents in Hospitals

During the period under review; October 2019 to May 2020 there have been 540 deaths of Powys residents in hospitals. These deaths occurred in Powys community hospitals and in acute units in neighbouring Health Boards and NHS Trusts.

The graph below demonstrates that the majority of our deaths in hospital are in people over the age of 60 with a significant number of those being aged between 80 and 89 years of age.



The graph below breaks these deaths down by gender.



The table below shows deaths where the diagnosis primary cause was:

- 'The Big Four' Cancer, Mental Health, Respiratory and Cardio Vascular
- Other

	Diagnosis primary cause	PTHB Provider: Male	PTHB Provider: Female	Commissioned Services: Male	Commissioned Services: Female	Total
The Big Four	Cancer	50	31	35	32	148
	Mental Health	0	0	0	0	0
	Respiratory	12	7	38	37	94
	Cardio Vascular	14	15	57	48	134
	Other	17	27	45	43	132
	Total	97	86	175	172	540

The table below shows deaths where the diagnosis primary cause was:

- Infection/Sepsis primary cause
- Sepsis primary or contributing factor
- Dementia primary or contributing factor

Diagnosis primary cause	PTHB Provider: Male	PTHB Provider: Female	Commissioned Services: Male	Commissioned Services: Female
Infection/Sepsis primary cause	11	15	44	38
Sepsis primary or contributing factor	Less than 5	0	9	Less than 5
Dementia primary or contributing factor	Less than 5	11	11	7

COVID19

The table below shows those Powys Residents who have Covid 19 given as main cause of death or contributing cause on their death certificate:

Normal Place of Residence	Place of Death	Number
Care Home	Care Home	45
Care Home	Hospital	Less than 5
Private Residence	Private Residence	6
Private Residence	Hospital	31

While this report fulfils the requirement to review mortality and identify how the review process needs to develop and mature in Powys, it has to be acknowledged that the greater part of this system change will be informed by the arrival of the new Medical Examiners.

The principles of being open are to be applied following all deaths. The statutory 'Duty of Candour' is triggered when patient safety incidents are reported and validated as moderate harm or above-as identified through the Serious Incident process.

PTHB will take a consistent and evidence-based approach to reviewing case records of patients who have died in our community hospitals but also in acute hospital settings where secondary and tertiary care is provided through commissioning arrangements with Health Boards and Trusts across Wales and England. acute hospitals.

The Welsh Health Service has been undertaking work, completing reviews of the clinical records of patients that die in hospital. The process has been developed using a Universal Mortality Review (UMR) tool to standardise the review process across Wales. The UMR means that every case has a stage 1 review to see whether there was good care, or whether there are some triggers present that mean a more detailed, Stage 2 review is needed. Utilising this will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning.

The learning from mortality case review will be used to drive service improvement and offer assurance to our patients, stakeholders and the Health Board that the causes and contributory factors of all deaths have been considered and appropriately responded to.

It is intended that the Mortality Review process will mature to demonstrate that PTHB:

- Has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- Adopts a robust and effective methodology for case record reviews of all selected
- deaths to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;

- Ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to EQ&S
- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- Shares relevant learning across the organisation and with other services where the insight gained could be useful;
- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and
- Works with commissioners to review and improve their respective local
- approaches following the death of people receiving care from their services.
- As a Commissioners we should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

To achieve this the Mortality Review Panel to meets on a monthly basis and is responsible for:

- Having oversight of the review of deaths within PTHB including all expected / unexpected deaths, of patients currently in PTHB care (and in addition within a 6 month period of discharge following mental health or LD care).
- Reviewing mortality data for Powys patients and service users
- Engaging with relevant external regional and national bodies contributing to the management and improvement of quality learning in relation to mortality management.
- Acting as the Health Board's expert advisory group in terms of reviewing for and consideration of national guidance and other relevant documentation.

The main purpose of this panel is to share and disseminate lessons learned from reports (negative and/or positive) and support actions to ensure that as a Health Board we learn, share and develop to improve our future care provision and delivery of care. The panel also reviews any National reports or reported trends and guidance to continue to develop and improve best practice.

Feedback is disseminated across PTHB by the panel members through internal governance processes. The panel reports to the Experience, Quality & Safety Committee (EQ&S) on a quarterly basis. Within the quarterly report the following is documented:

- Total number of deaths reported
- Total number of deaths that were subject to a stage 2 review

- Total number of deaths that were subject to a serious incident (SI) investigation
- Learning that has been identified from investigations and reviews.
- What changes have occurred as a result of our learning.

The quarterly report will also contain any relevant information in response to the following particular categories of patient death:

- Deaths of patients with learning disabilities
- Deaths of patients with significant mental health disorders
- Infant and child deaths
- Perinatal deaths

If any emerging themes are identified consideration is given to the need to review staff training to ensure we have a competent and responsive clinical workforce.

Next Steps

It is recognised that there are a number of actions to be undertaken to ensure we are able to provide a transparent and consistent approach to mortality reviews within the Health Board, driven by the introduction of the Medical Examiners across Wales who will refine and develop this process.

The maturity of this process together with robust and reliable data will enable the development of a range of signals that can be used to determine whether there is a problem with the mortality information and patterns being reviewed.

A Task / Finish Group will be established and will refine the detail of what the mortality review will deliver and from this will be able to define what information needs to be gathered, how frequently and who will lead on the analysis in order to deliver a dependable, repeatable, valid, transparent and robust review process that will identify issues and drive innovation, change and improvement. This group to comprise:

- Assistant Medical Director
- Assistant Director Innovation & Improvement
- Assistant Director Commissioning Development
- Assistant Director Quality and Safety
- Safety and Quality Improvement Manager
- Consultant in Public Health

The challenges faced by PTHB to ensure our ability to monitor the Summary Hospital Level Mortality Indicator for its main English DGHs published on NHS Digital to be escalated by the relevant director to NWIS.

RECOMMENDATIONS:

- That Experience, Quality and Safety Committee is asked to note the data and learning from and progress with implementing actions to improve our learning from deaths processes.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

Experience, Quality and Safety Committee	**Date of Meeting: 2nd July 2020**
Subject :	**Clinical Audit Programme**
Approved and Presented by:	Wyn Parry Medical Director
Prepared by:	Amanda Edwards Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	QGG 21st May 2020 EQ&S 4th June 2020

PURPOSE:

There have been a number of challenges relating to the improvement of clinical audit across the Health Board. A paper setting out the Clinical Audit Programme to provide assurance that Clinical Audit is being robustly developed and managed was considered by QGG on 21st May 2020 and was further considered at EQ&S on 4th June 2020.

The purpose of this paper is to provide and update to EQ&S regarding progress to date and to confirm the timeframes for delivery.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to note and approve the content

Approval/Ratification/Decision	**Discussion**	**Information**
✓	✖	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓

Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The PTHB clinical audit programme requires further improvement, as recognised by Welsh Audit Office and through two "limited assurance" internal audits.

A paper setting out the background to implementing a robust process to oversee the improvements which will provide evidence for assurance was considered by QGG on 21st May 2020 and was further considered at EQ&S on 4th June 2020. The programme is already underway with plans for and evidence of improvement as well as learning that will be shared across the organisation.

At EQ&S it was requested that an additional paper was presented to provide and update to EQ&S regarding progress to date and to confirm the timeframes for delivery.

DETAILED BACKGROUND AND ASSESSMENT:

Background

The challenges surrounding clinical audit within PTHB are well rehearsed.

The PTHB Clinical Audit Strategy for 2017-2020 was approved by the PTHB Executive Committee on 29 March 2017 and encompassed both the national clinical audit programme and locally-determined clinical audits.

Despite progress made in the determination, management and reporting of clinical audit activity in PTHB before and since the strategy was approved, the Welsh Audit Office Structured Assessment for PTHB for 2017 recognised (page 35) that the clinical audit strategy had not been fully implemented and that there should be "…more robust coordination of the Health Board's clinical audit programme…" In addition, the PTHB clinical audit programme has received two "limited assurance" internal audit ratings (most recently, in February 2018).

In July 2018 a Clinical Audit Improvement Plan was developed and approved by the Executive Committee. Despite the development of this improvement plan, there does not seem to have been a joined up approach to audit or the sharing of any associated learning across the Health Board. Importantly the context that audit works in, one of quality improvement and clinical effectiveness, appears not to have been fully appreciated.

Clinical Audit Programme

To address these issues a Clinical Audit Programme Plan aligned to the Clinical Quality Framework has been developed. This reflects the changes to both the governance arrangements of the Health Board and the organisational realignment.

In summary, the clinical audit programme will:

- Establish the process to plan the clinical audit programme at Directorate/Departmental level, including the prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks) and confirm operational management arrangements.

- Determine and prioritise clinical audit projects, linked to clinical and organisational risk and priorities. Ensure that the following area of clinical audit to be incorporated within the plan; National Audit Programme, Learning from Serious Incidents (SIs) or complaints, new or changes to existing policy / practice and areas where service improvement is required.

- Establish the timeframe and governance arrangements for the sign off of the annual programme of PTHB clinical audit activity for the following financial year. This is to include the agreed reporting process in terms of timeframes and frequency of reporting during the financial year.

- Set out the timeframe and governance process for the annual report of PTHB clinical audit activity for the previous financial year. This to include the end-of-year reporting of individual audits, including a clear impact statement and any recommendations for change

- Identify the management process to monitor progress and compliance against expected completion dates, track recommendations through to closure, identify where slippage against an expected completion date occurs and ensure that applicable relevant remedial action is taken by the service area and to monitor the remedial action.

- Ensure an appropriate audit trail for changes to the clinical audit plan to include the tracking of all changes together with a rational and justification for the changes.

A copy of an updated Clinical Audit Programme Plan that sets out progress to date can be found at **Appendix A**.

Clinical Audit Plan 2020 / 21

A Clinical Audit Plan has been drafted which incorporates within the plan:

- National Audit Programme elements as they apply to PTHB
- Learning from Serious Incidents (SIs) or complaints
- New or changes to existing policy / practice and areas where service improvement is required.
- The prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks

A copy this Clinical Audit Plan with updated timeframes can be found at **Appendix B. Next Steps**

- To regularly against progress of the Clinical Audit Programme and the Clinical Audit Plan to QGG and EQ&S

RECOMMENDATIONS:

- That Experience, Quality and Safety Committee considers the updates and approves the next steps listed above.

PTHB Clinical Audit Programme

2020 / 21

Updated 23rd June 2020

REF	ACTIVITIES (BOLD ARE ON HIGH LEVEL PLAN)	RESPONSIBLE LEAD	Mgt Lead	Deadline	BRAG STATUS	Update
1	**Ensure identify the lead officer with responsibility for clinical audit and development of the programme and ensure that this is fully reflected in their job description**	Medical Director	Safety & Quality Improvement Manager	31-Mar-20		Confirmed that the Strategic lead is MD and it's in the MD portfolio. Confirm that the management lead is HC and it is in his JD
2	**Develop the Clinical Audit Programme Plan**	Assistant Director I&I	Assistant Director I&I	30-Apr-20		Agreed at QGG & EQ&S
3	**In line with the Clinical Quality Framework, agree the governance arrangements for the annual clinical audit cycle**	Assistant Director I&I	Assistant Director I&I	31-May-20		Dates and process agreed with Board Sec
4	**Following approval of the Clinical Audit Programme at QGG and EQ&S, launch the clinical audit programme through a targeted communication to all key staff**	Assistant Director I&I	Assistant Director I&I	31-Jul-20		Planning of formal launch underway
5	**Integrate clinical audit into a wider programme of quality improvement and service development;**	Assistant Director I&I	Assistant Director I&I	30-Jun-2020 Revised to 31-Jul-2020		Clinical Effectiveness and Quality Improvement Strategy drafted. Implementation plan

	moving towards full integration of all aspects of service improvement by reviewing the current Clinical Audit Strategy and incorporate it within the Clinical Effectiveness and Quality Improvement Strategy					under development. Both documents to be considered at next EQ&S
6	To ensure the following area of clinical audit to be incorporated within the plan: National Audit Programme – these will be populated centrally Learning from Serious Incidents (SIs) or complaints New or changes to existing policy / practice Areas where service improvement is required	Assistant Director I&I	Safety & Quality Improvement Manager	30-Jun-20		Completed
7	Each service area to agree at least one clinical audit per annum which is based on NICE guidance/NICE quality standards	Safety & Quality Improvement Manager	Safety & Quality Improvement Manager	30-Sep-20		This is part of the development of the clinical audit plan for 2021/22
8	The annual programme of PTHB clinical audit activity for the *following* financial year to be signed off by PTHB Executive Committee (prior to QGG / EQ&S) no later than the January of the *previous* financial year (to encompass a rational balance of new and follow-up clinical audits; and anticipated completion dates for each audit)	Medical Director	Assistant Director I&I	31-Dec-20		Dates agreed with Board Sec
9	The annual report of PTHB clinical audit activity for the *previous* financial year to be signed off by PTHB	Medical Director	Safety & Quality Improvement	31-Aug-20		Dates agreed with Board Sec

	Executive Committee (prior to QGG / EQ&S) no later than the June of the *following* financial year		Manager			
10	Enhance senior clinical leadership for clinical audit through clinical Executive sponsorship for key audits (at least one clinical audit per clinical Executive, to be agreed as part of the clinical audit annual planning process)	Medical Director	Assistant Director I&I	30-Jun-20		DoTH sponsors CMATS audit DoN sponsors TBA
11	Confirm a lead clinician and lead manager for clinical audit for each Directorate/Service Area	Assistant Director I&I	Safety & Quality Improvement Manager	31-Mar-20		Completed
12	Develop a dedicated and regularly updated area for clinical audit on the PTHB intranet site (to include library of evidence-based clinical standard sets; other web-based support materials for clinical audit; and contact details for lead staff at PTHB corporate and Directorate level)	Assistant Director I&I	Safety & Quality Improvement Manager	31-Jul-20		This is in existence. It will be reviewed as part of our wider approach to clinical effectiveness and quality Improvement and how this is published on the intranet
13	Establish an agreed process to plan and deliver the clinical audit programme at Directorate/Departmental level, including the prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks)	Assistant Director I&I	Safety & Quality Improvement Manager	30-Apr-20		This was undertaken for the current clinical audit plan and will be further developed for future plans
14		Assistant				This is under development

	Define/develop role of PTHB primary care in supporting national primary care clinical audits	Medical Director	Assistant Medical Director	30-Jun-20		
15	To review National Clinical Audits as they would apply to PTHB commissioned services where and support PTHB Commissioning Team in interpreting/addressing any actions required.	Assistant Director I&I	Safety & Quality Improvement Manager	30-Apr-20		This was undertaken for the current clinical audit plan and will be further developed for future plans
16	Raise the profile of the clinical audit programme (both national and local projects) in PTHB through a programme of communication and engagement with staff and service users.	Assistant Director I&I	Safety & Quality Improvement Manager	31-Jul-20		Linked to 4 above
17	Clinical audit activity to be consistently reported as part of Directorate review processes	Board Secretary		30-Jun-20		Review of performance against clinical audit is part of the Directorate Performance Review process. These were stood down during Covid19. There are plans to reinstated these.
18	Develop a SOP to support the PTHB response (including actions) to all national clinical audits, whether in PTHB provided or commissioned NHS services	Assistant Director I&I	Safety & Quality Improvement Manager	30-Jun-2020 revised to 31-Jul-2020		Work on this had commenced but was delayed due to Covid 19
19	To complete a clinical audit training needs	Assistant	Safety &	30-Jun-2020		Work on this had commenced

	assessment for PTHB staff and develop the training offer to meet these defined needs	Director I&I	Quality Improvement Manager	revised to 31-Aug-2020		but was delayed due to Covid 19
20	Explore QA Tracking for the electronic monitoring of clinical audit	Assistant Director I&I	Assistant Director I&I	30-Jun-2020 revised to 31-Aug-2020		Work on this had commenced but was delayed due to Covid 19

The following PTHB-defined RAG ratings are used to indicate position against actions:

R	Red		Persistently not meeting objective/target (at least 3 months) and highly unlikely to meet objective/target within specified period
A	Amber		Persistently not meeting objective/target, but on an agreed performance improvement trajectory
G	Green		Objective/target achieved
B	Blue		Task completed

Appendix B

Clinical Audit Plan 2020/21

Primary, Community & Mental Health Care Services Directorate				
Community Nursing				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	Pulmonary Rehabilitation	April 2020	CSM South	To be determined nationally
National Audit Programme	Cardiac Rehabilitation Audit	Ongoing database	AD Community Services	Ongoing data collection Next report date to be determined nationally
Serious Incident Learning	DNACPR Audit	June 2020	Head of Nursing	July 2020
Serious Incident Learning	NEWS Chart use Audit	June 2020	Head of Nursing	July 2020
Mental Health				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Service Improvement required	Clozapine and physical health audit	Jan-20	Dr Sadid	Due to the challenges of recruiting substantive Psychiatrists the Mental

				Health Service are unable to confirm the completion dates of these audits at the present time
Service Improvement required	Audit of prescription charts against BNF standards	Mar-20	Clinical Director Mental Health and Learning Disabilities	As above
Changes to existing policy or practice	Mental Health Act Documentation	Mar-20	Clinical Director Mental Health and Learning Disabilities	As above
Changes to existing policy or practice	ECGs undertaken on Older Adult Mental Health in-patient units	May 20	Advanced Nurse Practitioner	As above
Serious Incident Learning	Care and Treatment Plan (CTP) audit	Feb-20	Senior Manager, Adult Mental Health Montgomeryshire	As above
Service Improvement required	Tawe Ward CTP audit	Jan-20	Ward Manager	Q4 2020/21
National Audit (Non-Programme)	Tawe Ward IPC audit	Aug 20	Ward Manager	Q4 2020/21
Changes to existing policy or practice	Tawe Ward Prescription audit	Jan-20	Ward Manager	Reporting started
Service Improvement required	NICE Guideline Dementia Ystradgynlais Older Adult CMHT	Jan-20	Community Mental Health Nurse	Reporting started

Serious Incident Learning	Audit of the Joint Working Protocol between adult substance misuse services and adult mental health services.	Jan-20	Service Manager - Adult Mental Health (North Powys)	Reporting started
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit (Non-Programme)	WHTM01-05	Apr-20	senior Dental Therapist	Jul-20
National Audit (Non-Programme)	Patient Experience Questionnaire (CDS)	May-20	Dentist	Aug-20
National Audit (Non-Programme)	Patient Experience Questionnaire (Oral Surgery)	Mar-20	Dental Nurse Oral Surgery Team Lead	Jun-20
Service improvement required	Radiography grading	Continuous yearly run chart	Dental Director	Continuous yearly run chart
Service improvement required	Hand Hygiene	April 2020 and Oct 2020	Senior Dental Therapist	May 2020 and Nov 2020
Service improvement required	Clinical record keeping	Nov-20	Dentist	Mar-21
Service improvement required	Clinical record keeping (special care)	Mar-20	Specialist in Special Care	Mar-21
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**

- New Chief Pharmacist now in post.
- Support in place to enable the development of a half year clinical audit plan in place to be implemented from 1st October for the remaining 6 months.
- Quality Improvement to work with Chief Pharmacist and MMT to develop a QI plan which will identify key areas for improvement and Clinical Audit going forward.

Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Core Audit	To be determined nationally	Remote audit of GP computer system	To be determined nationally
Service improvement required	Patient Safety Programme	Sept 19	Prescribing lead within each practice	Sept 20
Service improvement required	Reducing Stroke risk through improved management of AF in primary care clusters	Sept 19	Lead GP	Sept 20
Service improvement required	Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)	Sept 19	Antibiotic lead	Sept 20
Service improvement required	Diabetes Gateway	Apr 20	Diabetes lead	Dec 20
Women's and Children's Service				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Maternity and Perinatal Audit	To be determined nationally	Head of Midwifery	To be determined nationally

National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People	To be determined nationally	Consultant Community Paediatrician	To be determined nationally
Child Protection Quality Standards (UK)	Child Protection Medicals in Powys	TBC	Consultant Community Paediatrician	TBC
FOI request re FASD	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	TBC	Consultant Community Paediatrician	TBC
Therapies and Health Sciences Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Foot Care Audit	To be determined nationally	Head of Podiatry	To be determined nationally
National Audit Programme	All Wales Audiology Audit	To be determined nationally	Head of Audiology	To be determined nationally
National Audit Programme	Stroke Audit (SSNAP)	Ongoing	Professional Head Physiotherapy	Ongoing
Service improvement required	OT Documentation	Apr-20	Head of Therapies	Sep-20
Service improvement required	Documentation audit	Sept-20	Head of Podiatry	March 21
Service improvement required	Taxonomy audit	Dec-20	Head of Podiatry	Mar-21

Service improvement required	NICE Audit Low Back Pain	Dec-20	Clinical Specialist Physiotherapist	Mar-21
Service improvement required	Clinical Notes audit - Pain and Fatigue service	Nov-20	Clinical Specialist Physiotherapist	2021
Service improvement required	Parkinson's Care	2021	PD UK	2021
Service improvement required	SLT notes	2020 - 2x yearly	Head Adult Speech & Language	2021
Audit for re-accreditation	Radiography: Non-medical referrers audit	Sept-20	Team Lead/ Supt Radiographer	Oct-20
Audit for re-accreditation	Compliance with Standard operating procedures (SOP's)	Sept 20	Team Lead/ Supt Radiographer	Oct-20
Audit for re-accreditation	Compliance with gonad protection standards	Sept 20	Team Lead/ Supt Radiographer	Oct 20
Audit for re-accreditation	Reject analysis	Sept 20	Team Lead/ Supt Radiographer	Oct 20
Audit for re-accreditation	Recording of date of last menstrual period	Sept20	Team Lead/ Supt Radiographer	Oct 20
Audit for re-accreditation	Correct use of radiographic markers	Sept20	Team Lead/ Supt Radiographer	Oct 20
Audit for re-accreditation	Radiographer commenting audit	Sept20	Team Lead / Supt Radiographer	Oct 20
Service improvement required	Physiotherapy Notes	TBC	Professional Head Physiotherapy	March 21
Service improvement required	CMATS- referral management	TBC	DoTH Sponsor Professional Head Physiotherapy	March 21

Nursing Directorate				
Driver	Audit Title	Start Date	Lead	End Date
Serious Incident Learning	Falls Audit	Q3 2020	Assistant Director of Nursing	End Q4 2020
Service improvement required	Fundamentals of nursing care	Q4 2020	Assistant Director Quality & Safety	Q1 2021
Serious Incident Learning	Pressure Ulcer Prevention	Q3 2020	Assistant Director Quality & Safety	End Q4 2020
Serious Incident Learning	Compliance with the serious incident policy	Q4 2020	Assistant Director Quality & Safety	End Q4 2020
Safeguarding				
Driver	Audit Title	Start Date	Lead	End Date
Service improvement required	Safeguarding Maturity Matrix	Jul-20	Assistant Director Safeguarding	Sep-20
Service improvement required	Safeguarding Supervision Audit	Dec-20	Senior Nurse Safeguarding	Feb-21

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement

	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident
	Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

Experience Quality and Safety Committee	**Date of Meeting: 2nd July 2020**
Subject :	**Progress report for the implementation of the Once for Wales Concerns Management System**
Approved and Presented by:	Director of Finance and IT Services
Prepared by:	Assistant Director of Digital Transformation & Informatics Head of Information
Other Committees and meetings considered at:	Quality and Governance Group (in part)

PURPOSE:
The purpose of this report is to provide a status update for the implementation of the Once for Wales Concerns Management System (OFWCMS).
RECOMMENDATION(S):
The Experience Quality and Safety Committee is asked to note the current position and the issues and risks that arise at this stage of the project.

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	×
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The newly established Project Board was scheduled to meet for the first time in April (this has been rearranged due to Covid-19), this group will be responsible for the oversight and management of the transition and implementation to the new complaints system.

Key issues to note and recommended actions

- There has been a delay in establishing the hierarchies needed for the OFWCMS as not yet received appropriate guidance from the National Programme Team. Action to be completed on receipt of the guidance.

- As part of the transition period, data is now recorded via DatixWeb (previously being reported via PTHB IFOR), action needed to ensure accuracy of data and reporting. This action will significantly improve consistency in readiness for the implementation of the OFWCMS.

- It is recommended that the dashboard functionality within DatixWeb is used for reporting Complaints data (replace existing IFOR reporting).

- Business Case / Business Change Case being completed to identify the resource required to complete the migration and implementation of

OFWCMS and to deliver the expected improvements in efficiency and improved data resource to support learning and improvement.

DETAILED BACKGROUND AND ASSESSMENT:

Project Arrangements

The Head of Information is the project manager and supported by the Assistant Director of Quality and Safety.

The key task is to modernise and improve the current database that is used to record complaints data, this is crucial to ensure accurate on going reporting and successful migration to the new system. Relevant stakeholders have been identified (including the Data Warehouse Team) and they have been invited to the Project Board to help ensure that the database development follows best practice.

The PTHB project group is working closely with the National Programme Board to ensure that appropriate actions and deadlines are met in relation to the National Roll Out programme.

Initial task to create reporting hierarchies for the new system, this work is ongoing and subject to further national guidance before it can be completed. This is a vital first step in developing the database and reporting structures.

Senior Information Analyst has been nominated to be the PTHB RLDatix accredited practitioner (following completion of appropriate training). This will support the preparation needed and ongoing support for the current system to help manage the transition to the new system.

Dashboard Reporting

The Quality and Safety team have been using DatixWeb (for recording Complaints data) since 2019, this system is based on the Health Boards historic database but requires different methods of recording information.

The current system continues to have issues in relation to data quality (at a local and national level), this is mainly due to issues in relation to legacy data (e.g. when old cases are reopened) and a requirement to input data in a different way. Processes are in place to ensure that Data is validated for accuracy of reporting.

Adopting the use of the DatixWeb dashboard will improve the accuracy of data and transparency in the reporting process (as the reports only use the data that is displayed in the web interface).

This action will also help to support the migration to the OFWCMS. As per the National Plan the Complains Module is scheduled for rollout and implementation in quarter 2 2020 (not yet confirmed).

The National Programme Board for OFWCMS has made the decision **not** to migrate legacy information. This means that PTHB will be required to run DatixWeb and OFWCMS System in parallel for a significant period of transition. There will be a link established between the two systems to ensure consistent data use and reporting (both systems provided by the same provider).

Resources

A Business Case / Business Change Case is being completed to identify the resource required to complete the migration and implementation of OFWCMS and to maintain the current system during the transition period. This will be needed to deliver the expected improvements in efficiency and improved data resource to support learning and improvement.

NEXT STEPS:

The following action will be taken forward by the Programme Board and Project Leads: -

- Ongoing testing of the Datix reporting dashboards to ensure appropriate data capture for the for the National Complaints pro-forma report.
- Ongoing testing of the reporting outcomes on all data captured within the application.
- Information and Quality and Safety Teams to identify and resolve outstanding data capture issues in relation to the pro-forma.
- Go live with use of dashboard for reporting National Complaints for 2019-2020 from quarter 3 onwards.
- Identify the transition / parallel reporting period required for OFWCMS and Datix (once OFWCMS implementation date confirmed).
- Complete Business Case/ Business Change Case for decision.