Experience, Quality and Safety Committee

01 October 2020, 12:00 to 14:00
Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

EQS_Agenda_1_October_2020_Final.pdf (2 pages)

1.1. Welcome and apologies

1.2. Declarations of interest

1.3. Minutes of the previous meeting held on 30 July 2020 (for approval)

EQS_Item_1.3_UNCONFIRMED EQS Minutes 30 July 2020.pdf (14 pages)

1.4. Matters arising from previous minutes

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_01_October_20.pdf (3 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

3. ITEMS FOR DISCUSSION

3.1. Safeguarding

3.1.1. a) Annual Report 2019-20

EQS_Item_3.1a_Annual Safeguarding Report 2019-20.pdf (4 pages)

EQS_Item_3.1ai_Annual Safeguarding Report 2019-20.pdf (26 pages)

3.1.2. b) Experience Story

EQS_Item_3.1b_LAC Voice 2020.pdf (1 pages)

3.2. Commissioning Assurance Report

EQS_Item_3.2_CAF Escalation Report and SaTH update September 2020.pdf (10 pages)

3.3. Serious Incidents and Concerns Report

EQS_Item_3.3_Concerns and SIs.pdf (16 pages)

3.4. Inspections and External Bodies Report

EQS_Item_3.4_Regulatory Inspections Report.pdf (6 pages)

EQS_Item_3.4ai_Appendix 1 Powys Home from Home Birthing Centres - Final Published Report.pdf (38 pages)

EQS_Item_3.4aiv_Appendix 2 - Newtown CMHT - Final Published Report.pdf (46 pages)

3.5. Mental Health Act Compliance & Powers of Discharge Report

EQS_Item_3.5_Mental Health Act Compliance & Powers of Discharge 2020.pdf (10 pages)

3.6. Staff Well-being and Engagement Report

EQS_Item_3.6_Staff Wellbeing and Engagement (9 pages)

Update.pdf

3.7. Information Governance Quality Report

EQS_Item_3.7_Information Governance Compliance Report.pdf (9 pages)

3.8. The Public Services Ombudsman for Wales Annual Report and Accounts 2019/2020

EQS_Item_3.8_PSOW Annual Report Covering Paper.pdf (4 pages)

EQS_Item_3.8a_Appendix 1-HB - Powys Teaching University Health Board.pdf (7 pages)

3.9. Mortality Reporting

EQS_Item_3.9_Mortality Review Paper EQ&S 1.10.2020.pdf (8 pages)

3.10. Clinical Audit Report

EQS_Item_3.10_Clinical Audit Plan Update Report.pdf (13 pages)

4. ITEMS FOR INFORMATION

4.1. Review of Committee Programme of Business

EQS_Item_4.1_Committee Workplan_Sept20.pdf (2 pages)

EQS_Item_4.1a_EQS_Committee_Work Programme_2020-21_Sept20_RM.pdf (6 pages)

4.2. Putting Things Right Claims and Compensation Annual Report 2019- 2020 (Final)

EQS_Item_4.2_PtR CLAIMS AND COMPENSATION - ANNUAL REPORT 2019-2020.pdf (36 pages)

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 3 December 2020.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

1 OCTOBER 2020,
12:00 PM – 14:00 PM
TEAMS MEETING

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes of the previous meeting held on 30 July 2020 (for approval)	Attached	Chair
1.4	Matters Arising from Previous Meetings	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section.		
3	**ITEMS FOR DISCUSSION**		
3.1	Safeguarding a) Annual Report 2019-20 b) Experience Story	Attached	Director of Nursing and Midwifery
3.2	Commissioning Assurance Report	Attached	Assistant Director Commissioning
3.3	Serious Incidents and Concerns Report	Attached	Director of Nursing and Midwifery
3.4	Inspections and External Bodies Report	Attached	Director of Nursing and Midwifery
3.5	Mental Health Act Compliance & Powers of Discharge Report	Attached	Director of Primary, Community Care and Mental Health
3.6	Staff Well-being and Engagement Report	Attached	Director of Workforce & OD
3.7	Information Governance Quality Report	Attached	Board Secretary
3.8	The Public Services Ombudsman for Wales Annual Report and Accounts 2019/2020	Attached	Director of Nursing and Midwifery
3.9	Mortality Reporting	Attached	Medical Director
3.10	Clinical Audit Report	Attached	Medical Director

4	**ITEMS FOR INFORMATION**		
4.1	Review of Committee Programme of Business	Attached	Board Secretary
4.2	Putting Things Right Claims and Compensation Annual Report 2019- 2020 (Final)	Attached	Director of Nursing and Midwifery
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 3 December 2020, Board Room, Glasbury House, Bronllys Hospital		

Powys Teaching Health Board is committed to openness and transparency, and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a Committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Rani Mallison, Board Secretary, rani.mallison2@wales.nhs.uk).

In addition, the Board will publish a summary of committee meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 30 July 2020 VIA MICROSOFT TEAMS

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:

Alison Davies	Director of Nursing and Midwifery
Andrea Blayney	Community Health Council
Carol Shillabeer	Chief Executive
Claire Madsen	Director of Therapies and Health Sciences
Clare Lines	Assistant Director Commissioning Development
Elaine Matthews	Audit Wales
Helen Higgs	Head Internal Audit
Jamie Marchant	Executive Director of Primary, Community & Mental Health
Julie Rowles	Director of Workforce, OD and Support Services
Rani Mallison	Board Secretary
Rebecca Collier	Healthcare Inspectorate Wales
Stuart Bourne	Director of Public Health
Wendy Morgan	Assistant Director of Quality and Safety
Wyn Parry	Medical Director

Apologies for absence:

Geoffrey Davies	Community Health Council Representative
Katrina Rowlands	Assistant Director of Nursing
Mark McIntyre	Deputy Director Workforce and OD

Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary

EQS/20/39	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/20/40	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/41	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 2 July 2020** The minutes of the previous meeting held on 2 July 2020 were AGREED as being a true and accurate record given the changes stated below. EQS/20/27 Elaine Matthews identified the incorrect spelling of her name, to be corrected.
EQS/20/42	**MATTERS ARISING FROM PREVIOUS MEETINGS** The Committee Vice-Chair confirmed that mortality reporting was scheduled for the agenda of Experience, Quality & Safety Committee on 1 October 2020.
EQS/20/43	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/20/28 Work in respect of the Stress Management Policy Toolkit to start in quarter 2. Update included in the H&S Group Update, included on the agenda. This action was therefore marked as closed. EQS/19/74 Future Information Governance Quality reports would include further analysis and benchmarking. Item scheduled through Committee Workplan, included on the agenda. This action was therefore marked as closed. EQS/19/73 Health and Safety Report Update. H&S Group update included on the agenda and future reports scheduled through committee workplan. This action was therefore marked as closed. EQS/19/73 The 'Heat Maps' reported to the LPF would be provided to this Committee at the next Health & safety Update report. H&S Group update included on the agenda

	and future reports scheduled through committee workplan. This action was therefore marked as closed. EQS/19/71 Monitoring of the Maternity Assurance Framework. Scheduled through committee workplan, included on the agenda. This action was therefore marked as closed. EQS/19/68 An Annual "Putting Things Right" Report would be brought forward to this Committee in June 2020. PTR Annual Report included on the agenda. This action was therefore marked as closed. The Board Secretary noted the following items as deferred: EQS/19/89 Information regarding how PTHB receive assurance that visiting clinicians are compliant with training would be circulated with Committee Members. Deferred to Q4, 2020/21 (priority 3). EQS/19/76 The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework. Deferred to Q3, 2020/21 (priority 2). EQS/19/22 HIW/CIW Joint Inspection. Deferred to Q3, 2020/21 (Priority 3).
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/44	*There are no items for inclusion in this section.*
ITEMS FOR DISCUSSION	
EQS/20/45	**COMMISSIONING ASSURANCE REPORT** The Assistant Director of Commissioning presented the previously circulated paper which explained that it had not been possible to apply the PTHB Commissioning Assurance Framework during the COVID 19 pandemic, but that the monitoring of domains was continuing where possible. And highlights key risks in relation to Shrewsbury and Telford Hospitals NHS Trust. The Assistant Director of Commissioning advised that an unprecedented scale of change had been necessary in the NHS in order to respond to the COVID-19 pandemic. Health Boards and NHS Trusts have had to respond swiftly to the way forward set out by Government in England and Wales.

	This paper explains that the usual commissioning arrangements had not been in place and PTHB had been participating in strategic system command arrangements in Shropshire, Telford and Wrekin and for Herefordshire and Worcestershire covering some of the main District General Hospitals for the Powys population. The paper provides a high-level overview of the major changes needed and the process for service restoration and recovery. Whilst it had not been possible to operate the Commissioning Assurance Framework (CAF) during this period, monitoring of some domains was continuing where possible. Shrewsbury and Telford Hospitals (SaTH) NHS Trust was in special measures and three inspection reports were issued by the Care Quality Commission (CQC) on the 8th April 2020. Following unannounced inspections on the 9th and 10th June 2020 there had been a further warning of conditions being imposed on the trust, with the publication of the CQC report expected in August. The Assistant Director of Commissioning noted difficulty in the timing of the paper due to the first of the restored meetings being held on 23 July 2020 making the time frame tight for write up for ESQ on 30 July 2020. Following reports brought to EQS would be more standardised. Ongoing changes were noted to be as a result of Welsh Government requesting the suspension of routine work. Contributing factors were lack of capacity, PPE provisions and social distancing. NHS England was noted to have moved into command and control structures when assessing the availability of space and PPE. The Assistant Director of Commissioning confirmed Shropshire Telford and Wrekin are going through a restoration process. The questions relating to this item which were received in advance of the meeting were recapped and are available online (https://pthb.nhs.wales/about-us/the-board/committees-partnerships-and-advisory-groups/powys-teaching-health-board-committees/experience-quality-and-safety-committee/meetings-of-the-experience-quality-and-safety-committee/experience-quality-and-safety-committee-meeting-on-30-jul/).

	The Committee Chair commended the Assistant Director of Commissioning for the clarity of the paper and ENDORSED the comments. The Committee agreed the report as sufficiently DISCUSSED.
EQS/20/46	**CONCERNS & SERIOUS INCIDENTS REPORT** The Director of Nursing and Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with an overview of performance in concerns and update on the reporting and investigation of serious incidents, current assurance position, summarising lessons learnt and good practice. The Director of Nursing and Midwifery requested the committee acknowledge the report was in development. The Director of Nursing and Midwifery advised that the purpose of this report was to provide the Experience, Quality & Safety Committee with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for 2019/2020 and for Quarter 1 for 2020/2021. The report also outlines serious incidents reported to Welsh Government and a Regulation 28 report received from Her Majesty's Coroner. The questions relating to this item which were received in advance of the meeting were recapped and are available online (https://pthb.nhs.wales/about-us/the-board/committees-partnerships-and-advisory-groups/powys-teaching-health-board-committees/experience-quality-and-safety-committee/meetings-of-the-experience-quality-and-safety-committee/experience-quality-and-safety-committee-meeting-on-30-jul/). The Committee Chair requested that once the new Once for Wales Content Management System had been implemented and the safety culture further developed, the report would return to the committee for discussion. Owen James queried, the number of concerns were related to access to appointments, was that true of all of them. The Director of Nursing and Midwifery stated that the number of concerns related to a theme as outlined in the paper. Owen James queried, did the increase relate to how formal concerns were managed. The Director of Nursing and Midwifery responded that in previous reports Welsh

	Government had changed their parameters, time to respond to informal concerns was shortened. Due to the policy change there was significant change between formal and informal issues. The Director of Nursing and Midwifery offered to share more information outside of the committee. Owen James stated that the report was target driven rather than focused on the quality of outcomes. More patient feedback would assist in understanding the quality of the assurance. The Committee Chair suggested the committee request more patient stories to be included in the committee's workplan in the future. The Chief Executive noted that the Experience, Quality and Safety Committee had agreed the 'Putting Things Right' policy. As part of that individuals are tested on if the process was satisfactory. Learning from complaints could and would be shared across the organisation. The standard of data and surveillance are both undergoing improvement. The Assistant Director of Quality and Safety noted that other organisations across wales have been liaised with. The Director of Nursing and Midwifery brought to the attention of the committee that the Public Services Ombudsman for Wales (PSOW) is available in instances where people are dissatisfied with the process. Annual reports are received from the PSOW. The Committee Chair raised that patient feedback had to be taken into context of the clinical quality framework. Patient feedback needs a systematic approach to gathering data. The Committee Chair queried the level of assurance that could be taken from this report as it stands. The Director of Nursing and Midwifery stated a reasonable amount of assurance could be taken that the investigation and learning are robust enough to prevent recurrence. The Director of Nursing and Midwifery and the Assistant Director of Quality and Safety would review the inaccuracy. A paper with the correct numbers would be circulated outside the meeting. **Action: Director of Nursing and Midwifery and Assistant Director of Quality and Safety.** The Committee Chair thanked those involved in the development of the paper. The Committee Chair noted it would be important to consider the paper in the round. The Chief Executive added that the charts need to be understood and the denominator needs to be known for future versions.

	The Committee DISCUSSED the report and NOTED the actions underway to address areas of non-compliance and where further improvement was needed.
EQS/20/47	**USE OF PERSONAL PROTECTIVE EQUIPMENT FOR CARDIOPULMONARY RESUSCITATION AND NASOGASTRIC INTUBATION PROCEDURES** The Medical Director presented the previously circulated paper which reviewed guidance on the use of PPE during CPR and nasoenteral (principally nasogastric (NG) intubation procedures on patients during the Covid-19 pandemic and to secure the Experience, Quality and Safety Committee's endorsement of the proposed approach to these procedures. The Medical Director advised there was conflicting guidance on the indication for and use of PPE in settings where the following interventions are indicated and performed: • CPR • NE intubation National guidance from Public Health England (PHE) was at variance with that from a wide variety of specialist, advisory, educational, standard setting and professional groups. PHE's guidance was that full PPE was not required in either intervention, other bodies' advice was that it was. There was little published evidence on which to base a clear conclusion so the issue involves taking a risk-based approach. The theoretical AGP risk was likely to be small; the potential consequence of a staff member contracting Covid-19 during either intervention was significant however, the latter risk could be mitigated by the use of full PPE during these interventions. Taking that approach, the recommendation was that full PPE was to be used by all PTHB staff carrying out either intervention. This had already been the interim position adopted by the health board following review of the various sources of guidance. The Committee Vice Chair and Medical Director confirmed the PTHB's approach was to minimise risk to staff. The committee ENDORSED the proposal: • That full PPE was to be used for all elements of CPR procedures. • That full PPE was to be used for all NG tube insertions on PTHB patients in all clinical settings where these interventions are indicated and during the Covid-19 pandemic.

EQS/20/48	**HEALTH & SAFETY GROUP UPDATE** The Director of Workforce, OD and Support Services presented the previously circulated paper which provided the Experience, Quality & Safety Committee with an update on the Annual Work Programme in the following areas: • The HSE inspections and Improvement Notices relating to Legionella; • Review of progress against Internal Health & Safety inspections undertaken; • Plan topic specific inspections and audits; • Monitor compliance with Health & Safety suite of training; • Provide risk assessment guidance and support to Service Managers; • Undertake a desktop review of polices that should sit under Health & Safety; • Support the co-ordination of the Stress Steering Group; • Compile the Annual Health & Safety Report; • Training delivery/coordination The Health & Safety Forward Work Programme can be found at Appendix 1. The Director of Workforce, OD and Support Services advised that during Q1 2020/21 the Health and Safety team have had to respond to managing 'business as usual' Health and Safety aspects, alongside supporting PTHB in managing its Health and Safety responsibilities, during the COVID-19 pandemic. The assessment below provides the Experience, Quality & Safety Committee with an overview of the progress made against the Annual Plan for Health and Safety during Q4 of 2019/20 and Q1 of 2020/21. The Committee Vice Chair queried if the implementation of audit recommendations was being tracked. The Director of Workforce, OD and Support Services confirmed, initial feedback and recommendations had been received. The Committee Chair thanked the Director of Workforce, OD and Support Service and noted, on attendance of the Audit Committee positive progress had been made.

	The Director of Workforce, OD and Support Service noted further work was required on the policy framework, the key would be to ensure it was operationalised. The Committee Chair acknowledged that work around Covid-19 had been significant. The Chief Executive stated regular reports had been received from health and safety. The Committee DISCUSSED and NOTED the content of the update report for the work programme period October 2019 to June 2020.
EQS/20/49	**INSPECTIONS AND EXTERNAL BODIES REPORT** The Executive Director Nursing & Midwifery presented the previously circulated paper which asked the Committee to DISCUSS the report and NOTE areas of good practice and that appropriate actions are underway to address areas identified as requiring improvement. The Committee was also asked to NOTE the pending Phase 2 of the national maternity services review and the correspondence received from Health Inspectorate Wales (HIW) in relation to their future approach to assurance and inspections. It was important to note the Health Inspectorate Wales reports included in the report had been published and were therefore within the public domain. The Executive Director Nursing & Midwifery advised that the paper provides the Committee with an update on the most recent Regulatory Inspections undertaken and also any planned inspections the health board have been notified of. A key theme identified by HIW was the positive and excellent staff engagement with patients thus creating a positive patient experience. In relation to improvements needed, there are no concerns in relation to themes emerging. However, there are several environmental and estates related issues identified as in need of improvements. The health board was constantly striving to make improvements in these areas and would continue to do so in conjunction with the recommendations made by HIW. The questions relating to this item which were received in advance of the meeting were recapped and are available online (https://pthb.nhs.wales/about-us/the-board/committees-partnerships-and-advisory-groups/powys-teaching-health-board-committees/experience-quality-and-safety-committee/meetings-of-the-experience-quality-and-safety-

	committee/experience-quality-and-safety-committee-meeting-on-30-jul/). The Executive Director Nursing & Midwifery noted the pain management findings gave assurance that appropriate pain management would be introduced. Frances Gerrard commented that the HIW report was very positive and congratulated those involved. The Board Secretary raised that the committee should receive a report from the identified responsible individual for Cottage View. The Committee endorsed this. The Committee DISCUSSED this report and NOTED the outcomes of Regulatory Inspections across the health board.
EQS/20/50	**ANNUAL QUALITY STATEMENT** The Executive Director of Nursing & Midwifery presented the previously circulated paper which provided the Experience, Quality & Safety Committee with the draft Annual Quality Statement 2019/20 in readiness for approval and publication no later than the 30 September 2019. The Executive Director of Nursing & Midwifery advised that the AQS first draft was now in place, a few additions would be required to complete. Engagement and feedback were in progress to inform its development and comments would be considered in early August, the intention to complete by mid-August. The Committee Vice-Chair raised the importance of the Annual Quality Statement being a living document to allow progress to be tracked. The Chief Executive noted that it would be important to ensure the focus was to provide an accurate view of positives, challenges and issues. Ensuring the right balance for the population. The Annual Quality Statement should be linked in with the Performance and Quality Report. The Committee Chair confirmed an overarching review would be beneficial. The Committee NOTED and DISCUSSD the Annual Quality Statement, prior to reporting assurance to the Committee the Annual Quality Statement 2019/20 was being

	progressed and was on schedule for approval and publication no later than the 30 September 2019.
ITEMS FOR INFORMATION	
EQS/20/51	**QUALITY & ENGAGEMENT (WALES) ACT** The Board Secretary presented the previously circulated paper which provide an overview of the elements of the Act which would apply to Powys Teaching Health Board upon implementation. The Health and Social Care (Quality and Engagement) (Wales) Bill was passed by the Senedd – formerly, the National Assembly for Wales – on 17 March 2020 and had now received Royal Assent. Having received Royal Assent on 1 June 2020, the Bill was now The Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Board Secretary advised, the overriding aims – to improve the quality of health services and ensure the citizens of Wales are kept at the heart of ever-improving health and social care services – would be realised through its four main objectives: • Strengthen the existing duty of quality on NHS bodies and extend this to the Welsh Ministers in relation to their health service functions; • Establish an organisational duty of candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong; • Strengthen the voice of citizens, by replacing Community Health Councils with a new all-Wales Citizen Voice Body that would represent the interests of people across health and social care; and • Enable the appointment of Vice Chairs for NHS Trusts, bringing them into line with health boards. In his Statement of 3rd June 2020, Vaughan Gething MS, Minister for Health and Social Services, outlined that implementation was expected to take place within a two-year period, recognising the current focus and urgent priority in dealing with the Covid-19 pandemic. The Act was therefore "Not yet in force" and a date by which it would be appointed was to be confirmed, although Spring 2022 was anticipated. Citizen Voice Body, Community Health Councils and CHCs, are scheduled to meet with Welsh Government on the week of 3 August 2020 to go thorough arrangements. The Committee Chair raised that significant work would be created from the impact and compliance. The Board Secretary stated the PTHB would actively engage in

	matters developed. As steps are taken towards implementation it would be necessary to align with the Quality Framework Plan. The Committee NOTED the update for information.
EQS/20/52	**PUTTING THINGS RIGHT ANNUAL REPORT** The Executive Director of Nursing & Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with the Putting Things Right, Claims and Compensation Annual Report 2019/2020 prior to onward approval by the Board. The Executive Director of Nursing & Midwifery advised that it was evident the management and handling of concerns and serious incidents requires further improvement, and actions have been identified to address these areas. Learning from the citizen experience was evident in the report but a greater focus was needed on the learning and sharing of lessons, and assurance that changes had been put in place and sustained. Patient feedback supported the provision of services in Powys as generally positive, but it was recognised work was required to gather feedback from patients irrespective of where they access services, care and treatment. Improvement actions had been identified for 2020/21. The Executive Director of Nursing & Midwifery handed over to the Assistant Director of Quality and Safety. The Assistant Director of Quality and Safety noted there had been positive feedback from Welsh Government regarding the report's accessibility. Owen James raised the importance of quality being a key focus of putting things right. The Committee Chair queried if check points were needed to ensure a suitable level of assurance. The Assistant Director of Quality and Safety stated, going forward PTHB would improve the way concerns are managed, taking account of outcomes and what it means for Powys residents. The Executive Director of Nursing & Midwifery noted that analysing what informs the public Ombudsman's investigation would help inform PTHB.

	The Committee Vice-Chair noted that there should be synergy across reports, the Annual Quality Statement was also moving forward with concerns. Picking up on recurring issues would also be a feature of the Annual Quality Statement. It would be important to ensure PTHB acted on the most important issues and closed the loop. The Chief Executive raised the importance of the effective use of data and intelligence to identify key issues. When responding to requests from reports the Clinical Quality Framework would help guide and stimulate discussion on sources and use of data. Susan Newport queried, under the Concerns Statistics – Commissioned Services section, one of the 62 concerns was the closure of the Pain Management Clinic. The Chief Executive responded, the closure of the Pain Management Clinic refers back to 2019. The NHS trust changed the service around pain management, PTHB therefore was required to respond with a detailed pathway on pain management. This was led by the Assistant Director of Quality and Safety. The Committee NOTED and DISCUSSD the Putting Things Right, Claims and Compensation Annual Report 2019/20 prior to onward approval by the Board.
EQS/20/53	**PSOW ANNUAL REPORT** The Assistant Director of Quality and Safety presented the previously circulated paper which provides the Committee with an overview of the Public Services Ombudsman (Wales) Act 2019, resulting in changes to the jurisdiction of the Public Services Ombudsman for Wales and how it may affect the health board. In addition to providing a copy of The Public Services Ombudsman for Wales Annual Report and Accounts 2019/2020. The Assistant Director of Quality and Safety advised the Public Services Ombudsman (Wales) Executive Summary, Annual Report and Accounts 2019/2020 had been published. The Committee Chair noted the report provided a good overview. There were no questions. The Committee NOTED the annual Public Service Ombudsman for Wales Report and the Executive Summary.
EQS/20/54	**COMMITTEE ANNUAL WORKPLAN 2020/21**

	The Board Secretary presented the previously circulated paper which provided the Experience, Quality & Safety Committee with the 2020/21 workplan, as at July 2020. The Board Secretary advised the workplan outlined planned pieces of work for meetings scheduled during 2020/21. The Board Secretary note the Committee Workplan 2020-21 was APPROVED by Board on 29 July 2020. The Committee NOTED the 2020/21 Committee workplan.
OTHER MATTERS	
EQS/20/55	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be reported.
EQS/20/56	**ANY OTHER URGENT BUSINESS** There was no urgent business. The Committee Chair thanked all members.
EQS/20/57	**DATE OF THE NEXT MEETING** 1 October 2020, 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/19/22	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: 3.1a

Experience, Quality and Safety Committee	DATE OF MEETING: **01 October 2020**
Subject:	**Safeguarding Annual Report - 2019/20**
Approved and Presented by:	Executive Director of Nursing and Midwifery
Prepared by:	Jayne Wheeler-Sexton, Assistant Director of Nursing, Safeguarding
Other Committees and meetings considered at:	PTHB Safeguarding Group – 11.08.20 Quality Governance Group

PURPOSE:
The purpose of this paper is to provide an overview of the PTHB Safeguarding Annual Report 2019/20.
RECOMMENDATION(S):
The Committee is asked to DISCUSS and NOTE the report.

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 Annual Safeguarding Report outlines the key areas of development and achievement which have supported PTHB to meet its statutory responsibilities in safeguarding the people of Powys during 2019/20. Additionally, areas for improvement and recommendations for further development in the forthcoming year are highlighted.

DETAILED BACKGROUND AND ASSESSMENT:

Powys Teaching Health Board (PTHB) has a statutory duty to safeguard adults and children at risk and to promote their wellbeing. The Safeguarding Annual Report outlines, with some examples, how the safeguarding service is performing and promoting best practice. The report provides an update on safeguarding priorities during 2019/20 and identifies safeguarding key issues and priorities for 2020/21. It is recognised we need to build on that already achieved, to ensure that PTHB and all contracted services meets its statutory responsibilities, for preventing harm and acting on concerns about welfare in the delivery of services for people who live in, work in or visit Powys.

key areas of development and improvement during 2019/20

- Staff briefed on the new National Wales Safeguarding Procedures (2019) ahead of their launch in November 2019 and implementation in April 2020. A 7-minute briefing was developed and shared across the organisation to highlight the changes within the procedures.
- In consultation with WOD, the Safeguarding Team developed the Safeguarding Level 3 and Level 4 Training and Competency Passport, this was launched during National Safeguarding Week.
- ESR was updated to ensure a robust system is in place to accurately capture Level 3 and Level 4 safeguarding training compliance.
- Safeguarding adults Level 3 training launched.
- PTHB in conjunction with partner agencies commenced an audit into managing high risk victims of domestic abuse more efficiently and effectively.
- Commenced a programme of quality assurance (QA) of statutory health assessments of Looked After Children using the newly developed QA tool.
- PTHB *Managing Allegations of Abuse or Neglect made against Staff* policy ratified
- VAWDASV Group 1 Training reached 91% compliance
- Deprivation of Liberty Safeguards Policy and Procedure ratified. Implementation of Deprivation of Liberty Safeguards Training pack and 7 Minute Briefing
- Improvements made in Safe Recruitment with DBS checks carried out on all new staff and back log of outstanding check consistently reducing

Areas for Development in 2020/21

Improving Knowledge and Skill:

- Continue roll out of Group 2 Ask and Act training to all staff groups.
- Build on a Modular Training approach and offer training in different formats
- Improve knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards across services and commence preparations for the introduction of Liberty Protection Safeguards.
- To develop the MCA Policy and training pack.
- To update all Safeguarding Policies in line with the new Wales Safeguarding Procedures.
- Introduce Safeguarding Newsletter with 'What's New' in Safeguarding and Topic of the Month
- Develop suite of 7-minute Briefings

Service Development:

- Complete the 2020/21 NHS Wales Safeguarding Maturity Matrix, further building on areas identified for improvement.
- Update the Safeguarding Strategic Group Terms of Reference and establish a Safeguarding Operational Group

Partnership Working:

- Continue to be engaged with the Liberty Protection Safeguards Strategic Implementation Steering group helping in the preparedness for implementation of Liberty Protection Safeguards (MCA amendment).
- Contribute to the development of a regional policy on self-neglect via the Regional Adult Safeguarding Group.
- Fully launch the Powys' Children's Charter in collaboration with Powys Local Authority embedding children's rights throughout the health board
- Continue to work with the South, Mid and West Wales SARC Collaborative to develop a model and pathways for service provision for those affected by rape and sexual assault.
- Progress the relevant priorities identified in the Regional VAWDASV Strategy.
- PTHB are represented at the Children (Abolition of the Defence of Reasonable Punishment) (Wales) Bill

NEXT STEPS:

- The approved Safeguarding Annual Report 2019/20 will be accessible to staff via the PTHB Safeguarding Intranet Page.
- Areas identified for development in 2020/21 will inform the Safeguarding Maturity Matrix Improvement Plan

Safeguarding Annual Report 2019-2020

Contents

Introduction

Powys Teaching Health Board (PTHB) is responsible for providing health care and well-being services for approximately 133,000 people living across the area of Powys, that is a quarter of the landmass of Wales. The Health Board is responsible for the health services both provided and commissioned on its behalf.

PTHB employs 2669 members of staff, including 480 bank staff, with care being delivered across a network of services. The geography and rurality make access a challenge and the fragility of services around our borders presents a complex risk, which requires the health board to be innovative and creative to ensure timely access to high quality services to meet people's needs.

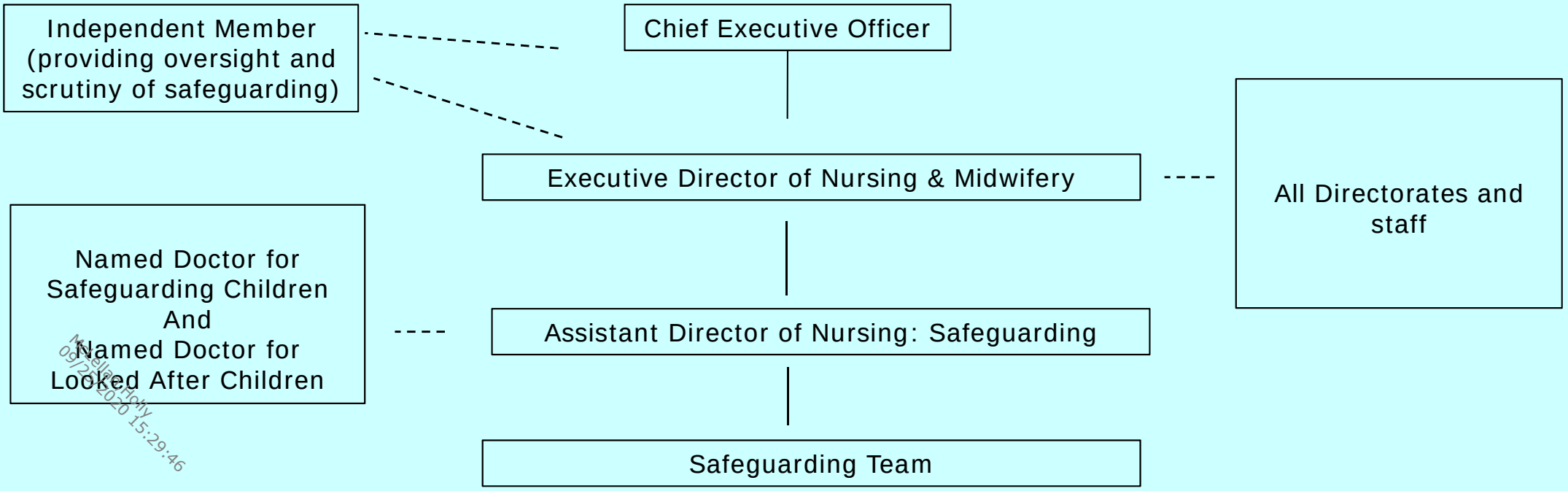
Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business and recognises that safeguarding children and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals.

This annual report outlines, with some examples, how the safeguarding service is performing and promoting best practice. The report provides an update on safeguarding priorities during 2019/20 and identifies safeguarding key issues, risks and priorities for 2020/21. It is recognised we need to build on that already achieved, to ensure that PTHB and all contracted services fully meets its statutory responsibilities, for preventing harm and acting on concerns about welfare in the delivery of services for people who live in, work in or visit Powys.

Introduction

The Chief Executive assumes overall responsibility for safeguarding, with the Executive Director of Nursing and Midwifery as the delegated Executive Lead for Safeguarding. The Health Board's Vice Chair is the designated lead Independent Member for children's and young people's services with responsibility for providing oversight and scrutiny of the broader safeguarding agenda.

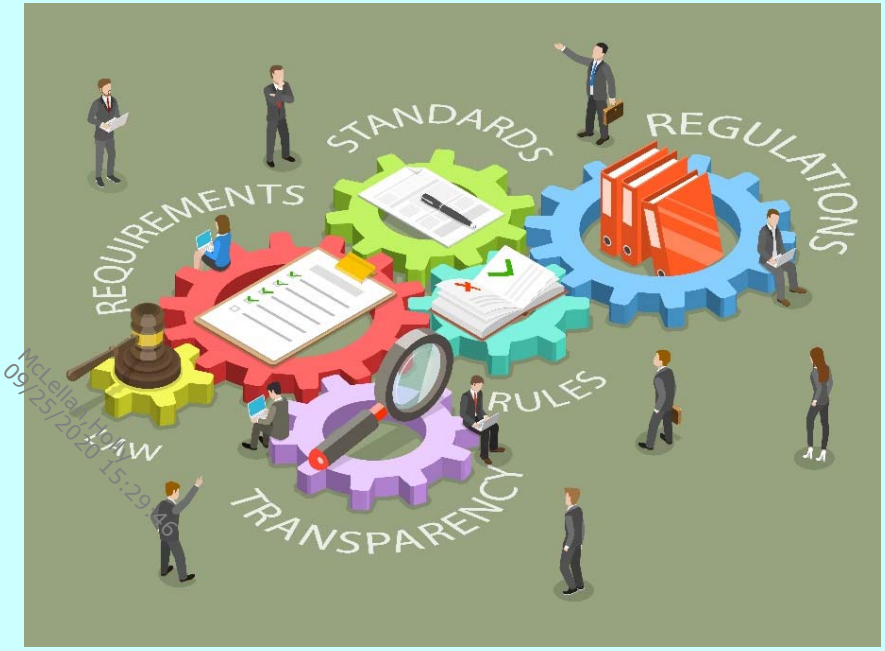
Safeguarding Lines of Accountability



Governance

Governance and Reporting Arrangements

The PTHB Safeguarding Group met quarterly in 2019/20, acting as a forum for sharing learning from Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews and audits; disseminating changes in legislation, policy and guidance; monitoring compliance with safeguarding mandatory training and sharing information from external meetings such as the Regional Safeguarding Board, the Local Safeguarding Operational Group and the NHS Safeguarding Network.



Governance Reporting Structure

- Board
- Experience, Quality and Safety Committee
- Quality Governance Group
- Safeguarding Group
- Team/Service Meetings

Governance

Legislation and associated guidance details the roles and responsibilities of agencies in relation to safeguarding and public protection. This includes levels of accountability; responsibilities and duties of staff; the skills and competencies required by staff to perform their duties; handling individual cases and effective interagency working at all levels. These include;

- Children Act 1989
- Children Act 2004
- United Nations Convention on the Rights of the Child UNCRC
- Wales Safeguarding Procedures (2019)
- Working Together to Safeguard Children (2018)
- Protecting Children & Young People, GMC (2012)
- Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff – January 2019 4th Edition
- Adult Safeguarding: Roles and Competencies for Health Care Staff – August 2018 1st Edition
- Social Services & Well-being (Wales) Act 2014
- NSF, Health Inspectorate Wales, Vulnerable Groups Act (2006)
- NICE 16, Standard 13 (Vulnerable Groups)
- In Safe Hands (2000) [*currently under review*]
- Mental Capacity Act 2005 & Mental Capacity (Amendment) Bill 2019 (Liberty Protection Safeguards)
- Dignified Care: Two Years On (2014): Older Peoples
- Violence Against Women, Domestic abuse and Sexual Violence (Wales) Act 2015
- Mental Health Act, 1983
- Health and Care Standards (April 2015) Standards 2.7
- Counter Terrorism and Security Act 2015
- The Well Being of Future Generations (Wales) Act 2015

Update on Safeguarding Priorities 2019/2020

Some key areas of developments and improvement during 2019-20:

- Staff briefed on the new National Wales Safeguarding Procedures (2019) ahead of their launch in November 2019 and implementation in April 2020. A 7 minute briefing was developed and shared across the organisation to highlight the changes within the procedures.

- In consultation with WOD, the Safeguarding Team developed the Safeguarding Level 3 and Level 4 Training and Competency Passport, this was launched during National Safeguarding Week. ESR was updated to ensure a robust system is in place to accurately capture Level 3 and Level 4 safeguarding training compliance.

- Safeguarding adults Level 3 training launched.

- PTHB in conjunction with partner agencies commenced an audit into managing high risk victims of domestic abuse more timely and effectively.

- Commenced a programme of quality assurance (QA) of statutory health assessments of Looked After Children using the newly developed QA tool.

- Children's Pledge Launched on Children's Rights Day

- PTHB *Managing Allegations of Abuse or Neglect made against Staff* policy ratified

- VAWDASV Group 1 Training reached 91% compliance

- Deprivation of Liberty Safeguards Policy and Procedure ratified. Implementation of Deprivation of Liberty Safeguards Training pack and 7 Minute Briefing

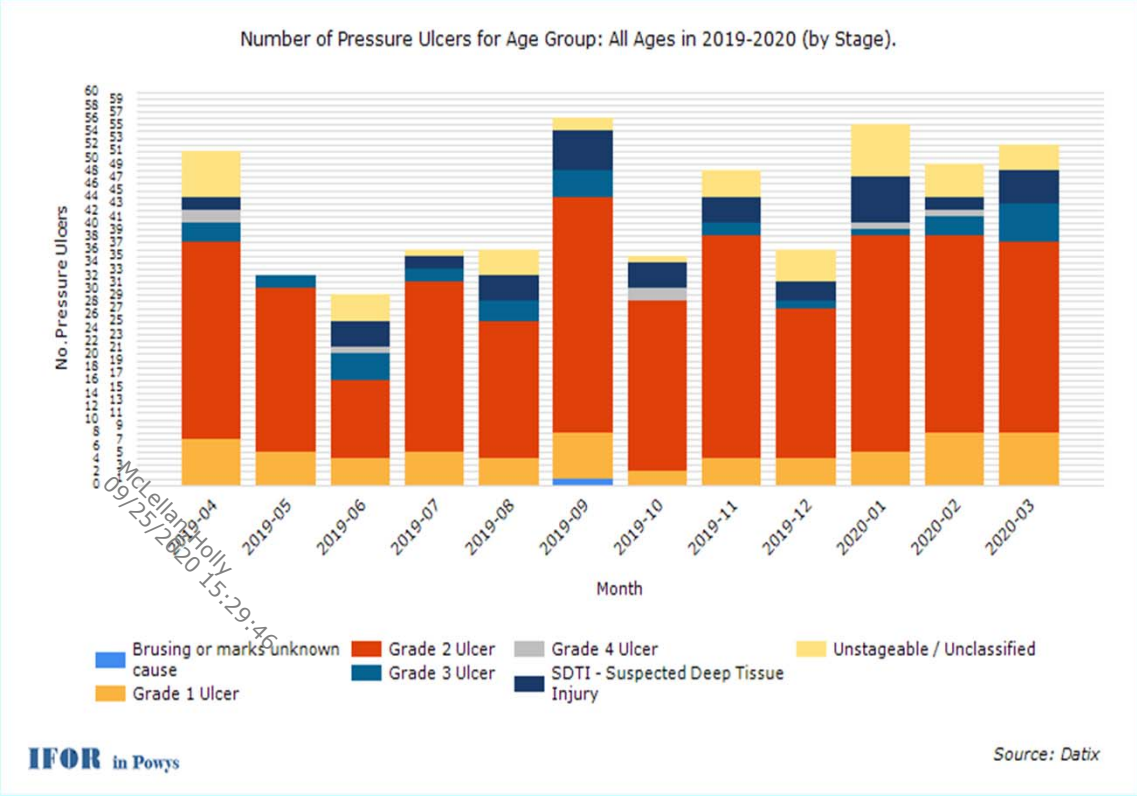
- Improvements made in Safe Recruitment with DBS checks carried out on all new staff and back log of outstanding check consistently reducing

Safeguarding People

Pressure Damage

PTHB Pressure Ulcer Policy and Pathway which clearly defines when to make a safeguarding report is currently out for consultation. A senior member of the safeguarding team is a panel member on the PTHB Pressure Damage Scrutiny Meeting which promotes learning, challenge and best practice.

Table 1. PTHB Pressure Damage 2019-2020 as at 31.03.20



Deprivation of Liberty Safeguards (DOLS)

In 2019 an internal audit was undertaken into the Deprivation of Liberty Safeguards inline with the internal audit plan, the results of which was limited assurance. In response to this audit the Safeguarding Team have developed the following:

- SGP042 Deprivation of Liberty Policy and Procedure which was ratified in November 2019
- DoLS training pack with 6 training sessions offered.

- A action from the audit was to develop a Mental Capacity Act 2005 Policy and a Mental Capacity Act training pack

Table 2. PTHB DoLS Data 2019/2020 as at 31.03.20

Number of DoLS Granted - Total	63
% completed in Timescales - Total	43%
Number Granted - Urgent	48
Number completed in Timescales - Urgent 7 days	15
% completed in Timescales - Urgent 7 days	31%
Number Granted - Standard	14
Number completed in Timescales - Standard 21 days	12
% completed in Timescales - Standard 21 days	86%

Safeguarding People

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Violence against women, domestic abuse and sexual violence are large scale, pervasive problems, which every year causes needless deaths and damage to thousands of lives across Wales. Violence and abuse in any form is unacceptable.

Those who experience these forms of violence and abuse are known to under-report and official data therefore represents an under representation of the problem.

Violence against Women, Domestic Abuse and Sexual Violence has far reaching consequences for families, children, communities and society. The direct harm to the health and well-being of victims is clear, and at its most severe can, and does, result in death. However, impacts are wide-ranging not just on health and wellbeing but include human rights, poverty, unemployment, homelessness and the economy.

PTHB is represented at the Regional VAWDASV Strategic Group, the Regional Delivery sub-group and the NHS Safeguarding Network VAWDASV Working Group, helping to ensure Powys continues to embed the VAWDASV (Wales) Act 2015

The VAWDASV National Training Framework sets out minimum standards for training across all public services.

The training framework outlines groups of training from one to six.
Group 1 is for all health board staff to complete at least once.

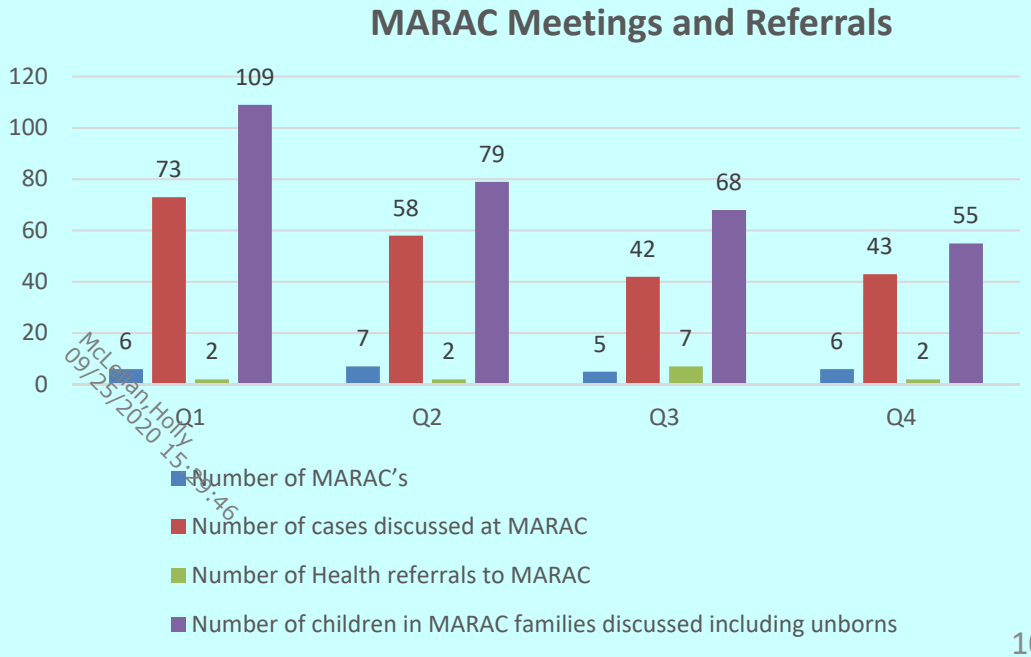
The Safeguarding Team have been proactive in promoting VAWDASV especially during lockdown as there has been increased concern about the hidden harm. The Safeguarding Team have continued to actively engage with our partner agencies within the MARAC process and the Daily Domestic Abuse discussions.

Safeguarding People

Multi Agency Risk Assessment Committee (MARAC)

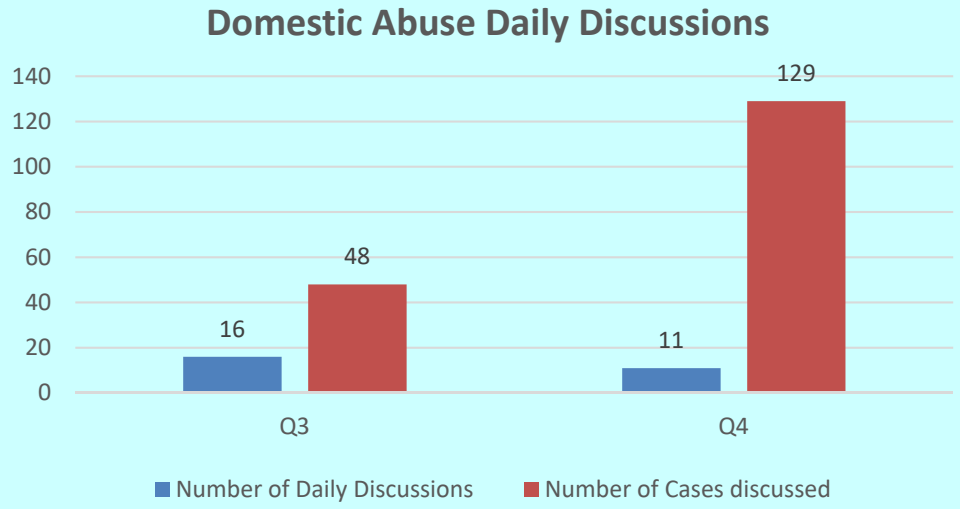
The Safeguarding Team continues to represent PTHB at fortnightly MARAC meetings, helping to develop plans to ensure high risk victims of domestic abuse and their children are safeguarded. A total of 216 cases were discussed at MARAC during 2019/2020.

Table 4: Number of MARAC meetings and referrals from PTHB 2019/2020



Domestic Abuse Daily Discussion (DADD) Pilot

DADD is a multi agency conference call where all high risk case of VAWDASV are discussed within 48 hours of the domestic incident. This enables earlier intervention, a single point of contact for the victim, joint decision making and decisions around Claire's Law disclosures are made earlier. If a decision is made to go to MARAC, the MARAC is better informed regarding risk and it is possible to review the actions agreed at the daily discussion call. If a key agency is not available, the case will be put forward to MARAC. The Pilot appears to be having the intended impact on supporting and protecting high risks victims more timely and reducing the number of MARAC cases allowing more robust discussions of the cases in MARAC.



Safeguarding People

Multi-agency Public Protection Arrangements (MAPPA)

The Safeguarding team has supported the work of the MAPPA Senior Management Board (SMB) by the attendance of the Senior Nurse for Safeguarding at a Quality Assurance Event held in Powys in January 2020. A quality assurance tool kit was developed to review a sample of MAPPA Level 2 and 3 cases from across the region to provide assurance to the SMB that MAPPA arrangements are working effectively and to identify any improvement needed.

2019/20	MAPPA 2 Meetings	Number of cases discussed	MAPPA 3 Meetings	Number of cases discussed
Q1	2	5	1	1
Q2	3	10	3	1
Q3	3	6	4	1
Q4	3	11	2	1

MAPPA Strategic Management Board and the Wales Integrated Serious and Dangerous Offender Management (WISDOM) meetings are attended by Senior Managers within PTHB Mental Health Services.

PREVENT

PTHB via the Safeguarding Team are engaged the PREVENT agenda, representing PTHB on the local PREVENT Operational Group and at the National PREVENT forum. One Channel Panel (the multi-agency process to identify and support individuals at risk of being drawn into terrorism) was held in Powys during 2019/20.

Safeguarding People

Modern Slavery encompasses:
Human trafficking Slavery, servitude and forced or compulsory labour. The Modern Slavery Act 2015 gives law enforcement the tools to fight modern slavery, ensure perpetrators can receive suitably severe punishments for these appalling crimes and enhance support and protection for victims.
A Senior Representative from the PTHB Safeguarding Team will represent the Health Board at any Modern Slavery MARAC's held.

During 2019/2020 there was 1 Modern Slavery MARAC.

PTHB is represented at the quarterly Regional Anti-Slavery Group meetings.

Child Sexual Exploitation
During 2019/20 there were 5 Powys Multi-agency Child Sexual Exploitation(MACSE) meetings. PTHB were represented by a senior member of the Safeguarding Team. The purpose of the MACSE meetings has changed over the last 12 months from reviewing and planning the risk management of children at risk of Child Sexual Exploitation (CSE), to a strategic oversight meeting.

The new approach is currently being embedded. MACSE is now to be known as Multi agency Child exploitation (MACE) which encompasses all forms of child exploitation. A CSE Strategy is currently being developed by Powys County Council to reflect the changes.

Female Genital Mutilation (FGM)

Quarterly mandatory reporting to Welsh Government identified that there were **no** known cases of FGM in Powys during 2019/20.

Safeguarding People

Looked After Children (LAC)

292 Health Assessments of Looked After Children were completed during the reporting period with 76% completed within statutory timescales. Due to COVID 19 a number of health assessments for children living out of county were completed by the PTHB LAC Nurses via the telephone.

There has been delay in receiving some child placement notifications and record of consent from the allocated social worker, this will continue to be monitored throughout 2020/21

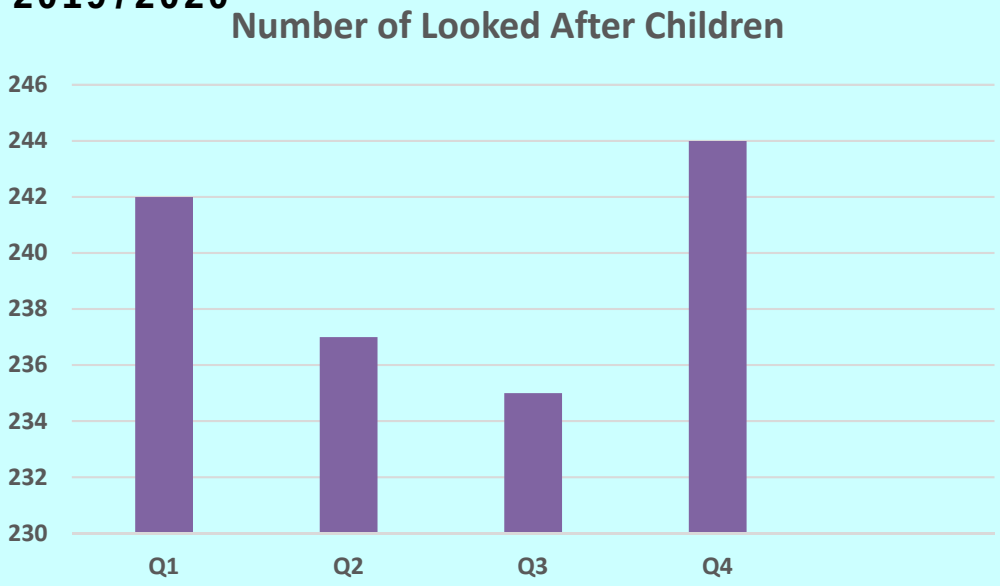
Quarterly reports on compliance with statutory timescales are presented at Powys Corporate Parenting Group.

The views of Looked After Children (LAC) are captured during statutory health reviews and help to shape the child's LAC Review.

Development of an IFOR database for Looked After Children (LAC). This went live in May 2019 and has supported speedier and more accurate LAC data thereby promoting greater compliance with statutory health assessment and reporting.

New LAC Health Assessment documentation has been piloted. Feed back from practitioners was very positive noting it to be more succinct. The new assessment tool has now been formally adopted and being used Nationally.

Table 5. – Number of Looked After Children 2019/2020



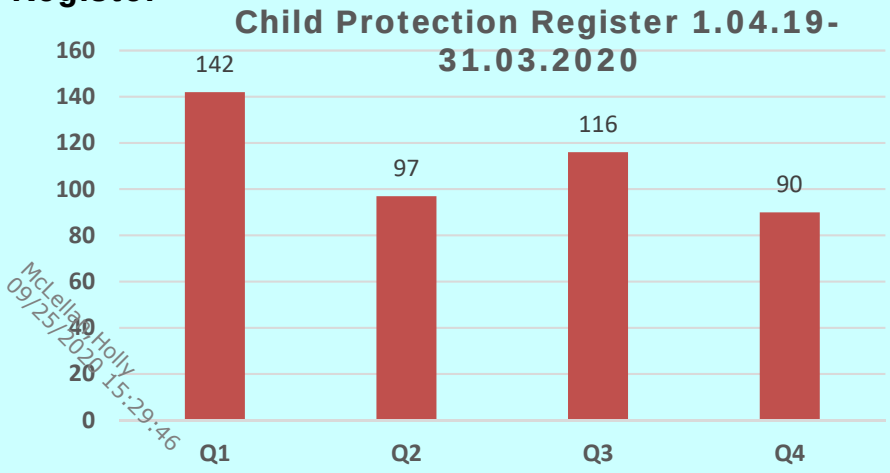
Safeguarding People

Powys Teaching Health Board staff have a duty and responsibility to co-operate with the child protection process, keeping the child as the main focus.

Throughout 2019-2020 the graph below demonstrates the amount of children on PCC Child Protection Register.

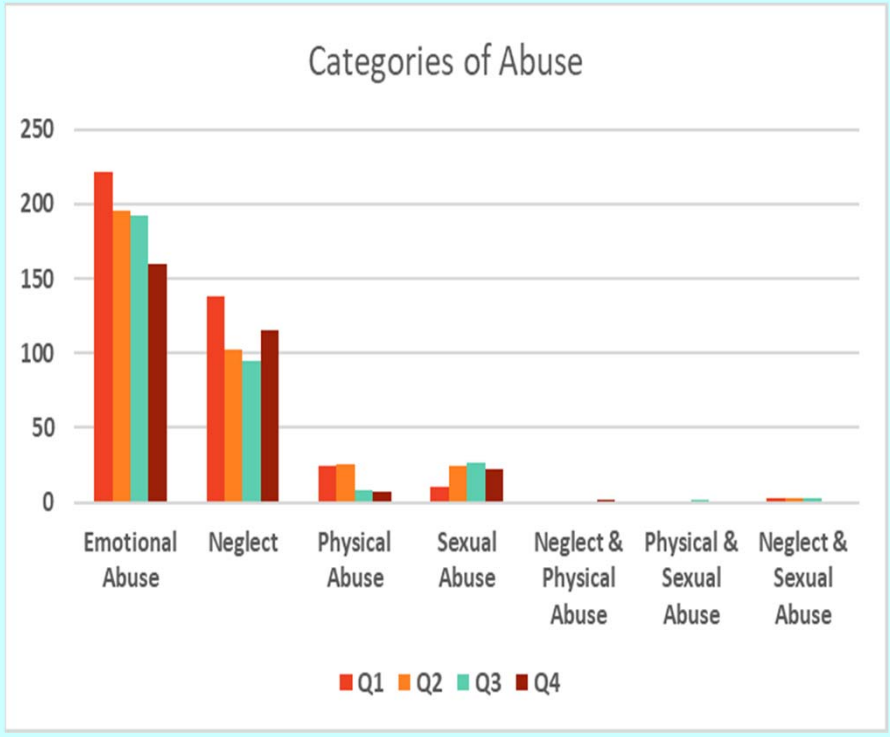
The introduction of intervention & prevention services and embedding of Signs of Safety, along with increased work with families has been attributed to the reduction in CP registrations.

Table 6 - Number of Children on Powys Child Protection Register



Emotional abuse and neglect are the highest categories for child protection registration throughout all quarters.

Table 7.– Categories of Child Protection Registration as at 31.03.19



Procedural Response to Unexpected Death in Childhood (PRUDIC)

The Procedural response to the Unexpected Death in Childhood (PRUDiC)

PRUDiC sets the minimum response for unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

PTHB PRUDiC leads are the Senior Nurse for Safeguarding
There have been a number of changes to the PRUDiC Process which aim to strengthen partnership working around child death. It is envisaged that the involvement of the RSCB will ensure that the process is fully implemented in every case and that lessons learnt will be instrumental in preventing future child deaths.

The procedural response will be followed when:

- a decision has been made that the death of a child is unexpected or
- there is a lack of clarity about whether the death of a child is unexpected or
- the cause of a child's death is not apparent and it is not possible to issue a death certificate

In 2019/20 there were 2 child deaths that have been managed via the PRUDiC process

Supporting Staff

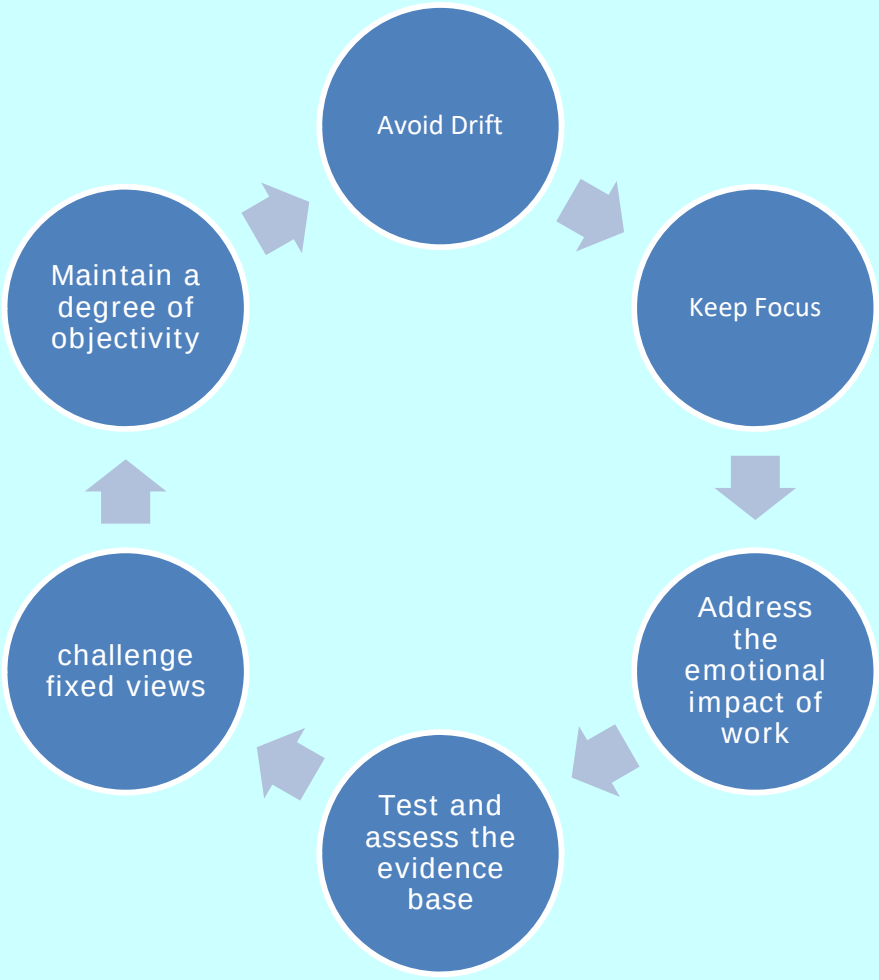
Safeguarding Supervision

Powys Teaching Health Board is responsible for ensuring that all staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults.

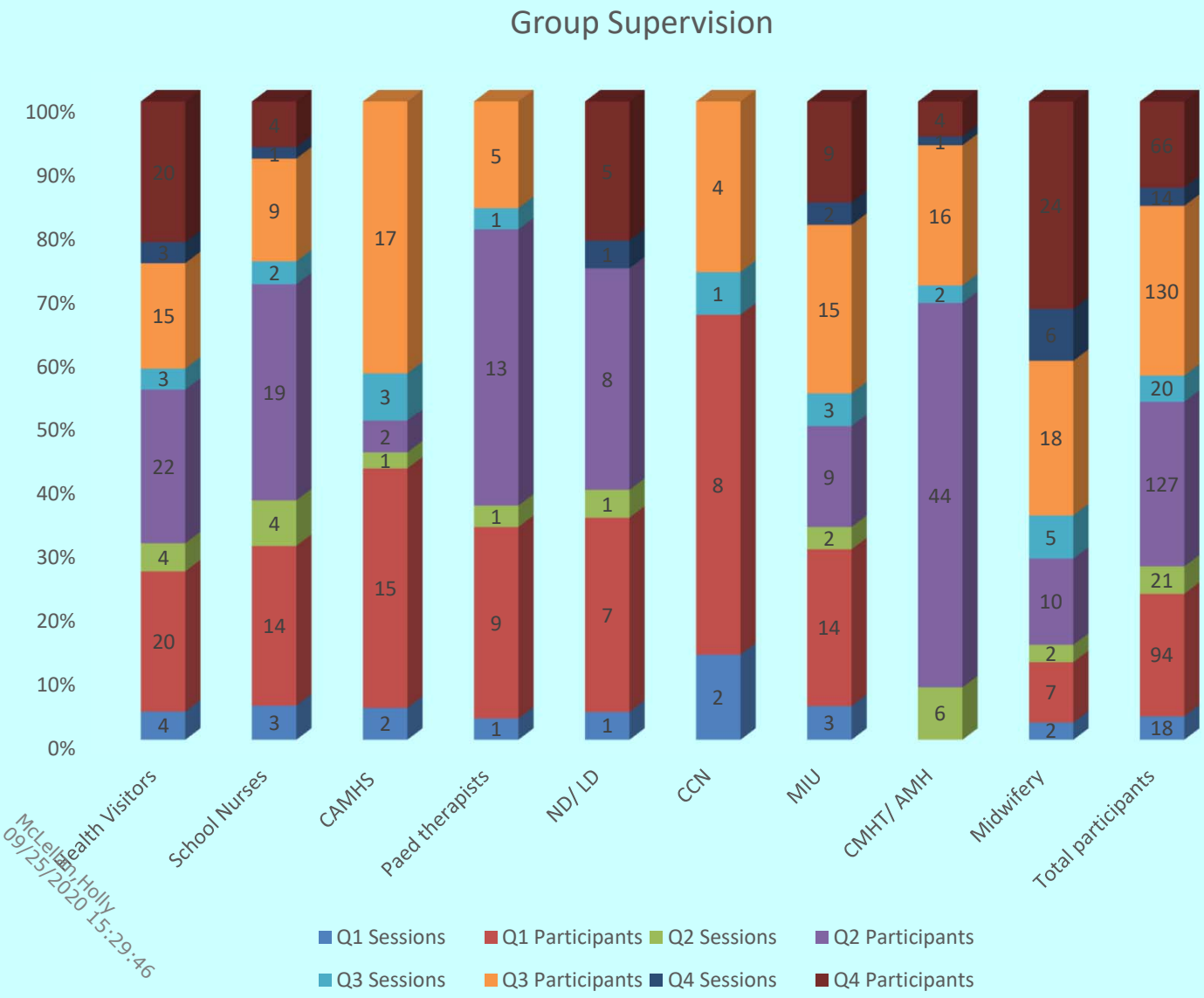
Staff should be able to raise concerns and feel supported in their safeguarding role.
Effective supervision is important in promoting good standards of practice and to support individual staff members; it should assist in ensuring health practitioners are competent and confident and provides a safe environment for challenging practice

Practitioners can access the safeguarding team for advise, support and supervision.
This can be ad hoc, one to one or via group supervision

Safeguarding supervision primary functions are to;



Supporting Staff



Supporting Staff

Policies and Guidance

Policies and procedures support and underpin the health boards response to how we keep people, our staff and our health board safe. During the last year there has been a focus on strengthening existing policies, procedures and guidance documents, along with developing new ones.

In addition we have provided feed back at each consultation phase during the development of the new National Safeguarding Procedures. The Procedures were launched in November 2019 and become in to force April 2020

Revised or new PTHB Safeguarding Policies, Protocols & Guidance 2019/2020

SGP 002 Safeguarding Supervision Protocol
SGP 005 Bruising in Non Mobile Babies and Babies under One Year Old Guidelines for Health Professionals
SGP 011 Operational Policy for Child Protection Medicals
SGP 012 Looked After Children (LAC) Guidance for Health Professionals
SGP 026 Graded Care Profile Guidelines
SGP 034 PREVENT Policy
SGP 035 Child Sexual Exploitation Guidance For Health Professionals Guidelines
SGP 036 Safeguarding Policy
SGP 039 VAWDASV Policy
SGP 041 Managing allegations of abuse or neglect made against professionals and members of staff (Oct_2019)
SGP 042 Deprivation of Liberty Safeguards (DoLS) Policy
SGP 049 Mental Capacity Act

PTHB have Contributed to the Regional and National Policies/ Procedures and Guidance during 2018/2019

- Regional Threshold and eligibility for support document The right help at the right time
- Regional Adult Safeguarding Threshold guidance
- Injuries in non mobile babies and children
- Regional Resolution of professional differences
- Regional protocol for safeguarding children affected by parents who are experiencing mental ill health
- Regional information sharing protocol
- Regional Safeguarding board complaints policy
- Community Safeguarding and public incidents policy and procedure
- Regional Elective home education protocol
- Regional Suicide prevention Assessment tool

Education and Training

A data cleanse of ESR was undertaken during 2019. Safeguarding Adults Level 3 competency became mandatory for over 750 staff. Safeguarding Children Level 3 has been mandatory for a number of years for approximately 250 staff. In order for staff to demonstrate compliance a training and competency passport was designed and launched during National Safeguarding Week in November 2019. The Competency Passport can be located at PTHB Training and Competency Passport.

During 2019/20 the following training was available to staff.

E learning:

- Safeguarding Adults and Children Level 1, (this was re launched in September 2019 and became one training package called Safeguarding People)
- Safeguarding Adults and Children Level 2

Delivered Training

- Level 3 Safeguarding Adults, Ask and Act, MCA and Deprivation of Liberty Safeguards.
- Participation in all classroom sessions was poor and a new approach needed to be considered to enable staff to achieve the training and competencies.

Level of Training	Frequency	No. of substantive staff required to undertake tr aining	No. completed training	Percentage Compliance	No. of Bank staff required to undertake training	No. completed training	Percentage Compliance
Child Level 1	3 years	883	737	83%	429	249	58%
Adult Level 1	3 years	856	683	80%	429	231	54%
Child Level 2	3 years	1238	1026	83%	927	608	66%
Adult Level 2	3 years	707	593	84%	556	329	59%
Child Level 3	3 years	213	76	36%	50	14	28%
Adult Level 3	3 years	776	151	19%	451	64	14%
Adult Level 4	3 years	5	3	60%	0	0	
Child Level 4	3 years	8	3	38%	0	0	
VAWDASV	3 years	2318	1876	81%	1456	913	63%

Learning from Reviews

The Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People: Volumes 2 and 3 sets out arrangements for multi-agency adult and child practice reviews in circumstances of a significant incident where abuse or neglect of a child or adult at risk is known or suspected.
The Corporate Safeguarding Team, along with other key staff from the Service Area's continue to engage with a number of Adult or Child Practice Reviews commissioned by the Mid and West Wales Safeguarding Board.

A Domestic Homicide Review is a multi-agency review of the circumstances in which the death of a person, aged 16 or over, has or appears to have resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. There is a statutory requirement for agencies to conduct DHRs within Home Office guidance (*Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016).* The Community Safety Partnerships within each Locality Authority area lead on DHRs

There was one published Child Practice Review during 2019-20
An action plan was developed by the Safeguarding team and representatives from Midwifery and Health Visiting to address the following;

- **Systems to improve communication between GPs, HVs and MWs should be put in place to promote information sharing about vulnerable people and to develop a holistic approach to supporting them.**
- **A review of discharge procedures from midwifery services is required to consider good practice standards when there is a safeguarding concern.**
- **All agencies should promote safeguarding training to ensure that all staff, volunteers and contractors are confident to make safeguarding referrals.**
- **A regional protocol for injuries in non- mobile babies should be developed.**

All actions have been completed and reported to the Regional Safeguarding Board.

Improving Quality

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which addresses the interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents and reviews. The self assessment tool is completed by each NHS Health Board and Trust annually and the improvement plans and scores submitted to the National Safeguarding Team, to inform the national report through the NHS Wales Safeguarding Network to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales

National Safeguarding Week

National Safeguarding Week was held between 11th and 15th November 2019. During this both the Deprivation of Liberty Safeguards Policy and Procedure and the Competency Training Passport were launched.

Safeguarding Training was made available to staff during the week.
Throughout the organisation 8 notice boards displayed safeguarding and public protection information including safe sleep, DoLS 7 minute briefing, information sharing and safeguarding team contacts

COVID 19 and the Impact on Safeguarding

February 2020 saw the start of the Coronavirus pandemic. This new virus swept through the world with unimaginable consequences to people lives and the communities. The NHS response was extraordinary as the modelling was predicting many deaths from this unknown invisible disease. In preparation to save lives PTHB response was to prepare all staff and services to deliver care and services outside of their normal duties and different ways of working for everyone.
From the start of the pandemic the Safeguarding Team looked at different ways of working across the organisation while striving to deliver the same standard of service. The team adapted extremely well to the situation, a single point of contact was established, staff were supported to work from home and continued to work effectively and efficiently in new environments.

Changes to practice during the pandemic include:

- Weekly meetings with Safeguarding Boards representatives to share regional challenges, lessons learnt and to enable speedy solutions to any issues identified
- Weekly meeting with PCC and colleagues to address local issues and provide local solutions
- The Looked After Children's Nurses undertaking children's health assessments and discussing any concerns over the telephone or digital platforms
- Set up weekly meetings to support the COVID 19 response within children's homes
- Group Supervision via skype
- Delivery of Safeguarding Level 3 training and Ask & Act via skype
- Developed a modular training approach
- Reaching out to staff groups in MIU's
- Regional agreement to DoLS and MCA

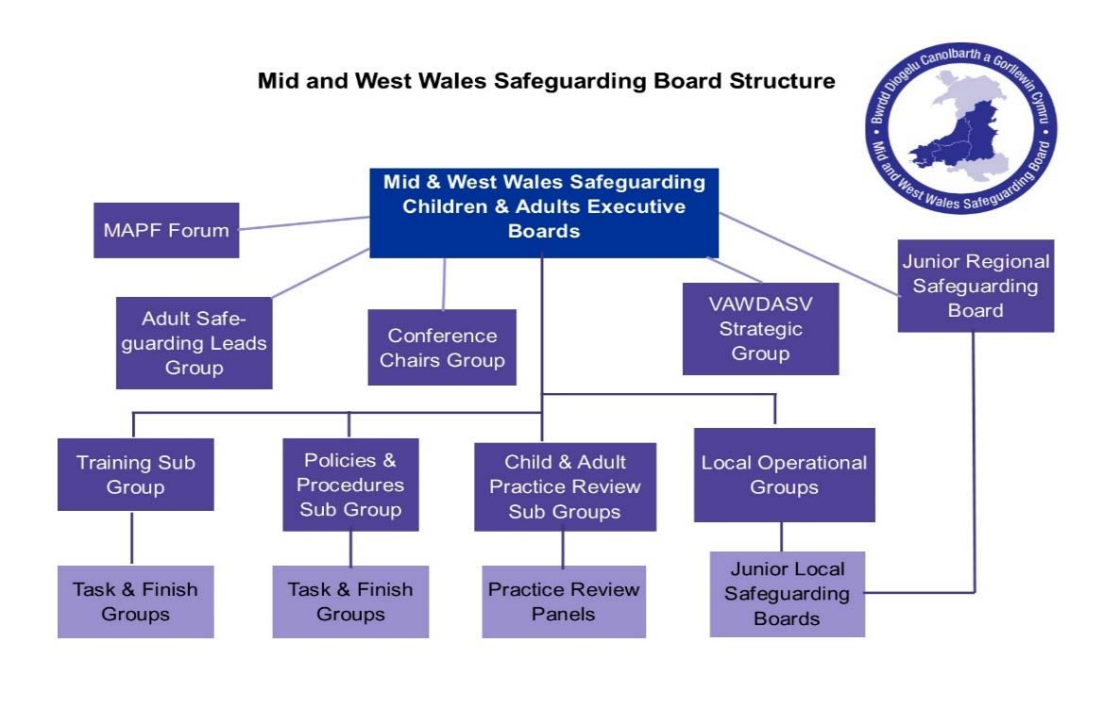
Partnership Working

PTHB has continued to make a significant contribution to the work of the Mid and West Wales Safeguarding Board and to demonstrate a strong commitment to partnership working. Senior managers are represented at the Executive Board, Powys Local Operational Group and all Board Sub Group meetings, supporting the ongoing development of safeguarding practice at a regional and local level. Engagement with our Junior Board members continues to develop our understanding of children's views of safeguarding and what matters most to them.

PTHB are represented on the VAWDASV Board and the sub groups.

PTHB are represented on the SARC Oversight and Assurance Board

At a national level, PTHB is an active member of the NHS Wales Safeguarding Network, contributing fully to all aspects of its 2019/20 work plan. Key achievements include the continued development of the Safeguarding Maturity Matrix and Peer Review, publication of the National Safeguarding Training Framework, contribution to the Wales Safeguarding Procedures(2019) and the ongoing work around VAWDASV.



Areas for Development 2020/21

Improving Knowledge and Skill:

- Continue roll out of Group 2 Ask and Act training to all staff groups.
- Build on a Modular Training approach and offer training in different formats
- Improve knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards across services and commence preparations for the introduction of Liberty Protection Safeguards.
- To develop the MCA Policy and training pack.
- Ensure staff are briefed on the new Safeguarding Procedures.
- To update all Safeguarding Policies inline with the new Wales Safeguarding Procedures.

- Continue to work with Workforce colleagues to identify a robust system to accurately capture Level 3 safeguarding training compliance.
- Introduce Safeguarding Newsletter with 'What's New' in Safeguarding and Topic of the Month
- Develop suite of 7 minute Briefings

Service Development:

- Continue to embed the group model of safeguarding supervision
- Expand the pool of senior managers in PTHB able to participate as panel members in statutory safeguarding reviews.
- Complete the 2019/20 NHS Wales Safeguarding Maturity Matrix, further building on areas identified for improvement.
- Update the Safeguarding Group Terms of Reference and establish a Safeguarding Operational Group

Areas for Development 2020/21

Partnership Working:

- Continue to be engaged with the Liberty Protection Safeguards - Strategic Implementation Steering Group in Wales and the National Safeguarding Team work plan objective to support NHS Wales preparedness for implementation of Liberty Protection Safeguards (MCA amendment).
- Contribute to the development of a regional policy on self neglect via the Regional Adult Safeguarding Group.
- Finalise and then launch the Powys' Children's Charter in collaboration with Powys Local Authority.
- Continue to work with the South, Mid and West Wales SARC Collaborative to develop an agreed model and pathways for service provision for those affected by rape and sexual assault.
- Progress the relevant priorities identified in the Regional VAWDASV Strategy 2019/20 Delivery Plan.
- PTHB are represented at the Children (Abolition of the Defence of Reasonable Punishment) (Wales) Bill

Impact of Lock down from a Looked After Childs perspective

I was upset I may never have the opportunity to do simple things again like go to Primark or something again

I was very uncertain about the future and what's going to happen with school, work, that kind of thing.

people are very selfish

Everything has completely changed

I didn't know what was going to happen if staff got sick.

Contact with family has completely stopped

I do think that people have been very irresponsible. It makes me feel upset and frustrated

I was worried my mental health would spiral

it's not a family situation

the only thing I'm allowed to do is go to the garage

I was talking to people a lot on line but then eventually I just kind of stopped.

If I wasn't in lockdown I'd be in work by now

I was scared

It is very difficult spending ten weeks completely on your own in a care home

It's like living on an isolated island

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.2

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 1 OCTOBER 2020**
Subject:	**COMMISSIONING ESCALATION REPORT AND SATH UPDATE**
Approved and Presented by:	Assistant Director Commissioning Development
Prepared by:	Assistant Director Commissioning Development
Other Committees and meetings considered at:	Scores were considered on the 22nd July 2020 at the Internal Commissioning Assurance Meeting, on the 20th August 2020 at the Delivery and Performance Group Meeting and 15th September 2020 at the Quality and Governance Group. The report also contains information received after that date.

PURPOSE:

The purpose of this paper is to highlight to the Executive Experience, Quality and Safety Committee any providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework. It also provides an update in relation to Shrewsbury and Telford Hospitals NHS Trust and other key issues.

RECOMMENDATION(S):

It is recommended that the Experience, Quality and Safety Committee DISCUSSES this Commissioning Escalation Report.

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:

This report highlights providers in Special Measures or scored as Level 4 at the July 2020 PTHB Internal Commissioning Assurance Meeting (ICAM), which was then considered at the Delivery and Performance Meeting on the 20th August and 15th September 2020 at the Quality and Governance Group. There has been an issue with the synchronisation of meetings, so this report also contains information received after those dates. There are:

- 4 providers with services in Special Measures
- 1 provider at Level 4

The report provides an update on a number of serious matters, particularly:

- Shrewsbury and Telford Hospitals NHS Trust (SaTH)
- accelerated system change affecting South Powys
- and the deteriorating position in relation to referral to treatment times (RTT) times.

DETAILED BACKGROUND AND ASSESSMENT:

PTHB's Commissioning Assurance Framework (CAF) helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients.

It considers patient experience, quality, safety, access, activity, finance governance and strategic change. It is a continuous process, considering information from a broad range of sources including "credible soft intelligence". It is not a performance report between fixed points.

Each PTHB Directorate is invited to contribute information to the CAF and to attend the ICAM.

Formal inspection reports for the NHS organisations commissioned are available on the websites of Health Inspection Wales (HIW) and the Care Quality Commission (CQC). PTHB attempts to draw from providers' existing Board reports, plans, returns to Government and nationally mandated information wherever possible.

As set out in previous papers to the Executive Committee and other Board Committees the usual commissioning arrangements have not been in place since March 2020, whilst the NHS, under civil contingencies arrangements, continues to deal with an unprecedented level of change in order to respond to COVID-19.

PTHB has been participating in strategic system command arrangements in Shropshire, Telford and Wrekin and for Herefordshire and Worcestershire covering some of the main District General Hospitals for the Powys population.

The suspension, restoration and recovery of services has not been "commissioned". The NHS continues to operate in "block" arrangements financially; activity does not reflect the patterns of previous years; performance arrangements were suspended; restoring non-essential routine services remains a significant challenge as capacity is limited by the need for social distancing, control of infection, testing, staffing and the need to preserve surge capacity.

There were no Commissioning Assurance Framework Escalation reports between the end of March 2020 and the end of June 2020 (although monitoring of some domains continued where possible). Since July, PTHB has been working to incrementally restore the CAF although there remain significant limitations and it is not possible to score all of the domains. Escalation processes cannot operate in the usual way where issues are widespread across the NHS, such as the deteriorating waiting times for routine services.

In the tables overleaf an attempt has been made to score the domains of quality and safety; patient experience; and access. However, information was not available from all providers.

Special Measures

Provider	Quality & Safety	Patient Experience	Access	Finance (Cost & Activity)	Change in Level Status	Governance & Strategic Change
Shrewsbury & Telford Hospital NHS Trust	July 2020	July 2020	July 2020	No score – Block agreement	↔	Not Rated
Worcestershire Acute Hospitals NHS Trust	July 2020	July 2020	July 2020 – Insuf info	No score – Block agreement	↔	Not Rated
Betsi Cadwaladr University Health Board	July 2020	July 2020	July 2020	No score – Block agreement	↔	Not Rated
Cwm Taf Morgannwg University Health Board (maternity)	July 2020	July 2020	July 2020	No score – Block agreement	↔	Not Rated

Level Four

Provider	Quality & Safety	Patient Experience	Access	Finance (Cost & Activity)	Change in Level Status	Governance & Strategic Change
Wye Valley NHS Trust	July 2020	July 2020	July 2020	No score – Block agreement	↔	Not Rated

Shrewsbury and Telford Hospitals NHS Trust (SATH)

This section summarises:

- The findings of the latest inspection report
- The Improvement Alliance with University Hospitals Birmingham Foundation NHS Trust (UHB)
- The PTHB Risk Reduction Plan

As previously reported to the Experience, Quality and Safety Committee in July, the Care Quality Commission (CQC) carried out a further unannounced inspection of SaTH on the 9th and 10th of June. This resulted in a letter, known as a Section 31 Notice, imposing further conditions on its regulated activity in relation to the assessment and management of risk, care planning and incident management.

The Trust also received warning notices to improve end of life care staffing, competencies, governance systems and support systems for personal patient preferences and individual needs.

The full reports were then published on the 13th August 2020 and can be accessed through the links below:

https://www.cqc.org.uk/location/RXWAT
https://www.cqc.org.uk/location/RXWAS

The focused inspection showed that the position had deteriorated:

	RSH	PRH
Overall rating	Inadequate	Inadequate
Are services safe?	Inadequate	Inadequate
Are services effective?	Inadequate	Inadequate
Are services responsive?	Inadequate	Inadequate
Are services well led?	Inadequate	Inadequate

The CQCs findings in the Section 31 Notice and inspection reports included concerns in relation to:

- Prompt risk assessment
- Safety incident management to protect patients from avoidable harm
- Person centred care
- End of life care
- The use of national guidance and evidence-based practice
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Leadership
- The culture
- Nursing documentation
- Effective governance systems to improve the quality of services
- Staff with the right qualifications, skills, training and experience
- Pressure area care
- Falls
- The oversight of audits and the improvement of outcomes

The PTHB Executive Committee and relevant Board Committees have been receiving up-dates through the CAF Escalation Report since SaTH was placed in special measures. This is summarised overleaf.

SaTH has been at CEO led escalation within PTHB's processes. Reports to the Experience, Quality and Safety Committee and Performance and Resources Committee have explained the work undertaken through CEO level meetings, the Commissioning Assurance Framework, including the development of a Maternity Assurance Framework. (Whilst PTHB is not the

main commissioner of SaTH, its DGH services are strategically important to the highly rural population in North Powys. The next nearest DGH is also part of an organisation within special measures)

The key questions from the PTHB perspective have been: whether the Trust has a clear understanding of the issues of concern; whether there is a comprehensive plan for improvement with the endorsement of key stakeholders; and whether the organisation has the capacity and capability in place to deliver those improvements. The PTHB CEO has liaised with key stakeholders including the Clinical Commissioning Group, NHS England Improvement (NHSEI) and the CQC to secure a way forward to improve the quality and safety of services**.**

SATH SUMMARY TIMELINE	
November 2018	The Trust is placed in special measures by NHS Improvement.
29th November 2018	The CQC tells the Trust it must: • Ensure sufficient and suitably qualified and trained staff are available to care for and protect people from the risk of harm. • Keep all environments safe for use. • Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe. • Take account of the report from the Royal College of Obstetricians and Gynaecologists' review of current practice in maternity services and formulate action plans to improve the service. • Review the processes around escalating women who are at high risk so that women who present at the midwifery led unit or day assessment unit receive a medical review without delay. • Review its policy on reduced foetal movements so there is a clear and defined pathway for midwives and sonographers to follow. • Ensure complaints are addressed within the timescale laid down by the trust's complaints policy. • Doctors covering out of hours must have the capability and confidence to review patients at the end of life, including prescribing. • All records must be safely and securely stored. • The trust must improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis. • Best practice must be followed when preparing, administering and storing medicines.
18th April 2019	CQC issues Section 31 Notice notably concerning children in Emergency Department.
2nd August 2019	Findings of the April Emergency Department CQC inspections published.
November 2019	Further letter issued by the CQC
6th December, 2019	The CQC publish a quality report following an unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital on the 16th April, 2019.
8th April 2020	The CQC publishes the findings of the inspection which took place between the 12th November 2019 to 10th January 2020. (The reports in relation to the quality visits on the 17th February are also published.) The overall trust quality rating is "inadequate".

	The safe, effective, responsive and well led key questions were all rated as inadequate. The caring key question went down to requires improvement. Royal Shrewsbury Hospital was rated requires improvement. The Princess Royal Hospital was rated as inadequate.
9th and 10th June 2020	CQC unannounced inspection
18th June, 2020	The Trust received a further Section 31 Notice

An "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust (UHB) has been established, as SaTH was not in a position to improve the quality and safety of its services alone. A new Chair of the Board of SaTH has been appointed from UHB and "Committees in Common" are being established. A new Director of Nursing has been appointed who is also from UHB. SaTH, within the "improvement alliance" will develop an improvement plan and progress will be reported to the PTHB Board. PTHB will continue to work with key stakeholders in the Shropshire, Telford and Wrekin system.

Wye Valley NHS Trust was helped to leave special measures through a similar model, which linked it to a trust already successfully providing high quality services.

PTHB is attempting to carefully balance risk in a situation. There are services in SaTH which are performing well (for example an innovative scheme to transform the lives of people living with cancer has been shortlisted for a prestigious national award). With key clinicians within Powys PTHB has been finalising a risk reduction plan including:

- Enhanced work in relation to specific patients and patient groups (including frail older people; people with impaired mental capacity; children with physical and mental health needs requiring hospital admission; and people at risk of falling)
- Admission avoidance and reduction
- Acceleration of the development of clinically appropriate services in Powys where possible. The North Powys Programme is pivotal development in this context.
- Further strengthened governance including patient experience

Aneurin Bevan University Health Board and Cwm Taf University Health Board

This year has been one of unprecedented challenge for all and civil contingency arrangements remain in place. Aneurin Bevan University Health Board (ABUHB) was one of the hardest hit areas in Wales in the first peak and its experience led it, understandably, to seek Ministerial approval

to bring forward the opening of The Grange to mid-November from Spring next year. The approval for this was given on the 27th August 2020.

The compressed timescale of the opening is a significant challenge as it is an accelerated system change involving Powys Teaching Health Board (PTHB), Cwm Taf Morgannwg Health Board (CTMUHB) and the Welsh Ambulance Service (WAST). Working together to ensure that patients are as safe as possible within this civil contingency is crucial.

Responding to the early opening of The Grange has been identified as a key strategic priority for the whole board of PTHB. A PTHB CEO chaired Programme Board is in place involving ABUHB, CTMUHB and PTHB. This will be the subject of a separate paper to the Board.

Referral to Treatment Times (RTT)

Following Government statements, frameworks and letters, from March 13th 2020 onwards, non-essential routine services were suspended as part of the response to the pandemic. These actions were designed to allow services and beds to be reallocated and for staff to be redeployed and retrained in priority areas. Access to cancer and other essential treatments such as renal dialysis was to be maintained. The key principle was to keep people safe and to keep patients out of clinical settings if there was no urgent need to attend.

In Quarter 2 there has been a focus on ensuring access to urgent and essential services and on attempting to restore other routine services. Due to the significant challenges set out earlier in the document, there is a deteriorating picture in terms of the number of Powys patients waiting more than 36weeks for treatment. (Based on unvalidated waiting lists received from Wye Valley NHS Trust– showing 82 patients over 52 weeks - there are now thought to be a total of 363 Powys patients waiting over 52 weeks for treatment.)

In line with Welsh Government guidance routine referrals continue to be accepted by providers. Risk stratification processes are, increasingly, being applied so that patients are seen on the basis of clinical need and then in-turn.

Addressing growing waiting times was one of the major priorities presented to the Board in July. Orthopaedics is one of the most challenging areas. It is crucially important that the use of local services such as the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is maximised and that there is rigorous referral management – including access to pre-referral advice.

New ways of working, such as the modernisation of follow-up, can help with the re-balancing of demand and capacity. However, regional and national collaborative solutions are also going to be needed.

As well as increasing the need for validation, referral management and new ways of working, the number of harms reviews undertaken and monitored through the CAF will need to be increased. The inclusion of a harm review table will be reinstated in reports to the relevant Board Committees.

Latest Snapshot	Jul-20		
Welsh Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	Patients waiting 36-51 weeks	Patients waiting 52 weeks and over
Aneurin Bevan Local Health Board	58.5%	294	45
Betsi Cadwaladr University Local Health Board	50.0%	72	44
Cardiff & Vale University Local Health Board	47.8%	77	23
Cwm Taf Morgannwg University Local Health Board	45.1%	90	25
Hywel Dda Local Health Board	54.8%	181	12
Swansea Bay University Local Health Board	47.0%	277	132
Latest Snapshot	Jun-20	WVT May-20	
English Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	Patients waiting 36-51 weeks	Patients waiting 52 weeks and over
English Other	75.5%	10	<5
Robert Jones & Agnes Hunt Orthopaedic & District Trust	71.0%	200	0
Shrewsbury & Telford Hospital NHS Trust	62.9%	373	0
Wye Valley NHS Trust (May-20)	68.7%	202	12*

Conclusion

Due to the civil contingency arrangements needed in order to respond to the COVID-19 pandemic the usual commissioning processes are not in place. However, PTHB has been working to reintroduce the Commissioning Assurance Escalation report, although it is not possible to score all the domains in the previous way and information remains incomplete.

An unannounced inspection by the Care Quality Commission on the 9th and 10th June, resulted in a further letter imposing conditions on SaTH's regulated activity. This extremely serious situation re-enforced that it was not possible for the SaTH to improve the quality and safety of its services alone. It was subsequently announced that an "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust was being established. A new Chair of the

Board of SaTH has been appointed from UHB and "Committees in Common" are being established.

Accelerated work is underway to ensure system readiness in relation to the earlier opening of The Grange University Hospital, involving PTHB, ABUHB, CTMUHB and WAST.

Work is underway across providers to ensure access to essential services. However, the restoration of other routine services is exceptionally challenging in an environment where capacity is limited due to COVID-19. There has been a significant deterioration in the number of Powys patients waiting over 52 weeks. It is a priority to address long waiting times, however system wide solutions are going to be needed.

NEXT STEPS:

In line with the PTHB Commissioning Assurance Framework providers scored as Level 4 or in Special Measures will continue to be reported to the relevant Board Committee.

Agenda item: 3.3

EXPERIENCE, QUALITY & SAFETY COMMITTEE	DATE OF MEETING: 01 October 2020
Subject:	**CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Rebecca Membury, Senior Manager Putting Things Right
Other Committees and meetings considered at:	Quality Governance Group 15 September 2020

PURPOSE:

The purpose of this report is to provide the Experience, Quality and Safety Committee with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for July 2020. The report also outlines serious incidents reported to Welsh Government and Her Majesty's Coroner's enquiries that have been received by the health board.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to DISCUSS and NOTE the contents of this report.

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 purpose of this report is to provide the Experience, Quality and Safety Group with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for July 2020. The report also outlines serious incidents reported to Welsh Government and Her Majesty's Coroner's enquiries that have been received by the health board.

DETAILED BACKGROUND AND ASSESSMENT:

1. Management of Compliments and Concerns

1.1 Once for Wales Concerns Management System

The data depicted above and further within this report is taken from the Datix system, unless otherwise specified, and is correct at the time it was taken from the system. The data quality and confidence are subject to limitations of the current Datix system, which is subject to change as part of the Once for Wales Concerns Management System initiative, currently due for implementation by April 2021.

The Once for Wales Concerns Management System programme is hosted by the Welsh Risk Pool, supported by Welsh Government and will provide integrated functionality to support a range of essential patient safety & experience functions including:

- Incidents Reporting & Investigation
- Complaints Management & Investigation
- PTR & Redress Case Management
- Claims Management
- Learning from Deaths (Mortality Reviews, link to Medical Examiner activity)
- Intelligent Monitoring & Quality Indicator Dashboards
- Safety Alerts Management & Compliance Log
- Professional Regulatory Referrals Case Management
- Safeguarding (adults & children) Referrals Log
- Serious Incident Notification & Closure Portal
- WRP Reimbursement Requests Portal
- Healthcare Risk Management (Risk Register, Board Assurance Framework)

The preparation for introduction of the Once for Wales Concerns Management System within the health board is overseen by a Programme Board led by the Executive Director of Finance.

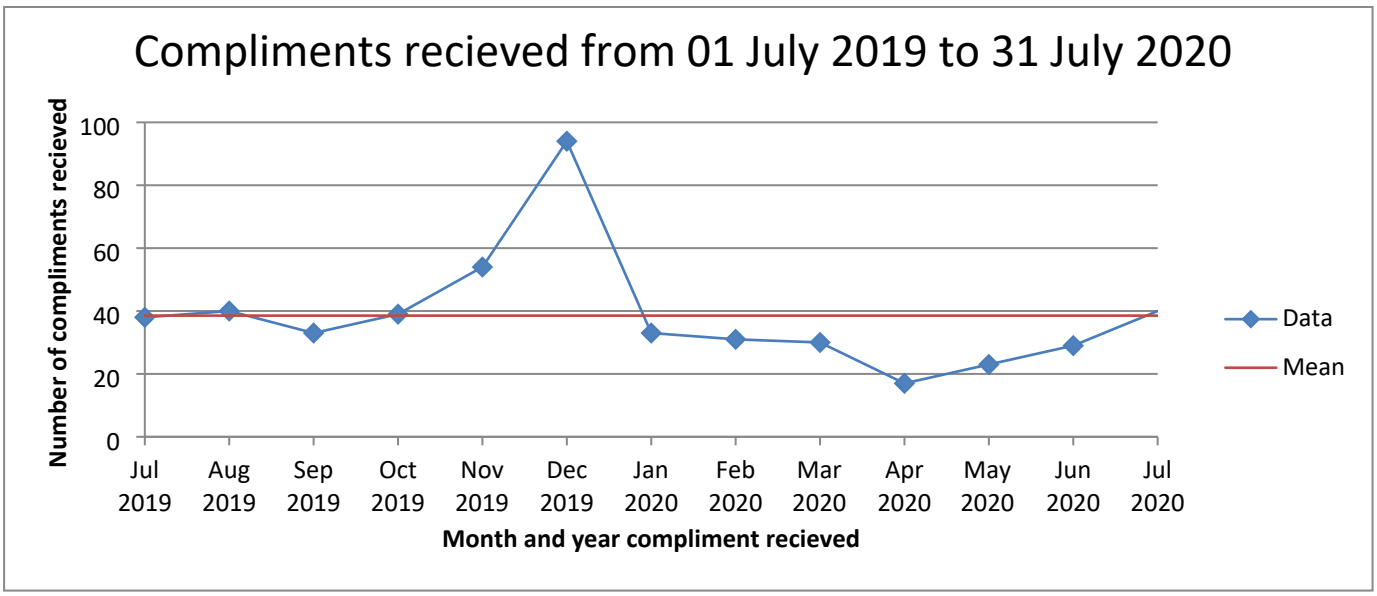
1.2 Management of Compliments:

During the period of 01 July 2019 and 31 July 2020, 578 compliments were received by the health board from patients and relatives. These consisted of a combination of cards, and small tokens such as chocolates, expressing thanks and appreciation for kindness, compassionate care and support provided.

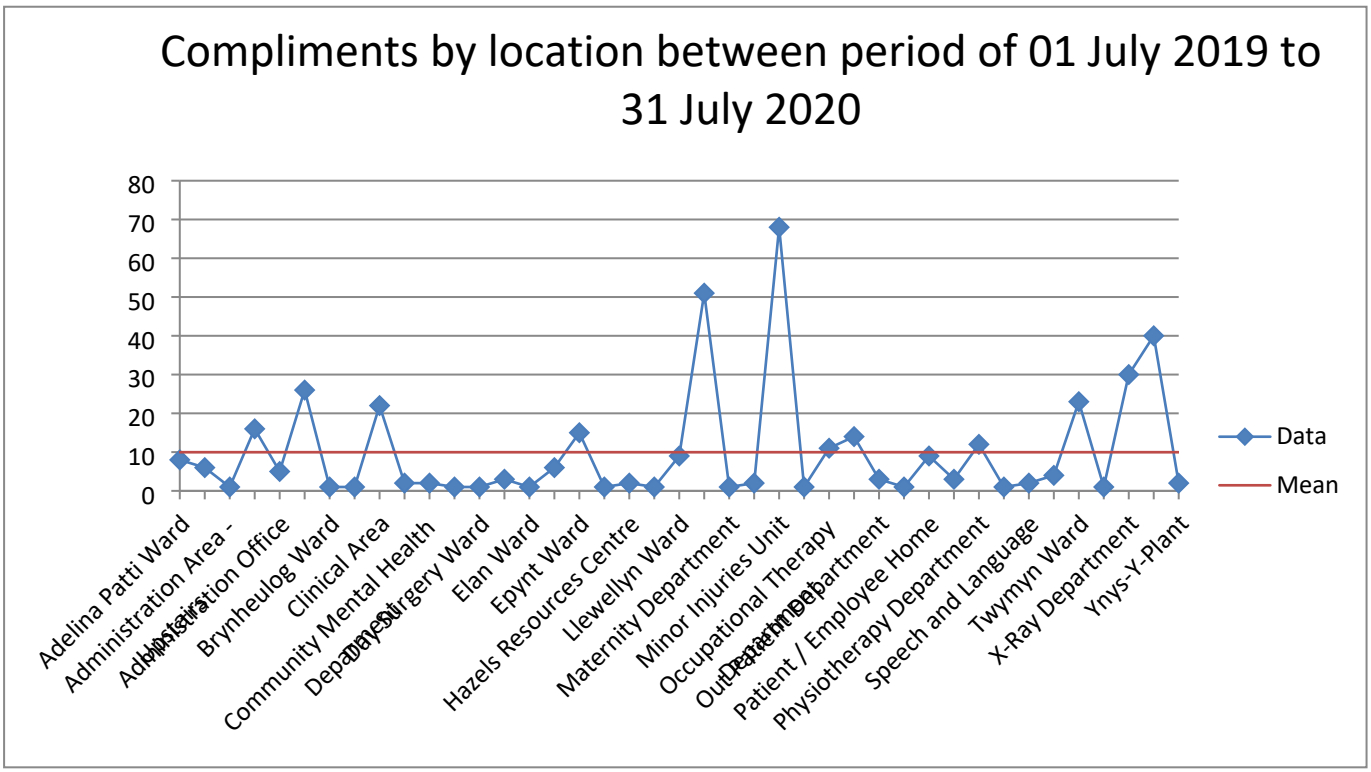
During the period of 01 July to 31 July 2020, the health board received 40 compliments with the audiology department have the highest number of compliments recorded for this time period.

The graph below illustrates a reduction in compliments with a return to baseline during July 2020, this may be in relation to the changes in accessibility and delivery of services during lockdown as a result of the covid 19 pandemic.

Graph 1 – Total number of compliments received between 01 July 2019 to 31 July 2020



Graph 2: Compliments received by Service Group during the period of 01 July 2020 to 31 July 2020



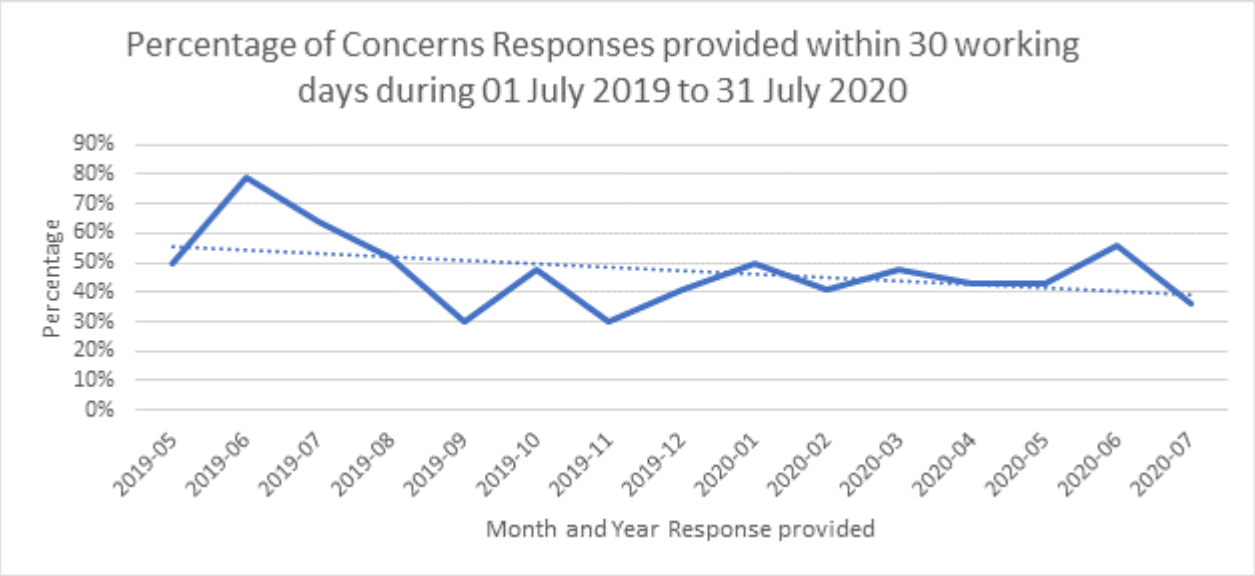
1.3 Complaints

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, are required to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. Informal concerns are usually acknowledged by way of verbal confirmation with the offer of written confirmation if required at the point of contact with the staff member. During the period of 01 July 2020 to 31 July 2020 the health board achieved 100% of this target. During the same period, the health board achieved 93% target in acknowledging formal concerns. Dedicated administration support is assisting improvements in this area.

The health board set an internal target of 90% of informal concerns to be responded to within the new Welsh Risk Pool Services and Welsh Government target of 2 working days. From 01 July to 31 July 2020, the health board received less than 5 informal concerns, none of which transferred to a formal concern as concerns were addressed and the person raising the concern content with the response provided. From review of the same period of 2019 there is no change in the number of informal concerns received.

During 01 July to the 31 July 2020 the health board received 17 formal concerns, mainly related to Primary Care Services which include General Practitioner Services and Dental Services, the concerns being raised relate mainly to access to the services.

During July 2020, the health board responded to 44% of formal concerns within the 30-working day target.



Data Source: IFOR

An organisation wide focus is being taken to maximise efficiency at every stage of the concern's management process, from the receipt of the concern, the development and quality of the response, through to approval by the Chief Executive Officer. A number of measures are being implemented to streamline wherever possible, whilst still ensuring transparency and robustness in answer to the concerns raised and achieve the 75% target as set by Welsh Government.

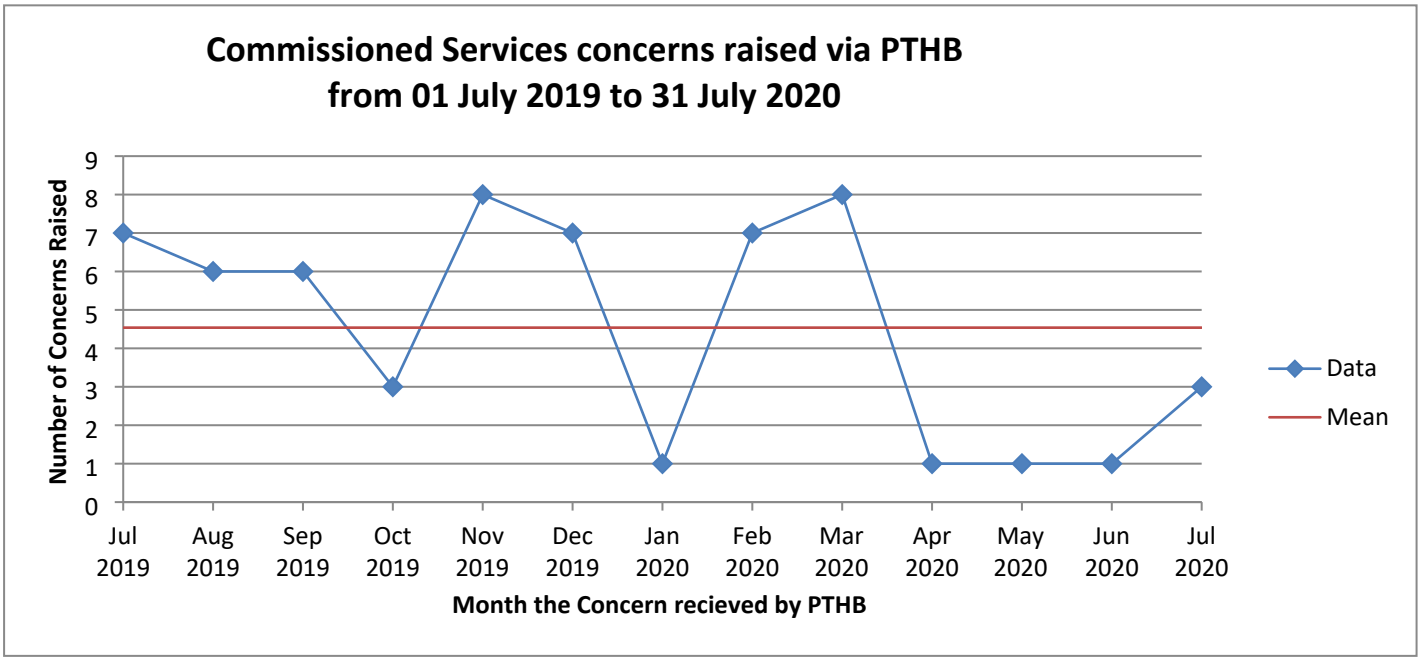
1.3.1 Concerns raised about Commissioned Services

The data presented below is based on the information held by the health board, and whilst it is a condition within the Long-Term Agreements made with commissioned services, there may be variance in the numbers of complaints made by residents of Powys, and the data shared with the health board, particularly as patients directly with the commissioned provider. Written communication is being made with commissioned services to reassert the requirement to inform in relation to concerns and this will be a focus within the quality review and performance meetings held regularly with providers.

During Quarter 1 of 2020/2021 the health board received notification of 6 concerns relating to commissioned services from differing sources, from review there are no themes or trends identified during this period.

From analysis of one year's period from 01 July 2019 to 31 July 2020, it can be seen from the graph below the number of concerns raised during the same period in 2019 are comparable. There is a decline in concerns being raised via the health board during the months of April 2020 to June 2020, this may be in part attributed to services being suspended due to COVID19, with the increase in July to correspond with services resuming within health boards.

Graph 3: Concerns raised via Powys Teaching Health Board all Commissioned Services providers

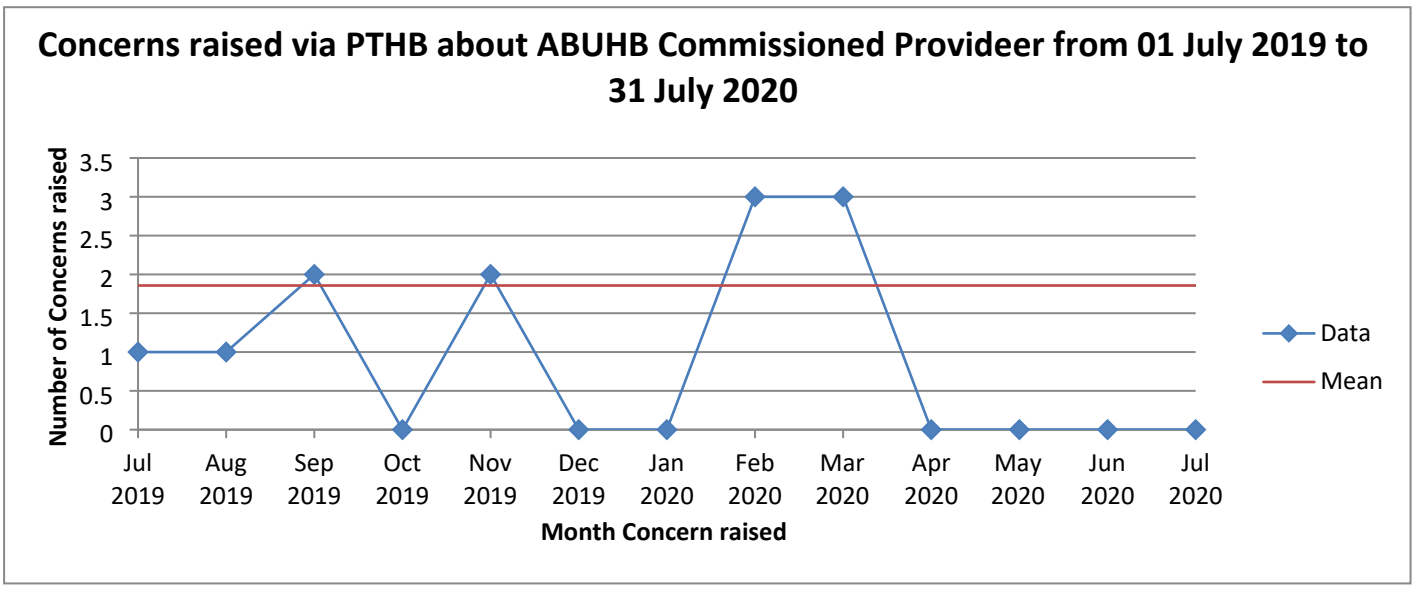


Where concerns are raised in relation to commissioned services, the small numbers do not readily enable meaningful identification of themes or trends, however, when triangulated data and intelligence from other sources, an overall perspective of the quality of services proved can be asserted, therefore whilst concerns are presented

specifically in this report, the health board's view is also informed by data collected as part of the commissioning assurance framework process.

In addition to the overarching review of the concerns received by the health board about commissioned services a review was also undertaken on the individual health board that services are commissioned from. It is noted that from 01 July 2019 to 31 July 2020, no concerns were received in relation to services provided by the following - Betsi Cadwallader University Health Board, University Hospitals Birmingham NHS Foundation Trust, Velindre University NHS Trust, Public Health Wales and Welsh Ambulance Service Trust.

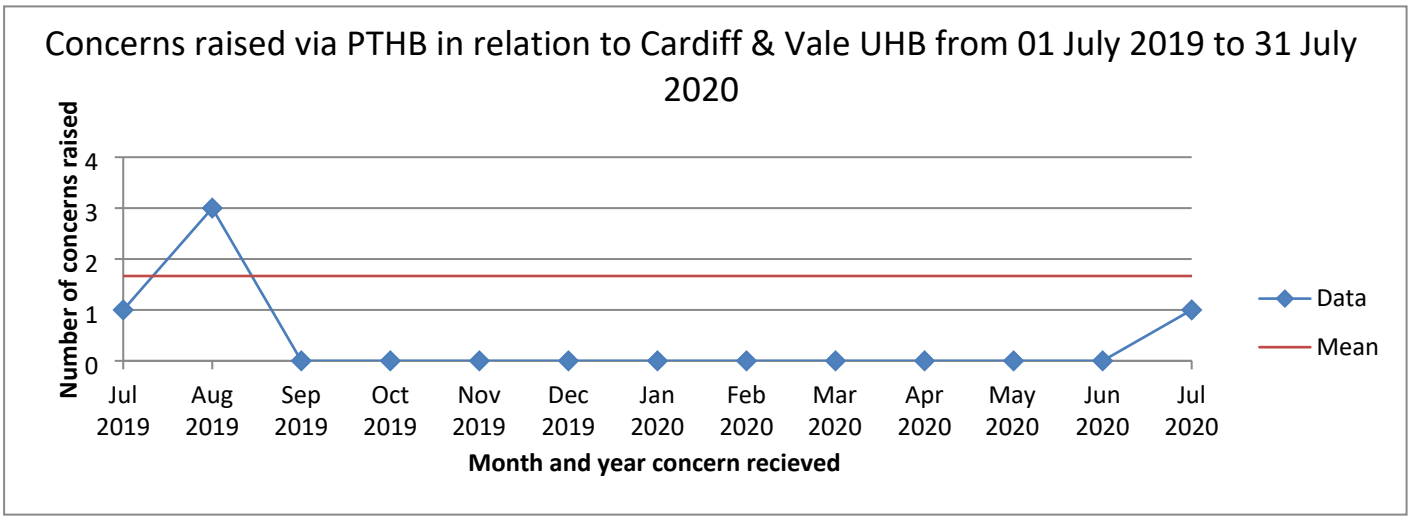
Graph 4 – Concerns received about commissioned services from Aneurin Bevan University Health Board (ABUHB)



From March 2020 to 31 July 2020 there have been no concerns raised via our health board about this commissioned provider. This could be in part related to the Covid19 where services were suspended but on the whole the number of concerns raised in relation to ABUHB are small.

Graph 5: Concerns received about commissioned services from Cardiff and Vale

University Health Board (C&VUHB)



It can be noted that for a period of 10 months, there were no concerns raised via Powys Teaching Health Board about Cardiff and Vale University Health Board, on the whole the concerns numbers are low.

Cwm Taf Morgannwg University Health Board

In relation to concerns received about commissioned services from Cwm Taf Morgannwg University Health Board, from review there were no concerns raised between 01 July 2019 to 31 December 2019 and the same post February 2020, on the whole the number of concerns raised are very low.

Hywel Dda University Health Board

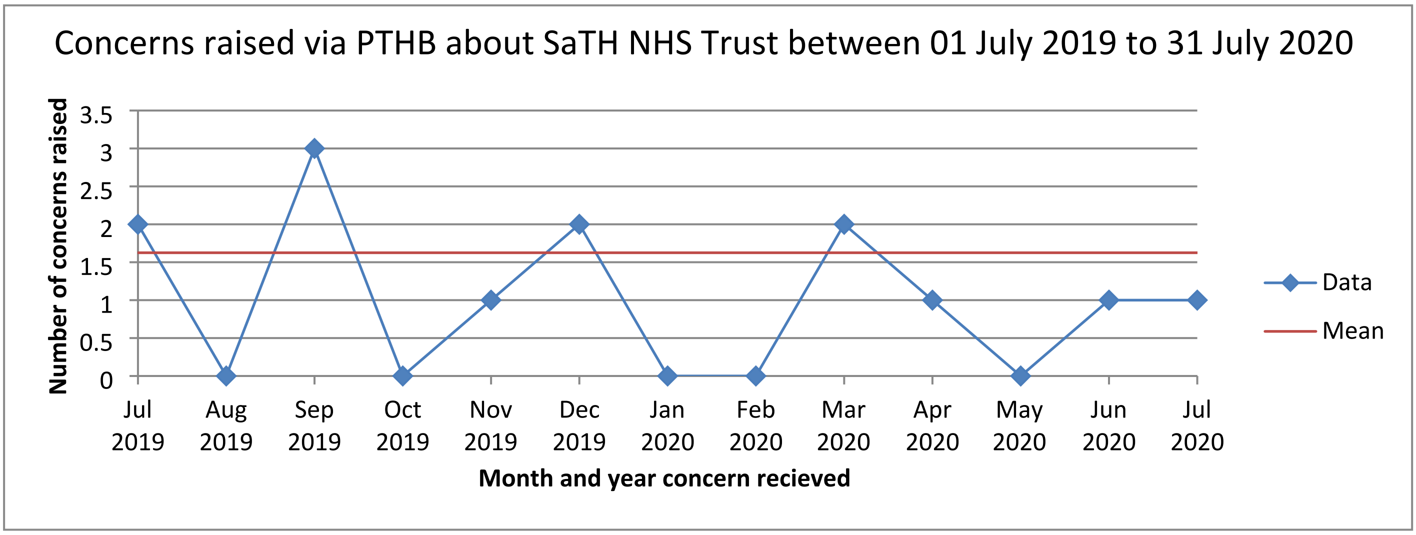
In relation to the concerns received about commissioned services from Hywel Dda University Health Board, the numbers are below five for the period of 01 July 2019 and 31 July 2020. It was noted on review, there were no concerns raised between July 2019 to October 2019 and there have been no concerns raised since December 2019 to 31 July 2020.

Robert Jones & Agnes Hunt NHS Trust

Between the period of 01 July 2019 to 31 July 2020, there have been less than five concerns raised via PTHB about Robert Jones & Agnes Hunt NHS Trust commissioned provider.

Graph 6 – Concerns raised via PTHB about Shrewsbury and Telford (SaTH) NHS

Trust from 01 July 2019 to 31 July 2020

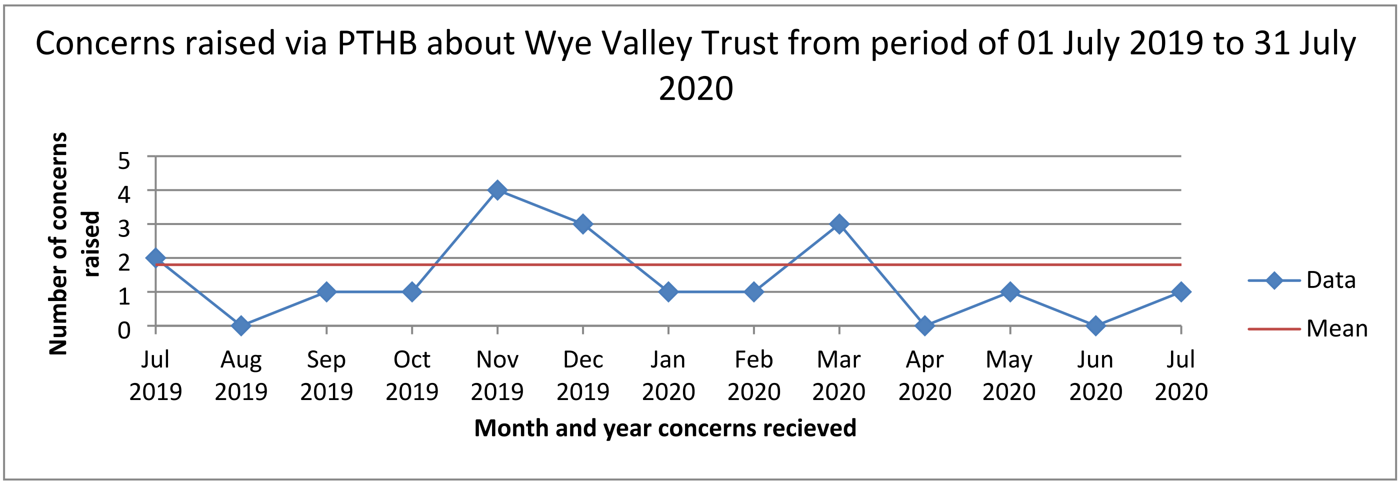


In relation to the concerns received in relation to Shrewsbury and Telford (SaTH) NHS Trust, across the period of 01 July 2019 to 31 July 2020 the number were noted to peak in September 2019 but since this time the number of concerns the health board are aware of has declined. In reviewing the 12 concerns raised by Powys Residents about SaTH there are no identified themes or trends in relation to these concerns.

Swansea Bay University Health Board

From analysis of the data, the health board has received less than 5 concerns about Swansea Bay University Health Board from 01 July 2019 to 31 July 2020.

Graph 7: Concerns raised via PTHB about Wye Valley Trust during 01 July 2019 to 31 July 2020



From review of the data in the above graph, it can be noted that there are peaks when the health board received an increased number of concerns about WVT, from analysis there were no identified themes or trends in relation to the concerns raised.

The concerns team will continue to undertake regular reviews of the concerns raised about commissioned providers to identify at the earliest point any themes or trends and the data will be reported in this paper.

1.4 Learning from Concerns and Patient Experience and Incidents

This is a key focus for the health board. Reports on learning are presented to the quarterly Patient Experience Steering Group meetings as well as individual learning through wards and departments, newsletters, and 'you said, we did' boards. Examples of learning and subsequent improvement are provided below:

- Recognising the emergence of a possible theme as a result of a patient safety incident and a concern, the Community Services Group have been able to make improvements in the provision of end of life care enabled through introducing a more efficient caseload management based on a holistic approach, improving patient experience and increased satisfaction of the team.
- Following a practice review of incident reporting relating to pressure damage, the Tissue Viability Team noted inconsistencies with grading and introduced learning opportunities, delivered as part of the pressure ulcer scrutiny panel meeting. The training was well evaluated, increasing knowledge of pressure damage grading.
- Maternity and health visiting services identified the need for, and subsequently received, joint learning exploring the importance of effective communication with families, along with identifying the need for additional support. A pan Powys bereavement support network have been established with the aim of enabling additional support throughout bereavement to women and families.

The Medical Director leads the development of the health boards approach to learning as part of the clinical quality framework implementation which will promote shared learning to support proactive learning from concerns. The continued development of clinical quality governance systems within the service groups will also support shared learning.

A survey seeking the views of people who have raised a concern within the health board, with regards to their experience, as opposed to the response itself, has been commenced. This is aimed at maximising the opportunity to ensure the health boards approach to managing concerns best meets individual's expectations along with meeting the requirements of Putting Things Right. The responses will be analysed over a 3-month period and reported to Quality Governance Group. In making the above improvements and taking forward the learning from patient concerns it is envisaged that this will improve the overall patient experience**.**

2. Incident reporting

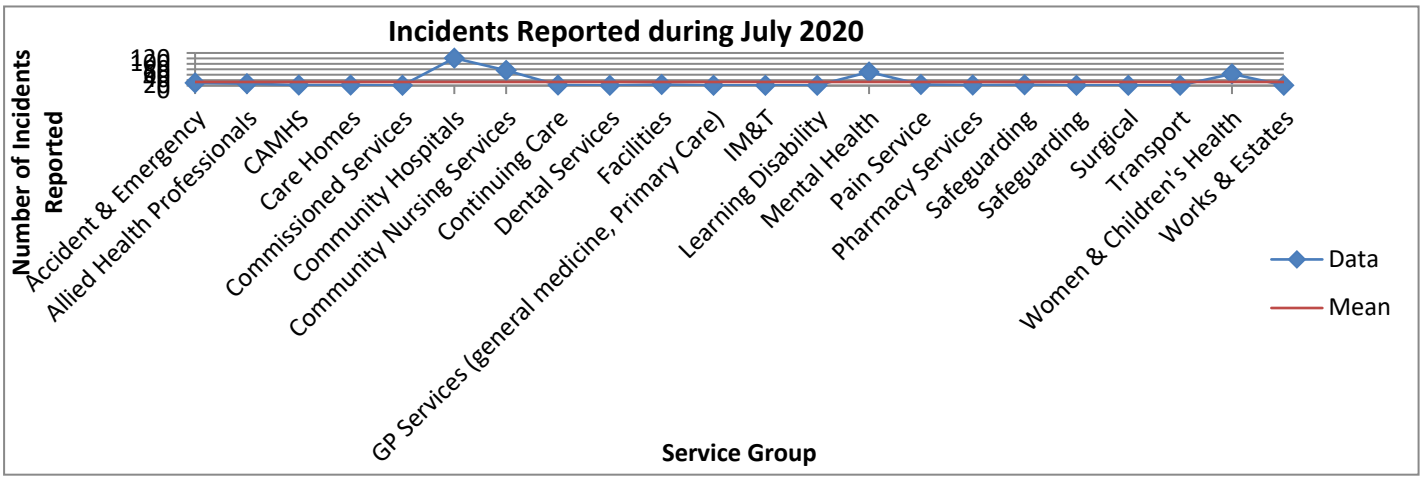
Incident reporting via the Datix system is promoted and this continues, as previously noted, recent work has shown some local variation in practice, resulting in some

timetabled executive led improvement work underway, and updated guidance has been issued to staff to support the improvement work. A training programme has been organised to continue familiarisation with the system; commencing October 2020.

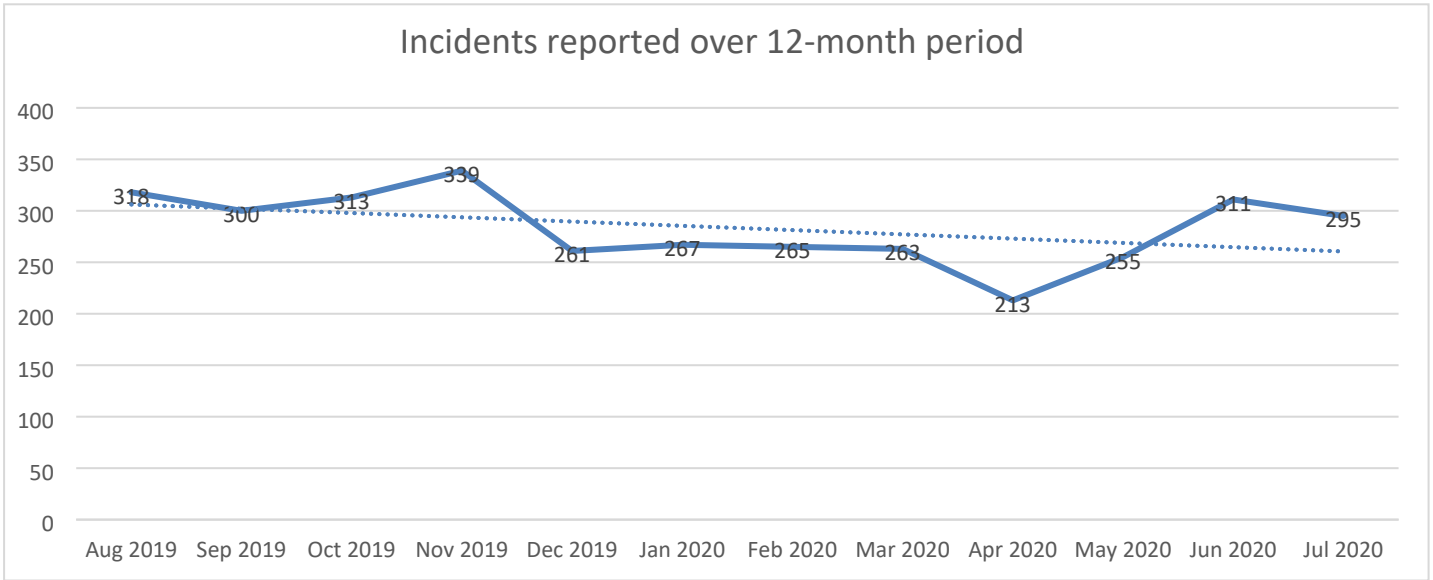
2.1 Reporting by Service Group

During the period 01 July 2020 to 31 July 2020, there have been 295 reported incidents (graph 7), which is reflective of the average number reported (see graph 8).

Graph 7: Incidents reported by Service Group for the period 01 July 2020 to 31 July 2020



Graph 8: Incidents reported the last 12 months 1 August 2019 to 31 July 2020



Over the last year, there is variation in the number of incidents reported month on month, the range 213-339, and average of 283 incidents per month. A total of 3,400 incidents reported for the whole year, a reduction is noted in the month of April 2020, which may

reflect the reduced activity and low bed occupancy as a result of Covid-19.

2.2 Notable themes and trends in other areas

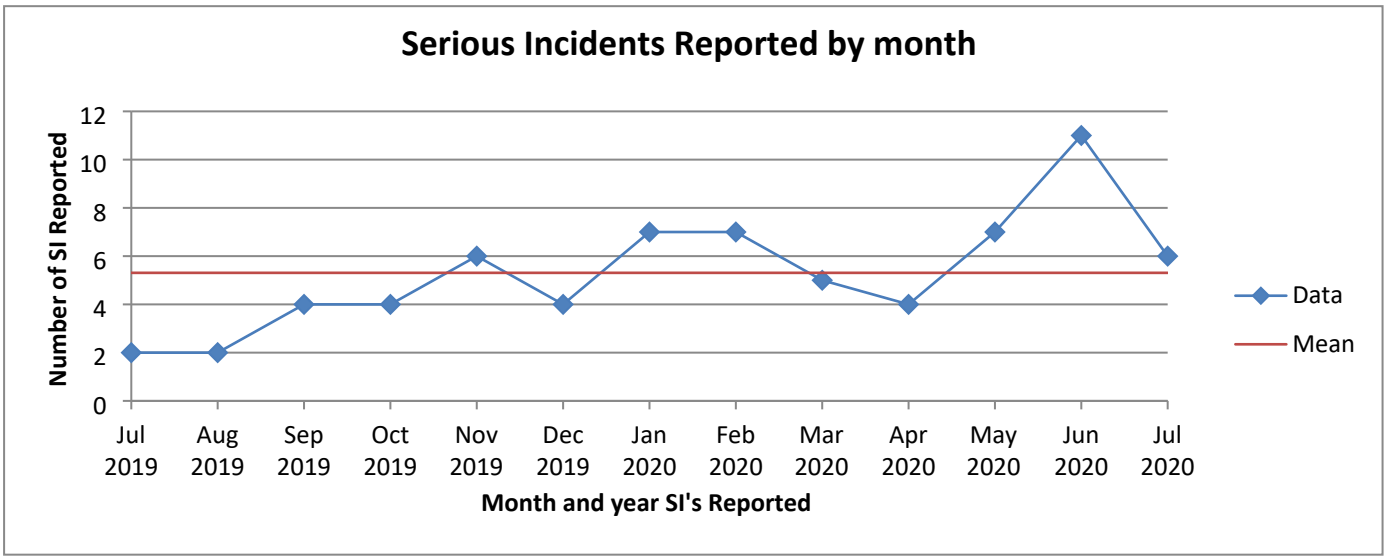
It is noted from review of the same period last year there has been an increase of incidents reported by the Mental Health Services in relation to the Child Adolescent Mental Health Services. There is also an increase in the incidents being reported by the Women and Children's Services. Heads of Service identify that the increase is likely to be as a result of the establishment of a dedicated resourse to support staff in reporting, investigating and learning from incidents and concerns.

2.3 Serious incidents

A serious incident is defined as an incident that occurred during the provision of NHS funded healthcare. All serious incidents are reported to Welsh Government. The temporary change to the reporting criteria for Serious Incidents due to COVID19, has been rescinded and the health board is required to provide Welsh Government with an assurance that a robust investigation for a serious incident has been completed and learning identified within 60 working days.

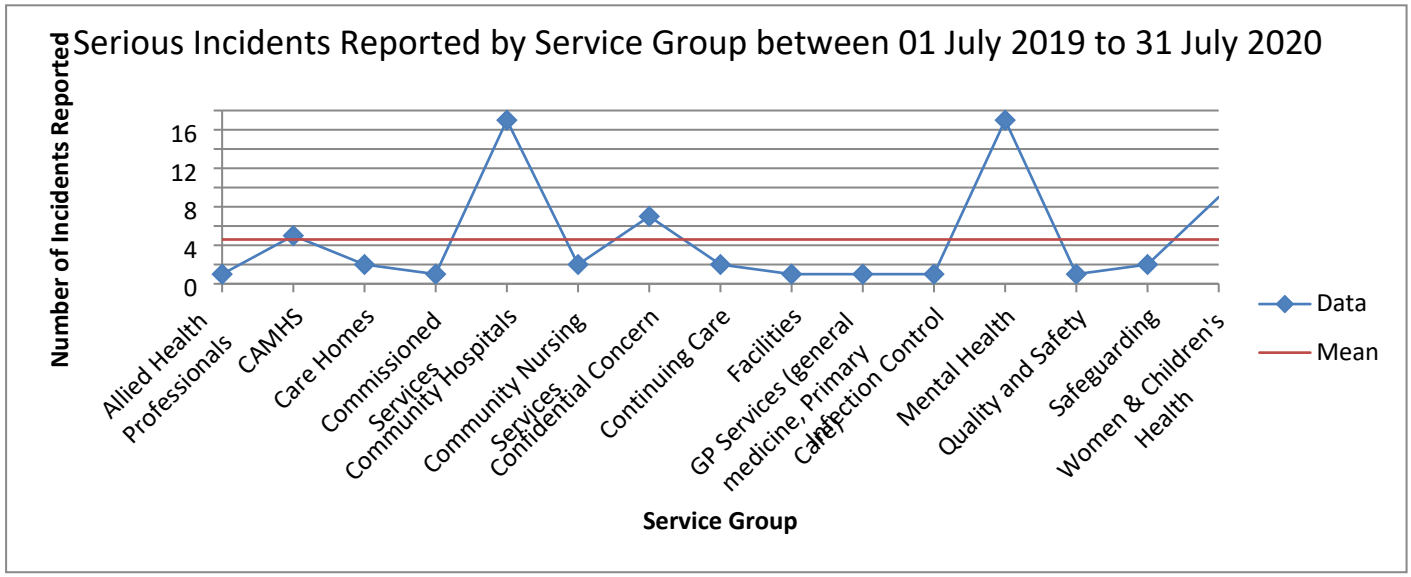
During the period of 01 July 2020 to 31 July 2020 the health board reported 6 serious incidents to Welsh Government. Whilst the pattern of reporting is variable month on month, the baseline is just under 6.

Graph 9: Serious incidents reported by month



The increase in serious incident reporting noted during June 2020, was generated in relation to the care and service provided within community hospitals, mental health services and related to infection prevention and control. There are no themes or trends identified within the issues reported. The service groups delivering direct patient care hold monthly meetings where serious incident reporting, investigation, lessons learned and improvements are discussed.

Graph 10: Serious Incidents by Service Group from 01 July 2019 to 31 July 2020



An increase in serious incident by the Mental Health Services is noted, with particular reference to the Child Adolescent Mental Health Services (CAMHS) in relation to patients under the age of 16 years old being placed on adult mental health wards. As an all Wales concern, the service is working with others to influence provision in Wales, alongside developing the health board's response to maximise quality and safety should a young person be cared for locally whilst awaiting a placement that best meets the young person's needs.

2.4 No surprises notifications

Welsh Government are notified of sensitive issues via a process known as 'no surprises' these are closed automatically within 3 working days. Between 01 July and 31 July 2020, the health board have made no reports to Welsh Government. From 01 August 2020, Welsh Government have agreed to accept a no surprises report in relation to a serious incident that has occurred in commissioned services. This will provide an added level of oversight and scrutiny in relation to the experience of the people of Powys in receipt of care from other providers, and will result in an increase in the number of no surprises reports made to Welsh Government, which will feature in subsequent reports.

3. Inquests

During the period of 01 July 2020 and 31 July 2020 there have been less than 5 HM Coroner Enquiries opened. As noted previously, due to Covid-19 the HM Coroner stopped all inquests from the 24 March 2020, a review took place in July 2020 following the issuing of guidance from the Senior Coroner indicating that all HM Coroner Courts should hold inquests remotely to avoid further delays.

The HM Coroner is currently considering alternative means by which to undertake

inquests. Dates are now being listed with the caveat of significant delays likely to exceed the 6 months' timescale detailed in the Coroners Rules 2009.

4. Public Service Ombudsman:

If a patient remains dissatisfied with a response to a concern investigated by the health board, the complainant has the right to raise the matter the Public Services Ombudsman (PSOW). The PSOW determines whether to pursue a full investigation, with the authority to impose sanctions on the health board by way of financial compensation to the complainant. In addition, there PSOW can issue a Public Interest Report and reports issued under Section 16 or Section 21. During the period of 01 July to 31 July 2020, the health board have received no new PSOW enquiries.

5. Claims

The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. The Executive Committee are required to provide copies of their meeting minutes to the Board for information purposes.

From 1 October 2019, Welsh Risk Pool Services (WRPS) process for reimbursement of claims requires a Learning from Events Report within 60 working days following an admission of liability. On approval of the learning the health board can seek financial reimbursement of the claim.

The emphasis has been reiterated on an all Wales basis that the learning has to be robust and any action that the health board say they will be undertaking from the identified learning will need to be evidenced. Additionally, if a number of claims submitted have the same issue and it is clear that the learning is not taking place then the health board can be financially penalised.

Quarterly meetings have been reinstated with health board and NHS Trust legal services managers/ team leads for clinical negligence and personal injury claims and general advice matters. This supports regular communication and discussion of claims and provides an opportunity for discussion on schemes of delegation and other related matters. A Post Covid-19, a meeting to discuss clinical negligence cases took place on the 31 July 2020, with further meetings scheduled.

5.1 Claims Profile

The health board has a relatively small compensation claims profile in respect of both clinical negligence and personal injury claims. As of July 2020, there a total there are 22

claims which are split as 15 clinical negligence and 7 personal injury claims.

Whilst Powys Teaching Health Board claims profile is small, it is being anticipated that due to Covid-19, there may be an increase across both clinical negligence and personal injury claims.

5.2 Clinical Negligence

As of 31 July 2020, the health board have 11 open clinical negligence (PCN) claims in which Legal and Risk are instructed with inclusive of two new claims being opened during Quarter 1 of 2020/2021.

There are cases which are pending letters of claim but NWSSP Legal and Risk Services are aware of these matters. Following review, as the investigations have not commenced, there is limited information on the cases and to date no theme or trend has been identified. The Committee will be kept appraised of the progress of these cases including any learning that may arise.

6. Patient Safety Solutions

Performance for all Health Boards and Trust in Wales can be found at http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data.

The health board reported compliance on the 28 August 2020 with PSA 008 nasogastric tube misplacement: continuing risk of death and severe harm (issue was 2017) the policy now developed, training provided and clinical audit scheduled. Five Patient Safety Solutions remain open, two of which are due for compliance by November 2020. See table below for current position:

PSN Number	Date of Issue	NHS Wales-Alerts	Compliance Deadline date	Non-compliant/ No response	31/08/2020
PSN034	28/09/2016	Supporting the introduction of the National Safety Standards for Invasive Procedures	28/09/2017	Non-compliant	Considerable work taken to date and recent action taken to check position re theatres and Outpatients Department (OPD) has identified some further local standards for invasive procedures (LocSSIps) are required for OPD procedures. This work is being progressed.
PSN 051	Feb-20	Depleted batteries	28/08/2020	Non-Compliant	Initial checks

		in intraosseous injectors			during covid-19 period reported this alert as not applicable, but a further check is being undertaken over the next two weeks to confirm this remains the position and aim to report compliance in the next few weeks.
PSN 052	Feb-20	Risk of death and severe harm from ingesting superabsorbent polymer gel granules	31/08/2020	Non-Compliant	Few areas have used this product. Risk assessments in place where they have been used. Further checks initiated, the aim to report compliance in the next few weeks.
PSN 053	Feb-20	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	05/11/2020	Not Due	Action taken and work in progress
PSN 054	27-Aug-20	Risk of death from unintended administration of sodium nitrite	12/11/2020	Not Due	Action taken and work in progress

NEXT STEPS:

(1) To DISCUSS and NOTE the contents of this paper.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 1 OCTOBER 2020**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Helen Kendrick, Quality and Safety Manager
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

The Experience, Quality and Safety Committee is asked to DISCUSS this report and NOTE the outcomes of Regulatory Inspections across the health board.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to DISCUSS this report and NOTE areas of good practice and that appropriate actions are underway to address areas identified as requiring improvement. Health Inspectorate Wales reports included in the report have been published and are therefore within the pubic domain.

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:

This paper provides the Experience, Quality & Safety Committee with an update on the most recent Regulatory Inspections undertaken and also any planned inspections the health board has been notified of. The health board is constantly striving to continue to make improvements in response to recommendations made following such inspections and ensure any learning is shared widely.

The monitoring and management of the Health Inspectorate Wales (HIW) electronic tracking tool, previously implemented by the Clinical Governance Team, has recently been handed over to the Quality and Safety Team, who will maintain the tracker, and develop means to close completed improvement plans with HIW.

DETAILED BACKGROUND AND ASSESSMENT:

Environmental Health Service (EHS)

An unannounced inspection was undertaken by EHS on 29th July 2020 following which the Food Hygiene Rating was revised from a 4 to a 5, which is the highest grade that can be awarded.

This means that 8 of 9 hospitals now have a rating of 5. Machynlleth Hospitals is on a rating of 4, with the kitchen currently decanted to the day hospital pending refurbishment.

Health Inspectorate Wales Inspections

Tier 1 Quality Checks General Hospitals

The health board was notified by HIW of a planned Tier 1 Quality Check to be undertaken on 16 September of Bryn Heulog Ward, Newtown Hospital. A revised date of 16 October has been agreed following a request from the health board to postpone the inspection due to staffing challenges amongst the senior team on the ward. The Tier 1 Quality Check is conducted remotely and will take place via Teams platform, with a completed self-assessment due to be submitted to HIW by 8th October. The Quality Check will focus on the following areas:

- Governance
- Infection Prevention and Control
- Environment

The Committee will be updated on outcomes following the inspection.

Tier 1 Quality Checks Mental Health

The health board has been notified by HIW of a planned Tier 1 Quality Check to be undertaken on 30 September of Tawe Ward, Ystradgynlais Hospital. The Tier 1 Quality Check is conducted remotely and will take place via Teams platform, with a completed self-assessment submitted to HIW by one week before the inspection. The Quality Check will focus on the following areas:

- Governance
- Infection Prevention and Control
- Environment

The Committee will be updated on outcomes following the inspection.

Review of Youth Services

HIW wrote to the health board on 11 September 2020 requesting information and assurance around the actions the health board has implemented following a review of youth services. The report *"How are healthcare services meeting the needs of young people?"* was published in March 2019. The report made 37 recommendations for the

Welsh Government, health boards and independent service providers to consider and action on. HIW have requested a response on all recommendations by 9 October 2020. The Committee will be kept informed of the outcome following submission to HIW.

National Maternity Review – Inspection of Birth Units

The national review of maternity services across Wales continues. HIW have undertaken inspections at birth units at Welshpool, Newtown, Llanidloes, Knighton, Llandrindod Wells and Brecon commencing on 10 February 2020.

The health board has not received any formal response from HIW since submission of the completed action plan on 30 June 2020. However, the final report was published by HIW on 21 July 2020 and can be viewed in **Appendix 1**.

Online Maternity National Review of Women and their Families

The national review has collected evidence in a number of ways, one of which is through the national online survey for women and their families. People who have experience of using maternity services in Wales were asked about their experiences through the antenatal period, while giving birth, and then how they felt about the post-natal support they received.

The health board has been notified of the user feedback specific to Powys Maternity Services which has subsequently been considered as part of a "Family Centred Care" Midwifery Management and Leadership meeting, held Tuesday 11th August, and actions to inform learning and service improvement agreed. The outcomes and actions will be monitored via the Quality Governance Group.

The health board has held discussions with HIW to understand more detail and context to the online survey. HIW have been supportive in providing additional information to inform our understand of the background, analysis and results, confirming the focus on the public report will be aimed at reporting themes. Noting the number of responses for Powys were low, we have requested access to the positive feedback.

The health board looks forward to receiving Powys specific feedback in full and the publication of the wider report of the All Wales themes. The group will kept informed.

Inspection of Community Mental Health Team (CMHT) – Newtown Hospital

The Group has previously been informed a joint inspection by HIW and Care Inspectorate Wales (CIW) took place on 4 and 5 February 2020. This followed the 2017/2018 Joint Thematic Review of Adult Mental Health in the Community and further CMHT inspections conducted in 2018-2019.

On 13 July 2020, the health board received notification from HIW the response to the improvement plan had been evaluated and they had concluded it provided sufficient assurance. This is because the improvements identified have either been addressed and/or progress is being made to ensure that patient safety is protected.

The final report was published by HIW on 20 July 2020 and can be viewed in **Appendix 2.**

Care Inspectorate Wales (CIW)

The Group has previously been notified that on 12 March 2020 CIW undertook an inspection of Cottage View Care Home, Knighton. Cottage View provides care and support for up to ten people. The registered provider is Powys Teaching Health Board with an appointed responsible individual (RI) to oversee the operation of the service. A manager has day-to-day responsibility and is registered with Social Care Wales (SCW).

The health board awaits the final report and notice of the intended date of publication.

Community Health Council (CHC)

Dyfi Valley Health, Machynlleth (GP Practice)

The Community Health Council undertook a visit at Dyfi Valley Health on 20 November 2019. The CHC contacted the health board on 7 September 2020 to advise there had been a delay initially with the Practice approving the draft report and then COVID-19. The health board has received the draft report and been given the opportunity to provide comments.

Once the report is finalised the committee will be informed of the findings including the recommendations and progress against them

Newtown Medical Practice (GP Practice)

The Community Health Council undertook an announced visit at Newtown Medical Practice on Wednesday 5th February 2020. The purpose of the visit was to obtain a view as to how the Practice is operating and to gain patients' comments. The visit consisted of observations and patient experience through survey. The impact of COVID-19 resulted in the draft report not being received by the health board until 11 September 2020. The health board is required to provide a written response to the CHC by 9 October 2020.

Once the report is finalised the committee will be informed of the findings including the recommendations and progress against them.

Health Inspectorate Wales Tracker

The monitoring and management of the Health Inspectorate Wales (HIW) electronic tracking tool, previously implemented by the Clinical Governance Team, has recently been handed over to the Quality and Safety Team, who will maintain the tracker, and develop means to close completed improvement plans with HIW.

The management and monitoring of the HIW Tracker have been adversely affected by the Covid-19 pandemic. This work has recommenced, with position updates against each

recommendation being collated. A detailed report in relation to compliance and any overdue actions will be available for the next Experience Quality and Safety Committee.

Hospital Inspection (Announced)

Community Hospital Free Standing Birth Units – Maternity Services, Powys Teaching Health Board

Inspection dates: 10 - 14 February 2020

Publication date: 21 July 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

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Website: **www.hiw.org.uk**

Digital ISBN 978-1-80038-912-0

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspections of the community hospital birth units within Powys Teaching Health Board on the 10 – 14 February 2020. These inspections are part of HIW's national review of maternity services across Wales[1].

The following hospital free standing birth units were visited during these inspections:

- Llandrindod Wells Memorial Hospital (Ithon Birth Centre), with a capacity of two birthing rooms including one birthing pool and one clinical room.
- Brecon Hospital (Brecon Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.
- Welshpool Memorial Hospital (Welshpool Birth Centre), with a capacity of three birthing rooms.
- Newtown Hospital (Newtown Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.
- Llanidloes War Memorial Hospital (Llanidloes Birth Centre), with a capacity of two birthing rooms including one birthing pool and one clinical room.
- Knighton Hospital (Knighton Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.

Our team, for the inspection comprised of two HIW inspectors and two midwife clinical peer reviewers. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

[1] https://hiw.org.uk/national-review-maternity-services

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspections

Whilst we identified some areas for improvement, overall we found evidence that the service provided respectful, dignified, safe and effective care to patients.

There were some good arrangements in place to support the delivery of safe and effective care, and positive multidisciplinary team working.

This is what we found the service did well:

- Women rated the care and treatment provided during their time in the units as excellent
- We observed professional and kind interactions between staff and patients, and care was provided in a dignified way
- There was a safe and robust process inspected for medicines management
- Documentation was of a high standard
- Excellent health promotion information was seen throughout the units
- Care given was to a high standard with clear continuity in care planning
- The units were all found to be clean, welcoming and suitable to meet the needs of mothers to be and their families.

This is what we recommend the service could improve:

- Evacuation methods of the birthing pool
- Review of emergency drill processes
- Review of environments within Llanidloes War Memorial Hospital and Knighton Hospital.

3. What we found

Background of the service

Powys is a rural health board that provides some services locally, through GPs, community hospitals and primary care community services. Powys provides services for some 133,000 residents over a large, rural geographical area.

Powys Teaching Health Board does not have its own District General Hospital, but pays for Powys residents to receive specialist hospital services in hospitals outside of the county. Shrewsbury and Telford Hospitals NHS Trust makes up the largest proportion of the commissioned activity and Wye Valley NHS Trust is the second largest. In Wales, the health board buys services from Hywel Dda, Aneurin Bevan, Swansea Bay and Cwm Taf Morgannwg University Health Boards. This covers all specialities, however Powys Teaching Health Board is not the majority commissioner of any acute provider.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages over 220 births per year, which has remained relatively stable over the last three years.

Women who birth within the health board area have the choice of two birth settings types. These include homebirths and free-standing midwife birthing units across the locality of Powys.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients were positive about their overall experience of the service. They told us they were happy with the care and support provided to them. Without exception, patients also told us that they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients.

Health promotion information was clearly displayed within the birthing units.

The health board should however, ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

During the inspections, we distributed HIW questionnaires to service users to obtain their views on the standard of care provided. A total of 15 questionnaires were completed. We were also able to speak with 12 patients during the inspections.

Comments from patients who completed questionnaires included:

> *"The staff were so supportive and brilliant the whole time from the midwives to the maternity support worker they're all amazing and go above and beyond for our needs"*
>
> *"This unit and the staff are absolutely amazing and would recommend it to anyone".*

Staying healthy

Across the units, we saw adequate information displayed for patients on notice boards, and leaflets were readily available to inform patients of how they can stay safe and healthy. Information in relation to breastfeeding and skin to skin advice was displayed within the units, to inform patients about the benefits of both, to

help them make an informed decision about their care. Hand hygiene posters and hand washing guides were also displayed.

We saw information in relation to smoking cessation throughout the birth units. We were also told that the health board are currently developing roles of smoking cessation leads to provide support and information to patients. We also noted leaflets on healthy eating and the recommended vaccinations during pregnancy widely displayed. We found from a sample of maternity care records reviewed, that public health messages were clearly documented, for example, smoking cessation advice.

Dignified care

During the course of our inspections, we saw examples of staff being kind and compassionate to patients. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of comments within the patient questionnaires were also very positive. We reviewed care documentation and did not find any areas of concern regarding dignified care.

There were en-suite facilities within the birthing rooms on all of the units, which helped promote patients' comfort and dignity during their stay. All patients who completed questionnaires told us that the units were clean and tidy. Patient comments included:

> *"It's always lovely and clean and quiet here at the unit".*

We saw that staff maintained patient privacy when communicating information. We noticed that it was normal practice for staff to close doors of rooms to protect the patient's privacy and dignity when providing care and support.

Most patients who completed questionnaires told us they saw the same midwife in the birthing units as they did at their antenatal appointments. The majority of patients were six to twelve weeks pregnant when they had their booking appointment, and all patients told us that they had been offered a choice of where to have their baby.

All of the patients who completed questionnaires agreed the midwife asked how they were feeling and coping emotionally in the antenatal period. All patients agreed that staff were always polite to them and to their friends and family, and agreed staff listened to them throughout the care given.

Patient information

We found that directions to the units were clearly displayed throughout the hospital sites we visited. This made it easily accessible for people to locate the appropriate place to attend for care.

When access was required out of core hours, signs were clearly displayed to direct people appropriately to the birthing units. The units were found to be secure and can only be accessed by a staff swipe card or buzzer entry to maintain security.

Information was available in both Welsh and English. Notice boards throughout the units highlighted areas such as Putting Things Right[2], Powys Birth Reflections and Trauma Service and Domestic Abuse services for Powys.

We saw within all units a 'Who's Who' staff information board which was useful in informing patients and families who they would be likely to see within the units.

We also noted that information was displayed within all units pertaining to dashboard data and statistics. We were told that this data was also regularly shared with the public on the open Facebook page, which the inspection team found to be good practice.

Communicating effectively

Overall, service users were positive about their interactions with staff during their time in the units. All patients who completed questionnaires told us they were offered the option to communicate with staff in the language of their choice.

The use of language line was available for those patients whose first language was not English, meaning they were able to access care appropriate to their needs. From a sample of maternity care records reviewed we also found documented evidence to highlight that communication needs, including the need for interpreters or for the information to be made available in other languages were fully assessed during antenatal appointments.

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[2] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

Staff we spoke with were aware of the translation services within the health board and how they were able to access these for patients who had difficulty understanding English.

Timely care

Although there were no labouring patients seen in the units at the time of the inspections, we were told by staff and patients who had been invited in to speak with us that, staff would always do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs.

All staff we spoke with in the birthing units told us that they were able to achieve high standards of care during their working day.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the birthing units.

We also found that family members or partners were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. Open visiting was available, allowing the partner, or a designated other, to visit freely.

We were told that patient's personal beliefs and religious choice would be captured during antenatal appointments, with a view to ensuring they were upheld throughout their pregnancy, during labour and throughout all postnatal care.

Patient's birth plans were also seen to promote independence by demonstrating birth place choices being met when clinically possible.

People's rights

As these were freestanding midwifery led units[3], visiting times were flexible. The birthing rooms were all private meaning that birthing partners or other family members could be present before, during and after giving birth, according to the woman's wishes.

All patients who completed the questionnaires agreed staff called them by their preferred name.

The birthing rooms within the units were equipped with a birthing ball, birthing mat and a bed to help meet the patients' birth choices. However, the option to have a water birth was not available to all patients as there was no birth pool in the Welshpool Birth Unit. This may have had a detrimental effect on the number of patients who booked to give birth there.

We were told that to help patients make informed choices, discussions about the birth options take place at the initial booking appointments and continued throughout the pregnancy. This was evident from the completed questionnaires with all respondents agreeing that staff had explained their birth options, any risks related to their pregnancy and that support they had been offered. These discussion were also found to be clearly documented in the sample of maternity care records we reviewed.

Listening and learning from feedback

We saw information leaflets and posters throughout the units relating to the complaints procedure for patients to follow should women or their families have concerns they wish to raise. Information was also available on raising concerns and advocacy support on the health board's website. We were told that staff were fully aware of the NHS process for managing concerns - Putting Things Right, and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints but that they did not routinely provide patients with details

[3] Freestanding midwifery led unit provides a home from home environment, enabling women to give birth within a non-clinical setting.

of the Community Health Council (CHC)[4], who could provide advocacy and support to raise a concern about their care.

Improvement needed

The health board must ensure that:

- Birthing pool facilities are reviewed within the Welshpool Memorial Hospital to increase birthing numbers within the unit
- Patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

[4] http://www.wales.nhs.uk/sitesplus/899/home

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We identified good processes in place within the units to support the delivery of safe and effective care.

We found that there were robust processes in place for the management of medicines, pain assessment and clinical incidents, ensuring that information and learning is shared across the service.

We found patient safety was promoted in daily care planning and this was reinforced within the maternity care records we reviewed.

However, we identified areas for improvement in record keeping.

The service described clear and concise arrangements for safeguarding procedures, including the provision of staff training.

Safe care

Managing risk and promoting health and safety

We found that the units were visibly well maintained, clean, appropriately lit and well ventilated. The units were well organised with a maintained stock of medical consumables.

We looked at the environment and found sufficient security measures in place to ensure that babies were safe and secure within the units. We noted that access to the birthing units was restricted by locked doors, which were only accessible with a staff identity pass or by a member of staff approving entrance.

We looked at the arrangements within the units for accessing emergency help and assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells to summon urgent assistance.

The inspection team reviewed the pool evacuation process within the birthing units of Llandrindod Wells, Brecon, Newtown, Llanidloes and Knighton and found that upon speaking with staff that there were inconsistencies in the processes being followed. It was also noted by the inspection team that evacuation

equipment, such as slide sheets or evacuation nets were not currently in place in all units.

We also noted that there were inconsistencies in emergency alarm drill testing in all of the units for emergency situations, such as a baby/patient requiring resuscitation. When the inspection team tested the processes, variance were seen in the emergency team arriving to the birthing units, with issues, such as their inability to access the units due to not knowing the access keypad number and staff arriving to the units without the defibrillation trolley.

Details of the immediate improvements we identified are provided in Appendix B.

We also saw from the maternity care records we reviewed and were told by staff that there were incidents regularly raised regarding communications between the units and the Welsh Ambulance Service Trust (WAST). These relate to the grading of the call being made and advice being given by the call handlers regarding the appropriate escalation processes to be followed by midwives. The health board reported that this was having a detrimental effect on response times to the community units in emergency situations.

Falls Prevention

We saw there was a risk assessment in place for patients admitted into the units and those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident reporting system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the birthing units were clean and tidy and we saw that Personal Protective Equipment (PPE) was available in all areas apart from the birthing rooms within the Welshpool Birthing Unit. We were advised by staff that PPE is readily available in all birthing kit bags, however it was advised by the inspection team that accessible equipment should be placed within all clinical rooms for ease. Patients who completed a questionnaire thought the units were well organised, clean and tidy.

During the inspections, we observed all staff adhering to the standards of being Bare Below the Elbow[5] and saw good hand hygiene techniques. Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for all. Hand hygiene gels were available throughout the units.

We were also assured that infection prevention and control training compliance was to a high standard, and any concerns that were raised regarding infection prevention and control would be escalated to senior members of staff. We saw results from an infection control audit which recently had been carried out by the health board. This audit showed that compliance with infection control was high and any work required was appropriately dealt with in a timely manner. Within all of the units, maternity statistics were also clearly displayed to show good practice, excellent compliance rates and achievements within the services as a whole.

We found equipment to be clean and ready for use in all units and we also noted that cleaning schedules for the units were in place and up-to-date.

We were told and saw evidence that the birthing pools in the relevant units were routinely cleaned every day, and a weekly check of the water was carried out. These checks ensured that the birthing pools were appropriately cleaned and safe to use.

The inspection team did however feel that upon review, the units within the Llanidloes War Memorial Hospital and Knighton Hospital required review to ensure that modernisation and improvements takes place.

[5] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

Improvement needed

The health board must ensure that:

- Escalation and engagement with WAST is reviewed to ensure patient safety in the event of an emergency
- Access to PPE within the units is reviewed to ensure infection prevention and control measures are in line with health board policy
- A review of the facilities within Llanidloes War Memorial and Knighton Hospitals takes place to ensure that infection prevention and control measures are in line with health board policy.

Nutrition and hydration

At the time of the inspections, no labouring patients were seen within units, however, we were told that hot and cold food and drinks were available 24 hours a day. Staff on the units had access to facilities to make food and drinks for patients outside of core hours, which allowed for nutritional needs being met throughout the day and night.

Within all of the community hospitals, there were facilities available to purchase drinks if required. We were also told by staff that water jugs and tea and coffee facilities would be made available in the birthing rooms.

Medicines management

We looked at the arrangements for the storage of medicines within the birthing units and found that the temperatures at which medicines were stored were consistently checked on a daily basis.

We observed the storage, checks and administration of drugs to be safe and secure.

We also noted that a medicines management policy was in place and up-to-date and the staff that we spoke to acknowledged that they were aware of where to access the policy.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be vulnerable or at risk. All staff we spoke with confirmed that they had received mandatory safeguarding training within the past 12 months.

Safeguarding training was included in the health boards mandatory study days and we were told that sessions included training and guidance regarding Female Genital Mutilation (FGM), domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. The lead safeguarding midwife was also available for telephone discussions to provide support and guidance to staff on the units.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the units, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We found the checks on the neo-natal resuscitaire[6] to be consistently recorded demonstrating that they had been carried out on a daily basis. We also found the neonatal resuscitaires within all units to be adequately and appropriately fully stocked.

We also found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

[6] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

Effective care

Safe and clinically effective care

The majority of staff who completed a questionnaire shared that they were always or usually happy with the quality of care they were able to give to their patients within the birthing units. We were told by staff that patients in the birthing units would always be kept comfortable and well cared for. We also saw good evidence of assessment and treatment plans throughout the maternity care records reviewed. Within this sample, we were also able to see that clinical need prioritisation was taking place and that it was forefront in care planning.

We were told that there is an infant feeding coordinator appointed within the health board, staff also said that they would feel happy to give support in all methods of feeding when required.

Quality improvement, research and innovation

A consultant midwife who is responsible for leading on clinical research and innovation was in post, and supported all maternity services across the health board. Midwives were also encouraged to get involved in research projects to support the team. The clinical research and innovation midwife was also involved in research associated with local university projects to support service and patient experience development.

A large element of the team's work involved developing service user engagement. We saw that the service had developed their social media, including a Facebook page as a way of reaching out to patients.

Information governance and communications technology

We found secure measures in place to store patient information, upholding patient confidentiality and to prevent unauthorised access within the units.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures, however, we found a number were out-of-date and requiring review and at the time of the inspections.

We found that a quarterly maternity dashboard was produced which included information in relation to each birth unit and across the health board. This provided information with regards to the clinical activity such as birth rates and infection prevention and control activity.

Record keeping

Overall, we found maternity care records had been generally well maintained with clear documentation which was completed in a timely manner.

We considered a sample of maternity care records which demonstrated that appropriate risk assessments, including those for deep vein thrombosis, had been completed. However, in one maternity care record we saw inconsistency in the routine enquiry form being completed. Records showed that pain was being assessed and managed appropriately.

We did however see good accountability and signage within the nine maternity care records we reviewed.

Improvement needed

The health board must ensure that:

- Concise record keeping is maintained
- Policies and procedures are reviewed and updated within appropriate timescales to ensure consistency in care.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Staff were striving to deliver a good quality, safe and effective care to patients within the units.

Staff reported that there was good multidisciplinary team working, and we saw evidence to support this.

Operational Team Leaders were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

We found evidence of supportive leadership and management. Staff who we spoke with were positive regarding the support they received from senior staff.

Governance, leadership and accountability

We found that there was good overall monitoring and governance of the staffing levels of the service, and we were assured that the internal risk register was monitored and acted upon when required.

We could see that there was an excellent level of oversight of clinical activities and patient outcomes. A monthly maternity dashboard was produced, which included information in relation to the whole health board, but also broken down to each unit. This provided information on the clinical activity on the units, such as category of births and also clinical indicators and incidents, such as complaints and investigations. The dashboard was rated red, amber and green depending upon the level of risk meaning that prioritisation and risk management could be managed appropriately.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies:

Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[7] and Each Baby Counts[8] were taken forward in the units. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies, such as MBRRACE, and ongoing work takes place to ensure the units are in line with the recommendations made.

We saw evidence of audit completion, such as internal infection prevention audits for hand hygiene. We also saw recent evidence of health and safety and fire drill audit compliance.

The health board demonstrated a clear and robust process for managing clinical incidents. A lead risk midwife was in post, who held responsibility for monitoring and reviewing clinical management of multidisciplinary investigations. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were not dealt with in a punitive manner. We were also told that all staff would be given the opportunity of non-clinical time, allowing them to review incidents appropriately, which was seen to be good practice.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead risk and governance midwife also presented themes and trends to this meeting, with the view of highlighting any areas of practice, which needed to be addressed across the health board. Following this meeting, a monthly feedback newsletter was produced and circulated to all staff, summarising the month's issues. We also saw that this newsletter was used to provide positive feedback to staff, and to highlight where good practice had been evident. We saw that minutes were produced and information/learning shared within maternity services and across the health board to support changes to practice and learning. This information also included other maternity sites within

[7] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

[8] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

the health board, with a view to sharing best practice and any learning in order to improve practice and processes.

Staff and resources

Workforce

During the inspections, we were able to speak with many members of staff within the units and we also received 52 completed staff questionnaires which we had distributed. Overall, the majority of staff told us that they felt fully supported by their senior managers and that peer support was also very good. Staff reported that there was good multidisciplinary working within the service. Some comments received in the completed HIW questionnaires were:

> *"Management very supportive and always has time to listen and help. Goes above and beyond to support individuals professionally and personally and the team as a whole. It is a privileged to have her as our team's band 7".*

> *"Our senior management team always encourage inclusion with meetings and decision making".*

The staff we spoke to also told us that the organisation encourages and supports team working.

The majority of staff who completed a questionnaire said they were involved in decisions about changes that affect their work, and half of staff said that communications were effective.

We were told by the staff that midwifery rotas were managed well within the units we visited.

We saw there were departmental escalation processes in place and staff we spoke with were aware of where to locate the policy and how to escalate issues, such as staffing shortages.

We saw evidence of robust induction programmes for midwifery staff and staff felt these were of benefit when commencing their role.

We found there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and control and safeguarding, is predominately completed on-line and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is Practical Obstetric and Multi-Professional Training (PROMPT)[9], which is a multidisciplinary training event used to encourage effective multidisciplinary working in emergency situations. All staff we spoke with, told us they attend the training and find it very useful. We were shown compliance figures for PROMPT training and were assured that training was appropriately taking place within the correct timescales.

The health board had a lead midwife for practice development/practice facilitator, and part of their role was to monitor compliance with training across the year. We were able to see that a quarterly report is produced for senior midwifery staff to show training compliance. Staff are required to book themselves onto the relevant training days, and attendance/non-attendance at training is reported to the senior teams.

There is also a clinical supervisor for midwives in place across the health board. This role offers group supervision and one to one meetings which were also seen to be compliant with the clinical supervisor for midwives key performance indicators[10]. The health board monitor compliance with this target during the previous financial year and were continuing to monitor it on an ongoing basis.

We were told that within Powys Teaching Health Board, all appraisals were up-to-date. Staff we spoke with told us they have regular appraisals which are completed by their operation team leaders. They saw them as positive meetings to help identify further training opportunities to increase continuous professional development.

We found that there was a good level of support in place from the operational team leaders, who we were told made efforts to be visible and approachable to staff within the units. Information provided to us during the course of the inspections demonstrated that they were knowledgeable about their specialist role.

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[9] PROMPT - Practical Obstetric and Multi-Professional Training. The course teaches attendees how deal with obstetric emergencies.

[10] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

4. What next?

Where we have identified improvements and immediate concerns during our inspections which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspections
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspections where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspections the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspections

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

The table below summaries the concerns identified and escalated during our inspections. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspections.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
N/A			

Appendix B – Immediate Improvement plan

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

Delivery of safe and effective care
During our inspections, we identified concerns relating to patient safety. As a result, we could not be assured that patient safety is maintained in relation to the issues detailed below. The inspection team reviewed the pool evacuation process within the birthing units of Llandrindod Wells, Brecon, Newtown, Llanidloes and Knighton and found that upon speaking with staff that there were inconsistencies in the processes being followed. It was also noted by the inspection team that evacuation equipment such as slide sheets or evacuation nets were not currently in place in all units. We noted that there were inconsistencies in emergency alarm drill testing in all of the units for emergency situations such as a baby/patient requiring resuscitation. When the inspection team tested the process, variance was seen in the emergency team arriving to the birthing units, such as:- • Inability to access the units due to not knowing the access keypad number • Staff arriving to the units without the defibrillation trolley.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take to: Ensure that the pool evacuation process is reviewed to ensure safety for women and staff performing the procedure and that staff are fully trained and aware of their responsibility in this area.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	* Interim Pool Evacuation Policy implemented to provide clarity of process for Evacuation whilst long term plans are being developed * Dry run drills provided to each of the midwifery teams and facebook live demonstration to ensure all staff familiar with updated procedure and use of relevant appendices * Equipment Devises Order Form processed for the purchase of Birthing Pool Evacuation slings and pairs of non-disposable slide sheets 198cm long and flat not a tube * Business plan for the implementation ceiling hoist systems to be purchased over a two-year period for each birth centre with Welshpool Birth Centre as a priority.	Head of Midwifery and Sexual Health Clinical Supervisor for Midwives Head of Midwifery and Sexual Health W&C Business Support	Completed 14th Feb 2020 1 week 21st February 2020 Completed 19th Feb 2020

The health board must provide HIW with details of the action it will take to ensure that: There is an appropriate system in place to ensure that emergency alarm drill testing for emergency situations, such as a baby/patient requiring resuscitation is carried out in line with health board policy and that staff are fully aware of their responsibility within this area.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	***** Schedule of regular call bell drills * Facilitate community hospital-based emergency call bell drills involving Powys Midwifery Teams & relevant community hospital staff * Powys Midwives to be involved with the development of the site-specific resuscitation plan * Ensure all midwifery staff participate in the regular mock drills carried out within their community hospitals * Seek assurance from all services that where emergency call bell drills	Governance Lead Assistant Head of Midwifery and Sexual Health Resuscitation Committee Head of Clinical Education	Completed 14th Feb 2020 1 – month 12th March 2020 30th June 2020 30th June 2020

		form part of the response to emergencies, that these are effectively undertaken. * Request to the Resuscitation Committee to oversee/review the mock arrest drills in place in all areas across the health board to ensure these involve a multi-professional response from linked areas, for example, general wards supporting birth centres, mental health areas, leaning disability areas and vice versa.	Resuscitation Committee Assistant Director Quality & Safety	30th June 2020 31st March 2020

Health Board Representative:

Name (print): **.....Julie Richards / Wendy Morgan …….....**

Role: **.....Head of Midwifery and Sexual Health / Assistant Director .....**

Date: **.....20th February 2020.....**

Appendix C – Improvement plan

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

The table below includes any other improvements identified during the inspections where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the birthing pool facilities are reviewed within the Welshpool Memorial Hospital to increase birthing numbers within the unit.	4.1 Dignified Care	Maternity services are working in partnership with Capital Estates and league of friends for the installation of birth pool facilities for Welshpool Memorial Hospital. Funding has been agreed with League of Friends and pool has been ordered	Women and Children's Business Support	Timeframe delayed for installation due to COVID19 Estates work planned to commence by

Improvement needed	Standard	Service action	Responsible officer	Timescale
				September 2020 and completed by December 2020
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	4.2 Patient Information	The contact details for the Community Health Council are displayed and available in all clinical areas Community Health Council details are provided to clients who raise informal concerns so they are aware of support and advocacy availability The compliance is monitored by Environmental audits by Band 7 Operational Team Leaders	W&C Governance Lead	Complete
Delivery of safe and effective care				
The health board must ensure that escalation and engagement with WAST is reviewed to ensure patient safety in the event of an emergency.	2.1 Managing Risk and Promoting Health and Safety	Maternity services are working in partnership with WAST colleagues for quarterly review of transfer times which have been collated from January 2020		Quarterly review arrangements in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective Care		W&C Governance Lead	Review September 2020
The health board must ensure that access to PPE within the units is reviewed to ensure infection prevention and control measures are in line with health board policy.	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care	Review of the Birth Centre areas has been undertaken and assurance gained that there is access to appropriate PPE to ensure infection prevention and control measures are in line with health board policy.	Assistant Head of Midwifery and Sexual Health	Complete
The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy.	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination	Maternity services are working in partnership with Capital Estates for review of Llanidloes War Memorial Hospital and Knighton Hospital to improve facilities for the environment Plans for Phase 1 (redecoration), 2 (bathroom improvement) and 3 (Pool	W&C Business Support	Knighton programme of work commenced with phase 1 completed. Timescales to be agreed in July Capital

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective Care	Hoist insertion and Double Bed) have been developed for Knighton Birth Centre Llanidloes Birth Centre improvement plan to be developed on completion of Welshpool and Knighton project plans.	W&C Business Support	Estate for Phase 2 and 3 work to be completed by March 2021 To present to Capital Estates meeting in September 2020
The health board must ensure that concise record keeping is maintained.	3.1 Safe and Clinically Effective Care	Clinical Supervisor for Midwives discusses documentation standards at group supervision session to ensure concise recordkeeping is maintained The Clinical Supervisor for Midwives also provides monthly recordkeeping audits for staff, where they can review sets of notes and learn directly from any good / poor practice identified in the session. The audit results are fed back at Group Supervisions session	Clinical Supervisor for Midwives	Monthly Monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales to ensure consistency in care.	3.1 Safe and Clinically Effective Care	Women's and Children's Policy and Procedures group has an action plan that lists all policies and guidelines developed, which include revision dates. All policy / guideline authors are approached by the appropriate forums within the Health Board when policy review is required Updated terms of reference for the Women and Children's Policies and Procedures Management for Service Leads for guideline development to meet review dates to enforce and support lines of accountability Monthly Women and Children's Governance meetings are monitoring progress and performance against the Policy and Procedures action plan	Women and Children's Policies and Procedures Management Group Chair Women and Children's Policies and Procedures Management Assistant Director for Women's and Children's Services	Reviewed June 2020 Monthly Completed June 2020 Monthly with review October 2021

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Julie Richards

Job role: Head of Midwifery and Sexual Health services

Date: 26th June 2020

HIW & CIW: Joint Community Mental Health Team Inspection (Announced)

Newtown Community Mental Health Team, Powys Teaching Health Board and Powys County Council

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales

Our values

Our Core values ensure people are at the heart of everything we do and aspire to be as an organisation.

- **Integrity: we are honest and trustworthy**
- **Respect: we listen, value and support others**
- **Caring: we are compassionate and approachable**
- **Fair: we are consistent, impartial and inclusive**

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction the next three years. These are:

- **To consistently deliver a high quality service**
- **To be highly skilled, capable and responsive**
- **To be an expert voice to influence and drive improvement**
- **To effectively implement legislation**

1. What we did

Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) completed a joint announced community mental health inspection (CMHT) of Newtown Community Mental Health Team within Powys Teaching Health Board and Powys County Council on 04 and 05 February 2020.

Our team, for the inspection comprised of two HIW inspectors, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one Care Inspectorate Wales (CIW) inspector. The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with the Act.

HIW and CIW explored how the service met the Health and Care Standards (2015) and the Social Services and Well-being (Wales) Act 2014. HIW also consider how services comply with the Mental Health Act 1983, Mental Health Measure (2010), Mental Capacity Act (2005).

Further details about how we conduct CMHT inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all Health and Care Standards (2015), Mental Health Act 1983 and the Social Services and Well-being (Wales) Act 2014.

We found the quality of service user care and engagement to be generally good and service users were mainly positive about the support they received.

All referrals received by the team are screened on a weekly basis by the multidisciplinary team. We found that information shared between professionals was responded to in a timely manner.

We found that a multidisciplinary, person centred approach was in place for the assessment, care planning and review and that service users and their families were involved, where appropriate, in the process. However, some care documentation requires amending to better capture and reflect service users' views on how they wish to be cared for.

We found discharge arrangements to be satisfactory, in general, and tailored to the wishes and needs of service users.

Staff feedback in relation to workload and the quality of management and leadership was mixed, and this requires further exploration by the management team.

This is what we found the service did well:

- Integrated service
- Well maintained environment
- Access to service and allocation of caseload
- Availability of advocacy

- Carer involvement
- Staffing complement and diversity of roles
- Medication management
- Access to psychology services
- Approved Mental Health Professionals service provision
- Visibility and accessibility of service managers
- Staff support and supervision.

This is what we recommend the service could improve:

- IT and electronic records management system
- Initial assessment form
- Format and wording of Care and Treatment Plan template
- Terms of reference and involvement of other teams/service in the multidisciplinary team meetings
- Terms of reference for the hub meeting and streamlining to free up staff time
- Consulting room availability
- Compliance with Mental Health Act and Code of Practice
- Physical health screening
- Interface with local GP practice
- Availability of Section 12 doctors
- Local in-patient bed availability
- Secure transport/conveyancing
- Consistency of service across the county.

3. What we found

Background of the service

Newtown Community Mental Health Team (CMHT) provides community mental health services at Fan Gorau, Newtown Hospital (Montgomery County Infirmary), Llanfair Road, Newtown, Powys, within Powys Teaching Health Board and Powys County Council.

Newtown CMHT is one of five teams covering the county of Powys, with the other teams located at Welshpool, Llandrindod Wells, Brecon and Ystradgynlais.

The team operates within the confines of the Welsh Mental Health Measure 2010 (WMHM) alongside the Social Services Well-being Act (SSWBA) 2014.

The staff team includes Community Psychiatric Nurses (including team lead), Social Workers, Senior Social Work Practitioner (also acting as interim team leader), Approved Mental Health Professionals (AMHP), Occupational Therapist, Healthcare Support Workers, Consultant Psychiatrist and Psychologist.

At the time of the inspection, the CMHT had a full complement of staff. Several members of the team were newly recruited as a result of staff turnover and a number of retirements, mainly within the health board staff group, over the past 12 months.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Overall, we found evidence that the service provided safe and effective care. However, we found some evidence that the service was not fully compliant with all standards in all areas.

The service users who contributed to the inspection by completing a questionnaire were generally positive about the services they received. Service users, in the main, felt included and respected by the choices they were given.

During the inspection we distributed HIW questionnaires to service users to obtain their views on the standard of care provided by the CMHT. A total of six questionnaires were completed.

The majority of service users who completed a questionnaire rated the CMHT as either excellent or very good and the others rated the service as good. Comments included:

> *"I have always had excellent care and attention from all members of the team"*

Care, engagement and advocacy

Based on the service users' responses to the questionnaire, we determined the quality of care and engagement to be good, with most stating that their Community Mental Health Team worker gave them enough time to discuss their needs and treatment and that they are treated with dignity and respect.

All the service users who completed a questionnaire said that their preferred language was English, and all said they were always able to speak to staff in their preferred language. One member of the team was Welsh speaking.

We were told that service users were able to access to advocacy through the Powys Advocacy Service and Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA). However, only half of the service users who completed a questionnaire said that they had been offered the support of an advocate.

Improvement needed

The health board and local authority must ensure that service users are offered the support of an advocate and that this offer is recorded within care documentation.

Access to services

The team had recently re-located to Fan Gorau from a base in the town centre, making the service less accessible to some service users. Service users without their own transport, who were able to drop in to the former town centre base, now have to walk some distance, most of it uphill, to the new base on the Newtown Hospital site. However, once at the hospital site, access to the Fan Gorau clinic was accessible to people with mobility problems, with limited, designated disabled parking spaces located near the main entrance, and lowered curbs leading to the main entrance. There were adapted toilet facilities available adjacent to the waiting area.

The whole of the accommodation was in a good state of repair both externally and internally. The furniture and fixtures throughout the building were also in a good state of repair.

The waiting area and consulting rooms were clean and tidy. However, the availability of consulting rooms was an issue due to demand.

Health promotion leaflets and posters were available within the waiting area together with magazines for people to read whilst waiting to be seen.

The team receives between 50 and 60 referrals a week. We found access to the service and the referral process to be good. Referrals are considered at a 'hub' meeting, which included a range of professional staff, taking place every Tuesday. Any referrals which are deemed urgent are dealt with through the duty system. Staff workload and skill sets are considered when allocating cases. We observed a referrals meeting during the course of the inspection, which was attended by the consultant psychiatrist, a CPN and primary health worker and a senior mental health worker, and found the information sharing process to be good. However, we suggested that pre-meeting filtering takes place to make the meeting more effective and make better use of the time of the individuals present.

Referrals that required an assessment under the Mental Health Act were passed to one of the Approved Mental Health Professionals (AMHP) for action. At the time of the inspection there were 13 AMHPs working across Powys, (eight in the north of the county and five in the south). In addition two social workers were

working towards AMHP accreditation. The service manager had taken an active approach to recruitment and retention of AMHPs, with support through group meetings, training and remuneration being looked at. The operational policies within the CMHT were also being reviewed to ensure that the role of AMHPs, and the demands on their time was recognised.

Where appropriate, and if service users do not meet the threshold for secondary health care, they are referred to other services better placed to meet their needs.

We found that referrals were, in the main, received via general practitioners (GPs). However, referrals were also accepted from various sources such as other health or social care professionals or police.

Two thirds of the service users who completed a questionnaire said that they were referred to the CMHT by their GP, one referred themselves following discharge from an inpatient ward.

One service user said that it took them up to one week to be seen by the Community Mental Health Team following their referral and another said it took around two weeks.

All respondents said that it was easy to access support from the CMHT when they need it, with most respondents telling us that they felt they were seen by the CMHT about the right amount of times, though one respondent said they were not seen enough when needed.

All respondents said they knew who to contact within the CMHT if they have a concern about their case.

Where appropriate, people with caring responsibilities were offered carer assessments under the requirements of the Social Service Well-being (Wales) Act 2014.

Staff and managers told us that there was very little delay in accessing psychology services and that waiting times had reduced from two years to between three and four months.

A multidisciplinary meeting is held each Wednesday morning to discuss general issues around care planning and risk management. An extended multidisciplinary meeting is held each month to discuss additional matters such as policies and procedures. The meetings are usually attended by the consultant psychiatrist, CPNs, Occupational Therapist, members of the primary care mental health service and members of the Crisis Team. The meetings are chaired alternately by the Health and Social Work team leaders.

We discussed the need for the terms of reference of these meetings to be reviewed and clarified so that all staff are clear as to the scope of the meetings and the remit of the individuals present. Consideration was being given to inviting other external agencies to these meetings, where appropriate, and in circumstances where such agencies have input in the provision of services.

Out of hours emergency access to mental health services was provided by Powys Local Authority Emergency Duty Team (EDT). EDT consisted of AMHP provision, for assessments under the Mental Health Act.

Two thirds of service users who completed a questionnaire said that they knew how to contact the CMHT out of hours service. Of the four respondents who said they had felt the need to contact the CMHT out of hours service in the last 12 months, only two said they got the help they needed.

Most respondents said they knew who to contact in the CMHT if they have a crisis. Of those who needed to contact the CMHT in a crisis in the last 12 months, all said they got the help they needed.

We were told that there was a need to further develop partnership links within the local GP practices, and that the senior managers are working on joint strategy which involves joint visits with the service manager and social care team manager to ensure GPs are fully aware of the role and functions of the CMHTs.

Improvement needed

The health board and local authority must ensure that:

- Sufficient numbers of consulting rooms are available to ensure privacy and timely access to services
- Pre-meeting filtering takes place to make the hub meeting more effective and make better use of the time of the individuals present
- Terms of reference are drawn up for the MDT meetings
- Service users receive the support they need when contacting the CMHT out of hours service.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate. However, some care documentation requires amending to better capture and reflect service users' views on how they wish to be cared for.

The service had a system in place to enable patients to raise concerns/complaints and the service was able to demonstrate that they considered patient feedback to improve services.

The medication management processes were safe and robust.

Record keeping was generally good and service users' care notes were generally easy to navigate. However, action is required to ensure that the service is compliant with the requirements of the Mental Health Act 1983, and to ensure that the Mental Health Act Administration files are easy to navigate.

During the inspection we were notified by members of staff that there was a long standing and on-going problem with the electronic records management system, which often broke down, resulting in staff not being able to access service users' records in a timely manner, in order to update them, or to review them prior to consultations or meetings with service users.

We were also told that appointments were sometimes cancelled due to staff not being able to access service user records held on the system.

The system was not accessible at times during the course of the inspection.

Our concerns regarding the electronic records management system were dealt with under our immediate assurance process. This meant that we wrote to the health board and local authority immediately following the inspection requiring

that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in insert Appendix B.

Managing risk and promoting health and safety

The environment was found to be free of any obvious risk to health and safety.

General and more specific environmental risk assessments were undertaken and any areas identified as requiring attention were actioned. There was a ligature point risk assessment in place.

From inspection of care files, we found that individual service users' risk assessments had been undertaken.

Staff told us that positive risk management was part of service planning and delivery. Staff had received training in the Wales Applied Risk Research Network (WARRN)[1] risk management framework.

Staff told us that the weekly multidisciplinary meetings afforded them the opportunity to discuss and escalate any concerns. In addition, regular discussions between consultant medical staff and care coordinators promoted the escalation and documentation of identified risks.

Medicines Management

We found the management processes to be safe and robust with all drug charts completed accurately.

The clinic room was clean and tidy with all cupboards kept locked. Stocks were kept in good supply.

The medication management policy was available to staff on the intranet.

We saw that service users' medication was being reviewed on a regular basis, ranging between monthly or annually.

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[1] http://www.warrn.co.uk/

Assessment, care planning and review

There was a multi-disciplinary, person centred approach to assessment, care planning and review. From the care files inspected, we found that service users were involved in the development of the care and treatment plans and relevant people such as family members or carers were also involved where appropriate. However, some care documentation requires amending to better capture and reflect service users' views on how they wish to be cared for. This is referred to further in the Compliance with Social Services and Well-being Act section of this report.

The care files we viewed were generally well managed and easy to navigate.

Most of the service users who completed a questionnaire said that the service provided met their needs and that they felt involved in the development of their care plan. All respondents said they received or were given an opportunity to have a copy of their care plan.

The majority of service users who completed a questionnaire said that they had a formal meeting or review with their care coordinator in the last 12 months and that they felt involved in the discussions and decisions made about their care.

Two thirds of respondents said they were given the opportunity to challenge any aspect of their care and treatment plan that they disagreed with during their formal meeting or review, and a third said they didn’t disagree with anything in their plan.

We found that the systems in place to manage service users' physical health could be improved.

Half of the service users who completed a questionnaire said that they had needed support for physical health needs in the last 12 months. Of the two respondents who asked their CMHT for help or advice with finding support for their physical health need, one said they received help and one said they did not.

Most questionnaire respondents said the CMHT involved a member of their family, or someone else close to them, as much as they would have liked. One respondent said they did not want their friends or family to be involved.

All respondents said they had been given information (including written) by the CMHT.

Improvement needed

The health board and local authority must ensure that service users' physical health needs are assessed and that they receive help or advice with finding support for their physical health when they need it.

Patient discharge arrangements

Following our inspection of case files, discussions with staff and consideration of service user questionnaire responses, we found discharge arrangements to be generally satisfactory. This is because the process, in the main, was service user-led and managed in accordance with service users' requirements.

Most of the service users who completed a questionnaire told us that their accommodation, employment and education needs had been met through the services provided by the CMHT. Half of the respondents said that their social needs, (such as being able to go out when they want), had been met by the services provided through the CMHT with the remainder indicating that they did not have these needs.

Community Connectors were being developed in Powys, and an example was given of a Community Connector, based in the north of Powys, who had recently supported staff in focusing on service users' resilience, rehabilitation and social inclusion.

Safeguarding

Staff we spoke with were clear about their responsibilities in relation to safeguarding adults and children and were able to describe the reporting processes. Any children or adult safeguarding issues were discussed at the weekly MDT meeting and actions agreed.

There were clear policies and procedures in place for staff to follow and the training information provided confirmed that staff had received adult and child safeguarding training.

There were systems in place to support both Multi Agency Risk Assessment Conference (MARAC)[2], and Multi-agency Public Protection Arrangements (MAPPA)[3].

Compliance with specific standards and regulations

Mental Health Act Monitoring

We reviewed the statutory documents of two service users who were subject of Community Treatment Orders (CTO)[4] being cared for by Newtown CMHT, and spoke with members of the Mental Health Act Administration team. We highlighted a number of areas for improvement in respect of documentation relating to the detention of patients under the Mental Health Act. Issues highlighted included:

- Chapter 4, Paragraph 4.2 of the Mental Health Act 1983 - Code of Practice - Patients rights' under 132A of the Mental Health Act 1983 not evidenced in the patients file
- Chapter 35, Paragraphs 35.12 and 35.13 of the Mental Health Act 1983 - Code of Practice - Medical scrutiny of legal documentation should be undertaken and recorded

[2] A Multi Agency Risk Assessment Conference (MARAC) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

[3] MAPPA stands for Multi-Agency Public Protection Arrangements and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

[4] Patients who have been detained in hospital under the Mental Health Act, may be discharged on to a community treatment order (CTO). A CTO is an order made by a responsible clinician to enable supervised treatment in the community.

- Chapter 25, Paragraph 25.87 of the Mental Health Act 1983 - Code of Practice - Cancel certificates which no longer authorises treatment
- Chapter 24, Paragraphs 24.31, 24.33, 24.34 and 24.37 of the Mental Health Act 1983 - Code of Practice - Unable to locate documented record that capacity to consent assessment was undertaken
- Chapter 27, Paragraph 27.17 of the Mental Health Act 1983 - Code of Practice - All Section 17 leave authorisation forms should be clearly marked as no longer valid
- Patients' legal files were difficult to navigate.

Improvement needed

The health board must ensure that services are provided in line with the requirements of the Mental Health Act 1983 and Code of Practice, and that all supporting documentation is accurately completed.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the Care and Treatment Plans (CTP) of a total of seven service users and found that the assessment of service users' needs was proportionate and appropriate.

We found some consistency in the tool used to assess service users' needs and found this addressed the dimensions of life as set out in the Mental Health Measure and the domains set out in the Social Services and Well-being (Wales) Act, in most cases. However, we were told by staff that the current assessment form was too lengthy and very time consuming to complete.

Care plans were generally well structured and person centred and reflected service users' emotional, psychological and well-being needs.

We found the process of identifying, assessing and managing risk to be good. We found that risk assessments informed the interventions identified in the service user's care plan.

Issues were highlighted around the availability of Section 12 Approved doctors for Mental Health Act assessments during office hours. Staff also expressed concerns about the availability of local in-patient beds for emergency admissions and availability of transport for timely and secure transfer of service users to hospitals.

Improvement needed

The health board and local authority must review the initial assessment form.

The health board must:

- Take steps to ensure adequate Section 12 Approved doctors cover during day time hours
- Ensure the availability of local in-patient beds for emergency admissions
- Ensure the availability of transport for timely and secure transfer of service users to hospitals.

Compliance with Social Services and Well-being Act

It was evident from the care documentation seen, and from service users' responses to the questionnaire, that their views and wishes were the main focus of the work conducted by the CMHT. Service users told us that they felt involved, included and consulted in the planning of the support services. We saw examples where some service users had positively engaged in 'what matters'[5] conversations.

Staff spoken with during the course of the inspection expressed concern about the format of the nationally agreed Care and Treatment Plan document, and also the language used within the sections designed to capture statements from service users regarding what is important to them in terms of their care and support. We found that the pre populated, drop down statement boxes restricted the capture of service users' views, and the language used within some of the sections were not reflective of the SSWBA and Code of Practice. We were told by local and senior managers that the problems had been identified by staff locally. Local representatives participated in a national group to redesign the

[5] A structured conversation between professionals and service users to determine what they value most and how they wish to be cared for.

process about five months ago (September 2019). However nothing had yet emerged from this exercise.

Improvement needed

The health board and local authority must review the Care and Treatment Plan document to ensure that the language used is reflective of the SSWBA and Code of Practice and that it accurately captures the views of service users.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards and the Social Services and Well-being Act.

We found that there were adequate links and communication between the management within the health board and local authority, with adequate overview of the service by both authorities.

Staff gave mixed comments in relation to management and leadership and suggested that aspects of communication between managers and staff could be improved, so too staff training and workload management.

Leadership, management and governance arrangements

The health and social care staff in Newtown CMHT were co-located and although there were separate line management structures in place, there was strong leadership culture within the team, with changes positively managed to ensure consistent service delivery and practice. Positive working relationships between both health and social care staff was evident with mutual support and sharing of skills despite the team having experienced some recent and significant changes in terms of health staffing.

Staff we spoke with comment that while Newtown CMHT was an excellent team to work in, in their view, this was not the case with regards some of the other CMHTs in Powys due, in the main, to the concept of joint working not being embedded to the same extent. This requires further exploration by both the local authority and health board management teams to ensure consistency of approach and delivery of service across all CMHTs.

There was a formal complaints procedure in place which was compliant with Putting Things Right[6] and the Local Authority's formal complaint process. Information about how to make a complaint was posted in the reception area.

Staff told us that emphasis was placed on dealing with complaints at the source in order for matters to be resolved as quickly as possible, as well as to avoid any further discomfort to the complainant and any need for escalation. All complaints are brought to the attention of the team managers who address them in line with relevant local authority and health board policy. Although there were two separate complaints processes in place, there was evidence of joint complaint investigation and reporting. Staff also told us that serious untoward incidents and concerns were recorded on the Datix[7] system, and discussed at weekly meetings.

We reviewed a sample of staff files employed by the health board and local authority. We saw that there was a formal staff recruitment process in place with all necessary pre-employment checks undertaken. We saw that there was a formal staff support and supervision process in place with regular one to one meetings being held between staff and their line managers. In addition to one-to-one meetings, staff told us that they received day to day, informal support from their line managers who were reported as being very accessible.

There were formal annual appraisals in place, managed under respective health board or local authority systems.

Professional support and supervision was accessible, both individually and as part of groups with staff able to access training from both the health board and local authority, although there are challenges around electronic recording of training due to being employed by separate agencies. Staff we spoke with told us that they were able to access mandatory and other service specific training and the training record we viewed confirmed this. Mandatory training completion

[6] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method

[7] Datix is a web-based incident reporting and risk management software for healthcare and social care organizations.

figures were variable and action is needed to ensure that completion rates for all staff are as near to 100% as possible.

We distributed HIW questionnaires to staff during the inspection to find out what working conditions were like and to obtain their views on the standard of care.

We received 13 completed questionnaires from a full range of staff. Respondents said they had been in their current role from a few months to over 10 years. The majority of respondents had been in post for more than four years.

Most staff who completed a questionnaire said that they had undertaken training in Health and Safety, Fire Safety, Mental Health Act 1983, Safeguarding Adults and Safeguarding Children, with a majority stating that they had undertaken training in Deprivation of Liberty Safeguards, the Mental Capacity Act 2005, Risk Assessment and Management as well as other service specific training. Around half of the respondents said they had undertaken training in Cognitive Behavioural Therapy (CBT)[8], Dialectical Behaviour Therapy (DBT)[9] and Liberty Protection Safeguards and a minority of respondents said they had undertaken training in the Mental Health (Wales) Measure 2010. Very few respondents had undertaken training in or Family Therapy.

Staff in responses to the questionnaire said that they would like training in Trauma work, psychosis assessment, Cognitive Approaches to Combatting Suicidality (CARMS), Clinical and Risk Management -20 (HCR -20)[10] and Sexual Violence Risk - 20 (SVR-20)[11].

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[8] Cognitive Behavioural Therapy (CBT) is a talking therapy that can help service users manage problems by changing the way they think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

[9] Dialectical Behaviour Therapy (DBT) is a type of talking treatment. It's based on Cognitive Behavioural Therapy, but has been adapted to help people who experience emotions very intensely.

[10] The Historical, Clinical and Risk Management – 20 (HCR -20) is a structured tool to assess the risk of violence.

[11] The SVR-20 is a set of guidelines designed to assist evaluations of risk for sexual violence. It is appropriate for use in cases where an individual has committed or is alleged to have committed an act of sexual violence.

Most of staff who completed a questionnaire said that training or learning and development helped them to do their job more effectively and said it helped them to stay up to date with professional requirements. Most said it helped them to deliver a better experience for service users.

A third of respondents said they had undertaken joint social services / health board training in the last 12 months with two thirds stating they had not.

A majority of respondents said they had an appraisal, annual review or development review of their work in the last 12 months. Most said their learning or development needs were identified, and said their manager supports applications for specialist training / additional training.

A majority of staff who completed a questionnaire said that they were able to make suggestions to improve the work of the team and that they felt involved in deciding on changes introduced that affect their work area.

Around half of respondents said they were unable to meet all the conflicting demands on their time at work. Comments included:

> *"Our duties are highly demanding. Our time doesn't feel enough, however, our team is supportive and we strive to give best possible care"*

Around half of respondents said they had adequate materials, supplies and equipment to do their work and the majority said that there was enough staff to enable them to do their job properly.

Most staff members who completed a questionnaire said that they were satisfied with the quality of care and support they are able to give to service users. Nearly all respondents agreed service users were informed and involved in decisions about their care.

All staff who completed a questionnaire agreed that the privacy and dignity of service users was maintained.

All staff who completed a questionnaire said that the organisation encouraged teamwork and that front line professionals, who deal with patients empowered to speak up and take action when issues arise in line with the requirements of their own professional conduct and competence.

Most respondents said that there was a culture of openness and learning with the organisation that supports staff to identify and solve problems. Around half of respondents said that partnership working with other organisations was generally effective.

The majority of respondents thought the team had access to the right information to monitor the quality of care and take swift action when there are.

Nearly all the staff members who completed the questionnaire agreed the team acts on concerns raised by service users.

Only a third of respondents said that service user experience feedback (e.g. patient surveys) was collected within by the team. A quarter said they receive regular updates on the service user experience feedback and slightly more said they did not. A quarter of respondents said feedback from service users was used to make informed decisions within the team.

Most respondents agreed they would recommend the organisation as a place to work and that they would be happy with the standard of care provided by the team if a friend or relative needed support. Comments included:

> *"I would be happy for any loved one to have support from my place of work"*

All staff members who completed the questionnaire agreed that their manager encourages those who work for them to work as a team and that they were supportive in a personal crisis. Comments included:

> *"Very supportive line manager"*

> *"My manager has been very supportive within both my professional and personal concerns and worries. They are supportive on professional development to become the best practitioner I could be"*

Nearly all respondents said their manager can be counted on to help them with a difficult task at work with most stating that management give clear feedback on their work and ask for their opinion before making decisions which affect their work.

Most respondents said that they know who the senior managers are, and that there is effective communication between senior management and staff with half of the respondents stating that senior managers try to involve them in important decisions. A majority of staff said that management act on staff feedback.

Nearly all respondents said senior managers are committed to patient care.

Around two thirds of respondents said that they had been made aware of the revised Mental Capacity Act and Liberty Protection Safeguards, and around a third said they had not.

Most respondents stated that their immediate manager takes a positive interest in their health and well-being. A majority of staff agreed that managers took positive action on health and well-being and that their current working pattern/off duty allows for a good work life balance.

The majority of respondents agreed that, in the event of challenging situations, they are offered full support, and one strongly disagreed.

The majority of staff who completed the questionnaire stated that duty arrangements in the team were well-planned, though nearly a quarter disagreed. A third of respondents agreed that duty arrangements in the team ensured that there was always cover available with nearly half of respondents disagreeing. Comments included:

> *"Duty is always available, however, can eat into your own time taking time away from cases you own"*
>
> *"Duty is not always smooth-depending on urgent referrals. There are times where both health and social care staff are released for training or on leave without checking what staff are left"*

None of the staff who completed a questionnaire said they had seen errors, near misses or incidents in the last month that could have hurt staff and a third of respondents said they had seen errors, near misses or incidents that could have hurt service users. Most respondents who had seen an error said they had reported it.

The majority of respondents agreed that management treat staff who are involved in an error, near miss or incident fairly and that they were encouraged to report errors, near misses or incidents. The majority of respondents agreed the CMHT would treat reports of an error, near miss or incident confidentially with most respondents stating that the organisation would not blame or punish the people who are involved in such incidents, though two respondents said it would. Most respondents agreed that action would be taken on incidents identified.

That majority of staff who completed the questionnaire agreed that they were informed about errors, near misses and incidents that happen in the team and that they were given feedback about changes made in response to reported errors, near misses and incidents. Comments included:

> *"Feedback is via learning & development group and fed back through (NAME)"*

Staff confirmed that there was a Lone Working Policy in place and most said they knew what arrangements should be put in place when they, or colleagues, were lone working.

All staff who completed the questionnaire said that, if they were concerned about unsafe clinical practice, they would know how to report it and that they would feel secure raising concerns about unsafe clinical practice. Most respondents were confident that their organisation would address concerns once reported.

Three respondents reported having personally experienced discrimination by service users, their relatives or other members of the public (grounds: age, other). One respondent said they had personally experienced discrimination by a manager / team leader or other colleagues.

Improvement needed

The health board and local authority must ensure:

- Consistency of approach and delivery of service across all CMHTs within Powys
- That all staff complete all mandatory training
- That staff receive training in trauma work, psychosis assessment, Cognitive Approaches to Combatting Suicidality, Clinical and Risk Management and Sexual Violence Risk
- That all staff are given opportunities to access joint social services/health board training
- That staff are able to meet all the conflicting demands on their time at work
- That staff have adequate materials, supplies and equipment to do their job properly
- That staff receive regular updates on the service user experience feedback
- That all staff are made aware of the revised Mental Capacity Act and Liberty Protection Safeguards
- That the duty arrangements in the team ensures that there is always cover available

- That staff are not subjected to discrimination by service users, their relatives or other members of the public.
- That staff are not subjected to discrimination by a manager/team leader or other colleagues.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect community mental health teams

Our inspections of community mental health teams are announced. The service receives up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how CMHTs are meeting the Health and Care Standards 2015, Social Services and Well-being Act (Wales) 2014 comply with the Mental Health Act 1983 and Mental Capacity Act 2005. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within community mental health teams.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were highlighted during this inspection.			

Appendix B – Immediate improvement plan

Service: Newtown Community Mental Health team

Date of inspection: 04 and 05 February 2020

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
During the inspection we were notified by members of staff that there was a long standing and on-going problem with the electronic records management system, which often broke down, resulting in staff not being able to access service users' records in a timely manner, in order to update them, or to review them prior to consultations or meetings with service users.	2.1, 3.1, 3.4, 3.5, and 5.1	Note – The Joint Senior Responsible Officers for the National WCCIS Programme are the Chief Executive, Powys Teaching Health Board and the Director of Social Services, Caerphilly Borough Council. The following measures have been taken:	Both Health and Social Services		

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
We were also told that appointments were sometimes cancelled due to staff not being able to access service user records held on the system. The system was not accessible at times during the course of the inspection. This places service users at risk of harm as staff are not always able to effectively review and assess service users' care and support needs in order to plan treatment and interventions. This also places staff at risk as they are not able to properly plan for consultations and meetings with service users, and not able to update records in a timely manner. Improvement Needed		Locally and Nationally - Powys Teaching Health Board Chief Executive together with the Caerphilly Director of Social Services, the Programme Director of WCCIS and National Wales Informatics Service has raised a formal escalation with the supplier (Advance) as a Major Incident – Complete with ongoing update. Nationally - the Programme Director of WCCIS and National Wales Informatics Service has raised a formal escalation with the supplier (Advance) as a Major ICT Incident. Nationally - Advance and NWIS have held an Emergency Change Advisory Board met to agree immediate increase in CPU capacity with immediate		Programme Director WCCIS / Assistant Director Digital and Informatics (PtHB) / Diane Reynolds Head of Digital Services (PCC) Programme Director WCCIS / Advance	Daily / Weekly Daily/ Weekly Daily/ Weekly Complete

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The Health Board and Local Authority must inform HIW and CIW of the measures to be taken to ensure that the electronic records management system is operating effectively, and that staff have unhindered access to service users' care notes in order to effectively plan and deliver care and support.		effect and this has been implemented. Locally - Powys County Council and Powys Teaching Health Board have implemented an immediate Data extraction work-around to ensure that reporting is available from the WCCIS system (using a SQL programme via night extract) This data extraction is performed daily. Locally - Secured Senior Clinical Informatics lead to support the critical nature of the issues and ensure we have strong clinical view and input to support work going forward. Locally - Internal investigation to ensure that no issues lie with local infrastructure – completed.		Head of Digital Services (PCC) /Head of Information PtHB Head of Information (PtHB) Senior Applications Specialist and	Daily and Ongoing Complete Complete

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
				Operations Manager	
		Locally – Implemented Problem Management Processes to further investigate root cause and any categories issues, to support identification of common themes and support trouble shooting and resolution.		Senior Applications Specialist and Operations Manager	Implemented and ongoing review
		Locally enhanced communication with national team to set up local contract review meeting with Supplier (Advance), to be done in conjunction with National actions.		Head of Digital Services PCC / Assistant Director Digital and Informatics PtHB	Contact has been made to arrange a contract meeting but has not yet been scheduled.
		Locally – Enhanced regular communication with all health and council users to notify them of any issues, keeping them up		IT Service Lead Operational Manager	Daily and weekly

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		to date and informed of the escalation and current situation and providing clarity regarding business continuity plans to be implemented (if needed). Locally - Major ICT Incident Report process in place to manage incidents. Nationally - Current performance issue has been raised at the National WCCIS Board (7th of February). The Board agreed: • Highest Level of escalation • Business Continuity Issues across the Board • Independent Review/Audit to be commissioned		IT Service Lead Programme Director - WCCIS Board.	Complete and ongoing Complete

Immediate improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
		• Meeting with Careworks / Advance to discuss solutions and agree action going forward.			

Appendix C – Improvement plan

Service: Newtown Community Mental Health Team

Date of inspection: 04 and 05 February 2020

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Quality of the patient experience					
The health board and local authority must ensure that: Sufficient numbers of consulting rooms are available to ensure privacy timely access to services. Pre-meeting filtering takes place to make the hub meeting more effective and make better use of the time of the individuals present.	5.1 Timely access; Well-being priority 1 4.1 Dignified Care LAQS 1b) provide services to prevent or delay people's need for care and support.				

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Terms of reference are drawn up for the MDT meetings. Service users receive the support they need when contacting the CMHT out of hours service.	LAQS 1h) Suitable arrangements for assessing and determining need and eligibility 1e) Treat people with dignity and respect.				
The health board and local authority must ensure that service users' physical health needs are assessed and that they receive help or advice with finding support for their physical health when they need it.	6.1 Planning Care to promote independence LAQS 1h) Suitable arrangements for assessing and determining need and eligibility				

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
The health board and local authority must ensure that service users are offered the support of an advocate and that this offer is recorded within care documentation.	6.2 Peoples rights SSWBA Codes of Practice Part 10				
Delivery of safe and effective care					
The health board must ensure that services are provided in line with the requirements of the Mental Health Act 1983 and Code of Practice, and that all supporting documentation is accurately completed.	Application of the Mental Health Act				
The health board and local authority must review the initial assessment form. The health board must:	Monitoring the Mental Health Measure LAQS 1h) Suitable arrangements for assessing and determining				

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Take steps to ensure adequate Section 12 Approved doctors cover during day time hours. Ensure the availability of local in-patient beds for emergency admissions. Ensure the availability of transport for timely and secure transfer of service users to hospitals.	need and eligibility				
The health board and local authority must review the Care and Treatment Plan document to ensure that the language used is reflective of the SSWBA and Code of Practice and that it accurately captures the views of service users.	Social Services and Well-being Act LAQS 1f) People have control over planning and delivery of care				

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
Quality of management and leadership					
The health board and local authority must ensure: Consistency of approach and delivery of service across all CMHTs within Powys. That all staff complete all mandatory training. That staff receive training in trauma work, psychosis assessment, Cognitive Approaches to Combatting Suicidality, Clinical and Risk Management and Sexual Violence Risk.	Health and Care Standards - Governance, Leadership and Accountability; Social Services and Well-being (Wales) Act - Part 8				

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
That all staff are given opportunities to access joint social services/health board training. That staff are able to meet all the conflicting demands on their time at work. That staff have adequate materials, supplies and equipment to do their job properly. That staff receive regular updates on the service user experience feedback. That all staff are made aware of the revised Mental Capacity Act					

Improvement needed	Standard	Service action	Health/Social Services Lead	Responsible officer	Timescale
and Liberty Protection Safeguards. That the duty arrangements in the team ensures that there is always cover available. That staff are not subjected to discrimination by service users, their relatives or other members of the public. That staff are not subjected to discrimination by a manager/team leader or other colleagues.					

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role:

Date:

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Experience, Quality and Safety Committee	**Date of Meeting: 1st October 2020**
Subject:	**Mental Health Act Compliance Report for the 6 month period :** **1 January to 31 March 2020 i.e. Quarter 4 (Q4) and 1 April to 30 June 2020, Quarter 1 (Q1)**
Approved and Presented by:	Jamie Marchant Executive Director Primary Care, Community and Mental Health
Prepared by:	Anne Woods, Mental Health Legislation and Quality Manager. Amanda Rees, Mental Health Administrator. Ruth Derrick, Acting Assistant Director, Mental Health and Learning Disabilities
Other Committees and meetings considered at:	Quality Governance Group, 15th September 2020
References	*Monitoring the Mental Health* 2018/19 (2020). **www.cqc.org.uk/mhareport** *Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report* 2018/19 (2020)Healthcare Inspectorate Wales **www.hiw.org**

PURPOSE:
The purpose of this paper is to assure the committee that Powys Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA). Referencing the most recent quarterly management information and activity data in relation to the Hospital Managers' scheme of delegated duties under the MHA including amendments (section 23), the report demonstrates the activity undertaken regarding admissions and other related arrangements. This report is not to be considered as a performance report as the data and activity cannot be viewed in that way. This report summarises the activities pertaining to the use of Mental Health Act within Powys Teaching Health Board services in the reporting period and summarises the compliance with the Act accordingly.
RECOMMENDATION(S):
That the committee notes the contents of this report and that the activities of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

Approval	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 report provides assurance in respect of the work that has been undertaken during the reporting period that those functions of the Mental Health Act 1983 (the Act), which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework.

DETAILED BACKGROUND AND ASSESSMENT:

1. Introduction

Hospital Managers must ensure that patients are detained only as the Mental Health Act 1983 (amended 2007) allows; that their care and treatment fully complies with it, and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with other legislation which may have an impact, including the Human Rights Act 1998, Mental Capacity Act 2005 and Mental Health (Wales) Measure 2010.

Where there are low numbers to report, the *less than five* descriptive has been used when it has been felt necessary to protect patient identity.

2. Mental Health Act 1983

KEY TO SECTIONS

Part 2 – Compulsory Admission to Hospital or Guardianship

- **Section 5(4) Nurses Holding Power (up to 6 hours)**
- **Section 5(2) Doctors Holding Power (up to 72 hours)**
- **Section 4 Emergency Admission for Assessment (up to 72 hours)**
- **Section 2 Admission for Assessment (up to 28 days)**
- **Section 3 Admission for Treatment (6 months, renewable)**
- **Section 7 Application for Guardianship (6 months, renewable)**
- **Section 17A Community Treatment Order (6 months, renewable)**

Part 3 - Patients Concerned with Criminal Proceedings or Under Sentence

- **Section 35 Remand for reports (28 days, maximum 12 weeks)**
- **Section 36 Remand for treatment (28 days, maximum 12 weeks)**

- **Section 38 Interim Hospital Order (Initial 12 weeks, maximum 1 year)**
- **Section 47/49 Transfer of sentenced prisoner to hospital**
- **Section 48/49 Transfer of un-sentenced prisoner to hospital**
- **Section 37 Hospital or Guardianship Order (6 months, renewable)**
- **Section 37/41 Hospital Order with restriction (Indefinite period)**
- **Section 45A Hospital Direction and Limitation Direction**
- **CPI 5 Criminal Procedure (Insanity) & Unfitness to Plead (Indefinite period)**

Part 10 – Miscellaneous and Supplementary

- **Section 135(1) Warrant to enter and remove (up to 24 hours)**
- **Section 135(2) Warrant to enter and take or retake (up to 24 hours)**
- **Section 136 Removal to a place of safety (up to 24 hours)**

3. Data Collection and Exception Reporting

Section 5 of the MHA relates to patients who are already in hospital where the admission has been voluntary. At a point following this admission, known as an informal admission, the patient may present with a worsening of symptoms and their risk factors increased. They may express the desire to leave the hospital. Mental Health professionals have the power to detain the patient for short periods while further medical opinion and an approved mental health practitioner assessment is sought. During this period, treatment cannot be made compulsory, nor may a patient appeal against the short holding power.

The table below summarises the key uses of the Mental Health Act (1983) during the period:

i) Detention under Section 5 – Holding Powers

Section 5(4) is used by mental health and learning disability nurses in mental health in-patient settings for up to 6 hours to allow for a further assessment to take place. Section 5(2) is used by doctors in both mental health and general hospital settings to detain an in-patient for up to 72 hours to allow for a mental health act assessment to take place.

Section 5(4)	**2020**	**2019 Comparison**
Quarter 4	None	
Quarter 1	2 occasions	Total 5 occasions
Section 5(2)		
Quarter 1	8 occasions	Total 8 occasions
Quarter 4	Less than 5 occasions	

ii) Section 2 – Admission for Assessment

This section authorises the compulsory admission of a patient to hospital for assessment, or for assessment followed by medical treatment for up to 28 days. At the end of this period, the patient either reverts to an informal status remaining in hospital, is discharged home or the section 2 is converted to section 3 if thresholds are met and treatment is required.

Section 2 was used on eighteen occasions during Quarter 4 and thirteen occasions during Quarter 1. The majority of patients reverted to voluntary status following this period of detention under the Act. Last year, section 2 was used on a total of 34 occasions, compared with this year's total of 31.

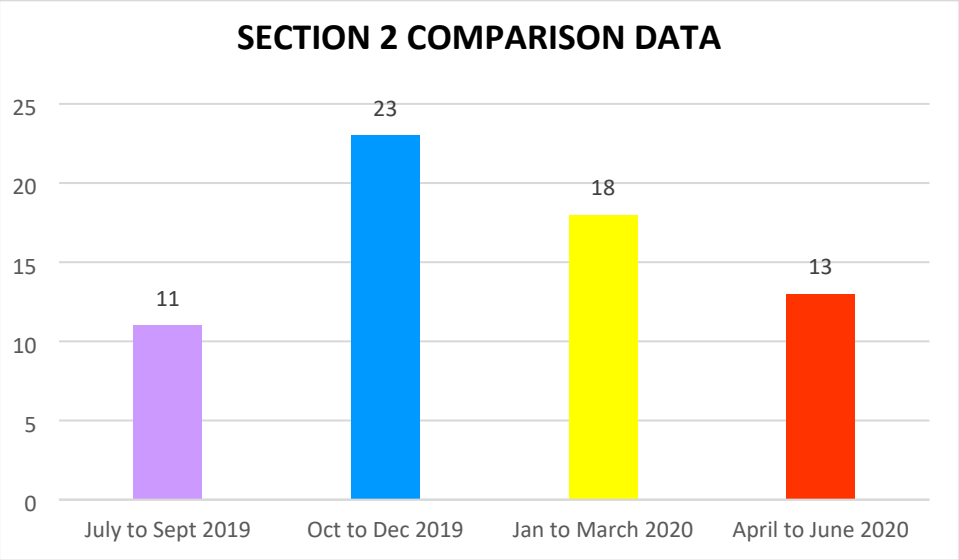


Table 1: Use of section 2 over the last 12 month period

iii) Section 3 – Admission for Treatment

This section provides for the compulsory admission of a patient to hospital for treatment for mental disorder. The detention can last for an initial period of six months.

During this period 1 January to 31 March 2020 (Quarter 4) section 3 was used on eleven occasions and during the period 1 April to 30 June 2020 (Quarter 1) section 3 was used on eleven occasions. Fewer than five patients subject to section 2 had their sections converted to section 3. Last year section 3 was used on a total of 18 occasions as compared with a total of 22 occasions in this reporting period.

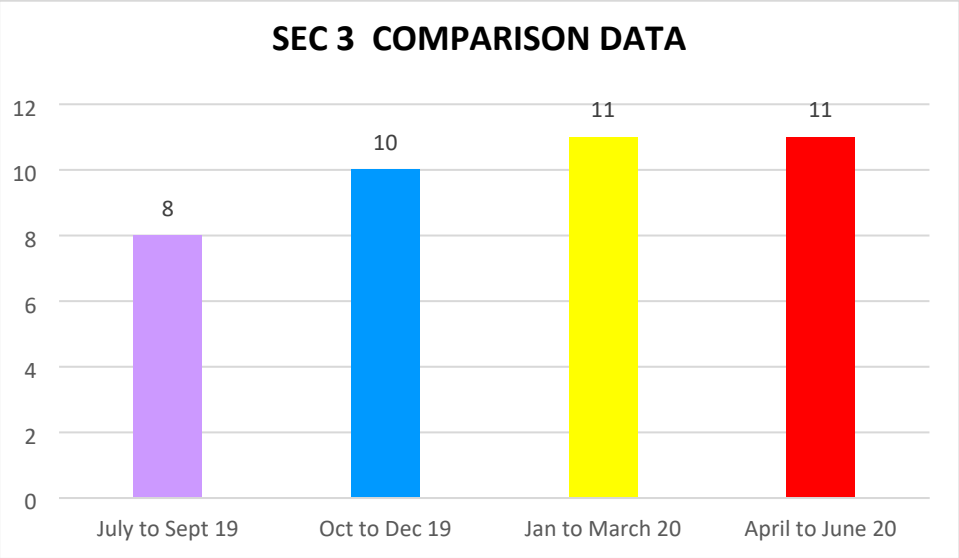


Table 2: Use of section 3 over the last 12 month period

iv) Section 4 – Emergency Admission for Assessment

The use of section 4 of the Mental Health Act 1983 is to enable an admission for assessment to take place in cases of urgent necessity. An alternative section is preferred if at all possible as best practice would involve two medical opinions. Section 4 should only be used to avoid an unacceptable delay and as such is infrequently used. This section is specifically examined by Mental Health Act Managers when it is applied. Section 4 was used fewer than five times during Quarter 4 and was not used at all during and Quarter 1, very similar to last year's figures.

v) Section 17A – Community Treatment Order (CTO)

This section provides a framework to treat and safely manage certain eligible patients who had been detained in hospital for treatment, to be treated in the community whilst still being subject to powers under the Act. Rather than the patient remaining in hospital for the continuation of treatment, a CTO supports the patient to live in the community and is therefore a less restrictive treatment option.

A CTO can only be used for a patient who has already been detained in hospital and there will be conditions that the patient must comply with regarding their treatment within the community. If the patient does not adhere to the conditions of the CTO, they can be recalled to hospital for up to 72 hours to enable an assessment of their mental health.

The national data on the use of CTO's is not reliable according to the Care Quality Commission report, *Monitoring the Mental Health* (2020), so local monitoring is encouraged to analyse local trends. In PTHB, there were sixteen community treatment orders in place as at 26 August 2020. CTO activity during the period 1 January to 30 June 2020 includes five new CTO's, ten extensions and fewer than five recall/revocations and discharges. No patients were discharged from their CTO by the Mental Health Review Tribunal (MHRT). The MHRT is a national and independent process to consider any challenges raised by a patient or his advocate

Future patient engagement will include patient views on how the use of a CTO has impacted on their lifestyle. CTO's are used for patients who have serious mental illness and have experienced admission to hospital under the Act. It is likely that they would need the support of a CTO to accept treatment that will help them to stay well outside of a hospital setting.

vi) Police Powers to Remove a Person to a Place of Safety under Section 136

This section empowers a police constable to remove a person from a public place to a place of safety if it is considered that the person is suffering from mental disorder and is in immediate need of care or control. Although the police station can be used as a designated place of safety, all of the assessments that took place under this section of the Act were carried out in a health based place of safety (POS), which is the preferred practice.

The number of occasions that section 136 was used during the six month period 1 January to 30 June 2020 was on ten occasions (Quarter 4 on three occasions and Quarter 1 on seven occasions). During the reporting period the majority of those assessed did not result in the admission or further detention of the person. The number of assessments undertaken under s136 powers, was lower than in the previous quarter (over the last five years approximately twenty s136 assessments are undertaken per year), however all assessments referred and conducted were appropriate.

Seven people assessed under s136 powers were previously known to mental health services. A new s136 suite is now operational at Bronllys Hospital. There is a multi-disciplinary sub-committee of the Mental Health Planning & Development Partnership (called the Powys Crisis Care Forum) dedicated to reviewing the use of s136 powers and meets regularly to discuss cases and identify areas for improvement and learning.

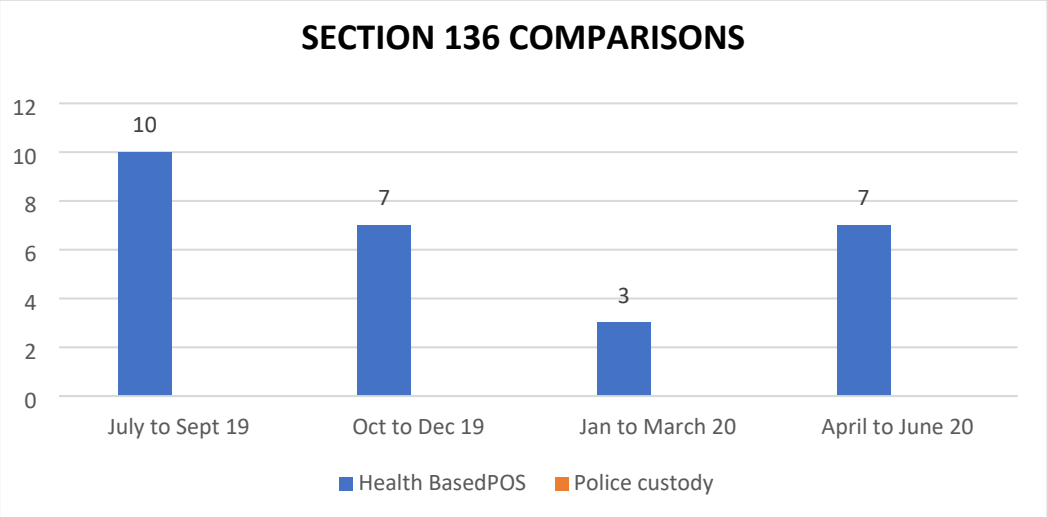


Table 3: **Location of completed section 136 assessments highlights that no police cells were used as a place of safety during the period**

vii) Scrutiny of Documents

Hospital managers must ensure that Mental Heath Act admission documents are received and scrutinised correctly by formally delegated officers. Section 15 of the Act provides for certain admission documents, which if found to be incorrect or defective must be rectified within fourteen days of the patient's admission. Rectification or correction is mainly concerned with inaccurate recording and it cannot be used to enable a fundamentally defective application to be retrospectively validated. For example, a spelling error on a document, if corrected ensures the detention remain valid. Overall, last year we reported 22 rectifications and no fundamentally defective detentions. The Health Inspectorate Wales review during 2019/20 identified some actions relating to the paperwork. All actions were completed in a timely manner and in accordance with the response plan.

The number of statutory documents scrutinised totalled 73 for the reporting period 1 January to 31 March 2020 and 51 for the period 1 April to 30 June 2020, this was compared to 87 for the previous three months (October to December 2019). Errors found that were required to be rectified within the fourteen days statutory time limits under section 15 of the Act were:

Rectifications	**Number of Errors**
Quarter 4 1 January to 31 March 2020	Ten occasions (6 spelling errors in either patient name or address & 4 occasions of no recorded evidence of risk to others)
Quarter 1 1 April to 30 June 2020	One occasion (spelling errors in either patient name or address)

Fundamentally Defective Detentions	
Quarter 4 1 January to 31 March 2020	One occasion (H08 medical recommendation form not signed by doctor)
Quarter 1 1 April to 30 June 2020	None (There were no fundamentally defective detentions recorded for this period)

viii) Deaths of detained patients

During the period there were less than five deaths recorded for patients who were subject to detention under the Mental Health Act 1983.

ix) Application for Discharge to Hospital Managers and Mental Health Review Tribunal (MHRT)

During the reporting period twelve applications/referrals were made to the MHRT and seven hearings took place;

- Fewer than five patients were discharged.
- No hearings were adjourned or postponed.
- Fewer than five patients were discharged by the responsible clinician and fewer than five patients withdrew their applications**.**

During the six month reporting period, the Hospital Managers received less than five applications from a patient or advocate for discharge from detention.

Twelve Hospital Managers Hearings were held during the period, fewer than five hearings were held to review the continued detention of the patient under Sec 3 and eleven hearings were held for the extension of a Community Treatment Order. The use of the MHA was supported.

All patients attending tribunals are entitled to be accompanied by an Independent Mental Health Advocate (IMHA) and are provided with information about this service in order to have representation. In this quarter, IMHAs attended one of the hearings, largely due to the nature of the tribunals and the decisions the patients made not to attend themselves.

This is reviewed by the quarterly Powers of Discharge Committee which is satisfied that patients are being made aware of their rights and have sufficient information to appoint an advocate if they want one.

4. Hospital Managers Power of Discharge Committee

A meeting for the above committee made up of the Hospital Managers and Independent Members was held on 30 January 2020 and quarterly performance was reported, scrutinised and discussed. A further two meetings were arranged for 23 April 2020 and 13 August 2020 but consequently cancelled due to current Covid 19 pandemic. The next meeting is scheduled for 22 October 2020.

An All Wales training day for Hospital Managers was arranged for 20 September 2020, due to be held in Powys, but this has been postponed until Spring 2020 due to current Covid 19.

A review of the Powers of Discharge Committee Policy and Terms of Reference has commenced and will be considered at a future Board meeting.

5. Healthcare Inspectorate Wales (HIW) Visits to Mental Health & Learning Disabilities Units

During the reporting period there were no visits by HIW to hospital inpatient units.

SUMMARY AND RECOMMENDATIONS:

The paper summarises the activities pertaining to the Mental Health Act 1983 by Powys services during the reporting period. This report has outlined the activities and the processes for reviewing these activities to provide the necessary assurance of compliance with the legislation.

The committee is asked to note the contents of the report.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Experience, Quality and Safety Committee	**Date of Meeting: 01 October 2020**
Subject :	**Staff Well-being and Engagement Update (including Staff Survey)**
Approved and Presented by:	Julie Rowles, Director of Workforce, OD and Support Services
Prepared by:	Rhys Brown, Head of Organisational Development Karolina Kobylnik, Workforce Strategy, Policy and Performance Manager
Other Committees and meetings considered at:	n/a

PURPOSE:
The purpose of this paper is to update the Experience, Quality and Safety Committee on staff well-being and engagement.
RECOMMENDATION(S):
The Experience, Quality and Safety Committee is asked to **NOTE** and **DISCUSS** the provided information.

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 wellbeing and engagement of staff is a key strategic priority for the health board and has been an integral part of the IMTP for a number of years. Immediately prior to COVID-19 emerging as a significant risk, PTHB were externally assessed against the Corporate Health standards and successfully maintained its Gold level status.

The report provides an update on actions taken by the health board in response to the new and emerging issues created by COVID-19 and the support provided to staff during the past 6 months.

DETAILED BACKGROUND AND ASSESSMENT:

Workforce Indicators:

The health board has continued to review key workforce performance indicators including daily monitoring of absence levels together with monthly monitoring of statutory and mandatory training and performance appraisal compliance.

Statutory and Mandatory Training

Overall compliance as of August remains unchanged at 85%. This level has been sustained for the last 4 months and remains within the National Target. Compliance has risen by 3% compared to August 2019 (82%).

PADRs

An instruction was given to managers at the beginning of April to suspend all business as usual activity, which included the undertaking of PADR's due to Covid-19 preparations. Prior to this period compliance was 79%. Compliance therefore reduced to 69% in May, but has since start to rise again and was 72% in August.

Sickness Absence

Actual sickness rates for August were 4.05% (0.79% short term and 3.26% long term). In comparison to August 2019 (4.36%) sickness is 0.31% lower. Covid-19 sickness contributed 0.12% to the monthly sickness absence rate in August with 4 reported episodes of which 2 remain absent.

Performance Measure	WG Target	Current Performance August 2020	Previous Month July 2020
Percentage of staff completing Statutory & Mandatory Training	85%	85%	85%
Percentage of staff undertaking performance appraisal	85%	72%	73%
Cumulative 12 Month Sickness Absence Rate	4.10%	5.05%	5.07%

Table Source: Workforce and OD Directorate Performance Reporting August 2020

Staff Wellbeing Survey

A staff survey was undertaken in June 2020 to check on the current status of how staff were feeling about their wellbeing. 279 responses were received and there were many positive comments around staff enjoying daily exercise and taking care of their own wellbeing. The aggregate score staff gave themselves in terms of their wellbeing was 3.92 out of a possible 6. Understandably, a number of employees also highlighted anxieties around contracting COVID-19, potential redeployment and worries about isolation for those working from home.

There was very little feedback given around the requirement for additional large-scale organisational initiatives, with most focusing on their immediate safety and personal situation. However, a number of issues identified by staff

were already being addressed through a range of health board wide initiatives including:

- Logistics activity to provide appropriate PPE;
- Social Distancing measures;
- Interim guidance on home working;
- Introduction of Office365 and Teams that have significantly improved the ability to use technology from anywhere and keep people connected.

Wellbeing Hubs

A partnership between the Trade Unions, Chat2Change, Organisational Development and the Communications team, with funding from Unison and Charitable Funds saw the creation of Wellbeing Hubs across the organisation. The main hubs were sited within the 10 main hospital sites in staff areas and included digital information display screens (paid for by Charitable Funds and organised by the Communications Team), 'Thought Boards' white boards for noting comments organised through Chat2Change, and a range of refreshments provided by Unison and Charitable funds, organised by Organisational development through the Chat2Change Champions.

In addition to the main sites, refreshments were also sent out to the 16 outreach centres and smaller sites.

The current funding for refreshments has been given by Charitable Funds to maintain refreshments for a 5-month period. So far £2,163 has been spent since June and feedback has been positive.

PTHB Wellbeing SharePoint Pages

Following the evidence in the wellbeing survey that staff like to access wellbeing information through the intranet and Facebook pages (see below), it was recognised that the current wellbeing intranet pages are difficult to edit and lack the technological capability to display engaging content effectively. This coupled with the release of Office365 enabled the creation of a Wellbeing SharePoint site that is easy to edit, can display engaging content and can be viewed from any device utilising the Office365 log in.

Currently the pages have largely been built in draft and focus on 5 areas of wellbeing (physical, psychological, financial, social and environment) and a number of people trained to add their own content to areas relevant to them. This now needs to be presented to the Wellbeing at Work Group and finalised with the intention to launch in October.

Florence

Significant work has been undertaken to utilise the Florence Text Messaging Service as a wellbeing support tool. This service enables participants to receive regular text messages of ideas for activities and links to resources to help them manage their own wellbeing. The service has been initially tested within the

WOD directorate with some technological issues needing to be resolved. Work is being undertaken on these during September with the aim to launch the trial in early October.

Regular communication and engagement

- Prior to COVID 19, regular Powys Announcements were sent out to the organisation via email about various news items and opportunities. At the start of the COVID-19 situation, these were stopped and brought together into a single daily bulletin of key information that could be easily disseminated and not lost in the email inbox. The information in these bulletins was a joint effort between OD and the Communications team who ensured that key Gold Team messages were passed on, whilst good news stories and any key bits of information were relayed.

  As services started to form a 'new normal' and announcements became more routine in content, the COVID-19 bulletins were changed to PTHB News, still collated on a daily basis, with the option of releasing COVID-19 bulletins for significant situations.

- The Facebook group was created as a closed group for PTHB staff as a place for less formal networking, sharing information and socialising. This group has been highly successful in disseminating information, sharing stories and supporting each other. There are currently over 1100 members of staff within the group.

- To help staff ask direct questions to the Executive Team, an Ask the CEO page was set up on the intranet with OD support to manage the system, gain feedback from the Executives and respond. The services have had limited traffic, with some initial feedback concerns about anonymity.

- Powys Workforce and OD Directorate supported the development of a national FAQ to respond to Workforce and was regularly updated and staff notified.

University of South Wales Coaching Support

The university of South Wales in conjunction with the Professional Development Centre (who deliver the leadership programme) offered free coaching support to anyone feeling overwhelmed by the COVID-19 situation. This offer has now finished, but during this time 13 people accessed coaching support.

Social Distancing

Ensuring social distancing and health and safety requirements are implemented for staff continues to be a key area of focus. Clear guidance has been developed and cascaded in consultation with staff side across clinical and non-clinical areas. Dedicated Trade Union Health and Safety Support in implementing the social distancing guidance has been provided for each service area. This work has been essential in enabling the health board to recover and restart non-Covid activity at its sites. A Social Distancing Audit is currently being undertaken to check compliance; and the distribution of the All Wales 'keep your distance' badges and lanyards has commenced.

Staff Testing

Testing will continue to play an important part in support the wellbeing of staff. The revised national risk assessment tool has also been now completed for all vulnerable groups and will be kept under review.

Testing is a priority for staff members who are symptomatic. This is accessed from the Community Testing Units in Bronllys and Welshpool hospitals. Staff are advised to book their tests directly with the Covid-19 Administration Hub in order to expedite the appointment, and to alert Occupational Health of their symptoms.

- We have improved test to result turnaround times to 30 hours for samples sent to PHW laboratories, through working with Shared Services couriers;
- Staff able to receive their test results by SMS text;
- Staff advice on antigen testing from PTHB's Occupational Health Department and from the Clinical Lead for the testing service;
- Antigen testing for staff who are not symptomatic is currently under review;
- Antibody testing is being offered to all PTHB staff at clinics running throughout September 2020.

Risk Assessment for Vulnerable Groups

An updated national risk assessment tool for COVID-19 was issued on 6th August 2020, immediately prior to Shielding in Wales being paused from the 16th August 2020. The scope of the updated tool has been widened from BAME staff to identify the risks for those staff who were identified as highly vulnerable and had previously received a Shielding letter. Those staff over the age of 70 were also identified for the first time as a separate and distinct category. The inclusion of the over 70 age category has required a separate assessment to be undertaken for those falling within this group, who were not Shielding or socially distancing at home.

All risk assessments have for the vulnerable groups have been completed and further work is on-going to support staff within these categories to either return to work or undertake meaningful work in a COVID-19 secure location environment, including consideration of training requirements. However further clarification is needed on what areas would be classified as COVID-19 secure within Powys THB.

Occupational Health Support Counselling

Occupational Health continues to support staff members who are experiencing anxiety, stress and depression with advice and referrals for counselling. Staff Counselling is provided by 'Network of Staff Supporters Ltd' (NOSS). All staff are offered an appointment within 7 days. Emergency contact with a Counsellor by telephone is delivered on the same day as requested.

Month	No. of sessions	No. of new referrals	No. of client seen	No. of DNA/cancellations
March	68	19	46	6
April	78	13	44	6
May	72	9	43	6
June	59	12	37	3
July	67	16	38	2
August	75	19	46	8

Agile Working Policy

Agile Working Policy has been approved by WPRG and Executive Committee on the 23rd of September 2020.

Introduction of the Agile Working policy will help formalise arrangements made during the Covid-19 pandemic. Additionally, it will support Social Distancing Programme of Work; as well, as ensure that PTHB is prepared for the possibility of a second wave of COVID-19. Agile Working arrangement will allow the most vulnerable employees (BAME staff and staff with certain medical conditions) to be able to perform their duties or support them to be redeployed or undertake meaningful work in a different way.

Benefits of Agile Working:

- **Improved Work-Life Balance**
  - It is now more important than ever to the current workforce to have a balance between their work life and home life. With a reduced travel time they can spend more time with their loved ones.

- **Increased Retention**
  - With working practices changing more people are looking for employment offers, where agile working is part of the business as usual. Additionally, it ensures employees do not have to worry about travelling in bad weather or work absence when their means of communication temporarily fail.

- **Increased Productivity**
  - Offering an agile working might increase productivity; instead of focusing on attendance and time the emphasis shifts to outcomes, outputs and productivity; which leads to a positive cultural change within the organisation.

- **Travel Reduction**
  - It is expected that agile working will reduce expenses associated with business travel by embracing Team and Skype meetings. Additionally, it will reduce a need to Lease Cars and Pool Cars.
  - By reducing travel to and from work, Agile Working supports the Welsh Government's agenda regarding climate change and its commitment to reduce emissions.
  - It is expected long term certain office-areas can be reduced and utilised as clinical or training settings.

NEXT STEPS:

As wellbeing and engagement is a key national agenda item, there will now be an increased focus on the wellbeing initiatives delivered within the organisation. This will enable us to maintain and improve upon the Gold Corporate Health Standard and ensure that as the COVID-19 situation becomes a long-term issue, that staff are sufficiently supported.

The next steps will include:

- The Well-being at Work (WBAW) Group will be reconvened officially for the first time since the start of the COVID-19 situation. The aim of the group will be to initially focus on developing the on-going support for staff during the winter period, building on the work already undertaken

in response to Covid-19. The development of a longer-term strategic plan will be reprioritised to next year.

- The WBAW group will take ownership of the SharePoint Wellbeing Site as the overarching governance group for the site, as well as content owners of specialist areas. The group will aim to launch the site in October.
- Following overcoming the technical challenges, Florence will be launched as a trial for 200 people in early October.
- We will continue to review and monitor the National Risk Assessment Tool providing updates for all staff who identify themselves as BAME, have been shielding or socially distancing at home, and/or are over 70 years of age;
- We will provide occupational health advice for all staff within the vulnerable categories to ensure where it is safe to do so staff return to their substantive roles or are redeployed;
- We will ensure referrals to the counselling service are prioritised;
- We will monitor staff's annual leave to avoid a build-up on untaken leave during the latter part of the leave year;
- We will deliver the Flu Vaccination for staff.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 01 October 2020**
Subject:	**Information Governance Quality Report**
Approved and Presented by:	Rani Mallison, Board Secretary
Prepared by:	Amanda Smart, Information Governance Manager
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

The purpose of this paper on the quality of key information governance aspects is to provide assurance to the Experience, Quality and Safety Committee.

RECOMMENDATION(S):

The Committee is asked to NOTE the content of this report and to identify any areas of further assurance required. The reporting period is 1 January to 31 August 2020.

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:

This paper has been developed to provide an assessment against key information governance (IG) quality indicators.

DETAILED BACKGROUND AND ASSESSMENT:

Datix Incidents (Breach Reporting)

The General Data Protection Regulation (GDPR) introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority i.e. the Information Commissioner's Office (ICO) within 72 hours of the organisation becoming aware of the breach. These breaches (incidents) are reported using the Datix Incident Management system and those with IG relevance are reviewed daily by the Information Governance Team. To manage this, the Team has implemented a robust process for breach detection, investigation and reporting and to support this a record of IG incidents is maintained. A personal data breach risk assessment is carried out and the form is added to the Datix Incident Management system. This facilitates the decision-making about whether or not to notify the ICO and the affected individuals.

The Datix incidents are routinely monitored on a daily basis, however during the Covid-19 pandemic the team did not have the capacity for this frequency. Between March and June the incidents were checked every other day, but from July have recommenced back to daily monitoring.

In the reporting period of 1 January to 31 August 2020, **79** information governance incidents have been reported. **33** of these incidents were not reported on Datix within the required 72 hours. This was due to service delays in reporting. This figure includes **one** incident reportable to the ICO that was not reported in the 72 hour deadline. The IG team are in the process of developing breach management processes and local guidance in relation to reporting breaches to aid service improvement in this area. The table below shows the breakdown of the number of incidents.

Those non-PTHB incidents are incidents that have affected the health board but did not originate within the health board e.g. district general hospital, GP Practice. In these circumstances should a common theme appear when reviewing the data the IG Team will liaise with the lead for PTHB's service lead, IG lead in the neighbouring organisations or GP practice directly to alert them to the incident and work with them to ensure recurrence of these types of incidents do not happen again.

Number of incidents for the period 1 January – 31 August 2020, is shown below:

	Q4	Q1	Jul	Aug	Total
Total Number of PTHB IG Incidents reported	31	24	12	12	**79**
Of the total - Number of incidents NOT reported within the 72 hours onto the Datix system	10	14	8	1	**33**
Of the total – Number of Non PTHB incidents	8	8	5	4	**25**

Incident Themes

The incidents for this time period have been reviewed with themes identified. The top 3 themes were:

- Records Management - IT/WCCIS failures causing loss of availability of information (loss of availability is considered a breach under GDPR) (12 incidents)
- Records Management – Missing Records (7 incidents)
- IT / Telecoms Systems – Telecoms unavailable – (7 incidents)

Following investigations into these incidents there are particular issues, for example: wrong email address/wrong attachments and leaving drawers or computers unlocked, which can be prevented. To reinforce good practice from the mandatory IG training, the IG team aims to send out IG Alerts and various guidance to all Health Board staff to ensure all staff are following IG guidelines. The team also contact services directly to remind them of their responsibilities in terms of policies and procedures.

The table below shows a full breakdown of the themes of reported incidents during the time period:

Incident type	Incident detail (theme)	No. of incidents	Total
Records Management	missing records	7	
	inaccurate clinical information documented	5	
	misfiled documentation	4	

	referral process	4	
	transportation of records	1	
	Missing documentation	4	
	Unable to retrieve medical records back from DGH	0	
	Wrong patient visited	1	
	IT/WCCIS Systems failure	12	
	Letter/Email sent to the wrong address	5	
	Wrong PII on health records documentation	6	
	Lost/delayed post	2	
	Incorrect records sent	0	
	Delay in blood sending off	1	
	Incorrect X-Ray	1	
IT /Telecoms Systems	Network issues	3	
	Telecoms unavailable	7	
	Network issues with WPAS	0	
Communication	poor communication of PII between staff	2	
	Fax sent to wrong recipient	0	
	Emailing – sending PII to wrong recipient (attachment and in body of email)	2	
Security of Information	Physical security – doors left open/lock broken	5	
	Excessive password information stored on sharepoint	0	
	Unauthorised access to emails	1	
Confidentiality	Breach of patient confidentiality	3	
	Inappropriate disclosure on social media	1	
	Inappropriate disclosure to relative	0	
	Inappropriate access of information via ShropDoc to NWIS	1	
	Criminal Incident resulting in access to information	1	
TOTAL NO PTHB IG INCIDENTS			**79**
	Fax received to wrong dept from GP practice	0	
	Misdirected mail	3	
	Missing discharge documentation from DGH	8	
	PII of another patient found on clinical docs	1	
	Non PTHB clinical system failure	0	
	Misfiled documentation	1	
	Poor Communication	2	
	Missing records from DGH	7	
	Breach of confidentiality	1	
	NWIS issue on misfiled data	2	
TOTAL NO OF NON PTHB INCIDENTS			**25**

The number of PTHB incidents has decreased slightly from **88** for reporting period 1st January - 31st August 2019. From reviewing 2019 data for the same time period shows the number of non PTHB incidents has increased significantly from **5** in the same period. Further analysis will be undertaken by the IG Team to ascertain the possible reasons for this increase.

Incident Management and Reporting to the Information Commissioner's Office (ICO)

Following the submission of a personal data breach report, the ICO investigate the breach, and may provide recommendations back to the health board where they feel improvements need to be made. All recommendations made by the ICO are added to the ICO Recommendations log which is due to be presented to the Executive Team in the forthcoming months for oversight and tracking. In addition any IG actions required as a result of these recommendations have been added to the IG Workplan.

Of the **79 incidents reported**, **5** of these were deemed significant breaches and were reported to the ICO. All **5 incidents** reported to the ICO during this period received recommendations. These recommendations were in terms of; improving our compliance with reporting within the 72 hours if we failed to meet that obligation, Policies and Procedures, Records Management, and Staff Training:

Policies and Procedures – it was recommended that the health board review Records Management policies and procedures where required, and ensure staff are aware of these documents. It was also recommended that information governance policies be reviewed, however this is a standard recommendation due to the nature of the reporting, and the National IG policy is already reviewed on an annual basis by the Information Governance Management Advisory Group (IGMAG) – a network of IG managers from Welsh health boards, trusts, NWIS (NHS Wales Informatics Service) and an ICO representative.

Records Management – it was recommended that the health board remind staff of good practice in terms of accurate labelling and filing, double checking email recipients before sending emails and processes for dealing with missing records.

Staff Training – it was recommended that the health board review training provision for records management and information governance, and ensure that training compliance is routinely monitored. During Covid-19 it has not been possible to provide training due to team capacity.

On the table below, it can be seen that **one** of the total reported **5** incidents to the ICO was not reported within the legislated timeframe. This was due to service delay where IG had asked the service to expand on the details provided to ensure we had sufficient information for the report to be submitted.

	Q4	Q1	July	Aug	Total
Total Number of IG Incidents Escalated to ICO	3	1	1	0	5
Out of the total - Number of incidents NOT reported to ICO within the 72 hour requirement under GDPR	1	0	0	0	1

Complaints & Learning:

No IG related complaints have been raised as reported during this reporting period.

The National Intelligent Integrated Audit Solution (NIIAS)

National Intelligent Integrated Audit System (NIIAS) is a national tool procured by NHS Wales to detect potential misuse of national information systems. It will highlight instances when employees may have abused their access rights to view personal information that they may not be entitled to. The purpose of the tool is to assist the organisation in complying with its Data Protection responsibilities. This gives the public and its partners more confidence in the Health Board's ability to ensure confidentiality and privacy of their personal data.

The IG Team runs the NIIAS report weekly, notifications are investigated and respective line managers and the Workforce & OD Team are engaged in the process when necessary. During Covid-19, the reports were run fortnightly for the first 3 months to allow the team to focus on statutory requirements such as information requests and risk assessing prioritised applications and systems for use during the Coronavirus pandemic.

The NHS Wales Informatics Service (NWIS) has developed a national NIIAS Usage Report which is reported to the monthly All-Wales Medical Directors' meeting. The purpose of the report is to inform and build mutual assurance and trust with each health board to enable the further sharing of patient data between organisations and to show organisational commitment to auditing access to national systems. During Covid-19, this reporting has not been requested on a monthly basis, to allow organisations to prioritise resources appropriately.

Powys Teaching Health Board report on the number of individuals who have potentially accessed their own record, or that of a family member (home relation). There were **38** NIIAS notifications reported for the period 1 January 2020 – 31 August 2020. **37** were first time offences with **one** repeat offence reported to the Workforce and Organisational Department. None of the notifications were deemed to be a reportable breach to the ICO following investigation. The table below shows a breakdown of the notifications received:

Month	Q4	Q1	Jul	Aug	Total
Own Record - 1st offence	6	8	1	1	16
Own Record - repeated	0	1	0	0	1
Home Relations (Family) Record - 1st offence	11	9	0	1	21
Home Relations (Family) Record - repeated	0	0	0	0	0
Both home relations and own record accessed	0	0	0	0	0
Notification for Non-PTHB member of staff	0	0	0	0	0
Total	**17**	**18**	**1**	**2**	**38**

The figures during this reporting period are significantly higher than for 1 January to 31st August 2019 (**20**). The IG team aim to address this increase by providing

further reminders, developing staff training videos and inclusion in future IG alerts.

Information Sharing Protocols (ISP)
Many organisations directly concerned with the health, education, safety, crime prevention and social wellbeing of people in Wales have signed up to the Wales Accord on the Sharing of Personal Information (WASPI). WASPI is tool to support the sharing of information between these organisations effectively and lawfully, whether that is the network providing support and good practice guidance, or the collective development and use of template documents such as an Information Sharing Protocol (ISP) agreement. Although the development of ISPs is not mandatory, it is promoted across Wales as good practice and is endorsed by the ICO. It underpins the WASPI framework and supports the regular, reciprocal sharing of personal information between organisations.

During the reporting period, **5** ISPs have been reviewed or supported by the IG team. None of which were as a direct response to Covid, however **1** regarding sharing Care Home patient information with PCC was put on hold due to Covid, and then reinstated with a view to include the various arrangements that have been put in place around Covid and care homes. There are also 2 ISPs yet to be started, neither of which are Covid related. These are then presented nationally as part of the WASPI quality assurance group if requiring approval. The IG team will continue to promote the development of ISPs, where possible. Work also continues to review outstanding and identify new agreements.

Initiatives/ Programmes Requiring IG Input

<u>Background</u>

Under the General Data Protection Regulation there is a requirement that any new initiative should complete a Data Protection Impact Assessment (DPIA). A DPIA is a process that helps to identify and minimise the data protection risks of a project or proposed new way of sharing information. A DPIA must be carried out where the initiative is likely to result in high risk processing, and it can be a lengthy process when the project is substantial or the data involved is special category data. The DPIA process may require direct supplier input and we may also need to involve the health board Senior Information Risk Officer (SIRO) or Caldicott Guardian. Senior members of the IG team will review a DPIA, and will guide the service to ensure the relevant information is included. The health board Data Protection Officer (DPO) then advises if the DPIA review has concluded there are appropriate technical and organisational security measures in place to enable sign off.

The IG team have representation on the ICT Governance Group, and a large proportion of the work undertaken by the team is to impartially support the procurement of software, systems, and new ways of data sharing, where appropriate. This would include supporting services in populating Data Protection

Impact Assessments (DPIA), Data Processing Agreements (DPA), contracts, ISPs and any review work associated with ensuring that we comply with the GDPR and other data protection legislation. It is important to note that not all programmes of work have required a DPIA, DPA or ISP. In some circumstances, IG involvement has included researching guidance and providing advice regarding all data protection legislation. There is no set timeframe for completing DPIAs, DPAs and ISPs, IG support is provided on a first come, first served basis but the team will prioritise urgent requests where needed.

Initiative Work Undertaken

From the 1st January to 31st August 2020, the IG Team have been asked to provide IG input on **77** Initiatives/programmes of work:

- Overall the team have progressed **73** out of the **77**.
- Covid-19 related work was prioritised first but only **16** of the **77** have been identified as being directly required for Coronavirus related purposes (this number includes local, national and Welsh Government initiatives)
- **61** programmes of work were local requests, **12** were national All Wales projects, and a further **4** were requested directly from Welsh Government.
- The IG team have completed **28** of these initiatives, **11** of which were Covid-19 related.
- Of the **45** requests in progress there are **5** that are Covid-19 related initiatives requiring on-going work (4 national and 1 local). The requests may be in progress due to: capacity in the IG team, they may have been returned to the service for further work, or they may have been put on hold during Covid (if not Covid-19 related)
- The **4** not started are not Covid-19 related and the services have been notified that there will be a delay.

A review of the current Data Protection Impact Assessment template was undertaken and updated to provide more clarity and streamline the process. During the reporting period, **28** Data Protection Impact Assessments and **10** Data Processing Agreements have been reviewed. Some services are yet to submit their first draft DPIA or DPA for review so these have not been counted for this report. Other initiatives required guidance or legislation advice rather than support with a DPIA, or DPA.

During the Covid-19 pandemic, the team experienced an unprecedented increase in the demand for providing support. In some instances, there were extremely tight timescales for the work to be undertaken (in particular from Welsh Government) to ensure processes could be implemented quickly but safely and in line with relevant legislation. The transition period for Brexit, and the national roll out of Microsoft Office 365, which was brought forward ahead of the initial pilot phase to assist staff and patients during the pandemic are examples of the many projects that have significantly increased the work load.

It is also important to note that not all requests for IG input during this time have been Covid-19 related work. Those services who were stepped down during the pandemic have taken the opportunity to progress service improvement which has required IG support, adding to the significant pressure the team have been under. As mentioned above, the team have developed a service improvement workplan and manage requests for support on his workplan to ensure that those non-Covid related requests are still sighted when the team has capacity to support them. This workplan will be presented at a later date to the Digital Transformation Board and ICT Governance.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 1 October 2020**
Subject :	**Public Services Ombudsman (Wales) Act 2019** **The Public Services Ombudsman for Wales Annual Report and Accounts 2019/2020**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan Assistant Director Quality & Safety Rebecca Membury, Senior Manager Putting Things Right
Other Committees and meetings considered at:	Quality Governance Group 23 July 2020

PURPOSE:

This report provides the Experience, Quality and Safety Committee with an overview of the Public Services Ombudsman for Wales Annual Letter for 2019/2020

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to NOTE the annual Public Service Ombudsman for Wales Annual Letter 2019/2020

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:

This paper provides the Experience, Quality and Safety with an overview of the Public Services Ombudsman (Wales) Annual Letter and to discuss any considerations made by the Public Services Ombudsman for Wales.

DETAILED BACKGROUND AND ASSESSMENT:

The Public Services Ombudsman for Wales Annual Letter (final version) has been issued on the 7 September 2020 detailing the concerns that have been raised via the Public Services Ombudsman for Wales Office during 2019/2020 **– Appendix 1.**

It is noted that the Public Service Ombudsman for Wales (PSOW), had to intervene in (uphold, settle or resolve early) a smaller proportion of complaints about public bodies in Wales: 20% compared to 24% last year.

With regard to new complaints about public bodies, 1020 or 45% related to NHS bodies— an increase of 1.3% compared to 2018/19. Complaints about NHS bodies related predominantly to health (88%). However, as in previous years, a significant proportion of these complaints related to complaint handling (8%).

It is noted that the Public Service Ombudsman for Wales will continue to work with NHS bodies on reducing the number of these complaints, including as part of our new Complaints Standards role. The Public Services Ombudsman for Wales note that they look forward to working more closely with the health board in the coming months to help embed the new 'Once for Wales' system and, for the first time in Wales, provide complaints handling training to Health Boards, free of charge.

The Annual Letter advises that that Powys Teaching Health Board had 23 complaints received in total which included the All Wales Continuing Health Care complaints the information relating to which has been separated within the Annual Letter. It will be noted that the Public Service Ombudsman for Wales intervened on 54% of the 23 cases opened during 2019/2020.

The Public Services Ombudsman of Wales noted that 13 Cases (56.52%) raised during 2019/2020 related to the All Wales Continuing Heath Care Retrospective Scheme. Of these 13 cases, 61.54% (8 Cases) were closed by the Public Services Ombudsman for Wales following the initial consideration of the cases and the information provided by the health board. With less than 5 cases (30.77%) which the health board agreed an early resolution with the Public Services Ombudsman of Wales by agreeing to issue a letter of apology and made financial redress to all affected by the delays of the All Wales Continuing Health Care project.

The Public Services Ombudsman of Wales has requested by the 30 November outcomes on the following actions:

- Presentation of the Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance.
- Work with the PSOW Improvement Officer and Complaints Standards colleagues to improve complaint handling practices and standardise complaints data recording.
- Inform the PSOW of the outcome of the Health Board's considerations and proposed actions within the Annual Letter.

Contact with the PSOW office to explore the opportunity of training on complaints handling is being progressed, as part of the health board's clinical quality framework implementation plan.

NEXT STEPS:

1) To provide feedback to the PSOW on the actions as stated by the 30 November.
2) The health board will provide the Committee updates on the implementation of the future provisions of the Public Services Ombudsman (Wales) Act 2019.

Ombwdsmon
Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 September 2020

Communications
@ombudsman-wales.org.uk

Professor Vivienne Harpwood
Chair of the Board
Powys Teaching Health Board

By Email Only
Vivienne.Harpwood@wales.nhs.uk

Dear Professor Harpwood

Annual Letter 2019/20

I am pleased to provide you with my Annual Letter (2019/20) for Powys Teaching University Health Board.

I write this at an unprecedented time for public services in Wales and those that use them. Most of the data contained in this correspondence relates to the period before the rapid escalation in Covid-19 spread and before restrictions on economic and social activity had been introduced. However, I am only too aware of the impact the pandemic continues to have on us all.

I am delighted to report that during the past financial year, we had to intervene in (uphold, settle or resolve early) a smaller proportion of complaints about public bodies in Wales: 20% compared to 24% last year.

With regard to new complaints about public bodies, 1020 or 45% related to NHS bodies— an increase of 1.3% compared to 2018/19.

Complaints about NHS bodies related predominantly to health (88%). However, as in previous years, a significant proportion of these complaints related to complaint handling (8%). We will continue to work with NHS bodies on reducing the number of these complaints, including as part of our new Complaints Standards role.

Work has already started as part of our Complaints Standards role for Wales, so far predominantly with Local Authorities. We have already seen great benefits already from this work, including the standardisation of complaints data recording. We look forward to working more closely with you in the coming months to help embed the new 'Once For Wales' system and, for the first time in Wales, provide complaints handling training to Health Boards, free of charge.

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
www.ombudsman-wales.org.uk | www.ombwdsmon-cymru.org.uk
01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance.

- Work with my Improvement Officer and my Complaints Standards colleagues to improve complaint handling practices and standardise complaints data recording.

- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **30 November**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Ombudsman

CC: Carol Shillabeer, Chief Executive
Wendy Morgan, Contact Officer

Factsheet

A. Complaints Received

Health Board	Complaints Received	Complaints received per 1000 people (population)
Aneurin Bevan University Health Board	140	0.24
Betsi Cadwaladr University Health Board	227	0.33
Cardiff and Vale University Health Board	100	0.20
Cwm Taf Morgannwg University Health Board	80	0.18
Hywel Dda University Health Board	92	0.24
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	91	0.23
	753	0.24

B. Complaints Received by Subject with percentage share

Powys Teaching University Health Board	Complaints Received	
Complaint Handling- Health	1	4.35%
Health - Appointments/admissions/discharge and transfer procedures	1	4.35%
Health - Clinical treatment in hospital	5	21.74%
Health - Clinical treatment outside hospital	2	8.70%
Health - Continuing care	13	56.52%
Health - Other	1	4.35%

C. Complaint Outcomes (* denotes intervention)

Complaints Closed	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part*	Public Interest Report *	Grand Total
Powys Teaching UHB	0	0	5	2	1	0	5	0	13
Percentage Share	0.00%	0.00%	38.46%	15.38%	7.69%	0.00%	38.46%	0.00%	

Complaints Closed	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part*	Public Interest Report *	Grand Total
Powys Teaching UHB - All Wales Continuing Health Care cases	0	1	8	4	0	0	0	0	13
Percentage Share	0.00%	7.69%	61.54%	30.77%	0.00%	0.00%	0.00%	0.00%	

D. Number of cases with PSOW intervention

	No. of Interventions	No. of Complaints Closed	% Of Interventions
Aneurin Bevan University Health Board	55	165	33%
Betsi Cadwaladr University Health Board	67	217	31%
Cardiff and Vale University Health Board	29	104	28%
Cwm Taf Morgannwg University Health Board	9	59	15%
Hywel Dda University Health Board	29	92	32%
Powys Teaching Health Board	7	13	54%
Powys Teaching Health Board - All Wales Continuing Health Care cases	4	13	31%
Swansea Bay University Health Board	7	62	11%
Former Health Boards			
Abertawe Bro Morgannwg University Health Board	26	36	72%
Cwm Taf University Health Board	9	21	43%
Grand Total	**242**	**782**	31%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office during 2019/20, and the number of complaints per 1,000 residents (population).

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2019/20 with the percentage share.

Section C compares the complaint outcomes for the Health Board during 2019/20, with the percentage share.

Section D provides the numbers and percentages of cases received by the PSOW in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 01 October 2020**
Subject :	**Mortality Review (Community Hospital Deaths)**
Approved and Presented by:	Paul Buss Medical Director
Prepared by:	Amanda Edwards Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	Quality, Governance Group 15th September 2020

PURPOSE:

This purpose of this paper is to provide an update to Experience, Quality & Safety Committee 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 & Safety Committee is asked to DISCUSS and NOTE the content of this paper.

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:

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.

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.

During the period under review 1st May to 31st August 2020 there have been 205 deaths of Powys residents in hospitals. These deaths occurred in Powys community hospitals and in acute units in neighbouring Health Boards and NHS Trusts. A breakdown of those deaths is provided within this paper.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

Death comes to everyone and for many, it is caused by acute or chronic illness for which the individual was being treated. The PTHB 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. The NHS is committed to improving the quality of care and the experience that the patient has whilst being cared for. This commitment requires the NHS, at the institutional level and at the individual worker level, to exploit and export what is good, to remediate what is not so good and to learn continuously from our performance. There are several processes that inform this continuous process of service improvement and one of them is mortality review; analysing the care that the deceased received in their final illness with a view to extracting all the learning possible from this last episode; be it related to clinical, administrative, social, individual or team issues and examples of outstanding care or care that could and should have been better.

The PTHB approach to mortality review will be through the analysis of clinical records which will be undertaken where patients die in hospital. In the first instance, this will be within Powys community hospitals but it will remain the PTHB ambition to review all deaths in hospital including those that die in acute units outside the county.

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.

Within PTHB it is recognised that there is a need to standardise and incorporate mortality reviews into current organisational governance processes for learning and

improving systems of care. Effectively run audit and peer review processes, incorporating analysis of mortality cases, contribute to improved patient safety and professional development.

The mortality review meetings support a systematic approach to the review of patient deaths or care complications to improve the quality of patient care and provide professional learning.

It must be clear that the development of the mortality review process will be to focus on the quality of care and the clinical processes offered un relation to care in relation to learning and system improvement. It will serve to compliment the National roll out of the Medical Examiner role from next summer across Wales.

The Medical Examiner Role

Following the Shipman report and further issue in relation to Care at Mid Staffs NHS Trust in England the intention has been for the development of a national system to ensure consistency in relation to the cause of death and death certification. This led to the development of a UK outline process for the Medical Examiner in England and Wales.

Our Medical director has been leading the programme board which heads the development and roll out of this process in Wales. At this moment there have been qualified clinical medical examiner appointments for all areas of Wales including Powys and the development of Medical examiner officer roles to support the process. The aim is for all hospital deaths in Wales (including community hospitals) to be scrutinised through this independent process by the summer of 2020 and for all deaths to be subject to the process by 2021. An update report will be made to board separately in relation to this in due course.

The Datix Mortality Module

The Once for Wales Concerns Management System (OfWCMS) establish the core functionality for the Learning from Mortality system to ensure that mortality reviews can be undertaken in a consistent and evidence based manner in order to identify problems in care, maximise and promote system learning and provide assurance to healthcare providers, service users and Welsh Government.

This mortality module provides the opportunity for Powys to use a standardised platform for the recording and management of deaths in PTHB Community Hospitals through the introduction of an electronic system for recording deaths which will ensure that data (in terms of numbers/ cause of death) on inpatient deaths is complete and accurate.

Additional benefits of the web-based reporting system ensure the health board are better placed for the introduction of the Medical Examiner Service for Wales.
The use of this Datix mortality module promotes visibility, supports escalation and provides assurance that learning opportunities are being sought following every in-hospital death.

PTHB Quality of Care Mortality Review and Organisational Learning

A mortality review describes a systematic approach that provides the opportunity for peer review of adverse events, complications or mortality to reflect, learn and improve the quality of patient care and enables collective learning and quality improvement and is an integral part of organisational clinical governance systems. Mortality reviews are also an opportunity to focus on learning from normal everyday clinical work and excellence in care.

The success of PTHB mortality reviews is dependent on the existence of a learning culture. A structured approach to reporting, recording and learning provides will provide a memory of outcomes from mortality reviews which is relevant for identifying trends and conducting appropriate analysis or audits of care. The revised mortality review process within PTHB relies on a number of key factors:

- Clinical leadership and ownership
- An organisational culture of openness, honesty, transparency and professional accountability, based on sound educational principles
- A focus on learning and improvement of systems and processes of care and not on individual performance, which includes learning from excellence in care and sharing good practice
- A systems approach to the discussion and analysis of case presentations is necessary at all times to ensure in-depth understanding, effective team learning, the implementation and development of appropriate improvement actions and recommendations

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 quality of care provided to patients who die should be integral to our clinical governance and quality improvement work.

Cases to be reviewed

The opportunity to identify ways to improve and understand services for patients goes beyond simply the immediate cause of death. The PTHB mortality review process will ensure that community hospital inpatient deaths are reviewed and that the potential to learn lessons in order to improve clinical care, systems and processes at an individual, team or hospital system is optimised.

Initially, during September, October and November, to provide assurance and to capture learning from across the Health Board each community hospital site will be visited by a senior clinician and the patient notes relating to the previous 15 deaths will be independently reviewed using an agreed template. This aims to deliver the independent review of 135 cases which would give us a really good overview on any emergent issues related to quality of care that may require focus through audit or education. The senior clinicians involved in these independent reviews will be the Medical Director, the Assistant Medical Director and the Professional Head of Nursing.

In addition to the onsite independent reviews, a Mortality Review Group will meet on a bi monthly basis and will consider:

- All deaths that are unexpected, unusual, of concern or are subject to a Serious Untoward Incident will be appropriately reviewed to assess if there is potential for organisational learning.
- In addition, a representative proportion from the independent review of community hospital deaths will be selected and reviewed.
- In addition, during the current emergency period and until further notice, we are required to continue to undertake mortality reviews for those deaths where there may be a concern or unusual circumstances.

The Mortality Review Group would comprise the following:

- Medical Director – Chair
- Assistant Medical Director
- Assistant Director Innovation & Improvement
- Assistant Director Community Group
- Head of Nursing
- Head of Therapies
- Chief Pharmacist

The group will be supported by the Safety and Quality Improvement Manger.

The main purpose of this group is to share and disseminate lessons learned from reports 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 and revised organisational learning processes. The panel reports to the Experience, Quality & Safety Committee (EQ&S) on a quarterly basis.

Death Powys Residents in Hospitals 1st May – 31st August 2020

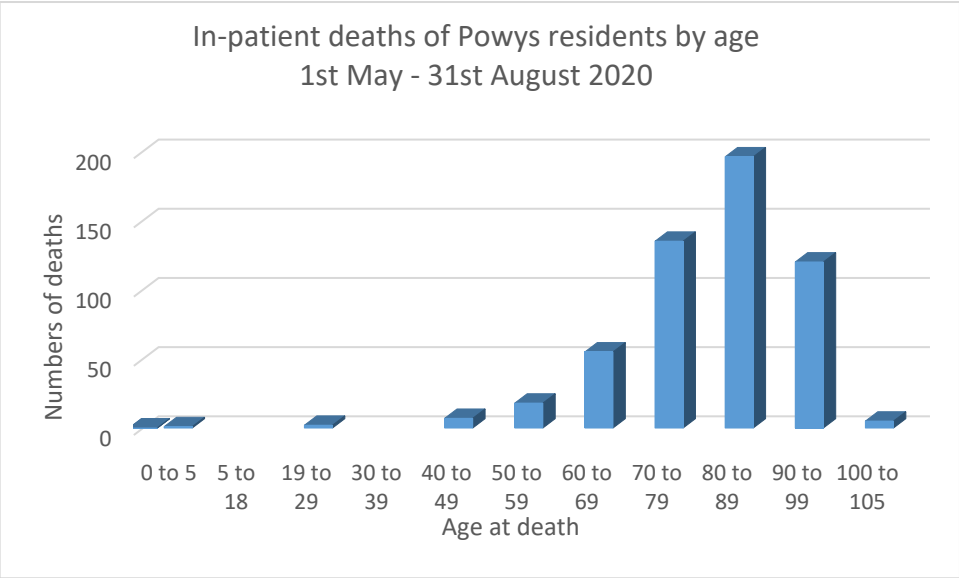
During the period under review there have been 205 deaths of Powys residents in hospitals. These deaths occurred in Powys community hospitals and in acute units in neighbouring Health Boards and NHS Trusts.

Total number of reported deaths of Powys residents in hospitals.	205
Deaths in Powys community hospitals	72
Deaths in acute units in neighbouring Health Boards and NHS Trusts	133
Total number of deaths that were subject to a stage 2 review	Less than 6
Total number of deaths that were subject to a serious incident (SI) investigation	Less than 6
Deaths of patients with learning disabilities	This is not data currently available in the Health Board
Deaths of patients with significant mental health disorders	
Infant and child deaths	0

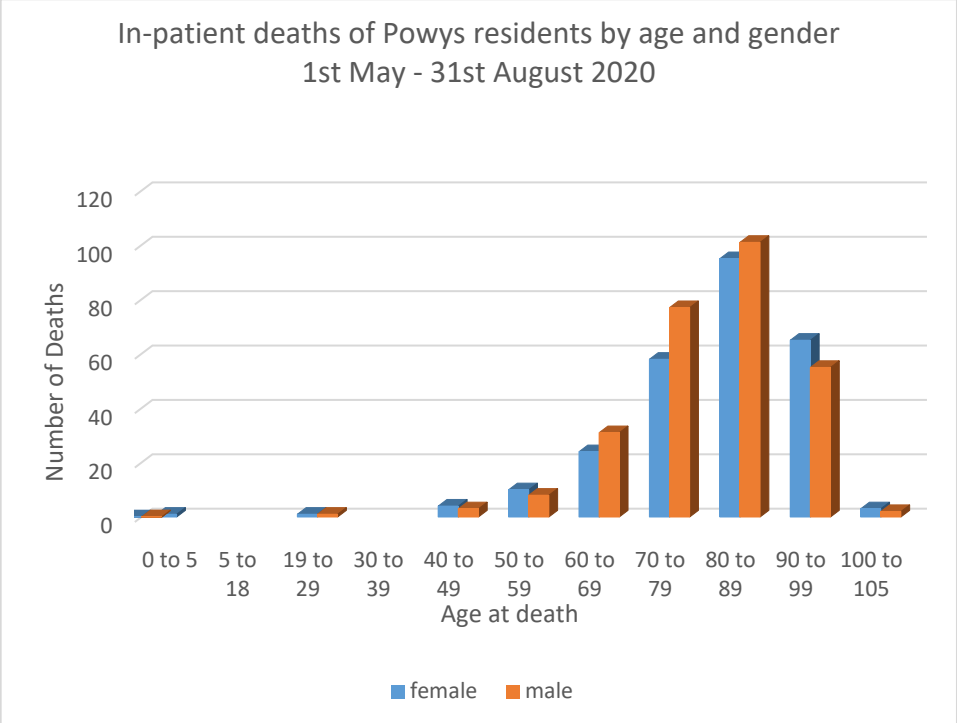
Perinatal deaths	Less than 6

The perinatal deaths referred to were due to fetal abnormalities that had been detected during screening and where the women concerned were aware that the prognosis was very poor.

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
- Dementia
- Covid-19
- Other

	Primary Cause of Death	PTHB Provider Male	PTHB Provider Female	Commissioned Services: Male	Commissioned Services: Female	Total
The Big Four	Cancer	17	11	16	19	63
	Mental Health	1	0	0	0	1
	Respiratory Disease	2	1	10	10	23
	Cardiovascular Disease	7	8	21	16	52
	Dementia	3	3	3	7	16
	Covid 19	1	3	3	4	11
	Other causes	6	9	9	15	39
	Total	37	35	62	71	205

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	Total
Infection/Sepsis primary cause	2	5	11	8	26
Sepsis primary or contributing factor	2	1	15	15	33
Dementia primary or contributing factor	2	0	13	6	11

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 are issues relating to the quality of care.

An organisational approach to understanding and sharing the learning across the Health Board is under development.

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: 1 October 2020**
Subject :	**Update of the 2020/21 Clinical Audit Plan**
Approved and Presented by:	Paul Buss, Medical Director
Prepared by:	Howard Cooper, Safety & Quality Improvement Manager
Other Committees and meetings considered at:	Quality Governance Group 15 September 2020

PURPOSE:

The purpose of this paper is to inform the Experience, Quality and Safety Committee regarding the progress of the 2020/21 Clinical Audit plan and request permission for changes to the annual audit plan.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to receive this report and APPROVE the proposed changes to the annual audit plan.

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:

This report provides a **current position in relation to the** 2020/21 Clinical Audit plan. As the Clinical Audit plan is a Board-owned document, the Directors and Service Leads request that the Experience, Quality and Safety Committee **acknowledge that new arrangements are being developed to link the future audit programme more closely to professional development through medical and nursing revalidation and organisational risk and to give approval for the proposed changes to the plan requested in this report.**

DETAILED BACKGROUND AND ASSESSMENT:

Background

This report provides an update on the position of the 2020/21 Clinical Audit Programme. The Directors and Service Leads have asked for the committee to give their approval for a number of requested changes to the Clinical Audit plan.

This report **does not** provide an update to the **Clinical Audit Improvement Plan** which will be reported separately.

The original 2020/21 Clinical Audit plan is listed in **Appendix A**.

Audits reporting their findings this period.

The audits on the completion of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order form and on the use of the National Early Warning Score (NEWS) patient status monitoring document have been completed by the Community Nursing staff. The DNACPR audit showed excellent level of compliance in the completion of the DNACPR form. No improvement actions were identified.

The NEWS and patient monitoring audit revealed that across all Powys hospital wards the recording of both the standing and lying blood pressure of patients was poor. Failure to record both readings will result in not identifying patients who are at an increased risk of falling because they are unable to maintain their blood pressure in response to changes in position. At some sites a further issue was identified in that equipment that was cleaned and ready for use was not marked as such risking confusion with equipment that had not been cleaned.

An action plan to address issues identified has been completed and distributed to the nursing teams.

The Radiography Grading Audit and Hand Hygiene Compliance Audit were completed by the Community Dental Service. A perfect score was recorded in both these audits.

The Committee is asked to note the completion of these audits.

National Clinical Audit Programme.

These are audits that have been identified by Welsh Government as mandatory to complete by organisations offering the service covered by the audit.

The following National Clinical Audits have announced that data collection is underway for the current round of the audit.

- National Pulmonary Rehabilitation Audit — Community Nursing Care
- National Diabetes Core Audit — Primary Care

The end date for data collection in the Pulmonary audit has yet to be announced but the end date for data collection in the Diabetes Core audit has been set as 31 March 2021. The National Report of the Diabetes Core audit is scheduled for Autumn 2021.

The Committee is asked to note that these audits are underway.

Changes to the National Audit Programme

The National Audit of Seizures and Epilepsies in Children and Young People, The All Wales Audiology (Paediatric) Audit and The National Diabetes (Foot Care) Audit have all announced that due to the Covid 19 epidemic they will not be undertaking audit activity this financial year.
However, staff of the Women and Children's service intend to still collect data using the National Audit of Seizures and Epilepsies and use it for a local audit.

The committee is asked to approve change of the Epilepsy audit from National to local status and to note the removal of the other National Audits from the 20/21 Clinical Audit plan.

Changes to the local 2020/21 Clinical Audit plan

The Directors and Service Leads request that the committee gives their approval for the following requested additions to, delays in, or removals from the 2020/21 Clinical Audit plan.

Service Area	Name of Audit	Change requested	Reason for change	Risks involved	Proposed new date of audit
Pain and Fatigue Management Service	Consent taking and initial assessment process.	**Addition** of this audit to programme.	To support a service improvement initiative.	None	Immediate
Speech and Language Therapies	Documentation audit.	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Immediate
Ward based nursing	Care of patients fed *via* naso-gastric tubing audit.	**Addition** of this audit to programme.	To monitor compliance with the newly introduced policy	None	Q4 2020/21

			GNP072 Nasogastric Feeding Tube Insertion and Management.		
Community Dental Service	WHTM01-05 (equipment decontamination audit).	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Immediate
Community Dental Service	Patient Experience Questionnaires (Community Dental Service and Oral Surgery).	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Q4 2020/21
Community Dental Service	Clinical Record Keeping Audit (Usual and Special Care).	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Q4 2020/21
Mental Health	Clozapine and physical health audit.	**Delay** to start date of audit.	Unable to progress due to original auditor leaving organisation.	Risk Low. Risk tolerated by Directorate.	Q4 2020/21
Mental Health	Audit of prescription charts against BNF and Mental Health Act Documentation.	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Q4 2020/21
Mental Health	ECGs undertaken on Older Adult Mental Health in-patient units.	**Delay** to start date of audit.	Unable to progress as scheduled due to Covid 19 pressures.	Risk Low. Risk tolerated by Directorate.	Q4 2020/21
Mental Health	Care and Treatment Plan (CTP) audits	**Delay** to start date of audit.	Unable to progress due to original auditor leaving organisation. A new Quality Improvement Manager has been appointed.	Risk Low. Risk tolerated by Directorate.	Q3 2020/21
Mental Health	Audit of the Joint Working Protocol between adult substance misuse services and adult mental health services.	Request to **withdraw** audit from the 20/21 annual plan.	On further review it was decided by the Service that audit was not the right approach at this time and instead there will be externally commissioned work to review the provision of services and the interface between professional groups that will address any issues of concern.	Risk Low. Risk tolerated by Directorate.	Withdrawn

Mental Health	Tawe Ward Prescription audit.	Request to **withdraw** audit from the 20/21 annual plan.	Originally this audit was planned by the specialist mental health pharmacist. Unfortunately, the organisation no longer has such a person in-post and so the audit is no longer possible. As an alternative risk management measure, the prescription sheets are examined weekly by the generically trained pharmacist attached to the hospital.	The lack of a specialist mental health pharmacist is recognised as a high risk for the service and has been noted on the organisational risk register.	Withdrawn
Women and Children's Service	WAST Transfer Audit.	**Addition** of this audit to programme.	The audit will measure compliance with a newly changed operational framework.	None	Q4 2020/21
Women and Children's Service	Birth Trauma Service Audit.	**Addition** of this audit to programme.	The audit will help support the work of providing better perinatal Mental health care.	None	Q4 2020/21
Women and Children's Service	Paediatric Triage Audit.	**Addition** of this audit to programme.	The audit will measure compliance with a new service initiative which is in line with RCPCH standards.	None	Q4 2020/21

The committee is asked to give their approval for these changes to the Clinical Audit Plan.

RECOMMENDATIONS:

The Experience, Quality and Safety Committee is asked to NOTE the content of this report and to APPROVE the requested changes to the 2020/21 clinical audit plan.

Appendix A

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	

Service Improvement required	Audit of prescription charts against BNF standards	Mar-20	Clinical Director Mental Health and Learning Disabilities	
Changes to existing policy or practice	Mental Health Act Documentation	Mar-20	Clinical Director Mental Health and Learning Disabilities	
Changes to existing policy or practice	ECGs undertaken on Older Adult Mental Health in-patient units	May 20	Advanced Nurse Practitioner	
Serious Incident Learning	Care and Treatment Plan (CTP) audit	Feb-20	Senior Manager, Adult Mental Health Montgomeryshire	
Service Improvement required	Tawe Ward CTP audit	Jan-20	Ward Manager	
National Audit (Non-Programme)	Tawe Ward IPC audit	Aug 20	Ward Manager	
Changes to existing policy or practice	Tawe Ward Prescription audit	Jan-20	Ward Manager	
Service Improvement required	NICE Guideline Dementia Ystradgynlais Older Adult CMHT	Jan-20	Community Mental Health Nurse	
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)	
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: 4.1

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**DATE OF MEETING: 01 October 2020**
Subject:	**COMMITTEE WORKPLAN 2020-21**
Approved and Presented by:	Rani Mallison, Board Secretary
Prepared by:	Rani Mallison, Board Secretary
Other Committees and meetings considered at:	Workplan approved by Board on 29 July 2020 (scheduled at the time of writing)

PURPOSE:

The purpose of this paper is to provide the Experience, Quality & Safety Committee with the 2020/21 workplan, as at September 2020.

RECOMMENDATION(S):

The Committee is asked to NOTE the 2020/21 Committee workplan which outlines planned pieces of work for meetings scheduled during 2020/21.

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	✓

EXPERIENCE, QUALITY & SAFETY COMMITTEE
PROGRAMME OF BUSINESS 2020-21

The scope of the Experience, Quality & Safety Committee extends to the full range of PTHB responsibilities. This encompasses all areas of experience, quality and safety relating to the workforce, patients, carers and service users, within directly provided services and commissioned services. The Committee embraces the Health and Care Standards as the Framework in which it fulfil its purpose

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board;
- the Board's Assurance Framework;
- key risks identified through the Corporate Risk Register, Commissioning Assurance Framework; and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee);
- key statutory, national and best practice requirements and reporting arrangements.

In May 2020, the Board agreed its governance arrangements during the COVID-19 Pandemic. It was agreed that Formal meetings of the Board's Committees would have a shortened, concise agenda focussing on essential matters only and will be held virtually to ensure compliance with social distancing guidance.

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Annual Reports							
Putting Things Right Annual Report	DNM			✓			
Public Services Ombudsman Annual Report	DNM			✓			
Annual Report of the Accountable Officer for Controlled Drugs	MD				✓		✓
Safeguarding Annual Report	DNM				✓		
Annual Report of the Caldicott Guardian	MD						✓
Annual Data Quality Report	DF&IT					✓	
Annual Quality Statement	DNM			✓			
Quality & Safety Assurance Reports							
Clinical Quality Framework Implementation Plan	DNM			✓		✓	
Organisational Quality Governance Actions - Update	BS		✓			✓	
Clinical Audit Programme	MD		✓	✓			
Clinical Audit Report	MD				✓		
Quality Performance Report (Provided and Commissioned Services)	DNM				✓	✓	✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Serious Incidents and Concerns Report	DNM		✓	✓	✓	✓	✓
Inspections and External Bodies Report	DNM			✓	✓	✓	✓
Mortality Reporting	MD			✓	✓		✓
Mental Health Act Compliance & Powers of Discharge	DPCCMH				✓		✓
HIW Action Tracking	DNM / BS				✓	✓	✓
Information Governance Quality Report	BS				✓		✓
Staff Well-being and Engagement Update (including Staff Survey)	DWOD	✓			✓		✓
Quality Improvement Programme	MD					✓	
Infection Prevention & Control Report	DNM		✓			✓	
Safeguarding Report	DNM		✓				✓
Estates Compliance Update	DPP	✓ Moved to P&R Committee					
Health and Safety Update	DWOD			✓			✓
Welsh Language Standards Update	DTHS						✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Audit and Regulatory Reports		As and when identified					
Additional reports Scheduled as an Organisational Priority/Strategic Risk							
Maternity Services Assurance Framework	DNM					✓	
Commissioning Arrangements: Shrewsbury & Telford Hospitals NHS Trust	ADCD		✓	✓	✓	✓	✓
Once for Wales Complaints Management System (DATIX) Implementation Update	DF&IT			✓			✓
Refreshed Patient Experience Framework	DNM						✓
Refreshed Values and Behaviours Framework	DWOD						✓
Quality & Engagement (Wales) Act	BS			✓			✓
Coronavirus (COVID-19): • Overview • Non-COVID Activity • Staffing of Clinical Response Model • PPE Arrangements • Ethical Framework • Clinical Decision Making	CEO & Directors	✓					
Risk Assessment: Transmission of COVID-19 in the workplace			✓				
Support to Care Homes during COVID-19			✓				

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Use of PPE for CPR procedures during COVID-19	MD			✓			
Committee Governance Reports							
Committee Risk Register	BS				✓	✓	✓
Policies Delegated From the Board for Review and Approval	BS	**As and when identified**					
Review of Committee Programme of Business	BS			✓	✓	✓	✓
Committee Requirements as set out in Standing Orders							
Development of Committee Annual Programme Business	BS						✓
Annual Review of Committee Terms of Reference 2021-22	BS						✓
Annual Self-assessment of Committee effectiveness 2021-22	BS						✓
The Committee will meet in a closed session to discuss any matters deemed of a confidential and/or sensitive nature, including where reports include patient identifiable information							

KEY:

CEO:	Chief Executive
DPP:	Director of Planning and Performance
DF&IT:	Director of Finance and IT
DPCCMH:	Director of Primary, Community Care and Mental Health
MD:	Medical Director
DoN:	Director of Nursing
DoTHS:	Director of Therapies and Health Sciences
DWOD:	Director of Workforce & OD
DPH:	Director of Public Health
BS:	Board Secretary
ADC&E:	Associate Director of Capital & Estates
ADCD:	Assistant Director of Commissioning Development

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

PUTTING THINGS RIGHT
CLAIMS AND COMPENSATION
ANNUAL REPORT 2019- 2020

Contents:

Introduction

The Putting Things Right Annual Report provides information on the progress and performance of Powys Teaching Local Health Board (hereafter, the health board) in their management of concerns during 2019-2020. This report includes compensation claims management.

The Report is prepared in line with 'The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011', of which Regulation 51 provides that a responsible body must prepare an annual report.

The Report is published in support of the health board's Annual Quality Statement.

Focus of Report

Formal Concerns

Serious Incidents

Informal Concerns

Never Events

Redress

Compliance with Regulations

Compensation Claims

Trends, themes and lessons learnt

Compliments and overall patient experience

Overview of 2019-2020

	Total Number 2018-2019	Total Number 2019-2020
Formal Concerns	208	267
Informal Concerns	127	53
Redress	12	16
Legal Claims	7 clinical negligence claims (Inc. 3 new claims in year) 3 personal injury claim (Inc. 2 new claims in year)	14 clinical negligence claims (inc 2 new cases in a year 3 Personal Injury (inc 2 new cases in year)
Serious Incidents	55	53
Never Events	0	0

How did we do?

Formal Concerns 2019 – 2020	2017 -2018	2018-2019	2019 -2020
Acknowledged in 2 working days	89%	77%	82%
Managed and responded to within 30 working days against a target of 75%	65%	59%	47%
Managed and responded to within 30 working days and 6 months	37%	37%	34%
Managed and responded to over 6 months	6%	4%	5%

Informal Concerns 2019 -2020			
Managed and responded to within 2 working days against a target of 100%	82%	59%	73%

Background

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (hereafter, the 'Regulations') that apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care were introduced in April 2011.

Since this time, work has progressed to put in place an integrated approach for people to raise concerns.

A concern means any complaint, claim or reported patient safety incident.

Arrangements in place for dealing with concerns

The strategic oversight for concerns rests with the Executive Director of Nursing, the portfolio holder changing in year:

Rhiannon Jones (from April 2019 to July 2019

Carol Shillabeer (CEO) (from July to February 2020

Alison Davies (from February 2020)

The team responsible for managing concerns day-to-day consists of a Senior Investigations Manager (the Assistant Director Quality & Safety), a Senior Manager Putting Things Right and a Patient Experience/ Concerns Officer.

The health board have operated with one staff member less from July to late August due to staff illness and bank cover to assist the Senior Manager Putting Things Right.

Arrangements in place for dealing with concerns

Independent scrutiny, governance and reporting arrangements

The Putting Things Right Redress Panel (hereafter known as the 'Panel') provide independent scrutiny of the management of concerns, and remain accountable to the Executive Team.

The Executive Director of Nursing, as the Chair, is required to provide quarterly reports to the Executive Team and assurance to the Patient Experience, Quality and Safety Committee, (subsequently renamed the Experienced, Quality and Safety Committee). In addition to this from July 2019 reports are also provided to the Quality Governance Group which is Chaired by the CEO

Arrangements in place for dealing with concerns

Procedure for the Handling and Investigation of Concerns

There has been a continued focus on improving the management and response to concerns throughout the year, ensuring processes and procedure were firmly embedded across the health board. However, there has been a decline in performance overall impacted by staff sickness and the new Senior Manager Putting Things Right developing. Measures put in place to support improvement included:

- Daily training and support
- Training opportunities, e.g. Sage and Thyme Training, shadowing of key areas/ individuals such as within the health board and other NHS Trusts
- Use of bank staff to support a period of sickness
- Review of existing wider quality and safety team resource to support daily work
- Strengthened processes in the management and response to concerns through the Directorates and Service areas

Concerns Statistics

Assessment of Concerns Grading on Receipt

We continued the work to ensure concerns were assessed on receipt as to the complexity of the concerns and the anticipated work and timescale required in investigating and providing a final response to the person(s) who raises the concerns. This was aimed at assisting staff management of concerns and expected response timeframes, but more importantly in managing complainant's expectations and ensuring they have clarity at the point of raising a concern regards when they will receive timely communication.

Concerns were graded on receipt, from grade 1 (low) to grade 5 (high). Once the matter is investigated and the full outcome is known, on completion of the concern a final grading is then assigned. Again, this replicates the grading from 1 to 5 and can change reflecting the findings of the concern.

During 2019/2020 all concerns were checked for grading and 100% were assessed accordingly and assigned a rating of 1 to 5.

Concerns Statistics -Formal Concerns

During 2019-2020 the Health Board received 3 formal concerns (Table 1); relating to services provided by Powys Teaching Health Board, the remaining relating to commissioned provider services.

	TOTAL NUMBER OF INFORMAL CONCERNS	TOTAL NUMBER OF FORMAL CONCERNS	TOTAL
2019-2020	53	205	258
2018-2020	127	208	335
2017-2018	70	170	240
2016 – 2017	80	246	326
2015-2016	67	154	221

Table 1: Table showing year on year numbers of concerns received by the health board

The decrease in informal concerns is considered to be a result of the change in the reporting timescales from 5 days to 2 days. The health board encourages staff to report concerns and resolve them informally where possible. Staff are informed through training such as Sage & Thyme, implemented through out the year to remind them how to listen and how to respond in a way which empowers the patient, additionally skilling our staff to provide person-centred support to someone with concerns. Examples of informal concerns reported related to access to services such as podiatry, staff attitude and timely appointments.

Concerns Statistics – Commissioned Services

- Of the 62 concerns relating to commissioned services the focus was:
  - Care and treatment
  - Access to services
  - Diagnosis failed or delayed
  - Patient information
  - Waiting times for treatment, e.g. surgery
  - Referral pathways
  - Treatment and intervention
  - Closure of the Pain Management Clinic in Robert Jones Agnes Hunt Orthopaedic Hospital.

Action was taken on all concerns and the key lessons related to ensuring patients are aware of how information systems communicate with other cross border organisations, communication and explanation on waiting lists and order of surgery for English and Welsh patients.

Concerns Statistics -Formal Concerns

Timeframes for Responding to Formal Concerns

The reporting of concerns data and compliance for the period 2019-2020 reflects the quarterly reporting of concerns data to Welsh Government. Data validation was strengthened in year to ensure accurate data presented.

	Number 2019/2020	Number 2018/2019
Total Number of Formal Concerns	320	208
No of formal concerns assessed and responded to within 30 working days of receipt	47%	59%
No of formal concerns assessed and responded to within a period exceeding 30 working days but within 6 months of receipt	34%	37%
No of formal concerns assessed and responded to within a period exceeding 6 months of receipt	5%	4%

Table: Timeframes for responding to concerns. Please note some concerns remain ongoing.

Concerns Statistics -Informal Concerns

Changes to recording informal concerns (early resolution)

It was agreed at an All Wales level in January 2019 that health bodies cease using the term ‘informal concerns’ as it gives the impression the concern raised is of less importance. The term has been replaced by ‘early resolution’.

Further the timeframe for dealing with such matters reverts to them being resolved within 2 working days of receipt (including the day of receipt) as opposed to 5 working days which has been used in the past three years.

This change will result in formal concerns artificially appearing to increase as the tighter definition of early resolution will remove a large number of complaints previously determined as informal.

Concerns Statistics -Informal Concerns

These are commonly termed ‘on the spot’ concerns, and are normally resolved within 2 working days. A total of 53 informal concerns were raised in 2019-2020, compared to 127 in 2018 -2019.

Timeframes for Responding to Informal Concerns

The health board set a target of 90% of informal concerns being responded to within the new target of 2 working days, we achieved 79% compliance.

A review of the data has shown a the decrease of the informal concerns does relate to the shorter timescale to be able to respond. The key issues being dealt with ‘on the spot’ are:

- Staff attitude
- Appointments
- Prescription issues

Putting Things Right Redress Panel

Where the investigation of a concern concludes there has been a breach of duty the case is presented to the Putting Things Right Redress Panel.

The Panel are required to consider whether redress applies in situations where a patient may have been harmed and the harm was caused during care provided by the health board or in relation to care commissioned from other providers on their behalf in other parts of the United Kingdom.

Redress can be the giving of an explanation, a written apology, the offer of financial compensation and / or remedial treatment, on the understanding that the person will not pursue the same through civil proceedings.

- The redress panel met on 8 occasions during 2019-2020.
- A total of 12 cases were considered resulting in Expert opinions being sought, financial payments being made .

Putting Things Right Redress Panel

- All cases concluded have resulted in the issue of one of a number of responses:

  - Regulation 24 letter confirming no breach of duty / causation and extension of an apology.
  - Regulation 26 interim response letter where the health board has considered a qualifying liability exists.
  - In accordance with Regulation 33, the health board has communicated its final decision to either offer Redress in the form of financial compensation, treatment or combination of both or, if no liability could be established as a result of investigations carried out in accordance with Part 6 of the Regulations, not to make an offer.

- Upon the appointment of the new Senior Manager for Putting Things Right it was agreed there was no need for a representative from Legal and Risk Services to attend the meetings on a regular basis.

Legal Claims – Clinical Negligence

The health board continues to have a very small compensation claims profile.

At the end of 2019/2020 the health board had 10 clinical negligence claims (inclusive of 3 new claims in year) the estimated combined damages £ 15.7 Million and defense costs totaling £591,789.90.

Cases were settled in the year, with total damages of £22,000.

Legal Claims – Personal Injury

For the period 2019/2020 the number of Personal Injury cases has remained low, with 4 cases remaining open at the end of year (inclusive of 2 new claims in year). The estimated damages for these cases equate to £315,530 plus defence costs of £ 255,000.

Serious Incidents

A serious incident is defined as an incident that occurred during the provision of NHS funded healthcare. All serious incidents are reported to Welsh Government.

53 serious incidents were reported in 2019/2020, compared to 47 the previous year.

The reduction in reporting is attributed to the change in reporting of pressure ulcers since 2 January 2019, all health boards now reporting only avoidable pressure ulcer damage. No avoidable pressure ulcers were reported during quarter 4.

The health board is required to provide Welsh Government with an assurance that a robust investigation for a serious incident has been completed and learning identified within 60 working days. The health board have reported varying rates of assurance each month from 0% - 100%. A proactive action plan is in place to support improvement.

No themes or trends were reported.

Examples of lessons learnt included:

- Photographs of pressure ulcers invaluable in providing accurate picture of damage
- Importance of maintaining training in use of 'skin bundles' to prevent pressure ulcers

Never Events

Never events are serious, largely preventable patient safety incidents which should never occur if preventative measures have been put in place.

The health board had no Never Events in 2019/2020.

Coroner Enquiries

A total of 21 enquiries were made by the Coroner's Officers to the health board during 2019/2020, of which no further actions and improvements were identified.

The majority of the enquiries related to patients who had possibly accessed or had accessed mental health services at some time during their life.

Referrals to the Public Services Ombudsman for Wales

- A total of 23 enquiries from the Public Services Ombudsman for Wales (PSOW) were recorded as received in year.
- The main themes relating to:
  - Retrospective NHS funded continuing healthcare (13 complaints received)
  - Complaints handling
  - Clinical Treatment in hospital

- The health board has received complaints relating to delays in determination of retrospective claims for NHS funded continuing healthcare. It was found that the health board failed to determine the claims within the recommended timeframe, or even within a reasonable time, concluding maladministration. It was felt the claimants suffered the injustice of not knowing whether their claims would succeed, and if they were successful, the delay in receiving reimbursement for the costs incurred. The health board were required to apologise to the complainants and make a payment of £125 to each, in recognition of the delay experienced.

Referrals to the Public Services Ombudsman for Wales

- There have been complaints to the Ombudsman about how the health board had handled complaints over the past year received, the following points identified:

  - lack of communication with the complainant;
  - the complainant was unsure as to whether the complaint was being taken forward;
  - the complainant had to repeatedly contact the health board for updates;
  - delay in responding; and,
  - the health board's failure to advise the complainant their response would exceed 30 working days.

- In reflecting and learning from the interventions above, action has been taken by the Concerns Team to review and refresh the systems and processes for managing concerns and ensuring timely responses, this includes clarity for complainants as to when they can expect to receive a response and regular communication with the complainant.

Themes, trends and any key issues emerging from Concerns

KEY ISSUES / THEMES/ TRENDS 2019-2020 (primary issues)
Access (to services)
Accident / falls
Attitude / behaviour
Clinical treatment / assessment
Consent
Medication
Monitoring/Observation issues
Monitoring / observation issues
Referrals
Record Keeping
Resources
Other

From the key areas of concerns summarised there are no trends or patterns to report.

Access to services remains the main concern raised, followed by clinical treatment, attitude and behaviour of staff and monitoring / observation issues.

Lessons learnt from Informal Concerns (Early Resolution)

- The importance of communication and provision of information to residents when services are impacted by staffing sickness and absences supported by an explanation of actions to secure improvements
- When delivering information to residents at times of high service demand, health board staff consider the language used and the manner within which it is delivered
- Referrals in primary care to be typed up timely and accurately to mitigate appointment and assessment delays
- Importance that residents are fully informed of their care pathway to assist with expectations around timely appointments

Lessons Learnt from Formal Concerns Staff Attitude

- Staff to discuss concerns directly with complainants to work together to get the best outcome at that time
- Staff to attend dementia awareness courses to enhance their knowledge and recognise the importance of communication and effective interpersonal skills
- Staff encouraged and supported to attend Sage and Thyme Training.

Lessons Learnt from Formal Concerns Access

- Ensuring patients are advised of their expected pathway of care and treatment
- The importance of sharing actions being taken to improve waiting times
- The need for strengthening of communication between NHS bodies in managing waiting lists and delays for surgery
- The importance of communication with patients where delays in care and treatment known
- The need for communication when service changes taking place

Lessons Learnt from Formal Concerns Care and Treatment

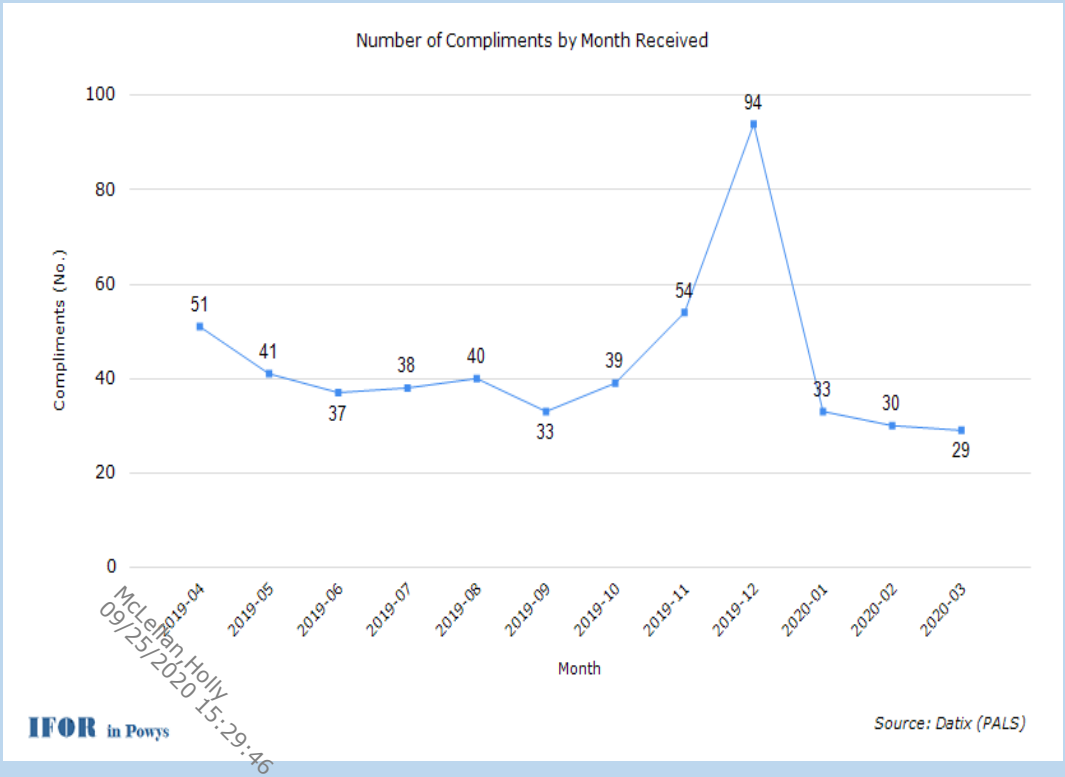
- Importance of communication to patients when appointments rescheduled
- Explanation to patients when procedures can be uncomfortable in addition to communication throughout
- GPs should have mental health literature detailing support groups available
- Importance of sharing clearly plans for ongoing care if clinics have to close

Compliments and overall patient experience

A total of 514 compliments reported for 2019-2020.

A combination of cards, letters and gifts, such as chocolates and biscuits, all expressing their sincere thanks and appreciation for their kindness, compassionate care and support provided.

Compliments and overall patient experience



Overall satisfaction with the service was scored 5/5 by all respondents 100%.
100% of respondents said that they had been treated with dignity and respect by staff in Powys.
"always put at ease"
"10/10 happy with the service all round"
"Always friendly staff"

Compliments and overall patient experience

Examples of what patients stated Powys Teaching Health Board should/ should not change:

No Change:

"Currently I can't think of anything I would change".

"Nursing care brilliant"

"Treated with dignity and respect at all times"

"I would change nothing".

McLellan Holly 09/25/2020 15:29:46

Change:

"time is long on the ward with nothing to do :

Patio area created outside back of ward, purchased table, chairs and parasol and board games purchased.

Extra Sandwiches and Tea available for Bowel Screening Wales patients

"Clear explanation of process beforehand would to make patients feel at ease" –

The Patient Experience Annual Report can be accessed via http://www.powysthb.wales.nhs.uk/patient-experience/

Conclusion and priorities for improvement

It is clear the management and handling of concerns in 2019/20 has seen a decline in performance and focussed work is required throughout 2020/21 to improve the position.

There is stability in the team and focussed work being undertaken to look at streamlining processes to improve response times to achieve the targets.

Conclusion and priorities for improvement

Key areas of focus aimed at continuing the improvements from 2019/2020 into 2020/21 will include:

- Improve response times for concerns within 30 working days from 47% to 75%.
- Improve response times to informal concerns within 2 working days from 73% to 100%.
- Improve the management and handling of concerns.
- Improve compliance with serious incident assurance timeframes and focus on learning, sharing of lessons and evidence of changes.
- Refresh and relaunch the Putting Things Right training programme to improve staff knowledge and skills in managing concerns.
- Improve systems and processes for patient experience feedback in both provider and commissioned services.

Further information can be found at:

Complaints/ Concerns

Our Annual Quality Statement also provides further information on how the health board has improved the quality and safety of healthcare services for Powys residents throughout 2018/19.

See the health board's website:

www.powysthb.wales.nhs.uk

Putting Things Right Information page:

www.wales.nhs.uk