Experience, Quality and Safety Committee

30 July 2020, 10:00 to 12:00
Skype Meeting

Agenda

1. PRELIMINARY MATTERS

EQS_Agenda_30July2020_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes of the previous meeting held on 2 July 2020 (for approval)

EQS_Item_1.3_2020-07-02 EQS Minutes draft v4 (RM).pdf (6 pages)

1.4. Matters Arising from Previous Meetings

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_2020-21_Jul20_v3.pdf (6 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

3. ITEMS FOR DISCUSSION

3.1. Commissioning Assurance Report

EQS_Item_3.1_Commissioning Assurance_July 20.pdf (9 pages)

3.2. Concerns & Serious Incidents Report

EQS_Item_3.2_ Concerns Report 24072020.pdf (20 pages)

3.3. Use of Personal Protective Equipment for Cardiopulmonary Resuscitation and Nasogastric Intubation procedures

EQS_Item_3.3_PPE CPR NGT 30 July 2020.pdf (4 pages)

3.4. Health & Safety Group Update

EQS_Item_3.4_HS report July 2020.pdf (9 pages)

EQS_Item_3.4a_App 1 H&S Report.pdf (2 pages)

3.5. Inspections and External Bodies Report

EQS_Item_3.5_Regulatory Inspections Report.pdf (6 pages)

EQS_Item_3.5a_APPENDIX 1 - Alun Jones HIW to Powys Teaching HB HIW approach to Assurance and Inspection.pdf (2 pages)

EQS_Item_3.5b_APPENDIX 2 - HIW- Phase Two - Community Clinic Information Request Letter - July 2020.pdf (1 pages)

EQS_Item_3.5c_APPENDIX 3 - Llewellyn Ward - Final Report.pdf (36 pages)

EQS_Item_3.5d_APPENDIX 4 - Felindre Ward - Final Report.pdf (44 pages)

3.6. Annual Quality Statement

EQS_Item_3.6_AQS Covering (5 pages)

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Paper_30_July_2020.pdf

EQS_Item_3.6a_AQS 2019-2020 DRAFTV1 20 July 2020_30_July_2020.pdf (63 pages)

4. ITEMS FOR INFORMATION

4.1. Quality & Engagement (Wales) Act

EQS_Item_4.1_Quality_&_Engagement_Act_30_July_2020.pdf (6 pages)

4.2. Putting Things Right Annual Report

EQS_Item_4.2_PtR Annual Report Covering Paper.pdf (4 pages)

EQS_Item_4.2a_APPENDIX 1 - PtR CLAIMS AND COMPENSATION - ANNUAL REPORT 2019-2020.pdf (36 pages)

4.3. PSOW Annual Report

EQS_Item_4.3_PSOW Annual Report Covering Paper_30_July_2020.pdf (4 pages)

EQS_Item_4.3a_APPENDIX 1- Annual-Report-2019-20-Exec-summary-ENG-FINAL_30_July_2020.pdf (6 pages)

EQS_Item_4.3b_ PSOW-Annual-Report-and-Accounts-2019-20_30_July_2020.pdf (134 pages)

4.4. Committee Annual Workplan 2020/21

EQS_Item_4.4_Committee Workplan_July20.pdf (2 pages)

EQS_Item_4.4a_EQS_Committee_Work Programme_2020-21_July20_RM.pdf (6 pages)

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

5.2. Any Other Urgent Business

5.3. Date of the Next Meeting:

1 October 2020 from 12:00, Board Room, Glasbury House, Bronllys Hospital.

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POWYS TEACHING HEALTH BOARD EXPERIENCE, QUALITY & SAFETY COMMITTEE

30 JULY 2020,
10.00AM – 12.00PM
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

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 2 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	Commissioning Assurance Report	Attached	Assistant Director of Commissioning
3.2	Concerns & Serious Incidents Report	Attached	Director of Nursing and Midwifery
3.3	Use of Personal Protective Equipment for Cardiopulmonary Resuscitation and Nasogastric Intubation procedures	Attached	Medical Director
3.4	Health & Safety Group Update	Attached	Director of Workforce and Organisational Development
3.5	Inspections and External Bodies Report	Attached	Director of Nursing and Midwifery
3.6	Annual Quality Statement	Attached	Director of Nursing and Midwifery
4	**ITEMS FOR INFORMATION**		
4.1	Quality & Engagement (Wales) Act	Attached	Board Secretary
4.2	Putting Things Right Annual Report	Attached	Director of Nursing and Midwifery
4.3	PSOW Annual Report	Attached	Director of Nursing and Midwifery
4.4	Committee Annual Workplan 2020/21	Attached	Board Secretary

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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: • 1 October 2020, Board Room, Glasbury House, Bronllys Hospital		

In order to be able to use the time in virtual meetings most efficiently, Board Members are invited to submit questions in relation to items on the agenda in advance of the meeting. It is still be possible for Members to ask questions regarding agenda items during the meeting.
A summary of questions received outside of the meeting, along with answers, are made available on the health board's website: 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/

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 meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of the board or its committees, 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 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 2 July 2020
VIA SKYPE MEETING

Present:	
Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Owen James	Independent Member (Community)
Frances Gerrard	Independent Member (University)
Susan Newport	Independent Member (Trade Union)
In Attendance:	
Carol Shillabeer	Chief Executive
Claire Madsen	Director of Therapies and Health Sciences
Elaine Mathews	Audit Lead / Inspection Wales Programme Manager
Ian Phillips	Independent Member (ICT)
Jamie Marchant	Director of Primary, Community Care and Mental Health
Julie Rowles	Director of Workforce, OD and Support Services
Osian Lloyd	Deputy Head of Internal Audit
Pete Hopgood	Executive Director of Finance and IT Services
Rani Mallison	Board Secretary
Rebecca Collier	Relationship Manager, Health Inspectorate Wales
Vivienne Harpwood	PTHB Chair
Wendy Morgan	Assistant Director of Quality and Safety
Wyn Parry	Medical Director
Apologies for absence:	
Alison Davies	Director of Nursing and Midwifery
Committee Support:	
Stella Parry	Committee Secretary
Holly McLellan	Senior Administrator / Personal Assistant to Board Secretary

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EQS/20/27	**WELCOME AND APOLOGIES FOR ABSENCE** The Vice-Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/20/28	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/29	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 4 June 2020** The minutes of the previous meeting held on 4 June 2020 were AGREED as being a true and accurate record given the changes stated below. EQS/20/10 Jamie Marchant was not in attendance and sent his apologies.
EQS/20/30	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.
EQS/20/31	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. The Board Secretary reported no significant movement on actions due to the meeting held on 2 July 2020 being a supplementary meeting. EQS/19/75 The National Ophthalmology Audit would be addressed later on 2 July 2020 as part of the Clinical Audit Update Paper. This action was therefore marked as closed. The following actions were agreed as complete as they were included as substantive items on the agenda. Any actions arising from the discussion would be recorded as new action: EQS/19/75 The Item Clinical Audit Plan & Update. EQS/19/72 The In-Patient Mortality Reviews.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/32	**CLINICAL QUALITY FRAMEWORK: IMPLEMENTATION PLAN** The Chief Executive presented the Clinical Quality Framework Implementation Plan for endorsement. The Chief Executive reminded the Committee that in the last 2 quarters of 2019 a review was undertaken to explore a refreshed approach to clinical quality and subsequently the Board approved its Clinical Quality Framework on 29

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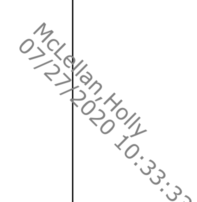
	January 2020. The specific purpose of the framework is to realise a vision of systematic, clinically-led, continuous and sustained, year-on-year improvement in the quality of clinical care provided by PTHB. The framework encompasses pre-determinates of the delivery of high quality clinical care including: • Organisational Culture – encompassing honesty and opening • Clinical Leadership • The improvement methodology in place in the organisation • Clinical quality intelligence and performance reporting The framework is structured around 5 organisational goals and linked improvement activities to determine good quality care in PTHB clinical services during the period 2020-2023. Further work will be completed during 2020/21 to ensure that the existing Commissioning Assurance Framework is fully aligned to the Clinical Quality Framework. The Chief Executive advised that the implementation plan had been developed to set out the priorities for delivery in the next 3 years, recognising the impact that COVID-19 had made in 2020/21. It was noted that each goal within the plan had been allocated to a Clinical Director who would be responsible for co-ordinating the delivery of the actions set out within. Owen James queried how periodic Deep Dive reviews would be determined, as set out in goal 3 of the plan. The Chief Executive confirmed that these would mainly be derived from a risk-based approach, or where there was a change in evidence base. The Chief Executive confirmed that, upon the Committee's support, the Framework and implementation plan would be shared with clinical leads and senior managers. The Committee Chair thanked the Chief Executive for the plan which set out realistic timeframes for implementation. The Committee noted that during the COVID-19 pandemic, an element of flexibility would need to remain. It was noted that this would help shape the focus of the Committee's priorities during this time. The Committee ENDORSED the Clinical Quality Framework Implementation Plan for the next 3 years.

ITEMS FOR DISCUSSION	
EQS/20/33	**MORTALITY REPORTING** The Medical Director presented the previously circulated paper providing 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 Medical Director confirmed that during October 2019 to May 2020 there had been 540 deaths of Powys residents in hospitals. These deaths occurred in Powys community hospitals and in acute units in neighbouring Health Boards and NHS Trusts. It was noted that the majority of these 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 Medical Director noted that there remained a number of actions to be undertaken to ensure PTHB is 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. It was noted that a Task & Finish Group would be established to take this work forward. The Medical Director confirmed that PTHB would take a consistent and evidence-based approach to reviewing case records of patients who have died in our community hospitals but also in acute hospital settings where secondary and tertiary care is provided through commissioning arrangements with Health Boards and Trusts across Wales and England. The Vice-Chair queried the nature of the Mortality Review Panel which had recently met, as outlined in the paper. The Medical Director confirmed that due to the number of cases, monthly meetings have been identified as necessary, although it has only recently been possible for the panel to initiate meetings due to COVID-19 pressures. The Director of Workforce, OD and Support Services questioned the standard of case reviews due to the quantity processed within the time constraints. The Medical Director confirmed that the cases were not reviewed to the standard of Universal Mortality Review, however circumstance of death and Serious Untoward Incident status were identified by the Medical Director, Director of Primary, Community Care and Mental Health and the Assistant Director.



	Frances Gerrard queried benchmarking information. It was noted that these would differ to other Health Boards in measuring mortalities as there is no standard approach. The Committee Chair raised that a development session would be beneficial to understand mortality reporting more widely. This was supported by the Committee. **Action: Board Secretary** The Chair thanked the Medical Director for the paper and acknowledged that there was further work to be done in respect of review, analysis and learning.
EQS/20/34	**CLINICAL AUDIT PROGRAMME** The Medical Director provided an update to the Experience, Quality & Safety Committee regarding progress of the Clinical Audit Programme and to confirm the timeframes for delivery, as requested by the Committee on 02 July 2020. The Medical Director confirmed that the clinical audit programme was already underway with plans for and evidence of improvement as well as learning that will be shared across the organisation. The Committee Chair raised that a development session would be beneficial to understand the clinical audit cycle more widely. This was supported by the Committee. **Action: Board Secretary** The Committee NOTED the Clinical Audit Plan 2020/21 and timescales for delivery. It was further noted that quarterly reporting on audit outcomes would be presented to the Committee.
EQS/20/35	**ONCE FOR WALES COMPLAINTS MANAGEMENT SYSTEM (DATIX) IMPLEMENTATION UPDATE** The Executive Director of Finance and IT Services presented the Committee with an update on the implementation of the Once for Wales Complaints Management System. It was noted that a newly established Project Board was scheduled to meet for the first time in April (this has been rearranged due to Covid-19), and would be responsible for the oversight and management of the transition and implementation to the new complaints system. The key task will be to modernise and improve the current database that is used to record complaints data, this is crucial to ensure accurate on going reporting and successful migration to the

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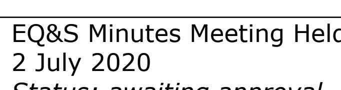

	new system. Relevant stakeholders have been identified (including the Data Warehouse Team) and they have been invited to the Project Board to help ensure that the database development follows best practice. The Director of Finance & IT noted that the PTHB project group is working closely with the National Programme Board to ensure that appropriate actions and deadlines are met in relation to the National Roll Out programme. The Assistant Director of Quality and Safety team advised that PTHB had been using DatixWeb (for recording Complaints data) since 2019, this system is based on the Health Boards historic database but requires different methods of recording information. The current system continues to have issues in relation to data quality (at a local and national level), this is mainly due to issues in relation to legacy data (e.g. when old cases are reopened) and a requirement to input data in a different way. Processes are in place to ensure that Data is validated for accuracy of reporting. The Committee was assured that adopting the use of the DatixWeb dashboard will improve the accuracy of data and transparency in the reporting process (as the reports only use the data that is displayed in the web interface). The Committee noted the work underway and that training to support roll-out would be key. The Committee NOTED the update provided.
ITEMS FOR INFORMATION	
There were no items for inclusion in this section.	
OTHER MATTERS	
EQS/20/36	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be reported.
EQS/20/37	**ANY OTHER URGENT BUSINESS** No other urgent business. The Chair thanked all members.
EQS/20/38	**DATE OF THE NEXT MEETING** 30 July 2020, 10:00am, Board Room, Glasbury House, Bronllys Hospital.

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Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Arising from Meetings of the Experience, Quality & Safety Committee (2019/20)					
ARA/20/28	25 June 2020	Board Secretary to pick up with DWOD that work in respect of the Stress Management Policy Toolkit starts in quarter 2, as specified in the audit recommendation, to ensure the health board maintains its support to staff.	Board Secretary	30 July 2020 Update included in the H&S Group Update, included on the agenda. 25 June 2020 Action transferred to the EQS Action Log from ARA Committee, as the Committee responsible for receiving assurances on staff wellbeing.	
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).	

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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	<u>16 April 2020</u> The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	
EQS/19/74	3 December 2019	Future Information Governance Quality reports will include further analysis and benchmarking	Board Secretary	<u>30 July 2020</u> Item scheduled through Committee Workplan, included on the agenda. <u>16 April 2020</u> The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

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EQS/19/73	3 December 2019	A Health and Safety Report Update will be brought to the Committee in the next 6 months	Board Secretary/Director of Workforce & OD	30 July 2020 H&S Group update included on the agenda and future reports scheduled through committee workplan. 16 April 2020 Some areas would be considered COVID-19 Priority 1, update reports would continue to be received. Scheduled for 30 July 2020 meeting.	
EQS/19/73	3 December 2019	The 'Heat Maps' reported to the LPF will be provided to this Committee at the next Health & safety Update report	Director of Workforce & OD	30 July 2020 H&S Group update included on the agenda and future reports scheduled through committee workplan. 16 April 2020 To be included in Health & Safety Updates, as above.	

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EQS/19/71	3 December 2019	The Committee will continue to monitor the Maternity Assurance Framework periodically	Director of Nursing & Midwifery	30 July 2020 Scheduled through committee workplan, included on the agenda. 16 April 2020 HIW had stood down the regulatory inspection of Maternity Services in Powys, however, PTHB were in regular contact with commissioned services providers and were monitoring provided services.	
EQS/19/68	3 December 2019	An Annual "Putting Things Right" Report will be brought forward to this Committee in June 2020	Assistant Director of Quality & Safety	30 July 2020 PTR Annual Report included on the agenda. 16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3-4, 2020/21 (priority 3).	

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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	16 April 2020 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. 03 December 2019 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. 10 October 2019 There is an ongoing	

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				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.	

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AGENDA ITEM: 3.1

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	DATE OF MEETING: 30 July 2020
Subject:	**COVID-19: COMMISSIONING ASSURANCE**
Approved and Presented by:	Director of Nursing and Medical Director
Prepared by:	Assistant Director Commissioning Development
Other Committees and meetings considered at:	DGH and Specialised Services Workstream April/May/June weekly meetings reporting to PTHB Gold Command on an exception basis. Presentations to the Delivery and Performance Executive Group on the 15th July and to the Quality Governance Group on the 23rd July.

PURPOSE:

The purpose of this paper is to:

- explain that it has not been possible to apply the PTHB Commissioning Assurance Framework during the COVID 19 pandemic, but that the monitoring of domains is continuing where possible;
- highlight key risks in relation to Shrewsbury and Telford Hospitals NHS Trust.

RECOMMENDATION(S):

It is recommended that the Experience, Quality and Safety Committee DISCUSS this report.

Approval/Ratification/Decision	Discussion	Information
	✓	

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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:

An unprecedented scale of change has 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 have not been in place and 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 paper provides a high-level overview of the major changes needed and the process for service restoration and recovery. Whilst it has not been possible to operate the Commissioning Assurance Framework (CAF) during this period, monitoring of some domains is continuing where possible.

Shrewsbury and Telford NHS Trust (SaTH) is 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 has been a further warning of conditions being imposed on the trust, with the publication of the CQC report expected in August.

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DETAILED BACKGROUND AND ASSESSMENT:

The fast-moving changes within the NHS during the COVID Pandemic have been in response to government statements, letters and frameworks.

On the 13th March 2020 the Minister for Health and Social Care in Wales issued a statement moving the preparations of the NHS from the "contain" phase to the "delay" phase of COVID-19 through a framework of actions including:

1. Suspend non-urgent outpatient appointments and ensure urgent appoints are prioritised
2. Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery)
3. Prioritise use of Non-Emergency Patient Transport Service to focus on hospital discharge and ambulance emergency response
4. Expedite discharge of vulnerable patients from acute and community hospitals
5. Relax targets and monitoring arrangements across the health and care system
6. Minimise regulation requirements for health and care settings
7. Fast track placements to care homes by suspending the current protocol which give the right to a choice of home
8. Permission to cancel internal and professional events, including study leave, to free up staff for preparations.
9. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners.
10. Suspend NHS emergency service and health volunteer support to mass gatherings and events

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. The NHS was just emerging from a winter involving flooding and was facing extremely difficult circumstances.

With no DGH or specialised services within Powys, the health board was having to work with a range of other health boards and NHS Trusts across England and Wales to ensure that the needs of its population were included alongside the resident populations for those areas.

In parallel, the Government in England asked the NHS to free-up the maximum possible inpatient and critical care capacity and to prepare for, and respond to, the anticipated large numbers of COVID-19 patients – including removing routine burdens and moving to block contracts to cover finance.

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In England providers moved into regional strategic system command structures so that decisions were being made on a system wide basis as opposed to by individual providers. This meant the role of some providers changed to alleviate pressure elsewhere in the system. For example, Robert Jones Agnes Hunt NHS Trust (RJAH) took on more trauma and orthopaedic work from Shrewsbury and Telford Hospitals (SaTH) on a temporary basis.

PTHB has participated in the strategic system command arrangements in Shropshire, Telford and Wrekin (covering key providers such as SaTH, RJAH, Midlands Partnership NHS Trust and Shropshire Community NHS Trust) and for Hereford and Worcestershire including Wye Valley NHS Trust.

On the 6th May 2020 Welsh Government issued an Operating Framework for the first quarter of 2020/21 setting out how essential services should be maintained and plans developed to start to scale up "normal business" in an environment that still needs to respond to COVID 19.

PTHB has been assessing the availability of essential services across its key providers and a presentation was given to the recent Performance and Resources Committee.

Health Boards and NHS Trusts have focused on ensuring that emergency, urgent and essential services are in place. Where possible routine services have been maintained via telephone and virtual means – particularly in relation to out-patient services. Quarter 2 Plans in Wales, and the equivalent in England, set out the timing for restoring more routine services.

However, there are complex interdependencies. In neighbouring English regions approval to re-instate services has been part of the system command and regional arrangements. This is because there has to be careful prioritisation due to reduced capacity arising from physical distancing; a changed balance of clinical risk for some patients in terms of routine procedures; the impact of delayed demand; staff absence due to shielding and sickness; the availability of PPE and other supplies; anticipated difficulties in Q3 and Q4 through the combination of winter pressures, flu and the continued presence of COVID; and the need to preserve surge capacity.

It has not been possible to operate the PTHB Commissioning Assurance Framework in the usual way during the pandemic. Whilst it has been suspended, monitoring within domains is continuing where possible – and incremental restoration will take place during Quarter 2. Following a presentation to the Delivery and Performance Executive Group on the 15th July, an Internal Commissioning Assurance Meeting (ICAM) was held on the 22nd July. This attempted to move back to the usual format, although recognising the information flows are still being restored and it is not possible to score some domains for the reasons set out below.

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Access: Most routine activity and performance management arrangements for scheduled and unscheduled care were suspended following the letters from central governments. PTHB is attempting to monitor key issues in relation to essential services such as Cancer breaches. In line with other health boards it has reported to Welsh Government on access to essential services. Whilst usual information flows are being restored initial data (some of which is unvalidated) indicates that the number of patients waiting over 52 weeks is increasing. This will have implications in terms of reviewing any potential harm to patients and will also have knock on effects for 2021/2022.

Finance and Activity: The usual financial arrangements are not in place and block funding arrangements are being used (and may be extended during this year). Thus, it is not possible to monitor financial performance and activity against that forecast for 2020/21 as set out in the IMTP, savings plan and LTAs. (Activity patterns have shifted dramatically from those forecast for 2020/21 with the initial significant reduction in emergency activity, increase in critical care and suspension of non-essential services.)

Quality and Safety (& Patient Experience): Where possible quality and safety measures are continuing to be monitored. However, this is not straight forward as, for example, concerns related to the suspension of routine services are linked to a Government direction.

Governance and Strategic Change: A "District General Hospital Log" is being kept to try and record the multiple and complex pathway changes which are taking place during this period.

Maternity Thematic View: This is continuing (but it has not been possible to take forward the planned work with CTMUHB and ABUHB in Quarter 1).

Commissioning Quality Performance and Review Meetings (CQPRMs): did not take place during Quarter 1. The main English providers for PTHB are working within the regional system command arrangements described above. In line with government instructions the NHS is working within block finance arrangements. Some staff who would usually attend such meetings for providers were redeployed. Telephone conferences have taken place where possible with providers. During Q2 PTHB is seeking to hold meetings with providers covering the CAF domains.

CEO level meetings: CEO level meetings, also involving key executives, have taken place with providers which were escalated prior to COVID (SaTH and WVT). There remain significant concerns in relation to SaTH as set out below.

For the reasons above the Corporate Risk score for commissioned services has been increased to 20.

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SATH

PTHB is a highly rural area with no District General Hospital within its boundary, which spans about 100 miles from South to North. Wales does not have a "purchaser/provider" split but through long established arrangements PTHB's population accesses DGH services in surrounding regions in England and Wales, involving 15 other health boards and NHS Trusts. (PTHB is not the main commissioner of any of these organisations.)

SaTH is the main provider of District General Hospital (DGH) care for North Powys residents. The Executive Committee and relevant Board Committees have been receiving up-dates through the CAF Escalation Report since SaTH was placed in special measures.

The CQC's original Inspection Report was published on the 29th November 2018 and is available on the CQC website. The emergency department, critical care and maternity services were of particular concern. The trust had to take action to make all improvements necessary to give patients the standard of safe care they should be able to expect. The CQC told SaTH 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.

Whilst the CQC had imposed conditions on the Trust's regulated activity, at that time the CQC found staff to be caring and dedicated and that there were areas of outstanding practice.

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Further CQC inspections took place in April 2019 of the Emergency Departments at the Royal Shrewsbury Hospital and the Princess Royal Hospital. The findings, published on the 2nd August 2019, are available on the CQC website. The detail of the conditions imposed were reported to the Performance and Resources Committee on the 6th August 2019. The purpose of the conditions was to ensure that: all children who present to the emergency department are assessed within 15 minutes of arrival; there is effective monitoring of the patient's pathway through the department from arrival; and that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional. Strengthened processes were put in place and a retrospective clinical audit carried out.

In November 2019 the terms of reference of the Ockenden review of investigations in the maternal and perinatal deaths were extended, which had been originally commissioned by NHS England and Improvement (NHSEI) at the request of the Secretary of State in England.

The SaTH CEO received a further letter from the CQC due to the level of concern during its inspection in November, 2019. This was followed by a series of system wide Risk Summits led by NHSE/I, including the CQC, from December 2019, to consider further actions which could be taken focusing on the Emergency Department and consistent application of the Mental Health Act and Mental Capacity Act.

On the 6th December, 2019, the CQC published a quality report following an unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital on the 16th April, 2019. The full report is on the CQC website.

CQC reports were published on the 8th April 2020 based on the inspection in November 2019 and visits in February 2020. The inspection reports are available on the CQC website and have been provided to the EQS Committee. Overall the rating is as follows:

Overall trust quality rating	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Inadequate
Are services well-led?	Inadequate

In terms of the CQC published quality reports of the unannounced Emergency Departments in February 2020 the findings were:

- PRH: Safe - Inadequate; Caring - Requires improvement; Responsive- Inadequate; Well-led- Inadequate.

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- RSH: Safe – Inadequate; Caring – Inadequate; Responsive – Inadequate; Well-led – Inadequate.

The deterioration in the score for "caring" is of particular concern.

Further unannounced inspections took place on the 9th and 10th June 2020, resulting in a further warning of enforcement action and the CQC's report is expected to be published in August. In addition a review by NHS Improvement's Investigation team of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists (RCOG) on maternity services at SaTH has been published.
https://www.sath.nhs.uk/wp-content/uploads/2020/07/SaTH-RCOG-report-FINAL.pdf

PTHB is receiving copies of the weekly reports from SaTH to regulators. It is participating in meetings involving the main commissioners of SaTH (the Clinical Commissioning Groups in Shropshire, Telford and Wrekin) and regulators. (PTHB patients are less than 10% of the SaTH activity.)

The Assistant Director for Quality and Safety has been attending joint assurance meetings. During COVID the representation at the Safety Oversight and Assurance Group was restricted, but PTHB sought reinstatement which has been secured.

Up until the onset of the COVID period there had been monthly Commissioning Quality Review Performance Meetings led by PTHB. Whilst telephone conferences took place during the first COVID peak, from Quarter 2 virtual meetings following the CAF agenda are being restored.

There have been further changes to the senior executive and professional leadership structure of the trust, following a new Chief Executive who started in February 2020. A number of key Board posts are interim at present. Whilst the format had to change due to COVID-19 PTHB led CEO level calls, involving key Executives, have taken place on the 10th June 2020 and 22nd July 2020.

PTHB is liaising with key stakeholders about SaTH, so that it can advise the Board about next steps.

Conclusion

It has not been possible to continue to apply the PTHB CAF during the COVID pandemic but the monitoring of key domains is continuing where possible.

The CQC has issued a further warning of conditions being imposed on the trust, arising from concerns during an unannounced inspection in June 2020 and the report is expected to be published in August 2020.

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The corporate risk score for commissioned services has been increased to 20. The Quarter 2 Plan includes restoring key commissioning assurance processes where possible.

NEXT STEPS:

In line with the Quarter 2 Plan commissioning assurance processes will be restored where possible.

PTHB is liaising with key stakeholders in relation to SaTH, so that it can advise the Board about next steps.

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Agenda item: 3.2

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	Date of Meeting: 30 July 2020
Subject:	**Concerns and Serious Incidents Report**
Approved and Presented by:	Alison Davies – Executive Director of Nursing & Midwifery
Prepared by:	Rebecca Membury – Senior Manager, Putting Things Right Wendy Morgan, Assistant Director Quality & Safety
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 performance in concerns and update on the reporting and investigation of serious incidents, current assurance position, summarising lessons learnt and good practice.		
RECOMMENDATION(S):		
The Experience, Quality and Safety Committee are asked to DISCUSS this report and NOTE the actions underway to address areas of non-compliance and where further improvement is needed.		
Approval/Ratification/Decision	**Discussion**	**Information**
X	✓	X

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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 & 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.

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1. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

1.1 Patient experience:

During 2019-2020 a total of 514 compliments reported for 2019-2020. A combination of cards, letters and demonstrations of appreciation, such as chocolates and biscuits, were received, expressing their sincere thanks and appreciation for their kindness, compassionate care and support provided.

Table 1: number of complaints by month received

Number of Compliments by Month Received

Compliments (No.)

100
80
60
40
20
0

51 41 37 38 40 33 39 54 94 33 30 29

2019-04 2019-05 2019-06 2019-07 2019-08 2019-09 2019-10 2019-11 2019-12 2020-01 2020-02 2020-03

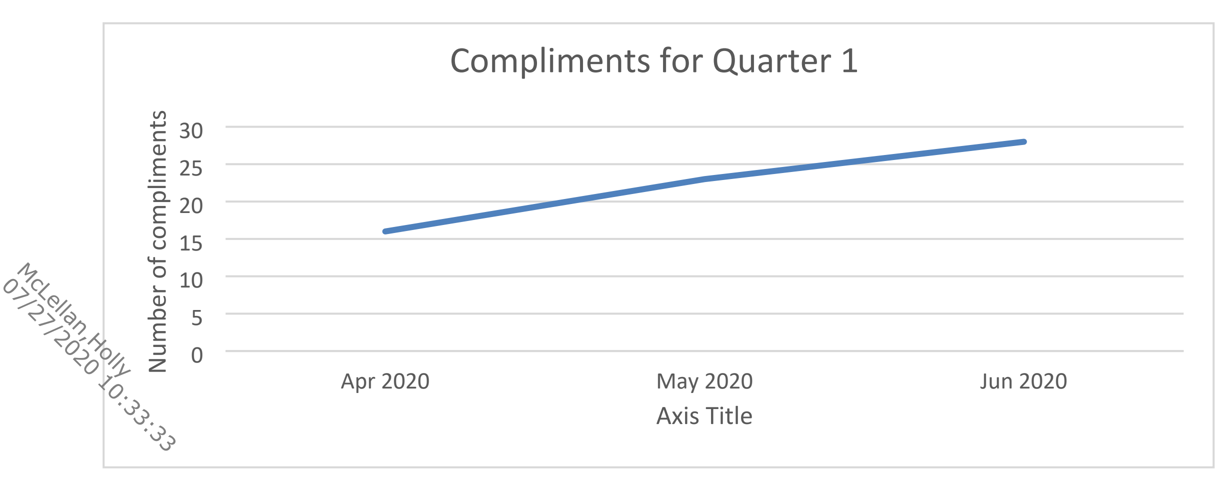
Month

IFOR in Powys

Source: Datix (PALS)

During Quarter 1 of 2020/21 the health board received a total of 67 compliments for our staff across the health board, thanking staff for all their hard work and for the care and treatment that has been provided to the patients. During further analysis of the data it is noted that audiology departments have received the most compliments during the last quarter.

Table 2: compliments for quarter 1



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Graph 1: compliments received quarter 1 by speciality

Compliments received during Quarter 1 by specialty

Specialty	Apr	May	Jun

1.2 Complaints

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, have to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. Informal concerns are usually acknowledged at the time of taking the call or at the point of contact with the staff member. The last quarter a 100% target was achieved in managing and acknowledging the informal 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, as opposed to the previous 5 days.

During 2019/2020 the health board received 57 informal concerns which is a significant decrease on the previous year of 127 informal concerns, the decrease is attributed to this change in process. Which is a decrease of 69% overall. During Quarter 1 of 2020/21 the health board has seen a further decrease in informal concerns, which is also reflective of the trend in the formal concerns being received by the health board. This decrease can be in part attributed to the change in management of the informal concerns, but also reflective of a trend in receipt of complaints overall during the Covid-19 pandemic.

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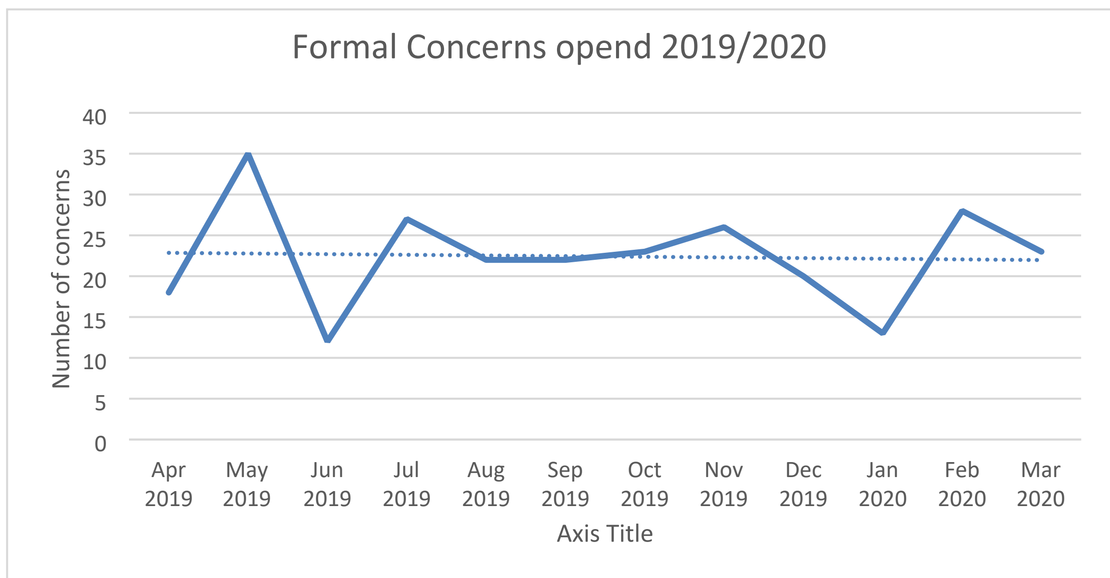
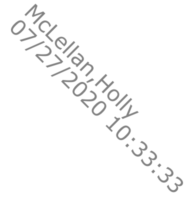
During 2019/2020 the health board received 267 formal concerns and 53 informal concerns, from review this was an increase on the previous year. The increase is attributed to the change in how informal concerns were managed. The graph below shows the numbers of concerns opened by month, it will be noted that there is an increase in concerns during May 2019 which from analysis relates to the concerns raised regarding the closure of the Robert Jones Agnes Hunt Orthopaedic Hospital Pain Management Services. A steady number of concerns continues until November 2019 where a decrease is seen during December and January 2020, the decrease in concerns during this time could be contributed to the Christmas period.

The graph below demonstrates by month the number of formal concerns received across the health board.

Graph 2: Formal Concerns opened during 2019/2020



During Quarter 1 of 2020/21 the health board has received a total of 36 formal concerns, this is a decrease on the same period of 2019/2020. The decrease is attributed to the Covid-19 pandemic and the temporary closure of a number of our services. From review of the data, the main concerns being raised relate to access to services and appointments.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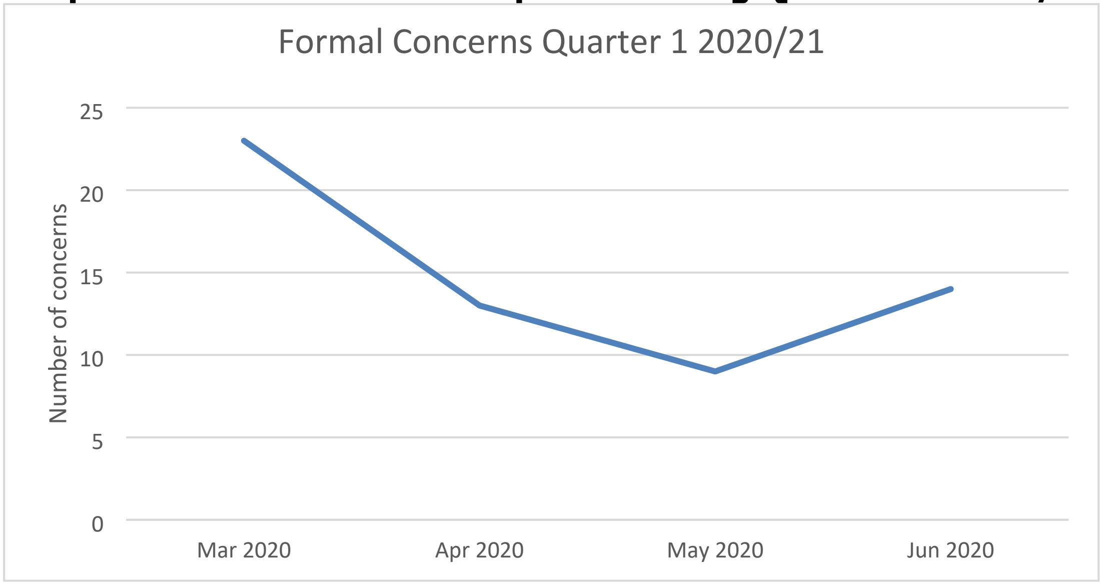
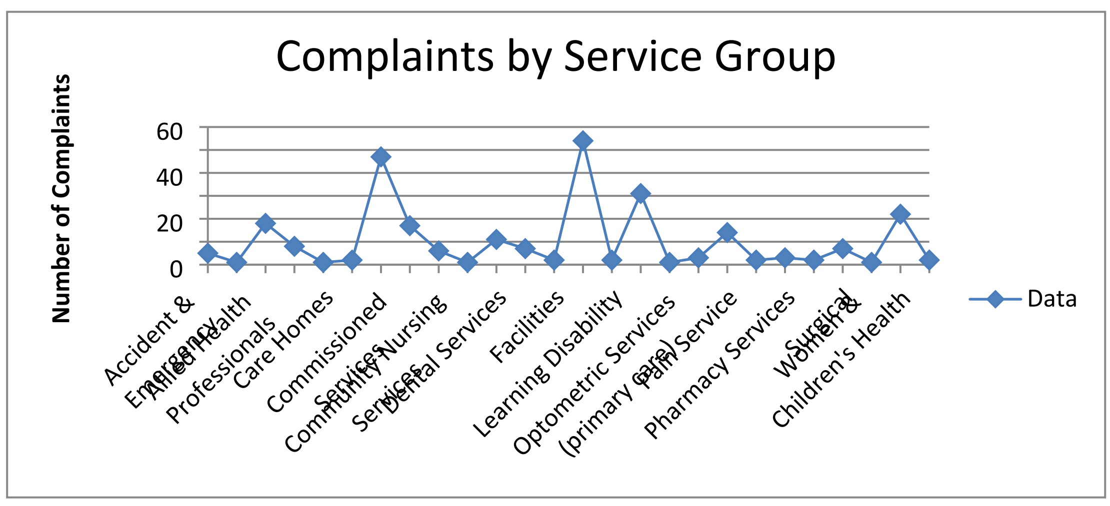
Graph 3: Formal Concerns opened during Quarter 1 2020/21



Following review of the concerns received it can be seen that primary services including General Practitioners have the highest number of formal concerns, the concerns relate to access to appointments. It will also be noted from the data in the graph below that our Commissioned Services have the second highest formal concerns, more detail in relation to these concerns is detailed later within this report. The report highlights that the Mental Health and Learning Disabilities Service Group have a high number of formal concerns. Following analysis of these concerns they relate to access to appointments and ongoing care and treatment.

Graph 4: Formal Complaints by Service Group



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During 2019/2020 the health board have achieved 47% of closing concerns within the 30 working days against the Welsh Government target of 75%. During the last two quarters of 2019/2020 the concerns team have been undertaking focussed work to secure improvements and achieve this target.

During Quarter 1 only 44% target has been achieved the focussed work will continue to achieve the 75% target, the low percentage compliance can be in part attributed to the Covid-19 pandemic where the response to the concerns were unable to be progressed in a timely manner.

Graph 5: response within 30 working days for Quarter 1

Response within 30 day target

8
6
4
2
0
apr-20
mai-20
jun-20
up to 30 days
30 days 6 months

The focused work continues to highlight to the team the importance of accurate assessment of concerns on receipt to ensure they are managed accordingly. Continued focused action remains in place to ensure effective management of concerns and this includes:

- Weekly meetings to discuss current cases and timescales;
- Proactive action to ensure responses are drafted timely to meet response timeframes;
- Escalation of concerns where timely responses not available;
- Timely closing of concerns on the database to reflect true closure timeframes;
- A concerns response tracker has been developed to proactively ensure timeliness of responses;
- Weekly trackers being sent to the Directorates; and,
- Allocation of cases between the team so there is ownership of the concern.

In addition, the concerns team have undertaken process mapping to see how processes can be streamlined to allow the team to become more efficient in their working. As part of this work the Director of Nursing & Midwifery has arranged a meeting with service area managers to map out the process external to the concerns team to have the wider picture to enable the whole process of responding to concerns to be reviewed and become more streamlined, the aim for responses to be processed in a timely manner.

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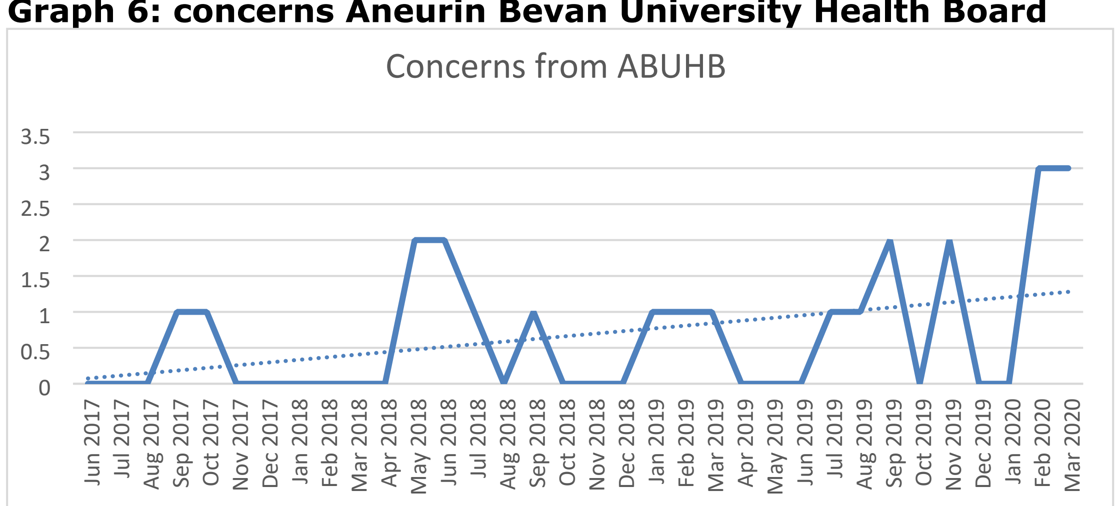
Concerns raised about Commissioned Services

Review of the concerns raised via Powys Teaching Health Board for our commissioned services over a 3-year period between 01 April 2017 to 31 March 2020, has been completed. This was aimed at understanding the issues being raised by Powys residents in respect of the of services the health board commissions from other Health Boards and NHS Trusts. The data below represents a small number of concerns and it is clear further work is required to understand the true figures. This data has to be considered in context and to note it represents information we have gathered through a variety of routes, namely:

- concerns patients have raised with Powys Teaching Health Board about services delivered through providers;
- concerns raised by patients or with the support of the Community Health Council directly with the commissioned service and a copy of the concerns letter has been provided to Powys Teaching Health Board for information;
- notification of a concern through other routes, for example, notification by the provider themselves or through other intelligence gathered such as provider meetings.

From reviewing the data, the key issues that arise across the commissioned services relate to appointments and waiting times.

Graph 6: concerns Aneurin Bevan University Health Board



From reviewing the concerns raised in respect of Aneurin Bevan University Health Board (ABUHB), the trendline shows an increase of concerns but this could be due to better recording of the concerns being received and patients raising the concern via our health board rather than ABUHB.

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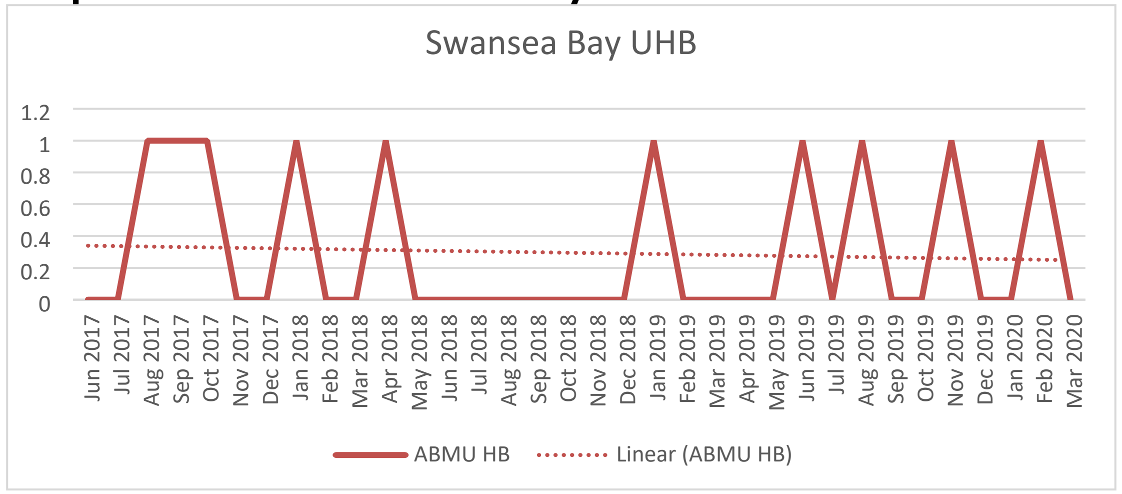
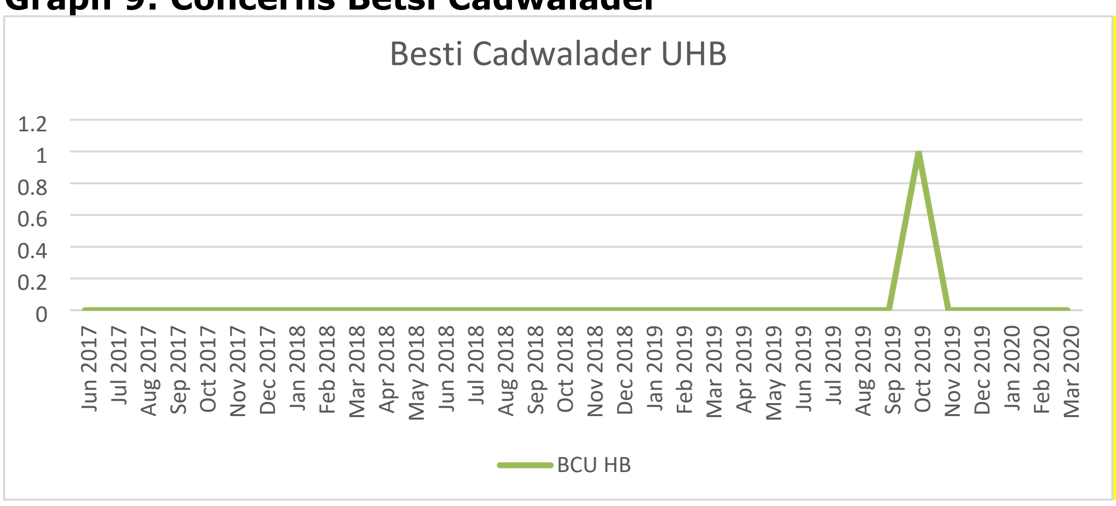
Graph 7: Concerns Swansea Bay UHB



The data from Swansea Bay University Health Board indicates there are peaks around certain times of the year. The analysis shows whilst there are clear peaks in the data these equate to less than five concerns being raised and between May 2018 to December 2018 there were no concerns raised by our patients.

The following provider data clearly shows the small numbers of concerns that we are aware of and it is evident further work is required to glean whether this is a true picture or simply that as a health board, we are not being notified of the concerns raised by Powys residents to our service providers.

Graph 9: Concerns Betsi Cadwalader



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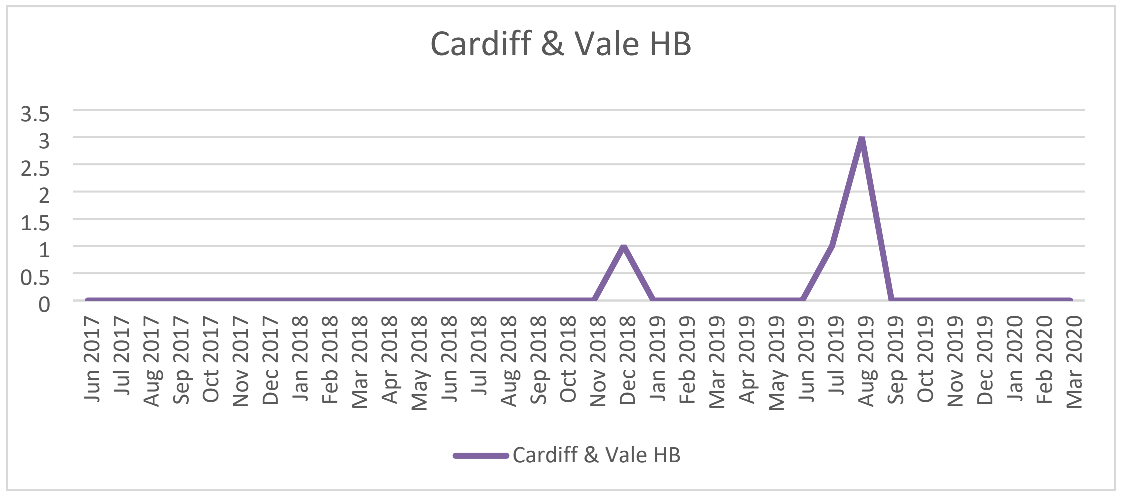
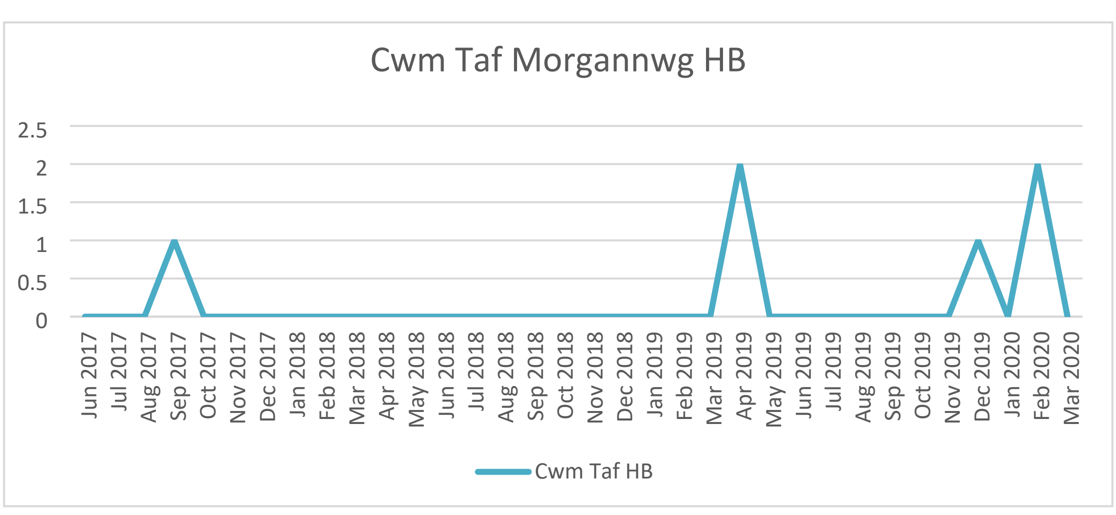
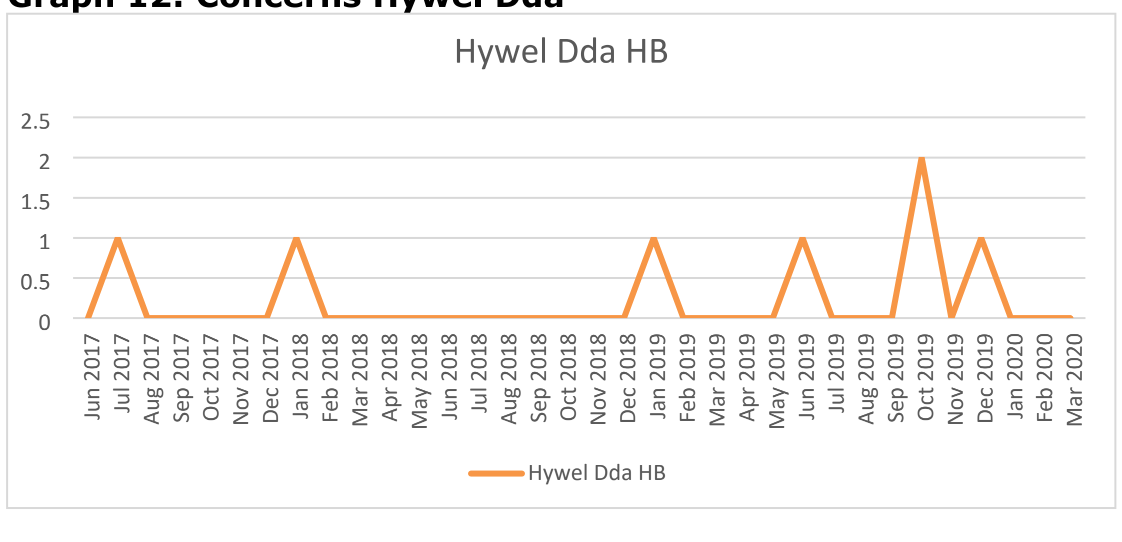
Graph 10: Concerns Cardiff & Vale UHB



Graph 11: Concerns Cwm Taf Morgannwg



Graph 12: Concerns Hywel Dda



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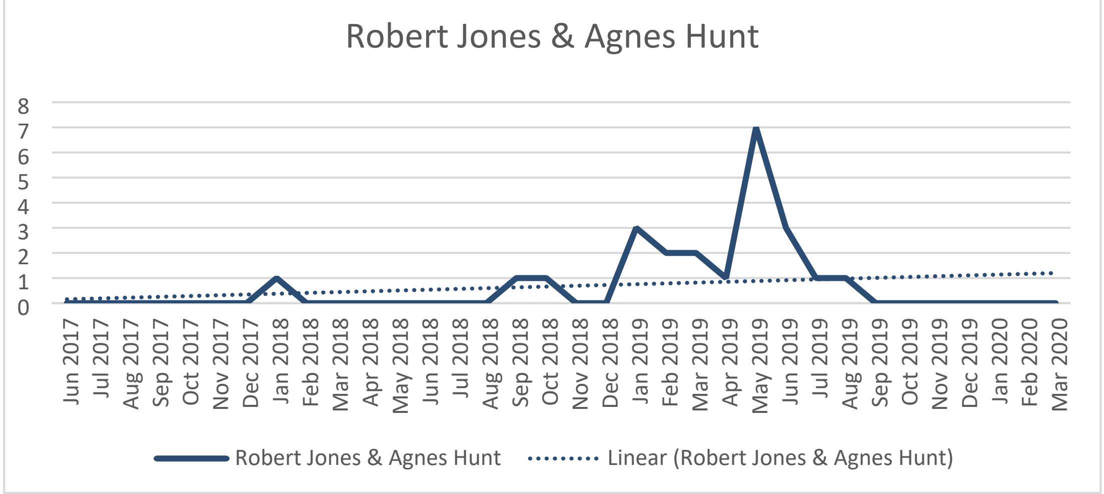
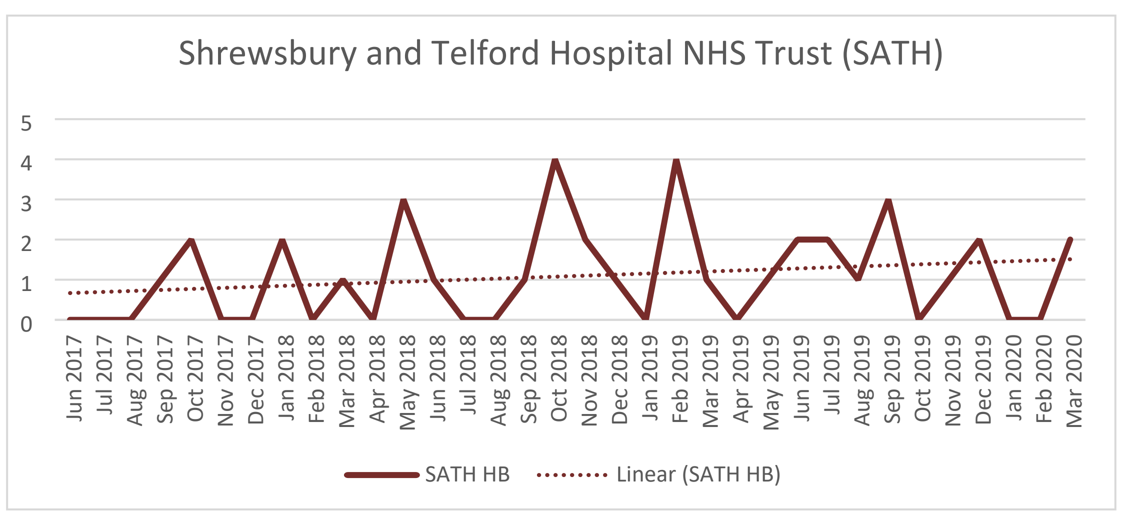
Graph 13: Concerns Robert Jones & Agnes Hunt



Following analysis of the data relating to Robert Jones Agnes Hunt, the increase in concerns in May 2019 reflected the concerns raised around the closure of the Pain Management Clinic. The health board saw an increase of concerns raised by patients who did not know the arrangements in place following this closure and patients and their local Ministers of Parliament, Assembly Members and local Councillors raised concerns with the health board around this matter.

Graph 14: Concerns Shrewsbury & Telford NHS Trust



The above graph showing numbers of concerns for Shrewsbury and Telford NHS Trust shows an increase in numbers notified between September and February 2018-2019, following review of these, there was no themes or trend identified from the review, as noted about these could be as a result of greater awareness and need for notification of concerns to Powys Teaching Health Board.

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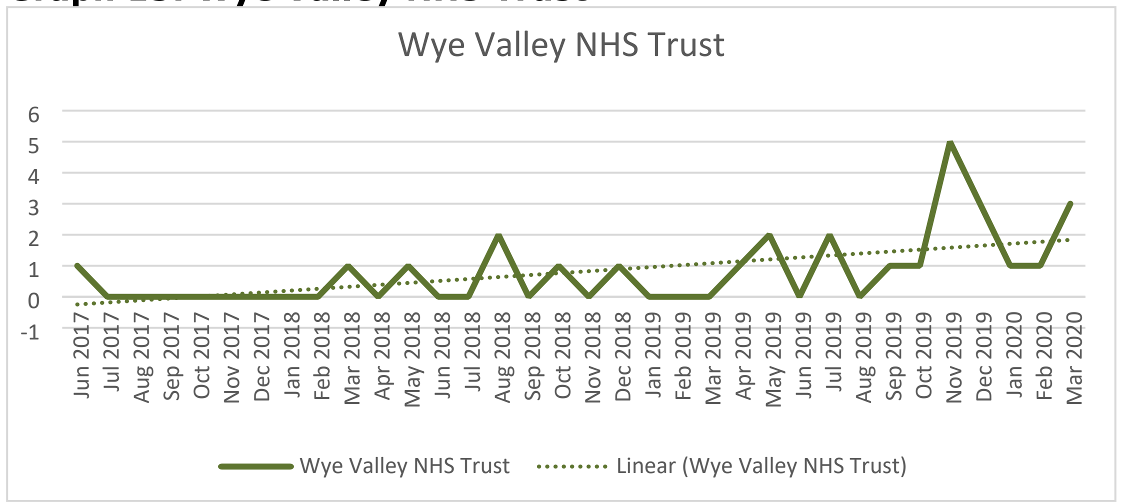
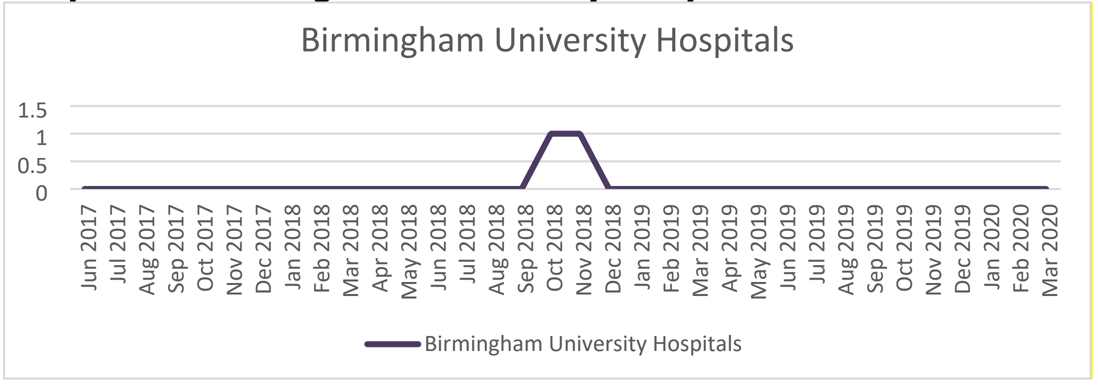
Graph 15: Wye Valley NHS Trust



The trend line in the above data for Wye Valley NHS Trust indicates an increase of the concerns being raised by patients, particularly around November 2019. From review of the data there is no trend identified.

Graph 16: Birmingham University Hospitals



In addition to the above data the health board currently have 10 open concerns that relate to the commissioned services, with no themes and trends identified. The concerns team will be reviewing on a quarterly basis the concerns raised in respect of commissioned services to identify any themes and trends. The outcome of this work will be fed into commissioning assurance meetings and identified lessons and improvements shared for wider learning.

Learning from Concerns and Patient Experience

There is a key focus from Welsh Government and the Welsh Risk Pool to promote the importance of learning from the concerns that are received within the individual health boards. 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.

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From the Learning Reports being presented at the Patient Experience Steering Group, the Directorates have been reminded of the importance of the evidence of the shared learning and to provide minutes of meetings and memorandums, for example to show that discussions have taken place with staff in relation to any learning identified and improvements made.

Directorates are also reminded that as part of sharing learning and evidencing the impact of any learning, there is a need to share any changes in processes and protocols as a result of concerns being raised by patients.

The review of lessons learnt from concerns for 2019/2020 and for Quarter 1 2020/21 the following key themes remain:

- Clear communication with patients
- Clear care plans in place for care for the patients and their families to understand the care that is needed for the patient
- Reminding staff of the importance of accurate record keeping
- Ensure appropriate discharge information is given
- To ensure all procedures are explained to patients before they undergo treatment
- Ensure patients are kept informed of changes in services

The above key themes have been recognised within the health board over a period of time. From reviewing the cases, it is clear the health board need to undertake further work around this to support staff and to ensure consistent and clear patient focused communication is provided to staff and that there clear learning being taken from the concerns that are being raised.

The Mental Health Directorate are by way of learning looking at providing staff with training to remind them of the importance of maintaining accurate and contemporaneous notes and ensuring all standard documentation is completed to the expected standard of the health board policy and in line with the Nursing and Midwifery Council and General Medical Council's rules.

In making the above improvements and taking forward the learning from patient concerns it is envisaged that this will improve the overall patient experience.

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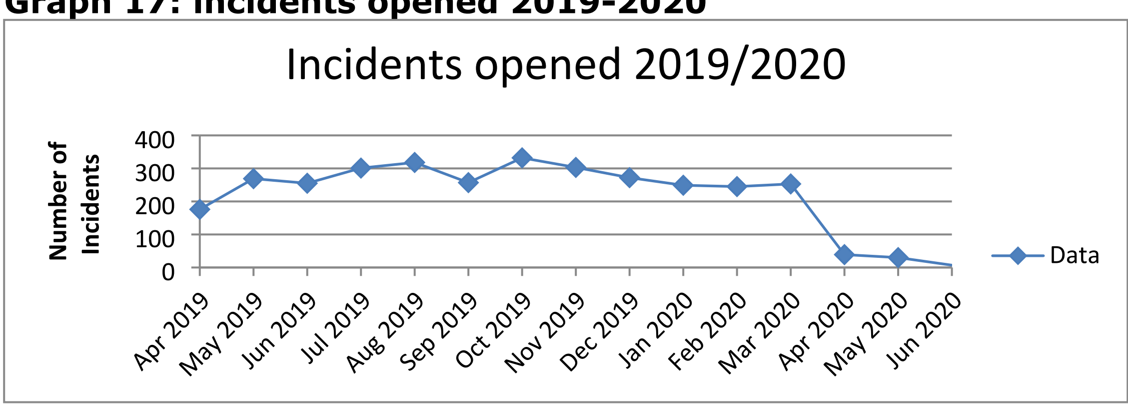
1.3 Incident reporting

The health board promotes incident reporting in support of enabling a robust safety culture, and uses the Datix system to do so. Whilst the current system supports reporting and some data analysis, the new Once for Wales Content Management System, now anticipated for introduction in April 2021, will greatly improve the data quality, integrity and accuracy available from the system, which will result in a higher degree of confidence in the data available as well as the level of assurance that can be taken rom it. To inform future reports, the Performance Team will further support the provision of robust datasets, ensuring standardised search terms and application of national data standards.

Introduction of the system will be complimented by the work being undertaken to implement the clinical quality framework and the focus of the Workforce and Organisational Development Team.

During 2019/2020, 3436 incidents were reported across the health board.

Graph 17: incidents opened 2019-2020



Data source: datix system accessed July 2020

During Quarter 1 there has been 758 incidents reported, which is less than our normal reporting levels, a decline noted in April 2020, which is considered attributable to the Covid-19 pandemic as the health board had less patients in the community hospitals and the temporary suspension of all non-urgent treatments.

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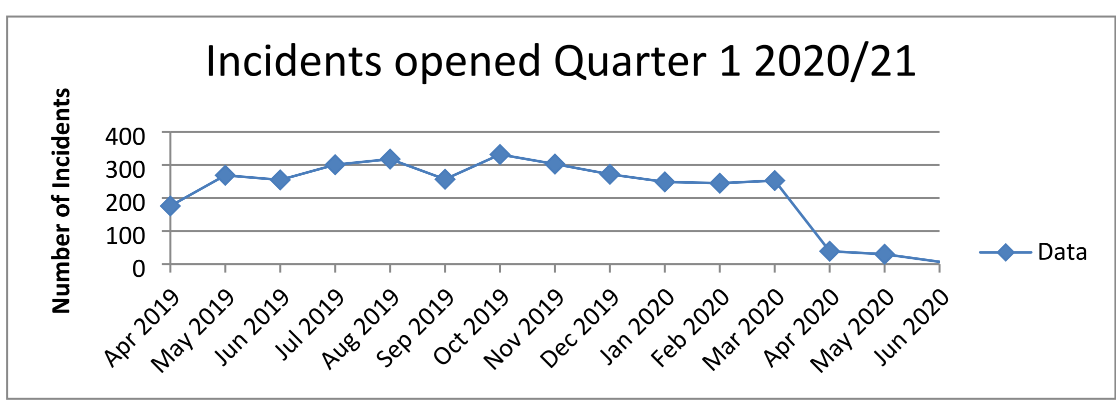
Graph 18: incidents opened during quarter 1 2020-2021

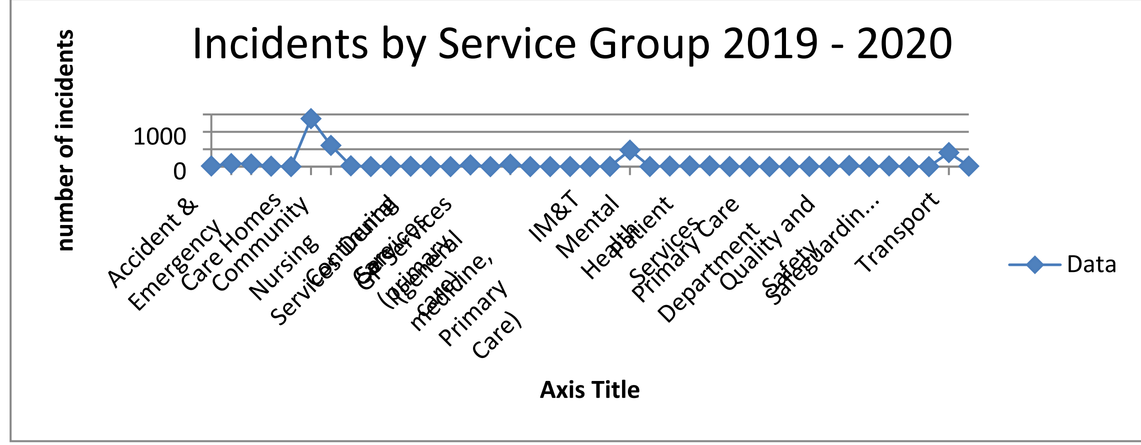


Data source: datix system accessed July 2020

1.3.1 Reporting by Service Group

Incident reporting is actively encouraged within the health board, to maximise safety and learning. During 2019/2020, community hospitals reported 1379 incidents. The timeliness, robustness and overall management of incidents, including the identification and application of learning, are key areas of focus.

Graph 19: incidents by service group 2019- 2020



Data source: datix system accessed July 2020

2.4 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 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. 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.

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Table 3: Serious incidents opened by Quarter for 2019/2020

Period 2019/2020	Number rereported
Quarter 1	13
Quarter 2	8
Quarter 3	14
Quarter 4	19

There was a slight increase in numbers during January and February 2020 which decrease during March and April, this decrease is likely to be related to the decrease in numbers of patients on the wards during the Covid-19 pandemic. Whilst it is useful to consider numbers of serious incidents reported, other important factors include significant variation, (increase or decrease), trends, themes and application of learning.

It should be noted that Welsh Government changed the serious incident reporting criteria form the end of March 2020 to assist in easing the pressure on NHS organisations during the Covid-19 pandemic. Only the following SI's were to be reported to Welsh Government from 18 March 2020:

- All never events
- Patient Suicides
- Maternal deaths
- Never events
- Neonatal deaths
- Homicides
- Unexpected deaths
- Human Tissue Authority incidents
- Incidents of high impact and likely to happen again

In light of best practice, the opportunity to maintain the principle of serious incident reporting, reporting has been maintained of all serious incidents. During Quarter 1 2020/21 the health board have reported 19 serious incidents to Welsh Government, with 9 being reported during June 2020, this shows a 66% increase on the same time last year. To note the percentages, need to be interpreted with caution as this can represent just a small increase in actual numbers. This increase reflects our position to continue reporting all serious incidents across the health board and will also represent increased activity as essential services start to resume and more patients are treated. No trends or themes identified.

Table 4: Serious incidents opened by Quarter for 2019/2020

Month	Number reported
April 2020	Less than 5
May 2020	6
June 2020	9

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During 2019-2020 the health boards community hospitals and mental health services reported the most serious incidents with a total of 35 Serious Incidents being reported between these two service groups.

Graph 20: serious incidents by service group 2019- 2020

2.4.1 Themes and trends

Following review of the of the data there has been an increase in reporting regarding young people requiring Child and Adolescent Mental Health (CAMHS) services being admitted in to adult wards. Work is being progressed to establish a local solution whilst the all Wales position is consolidated.

3. No Surprises

Welsh Government are notified of potentially sensitive issues via a process known as 'no surprises'. No surprise notifications can be review by Welsh Government and a decision made to manage using a serious incident focus. Between 01 April 2019 and 31 March 2020, 17 no surprises were reported, with no themes or trends identified. During quarter 1 for 2020/21 the health board reported less than 5 'no surprises' to Welsh Government; with no themes or trends noted.

4. Inquests

During 2019/2020 there have been 21 HM Coroner enquiries, the majority of which related to patients who may have accessed mental health services. During this time there have been no Regulation 28 Reports issued to the health board in respect of any of the enquiries made.

HM Coroner issued a south Wales wide Regulation 28 Report seeking clarity and confirmation related to how health boards managed the transfer of patients, seeking an agreement between the health boards. Powys teaching health board contributes to the work led by Cardiff and Vale University Health Board in relation to this matter. During quarter 1 of 2020/21 there have been less than 5 HM Coroner Enquiries opened.

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To note, due to the Covid-19 pandemic, HM Coroner stopped all Inquests from the 24 March 2020 and a review is due to take place in July about recommencing inquests, following guidance indicating that all HM Coroner Courts should hold inquests remotely to avoid further delays. Dates for inquests are now being listed but there are likely to be significant backlog which will exceed the 6 months' timescale detailed in the Coroners Rules 2009.

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 reviews the case and determines whether they wish to pursue a full investigation or not, 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

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, complaints handling and 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 within a reasonable time, concluding maladministration. The PSOW indicated that 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.

During Quarter 1 for 2020/21, the health board received enquiries from the PSOW which relate to the retrospective Continuing Health Care funding for patients.

Claims:
Powys Teaching Health Board has a small claims portfolio; there are currently 14 claims being considered, including clinical negligence and personal injury claims. During 2019-2020 the health board were managing 11 clinical negligence claims with 8 clinical negligence claims. From review of the claims for the health board there have been no identified themes and trends.

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

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The health board currently have two open patient safety solutions, one relating to 'nasogastric tube misplacement: continuing risk of death and severe harm', this is in the process of declaring compliance, the policy now in place and staff training completed. The outstanding patient safety notice relates to 'supporting the introduction of the National Safety Standards for Invasive Procedures', of which considerable work has been completed and progress towards reporting compliance is now being accelerated.

2. KEY RISKS/MATTERS FOR ESCALATION TO BOARD

No additional matters of note.

3. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report concentrates on quality of care, patient safety, and patient experience.
Related Health and Care standard(s)	Safe Care
	The work reported relates specifically to Standard 3.1 Safe and Clinically Effective Care, and Standard 6.3 Listening & Learning from Feedback.
Equality impact assessment completed	No (Include further detail below)
	Concerns are managed within the framework of Putting Things Right, ensuring that all issues are dealt with equitably. There are no specific implications relating to equity and diversity within this report
Legal implications / impact	Yes (Include further detail below)
	Concerns are managed in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2013
Resource (Capital/Revenue £/Workforce) implications /	Yes (Include further detail below)

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Impact	Resource implications relate to staff training in concerns management, claims and redress payments. Also, staff resource to enable timely investigation
Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

4. RECOMMENDATION

The Experience, Quality & Safety Committee is requested to: **DISCUSS and REVIEW** this report.

Agenda item: 3.3

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 30 JULY 2020**
Subject :	**Personal Protective Equipment (PPE) use for cardiopulmonary resuscitation (CPR) and nasogastric (NG) intubation procedures in patients during the covid-19 pandemic**
Approved and Presented by:	Wyn Parry Medical Director
Prepared by:	Wyn Parry Medical Director
Other Committees and meetings considered at:	Gold Group Quality Governance Group

PURPOSE:

The purpose of this paper is to review 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.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to endorse the proposal:

- that full PPE is used for all elements of CPR procedures
- that full PPE is used for all NG tube insertions

on PTHB patients in all clinical settings where these interventions are indicated and during the Covid-19 pandemic.

Approval/Ratification/Decision	Discussion	Information
✓	✓	✗

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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:

Conflicting guidance exists 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) is at variance with that from a wide variety of specialist, advisory, educational, standard setting and professional groups. PHE's guidance is that full PPE is not required in either intervention, other bodies' advice is that it is.

There is little published evidence on which to base a clear conclusion either way so the issue involves taking a risk based approach. The theoretical AGP <u>risk</u> is unknown though likely to be small; the potential <u>consequence</u> of a staff member contracting Covid-19 during either intervention is significant however. The latter risk could be mitigated by the use of full PPE during these interventions. Taking this approach, the recommendation is that full PPE is to be used by all PTHB staff carrying out either intervention. This has already been the interim position adopted by the health board following review of the various sources of guidance.

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DETAILED BACKGROUND AND ASSESSMENT:

For both interventions (CPR and NE intubation) the essential issue is whether or not these would be considered as aerosol generating procedures (AGPs) and hence represent a risk to staff when managing Covid-19 (known or suspected) patients, to the extent that full PPE would be required.

CPR

For patients where CPR is an appropriate and agreed intervention insofar as a distinction can be drawn between the elements of CPR, the precise focus around AGPs is on chest compression and/ or defibrillation. Guidance on this has been produced by PHE; the initial view was that chest compression is not an AGP and that PPE was not required. This view was though contrary to guidance from the Resuscitation Council UK (RCUK). The matter was referred to NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group) for review on 14/4/2020. NERVTAG's conclusions were published on 24/4/2020 following which PHE re-stated their view on 3/5/2020 that chest compressions were not an AGP. RCUK have also maintained their view that they are.

The evidence base on which to base any conclusion is small; both NERVTAG and RCUK have reviewed this. The evidence base is summarised within a Health Protection Scotland review in November 2019; there is no more contemporary evidence beyond this publication.

Essentially these separate views (NERVTAG/ RCUK) reflect differing opinions on a very small amount of information assessed theoretically as opposed to viewing the practical need to minimise staff exposure.

Taking a risk based approach to making a recommendation, three sources of information are relevant:

a) published data (Tran paper, 2012) which acknowledged the likelihood that chest compression was an AGP
b) clinical judgement/ opinion
c) best practice

In terms of b) and c) I have been assisted by Cwm Taf University Health Board and have had sight of their QIA in the preparation of this report.

Reviewing a) b) and c) it is clear that the recommendation has to be made that full PPE is used in all CPR interventions in patients during the covid-19 pandemic. This balances minimising the risks of transmission to staff by donning PPE against the risk to the patient of delaying commencing CPR whilst donning. The latter risk is currently unknown and there is no existing evidence indicating that this 'lost' time (circa 3 mins) adversely affects the outcome of CPR. Cwm Taf University Health Board will be analysing Datix data to evaluate this in their CPR events.

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NE intubation
Similarly, PHE's guidance is that NE intubation (for practical purposes and in PTHB's context this would be nasogastric intubation) is not an AGP. Again this view is contrary to many other sets of guidance, most recently that of BAPEN (British Association for Parenteral and Enteral Nutrition), NNNG (National Nutritional Nurse Group), BDA (British Dietetic Association), the Intercollegiate College of Surgeons General Surgery guidance and the RCN (Royal College of Nursing).

The issue with NE intubation is whether or not the intervention is acknowledged as inducing a cough or not. PHE acknowledge that a cough is an AGP though not of necessity that enteral intubation causes cough.

Again, looking at data, clinical judgement and opinion and best practice it is without doubt the case that enteral intubation is invariably associated with coughing.

Reviewing this information it is clear that the recommendation has to be made that full PPE is used in all enteral intubation procedures in patients during the current Covid 19 pandemic. The reasoning is precisely as for CPR as above.

NEXT STEPS:

Experience, Quality and Safety Committee is asked to support these recommendations. Following this, appropriate communication may be issued to colleagues that the extant interim guidance is the health board's definitive position.

Agenda item: 3.4

Experience, Quality & Safety Committee	Date of Meeting: 30 July 2020
Subject:	**Health and Safety Update**
Approved and Presented by:	Julie Rowles, Director of Workforce, OD and Support Services
Prepared by:	Sarah Powell, Assistant Director of OD
Other Committees and meetings considered at:	Quality Governance Group- 23rd July 2020

PURPOSE:

The purpose of this paper is to provide 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.

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RECOMMENDATION(S):		
The Experience, Quality & Safety Committee is asked to discuss and note the content of this update report for the work programme period October 2019 to June 2020.		
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:

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.

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DETAILED BACKGROUND AND ASSESSMENT:

The areas for Q1 2020 have not all been fully achieved due to the COVID-19 pandemic, commencing at the end of March where all business as usual activity was ceased. The detailed assessment below provides an explanation of the work to date against the plan and describes the areas that have been suspended due to COVID-19.

1. Review and monitor HSE inspections and Improvement Notices, relating to Legionella

At the end of November 2019 Powys Teaching Health board were served with two Improvement Notices relating to Water Safety:

- That legionella log sheets and log books were to be in place by February 2020
- That site risk assessments and schematic drawings were to be in place for Llandrindod Wells and Bronllys hospital sites by June 2020

The actions relating to the above Improvement Notices were managed through the Estates Department. Health and Safety advice and guidance was provided to the Estates Team as part of the HSE action plan. Progress against the HSE Improvement Notices were monitored through an agreed detailed action plan, overseen by the Executive Committee and reported through to Board.

Both Improvement Notices have been completed within the agreed timeframe and the HSE have written to confirm that they are satisfied with the actions and that no further work is to be undertaken. The HSE recommend that the Health and Safety team undertake an audit later in 2020 to ensure these aspects are fully implemented and embedded in operational working practices.

2. Review of progress against internal Health & Safety inspections undertaken

A number of detailed internal Health & Safety inspections had taken place during 2017/19 - see Appendix 1 for a full list.

During October 2019 detailed inspections were undertaken at Welshpool, Bronllys, Brecon, Llandrindod Wells and Ystradgynlais in preparation for the HSE re-visit. These were followed up by onsite checking visits between 25th – 28th November 2019. The focus of these internal inspections was around the

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compliance and embedding of the HSE recommendations, in relation to risk assessments for Manual Handling, Violence & Aggression and where appropriate ligature risk assessments. These inspections ensured that when the HSE undertook their onsite re-visit we were able to satisfy the Inspector with the Health Board's compliance.

The HSE Inspector confirmed that the Health Board had made significant progress against the agreed action plan and that no further action would be taken.

During the early part of 2019, Unison Health & Safety Trade Union representatives undertook independent inspections at Brecon, Knighton and Ystradgynlais. As part of working in partnership, it was agreed through the Health & Safety Group that further inspections would be undertaken jointly between the Trade Union representatives and the Health & Safety team, as this would reduce the number of reports Service Managers were receiving along with providing a consistent methodology and approach to future visits, inspections and reports. The first of which was undertaken in Llanidloes in the autumn of 2019, followed by Waterloo Road in Llandrindod Wells in early 2020. The findings of the inspections are provided to the appropriate Service Manager, Assistant Director and Executive Director for them to implement any actions required.

A review against progress of inspection recommendations for each site was scheduled to be a rolling programme over 2 years commencing from April 2020. However, due to the COVID-19 pandemic commencing in March the proposed schedule and timeframes have been put on hold.

3. Plan topic specific inspections and audits

This piece of work has been put on hold due to COVID-19.
The Health and Safety team have provided social distancing inspections for Welshpool on 15th May 2020, hospital bed spacing support for Knighton Hospital and a walk about visit at Newtown Hospital in April.

4. Monitor compliance with Health & Safety suite of training

Compliance with Statutory and Mandatory Health & Safety training has on balance remained constant for the period October 2019 to April 2020. The most notable % increase has been in Violence and Aggression training, where in June – September 2019 (before the Violence & Aggression Trainer was in

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post) compliance was at an average of 74%. Manual Handling has also seen a steady increase in compliance.

Training	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Fire Safety	93%	93%	93%	93%	93%	95%	92%
Health & Safety	94%	94%	94%	95%	95%	94%	94%
Violence & Aggression	83%	87%	88%	88%	88%	86%	85%
Infection & Prevention Control	74%	75%	77%	83%	85%	85%	85%
Manual Handling	78%	78%	78%	82%	84%	83%	83%
Resuscitation	71%	72%	76%	71%	74%	74%	73%
Violence Against Women	92%	92%	92%	88%	87%	83%	82%

Work was undertaken by the OD team from November 2019 through to January 2020 with each service area, to re-define the level of Statutory and Mandatory training required for each role, which was then uploaded to ESR and is now used to inform and plan Violence & Aggression and Manual Handling training courses throughout the year.

5. Provide risk assessment guidance and support to Service Managers

As part of the HSE action plan, dedicated risk assessment training relating to ligatures was arranged for Mental Health Services staff.

Dedicated manual handling risk assessment training for Managers in line with the new module G of the All Wales passport, was rolled out in November 2019. Four sessions a month were being held with a view to all managers being trained by June 2020. Sessions scheduled from March 2020 onwards have been suspended due to COVID-19. They are now planned to restart in September 2020, via the virtual classroom approach.

The Violence & Aggression trainer has been supporting and advising service managers within Mental Health Services to undertake Violence & Aggression risk assessments.

A risk assessment tool kit and template is now available on the Health & Safety pages of the intranet.

During Q1 2020 all planned support has been put on hold due to COVID-19, however the Health & Safety team have provided support and guidance

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relating to risk assessments for a range of aspects and services, for example: Dfyi Health GP practice in Machynlleth; Knighton Hospital bed spacing; Midwifery services; Presteigne GP Practice; Estates Department for their HAVS assessments.

6. Undertake a desktop review of polices that should sit under Health & Safety

The desktop review in Q1 had been suspended due to COVID-19.

The following Health & Safety polices were reviewed and approved between November 2019 and March 2020:

- Manual Handling
- Violence and Aggression
- Stress Management and stress tool kit
- Hand Arm Vibration Syndrome (HAVS)

Shared Services follow up Audit of Health and Safety.

During 2018/19 Internal Audit's review of Health and Safety shared services examined the extent to which a sample of key health and safety risks facing Powys Teaching Health Board were being managed, in accordance with key operational policies and procedure. In addition, the audit assessed progress made against the 'Strategic Health and Safety Improvement Action Plan' (formerly named the 'Health and Safety Rapid Improvement Action Plan'). This review was completed in October 2018 and delivered a **Limited Assurance**.

The purpose of the 2020/21 follow up review is to assess whether the Health Board has implemented the recommendations made following our review of Health and Safety in 2018/19.

This follow up review was due to commence in April / May of 2020 but had been postponed due to the COVID-19 pandemic preparations PTHB were faced with. The review has now commenced, with the initial scoping meeting and field work now being undertaken. The findings of the follow up review will be reported to through to the Executive Committee and the Board.

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7. Support the co-ordination of the Stress Steering Group

The Stress management and stress tool kit policy was approved in November 2019 and circulated within the organisation. The 2019/20 Shared Services Internal Audit of stress management reported **Reasonable Assurance**.

The creation of the Stress Steering Group was postponed due to Occupational Health staff being deployed to support COVID-19 testing. This will be scheduled for discussion at the next meeting of the Wellbeing at Work Group.

8. Compile the Annual Health & Safety Report

Due to COVID-19 the Annual Report has not been written or approved.

9. Training delivery/co-ordination Q4

Note: Due to COVOD-19 Training was suspended from Q1 2020. As part of the COVID upskilling and HCSW clinical skills training a stream lined version of people handling had continued to be delivered face to face, between March and June 2020.

Health and Safety now forms part of the Corporate Induction welcome day. A 30 minute session is included in the Induction day covering the following areas; Health & Safety Responsibilities, Violence & Aggression, Manual Handling, Fire Safety, Lone Working, Driving for work, DSE assessments and Datix reporting.

In line with the HSE action plan Manual Handling is now planned and scheduled every month for:

- 1 Day people handling refresher
- Object Handling
- 2 Day People handling
- Manual handling for managers

Violence & Aggression courses are planned and scheduled in the following modules :

- Module A - Induction and Awareness
- Module B - Theory of Personal Safety and De-escalation
- Module C - Breakaway
- Module D - Annual Refresher

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- Module D - Foundation Only

Fire Safety awareness training: In December 2019 the Fire Trainer transferred from Estates Department to Workforce and OD. The Trainer resigned and whilst seeking to recruit a replacement, one of our senior Health & Safety Officers continued to deliver the face to face sessions. This post has since transferred back to Estates Department from June 2020, to become part of the Fire Safety Officer’s role.

IOSH working safely
PTHB has registered with IOSH as a training provider. All 220 Band 7 and below Managers / Supervisors will undertake this certified training as part of the PTHB managers’ development 8-day programme. The first 2 cohorts of the development programme had commenced, but due to COVID-19 have been suspended. These are due to be reconfigured into virtual classroom sessions and the Health & Safety team are awaiting further information from IOSH in relation to delivery recommencing.

Executive / Board training
During December 2019 the HSE Inspector delivered a training / awareness session to the Board. The session covered areas such as corporate responsibilities, risk and assurance plus corporate manslaughter.

10. Process for identifying Corporate Health & Safety Risks

Identifying Corporate Health & Safety risks form part of the Forward Work Programme for quarter 2, 2020. The Health & Safety Group have a standing agenda item which discusses and agrees Corporate Health & Safety Risks, and are escalated through to the Corporate Risk Register.

11. Health and Safety support to the organisation during the Coronavirus

During the COVID-19 pandemic planning and preparation phase, April to June 2020, the Health and Safety team have been extremely busy delivering advice, support and guidance to the organisation in the following areas:

- Providing Managers and staff with up to date guidance and information relating to COVID-19 Health and Safety procedures, through regular updates released through the bulletins, along with a range of information and toolkits hosted on the intranet, via the dedicated COVID-19 Health and Safety pages; Working safely; Risk Assessment templates;

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Managers and Supervisors guidance. Advice and support to the PPE Group.

- Updating the PTHB COVID-19 Risk Register section 'COVID-19 may be transmitted in the workplace', ensuring sufficient controls and mitigating actions/measures are identified and are being implemented for areas such as; PPE training, Risk Assessments, Standard Operating Procedures, Staff wellbeing, Policies and Communication.

- Over an 8-week period during April and May, a suite of face 2 face upskilling sessions, designed specifically to support the pandemic preparations, were delivered to our Clinical and Support Services staff. Sessions such as Basic Life Support, Donning and Doffing of PPE, Manual Handling and Face Fit testing were included and well received.

NEXT STEPS:

For the Experience, Quality & Safety Committee to note the content of this update paper.

As part of re introducing some of the 'business as usual' work the Health & Safety Work Plan will be reviewed and refined at the next Health and Safety Group meeting.

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APPENDIX 1

HEALTH & SAFETY WORK PROGRAMME Q4 2019
FORWARD WORK PROGRAMME FOR 2020-2021

Area of work	2019/20	2020/21				UPDATE/ COMMENTS
	Q4	Q1	Q2	Q3	Q4	
Review and monitor progress of HSE Improvement action plan • Legionella improvement notices						
Review progress of H and S internal inspection (2017-2019) findings at: Welshpool Hospital Newtown Hospital Estates Department – Unit L, Newtown Machynlleth Hospital Llanidloes Hospital Knighton Hospital Llandrindod Wells Hospital Bronllys Hospital Estates Department - Courtyard Bronllys Brecon Hospital Ystradgynlais Hospital Glan Irfon Ynys y Plant Park Street Clinic **These sites will be reviewed over a 2 year period 2020-2022						
Plan and agree suite of topic specific inspection and audits						
Monitor compliance with H&S suite of training						
Provide risk assessment guidance and support to service managers						

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Area of work	2019/20	2020/21				UPDATE/ COMMENTS
	Q4	Q1	Q2	Q3	Q4	
Undertake desktop review of polices that should sit with H&S umbrella						
Review any outstanding policies						
Support the coordination of the stress steering group						
Compile annual H&S report						
Identify the high risk corporate H&S risk areas e.g Electrical safety, Medical gasses						
Health Safety and Wellbeing training						
• IOSH 1 day working safely						
• Coordinate the strategic approach to stress and resilience awareness sessions						
• Deliver a programme of Risk assessment training						
Coordinate appropriate training and advice: • Violence and Aggression • Manual Handling • Fire safety						

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Agenda item: 3.5

Experience, Quality & Safety Committee	**Date of Meeting: 30 July 2020**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Executive Director Nursing & Midwifery
Prepared by:	Helen Kendrick, Quality and Safety Manager
Other Committees and meetings considered at:	Quality Goverance Group 23/7/2020

PURPOSE:

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

RECOMMENDATION(S):

The 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. The Committee is 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 is important to note the Health Inspectorate Wales reports included in the report have been published and are therefore within the pubic domain.

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

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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 Committee with an update on the most recent Regulatory Inspections undertaken and also any planned inspections the health board have been notified of. It is pleasing to report a key theme identified by HIW is 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 is constantly striving to make improvements in these areas and will continue to do so in conjunction with the recommendations made by HIW.

DETAILED BACKGROUND AND ASSESSMENT:

<u>Health Inspectorate Wales Approach to Assurance and Inspection</u>

On 6 July 2020, Alun Jones, Interim Chief Executive of Health Inspectorate Wales wrote to the Chief Executive Officer and Chair of the health board in relation to future approach to assurance and inspection. The letter advises that HIW is working hard to consider the work programme and adapt the approach to ensure it is appropriate in the current climate, recognising that the healthcare system will be responding to COVID-19 demands for some time to come. HIW will be piloting a new way of working for the three-month period from August to October, followed by an evaluation of the approach to ensure it is appropriate in meeting its aims and objectives.

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The new methodology and inspection approach will allow HIW to deploy resources in a more agile way, responding to specific risks and issues whilst taking account of revised operating models during the pandemic. A key feature of the new approach will be the use of a three-tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as their primary method of gaining assurance.

Tier 1: inspection conducted entirely off site
Tier 2: combination of offsite and limited onsite inspection
Tier 3: onsite inspection

HIW anticipate the majority of their work throughout August and September to be through Tier 1. For this activity, where work is announced, there will be a shorter lead in time (at least 7 working days).

HIW will be updating their website with the details of the revised approach over the coming weeks.

The letter received from HIW can be viewed in **Appendix 1**.

Pending Inspections

Inspection of Maternity Community Clinic Sites

The health board has recently been notified (6 July 2020) that as part of the national review of maternity services HIW are planning phase two, which will consist of patient engagement and inspection visits to community clinics. The health board has been asked to provide the following information:

- Locations of all community clinics
- Lead Midwife contact details
- Working hours of the clinics
- Antenatal and postnatal groups held within the clinics
- Any other focus groups held within the area
- Caseload size of each community clinic

The health board has not been notified of expected timescales for phase two at this stage. The letter from HIW can be viewed in **Appendix 2.**

Health Inspectorate Wales Inspections

National Maternity Review – Inspection of Birth Units

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

The health board received the draft inspection report, factual accuracy and improvement plan templates on 15 June 2020. The completed documents were returned with some

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factual accuracy comments for consideration by HIW on 26 June and a response from HIW is awaited.

It is pleasing to note the summary comments from HIW included reference to the service providing respectful, dignified, safe and effective care to patients. Noting there were some good arrangements in place to support the delivery of safe and effective care and positive multidisciplinary team working, we recognise there are some area identified for improvement. The health board have already started to work towards ensuring these improvements are made and the improvement plan will be monitored internally via this Group as per governance and assurance arrangements.

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

<u>Inspection of Community Mental Health Team (CMHT) – Newtown Hospital</u>

This joint inspection by HIW and Care Inspectorate Wales (CIW) and 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.

The inspection was conducted over two days, and included discussions with CMHT staff, service users and carers, as well as examining documentation including service user records, policies, staff records and system reviews.

Immediately following the inspection both the health board and local authority were formally notified that areas of concern had been identified which would pose an immediate risk to the safety of patients. The inspection team had been notified during the inspection by members of staff there was a long standing and on-going problem with the electronic records management system (WCCIS). The health board and local authority had one week to provide immediate assurance to HIW with detail of action taken or intended to take to address the findings. A response was submitted to HIW on 12 February.

The health board received the draft inspection report, factual accuracy and improvement plan templates on 15 June 2020. The completed improvement plan was submitted to HIW on 26th June along with confirmation there were no points of factual accuracy to raise. HIW were advised documents had been completed jointly with local authority colleagues.

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

<u>Felindre Ward, Bronllys Hospital – November 2019</u>

The Group has previously been informed HIW completed an unannounced mental health inspection of Felindre Ward, Bronllys Hospital on the evening of 18 November 2019 and the following days of 19 and 20 November 2019. The findings have also previously been shared with the Group.

On 14 January 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 21st November 2019 and can be viewed in **Appendix 4**.

Llewellyn Ward, Bronllys Hospital – October 2019

The Group has previously been informed HIW completed an unannounced inspection of Llewellyn Ward, Bronllys Hospital on 29 and 30 October 2019. The findings have also previously been shared with the Group.

The health board has received the draft report and improvement plan which has been completed and returned to HIW. The health board has not yet received confirmation the improvement plan has been accepted as providing sufficient assurance. However, the Final report was published by HIW on 31st January 2020 and can be viewed in **Appendix 3**.

Care Inspectorate Wales (CIW)

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 inspection was a full one as part of the CIW inspection programme and was unannounced. It took place between 10:45am and 15:30pm.

The draft report, which the health board is in receipt of, reports that the overall assessment identified people were happy living at Cottage View. However, it also reported the leadership and management of the service needs improvement to ensure it is run in accordance with the legal requirements which led to a non-compliance notice (20/04/2020). The areas identified are listed below along with the response provided by the health board:

- The service does not notify the service regulator of events in line with the legal requirements. *The role of RI is now to be taken over by Assistant Director of Community Services. A review of the requirements for notification to the service regulator will be completed to meet the legal requirements.*

- There are no clear arrangements for the oversight and governance of the service. *The home is supported on a weekly call by the Community Services Manager and this has now to be strengthened with additional oversight from the Assistant Director of Community Services through a monthly review call. Reporting of the care home will be improved in line with legal requirements*

- The provider has failed to ensure the person designated as responsible individual has carried out their role effectively. *The role of RI is being transferred to the Assistant Director of Community Services.*

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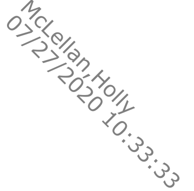
The health board awaits the final report and notice of the intended date of publication.

Environmental Health Service

There have been no recent visits by the Environmental Health Service (EHS).

Community Health Council

There have been no recent visits by the Community Health Council.



Direct Line: 03000 628120
E-mail: Alun.Jones39@gov.wales

Chief Executive and Chair
Powys Teaching Health Board
Via Email

06 July 2020

Dear Vivienne and Carol

HIW approach to Assurance and Inspection

In my letter to you on 6 May, I mentioned that at Healthcare Inspectorate Wales (HIW), we have been working hard to consider our work programme and adapt our approach to ensure that it is appropriate in the current climate, recognising that the healthcare system will be responding to COVID-19 demands for some time to come. We have been considering new ways of working which will give us flexibility and agility in delivering our role over the coming year and I am now at a point where I can share more detail of this approach.

We are planning and refining our routine work programme on an ongoing basis and will be piloting our new way of working for the three month period from August to October. Towards the end of this period we will evaluate the approach to ensure it is appropriate and in meeting its aims and objectives.

I'm acutely aware that we have had to move quickly to adapt as an organisation and this has not allowed us to engage with you about our approach in the way I would have wished. That said, our core role of checking whether standards and regulations are being met continues to be central to our approach. The new methodology and inspection approach will allow us to deploy our resource in a more agile way, responding to specific risks and issues whilst taking account of revised operating models during the pandemic.

A key feature of our new approach will be the use of a three tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as our primary method of gaining assurance.

Tier 1 activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via our standard concerns process and where the risk of conducting an onsite inspection remains high. Tier 2 will introduce a combination of offsite and limited onsite activity, whilst Tier 3 will represent a more traditional onsite inspection.

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We always reserve the right to conduct a full inspection at any time, but we expect the majority of our work to be Tier 1 throughout August and September. For this activity, where work is announced, there will be a shorter lead in time (at least 7 working days), a

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smaller inspection team with most of the assurance work being completed through a request for information, and a follow-up phone or video call with key personnel. Following a short period of factual accuracy checking, there will be a written summary and, where required, an improvement plan. We will publish the summary report as soon as possible after the activity has taken place and the accuracy checking has been completed.

This approach will enable us to seek assurance from services at a time when onsite inspection visits are far more challenging for both healthcare settings and ourselves. It also provides an incremental approach which in future will provide more flexibility by offering a wider range of methods for conducting our work.

We will be updating our website with the details of our revised approach over the coming weeks, however, I wanted to give you early indication of ours plans and an opportunity to raise any concerns you may have with me at this stage. I would be grateful if you could cascade the information contained in this letter to the appropriate staff within your organisation.

Many thanks for your contact with the inspectorate at this time, it is most appreciated. Should you wish to discuss anything contained in this letter then please do not hesitate to contact me directly.

Yours sincerely

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales

Cc. HIW Relationship Manager: Rebecca Collier
HIW Deputy Chief Executive, Stuart Fitzgerald

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Carol Shillabeer
Chief Executive
Powys Teaching Health Board

Carol.shillabeer2@wales.nhs.uk

6 July 2020

Dear Ms Shillabeer,

Re: Inspection of Maternity Community Clinic Sites

As you are aware, we are currently undertaking a national review of maternity services across Wales. As part of the review, we are now planning phase two, which will consist of patient engagement and inspection visits to community clinics across Wales.

In order for us to structure phase two, we require information informing us of which community clinics are currently in use across your health board. Please can you supply the following to assist in this:

- Locations of all of all community clinics
- Lead Midwife contact details
- Working hours of the clinics
- Antenatal and postnatal groups held within the clinics
- Any other focus groups held within the area
- Caseload size of each community clinic.

Once this information is received, we can progress with our plans and will make further contact if any additional information is required.

If you wish to discuss any aspect of the maternity review or have any concerns please contact Emma Scott at emma.scott001@gov.wales or on mobile number 07557840651. Alternatively, please contact HIWInspections@gov.wales or telephone 0300 062 8163.

Yours sincerely

V. L. Davies

Vanessa Davies
Head of Reviews

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Hospital Inspection (Unannounced)

Bronllys Hospital, Powys Teaching Health Board

Inspection date: 29 and 30 October 2019

Publication date: 31 January 2020

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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:

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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**

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1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Bronllys Hospital within Powys Teaching Health Board on 29 and 30 October 2019. The following hospital sites and wards were visited during this inspection:

- Llewellyn Ward

Our team, for the inspection comprised of two HIW Inspectors, one clinical peer reviewer and one lay reviewer. The inspection was led by a HIW inspection manager.

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

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

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2. Summary of our inspection

We found that the staff on the ward were committed to providing patients with safe and effective care.

Patients spoken with during the course of the inspection expressed satisfaction with the care and treatment received.

We found good management and leadership, with staff commenting positively on the support that they received from the ward manager.

However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Staff engagement
- Multidisciplinary working
- Provision of food and drink
- Palliative care suite
- Designated lounge and dining area
- Assessment, care planning and record keeping
- Medication management
- Management overview
- Clinical audits
- Staff training, support and supervision.

This is what we recommend the service could improve:

- Welsh language provision
- Pain assessment

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- Storage of wheelchairs and segregation of clean and dirty equipment
- General Risk assessment
- Maintenance in some areas
- Staff recruitment

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3. What we found

Background of the service

Powys Teaching Health Board (PTHB), is a rural health board that provides services locally, through GPs and other primary care services, community hospitals and community services. Powys provides services for approximately 133,000 residents over a large, rural geographical area.

PTHB does not have a District General Hospital, but pays for Powys residents to receive specialist services in hospitals outside of the county. Shrewsbury and Telford Hospitals NHS Trust makes up the largest proportion of 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, and others in smaller proportions.

Bronllys is a community hospital located on the outskirts of Brecon. There are two wards in the hospital, Llewellyn ward, which is a 15 bed GP led general ward, and Felindre ward, which is a mental health inpatient unit. This inspection focused on the services provided on Llewellyn ward.

Beds on Llewelyn ward are flexible in their use, as demand requires. GPs tend to admit patients from the community and Consultants from the District General Hospitals (DGH), mainly Hereford and Abergavenny. Patients are admitted for a variety of conditions including medical, post-operative rehabilitation, management of Parkinson's disease and palliative care. There was a palliative care suite on the ward which had been funded through donations and fund raising activities arranged by the hospital's League of Friends and PTHB charitable funds. The suite, known as Mynydd View, and offers a space to support patients at the end of life and their families and loved ones. The private bedroom has en-suite facilities, a kitchenette and garden access.

The ward was well supported by a multidisciplinary team which incorporates Physiotherapy, Occupational Therapy, Dietetics, Speech and Language Therapy, Parkinson's Specialist Nurse, Respiratory Nurse Speciality, Tissue Viability, Incontinence Nurse Specialist, Mental Health Team and Social Workers.

Other services provided at the hospital include:

- Podiatry
- Falls Programme
- Physiotherapy & Occupational Therapy

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- Pain & Fatigue Management Centre
- Occupational Health department
- Learning Disability – community service only
- Psychology
- Public Health
- Outpatients
- Day Hospital – currently open Mondays, Tuesdays and Thursdays from 10.00-16.00.

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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 spoken with during the course of the inspection expressed satisfaction with the care and treatment received. Patients told us that staff were kind and caring.

We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner.

Patients were being encouraged and assisted to change out of their nightwear and into day clothes to maintain dignity and promote independence.

We found that patients were able to move freely around the ward area.

We saw staff attending to patients in a calm and reassuring manner.

The ward environment was clean and tidy.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the standard of care provided to patients at the hospital. A total of thirteen questionnaires were completed. We also spoke with patients during the inspection.

Most of the patients who completed a questionnaire had been on the ward for more than two weeks.

Patients rated the care and treatment provided during their stay in hospital out of ten, and the average score awarded was 9.1 out of 10. The lowest score awarded was 7 out of 10.

Staying healthy

We found that patients were involved in the planning and provision of their own care, as far as was possible. Where patients were unable to make decisions for themselves, due to memory problems, we found that relatives were consulted

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and encouraged to help make decisions around care provision in accordance with the Health and Care Standards.

We saw good interactions between staff and patients, with staff attending to patients' needs in a discreet and professional manner. We saw staff spending time with patients and encouraging them to do things for themselves, thus maintaining their independence. We also saw staff involving patients in making decisions regarding daily activities.

The Butterfly[1] scheme was in operation on the ward, whereby butterfly symbols were used to identify patients with a diagnosis of dementia or cognitive impairment, and who required additional support or a different approach to the provision of care. Other symbols were also in use to identify patients who required additional support, such as different coloured lids on jugs for those patients requiring assistance with eating and drinking.

There was a patient lounge/dining area on the ward, and patients spoken with stated that they benefited from such facilities, which encourage mobility and helps maintain independence. This area was also used for activities. We saw some activities, facilitated by the healthcare support workers, taking place during the inspection.

Dignified care

We found that patients were treated with dignity and respect by the staff team.

We observed staff being kind and respectful to patients. We saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs. Patients confirmed that staff were kind and sensitive when carrying out care.

[1] The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

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Patients appeared well cared for with staff paying specific attention to people's appearance and clothing. We saw that patients were supported to change out of their nightwear during the day in order to maintain dignity, promote independence and assist with their rehabilitation and preparation for safe discharge.

The environment on the ward was generally clean and tidy, adding to the sense of patients' well-being. However, some of the window frames within the corridor area leading to the ward, were seen to be in need of repair. We were informed that the maintenance department were aware of the matter and were scheduled to commence the repair work in the near future. We also noted that handles were missing from some of the windows in the conservatory, which meant that the windows could not be fully closed, resulting in a through draught and cold temperatures. We also noted that some areas of the hospital grounds were overgrown and required attention.

We noted that staff wore household/gardening type green wellington boots whilst assisting patients when showering in the walk in shower/wet room. In our opinion, the use of these wellington boots is not appropriate for a clinical/caring environment, and we recommend that more appropriate footwear be considered.

Improvement needed

The health board must:

- Repair the window frames within the corridor area leading to the ward
- Repair the windows in the conservatory
- Ensure that the grounds of the hospital are suitably maintained.

Patient information

Health promotion information for patients and their families/carers was displayed and available on the ward. However, the information provided was mostly in English, and therefore, measures must be taken to ensure that information is also made available in Welsh.

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A Patient Status at a Glance (PSAG)[2] board was located in the nurses' station. The board was positioned in such a way that patients' information was kept confidential.

Improvement needed

The health board must ensure that patient information is made available in Welsh.

Communicating effectively

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner. Patients were referred to according to their preferred names. Staff were observed communicating with patients in an encouraging and inclusive manner.

All patients who completed a questionnaire agreed staff were always polite and listened, both to them and to their friends and family. Nearly all of the patients who completed a questionnaire agreed staff called them by their preferred name, and none disagreed. Comments included:

"Care assistants excellent - good banter".

The majority of patients told us that staff had talked to them about their medical conditions and helped them to understand them. One visiting relative told us that they are not always kept informed of changes in their relative's condition and/or care provision as they are not always able to be present during doctors' visits.

Improvement needed

The health board must take steps to ensure that, where appropriate, relatives are kept informed of changes in the patient's condition and/or care provision, if they are not able to be present during doctors' visits.

[2] The Patient Status At a Glance board is a clear and consistent way of displaying patient information within hospital wards.

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Timely care

We found that there were generally good assessment and care planning processes in place.

The ward team worked well with other members of the multidisciplinary healthcare team, to provide patients with individualised care according to their assessed needs. Multidisciplinary team meetings were taking place weekly with records maintained. There were robust processes in place for referring changes in patients' needs to other professionals, such as the tissue viability specialist nurse, dietician and speech and language therapist.

We found that there were adequate discharge planning systems in place, with patients being assessed by other professionals, such as physiotherapists, occupational therapists and social workers, prior to leaving the hospital. We looked at a sample of patient records and found the transfer of care documentation to be comprehensive. However, we found that there were delays in some patients being discharged, due in the main, to a lack of suitable social care provision.

Improvement needed

The health board must continue to engage with the local authority with a view to improving the availability of suitable social care provision in order to facilitate timely patient discharge.

Individual care

Planning care to promote independence

We found that the care planning process took account of patients' views on how they wanted their care to be delivered. Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their daily care needs. Patients also told us that staff assisted them and provided care when it was needed. We saw staff encouraging and supporting patients to be as independent as possible. For example, we saw staff encouraging patients to walk, and assisting them to eat and drink independently.

All patients told us that they were given a choice by staff about which method they could use if they needed the toilet, and agreed that when necessary staff helped with their toilet needs in a sensitive way so they didn't feel embarrassed.

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All of the patients who completed the questionnaire confirmed that they had access to a nurse call buzzer, and agreed that staff would come to them when they used the buzzer.

People's rights

We saw that staff provided care in a way to promote and protect patients' rights.

We found staff protecting the privacy and dignity of patients when delivering care. For example, curtains were used around individual bed areas and doors to single rooms were closed when care was being delivered.

We found that Deprivation of Liberty Safeguards (DoLS)[3] assessments were being conducted as required. However, we found the recording of mental capacity assessments to be inconsistent.

We found that Do Not Attempt Resuscitation (DNAR)[4] forms had been completed appropriately where required.

Improvement needed

The health board must ensure that staff are consistent with the process of mental capacity assessments and complete appropriate documentation for this.

Listening and learning from feedback

Patients and their representatives had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff.

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[3] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

[4] A Do Not Attempt Resuscitation assessment is conducted by a doctor, and tells the medical team not to attempt cardiopulmonary resuscitation (CPR). The assessment form is designed to be easily recognised and verifiable, allowing healthcare professionals to make decisions quickly about how to treat a patient.

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There were good systems in place for managing complaints and we were told by staff that the number of complaints received about the service were low.

There was a formal complaints procedure in place which was compliant with the NHS Wales Putting Things Right[5] process. There was information available, in the form of posters and leaflets, advising patients and/or relatives on how to make a complaint

[5] 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 for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

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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 found that the staff team were committed to providing patients with safe and effective care.

Suitable equipment was available and being used to help prevent patients developing pressure sores, and to prevent patient falls.

The ward was generally clean and tidy and arrangements were in place to reduce cross infection.

There were formal medication management processes in place.

Patients' care needs had been assessed by staff, and staff monitored patients to promote their well-being and safety

Safe care

Managing risk and promoting health and safety

We found the ward to be well maintained and systems were in place to report environmental hazards that required attention and repair. We were told that the hospital maintenance team was very responsive and attended to any repair work without undue delay.

The ward environment was generally free from any hazards to patient, visitors and staff safety. However, we noted that wheel chairs were being stored on the corridor leading to the ward which could present a trip hazard.

Clinical audits and risk assessments were being undertaken on a regular basis, in order to minimise the risk of harm to patients and staff, with results posted on notice boards on the ward. However, more general environmental risk assessments had not been undertaken for over 12 months. We were informed by the ward manager that they were awaiting further guidance form the health board in relation to this and that there had been a delay due to changes in senior management.

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Improvement needed

The health board must ensure that:

- Wheel chairs are not stored on the corridor leading to the ward
- General, environmental risk assessments are undertaken on a regular basis.

Preventing pressure and tissue damage

Staff assessed patients regarding their risk of developing pressure damage to their skin. We were also able to confirm that staff were taking appropriate action to prevent patients developing pressure and skin tissue damage.

We looked at a sample of care records and confirmed that written risk assessments had been completed using a recognised nursing assessment tool. We also saw that monitoring records had been completed, showing that patients' skin had been checked regularly for signs of pressure damage. Suitable pressure relieving equipment was available and being used to help prevent patients developing pressure damage.

The monitoring records we saw showed that patients had been assisted or encouraged to move their position whilst in bed, or in an armchair, regularly. We also saw staff assisting and encouraging patients to move around the ward environment. Both of these nursing interventions are known to help to reduce patients developing pressure ulcers.

Falls prevention

From examination of a sample of individual care files, we found that assessments were being undertaken to reduce the risk of falls and that prompt action was being taken in response.

Infection prevention and control

There was a comprehensive infection control policy in place and we found that regular audits were being undertaken to ensure that staff were adhering to the policy and good practice principles.

Infection control audit outcomes were displayed on a notice board within the ward.

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Staff had access to, and were using, personal protective equipment, such as disposable gloves and aprons to reduce cross infection. Hand washing and drying facilities were available. We also saw hand sanitising stations strategically placed near entrances/exits for staff and visitors to use, to reduce the risk of cross infection.

The ward environment was generally clean and tidy. However, we found that some dirty items of equipment were stored with clean items within one of the store rooms on the ward. This practice increases the risk of cross infection and must be discontinued.

All of the patients who completed a questionnaire felt that the ward was clean and tidy. Some comments included:

"The hospital is the best - clean and friendly".

"Staff always clean".

Improvement needed

The health board must ensure that dirty items of equipment are not stored with clean items, to reduce the risk of cross infection.

Nutrition and hydration

We saw that patients' eating and drinking needs had been assessed. We also saw staff assisting patients to eat and drink in a dignified and unhurried manner.

Patients had access to fluids, with water jugs available by the bedside.

We looked at a sample of care records and saw that monitoring charts were being used where required, to ensure patients had appropriate nutritional and fluid intake.

The ward promoted protected meal times. This ensured that patients were not unduly disturbed during meal times so as to ensure adequate nutritional and fluid intake. However, where deemed appropriate, relatives were encouraged to visit at mealtimes in order to provide assistance and support to patients with their meals.

We observed lunchtime meals being served and saw staff assisting patients in a calm, unhurried and dignified way allowing patients sufficient time to chew and swallow food. We also saw staff providing encouragement and support to patients to eat independently. All of the patients who completed a questionnaire

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told us that they had time to eat their food at their own pace and agreed that staff would assist them to eat and drink if needed; all patients agreed that water was always accessible.

The meals appeared well presented and appetising. Patients told us that the food was very good.

Hand wipes were available with staff seen to offer patients the opportunity to clean their hands before and after eating their meal.

Medicines management

We observed medication being administered to patients and found the process to be in line with the health board's policy. We saw staff approaching the administration of medication activity in an unhurried way, taking time to ensure that patients were able to take their medication without becoming anxious or distressed.

A pharmacist visited the ward three times a week, and a pharmacy technician twice a week, to undertake medication audits and to offer guidance and support to staff.

None of the patients in receipt of care at the time of the inspection were self-medicating and there was no formal policy in place to support this. However, a staff member gave an example of a patient who was awaiting discharge home who was having problems with self-administration of medication. A bespoke plan had been drawn up and agreed with ward staff, pharmacy and the patient. Written guidance had been drafted and the patient was being supervised with self-medicating to ensure safe practice prior to discharge.

We found evidence that the content of the emergency/cardiac arrest trolley was checked on a regular basis, and any items past their expiry date replaced.

.Improvement needed

The health board must produce a policy to support patient self-administration of medication.

Safeguarding children and adults at risk

There were written safeguarding policies and procedures in place and staff had undertaken appropriate training on this subject.

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We were told that there were no active safeguarding issues on the ward at the time of the inspection.

Medical devices, equipment and diagnostic systems

The ward had a range of medical equipment available which was maintained appropriately, and portable appliance testing was undertaken as required.

Effective care

Safe and clinically effective care

There was evidence of very good multidisciplinary working between the nursing and medical staff. General Practitioner (GP) ward rounds to review patients were held twice a week, with GPs visiting as and when required on all other days. We were told that there was good access to GP services at night and during the weekends.

We found that the Adult Nursing Assessment documentation had been fully completed on admission to the ward.

We found that care bundles, linked to the National Early Warning Scores (NEWS)[6] system, were being implemented as a structured way of improving the processes of care and outcomes for patients around preventing pressure ulcers, ensuring adequate nutrition and identifying patients who were at risk of deterioration through acute illness or sepsis.

We found that there were generally good care planning systems and processes in place. We found that the care planning took account of patients' views on how they wished to be cared for.

Pain management care plans had been drawn up and patients were being administered pain relief where needed. However, we did not see evidence of assessment taking place using a recognised pain assessment tool on the sample

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[6] NEWS is national system for recognising very ill patients whose condition is deteriorating and who need more intensive medical or nursing care.

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care files inspected. We were informed by the ward manager that the health board was developing a new pain assessment tool and that this was due to be implemented on the ward in January 2020.

Improvement needed

The health board must introduce a pain assessment tool for use by staff on the ward as part of the patient assessment and care planning process.

Information governance and communications technology

There was a robust information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of patient confidentiality.

Through examination of training records, we confirmed that staff had received training on information governance.

We were told that work was underway on developing an electronic records management system for use across the health board.

Record keeping

Patient care notes were found to be well maintained, easy to read, and reflective of the care and support provided.

Patients' care notes were stored within a locked trolley, which was stored in the locked nurses' office when not in use.

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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.

We found very good management and leadership at ward level, with staff commenting positively on the support that they received form the ward manager.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation, and that the communication between senior management and staff was generally effective.

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that the health board focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure which enabled nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

During discussions with staff, we were told that there were good informal, day to day staff supervision and support processes in place on the ward, along with regular formal staff meetings taking place on a regular basis, and minutes of the meeting available for those who could not attend.

We found very good internal communication between the multidisciplinary team.

Staff and resources

Workforce

We found friendly, professional staff team on the ward who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and were knowledgeable about the care needs of patients they were responsible for.

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We viewed copies of the staff rota which showed us that there was a good skill mix of staff on duty each shift. The number of staff on duty could vary from shift to shift, and took account of occupancy levels and those patients who required one to one assistance or supervision.

There were a number of staff vacancies at the time of the inspection. There was a rolling programme of staff recruitment in place. However, the health board was experiencing difficulties in recruiting permanent staff. This was due, in the main, to the location of the hospital. Consequently, the service was heavily reliant on agency staff. There were arrangements in place to ensure that, where possible, the same agency staff members were allocated to work on the ward. This provided a level of continuity of care, and enabled staff to develop stronger working relationships.

During our inspection we spoke with a number of staff members across all disciplines, and we distributed HIW questionnaires to staff, to find out what the working conditions are like, and to understand their views on the quality of the care provided to patients. We received six completed questionnaires.

Most staff indicated in the questionnaires that they had undertaken learning and development, in Health and Safety, Fire Safety, Infection Control, Mental Capacity Act/ Deprivation of Liberty Safeguards, Privacy and Dignity and Dementia in the last twelve months.

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

Staff training records viewed during the inspection showed that mandatory training compliance exceeded 80%. With evidence of staff having been booked on training that was outstanding.

All staff who completed a questionnaire told us that they had an appraisal, annual review or development review of their work in the last 12 months. All said that, as part of this process, their learning or development needs were identified and that their manager always supported them to achieve these needs.

All respondents said they were able to make suggestions to improve patient care and said they felt involved in decisions which affected them.

The majority of staff told us that they are able to meet all the conflicting demands on their time at work and that they have adequate materials, supplies and equipment to do their work. In addition, that there were enough staff at the

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organisation to enable them to do their job properly. However, one staff member commented that there were never enough staff:

> *"Too many mangers. Not enough experienced staff on the ground floor providing care."*

All staff members who completed a questionnaire were satisfied with the quality of care they are able to give to patients, and that patients and/or their relatives were involved in decisions about their care. They also agreed that the privacy and dignity of patients is always maintained, and patient independence promoted.

Most staff members said that the organisation encourages teamwork and that the organisation was supportive and that that there was a culture of openness and learning within the health board.

Within the questionnaires, staff told us that the care of patients is the organisation's top priority, and that the organisation acts on concerns raised by patients. Most staff agreed that they would recommend the organisation as a place to work and that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.

Staff were asked questions about their immediate manager, and the feedback received was generally positive. Comments included:

> *"I couldn't ask for better support from my manager."*

Staff told us that their manager encourages those who work for them, to work as a team and that they could be counted on to help them with a difficult task at work.

Staff who completed a questionnaire said that they knew who the senior managers were in the organisation, with a majority telling us that there was effective communication between senior management and staff.

The majority of staff told us within the questionnaire that their job was good for their health and that their immediate manager and the organisation in general take positive action on health and well-being. Comments included:

> *"Wellbeing breaks take place on the ward. Staff usually get together for a chat and cup of tea."*

> *"My limited time on this ward enables me to comment on the great support offered to me by my charge nurse and the*

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excellent agency staff that I have worked with. I feel very comfortable and valued already. What a lovely ward."

One staff member in response to the questionnaire said that they had seen errors, near misses or incidents in the last month that could have hurt staff and had seen errors, near misses or incidents that could have hurt patients. All staff agreed that their organisation encourages them to report errors, near misses or incident, and that the organisation would treat reports of an error, near miss or incident confidentially and not blame or punish the people who are involved in such incidents.

Staff told us that they were informed about errors, near misses and incidents that happen in the organisation, and that they were given feedback about changes made in response to reported errors, near misses and incidents.

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

All respondents said that the organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Improvement needed

The health board must continue with the plan and efforts to recruit permanent staff.

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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.

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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.

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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.			

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Appendix B – Immediate improvement plan

Hospital: Bronllys

Ward/department: Llewellyn

Date of inspection: 29 and 30 October 2019

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	Responsible officer	Timescale
No immediate assurance issues were highlighted during this inspection.				

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:

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Appendix C – Improvement plan

Hospital: Bronllys

Ward/department: Llewellyn

Date of inspection: 29/30 October 2019

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	Responsible officer	Timescale
Quality of the patient experience				
The health board must repair the window frames within the corridor area leading to the ward	4.1 Dignified Care	New bespoke timber window sashes to be manufactured.	Head of Estates and Works	To be installed W/C 2nd March 2020
The health board must repair the windows in the conservatory.		All UPVC sash handles replaced 23/1/20. Specialist Contractor required to provide report on sliding door mechanism. Report to be provided by 31/1/20, all identified works to arranged following receipt of the report.	Head of Estates and Works	14th February 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the grounds of the hospital are suitable maintained.		Area to be cut back and cleared.	Head of Estates and Works	31st January
The health board must ensure that patient information is made available in Welsh.	4.2 Patient Information	Welsh translation of 'Know How You Are Doing Boards' is available, ward to access this for advice.	Ward Sister	10th February 2020
The health board must take steps to ensure that, where appropriate, relatives are kept informed of changes in the patient's condition and/or care provision if they are not able to be present during doctors' visits.	3.2 Communicating effectively	Arrangements can be made for relatives to meet the lead doctor. Sister to operate an open communication clinic, whereby relatives can come and discuss with their family member time slots available throughout 4 days a week.	Ward Sister Ward sister	Completed Completed
The health board must continue to engage with the local authority with a view to improving the availability of suitable social care provision in order to facilitate timely patient discharge.	5.1 Timely access	PTHB appointed a clinical lead for unscheduled care to support patient flow in July 2019. There is daily liaison with Social Services to work together to facilitate timely discharges and reduce the number of Delayed Transfers of Care (DTOC) currently on the ward.	Lead for unscheduled care	In place

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Improvement needed	Standard	Service action	Responsible officer	Timescale
		Hospital based Social Workers commenced 3rd December 2019 to test new ways of working for 4 months. Lead Unscheduled Care Manager liaises with 3rd sector and local authority colleagues at a strategic level with a view to improving the availability of suitable social care provision. The Patient flow team liaise daily with all wards to discuss discharge arrangements and bed calls are held daily to which local authority are invited. Twice weekly DTOC calls with senior managers in the local authority take place. Senior Nurse for patient flow attends – Ward Sisters Forum providing supportive discharge information.		
The health board must ensure that staff are consistent with the process of mental capacity assessments and complete appropriate documentation for this.	6.2 Peoples rights	Mental Health Act training to be developed corporately for staff working within Adult Services.	Head of Safeguarding	31st January 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
		E learning Level MCA 1&2 training available to staff work in progress with WoD to add to mandatory training requirements for RN's. Staff reminded and encouraged to undertake their mandatory training. MCA 7 minute briefing poster developed to support staff – this was launched national Safeguarding week November discussed and distributed to ward sisters at Sisters Forum November 2019.	Ward Sister Ward Sister Ward Sister	31st January 2020 Completed Completed
Delivery of safe and effective care				
The health board must ensure that wheel chairs are not stored on the corridor leading to the ward.	2.1 Managing risk and promoting health and safety	Remove wheelchairs to an appropriate area.	Ward Sister	Completed
The health board must ensure that general, environmental risk assessments are undertaken on a regular basis.		General Risk Assessment has been developed and to be used on a regular basis.	Ward Sister	Completed

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Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that dirty items of equipment are not stored with clean items to reduce the risk of cross infection.	2.4 Infection Prevention and Control (IPC) and Decontamination	Store room has been revised and condemned mattress removed.	Ward Sister	Completed
The health board must produce a policy to support patient self-administration of medication.	2.6 Medicines Management	The new medicines policy in draft awaiting ratification, supports Patient self administration. Further work is required regarding pharmacy capacity at ward level to be addressed in order to support the roll out of patient self administration.	Head of Medicines management	Ratification of policy by March 2020
The health board must introduce a pain assessment tool for use by staff on the ward as part of the patient assessment and care planning process.	3.1 Safe and Clinically Effective care	All Wales Pain risk assessment tool has been introduced throughout Powys January 2020 as part of the Nursing E-docs project.	Head of Nursing	January 2020
Quality of management and leadership				
The health board must continue with their efforts to recruit permanent staff.	7.1 Workforce	PTHB have Recruitment & Retention Framework in place. Multidisciplinary approach taken with recruitment exercise and engaging with Universities,	Head of Workforce	Work continues

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Improvement needed	Standard	Service action	Responsible officer	Timescale
		advertising via social media and local /national press. Retire and Return, Return to Practice offers being offered by the HB. Continue to support HCSW education opportunities to "grow our own" enabling HCSW's to access their nurse training.		

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): Nigel Broad

Job role: Community Services Manager

Date: 22 January 2020

NHS Mental Health Service Inspection (Unannounced)

Bronllys Hospital

Felindre Ward

Powys Teaching Health Board

Inspection date:

18 - 20 November 2019

Publication date: 21 February 2020

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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**

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1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Bronllys Hospital within Powys Teaching Health Board on the evening of 18 November 2019 and the following days of 19, 20 November 2019. Felindre Ward was visited during this inspection.

Our team, for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one lay reviewer. The inspection was led one of the HIW healthcare inspectors.

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

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

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2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection.

We were concerned by the volume of maintenance issues that were unresolved on the ward, this is impacting negatively on patient experience.

The health board needs to review the inpatient service provision for adult mental health, to ensure it has sufficient capacity to provide timely and dignified care to its population.

This is what we found the service did well:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Safe and effective medicine management
- Established governance arrangements that provided safe and clinically effective care.

This is what we recommend the service could improve:

- The maintenance of the hospital facilities
- The capacity of its adult inpatient mental health service
- The provision of information on the ward for patients
- The range of therapies and activities available to patients
- The effectiveness of emergency resuscitation equipment checks
- Review and update of policies.

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3. What we found

Background of the service

Bronllys Hospital provides NHS mental health services at Brecon Road, Bronllys, Powys LD3 0LU, within Powys Teaching Health Board.

Felindre is a twelve bedded acute adult mental health admission ward, with the addition of two crisis beds, serving the population of Breconshire, within the grounds of the old Bronllys hospital, Powys.

The service is a mixed gender ward, however gender separation is afforded careful consideration. At the time of inspection, there were 14 patients at the hospital and three patients were temporarily located in other mental services out of county.

The service employs a staff team which includes a ward manager and a team of registered mental health nurses and health care support workers .The multi-disciplinary team includes two consultant Psychiatrists, an occupational therapist and an assistant occupational therapist.

The hospital is supported by the health board's clinical and administrative structures.

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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.

We observed that staff interacted and engaged with patients appropriately, and treated patients with dignity and respect.

Patients we spoke to told us they were receiving good care at the hospital.

The maintenance of the physical environment of Felindre ward is neglected and this impacts negatively upon the patient experience.

Staying healthy

Although the hospital had a range of facilities to support the provision of therapies and activities, many of these facilities were not available for patients use at the time of the inspection. We were told that the occupational kitchen had been out of use for almost 18 months as a result of a leak in the ceiling area. The health board have clarified that the leak has been a reoccurring problem that has meant the Occupational therapy kitchen has been operational but closed on several occasions. However this is still not sufficient, if this keeps reoccurring the health board need to invest in meaningful repairs to this room to prevent further closures of this area. In addition, patients had not been able to access the recovery room for over two months due to a broken window. Both these issues had been reported to the health boards' maintenance and estates department, however they remained outstanding.

The hospital had a designated games room which contained arts and crafts resources, however this was also not available for patients due to broken light fittings.

At the time of our inspection, there was no occupational therapist or assistant therapist working on the ward due to sickness and secondments, however we have been advised that an occupational therapist was due to commence employment at the beginning of December 2019. It was evident that patients' activities had been adversely affected by their absence and this did not support or meet the current needs of the patients. We were told that patients participate in weekly pottery classes and we saw an activity timetable on the ward,

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however we did not observe patients participating in any activities during the course of our inspection.

The ward had a dedicated smoking room, it was reasonably clean and the room was kept shut so the smell did not spread onto the ward. However, the health board should consider alternative options for the provision of smoking so this ward area could be used for therapeutic activities.

Patients did have access to an enclosed garden area, which unfortunately was not well maintained. The area was overgrown and the outside light was broken meaning that patients did not have access to this area at night. This is of greater significance during the winter months when there is less daylight hours. At no time during our inspection did we observe any patients accessing the outdoor garden area.

The ward had designated times for providing patients with drinks throughout the day. Hot drinks were served on a two hourly basis from 6am through till 10pm. Patients told us that if they wanted hot drinks outside of the stipulated hours, staff would aim to provide them. The health board must explore options to support patients in accessing hot drinks throughout the day to lessen this institutional practice of designated times for hot drinks.

A water fountain was also available in the lounge area so that patients could readily access drinking water.

Improvement needed

The health board must make sure that :

- Immediate repairs are undertaken to the roof and ceiling in the occupational therapy kitchen
- Light fixtures in the game room are fixed
- The window in the recovery room is replaced and made safe
- Patients have the opportunity to participate in activities whilst on the ward
- Garden area is developed and regularly maintained
- Patients are able to easily access hot drinks throughout the day

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- Consider alternative options for provisions of smoking.

Dignified care

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

We attended staff meetings and staff demonstrated a good level of understanding of patients they were caring for. All patients spoken to, stated that they felt safe and able to speak with a staff member should they need to. There was clear mutual respect and strong relationship security between staff and patients.

The hospital was secured from unauthorised access by locked doors and an intercom system. The ward environments did not meet current standards[1] for adult acute mental health units in Wales. This presented challenges around aspects of dignified care.

The ward provided mixed gender care, most patients had their own bedroom. There was one shared bedroom on the male corridor, the two beds within this area had curtains between them, however, these only afforded the basic level of privacy for patients, and do not reflect modern mental health care provision.

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[1]Welsh Health Building Note (WHBN) 03-01 - Adult Acute Mental Health Units http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/WHBN%2003-01%20Adult%20Acute%20Mental%20Health%20Units%20-%20final.pdf

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Patient bedrooms did not have en-suite facilities; there were shared toilets, and shower facilities located on the ward corridors which were gender specific. The two crisis rooms did have en-suite facilities and appeared more welcoming than the ward bedrooms.

One bedroom was out of use because the door had been damaged and not replaced. We were told that this issue had been raised over a week prior to the inspection with the health boards' maintenance and facilities team. We were advised that these doors are specifically made to measure and that a replacement door had been ordered and would be replaced in due course.

During our inspection we saw that demand for inpatient care was greater than the health board's capacity. To enable patients to be admitted to the ward, some patients were admitted to bedrooms where a patient was on overnight leave from hospital. In addition at the time of our inspection there were three patients that had been transferred to other mental health providers because there was a lack of beds available within the health board. We have been advised that the health board has a long term agreement with Midlands trust, which is a designated pathway for North Powys patients. However despite this arrangement it is not a suitable solution for patients to be placed away from their local hospital as this can be distressing for patients and families. The arrangement also demonstrates that there is a requirement for greater provisions within the health board.

The bedrooms offered limited storage and patients were not able to personalise their room with pictures and posters. We noted that there were no vision panels on the bedroom doors therefore, when staff undertook hourly observations they were required to open the bedroom door to observe patients. This could disturb patients' sleep. The health board should consider options on ensuring staff can check on the well-being of patients with minimal disruption.

Patients were not able to lock their bedrooms. Patients told us that staff generally respected their privacy and dignity. During the course of our inspection we saw many examples of staff knocking on patients doors before entering the bedrooms.

Depending on individual risk assessment, patients were able to have access to their mobile phone but were prevented from using their mobile phones in

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communal areas. Patients also had access to a pay phone located in a private booth within the hospital to enable patients to make contact with family and friends.

In the nurse's office there was a patient status at a glance board[2] displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

There were laundry facilities at the hospital that the patients were encouraged to use, with support from staff where required.

We observed a CCTV monitor located within the ward. Staff confirmed the cameras were not recording and were capturing images in the main foyer area and entrance to the ward. The health board must ensure that there are clear governance arrangements around the use of CCTV and make sure that the decision to use CCTV is clearly documented. The health board must also ensure that the CCTV policy follows the Information Commissioner's Office guidance set out in their 2017 CCTV Code of Practice[3].

Improvement needed

The health board must ensure that :

- Improvements are made to the environment to ensure patient access to areas on the ward is based on individual risk assessments

[2] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

[3] https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf

The code also reflects the wider regulatory environment. When using, or intending to use surveillance systems, many organisations also need to consider their obligations in relation to the Freedom of Information Act 2000 (FOIA), the Protection of Freedoms Act (POFA), the Human Rights Act 1998 (HRA) and the Surveillance Camera Code of Practice issued under the Protection of Freedoms Act (POFA code).

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- Review the bed capacity and service provision available for adult mental health services, to ensure it can timely meet the needs of its population
- Consider options on ensuring staff can check on the well-being of patients with minimal disruption
- The health board's CCTV policy follows the Information Commissioner's Office guidance set out in their 2017 CCTV Code of Practice.

Patient information

There were no notice boards on the walls, we were told by staff that these had recently been damaged and ward staff were waiting for estates to wall mount the notice boards. The health board must make sure that particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors.

We noted that there was no information displayed in the hospital to help patients and their families understand their care, nor details about organisations that can provide help and support to patients affected by mental health conditions. A small poster located near the nurses' station was on display with contact details for the Advocacy service. Staff told us that information on advocacy and other support networks were included in the patient information booklet, provided to patients on their arrival at the hospital. We were also told that the Advocacy service attends the hospital on a weekly basis. However some patients we spoke to showed limited understanding on the role of Advocacy or how to contact Advocacy if required. Therefore the health board needs to consider how to further support patients in understanding the role of Advocacy and how to contact them if they so wish.

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We also identified through conversations with staff and patients that there was limited understanding of the language line facility[4]. Knowledge and understanding of the function of language line is crucial in order to help patients and staff to communicate, and to ensure that patients are able to fully understand their rights and entitlements whilst at the hospital.

There was no information available on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales[5]. During the course of our inspection it was evident that staff working on the ward had limited knowledge and understanding on the role of HIW.

There was also limited information on health promotion displayed, and no information on smoking cessation or supportive groups for patients. Senior managers at the inspection feedback session confirmed notice boards were due to be reviewed and replaced.

There was no information displayed about how patients could raise a concern about their care which included NHS Wales Putting Things Right[6] arrangements. This policy was also outdated and had not been reviewed since October 2018. We spoke to staff about the outdated policies and we were advised that they were in the process of reviewing and updating policies.

It was positive to note that outside the ward there was a board which displayed photos of staff, these assist patients and visitors in identifying individual staff members.

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[4] If English isn't your first language, NHS Direct Wales can provide confidential interpreters, in over 120 languages within minutes of taking your call. https://www.nhsdirect.wales.nhs.uk/aboutus/languagetranslationservice/

[5] Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their families and carers. https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

[6] Putting Things Right is the process for managing concerns in NHS Wales. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

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Improvement needed

The health board must ensure that a range of information for patients is displayed on the ward that includes:

- The NHS Putting Things Right process
- Guidance around mental health legislation
- Healthcare Inspectorate Wales
- Healthy eating and well-being
- Advocacy Service
- Language Line facility
- Welsh language literature is available.

Communicating effectively

We attended a number of clinical meetings and it was evident that discussions focused on what was best for the individual patient. Where the patient was present at the meeting all staff engaged respectfully and listened to the patient's views and provided the patient with clear reasons for the decisions taken.

There were a number of meetings that involved patients and staff, this included formal individual care planning meetings and group community meetings. We saw a variety of meeting records during our inspection which demonstrated that regular staff meetings were taking place and information was being shared amongst the teams.

Staff and patients told us about the patients' council, this is a positive initiative where previous service users attend the ward and listen to patients' views to help improve the experience on the ward. The patients' council is a project facilitated by the Powys Association of Voluntary Organisations (PAVO) who provide anonymous feedback on behalf of the patients to the hospital staff and senior Powys Teaching Health Board staff. We saw evidence of regular patient meetings and it was pleasing to hear staff and patients speaking about the patient council in a positive way.

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Timely care

The ward held a bed status management meeting every Friday to establish the bed occupancy levels. Meetings were also held every Monday to discuss patients who had been placed in services in other health boards or independent providers. Bed state meeting are facilitated by Mental Health Services and the ward is part of this meeting along with all in-patient areas, and commissioned beds from Midlands Partnership NHS Trust.

As previously highlighted in this report we saw that there were more patients requiring inpatient care than beds available within the health board's provision. This was not an isolated incident and demonstrated that health board's adult mental health bed occupancy levels is regularly exceeding the number available.

Felindre ward has a designated Section 136 suite[7] which facilitates the south Powys area. The Section 136 suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite. We were also told that meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these meetings and fed back to staff from both organisations. Close partnership working with the police and effective use of the Section 136 suite is crucial to ensure that people presenting with mental health issues are getting the right care in the right setting.

Improvement needed

The health board must make sure they review the bed capacity and service provisions available for adult mental health services, to ensure it can meet the needs of its population in a timely manner.

[7] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety

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Individual care

People's rights

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation. However during the course of reviewing records we noted that there were no capacity assessments being recorded in patient records. Therefore, there was no record to determine if the patient had capacity to make informed decision around:

- Administration of medication within the ward environment
- Understanding the salient points of having been admitted onto a locked ward with all of its inherent restrictions.

Information was displayed on the wards to inform patients, who were not restricted by the Act[8], about their rights to leave the ward. This is an improvement since our previous inspection.

There were places for patients to meet with visitors in private. Any child visitors to the hospital needed to be pre-booked to ensure an appropriate room was available. The visiting rooms were very bland, unwelcoming and appeared very clinical. There was a lack of information for visitors and the visiting rooms were not inviting for any child visitors.

Improvement needed

The health board must:

- Ensure that capacity assessments are completed and recorded in patient records
- Improve the visitor facilities at the hospital to include information for visitors and make more welcoming for children.

[8] Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

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Listening and learning from feedback

There were regular patient meetings where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. Apart from the Patients' Council project, the ward had no structured processes for gathering feedback from patients and relatives and then reporting back what action had been taken.

Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately. The majority of complaints ward staff dealt with predominantly featured around lack of menu choices for people with specific dietary requirements. The health board also had a process in place where patients could escalate concerns via the health boards' Putting Things Right complaints procedure. Patients could also provide anonymous feedback and suggestions on improvements for the ward via anonymous forms placed in a suggestion box provided at patient's council meetings.

It was positive to note that there was a large display of thank you cards on display in the nurse's office.

Improvement needed

The health board must put a system in place for patients and relatives to provide feedback on the services received.

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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 were established processes in place to support staff to provide safe and effective care. We found that staff were completing clinical processes and documentation as required.

Legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation.

We found that emergency resuscitation equipment was being checked but these checks were not completed properly.

Safe care

During the course of our inspection we noted that there was damage to a fire door within the hospital, the window had been broken and boarded up. The integrity of the fire door was therefore compromised which would reduce the effectiveness of the fire door in the case of fire. This means that there is inadequate fire safety precautions within the hospital.

Our concerns regarding damage to the door were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Managing risk and promoting health and safety

The health board had undertaken significant anti-ligature refurbishment to mitigate the risk of patient self-harm. The May 2019 ligature risk assessment identified a ligature point within a communal area of the hospital. The recommended action was that this ligature point should be removed, but this had not occurred and was therefore a potential risk to patient safety. At the time of the inspection this room was only being accessed by staff whilst awaiting maintenance works, however this will not remain the case on completion of the

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required works. The health board should ensure that this ligature point is removed.

Access to the wards was direct from the hospital car park which provided suitable access for people who may have mobility difficulties. Entry to the mental health unit and ward was secure to prevent unauthorised access.

There were no nurse call points around the ward corridors, the bedrooms with en-suite bathrooms and the crisis beds did have nurse call point within the bathroom areas, however there were no nurse call points in the remaining patient bedrooms. If a patient was in difficulty or distress within their bedroom, then they could not attract the attention of staff promptly. This issue needs to be reviewed, to provide clarity on how a patient should call for assistance.

Staff had access to personal alarms to call for assistance if required. The alarm system was also linked to the community teams located in a separate area of the building. This meant if activated the community team would provide additional support if present at the hospital.

Strategies were described for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical restraint of patients was used, but this was rare and only used as a last resort.

The ward had a specific area for staff to redirect patients, to manage their challenging behaviours. The Extra Care Suite was used by staff to take patients who were in an agitated and distressed state in order to deescalate their behaviour. This suite enables staff to protect the patient's privacy and dignity and to prevent other patients becoming distressed.

There was no Psychiatric Intensive Care Unit[9] (PICU) at Bronllys Hospital. If a PICU was required then patients would be transferred to another service which

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[9] A Psychiatric Intensive Care Unit is an in-patient mental health ward that provides greater support and lower risk for patients with a more restrictive environment and increased staffing levels than an acute ward. PICUs are designed to look after patients who cannot be managed on acute psychiatric wards due to the level of risk the patient poses to themselves or others.

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provided this facility. Staff we spoke with did not raised any concerns about this arrangement.

Improvement needed

The health board must make sure that:

- The ligature points identified for removal are completed
- Patients can alert staff that they require assistance from their bedrooms.

Infection prevention and control

The health board employed dedicated housekeeping staff for the wards. Cleaning schedules were in place to promote regular and effective cleaning of the hospital, and staff were aware of their responsibilities around infection prevention and control. Staff had access to Personal Protective Equipment when required.

There were suitable arrangements in place for the disposal of waste. Appropriate bins were available to dispose of medical sharp items, these were not over filled.

No hand hygiene products were available at the entrance point of the hospital and we would recommend that hand hygiene products are available at this location.

We also noted that chairs located in the dining area were dirty and one was ripped. The chair must be replaced and the remaining chairs cleaned as they pose a risk of possible infection and present a risk to patient safety.

The aim is for the patient's length of stay to be as short as possible to manage the increased challenging behaviours and then returned to an acute ward as soon as their mental state has stabilised to what can be safely managed there.

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Improvement needed

The health board must make sure that:

- Hand hygiene products are available at the entrance point of the hospital
- Chairs are cleaned and the damaged chair is repaired or replaced.

Nutrition and hydration

Patients were provided with meals at the hospital, making their own choices from the hospital menu.

Two weekly menus were displayed on the ward. Some patients told us that it was difficult for them to access varied choices if they had specific dietary requirements.

We observed meals being served, and the dining room was clean and tidy and provided a suitable environment for patients to eat their meals.

As highlighted earlier, there was an occupational therapy kitchen, however this area had not been available for patients to use for preparation of their own food due to maintenance issues which remained unresolved.

Improvement needed

The health board must ensure it takes into consideration patients' needs and preferences when compiling menu choices.

Medicines management

Overall, we noted that medication was securely stored. The clinic room was locked to prevent unauthorised access, as were medication cupboards. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person. Medication fridges were locked when not being accessed. There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. The temperatures of medication fridges and clinic rooms were being monitored and

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recorded, to check that medication was stored within the appropriate temperature range.

There was a regular pharmacy input, and audits were undertaken which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The Medication Administration Records (MAR Charts)[10] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages, their Mental Health Act legal status, or physical health measurements, such as body mass index, weight or height. Staff were consistently recording the administration of medication, or the reason why it had not occurred.

We requested to view a selection of clinic room polices. We were provided with a range of policies, however, upon review most of the versions we received from the staff had passed their review date. The following policies were found to be out of date:

- Self-administration insulin – Review due date July 2017
- Venepuncture – Review due date March 2016
- Remote prescribing – Review due date November 2018
- Infection control – Review due date Feb 2016
- Transcribing/amending inpatient charts – Review due date July 2017
- Resuscitations policy – Review due date August 2017.

In addition to the above clinical policies the following policy had also passed its review date

[10] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

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- Reducing and managing inpatient falls – Review due date December 2018.

We were not assured that staff were obtaining or being provided with the most up to date guidance to direct their professional practice. The health board must make sure that all policies are updated and reviewed, and that the updated policies are removed.

Improvement needed

The health board must make sure:

- That all policies are reviewed and updated
- That there is a routine audit of policies to ensure that ward staff have access to, and are referring to, the most recent version.

Safeguarding children and adults at risk

There were established processes in place to ensure that the hospital safeguarded vulnerable adults and children, with referrals to external agencies as and when required. During discussions with the ward manager she clearly demonstrated her knowledge on what constituted a safeguarding referral. Staff we spoke to also demonstrated good knowledge and understanding of safeguarding concerns and the referral process.

Medical devices, equipment and diagnostic systems

There was emergency resuscitation equipment available, and it was easily accessible to staff, with evidence of checks being completed. However we identified that an oxygen mask was out of date in the resuscitation bag as of 7 August 2019. Documentation we reviewed showed that weekly checks had been undertaken but this issue had not been identified by staff. The health board should remind staff of the importance of undertaking these checks. This matter was immediately highlighted to the nurse in charge and the oxygen mask was replaced.

There were a number of ligature cutters located on the ward, for use in the event of a self-harm emergency. During the inspection all staff we spoke with were aware of the location of ligature cutters throughout the ward.

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Improvement needed

The health board must make sure checks on resuscitation and other medical equipment include reviewing the expiry date of individual items.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. However, as detailed within the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendix C.

Quality improvement, research and innovation

During our discussions with ward staff and senior managers, we were provided with numerous examples where they were reviewing the provision of service on the ward and the wider health board. This was to assist in the modernisation of care and implement innovation to develop the service and provide additional patient beds.

However, as stated under the timely care section of this report, the health board must review the current adult service model to ensure that the provision of inpatient mental health services meet the needs of the health board's population.

It was positive to hear from staff that there was a clear vision for the future of the hospital, however the health board needs to focus on investment and improvement on the current hospital environment before implementing the future vision.

Record keeping

Patient records were mainly paper files that were stored within the locked nursing office. We observed staff storing the records appropriately during our inspection.

Staff completed entries that were factual, and entries regarding patient daily routine was documented in detail, which provided clear information regarding each patient's care.

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Mental Health Act Monitoring

We reviewed the statutory detention documents of one patient.

In general the records were well maintained in both Mental Health Act administrator file and medical notes. The medical file were divided into appropriate sections which made it easier to navigate the folder and locate information. This was also the case with legal documentation papers.

The quality of information contained within the file was generally of a good standard. We did note that section 17 leave paperwork had not been signed by the patient to evidence that the patient understood their responsibilities and agreed conditions of leave.

Improvement needed

The health board must make sure that section 17 paperwork has been signed by the patient to evidence that the patient understands the agreed condition of section 17 leave.

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

We reviewed the care plans of a total of three patients. Each patient had an up to date Care and Treatment Plan (CTP) in place.

Patient records contained detailed care plans that support staff in providing care for the patients. Care plans included detailed assessments of needs and risk on admission and CTPs were reviewed in a timely manner at review meetings.

The Wales Applied Risk Research Network (WARRN) assessments provided good summaries of personal and historical factors associated with risk. However risk management plans were not personalised. This could result in potential triggers not being identified and warning signs not being clearly described. Interventions could be improved by considering the use of recognised rating scales for symptom severity, medication side-effects and approaches that improve the consultation process between health care professionals and patients. This would provide measures of improvement/relapse that would guide evaluation and CTP reviews.

We also noted that some patients refused to collaborate with their CTP and would not sign it. The CTP is the patient's own personal plan and offers an

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opportunity to promote engagement with care and treatment, exploring and including the patient's perspective as far as is possible. It is therefore important that any refusal by a patient to sign a plan is documented and the reason for refusal is recorded within the patients care notes.

Improvement needed

The health board must make sure that

- Risk management plans are personalised.
- The health board must make sure that any refusal by a patient to sign a plan is documented along with the reason for refusal.

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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.

The ward had effective processes and audit arrangements to support staff in maintaining safe and effective care.

There was passionate leadership, strong team working and motivated staff, who provided dedicated care for patients. Staff were positive about the support they received from their colleagues and management teams.

The health board must address the maintenance issues in the hospital environment to improve the quality of patient experience and staff well-being.

Governance, leadership and accountability

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. These arrangements were clearly defined during the day, with senior management and on-call arrangements in place for the night shift.

There was dedicated and passionate leadership from the ward managers who were supported by committed ward multidisciplinary teams and senior health board managers. We found that staff were committed to providing patient care to high standards.

Staff spoke positively about the leadership and support provided by the ward manager. Staff also commented that team-working and staff morale on the wards was good. During our time on the ward we observed a positive culture with good relationships between staff who we observed working well together as a team. It was clear to see that staff were striving to provide high levels of care to the patient groups to expedite recovery and minimise the length of time

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in hospital. This was supported by close and productive working with the respective community mental health teams.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Any use of restraint was documented.

There was a hierarchy of incident sign-off which ensured that incident reports were reviewed in a timely manner. Regular incident reports were produced and reviewed at hospital and organisation level so that the occurrence of incidents could be reviewed and analysed.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

It was disappointing to see that staff were working in an office environment with poor lighting. The ceiling lights in the staff office had broken due to a leak in the ceiling which had not been fixed. This, and other environmental issues commented on in this report, were having an adverse effect on staff well-being and morale.

Improvement needed

The health board must make sure that the ceiling and light is fixed in the staff office.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain the safety of patients within the hospital at the time of our inspection.

Staff evidenced strong team working and appeared motivated to provide dedicated care for patients. Staff we spoke with were positive about the support they received from colleagues, and leadership by their managers.

We saw evidence of staff annual appraisals in staff files. These appraisals provide staff with a platform to discuss their employment and professional development and an opportunity for managers to give feedback to staff about

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their work. Some staff told us that it was difficult to plan supervision and often this would be rushed or cancelled due to the demands of the ward. The health board must devise a solution to ensure that regular supervision can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

Whilst there were a number of registered nurse vacancies, there was evidence that the health board was attempting to recruit into the vacancies. The occupational therapist was due to commence employment in December and the current nurse vacancies had been advertised. It was positive to note that the hospital were in the process of forging links with universities and colleges to help support the recruitment process. Staff told us that there have been instances where staff have been successfully offered positions but due to delays with the pre-employment checks, the individuls have sought employment elsewhere. The health board needs to review their pre-employment track system and ensure that there are no unnessecary delays in the appointments of new staff.

Where possible the ward utilised its own staff and regular staff from the health board's staff bank to fill these shortfalls. Any agency staff would have an induction at the beginning of every shift. It was positive to note that staff were undertaking additional shifts to assist in fulfilling rotas to maintain continuity of care. We reviewed staff rotas and spoke with the ward manager who confirmed that additional shifts were being monitored to prevent staff working excessive hours which may lead to fatigue.

The training information we reviewed, showed that staff were expected to complete mandatory training on a range of topics relevant to their roles. Training compliance was regularly monitored to ensure compliance was maintained. Mandatory training compliance was regularly monitored and overall compliance was in excess of 80 percent, and there were clear actions evident for addressing any outstanding training requirements. Staff also commented favourably on the opportunities to attended additional training and conferences relevant to their roles.

Health Care support workers were trained to undertake general medical checks such as taking blood and ECG readings, this training enabled the health care support workers to provide additional support to the nurses. In addition one member of staff was being supported to complete an advanced nurse practitioner qualification.

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Improvement needed

The health board must make sure that

- Processes are in place to ensure regular supervision takes place between staff
- No preventable delays are incurred during pre-employment checks
- Staff vacancies are filled and future initiatives are explored to encourage recruitment into the hospital.

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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.

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5. How we inspect NHS mental health services

Our inspections of NHS mental health services 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.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

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

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Appendix A – Summary of concerns resolved during the inspection

The table below summaries 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
Oxygen mask stored in emergency equipment had expired in August 2019, however weekly checks undertaken by staff had failed to identify that the oxygen mask was out of date.	This could affect patient safety.	This matter was immediately brought to the attention of nurse in charge.	Oxygen mask was disposed of and immediately replaced. Management will ensure staff are more diligent and accountable when undertaking checks on medical equipment.

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Appendix B – Immediate improvement plan

Service: Bronllys Hospital

Ward/unit(s): Felindre Ward

Date of inspection: 18 – 20 November 2019

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	Responsible officer	Timescale
The inspection team considered the arrangements for maintain the safety of patients, staff and visitors. There was damage to a fire door within the hospital, the window had been damaged and boarded up. Due to the damage to the window the integrity of the fire door was compromised which would reduce the effectiveness of the fire door in the case of fire. This means that there is inadequate fire safety precautions within the hospital.	2.1	The door was identified as Door No. 008. The vision panel was boarded over after having been damaged by a patient. The half leaf was also damaged and split. As an urgent action, the estates team will be replacing the glass in the vision panel, and replacing the half leaf door. Both the replacement glass and the replacement ½ leaf door have been ordered via the	Joy Garfitt Assistant Director of Mental Health Services	Glass replacement to be completed by w/e 21-12-19 ½ Leaf door replacement to be completed by 18-1-20

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Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that all damages are free from faults and any repairs are completed immediately.		supplier and installation will be completed by 18th January 2020, as a bespoke replacement door requires manufacture.		

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Appendix C – Improvement plan

Service: Bronllys Hospital

Ward/unit(s): Felindre Ward

Date of inspection: 18 – 20 November 2019

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	Responsible officer	Timescale
Quality of the patient experience				
The health board must make sure immediate repairs are undertaken to the roof and ceiling in the occupational therapy kitchen.	1.1 Health promotion, protection and improvement	The Mental Health Service has liaised with the Estates service to order the repairs to the roof and the works to the roof are part of the Mental Health Estate improvement plan.	Assistant Director for Estates	March 31st 2020
The health board must make sure that the lights in the games room are fixed.	1.1 Health promotion, protection and improvement	Repairs to the games room lights were on the Estates work plan prior to the inspection and have now been completed.	Assistant Director for Estates	Complete

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Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must make sure that the broken window in the recovery room is replaced.	1.1 Health promotion, protection and improvement	These works were on the Estates work plan prior to the inspection and the repairs have now been completed	Assistant Director for Estates	Complete
The health board must make sure that patients have the opportunity to participate in activities whilst on the ward.	1.1 Health promotion, protection and improvement	Band 6 OT has commenced in post. She is in the process of planning new activities. Nurses and HCSW all undertake activities with patients and these will continue.	Ward Manager	February 14th 2020
The health board must consider alternative options for the provision of smoking	1.1 Health promotion, protection and improvement	A smoking shelter for the garden has been ordered. Following its installation, the 'smoking room' will be refurbished to become a gym for patients use.	Assistant Director Mental Health	June 30th 2020
The health board must consider options on ensuring staff can check on the well-being of patients with minimal disruptions.	4.1 Dignified Care	This is currently under consideration and options for the replacement of all bedroom doors is being considered.	Ward Manager Assistant Director for Estates	June 30th 2020
The health board must ensure that a range of information for patients is displayed within the wards that includes:	4.2 Patient Information	Replacement notice boards have been received and we are awaiting the maintenance to fit and secure these in place. These notice boards will then contain	Assistant Director for Estates Ward Manager	January 31st 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
• The NHS Putting Things Right process • Guidance around mental health legislation • Healthcare Inspectorate Wales • Healthy eating and well-being. • Advocacy Service • Language Line facility.		the following information; • The NHS Putting Things Right process • Guidance around mental health legislation • Healthcare Inspectorate Wales • Healthy eating and well-being. • Advocacy Service • Language Line facility • Patient Art work		
The health board must review the bed capacity and service provisions for adult mental health services, to ensure it can timely meet the needs of its population.	5.1 Timely access	It should be noted that in addition to Felindre Ward, PTHB commissions beds from Midlands Partnership Trust and this is the pathway for North Powys Patients. When Midlands partnership is unable to accommodate North Powys patients, patients are admitted to Felindre Ward or other local private	Assistant Director Mental Health	30th May 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
		providers. Older or Frailer functional patients are also admitted to Clywedog Ward in Llandrindod on a case by case basis, depending on acuity levels. Over the winter period (January – March 20) Felindre ward will be increasing beds from 14 to 18 beds. The success of this trial will be monitored and a decision taken in Spring whether to continue the arrangement for additional bed capacity.		
The health board must make sure that capacity assessments are completed and recorded in patient records.	6.2 Peoples rights	Capacity is assumed as guidance directs and this is recorded on the patient weekly pro-formas.	Clinical Director/Ward Manager	Complete
The health board must put a system in place for patients and relatives to provide feedback.	6.3 Listening and Learning from feedback	Patients Council is held monthly and patients are given a pre-discharge questionnaire which is uploaded onto FOC. We are in the process of developing a feedback system for relatives that will work alongside the patient feedback system.	Ward Manager	March 31st 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board must make sure that the ligature point identified in the May audit is removed.	2.1 Managing risk and promoting health and safety	The risk has been removed.	Estates	Complete
The health board must make sure that hand hygiene products are available at the entrance point of the hospital.	2.4 Infection Prevention and Control (IPC) and Decontamination	Hand Hygiene system has been ordered through the FM facts system.	Facilities Team/ Ward Manager	January 31st 2020
The health board must make sure that the chairs are cleaned and damaged chairs are replaced in the dining area.	2.4 Infection Prevention and Control (IPC) and Decontamination	Replacement furniture has been ordered.	Ward Manager	March 31st 2020
The health board must make sure that all policies are reviewed and updated.	2.6 Medicines Management	We are in the process of developing a tracking system that will enable the recognition of policy review date and when action is required	Head of Nursing Quality and Safety	March 31st 2020
The health board must ensure there is a routine audit of policies to ensure that ward staff have access to, and referring to the most recent version	2.6 Medicines Management	We are in the process of developing a tracking system that will enable the recognition of policy review date and when action is required	Head of Nursing Quality and Safety	March 31st 2020

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Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must make sure checks on resuscitation and other medical equipment include reviewing the expiry date of individual items.	2.9 Medical devices, equipment and diagnostic systems	We have put in place a daily checking system to include medical equipment.	Ward Manager	In place and ongoing
The health board needs to focus on investment and improvement on the current hospital environment before implementing the future vision.	3.3 Quality Improvement, Research and Innovation	A paper on capital investment within Mental Health (including Felindre Ward) will be prepared for consideration at Executive Committee.	Assistant Director of Mental Health Assistant Director of Estates	June 2020
The health board must make sure that risk management plans are personalised.	3.5 Record keeping	Ward Manager will quality control Risk assessment as part of the WARRN. All Staff involved in completing WARRN will continue to receive training	Ward Manager Service Manager	June 2020
The health board must make sure that any refusal by a patient to sign a plan is documented and the reason for refusal is recorded.	3.5 Record keeping	Through supervision, ensure ward staff clearly document any refusal and reasons for this in patient records.	Ward Manager	Complete.
The health board must make sure that section 17 paperwork has been signed by the patient to evidence that the patient understands the agreed condition of section 17 leave.	Application of the Mental Health Act	Actioned as part of CTP/MDT reviews.	Clinical Director/Ward Manager	Complete

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Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must make sure that the ceiling and light is fixed in the staff office.	Governance, Leadership and Accountability	This repair is on the FM facts system and we are awaiting the repair of the roof.	Assistant Director of Estates	March 31st 2020
The health board must make sure that regular supervision takes place between staff.	7.1 Workforce	Ward Manager keeps an audit of all staff supervisions which are completed on a monthly basis.	Ward Manager	Complete
The health board must make sure that no preventable delays are incurred during pre-employment checks.	7.1 Workforce	This has been raised with WOD colleagues via Senior Management Team for feedback to Shared Services	WOD Business Partner	March 31st 2020

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): Joy Garfitt

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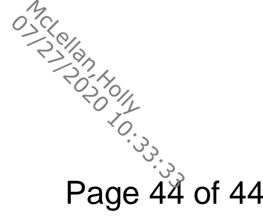
Job role: Assistant Director for Mental Health

Date: 3/1/20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Agenda item: 3.6

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 30 July 2020**
Subject :	**Annual Quality Statement**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan Assistant Director Quality & Safety
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:		
This report provides 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.		
RECOMMENDATION(S):		
The Committee is asked to NOTE and DISCUSS the Annual Quality Statement, prior to reporting assurance to the Experience, Quality and Safety Committee the Annual Quality Statement 2019/20 is being progressed and is on schedule for approval and publication no later than the 30 September 2019.		
Approval/Ratification/Decision	**Discussion**	**Information**
✗	✓	✗

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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 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 AQS first draft is now in place albeit a few additions are required to complete. Engagement and feedback are in progress to inform its development and comments will be considered in early August, the intention to complete by mid-August.

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DETAILED BACKGROUND AND ASSESSMENT:

Background

The *Welsh Health Circular (WHC) (2019) 042 Annual Quality Statement 2019/20 Guidance* published 23 December 2019 (see **Appendix 1**) sets out what the annual quality statement is and provides a template for production. As is noted the WHC is not dissimilar to previous years but it does set out that the AQS will be changing in future years mindful of the fact the Health and Social Care (Quality & Engagement) (Wales) Bill, anticipated Summer 2021, will include a new, broader duty of quality which requires NHS bodies in Wales to exercise their functions with a view to securing improvement in the quality of health services. The Bill contains annual reporting requirements which require NHS bodies to assess the extent to which the steps they have taken to comply with the new duty of quality have led to improvements in outcomes.

It is noted this new reporting requirement will build on and replace the existing AQS to form the basis of the mechanism through which the duty will be reported.

Developing the AQS

This is the eighth edition of the Annual Quality Statement.

The AQS focuses on looking back at the previous year to see what has been achieved and a forward look using the data and information available. The WHC provides a range of questions focussing on standards and patient experience across patient pathways to guide its development with examples of initiatives or work in specific areas cited for inclusion.

AQS Publication Date

In late March 2020, as a result of the Covid-19 pandemic arrangements and the shift from essential work, Welsh Government changed the publication date for the AQS from 31 May 2020 to 30 September 2020, reflecting the immediate impact of the Covid-19 pandemic situation at that time. At this point in time, work on the AQS stopped, restarting in mid-July.

Draft Annual Quality Statement

The draft AQS is available at **Appendix 2**.

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Engagement and Feedback

The AQS is only now at the stage of being shared. Comments will be considered in early August, the intention to complete by mid-August.

Action is currently progressing to share the draft AQS with the:

- Patient Groups
- Older People's Commissioner for Wales
- Children's Commissioner for Wales
- Community Health Council

Assuring the Content of the Annual Quality Statement

Internal Audit have made contact to progress activity to provide an opinion on the information published to ensure it is both accurate and representative of the quality of services provided and the improvements it is committing itself to within Powys.

In 2019/20 Internal Audit recommended (medium level priority within one month):

'To strengthen the information/evidence gathering process it is recommended that the Patient Experience Steering Group is considered as the editorial forum for the AQS, with AQS being a standing agenda item.

Nominated officers for each Directorate should be responsible for ensuring that evidence is collated and provided at the same time the narrative / data is submitted for inclusion in the AQS.

Nominated officers should ensure that staff within their Directorate are aware of what constitutes satisfactory evidence, and where appropriate, challenge evidence prior to submission.'

It was agreed the Patient Experience Group be used as the fora to discuss the draft AQS with members assisting with the shaping of the document. Further that individual Directorates had identified 'AQS Leads' and they would work to continue to ensure any information submitted for the AQS was appropriately evidenced.

The AQS became a standard agenda item on the Patient Experience Steering Group (PESG) meeting going forward, although the current timetable for the PESG meetings were suspended from February 2020, the next meeting scheduled for August 2020.

The development of the AQS has continued outside of the meetings.

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Timetable

The WHC provided guidance on providing timely data to meet publication deadlines aimed at the original publication date. Since the change in date for publication to the 30 September, full year data where available, has been used.

NEXT STEPS:

1) To present the Annual Quality Statement 2019/20 to the Experience, Quality and Safety Committee to provide assurance on its development and publication no later than the 30 September 2019.

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ANNUAL QUALITY STATEMENT 2019-2020

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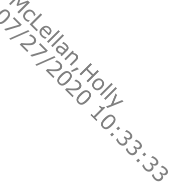

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INTRODUCTION

We are pleased to present our Annual Quality Statement for 2019-2020. The statement is about the quality of services provided by Powys Teaching Heath Board, recognising our purpose is to help improve the health and wellbeing of the people of Powys and to secure and provide excellent healthcare services.

Quality is described as a watchword in the NHS and is a clear expectation in a '*A Healthier Wales: our Plan for Health and Social Care'* (Welsh Government, 2018). It is emphasised how our Integrated Medium-Term Plans must continue to build on the opportunities presented by '*A Healthier* Wales' and demonstrate a truly integrated planning approach that links local population need to quality, service delivery and outcomes, ensuring quality and safety across all services. Some of the challenges that face the NHS can only be addressed sustainably through transformation and collaboration and as public bodies we have a role, collectively and individually, to respond to the wider remit within the Well-being of Future Generations Act.

We have through the Powys Health and Care Strategy 'A Healthy, Caring Powys' made a clear commitment to high quality services and positive patient and citizen experience. We recognise our approach to working with citizens, patients and carers is key in our efforts to improve services, experience and outcomes of care and treatment and this is further signalled through the health board's Integrated Medium-Term Plan 2020/2021 to 2022/2023.

Quality has been set as a key priority that must underpin all aspects of services, settings and contacts with the NHS in Wales. Ensuring quality is in everything that we do, the '*NHS Wales Planning Framework 2020/23'* (Welsh Government, 2019) makes clear how services should be developed to ensure quality is in all aspects of care, pathways and workforce planning and delivery.

The new Health and Social Care (Quality & Engagement) (Wales) Bill is coming in the next year and will include a new, broader duty of quality whereby NHS bodies will have a duty to secure quality in health services, whatever the setting. As a provider and commissioner of secondary and more specialist services we recognise the need to put and keep in place the arrangements for monitoring and improving the quality of the health care provided. In January 2020, we approved our Clinical Quality Framework the purpose of which is to realise the vision of '*Systematic, clinically-led, continuous and sustained, year-on-year improvement in the quality of clinical care provided by Powys Teaching Health Board.* This provides a toolkit of improvement methodologies for use across the health board and in partnership with our key stakeholders and offers a framework to further improve and assure the quality of Powys Teaching Health Board clinical

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services. Further work will be completed during 2020-2021 to ensure that the current Powys Teaching Health Board Commissioning Assurance Framework and associated performance monitoring arrangements are reviewed to ensure full alignment to the clinical quality framework described.

The latter part of 2019/20 saw the coronavirus (Covid-19) pandemic impact world-wide which resulted in stopping of essential services in order to respond. Preparatory work commenced with pace with changes in service delivery, responding to national guidance and ensuring all safety measures were in place for staff and patient safety. Staff were redeployed into new roles and a new clinical model was outlined for responding to coronavirus (Covid-19) in conjunction with partners both inside and outside the county in order to make this happen. The way in which services were delivered and how people worked to support the clinical model was swiftly enacted and the feelings of overwhelming pride for everyone in their response during this uncertain time were immense. Thank you to our staff, patients and partners for supporting this initial call to action.

Carol Shillabeer, CEO, Viv Harpwood, Chair

Chair of Quality and Safety Committee – Melanie Davies Vice-Chair

Executive Director of Nursing & Midwifery – Rhiannon Jones (April 2019-July 2019) Katrina Rowlands *(interim August 2019-January 2020)* and Alison Davies *(from January 2020)*

We are pleased to present Powys Teaching Health Board Annual Quality Statement for 2019-2020.

If you would like more information about patient experience and the quality and safety of our services the Experience, Quality and Safety Committee papers can be accessed online at: www.powysthb.wales.nhs.uk/experience-quality-and-safety-committee

You can access our:

Health and Care Strategy at www.powysthb.wales.nhs.uk/document/312141
Integrated Medium Term Plan (IMTP) at www.powysthb.wales.nhs.uk/strategies
Clinical Quality Framework at www.powysthb.wales.nhs.uk/board-meeting-29-january-2020

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Health Board Profile

The health board is responsible for improving the health and well-being of approximately 133,000 people living in Powys. Powys covers a quarter of the landmass of Wales, but with only 5% of the country's population – it is a very sparsely populated and rural county. Geography and rurality make access a challenge, with residents of the county accessing acute hospital care from 15 providers around its borders across Wales and England. This requires the health board to be innovative and creative to ensure timely access to high quality services to meet people's needs.

The needs of our population differ to the rest of Wales, people are older and the working age adult population is smaller. It is predicted that there will be:

- 8% decline in population by 2039
- 15% Population aged 15 and under
- 59% Population aged 16 to 65
- 26% Population aged 65 or over

The number of young people and those under 65 will decrease while older adults will increase
44% increase of people with dementia
83% report they feel they belong to their local area (Wales 75%)
For a full analysis of our Wellbeing Assessment visit: https://en.powys.gov.uk/article/5794/Full-Well-being-assessment-analysis

Primary and Community Care

Care is also provided through our primary care contractors. The health board directly provides healthcare services through its network of community services and community hospitals. There is also provision of an increasing range of consultant, nurse and therapy led outpatient sessions, day theatre and diagnostics in community facilities, bringing care closer to home.

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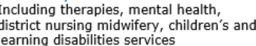
General Practice
16 practices providing general and extended services and managing inpatient beds

Community Hospitals
Providing a wide range of outpatient, inpatient, mental health inpatient, diagnostic and theatre services



Community Services
Including therapies, mental health, district nursing midwifery, children's and learning disabilities services

Community Pharmacy
Dispensing and supporting medicines management in care home, home, GP and community hospital settings

Eye Care
Primary care optometry and accredited optometrists providing out of hospital services

Community Dentists
General dental services and more immediate and specialist procedures and services

Commissioned Services

We buy in services on behalf of our residents from other health boards and NHS Trusts in Wales and England. The health board budget is around £300 million a year; with 50% spent on services that we commission; 30% on directly provided services and 20% on primary care. For more information see our IMTP at www.powysthb.wales.nhs.uk/strategies

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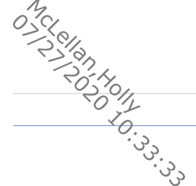
STAYING HEALTHY

Staying healthy physically can help you stay healthy emotionally too. Through our Health and Care Strategy www.powysthb.wales.nhs.uk/document/312141 our focus is to promote, support and facilitate the physical and mental well-being of people in Powys to reduce avoidable ill-health and enable the people of Powys to effectively manage their health.

We said...	Target	How we did
Provide effective stop smoking services	• Percentage of current smokers treated by NHS smoking cessation services. • Percentage of treated smokers' carbon monoxide validated as successfully quit at 4 weeks.	***Public Health Data requested***
Keep smoking prevalence below 2016 target levels.	• Self-reported smoking status (via National Survey for Wales)	***Public Health Data requested***
Improve flu vaccination uptake	Percentage uptake in: • Over 65yrs. • Under 65yrs "at risk". • Pregnant women. • Healthcare staff.	No statistics available for 2019-20
Maintain childhood vaccination uptake	• Percentage of children who receive 3 doses of the hexavalent '6 in 1' vaccine by age 1yr. • Percentage of children who receive 2 doses of the MMR vaccine by age 5yrs.	No annual statistics but most recent data for Jul-Sept 2019: • 96.4% 3 x 6 in 1 by age 1yr • 93.3% of 2 doses of MMR by age 5 years



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Quality Assurance project leads to increases in recorded vaccination uptake

A quality assurance project on COVER data, a long-established vaccine coverage collection that has been running since 1987, has recently been completed in Powys which has led to improvements in the accuracy of COVER data and increases in recorded vaccine uptake in Powys and across Wales.

This was a joint project between the health board, Powys Local Public Health, the Public Health Wales Vaccine Preventable Disease Programme Team and NHS Wales Informatics Service. It was undertaken in response to concerns that local data didn't appear to match the national COVER data along with national concerns about declining uptake of three doses of "5 in 1" vaccine at age five despite uptake of three doses of "5 in 1" vaccine at one year of age being above 95% for over ten years. This provided an opportunity for an in-depth evaluation of the quality of the COVER data compared to local data and to develop methods for repeating the audit in other areas of Wales.

The findings showed a high degree of agreement between local and national data for one and two-year old's and for older children when measured close to the time of vaccination. However, the project identified a systematic difference affecting the reported coverage of some vaccines in children who had moved between areas, meaning the way the vaccine records were set up meant that vaccination records for children who had moved between areas, was limited to data for the two years prior to their move. As a result, although the local records contained a full history for these children, records for vaccinations given prior to two years before a child moved area were not included leading to an underestimation of uptake of some vaccines in the COVER reports.

When the discrepancy was corrected an increase was seen in the uptake of some vaccines for children aged over four. The charts show a summary of the COVER data for the period October-December 2018 before (figure 1) and after (figure 2) the changes were made. These show that the recorded uptake of MMR2 at 5 years increased by 3.8 percentage points from 87.1% to 90.9%, moving this "tier 1" indicator from red to amber. An even higher increase was seen amongst 16 years where recorded uptake increased from 77.4% to 87.9% (10.5 % percentage points).

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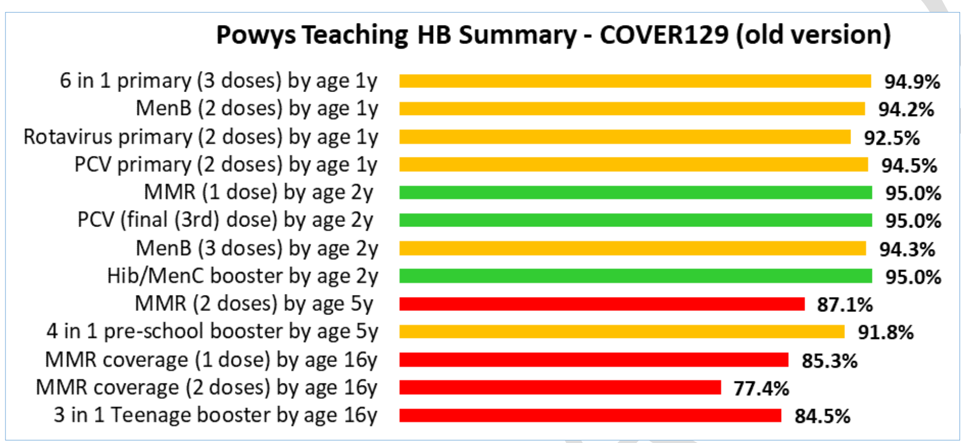
This work has improved the completeness and accuracy of COVER data in Powys and across Wales and will be used to inform ongoing local work to ensure that local data is as accurate and timely as possible and to improve uptake of childhood vaccinations.

Figure 1: Summary of COVER data for Powys for the period October to December 2018 (COVER report 129) before correction of algorithm



Source: Public Health Wales, Vaccination Preventable Disease Programme

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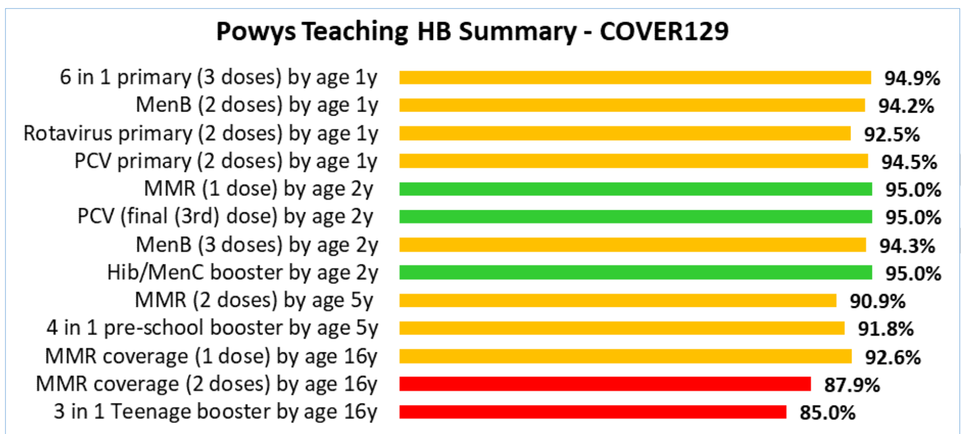
Figure 2: Summary of COVER data for Powys for the period October to December 2018 (COVER report 129), after correction of algorithm



Source: Public Health Wales, Vaccination Preventable Disease Programme

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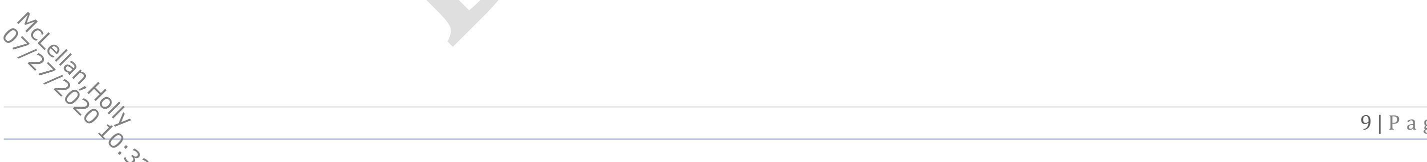
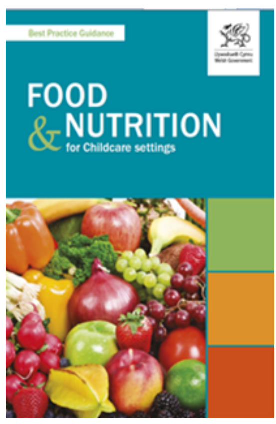


Bach a Iach and Dietetics working together to promote healthy eating for pre-school children



Welsh Government's best practice Guidelines Food and Nutrition for Childcare Settings was published in November 2018. Bach a Iach (Small and Health) initiative (part of the Powys Healthy Pre-school Scheme) is named as an example of good practice model in this guidance and in 2019, Powys Healthy Schools and Dietetics teams worked together to promote the guidance to local pre-school settings.

This work built on the strong links between the Healthy Schools Team and local pre-school settings that have been developed over recent years through Bach a Iach, and the close working partnership between Bach and Iach and Dietetics.

The teams worked together to develop bespoke training for pre-school settings. Three training sessions were delivered across Powys by a Dietitian and were attended by 35 staff from 22 pre-school settings. Hard copies of the guidance were also printed and distributed to the settings.

The training and resources received good feedback and it was encouraging to hear staff planning to cascade the learning to their colleagues and to parents. 65% of staff who attended the training said that they planned to make changes to improve the menu in their childcare setting.

Of those who attended only 18% reported any previous formal nutrition education and 83% were interested in receiving further nutrition training. 46% reported that they were already aware of the new guidance but only 37% said that they had been using it prior to training.

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Children develop their eating habits at a young age and early years settings are ideally placed to promote healthy eating messages. This work shows that preschool settings are keen to positively influence children's eating habits. Further sessions are planned to meet demand from those who were unable to attend the first run and two Community Food and Nutrition Skills for the Early Years courses are planned in the new year to further develop the skills of pre-school staff.

Bach a Iach won the 'Early Help and Support' Award at the Powys Teaching the health board's 2019 Excellence and Long Service Awards ceremony, and the 'strong partnership working' between Community Dietetics and the Healthy Pre-Schools Team was highlighted.
Bach a Iach was also invited to present at the Public Health Wales Annual Conference (October 2019).

Following the phased implementation of the **Midwife-led influenza immunisation** in Powys last year, whereby pregnant women were being encouraged to access their flu vaccine from the midwives, it is anticipated if the phased implementation is successful, midwives will become the default provider for flu vaccination of all pregnant women across Powys from 2019/20 flu season.

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2 SAFE CARE

We said…	Target	How we did
We will improve the management of urinary tract infections and catheter usage	• Reduction in the number of catheter associated urinary tract infections • Reduction in the number of catheters in use	The catheter passport was used from January 2020. Catheter usage prevalence for February 2020 was 22.5%, a reduction from 25% reported in 2018.

Nutrition and Hydration

Food Supply

Work is completed to ensure that all purchases for the health board are made through the NHS procured supply chain which ensures value for money, effective food screening and ethical purchasing.

Site	Current Food Hygiene Rating
Bronllys	4
Brecon	5
Knighton	5
Llanidloes	5
Llandrindod	5
Machynlleth	4
Newtown	5
Welshpool	5
Ystradgynlais	5

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Food Hygiene

We aim to achieve a Level 5 food safety award at each of our nine kitchens. Of these seven currently have a rating of Level 5, the remaining two have a rating of Level 4. We apply a zero tolerance to any shortfalls found in the safe delivery of catering and are responding robustly where we have less than optimal rating, in close collaboration with our Environmental Health and Infection Control partners, and also in the areas where we need to maintain a rating of Level 5.

International Dysphagia Diet Standardisation Initiative (IDDSI)

Powys Teaching Health Board have implemented the IDDSI guidelines, which were founded with the goal of developing new global standardised terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures. We have trained 122 members of ward and catering staff over 18 training sessions across 9 sites in Powys, with 99% of participants reporting that their expectations of the training were met. New patient menus have been developed and implemented to reflect the changes.

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NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP)

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

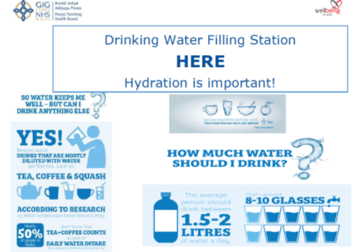
*Date_____ Height _____ m Weight______ kg (on admission) *BMI ____kg/m²
(state if this is **M**easured, **R**eported, **E**stimated, or **U**nable to weigh and record reason in notes)

Category								
	Date		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	Time (24hour clock)		HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM
	Weight (kg) / indicate reason if no weight							
Weight (consider fluid retention when assessing weight history)	Weight loss of 6 kg or more (1 stone) within last 6 months, extremely thin or cachexic, *BMI < 18.5 kg/m²	**7**						
	Unintentional weight loss 3kg (7lb) within last 6 months	**2**						
	No weight loss	**0**						
Appetite (current)	Little or no appetite or refuses meals and drinks	**4**						
	Poor – eating less than a quarter (1/4) of meals and drinks	**3**						
	Reduced – eating half of meals	**1**						
	Good – eats 3 meals/day or is fully established on tube feed	**0**						
Ability to eat (current)	NBM for more than 5 days	**7**						
	Unable to tolerate food via gastrointestinal tract due to nausea or vomiting, constipation or diarrhoea, difficulty chewing/swallowing due to dysphagia or mucositis	**4**						
	Requires prompting, encouragement or assistance to eat and drink	**1**						
	No difficulties- able to eat and drink normally and independently	**0**						
Stress Factor (if clinical condition is not listed, choose a similar condition)	Upper GI cancer – pre/post-surgery, extensive bowel resection/high output stoma/fistula. Head &neck cancer surgery, kidney & pancreatic transplant BMT, 20% and above mixed depth burn	**7**						
	Moderate surgery e.g. cardiothoracic, kidney transplant, vascular Malignant disease, with complication e.g. infection. Recent multiple injuries e.g. spinal injury/trauma, head injury, GBS Uncomplicated bowel surgery, decompensated liver disease Acute kidney injury, renal replacement therapy (HD/PD) Severe infection, sepsis, endocarditis, pneumonia, peritonitis Acute and chronic pancreatitis, HIV, 15-20% mixed depth burn	**4**						
	MND, MS, Parkinson's, dementia, heart failure, COPD, CVA Fractured neck of femur, inflammatory bowel disease	**2**						

The health board has rolled out the new **All Wales standardised nutritional risk assessment** in October 2019. The Adult Nutritional Risk Screening Tool (WAASP) has been validated as the tool for inpatient use whilst the Malnutrition Universal Screening Tool (MUST) will remain in use in the community setting.

Drinking Vessels and \Nutritional Drinks:
The number of coloured glasses on the wards have been increased. It has been recorded that that patients drink more from a coloured glass rather than a clear one. As well as using coloured glasses, ward staff have access to nutritional drinks which include milk shakes, to encourage the fluid intake of patients, particularly in hot weather.

The **Water Safety Group** remit is to maintain the safety of water supplies across the health board; this includes drinking water, ice cubes, showers, sinks and baths and ensures that patients and staff have access to safe water.



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Staff and Visitors Menus

Staff menus have been aligned with the new NHS Wales-wide patient menu, reducing cost and waste and improving nutritional and dietary standards.

Digitisation of Nursing Documentation – In-Patient Wards

This is the national project aimed at changing the documentation nurses are required to complete every day. The project focused to design, develop, pilot and implement e-nursing documents across Wales. The aim is to release nurses from the administrative burden of completing paper documents in order to spend more time on direct patient care. Since last year, the health board has appointed into a full time substantive Senior Nurse Clinical Informatics role as their representative on clinical digitalisation projects.

The inpatient e-documentation project indicated as taking place in June 2019 will be taking place on Y Bannau ward in March 2020. The aim of the project is to make patient's information more accessible, cutting down on duplication, streamlining the admission process and giving nurses more time back at the bedside. The vision to implement consistent information across Wales has been well received in Powys and core risk assessments have been imbedded in adult in-patient wards. Alongside this Y Bannau ward are about to trial a new electronic bed management system which aims to save resources, administration time and duplication whilst providing a clear and up to date view of bed capacity across the organisation.

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Safeguarding the people of Powys is at the heart of all the care and services we deliver. If we are concerned about a person's wellbeing and/or safety we aim to work with people, their families and carers to encourage them to make their own decisions with clear information. Safeguarding people is the responsibly of all our employees, at times who have a duty to share information and work with our statutory partner agencies to promote, support and offer solutions that are tailored to your needs and based on best practice.

We work openly and transparently learning lessons to improve care from local and national reviews. Our staff have access to safeguarding training, support and supervision from a specialist team in our health board, all our work is guided by local and national polices

Maternity Assurance Framework

In response to the Royal College of Obstetricians and Gynaecology and Royal College of Midwives Independent Review of Maternity Services in the former Cwm Taf University Health Board published on 30th April 2019 (https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board) Powys Teaching Health Board acted to review maternity services provided and an approach was taken to assess the health board as a whole, rather than just look at maternity and midwifery services.

The quality and safety of midwifery-led care provided in Powys was considered to be of a good standard. Areas for improvement were highlighted within provided services, namely, information analysis and intelligence reporting, Clinical Quality Review Meetings with our 15 NHS providers, concerns management, risk management, clinical audit and Board development, plus a great area of focus related to commissioned services. The full report can be found at www.powysthb.wales.nhs.uk/2019-20-eqs-2-4-june-2019.

The latest update report on maternity services for 2019/20 can be found at www.powysthb.wales.nhs.uk/2019-20-experience-quality-safety-commit-2

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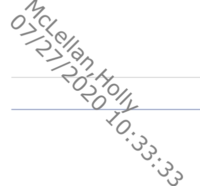

Medical Equipment and Devices

Work has taken place over the last year to improve the management of medical devices for patient safety. Key actions taken includes:

- Policies for the effective management of medical devices approved and in place.
- The development of an asset management system to handle, for example, service scheduling and creating a central medical device replacement programme.
- Working with service leads to ensure effective ordering and processing of equipment and devices in conjunction with procurement colleagues.
- Carrying out spot checks on how medical devices and equipment is stored in wards and departments resulting in action being taken to address poor storage conditions of some equipment/devices, the cleanliness of devices and equipment and security of equipment.
- Replacement of devices health board wide including patient hoists, electrocardiogram (ECG) machines and patient baths and staff training provided in their use.

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3 EFFECTIVE CARE

We said…	Target	How we did
We will progress the implementation of the Neighbourhood Nursing Pilot	• Reduction in hospital admissions • Reduction of length of stay in hospital	The overall number of admissions for this financial year is lower than when compared to the same quarter for the previous financial year (Figure 1).

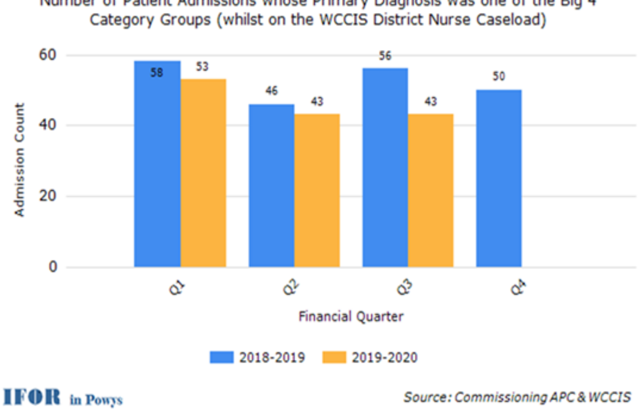

Figure 1: Chart showing overall number of admissions

The Chart below (Figure 2) does look more specifically at the diagnosis category for the emergency admission, and this does show some slight variations per quarter for the number of admissions.

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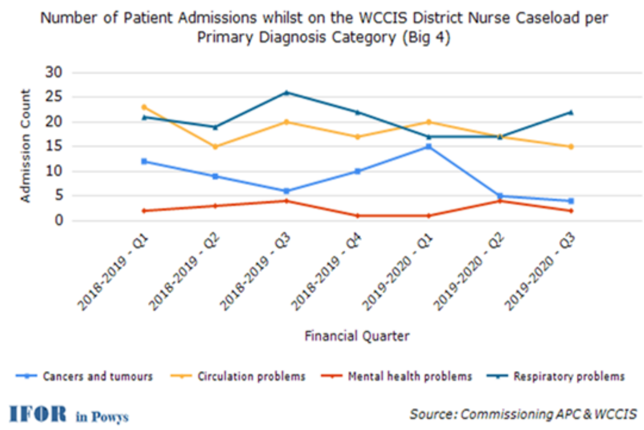

Figure 2: Chart showing diagnosis category for number of admissions

The Chart (Figure 3) shows the average length of stay based on the emergency admissions during each financial quarter. Mental Health does appear to be the one where length of stays are longer but the number of admissions with this diagnosis category are small so there is more of an impact on the average.

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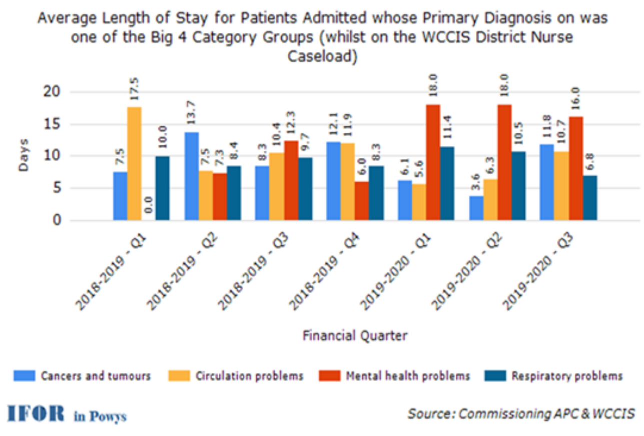

Figure 3: Chart showing average length of stay

Managing Type 1 Diabetes through DAFNE
DAFNE stands for Dose Adjustment for Normal Eating and is a way of managing Type 1 diabetes for adults and provides the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin.

The aim of DAFNE is to help patients with Type 1 diabetes lead as normal a life as possible, while controlling their blood glucose levels, hence reducing the risk of long-term diabetes complications. DAFNE allows people to fit diabetes into their lifestyle, rather than changing their lifestyle to fit in with their diabetes.

The Diabetes delivery plan for Wales 2016-2020 recommends that structured education should be offered to all patients with Type 1 diabetes. It has to be delivered by a Diabetes Specialist Nurse and a Dietician. The health board has received Welsh Government funding to train Eleri Evans, Diabetes Specialist Nurse

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and Hayley Kemp, Dietician, to attend the course enabling them to deliver the education to diabetic patients in Powys since June 2019. The course has been of benefit for patients.

"I've just completed a DAFNE course and just wanted to say wow what a fantatsic course. I've had type 1 diabetes for 33 years and was very sceptical about attending as I thought I knew the correct way to manage my diabetes but I can honestly say this course has been really beneficial, it has helped me to get my blood sugars within range and an improved hba1c as well.

Previosuly I was having highs and then lows then highs then lows, a constant vicious circle, this course helped me to understand how to treat a low blood sugar correctly and minimise havinng a high after, it also helped me to reduce the high but not have a low this for me was a massive eye opener and has stopped these from occurring.

The course is all about fine tuning your insulin and carbohydrate ratios and not acting too quickly as most fast acting insulin's last for 4 hours so testing 2 hours after food as previously advised was of no benefit as that vicious circle I mentioned above will start.

The course is designed to allow you to live your life and be able to eat the foods you like so rather then allowing diabetes to control you, you can control diabetes.

This I'm sure appeals to a lot of type I diabetics. The course was an interactive course that allowed me to learn from other type I diabetic's experiences which was a massive improvement in any other courses I have attended.

So I'd like to say a huge thank you to PTHB for proviidng this course and suggest to anyone with type 1 diabetes to grab this opportunity to attend a very thorough and worthwhile course with both hands as it will improve your control drastically (Take it from someone who's had diabetes for over 30 years.)"

"I agree with Anna 100% here. The DAFNE Course has given me the confidence back to control my type 1 diabetes and not let it control me.

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I've spent five weeks with other diabetics, who all know how the daily struggles feel, and I'm so grateful to ***Powys Teaching Health Board*** *for the opportunity ti take part in this course.*

Having had a rough few years with diabetic complications I wanted to do something to ensure I keep any more of these at bay for as long as possible, as well as making sure I am fully up to date with ever-changing practices.

Managing Type 1 Diabetes is a full time job, and evern after nearly 28 years it is a constant learning curve, but with the support of DSN Eleri and Dietician Hayley, as well as other diabetics on the course and the DAFNE course materials, I feel like I'm far more equipped to deal with it 💙 #DAFNE#Type1Diabetes "

We opened a new **paediatric audiology suite in Brecon** aimed at providing more audiology services in Powys for children and young people. *(insert picture and some more text)*

Creating a first-class continence service for children in Powys
Following action to set up a paediatric continence service, the launch planned for 2019, the service was launched with an ERIC led learning event for Health Visitors and School nurses to explore continence issues in children and young people. A clinical nurse specialist was employed to implement the single integrated service and dedicated clinics commenced in Autumn 2019. The nurse is currently completing her advanced practitioner MSc training which includes advanced clinical assessment and independent prescribing. This will allow children to be seen for complex or chronic continence problems in Powys without the need to travel outside the county thus supporting the care closer to home agenda. The service also employs an assistant practitioner who provides direct support for children and parents in their own homes or school as appropriate and also providing structured assessment for the provision of containment products.

As part of the drive to provide effective care closer to home, the Community Children's Nursing Team identified that **children and young people with epilepsy** across Powys were receiving variance in the care they were receiving. An epilepsy link nurse was identified and underwent specialist training to specifically work with the epilepsy care teams in all the adjoining health boards in wales and Trusts in England. She has audited the service provision in each area and worked with clinical nurse specialists to agree the input required to ensure families who have a child with epilepsy in Powys are supported locally.

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This initiative has reduced the travel for families and there has been positive feedback on having a local contact. The link nurse also works with schools and provides training across Powys and support the writing of education health care plans.

A pilot for **a Neurodisability joint clinic** with Community Paediatric consultant and physiotherapist commenced in December 2019. This joint approach will provide a holistic review of the child's needs, prevent assessment duplication for practitioners and reduce the number of clinic attendances with associated travel time for the parent and time out of school for the child.

The **Cerebral Palsy register for Wales** is being piloted in Powys with planned rollout nationally through electronic health systems. Our aim is to establish a systematic approach to the monitoring and surveillance of cerebral palsy in Wales and to support research into the condition. For more details see https://cerebralpalsyregister.wales/welcome-to-http-cerebralpalsyregister-wales

'Be Hear, Be Clear'

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The project is now half way through completion. Data for the new manual is now being collected and aims to be completed in October 2020. The Adopt and Spread Bevan Exemplar scheme has seen four regions in Wales also gaining funding to use the programme and a further project is being developed to support these teams in its roll out.

Aromatherapy in Maternity Services
A pilot scheme was run in Powys which aimed to test whether aromatherapy could help women and families to achieve the birth they wanted. Having been monitored over the past 12 months the feedback has been positive:

"One week overdue and tired of being pregnant, midwife Rachel arrived armed with aromatherapy! It was instantly relaxing while being used during a hand massage, then a few drops in the bath before bed. When labour pains started, it was a great distraction and helped me to stay at home longer before heading into the birth centre".

Endoscopy Services
2019-2020 has been another busy year for endoscopy services.

- In April 2019 the health board were awarded another of year JAG accreditation for the unit. The health board remains one of only six units in Wales (out of a total of 20), to gain this accreditation.

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The inspection specifically reviewed the clinical care of patients within the unit, the patient experience, decontamination facilities and workforce performance and satisfaction. All endoscopists were rigorously analysed regarding their performance. Staff contributed upwards of 15 clinical audits to support evidence presented and all documents pertaining to endoscopy were re-written or reviewed.

- Additional toilet facilities were opened to improve patient privacy and dignity. During the building work no endoscopy bookings were cancelled ensuring patients were being seen in a timely way.
- In January 2019 the health board employed an Advanced Nurse Endoscopist, Dr Helen Griffiths, to replace and expand the upper endoscopy service.
- A new endoscopy suite has been developed in Llandrindod Wells Hospital. It is expected to open in Spring 2020. This will be the first endoscopy facilities in mid Powys for over 8 years. It is aimed to work toward getting this facility JAG accredited in 2022.
- The health board has seen growth in endoscopy referrals by approximately 10% yearly for the past 4 years (in line with Welsh Government and UK predictions), and work is taking place across the health board including operational teams and senior leadership to ensure there are prospective and pragmatic plans to meet the increased demand and the anticipated 10% yearly growth for the next 5 years.
- Bowel Screening Wales have continued their services to the Powys population. We anticipate increased growth in the immediate and intermediate future in numbers of patients attending as Bowel Screening Wales Faecal Immunochemical Testing (FIT) is introduced and the age range is widened. For more information on FIT testing please see
- I completed my PhD in Medicine & gained a post as an Honorary Lecturer in Medicine with Swansea University.
- I have a secondment a clinical lead of the National Endoscopy Program in Wales.
- I have recently returned from a charitable visit to Bangladesh teaching nurses and drs in advanced endoscopic techniques. We had an audience with the Prime Minister to discuss our educational program.

Neighbourhood Nursing

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A patient and staff survey have been undertaken to capture feedback at the end of the project, which was due to complete the 1st April. A formal evaluation of the project is to be undertaken by the University of South Wales.

Carers

A Carers plan on a page was approved via the Regional Partnership Board (RPB). The Carers Steering Group continues with good representation from Carers. Key areas of focus have been agreed and funding has been made available to take forward flexible respite.

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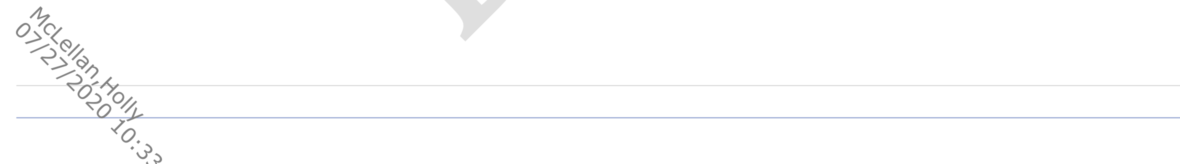

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4 DIGNIFIED CARE

We said...	Target	How we did
We will work with our partners to increase the number of Powys communities signing up as 'Dementia Friendly Communities.	• Increase in the number of Powys communities signing up as 'Dementia Friendly Communities.	We now have 4 dementia meeting centres across Powys

Dementia
The health board is working to achieve the themes within the Dementia Action Plan for Wales 2018 – 2021 (*insert hyperlink*), overseen by the Dementia Leads groups and progress reported Welsh Government six monthly.

Collaborative work continues with our third sector partners to raise awareness in local communities and there are currently twelve towns working towards becoming dementia friendly in Powys. Dementia Friends sessions continue to be run through the dementia friendly communities. In one area the Virtual Dementia tour bus was hired and available free for the public to go through the bus to raise awareness of what a person with dementia may experience. Over 95 people completed a session in the virtual dementia bus.

Dementia Matters in Powys have successfully opened a fourth dementia meeting Centre, now running in Ystradgynlais, Brecon, Llandrindod Wells and Newtown. These Centres offer support, education and activities that are led by the people who attend. Intergenerational projects continue with Schools across Powys.

The Memory Assessment service is currently part of a trial to complete the audit workbook for Memory services in conjunction with Improvement Cymru, before it is rolled out nationally.

Engagement work with General Practices continues and a project to raise awareness about dementia using the electronic screens is being developed in one area.

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The Dementia Lead is working with Improvement Cymru to progress the Dementia Action Alliance, Dementia Friendly Hospital Charter which has recently been adopted by Welsh Government and is planned to be launched in September 2020. This has already been adopted in England. Hospitals continue to use the Butterfly Scheme and John's Campaign to support the recommendations in the Royal College of Psychiatry National Audit of Dementia Care in general hospitals.

The Dementia Home Treatment team in South Powys has been developed and opened as a service in November 2019. Its purpose is to provide rapid assessment, treatment and review; to reduce the need for hospital admission, and to enable the patient to be assessed and supported in their usual place of residence. They are based in Bronllys and currently operate between the hours of 9am – 5pm, Monday – Friday.

There is a focus on dementia training in February and March 2020 when all staff are being encouraged to complete the NHS All Wales dementia e-learning module with the dementia lead attending hospital wards to support work-based learning. A classroom programme has been arranged throughout 2020 pan Powys. There is a Welsh Government evaluation of the work that has been completed in Powys in April 2020.

Mental Health and Partnerships

Together for Mental Health (T4MH) is the Welsh Government's 10-year strategy to improve mental health and well-being in Wales. The last year of the second Delivery Plan which covers the 2019/20 period, continues to require a cross-cutting approach with actions jointly achieved by partners, including Welsh Government, Health Boards, Local Authorities, the Third and Independent sector, Education, Public Health Wales, Police, Fire, Ambulance, people using services and those close to them. The health board and partners spent considerable time during the year consulting and supporting local engagement around the new T4MH Delivery Plan (2019-2022). Whilst there are some areas of development in the new plan, Powys is actually ahead in some aspect of the plan such as in Workforce Planning and Co-Production with our Service Users. The work is overseen by the National Partnership Board and there continues to be a Local Partnership Board (LPB) in each area. In Powys the LPB is known as the Mental Health Planning and Development Partnership (MHP&DP) and our strategy for mental health is outlined within the "Health and Care Strategy", outlining local outcomes for our population.

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Throughout 2019/2020, a range of actions have been undertaken to achieve the Partnership's vision to promote mental and emotional health and wellbeing for all ages and to enable the provision of truly integrated care, thus making a positive difference in the lives of people in contact with our services.

During 2019/2020, the health board's Partnership Manager working jointly with the **Powys Area Planning Board**, overseeing services supporting people living with substance misuse issues, followed up key actions from last year by:

- Securing funding from Welsh Government for a post looking specifically at Harm Reduction across agencies to help support the work of substance misuse services and importantly helping reduce the instances of harm across people living with substance misuse and mental health distress
- Obtaining further funding for two new posts providing additional support to people who are living with complex needs in relation to substance misuse and mental health distress, working directly with Community Mental Health Teams, Police, Social Services and the Third Sector to coordinate care and support for people
- Further capacity has been augmented by securing funding for four posts, based in the Third Sector, looking at complex care needs for people with mental health, substance misuse and housing issues.
- Jointly looking at the need for an independent "Clinical Audit" of the currently commissioned service to determine what is working well and what could be improved in currently commissioned substance misuse services.

We continue to prioritise the work of the **Powys Armed and Ex Forces Forum** (PAEFF), which is a multi-agency group, including representatives of Veterans and Ex Forces Personnel and people with lived experience of mental distress who have been in active duty within the armed forces. The Forum's role is to ensure that health issues relating to the Armed Forces Covenant are appropriately reflected in NHS service design and continually improves across all services.

The Partnership continues to deliver a joint action plan to ensure mental health services for Veterans in Wales are able to meet needs in a timely and appropriate manner. Ongoing awareness raising of the mental health support services for Veterans within the community and across other health and social care services continues. We have recruited a new representative to sit on the board and continue to look at how people can access the service across Powys. Of particular interest this past year has been linking in new community services such as Community Connectors and other local Third Sector services personnel may not know

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about and the commitment to ensuring that any personnel applying for posts within the NHS are well positioned to receive support.

The MHP&DP continues to bring together key partners, facilitated by the health board, and great care is taken to involve people who use services, parents and carers in the ongoing planning and in the delivery of our local Health and Care Strategy. There is a significant amount of **co-production and involving our patients and service users** that goes on annually. Individual representatives of people using services are active members of the Partnership. They provide the Partnership with feedback from local networks (formal and informal) and from the national service user's and carer's forum and national partnership boards and ensures that key priorities of the local delivery plan stay at the forefront of Partnership business. Representatives are heavily involved in the Partnership's work streams.

The Engage to Change group is a subgroup of the MHP&DP Board and encompasses representatives from our partner agencies and citizens. The subgroup was established to more widely promote the Partnership and seeks to resolve issues raised by people in contact with services and those close to them at local and regional levels with staff. The group considers feedback gathered from people using services and uses it to help inform and improve services developed through the partnership. Some of the group activities in 2019/2020 supported a number of mental health awareness events throughout the year. Members (and their respective organisations) have participated in "Time to Talk Day", "World Mental Health Day" and "Self-Injury Awareness Day" (inset) amongst others. In 2019/2020, our individual representatives conducted a survey of some people using mental health services in Powys and used the findings to make small but effective improvements to mental health services, such as working to update the patient information provided in relation to Part 3 of the Mental Health Measure.

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Listening to our patients/service users and citizen representatives, the health board have secured funding this year for a new **Early Intervention in Psychosis service** that is now fully staffed and beginning to roll out across Powys. They are actively seeking to work with patients and family members in co-designing the service based on the lived experience and patient stories of people who have experienced first episode psychosis.

In addition to our continued success with our on-line CBT Service Silver Cloud (blended with face to face counselling) offering greater access to psychological therapies, we have developed a new service relating to **complex trauma** and **personality disorders** and have recruited in 2019/2020 specialist staff. We are also upskilling current staff with new interventions and specialist skills ensuring that access to the best and latest quality therapeutic tools and is provided.

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Suicide and Self-Harm reduction continue to be a key priority for us and our statutory partners and this year has seen us secure funding from Welsh Government for a specific coordinating post across partners which will help us continue to deliver the priorities in the Suicide Prevention Plan (Talk to Me 2).

In working with our partners in the **Third Sector**, we are also looking at the need for more focused **"social prescribing**" within mental health, new areas such as **"Arts in Health"** and we are actively recruiting a coordinator this year to help deliver projects across our hospitals, community groups and partners in addition to **"Green Prescribing"** links with "**Eco-therapy**" related projects provided by our partners in the Third Sector, County Council's Countryside Services, National Park Authorities and Natural Resources Wales.

The Child and Adolescent Mental Health Service (CAMHS) this year moved to the Mental Health Directorate and prioritised delivering integrated services, developing emotional health and resilience for young people. We were successful in receiving funding through the Regional Partnership Board (RPB) to develop a virtual emotional health and wellbeing service, bringing together many partners such as children's social services, youth services, both universal and targeted, in addition to Xenzone – counselling service and education. Much work has been undertaken on developing a single point of access/integrated access to our service model.

A partnership with Montgomery Wildlife Trust in North Powys is developing specifically in relation to green/social prescribing for young people from primary and secondary care, along with providing joined up support with other partners in the Voluntary Sector.

Mental Health transformation funding has also been utilised to develop increased support through primary mental health care workers in schools, including year six primary schools and developing links with children's social services to provide dedicated consultation and training to staff.

Moving to the Mental Health Directorate has also been a spring board to secure an age appropriate bed for inpatients in Powys.

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The work of the **Crisis Care Forum**, pushing the Crisis Care Concordat with our partners in the Police, social services, Third Sector and health has gathered momentum in 2019/2020 and Powys continues to lead on the work of our **Integrated Risk Intervention Support (IRIS)** launched last year. We have seen the use of IRIS increase appropriately and this unique multi-agency approach to collaborative risk assessment and case management and review has proven invaluable in our integrated approach to providing specialist support for people at risk.

Equality and Diversity

The health board has continued to build upon the work already undertaken around Equality and Diversity which aims to improve service delivery for those with a protected characteristic under the Equality Act 2010. Our aim has also been to increase staff awareness of the challenges that individuals face and promoting best practice.

Following a review of our Strategic Equality Plan (SEP) for 2016-2020 undertaken with the Equality and Human Rights Commission in October 2019, the health board is performing well but we recognise that there is much more that we can do, especially in terms of engaging with local communities and individuals with specific needs in order to help us better plan and deliver our services accordingly.

The health board has developed a new 4year SEP which looks to build upon the existing work already undertaken to ensure that services are accessible to all and we aim to ensure that those with a protected characteristic are not disadvantaged in any way when accessing healthcare services.

The All Wales Standards for Accessible Communication and Information for People with Sensory Loss continue to be implemented across the health board. Our local Eye Care Liaison Officer regularly attends eye care clinics to offer information and advice on a wide range of support services available to those with sensory loss. Audiology departments have introduced methods to identify dementia patients with hearing loss and have put new ward referral procedures in place to ensure that these patients are seen urgently. Our priorities going forward for are to work with individual 3rd sector organisations who can also support people with sensory loss. Going forward, the health board will be looking to source additional specialist training to equip our clinical staff with further knowledge and skills when dealing with those who have a sensory loss.

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Significant achievements have been made throughout 2019-2020, most notably within our Dementia Services. The health board has made considerable efforts to make improvements to the lives of our dementia patients and their families. There are now 4 dementia meeting centres across Powys where people can access support, advice and meaningful activities along with their carers. Dementia home treatment teams have been developed to support people with increased needs to prevent hospital admission. The recommendations of the 'Trusted to Care' Report (https://gov.wales/sites/default/files/publications/2019-04/trusted-to-care.pdf) have been implemented successfully to help improve patient experience for dementia suffers with physical health issues, and initiatives implemented include:

- 'John's Campaign' to allow families and carers open access to visiting.
- Purchase of the Reminiscence and interactive activity units (RITA) to provide meaningful activities for people on the wards and in 2019-2020.
- Welshpool hospital nursing and allied health professional's dementia care training team were recognised at the health board internal staff excellence awards for the work they have done to improve the environment for dementia patients.

Other examples of achievements within other departments include:

- Our Mental Health Directorate has been working with Diverse Cymru to implement the Cultural Competency Toolkit as part of our ambition to achieve the black and minority ethnic (BME) Mental Health Workplace Good Practice Certification Scheme.
- A successful Maternity Day Assessment Project has been rolled out providing vital access to scans and support in the county, reducing the need for expectant parents to travel to neighbouring District General Hospitals. The Maternity Flu Immunisation Project Team is also leading the way in midwife-led flu immunisation.
- The health board has also recognised the needs of the local Nepalese community and has responded to the need for information to be made available in Nepalese. As a result, a series of mental health patient leaflets are being translated.
- Staff at Ynys y Plant, Newtown were recognised at the health board internal staff excellence awards for their efforts in making life better in Powys for people with disabilities.

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External Inspections

National Maternity Review – Inspection of Birth Units

As part of the national review of maternity services across Wales, Healthcare Inspectorate Wales (HIW) have undertaken inspections at birth units at Welshpool, Newtown, Llanidloes, Knighton, Llandrindod Wells and Brecon commencing on 10 February 2020.

It is pleasing to note the summary comments from HIW included reference to the service providing respectful, dignified, safe and effective care to patients. Noting there were some good arrangements in place to support the delivery of safe and effective care and positive multidisciplinary team working, we recognise there are some area identified for improvement. The health board have already started to work towards ensuring these improvements are made and the improvement plan will be monitored internally via this Group as per governance and assurance arrangements.

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

This 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.

The inspection was conducted over two days, and included discussions with CMHT staff, service users and carers, as well as examining documentation including service user records, policies, staff records and system reviews.

Immediately following the inspection both the health board and local authority were formally notified that areas of concern had been identified which would pose an immediate risk to the safety of patients. The inspection team had been notified during the inspection by members of staff there was a long standing and on-going problem with the electronic records management system (WCCIS).

Felindre Ward, Bronllys Hospital – November 2019

Felindre is a 12 bedded acute adult mental health admission ward, with the addition of two crisis beds, servicing the population of Breconshire.

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Health Inspectorate Wales (HIW) completed an unannounced mental health inspection of Felindre Ward, on the evening of 18 November 2019 and the following days of 19 and 20 November 2019.

During the initial feedback HIW requested immediate assurance in relation damage to a fire door, the window had been damaged and boarded up. Due to the damage to the window the integrity of the fire door was compromised which would reduce the effectiveness of the fire door in the case of fire. The door was replaced.

The HIW report identified a dedicated staff team that were committed to providing a high standard of care to patients. They observed that staff interacted with patient respectfully throughout the inspection. Concern was raised with the number of maintenance issues that were unresolved on the ward, which was impacting negatively on patient experience. Action was put in place to rectify these issues.

HIW reported positively in the following:

- Staff interaction and engagement with patients respectfully
- Good team working and motivated staff
- Safe and effective medicine management
- Established governance arrangements that provided safe and clinically effective care

HIW recommended the health board needed to improve in the following:

- The maintenance of the hospital facilities
- The capacity of its adult inpatient mental health service
- The provision of information on the ward for patients
- The range of therapies and activities available to patients
- The effectiveness of emergency resuscitation equipment checks
- Review and update of policies

The final report was published by HIW on 21st November 2019.

Llewellyn Ward, Bronllys Hospital – October 2019

An unannounced inspection of Llewellyn Ward, Bronllys Hospital took place on 29 and 30 October 2019. Llewellyn Ward is a 15 bed GP led general ward. The report identified staff were committed to providing patients with safe and effective care. Patients spoken with during the course of the inspection expressed

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satisfaction with the care and treatment received. They found good management and leadership, with staff commenting positively on the support that they received from the Ward Manager. However, there was some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

HIW reported positively in the following:

- Staff engagement
- Multidisciplinary working
- Provision of food and drink
- Palliative care suite
- Designated lounge and dining area
- Assessment, care planning and record keeping
- Medication management
- Management overview
- Clinical audits
- Staff training, support and supervision

HIW recommended we need to improve in the following:

- Welsh language provision
- Pain assessment
- Storage of wheelchair and segregation of clean and dirty equipment
- General Risk assessment
- Maintenance in some areas
- Staff recruitment

The final report was published by HIW on 31st January 2020.

HIW reports for Powys can be accessed via https://hiw.org.uk/service-index?search_api_fulltext=&latlon%5Bdistance%5D%5Bfrom%5D=32&latlon%5Bvalue%5D=powys&field_service_type%5B17%5D=17&display_map=false

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5 TIMELY *CARE*

We said	Target	How we did
Implement serial casting across Powys	• Serial casting services in place	The service is being brought back into Powys from April 2020

Serial casting is a common conservative intervention for children and young people who are idiopathic toe walkers, or who have cerebral palsy and develop calf muscle contracture (shortening). It involves the use of a lightweight cast over several weeks to gradually stretch the muscle.

The repatriated Serial Casting service has now been established across the whole of Powys, conducting our first Serial Casting Board meeting in January 2020. The Bevan Exemplar leading to the Serial casting service transformation work in Powys is now being rolled out across the whole of Betsi Cadwallader University Health Board as part of the Bevan Adopt and Spread work. The repatriation has led to enhanced staffing, skills and products within Powys that will ensure the long-term delivery of these services closer to home to children and families.

A **community paediatric remodelling project** is in progress within the Women and Children's Directorate. This project has sought to develop a whole systems approach to the delivery of paediatric services within Powys. As part of this project a pilot to triage paediatric referrals (both community and General Practice referrals for out of county hospitals) was initiated in October 2018 with an aim to ensure that children and young people are seen in a timely way by the most appropriate practitioner. The triage team comprises of the children's patient service manager and senior clinical staff from nursing with input from the paediatricians when required.

This prudent approach has resulted in children being seen more quickly and reduced the pressure on the community paediatric waiting list. Of 600 accepted referrals, 400 were directed to a professional other than a paediatrician, for example a Therapist, Health Visitor or School Nurse.

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The **neurodevelopmental service commenced** in February 2018, requests for assessment outstripped the capacity leading to a lengthy waiting list for children and their families. A plan to reduce waiting times to meet the 26-week referral to assessment time was put in place. This included dedicated project management time with the result of bringing the waiting time for first appointment from over 36 weeks back to under 26 weeks within a 6-month timeframe.

Commissioning

Quality & Safety in Commissioning Services

There is no District General Hospital within Powys Teaching Health Board and a range of services, across all ages and specialties, emergency and planned care are commissioned from surrounding Health Boards and NHS Trusts across England and Wales. The health board continuously communicates with seventeen main organisations to ensure all essential care and needs for patients within a rural area are safely, equally, effectively and successfully delivered.

The health board monitors quality and safety of services ensuring Powys residents have good clinical outcomes and a positive experience; to achieve this the health board works to ensure patients are treated and cared for in high quality, safe environments which protect them from avoidable harm.

The health board monitors patients experience, quality, safety, access to services, activity, finance governance and strategic change. Continuously assessing, monitoring and measuring a range of information through data and information gathered and attendance at meetings, such as with English health bodies Commissioning Performance and Review Meetings and Clinical Quality Review Meetings.

Formal Inspections reports for the NHS organisations commissioned are available on the websites of Healthcare Inspectorate Wales (HIW) www.hiw.org.uk and the Care Quality Commission (CQC) www.cqc.org.uk These websites are monitored weekly and reports are shared by the commissioned provider when available.

There are some fragile services across providers and specialties, these are:

Shrewsbury and Telford NHS Trust is one of the main providers of secondary care for the North Powys population. They are currently under Special Measures since November 2018. Under Section 31 of the

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Health and Social Care Act 2008, the CQC have imposed conditions relating to activities across the Emergency Departments and on the inpatient wards and clinical areas across the Trust.

The health board holds monthly Commissioning Performance and Review meetings with the Trust and there is an established Chief Executive Level meeting in place. The health board has direct line of communication with the CQC and participates in a Safety Oversight and Assurance Group and involving regulators, receiving copies of weekly update reports. Proactive tracking and support to maternity patients is provided through the Health and Care Hub.

Cwm Taf Morgannwg University Health Board maternity services is progressing and showing improvements, however remain under Special Measures. Powys Teaching Health Board continue to engage and hold regular commissioning performance meetings.

Worcestershire Acute Hospital urgent and emergency services were rated as inadequate following a CQC unannounced focused inspection on the 13th February 2020. The CQC found some patients had delays to initial assessments and timely treatments. The Trust was implementing a range of actions to reduce overcrowding. A Section 31 condition was imposed upon the Trust to ensure urgent improvements in the timeliness of assessment, care and treatment for patients.

Betsi Cadwaladr University Health Board is continuing to improve its governance arrangements, but remains in special measures.

Welsh Health Specialised Services

Specialised services support people with a range of rare and complex conditions which are provided in relatively few hospitals accessed by comparatively small numbers of people. They are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally, specialised services are planned nationally by Welsh Health Specialised Services (WHSSC) on behalf of the seven Health Boards in Wales.

The quality of care that patients and their families receive, and their experience is central to the commissioning of specialised services driving quality assurance and improvement. One of the key features of the quality assurance framework is the strengthening of the relationships between health

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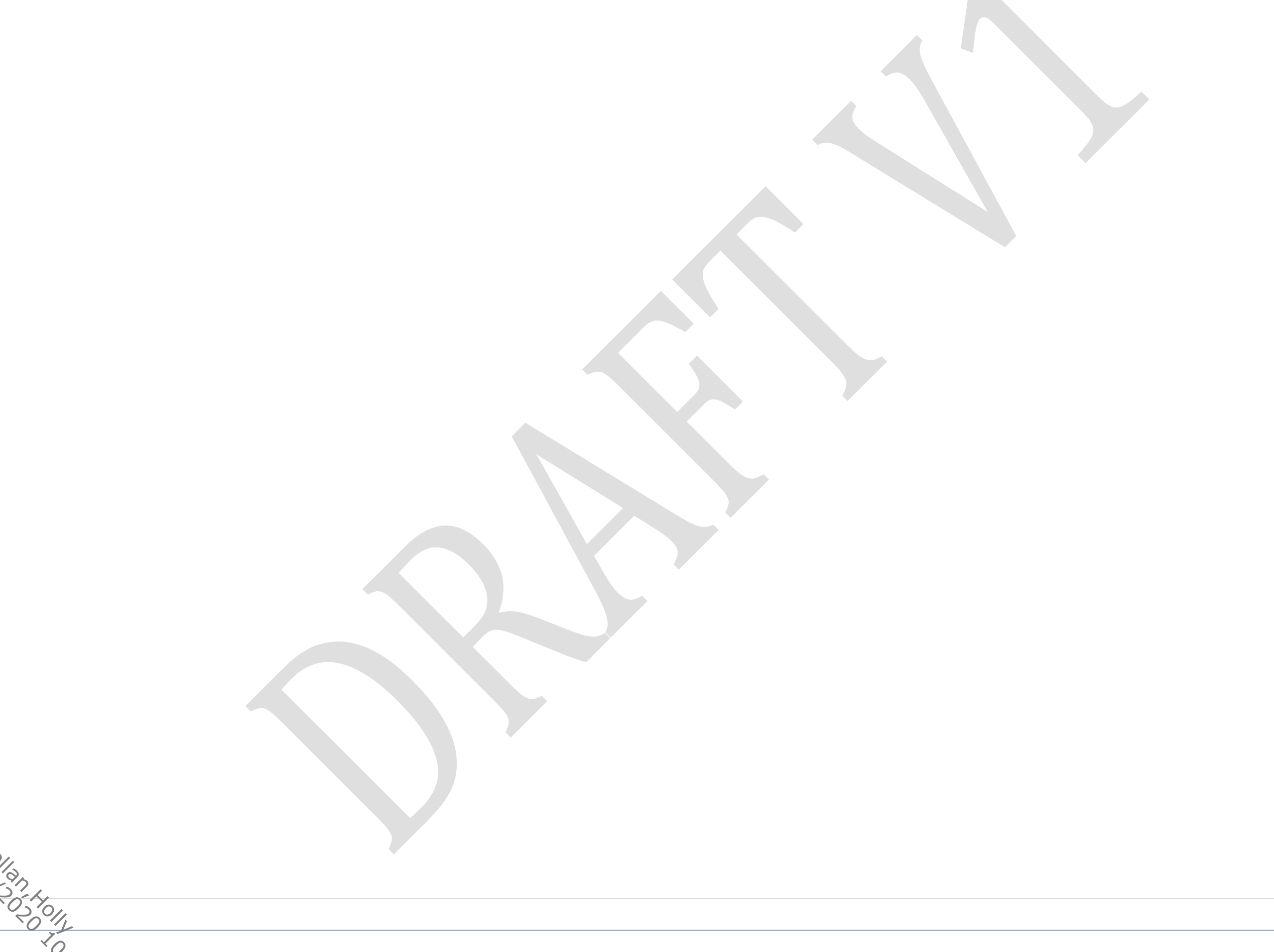
boards and the role of their Quality & Patient Safety Committee. This is core to ensuring that each health board is assured regarding the quality of the services commissioned for their population but also to facilitate shared learning.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6 INDIVIDUAL CARE

We said	Target	How we did
Improve our management of concerns	• Percentage increase in the number of complaints responded to within 30 working days • Number of informal concerns responded to within 2 working days • Reduce the number of concerns reported to the Public Services Ombudsman for Wales • Strengthened feedback on citizen experience and the use of stories with a focus on outcomes and learning.	• We achieved 54% in quarter 3 compared to 59% in 2018/19 • 76% of informal concerns responded to compared to 59% previously. • Across Wales, the proportion of new complaints about complaint handling has decreased from 11% to 9%. • Citizen experience
Strengthened feedback on citizen experience and the use of stories with a focus on outcomes and learning.	• Evidence of outcomes and learning from patient stories • Consistent data collection of citizen experience that is reported and supported with improvements and learning, where indicated	• To add
Achieve compliance with the Welsh Language standards as per plan.	• Welsh Language improvement plan in place and evidence of improvement	A welsh language improvement plan is in place and there is evidence of improvement.

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Patient Stories (text to be added)

Patient experience Feedback

"I just wanted to say the midwives of Brecon are brilliant. Never have I had a midwife come to my home whenever I needed them. My midwife is Sally and she's been fantastic, and the other midwives are so brilliant and kind and will come see you asap and I just think there all so fantastic and deserve recognition."

In April 2019, the **Children's Audiology Services in Brecon** carried out a **Patient Satisfaction Survey**, in conjunction with the All Wales Audiology Quality Standards. 13 questions were asked focusing on accessibility, surroundings, staff, treatment and their overall view of the services provided. Eighteen responses were received, of which only 2 responses recorded as very dissatisfied with accessibility, that is, the location of the appointment and communication with the service. 6%-17% of respondents indicated

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they were satisfied with regards their surroundings and staff, and between 83%-100% of respondents reported very satisfied to all remaining questions.

Numerous comments were received, examples included:

"very happy all round"
"all aspects are 10/10"
Everything went smoothly throughout the appointment"
"nothing needs improving"

Children's comments on what went well:

"she said it was great, she loved the ship"
"he liked the hearing game and the clicking noise, he liked the toys 😉"
"He would like to say thank you for letting him pick his favourite colour"

An Occupational Therapy-led Discharge to Recover and Assess Model in Powys is supporting people to return home promptly and safely from hospital

The rural nature of Powys means that our residents rely on neighbouring district general hospitals for their acute care. Even their nearest community hospital may be some distance away. Extended hospital stay can lead to deconditioning, and the unfamiliarity of a hospital environment can mean that reablement and recovery plans develop at hospital may not necessarily be "what matters" and "what works" when the patient returns home. An Occupational Therapy-led "discharge to recover and assess" programme in Powys is helping to tackle this.

With strong leadership from the Occupational Therapists team, a co-productive approach was taken, utilising the full range of community assets. This has included the patient and their circles of support, adult social care & reablement, health board multi-disciplinary teams, General Practices and the third sector. This has created a Discharge to Recover and Assess approach that works with patients to ensure that those that can be supported in their own home are discharged from the ward quickly with

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wraparound support if required and assessments taking place in their own home environment following discharge.

An in-reach model was implemented, with designated Reablement Occupational Therapists working alongside the ward multi-disciplinary team to identify patients that were at a functional level and could be discharged home with community support. The Occupational Therapists then linked with social care to ensure that referrals were prioritised. They carried out strength-based assessments and worked closely with patient's families and used different agencies to support patients to ensure that they could be discharged home in a timely and supported way, for example Red Cross hospital from home as an alternative to Reablement. This was also done as patients' needs changed following discharge

Patients were either seen on day of discharge or next day at home by the Occupational Therapists to "right size" any support package and ensure that the patient and their family had an opportunity to discuss any concerns they may have.

First and foremost, the programme has provided an opportunity to improve patient experience. Importantly we have also been seeing significant productivity benefits for the NHS through measures such as shorter length of stay. There has also been valuable learning. Whilst the team has been able to discharge quicker, this has been dependent upon cooperation of all NHS staff – and it can be resource intensive. Having the right conversation with the patient and their family has been critical, so that they feel supported and in control of decisions when planning their discharge from hospital. Cultural change within the hospital ward to create new approaches to the successful management of risk has also been vital. Going forward, it is also clear that more could be achieved as the project develops including through strengthened partnerships with the third sector.

The next steps including rolling out the model across the whole of North Powys and then across all 2000 square miles of Powys. This is expected to include increasing the scope of patients that are included (minimise risk aversion & 'cwtch' culture), supporting increasing numbers of patient's home from acute settings on a discharge to assess pathway (home first), enabling timelier and more responsive step-down support (e.g. Red Cross, PURSH, Community Connectors), and remodeling the therapy workforce, to promote an in-reach model from community onto ward.

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"Everybody was so nice, they got me packed. Everyone looked after me wonderfully at Welshpool Hospital but it is always nice to get home to my own surroundings and I was so pleased to have Physiotherapy in the warmth of my home. Everyone is kind, cheerful and the physiotherapist and her staff gentle and encouraging, keeping me happy when I was down. The Reablement team came each morning and evening and made me feel very supported"

Welsh Language

Significant progress has been made during 2019-2020 with the implementation of the Welsh Language Standards. Following the appointment of a new Service Improvement Manager a Welsh Language Service Leads Group has also been established to monitor the progress being made across each department. Key achievements during 2019/2020 include:

- Development and promotion of new Welsh language resources and procedural guidelines for staff;
- Higher compliance rates and strengthened reporting mechanisms which include baseline assessments and recording statistical data to provide assurance to the Board;
- Improved quality and quantity of available bilingual documentation. This has been aided by the review of external translation companies and the appointment of an internal Welsh Language Communications Officer;
- The development and roll-out of a new interactive Welsh Language Awareness Training session for staff groups to raise awareness of the 'Active Offer Principle';
- Extending the use of Datix risk management software to identify incidents relating to Welsh language;
- Improved relations and joint-working approach to Welsh language requirements between the health board and independent primary care contractors;
- Increase in available data of staff Welsh language skills on the electronic staff record;
- Bilingual Take Control of your Recruitment Process (TRAC) functions to support Welsh speaking applicants; and
- Strengthened links with Welsh Language Leads across NHS Wales, Welsh Government and the Welsh Language Commissioner's Office.

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The health board has also ensured that their renewed integrated medium-term plan (IMTP) for 2020-2023 has clear links with the requirements of the Wellbeing of Future Generations (Wales) Act 2015, and the wellbeing objective 'A Wales of Vibrant Culture and Thriving Welsh Language' has been cross-referenced with our IMTP objectives. This ensures that Welsh language requirements are monitored as part of the reporting procedures for the IMTP which can highlight any associated risks and outline the necessary mitigating actions.

Going forward, the health board intends to continue with its implementation of the Welsh Language Standards to drive forward improvements to bilingual service provision. A key action for 2019-2020 will be to liaise with NHS Wales Shared Services (NWSSP) to undertake a detailed audit of compliance levels with the Standards and to identify areas for further improvement.

The health board will refer to the new 5-year plan which will be published in line with Standards 110. This will outline our plans to increase our capacity to carry out clinical consultations in Welsh with a focus on the following:

- Increasing staff skills and capacity to support clinical consultations in the medium of Welsh
- Recording patient language choice and pairing them with Welsh speaking staff
- Promoting Welsh as a skill in the workplace
- Pairing Welsh speaking mentors with Welsh speaking students whilst on placement
- General awareness raising of the 'Active Offer Principle'

Work is ongoing at a national level in collaboration with NWSSP to look at implementing Standard 106A and 107A which refers to bilingual job advertisements and bilingual job descriptions which is also a challenging target for all health boards.

Compliments

During 2019-2020 a total of 514 compliments were reported. 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.

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Letters and cards have been sent to staff across the health board to thank them for the care they have provided. Some of the notable comments are:

"thank you for giving me back my confidence" This was received from a patient who was receiving physiotherapy

"thank you to all the staff who have provided care and treatment over the last 10 days… you have helped me get through an exceptionally difficult time".

Complaints (known as Concerns)

The health board recognises patient feedback as a rich source of patient and citizen experience that can lead to improved services. We want to ensure that Powys residents have safe, effective and compassionate care and when the quality of care gives cause for concern, whether it is within Powys or through services we commission, we want our systems to act swiftly in response. In the last year we made key policy commitments:

- We will listen
- We will act
- We will learn

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, have to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. Informal concerns are usually acknowledged at the time of taking the call or at the point of contact with the staff member. The last quarter of 2019/2020 we achieved 100% in managing and acknowledging informal concerns.

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, as opposed to the previous 5 days. During 2019/2020 the health board received 57 informal concerns which is a significant decrease on the previous year of 127 informal concerns, the decrease is attributed to this change in process.

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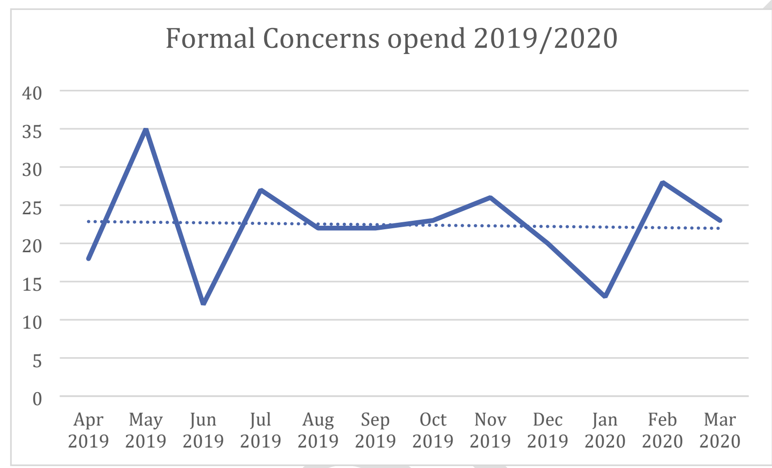
During 2019/2020 the health board received 267 formal concerns and 53 informal concerns, an increase on the previous year. The increase is attributed to the change in how informal concerns were managed, as described above. The graph below shows the numbers of concerns opened by month, it will be noted that there is an increase in concerns during May 2019 which from analysis relates to the concerns raised regarding the closure of the Robert Jones Agnes Hunt Orthopaedic Hospital Pain Management Services.

The graph below demonstrates by month the number of formal concerns received across the health board.

Graph 1: Formal Concerns opened during 2019/2020



Primary Care Services including General Practitioners have the highest number of formal concerns, the concerns relate to access to appointments. The report highlights that the Mental Health and Learning Disabilities Service Group have a high number of formal concerns. Following analysis of these concerns

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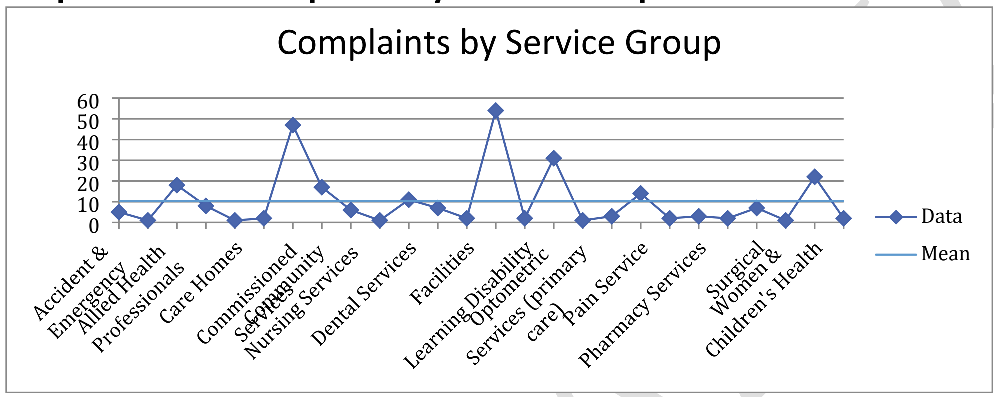
they relate to access to appointments and family members seeking to obtain information about ongoing care and treatment.

It will also be noted from the data in the graph below that Commissioned Services have the second highest formal concerns, see later detail in relation to these concerns.

Graph 3: Formal Complaints by Service Group



During 2019/2020 the health board achieved 47% of concerns closed within the 30 working days against the Welsh Government target of 75%. During the last two quarters of 2019/2020 the concerns team have been undertaking focussed work to secure improvements and improve upon this target.

Focused work continues to ensure effective management of concerns and this includes:

- Weekly meetings to discuss current cases and timescales for responding to concerns;
- Proactive action to ensure concerns responses are drafted timely to meet response timeframes; and,
- Escalation of concerns where timely responses are not available.

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Concerns raised about Commissioned Services

A review of the concerns raised via the health board for our commissioned services over a 3-year period between 01 April 2017 to 31 March 2020, has been completed. This was aimed at understanding the issues being raised by Powys residents in respect of the of services the health board commissions from other health boards and NHS Trusts. The data below represents a small number of concerns and it is clear further work is required to understand the true figures. This data has to be considered in context and to note it represents information we have gathered through a variety of routes, namely:

- concerns patients have raised with the health board about services delivered through providers;
- concerns raised by patients or with the support of the Community Health Council directly with the commissioned service and a copy of the concerns letter has been provided to the health board for information; and,
- notification of a concern through other routes, for example, notification by the provider themselves or through other intelligence gathered such as provider meetings.

From reviewing the data, the key issues that arise across the commissioned services relate to appointments and waiting times.

Following analysis of the data relating to Robert Jones Agnes Hunt, an increase in concerns in May 2019 reflected the concerns raised around the closure of the Pain Management Clinic. The health board saw an increase of concerns raised by patients who did not know the arrangements in place following this closure and patients and their local Ministers of Parliament, Assembly Members and local Councillors raised concerns on behalf of Powys residents. Action was taken to …

Further information can be found in our Putting Things Right Annual Report 2019/2020 at:
http://www.powysthb.wales.nhs.uk/concerns-and-compliments

Putting Things Right and Learning from Concerns

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Learning from formal and informal concerns is reported through the health board's quarterly Patient Experience Steering Group meetings as well as individual learning through wards and departments, newsletters, and 'You said, we did' boards.

Key lessons identified include:

- Clear communication with patients.
- Clear care plans in place for care for the patients and their families to understand the care that is needed for the patient.
- Reminding staff of the importance of accurate record keeping
- Ensure appropriate discharge information is given
- To ensure all procedures are explained to patients before they undergo treatment
- Ensure patients are kept informed of changes in services

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.

During 2019-2020 the health boards community hospitals and mental health services reported the most serious incidents with a total of 35 serious incidents being reported between these two service groups.

Themes and trends

Following review of the of the data there has been an increase in reporting Child and Adolescent Mental Health (CAMHS) patients being admitted in to adult wards. There is work being undertaken around this to reduce this and to engaged with colleagues to appropriately place these patients.

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No Surprises

Welsh Government are notified of sensitive issues via a process known as *no surprises*. Between 01 April 2019 and 31 March 2020, the health board reported 17 no surprises; no themes or trends identified.

No *never events* have been reported.

Examples of lessons learnt include:

- To continue to follow the falls policy and maintain patient safety.
- Continue with regular updating of falls assessments and implementation of falls policy instantly in the event of a fall.
- Blood glucose not documented as per falls policy; the importance of completing a blood glucose test following a fall.
- Keeping family's informed and keeping communication open at all times.

Coroner Cases

During 2019/2020 there have been 21 HM Coroner enquiries, the majority of which related to patients who may have accessed mental health services. During this time there have been no Regulation 28 Reports issued by the HM Coroner in respect of any of these cases.

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It should be noted that due to Covid-19 the HM Coroner stopped all Inquests from the 24 March 2020 with a planned review date in July 2020 reference recommencing inquests.

Public Service Ombudsman for Wales

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 directly with the Public Services Ombudsman for Wales (PSOW). The PSOW reviews the case and determines whether they wish to pursue a full investigation or not, with the authority to impose sanctions on the health board by way of financial compensation to the

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complainant. In addition, there PSOW can issue a Public Interest Report and reports issued under Section 16 or Section 21 (see PSOW website for more information https://www.ombudsman.wales/?emergency=1)

A total of 23 enquiries from the PSOW were recorded as received in year, down from 26 the previous 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.

Claims

The health board has a small claims portfolio. During 2019/2020 the health board were managing 11 clinical negligence claims with 8 clinical negligence claims pending reflecting the position of medical records being disclosed with the intention of bringing a claim against the health board.

For the period 2019/2020 the number of personal injury cases has remained low.

Further information can be found in our Putting Things Right Annual Report 2019/2020 at: http://www.powysthb.wales.nhs.uk/concerns-and-compliments

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7 STAFF AND RESOURCES

We said	Target	How we did
Increase the number of volunteers working across Powys	• Percentage increase in the number of volunteers working across Powys	We have increased a number of our volunteers by 19% through Red Kite, League of Friends and generic volunteers.

Health Care Support Worker Development (HCSW)

As part of the HCSW framework, mandatory clinical induction was introduced to all HCSW's new to employment since April 2016. Previously, the health board commissioned the delivery of clinical induction from external education providers but have now employed 2 x Clinical Skills Trainers who are responsible for the delivery of the Clinical Induction Programme, allowing the design and delivery to be more flexible and very Powys focused. As part of our 'grown our own' approach an apprenticeship programme has been launched in January 2020 offering a 13-month programme to apprentices to work as a Nursing HCSW and they will be working towards gaining a Level 2 qualification. The health board is committed to the development of our current HCSWs and have 22 HCSWs from across nursing and Allied Health Professionals signed up to a Level 2 qualification, and 58 HCSWs signed up to a Level 3 qualification. The health board is working closely with Neath Port Talbot College to improve the flexibility of the HCSW qualification offer, with a view to a further 60-80 Nursing HCSWs signing up to the qualification over the next few months.

Workforce Futures

During 2019/20 the health board has progressed the Workforce Futures Programme at pace. As a key enabler of the Health and Care Strategy, which aims to create a 'Healthy, Caring Powys' between now and 2027, the Workforce Futures programme has focused on developing a Health and Care Strategic Framework. Being the first Health and Care Workforce Futures Strategic Framework in Wales, we have taken time to develop the framework with the people of Powys and partners of the Regional Partnership Board, including

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representatives from social care, health, the voluntary and independent sectors. Over 300 people were engaged with as part of the development of the framework.

The Strategic Framework articulates our aspirational outcomes we want to achieve between now and 2027. It focuses on 5 key themes which include Designing, Planning and Attracting the Workforce; Leading the Workforce; Engagement and Wellbeing; Education, Training and Development and Partnership & Citizenship. Each of the themes are underpinned by Utilising Technology and a Digital Infrastructure.

Early 2020, partners across the county will collectively progress the implementation of the Strategic Framework in Powys. This is a significant move forward in Wales to address the transformation of health and care service delivery through supporting the workforce in the best way.

Mental Health Support and Wellbeing at Work

The Wellbeing at Work Group held regular meetings throughout 2019, the group organised Wellbeing at Work Roadshows across Powys. Roadshows are open to all health board colleagues and aim to provide an opportunity to promote the benefits and support the health board can offer employees.

Mental health support continues to be one of our main priorities. A robust Occupational Health (OH) triage is in place through rapid telecom access to the OH Mental Health Nurse/OH Manager. The OH Registered Mental Health Nurse is able to support employees' mental health by delivering stress management awareness sessions, as well as employee resilience training.

In addition, PTHB offers SilverCloud, which is an online Cognitive Behavioural Therapy (CBT) programme that staff can access through primary care, mental health, the Occupational Health department or through self-referral. The programme offers a broad choice of supportive modules and the provider is able to add modules specific to the need of Powys workforce.

Through external provider we have been able to increase a number of counsellors, who can offer weekly sessions in Bronllys, Welshpool and Newtown; as well as supporting additional locations across the county and immediate telephone provision.

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Organisational Development Framework
The Organisational Development (OD) Strategic Framework has been developed and approved at Executive Board and provides an organisational Operating Model and high-level key priorities. The role of the framework is to focus on improving the effectiveness of Powys Teaching Health Board and to support the alignment, delivery and improvement approach across all areas and levels.

Leadership and Management Training

Leadership and management development is a key priority in the Organisational Development Strategic Framework and fundamental for continued improvement as shown in the 2018 staff survey. At the core of all of the programmes is the Compassionate Leadership Model developed by Professor Michael West at Kings Fund.

A leadership and management development framework has been created to ensure that managers at each level have access to the development that they require to undertake their role effectively. This includes:

- Introduction of an internal Manager's programme for all managers at Band 7 and below.
- The continued delivery of the Level 5 Diploma in Leadership and Management, again through USW as part of the Apprenticeship Framework. This also sees the continued joint working with Powys County Council.
- The development of an Assistant Director Development Programme to support the transition from operational to strategic leadership positions.
- An Executive Development Programme that has involved the Executive Team undertaking observed sessions, coaching and feedback as well as away sessions to explore their development as a team.

Resourcing: Recruitment, Retention and Temporary Staffing

Recruitment and retention of staff continues to be an important area of work for the health board. The Recruitment and Retention Group has now been amalgamated with the Workforce Improvement & Efficiencies Group, which is exploring new and innovative approaches in terms of recruitment. We are further developing new relationships with schools in the hope of nurturing our future workforce through avenues such as the Powys Careers Fair, mock interviews and presentations. We continue to maintain relationships

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with the local Job Centres and Careers Wales to expand the promotion of our job opportunities within the communities of Powys. Work to support armed forces veterans into employment continues, with the health board now signed up to the Armed Forces Covenant.

The achievements to date that have supported the work of resourcing team and temporary staffing unit are:

- the centralising of bank and agency requests and bank worker recruitment;
- continue the pilot of the 'Hard to Fill' enhanced shift payment scheme;
- all bank workers now receive electronic payslips;
- new process agreed to fast track registered nurses through the recruitment shortlisting process and therefore guarantee them an interview for bank and substantive roles.
- new Health Care Support Worker (HCSW) fast track process for 1st year student nurses has been agreed.
- successful appointment of 4 newly qualified nurses via the student streamlining process.

Nurse Staffing Act

The All Wales Staffing Group work steam has focused on the reporting requirements of the Act, namely section 25E (2a) whereby health boards have to report 'the extent to which the nurse staffing levels have been maintained'. The Act will be extended to Paediatric Services, interim principles are now in place and compliance is being submitted twice yearly.

Interim District Nursing Principles remain in place whilst the Welsh Levels of Care Acuity Tool is developed for District Nursing. The health board is generally compliant against all but two of the principles.

A Nurse Staffing Annual report will be submitted to the Board in early 2020.

Wales for Africa

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They have a sitting volleyball project going at the moment to raise the profile of disabled people for which we had a fundraiser this week.

Awards (pics needed)

Benefits of a Local serial Casting service for Children and Young People in Powys shortlisted for an NHS award 2019
.
First leadership conference held for Paediatric Physiotherapists from whole of Wales August 2019

Paediatric & 14+ Physiotherapy Technician 2nd in Wales to complete the Level 3 Agored Cymru Diploma

Paediatric Physiotherapist presented at Physiotherapy UK 2019 & the Senedd in Cardiff on Serial casting

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LOOKING FORWARD

Table 2: What we'll do in 2020/21

	What we'll do	How we'll measure it
Staying Healthy	To be added	To be added
Safe Care	To be added	To be added
Effective Care	To be added	To be added
Dignified Care	To be added	To be added
Timely Care	To be added	To be added
Individual Care	Liaise with NWSSP to undertake a detailed audit of compliance levels with the Welsh Language Standards and identify areas for further improvement.	Increased compliance with the Welsh Language Standards
	The health board will launch a new bilingual website in May 2020.	Bilingual website in place
Staff and Resources	Increase in the number of managers trained through our internal Manager's Programme	Percentage increase in the number of managers trained through our internal Manager's Programme

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Thank you for reading our Annual Quality Statement

Our mission is to deliver high quality care and services to you.

We welcome your feedback on this publication. Please access our Survey and tell us what you think works well and what we can do better next year.

If you would like to comment on this publication you can contact us in the following ways;

Post:
Powys Teaching Health Board
Glasbury House
Bronllys Hospital
Bronllys
LD3 0LS

Email: ***powys.geninfo@wales.nhs.uk***

Telephone: **01874 711661**

Website: ***www.powysthb.wales.nhs.uk***

Facebook: ***www.facebook.com/PowysTHB***

Twitter: ***@PTHBhealth***

YouTube: ***www.youtube.com/PowysTHB***

We welcome all comments and are happy to provide further information on request.
WWW www.powysthb.wales.nhs.uk
www.facebook.com/PTHBhealth

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Find out more...
Please contact us to request this report in a different format.

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AGENDA ITEM: 4.1

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**DATE OF MEETING: 30 July 2020**
Subject:	**Health and Social Care (Quality and Engagement) (Wales) Act 2020**
Approved and Presented by:	Board Secretary
Prepared by:	Board Secretary
Considered by Executive Committee on:	Not discussed previously
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

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 has now received Royal Assent. Having received Royal Assent, the Bill now becomes The Health and Social Care (Quality and Engagement) (Wales) Act 2020.
https://gov.wales/health-and-social-care-quality-and-engagement-wales-act

The purpose of this paper is to provide an overview of the elements of the Act which will apply to Powys Teaching Health Board upon implementation.

RECOMMENDATION(S):

The Experience, Quality & Safety Committee is asked to NOTE this update for information.

Approval/Ratification/Decision	**Discussion**	**Information**

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		✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	
	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. 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	✓

INTRODUCTION:

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 has now received Royal Assent. Having received Royal Assent on 01 June 2020, the Bill is now The Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The purpose of the Act is to support an ongoing, system-wide approach to quality improvement within the NHS; to further embed a culture of openness and honesty; and to help drive continual public engagement in the design and delivery of health and social care services.

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 – will 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;

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- strengthen the voice of citizens, by replacing Community Health Councils with a new all-Wales Citizen Voice Body that will 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 is therefore "Not yet in force" and a date by which it will be appointed is to be confirmed, although Spring 2022 is anticipated.

BACKGROUND AND ASSESSMENT:

In 2018, the Parliamentary Review of Health and Social Care in Wales set out a number of recommendations including those relating to improvement in the quality of services and closer integration of health and social care. These form key threads within the Welsh Government's response: A Healthier Wales: our Plan for Health and Social Care and are supported by provisions in the Act.

Continuous improvement in quality will be key to making the health and social care system in Wales both fit for the future and one which achieves value. The establishment of a Citizen Voice Body, covering both health and social services, will ensure that the voices of citizens are engaged, listened to and clearly heard. This will support the delivery of health and social care services that are designed around the needs and preferences of individuals.

Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture. To help achieve this, the Act:

- places an overarching duty of quality on the Welsh Ministers; and
- reframes and broadens the existing duty on NHS bodies.

This ensures the concept of "quality" is used in its broader definition, not limited to the quality of services provided to an individual nor to service standards.

The Act will ensure Welsh Ministers (in relation to their health functions) and NHS bodies exercise their functions with a view to securing improvement in the quality of health services.

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The duty is not intended to deliver a particular outcome or to ensure a particular level of service is attained; it will require that, when the Welsh Ministers and NHS bodies make decisions about health services, they must actively consider whether the decision will improve service quality and secure improvement in outcomes. This approach supports the five ways of working as set out within The Well-being of Future Generations (Wales) Act 2015, by encouraging long-term thinking and integrated and collaborative action that works to achieve the well-being goal of A Healthier Wales.

Additionally, the duty seeks to strengthen governance arrangements by requiring the Welsh Ministers and NHS bodies to report annually on the steps they have taken to comply with the duty and assess the extent of any improvement in outcomes.

The details of how the duty will work in practice will be contained in statutory guidance, which will be developed in partnership with stakeholders, and training will be developed to support implementation.

The responsibilities of Powys Teaching Health Board in respect of the Duty of Quality will be set out in statutory guidance as mentioned above.

Duty of Candour

A culture of openness, transparency and candour is widely associated with good quality care. To help achieve this, the Act places a duty of candour on providers of NHS services (NHS bodies and primary care) - supporting existing professional duties.

The duty requires NHS providers to follow a process – to be set out in Regulations – when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

The Act contains a power for Welsh Ministers to issue statutory guidance in relation to the duty of candour. It is intended that this guidance will be a practical document, developed by Welsh Government with stakeholders, to aid in the implementation of the duty. In particular, it is intended that the meaning of "more than minimal" harm will be set out in the guidance with examples and illustrative case studies in order to aid understanding and promote consistency in the application of the duty across Wales.

The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

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The Act requires NHS providers to report annually about when the duty has come into effect - how often the duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence.

Using existing statutory powers, the Welsh Government also plans to make separate regulations (under the Care Standards Act 2000) to place a duty of candour on regulated independent healthcare providers. This will align the NHS and regulated independent healthcare, whilst complementing the duty placed on providers of regulated services (under the Regulation and Inspection of Social Care (Wales) Act 2016), to create a whole system approach to candour.

The responsibilities of Powys Teaching Health Board in respect of the Duty of Candour will be set out in regulations and statutory guidance as mentioned above.

Citizen Voice Body

The drive towards closer integration of health and social services with improved public engagement is reflected in the aims of Welsh Government's *A Healthier Wales.* This sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement.

To realise this ambition, the Act will replace Community Health Councils (who currently represent the patient voice in the health service only) with a new national body - the Citizen Voice Body ("CVB") - that will exercise functions across health and social care. The aims of the new body are to:

- strengthen the citizen voice in Wales in matters related to both health and social services, ensuring that citizens have an effective mechanism for ensuring that their views are heard;
- ensure that individuals are supported with advice and assistance when making a complaint in relation to their care; and
- use the service user experience to drive forward improvement.

This new organisation will be established as a national body but it will be structured in such a way as to enable it to perform its functions at a national, regional and local level. The Act places duties on the new body, NHS bodies and local authorities to make arrangements to co-operate, with a view to supporting each other to promote awareness of the CVB. They are also under a duty to make arrangements to support the new body in seeking the views of the public in respect of health services and social services.

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It is expected that Welsh Government will publish a code of practice about requests from the CVB to enter health and social care premises to seek the views of individuals. There will also be statutory guidance to which NHS bodies and local authorities must have regard when dealing with representations made to them by the CVB.

Powys Teaching Health Board formally hosts the seven Community Health Councils that operate across Wales and the Board of Community Health Councils in Wales. Transition arrangements will need to be taken forward in partnership with Welsh Government, the Health Board and Community Health Councils.

Vice Chairs

At present, NHS Trusts are only able to appoint a Vice Chair from their existing Independent Members and these are only able to provide cover in times where the Chair may be unavailable or unable to undertake their responsibilities.

The new powers within the Act will provide for Welsh Ministers to appoint a specific Vice Chair role on the boards of NHS Trusts. This will enable Vice Chairs to fully contribute to the work of NHS Trusts, strengthen the capability of their Independent Membership, improve governance and decision-making processes, and provide consistency across Wales.

Appointment to a position with a defined role and greater time commitment may lead to widening the application pool and interest from candidates, with Ministers able to clarify a different and more appropriate skill set within the job description.

This element of the Act will not apply to Powys Teaching Health Board which is established as a Local Health Board under the National Health Service (Wales) Act 2006.

NEXT STEPS:

An Implementation Plan will be developed, linked to the Board's Clinical Quality Framework, and other relevant arrangements, once statutory guidance and regulations are finalised. PTHB will engage in the development of national work where appropriate.

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Agenda item: 4.2

EXPERIENCE, QUALITY & SAFETY COMMITTEE	30 July 2020
Subject:	**PUTTING THINGS RIGHT, CLAIMS AND COMPENSATION ANNUAL REPORT 2018-2019**
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 23/07/2020

PURPOSE:

The purpose of this report is to provide the Experience, Quality and Safety Committee with the Putting Things Right, Claims and Compensation Annual Report 2019/2020 (see **Appendix 1**) prior to onward approval by the Board.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to NOTE and DISCUSS the Putting Things Right, Claims and Compensation Annual Report 2019/20 prior to onward approval by the Board.

Approval/Ratification/Decision	Discussion	Information
✘	✓	✘

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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 Committee with the Putting Things Right, Claims and Compensation Annual Report 2019/2020 prior to onward approval by the Board.

It is 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 is evident in the report but a greater focus is needed on the learning and sharing of lessons, and assurance that changes have been put in place and sustained.

Patient feedback supports the provision of services in Powys as generally positive, but it is recognised work is required to gather feedback from patients irrespective of where they access services, care and treatment.

Improvement actions have been identified for 2020/21.

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DETAILED BACKGROUND AND ASSESSMENT:

Background

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care. The health board is required to implement and comply with these Regulations and provide redress as appropriate.

Putting Things Right Arrangements

The arrangements for managing Putting Things Right remains the delegated responsibility of the Executive Director of Nursing & Midwifery. The Assistant Director Quality and Safety continues as the Senior Investigation Manager and oversees the Patient Experience / Concerns Team.

Publication

The publication of an annual report is required in accordance with Regulation 51 and 51(1). The report will be made available via the intranet and internet and a copy sent to Welsh Government.

Concerns and Patient Experience 2019/2020

Progress in managing **concerns** (complaints) 2019/2020 continues with improvement work detailed in the previous year work still being undertaken with further robust actions being implemented including:

- Daily training and support;
- 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; and
- Weekly reports being provided to the Directorates.

The year-end position for responding to concerns within 30-working days is below the expected target of 75% and actions are in place to address the areas for improvement.

Complaints to the Public Services Ombudsman for Wales about how the health board had handled complaints decreased over the past year, but there are still key areas for improvement highlighted as communication and delay in providing responses to complainants. Action is ongoing to address areas for improvement.

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In respect of **serious incidents**, NHS Organisations are required to provide Welsh Government with an assurance that a robust investigation has been completed and learning identified within 60 working days. The health board's assurance compliance has varied from 0%-100%. A proactive action plan has been put in place to address areas for improvement and new processes being established and a new Serious Incident Policy being approved with a toolkit to support staff who are undertaking investigations to ensure that learning is captured.

There is a keen focus on establishing learning at an earlier stage which has come from both Welsh Government and from the Welsh Risk Pool to ensure that all health boards are sharing the learning from all incidents, concerns and claims.

A variety of mechanisms are in place to gather **patient experience** feedback, the majority of which focusses on provided services. Work progressed through the year via Health & Care Standards Monitoring system has resulted in health board wide feedback, an example of which shows overall patients are generally pleased with the standard of care provided. It is recognised this work requires focus in 2020/21 to strengthen the systems and processes in place for listening to patients, carers, families and residents, irrespective of where they access care, treatment and services.

Going Forward

Improvement actions are in place to address the areas highlighted and these are subject to weekly discussion, monitoring and action.

NEXT STEPS:

1) The Putting Things Right Annual Report 2019/20 will be submitted for Board approval.

2) Publish the Putting Things Right Annual Report 2019/20.

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PUTTING THINGS RIGHT
CLAIMS AND COMPENSATION
ANNUAL REPORT 2019- 2020

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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.

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The Report is published in support of the health board's Annual Quality Statement.

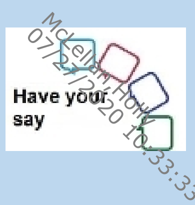
Focus of Report

Formal Concerns

Informal Concerns

Redress

Compensation Claims

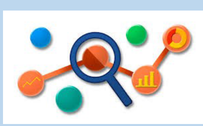


Compliments and overall patient experience

Serious Incidents

Never Events

Compliance with Regulations



Trends, themes and lessons learnt

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)	15 clinical negligence claims (inc 2 new cases in a year 4 Personal Injury (inc 2 new cases in year)
Serious Incidents	55	53
Never Events	0	0

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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%

McLellan,Holly
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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.

McLellan,Holly
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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 & Midwifery, 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.

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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 & Midwifery, 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 Chief Executive Officer.

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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

McLellan, Holly
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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.

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Concerns Statistics -Formal Concerns

During 2019-2020 the Health Board received 258 concerns (Table 1); relating to services provided by Powys Teaching Health Board.

	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.

McLellan,Holly
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Concerns Statistics – Commissioned Services

- Of the 62 concerns notified to the health board 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

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.

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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.

McLellan,Holly
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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.

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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:

McLellan,Holly
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- 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 .

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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.

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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.

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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.

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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.

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No themes or trends were reported.

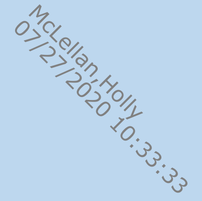
Examples of lessons learnt included:

- 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.

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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.

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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.

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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

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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

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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.

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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

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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

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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.

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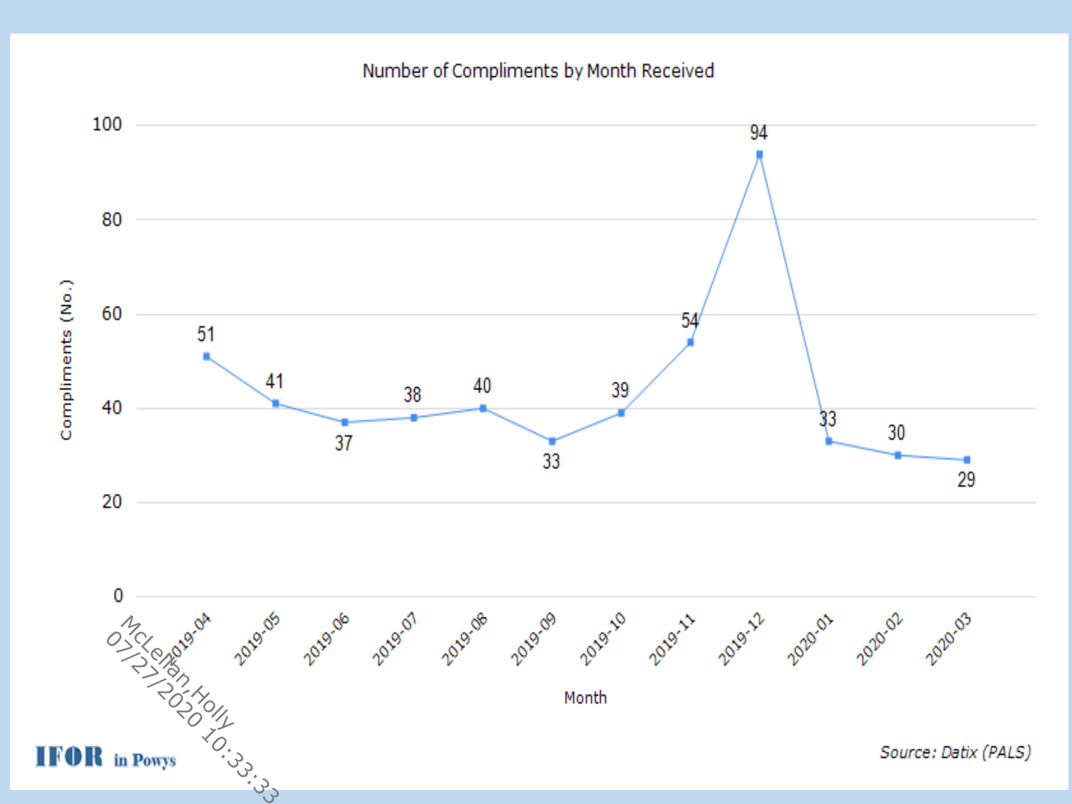
Compliments and overall patient experience



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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".

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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.

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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.

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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

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Putting Things Right Information page:

www.wales.nhs.uk

Agenda item: 4.3

EXPERIENCE, QUALITY & SAFETY COMMITTEE	30 July 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**

PURPOSE:		
This report provides the Experience, Quality & Safety 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.		
RECOMMENDATION(S):		
The Committee is asked to NOTE the annual Public Service Ombudsman for Wales Report and the Executive Summary that has been published.		
Approval/Ratification/Decision	**Discussion**	**Information**
✗	✗	✓

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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 overview of the Public Services Ombudsman (Wales) Executive Summary, Annual Report and Accounts 2019/2020 which has been published.

DETAILED BACKGROUND AND ASSESSMENT:

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

The Public Services Ombudsman for Wales Annual Report and Accounts and Executive Summary 2019/2020 has been published on line via the following link **Annual Report and Accounts 2019/20**. The headlines indicate that the number of complaints being raised has seen an 1.6% increase from 2018/2019 with 65% of the new cases being queries and a noted 2% decrease in complaints being in relation to the concerns handling. The executive summary can be found at **Appendix 1**.

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The Annual Report (**Appendix 2**) notes there has been a 1.3% increase of complaints being raised in relation to NHS Bodies which including health boards, NHS Trusts, Dentists, General Practitioner's, Opticians and Pharmacists. Healthcare concerns continue to constitute the main subject of new complaints reaching the Public Service Ombudsman Office and it is noted there is with no significant change since 2018/19 report in respect of this.

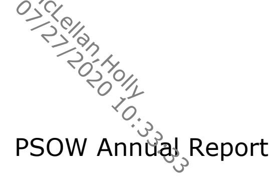
The proportion of new complaints about complaint handling has decreased from 11% to 9%. It is noted as a welcomed trend by the Public Service Ombudsman (Wales) this is considered the volume of complaints about complaint handling as an important indicator of the overall standard of complaint handling in the public sector. Which was an issue for the health board that was identified in last year's report and there is still work and processes being established to strengthen the position around complaints handling.

The Public Service Ombudsman Report has separated complaints in this year report in to two sections complaints against Powys Teaching Health Board and complaints about the All Wales Continuing Health Care cases

The health board has seen a reduction in complaints to the PSOW by 11.5% on last year and there has been a 5% decrease on the intervention rates from last year to 54% from 59% and there has also been 13% decrease in interventions in respect of the All Wales Continuing Health Care Cases from 44% during 2018/2019 to 31% during 2019/2020.

The report shows that, compared to last year, the Public Service Ombudsman rate of intervention in complaints against all health boards decreased from 39% to 31%. Whilst the report records a high intervention rate for Powys Teaching Health Board (excluding All Wales Continuing Health Care cases) which was 54%. The report reflects the following that it is important to note that the overall number of complaints about the health board that closed this year was very small as there were only 13 cases.

The team have been working with the Public Service Ombudsman office to have open communication with them and the complainant at the earliest opportunity with the view to resolving as many complaints at the early resolution stage. The team have also engaged with other health boards to discuss areas of good practice to learn and improve on this position.



NEXT STEPS:
1) The health board will provide the Committee updates on the implementation of the future provisions of the Public Services Ombudsman (Wales) Act 2019.

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PUBLIC SERVICES OMBUDSMAN FOR WALES
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Delivering Justice

The Public Services Ombudsman for Wales

ANNUAL REPORT AND ACCOUNTS

2019/20

Executive Summary

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Message from the Ombudsman

This document was prepared during the Covid-19 global pandemic which has put unprecedented pressures on Welsh public services, particularly health and social care. I am therefore glad to report this year some trends that could indicate improvement in practice by bodies in my jurisdiction.

We saw this year fewer new complaints; a smaller proportion of cases where we found maladministration or service failure; and fewer most serious cases, requiring us to issue a public interest report or refer an alleged breach of the Code of Conduct to the Adjudication Panel for Wales or Local Authority Standards Committees.

Amongst the main highlights of the year, in 2019 the National Assembly for Wales passed our new Act. We are now the first ombudsman office in the UK to have full and operational powers to drive systemic improvement of public services through investigations on own initiative and the Complaints Standards role. We took this year major steps to implement these new powers, alongside our more traditional work to promote improvement.

None of this work would have happened without my dedicated staff. My thanks to them for the excellent work that they have done in delivering justice in Wales.

Nick Bennett
Public Services Ombudsman for Wales

About us

We have three main roles:

- handling complaints about public service providers
- considering complaints about breaches of the Code of Conduct by elected members
- driving systemic improvement of public services.

We are independent of all government bodies and the service we provide is free of charge.

We are based in Pencoed, South Wales. We also have a small office in North Wales.

Contact us

1 Ffordd yr Hen Gae, Pencoed, CF35 5LJ

0300 790 0203

ask@ombudsman.wales

https://www.ombudsman.wales/

We have **73** staff

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We deliver for those who have suffered injustice

	2019/20	2018/19
New enquiries and complaints	7200	7116
New complaints about public bodies	2242	2207
About		
Health	41%	41%
Housing	15%	12%
Complaint handling	9%	11%
Social services	8%	9%
Planning and building control	7%	9%
Other	20%	18%

1.6% more new complaints about public bodies. This could indicate a drop in their performance - but could also be attributed to increasing awareness of our service.

Despite the same level of complaints about health overall, **3%** fall in new complaints about Health Boards, suggesting that our work with these bodies may be helping to support improvement.

	2019/20	2018/19
New Code of Conduct complaints	231	282
About		
Promotion of equality and respect	49%	51%
Disclosure and registration of interests	17%	17%
Accountability and openness	11%	7%
Integrity	10%	13%
Duty to uphold the law	7%	9%
Selflessness and stewardship	3%	1%
Objectivity and propriety	2%	2%

18% fewer allegations of breaches of the Code of Conduct, due to a significant and welcome drop in frivolous complaints made against members of Town and Community Councils.

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We had to intervene in (uphold, settle or resolve early) a smaller proportion of complaints about public bodies: 20% compared to 24% last year.

We also referred a smaller proportion of Code of Conduct complaints to a Standards Committee or the Adjudication Panel for Wales: 2% compared to 3% last year.

1222 recommendations issued to public bodies.

Almost £80k of financial redress recommended.

0 We did not need to issue any special reports.

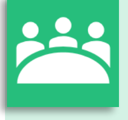
20% of our recommendations highlighted retraining or process reviews. This can lead to significant improvement in public services.

An example of impact of our recommendations

We investigated this year a complaint brought to us by the family of someone who had sadly died. The family was concerned about the care given by the Health Board in question, including intravenous (IV) fluid management. We recommended that the Health Board review its procedures. As a result, the Health Board recognised it did not have an up to date IV fluid management policy. The Health Board also appointed a clinical lead to co-ordinate new guidelines and, in December 2019, published new guidance on this issue.

We innovate and drive improvement across the public sector

Our new legislation passed in 2019 gave us new powers to undertake investigations on 'own initiative' as well as to establish a Complaints Standards role.



We launched a consultation on our proposal to focus our first own initiative investigation on homelessness.

We finalised our Complaint Handling Principles, Model Complaints Handling Policy and accompanying guidance.

We engaged extensively about our new powers with stakeholders across Wales.

We issued criteria and a process for undertaking own initiative investigations.

We started to gather data from Local Authorities on their complaint handling, finding much divergence in practices across Wales.

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We also continued to share our findings through public interest reports, casebooks, thematic reports and annual letters to the bodies in our jurisdiction.

We issued:	About		
4 public interest reports	Health		2
	Planning		1
	Student loans		1
1 thematic report	Justice Mislaid: Lost Records and Lost Opportunities		

We published our first Equality and Human Rights Casebook

"The new Human Rights Casebook by the Public Services Ombudsman for Wales is an excellent resource for ensuring that public bodies remain committed to their equality and human rights obligations."

Equality and Human Rights Commission

We embrace learning and welcome feedback

227 review cases were closed.

11% of these reviews identified that we could do more, often where additional evidence was provided by the complainant.

32 complaints about us were closed.

22% of these were upheld or partially upheld.

57% of all complainants questioned were satisfied with our customer service...

...rising to **98%** amongst those satisfied with the outcome of their complaint.

We strive to ensure and promote accessibility, equality and diversity

91% of our customers questioned found it easy to contact us.

48% of respondents to a national survey knew about us.

2% of complaints were received orally. We are planning more outreach around this power in 2020/21.

87% of respondents to our staff survey felt that PSOW is committed to creating a diverse, equal and inclusive workplace.

We signed up as a Disability Confident Committed Employer.

FAIRPLAY EMPLOYER

We achieved the silver FairPlay Employer level for gender equality.

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We care for and invest in our staff

99% of respondents to our staff survey were proud to work for PSOW.

93% of staff completed 28 or more hours of continuing professional development.

We saw the average percentage of working days lost through staff sickness increase to **3.4%**

... but we launched our new Wellbeing Strategy and a number of actions to support staff wellbeing.

We are accountable and transparent about our performance and use of resources

Our budget **£4,954k**

92% of our budgeted funding for new powers (£231k) was actually spent on implementation.

Our unit cost per case **£669**

Over the last 7 years we have seen

a **34%** rise in workload

a **14%** fall, in real terms, in unit cost per case.

We attended two scrutiny sessions with the National Assembly for Wales.

We reduced our energy usage by 2%.

We maintained close links with colleagues in the UK, Europe and around the world.

We reduced our waste by 13.2%.

We avoided **41%** more commuting mileage per day.

McLellan,Holly
07/27/2020 10:33:33

Delivering Justice

The Public Services Ombudsman for Wales

ANNUAL REPORT AND ACCOUNTS

2019/20

McLellan,Holly
07/27/2020 10:33:33

COVID-19

This Report was produced in April and May 2020, against the backdrop of the Covid-19 outbreak. Most of the data in this Report relates to the period before the rapid escalation in Covid-19 spread and before restrictions on economic and social activity had been introduced. However, Covid-19 has affected our activity towards the end of the year and this is acknowledged, where appropriate, in the Report.

The Annual Report was produced while staff were working at home. Whilst staff had access to our systems and to our data, working remotely has been challenging and this may be reflected in the final Report.

THE WELSH PARLIAMENT

On 6 May 2020 the National Assembly for Wales became 'the Welsh Parliament' or 'Senedd Cymru'. This report refers to the period prior to this change, therefore for correctness we still use the name 'National Assembly for Wales' in the relevant sections.

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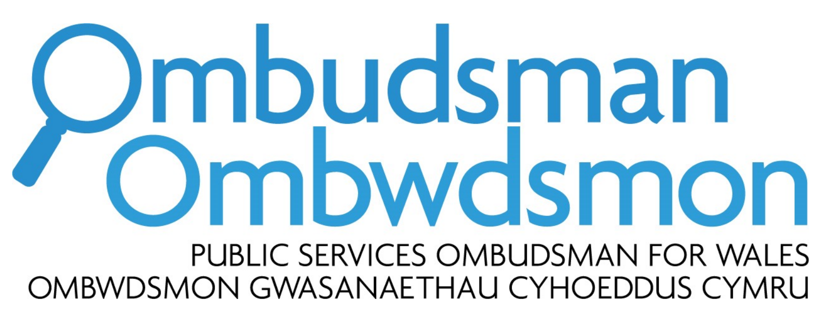

Annual Report and Accounts 2019/2020

of the Public Services Ombudsman for Wales

for the year ended 31 March 2020

Laid before the Welsh Parliament under paragraphs 15, 17 and 18 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019.

McLellan,Holly
07/27/2020 10:33:33

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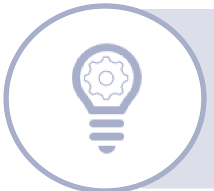
Key messages

We deliver for those who have suffered injustice.



We innovate and drive improvement across the public sector.

We embrace learning and welcome feedback.

We strive to ensure and promote equality and diversity.

We care for and invest in our staff.

We are accountable and transparent about our performance and use of resources.

McLellan,Holly
07/27/2020 10:33:33

Foreword

This document was prepared during the Covid-19 global pandemic. Never have Welsh public services, particularly health and social care, experienced such pressures or levels of appreciation. It is pleasing, in that context, that the level of complaints, received by my office in 2019/20, about public bodies was similar to that in the previous year (an increase of only 1.6%). The proportion of our interventions – cases where we find maladministration or service failure – was also lower (20%, compared to 24% last year).

Our most serious cases, on which we publish public interest reports, totalled only 4, compared to 14 the previous year - a reduction of 71%. These related to Flintshire Council, Swansea Bay University Health Board, the Student Loan Company and a joint report involving Betsi Cadwaladr University Health Board, Gwynedd County Council and Cartrefi Cymru. We saw this year a very welcome drop in complaints about breaches of the Code of Conduct (-18%). We also referred fewer investigations of likely breaches of the Code of Conduct to the Adjudication Panel for Wales or Standards Committees, though there were several high profile cases which demonstrated why the ethical standards regime is required to maintain high standards of conduct in public office in Wales.

This Annual Report covers the first year of the implementation of our new Corporate Plan, 'Delivering Justice', and I am delighted to report excellent progress. In one of the key developments during the year, in 2019 the National Assembly for Wales passed our new Act (the 'PSOW Act 2019'), which received Royal Assent in May. We created a new Improvement team with talent from inside and outside the organisation to lead the new work streams on own initiative investigations and Complaints Standards, as well as enhancing policy and communication resources and increasing our emphasis on internal and external complaints handling and service quality. The team wasted no time in getting key stakeholders up to speed, explaining the changes to the bodies in our jurisdiction, public service leaders from across Wales, senior civil servants and key third sector bodies. In October, we laid the criteria for exercising the new powers of Complaints Standards and own initiative investigations before the National Assembly.

Both powers are now operational and in March 2020 we commenced consultation on the proposal for our first own initiative investigation. The Complaints Standards team has begun the ground-breaking work of collecting and analysing data about complaint handling in the public sector.

McLellan,Holly
07/27/2020 10:33:33

This work is still at an early stage, but it already begins to indicate that my caseload represents the tip of the iceberg in terms of the volume of complaints handled by local authorities alone.

In addition to launching the new powers, we continued our other efforts to promote the improvement of public services in Wales. I met key bodies in jurisdiction, including the leaders of Betsi Cadwaladr, Hywel Dda, Swansea Bay and Aneurin Bevan University Health Boards. I also met local government chief executives to discuss the new PSOW Act. We published our fourth thematic report 'Justice Mislaid' and our first ever Equality and Human Rights casebook. We also continued to inform the public policy process where appropriate.

As we do every year, we welcomed scrutiny by the Assembly's Finance Committee and the Equality, Local Government and Communities Committee.

Although I stood down as Chair of the Ombudsman Association in May, we sustained excellent relationships with the ombudsman community in the UK, Europe and across the world. We celebrated the new Act with a seminar in Aberystwyth University addressed by representatives of leading ombudsman schemes. The office also participated fully in the development of the 'Venice Principles', a new global standard of excellence for ombudsman schemes approved by the Council of Europe.

We have continued to liaise with stakeholders in Wales. Amongst many other engagements, I was pleased to attend the National Eisteddfod in Llanrwst and to meet the new Welsh Language Commissioner, Aled Roberts. In March, I was delighted to meet Sir Wyn Williams, President of Welsh Tribunals, following the launch of the report of the Thomas Commission on the future of justice in Wales.

None of this work would have happened without my dedicated staff. I was delighted with the results of our annual staff survey which found that 99% of respondents felt proud to work for PSOW. I was also pleased with the results of an external assessment by Chwarae Teg which demonstrated an excellent working culture. My thanks to my staff for the excellent work that they have done in delivering justice in Wales.

Nick Bennett
Public Services Ombudsman for Wales

McLellan,Holly
07/27/2020 10:23:33

About us

We have three main roles:
handling complaints about public service providers; considering complaints about breaches of the Code of Conduct by elected members; and driving systemic improvement of public services. We are independent of all government bodies and the service we provide is free of charge.

Complaints about public service providers

Our first role is to consider complaints about bodies providing public services where responsibility for their provision has been devolved to Wales. These bodies include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies

We are also able to consider complaints about privately arranged or funded social care and palliative care services and, in certain specific circumstances, aspects of privately funded healthcare.

We consider complaints about maladministration, service failure, or failure to provide a service. This means that we look to see whether people have been treated unfairly or inconsiderately or have received a bad service through some fault on the part of the service provider. If a complaint is upheld, we can recommend redress, or changes in process to ensure that mistakes are not repeated.

Code of Conduct complaints

Our second role is to consider complaints that elected members of local authorities have breached their Codes of Conduct, which set out the recognised principles of behaviour that members should follow in public life. These local authorities include:

- county and county borough councils
- community councils
- fire authorities
- national park authorities

McLellan,Holly
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We are also a "prescribed person" under the Public Interest Disclosure Act for raising whistleblowing concerns about breaches of the Code of Conduct by members of local authorities. Further explanation of our duties in this respect can be found on page 34 of the Report.

Systemic improvement of public services

Our third role is to drive broader improvement of public services. Whilst we have always tried to ensure that lessons from complaints are learned and that public bodies adopt good practice in complaint handling, our office was equipped with new powers to drive systemic improvement under the Public Services Ombudsman (Wales) Act 2019.

Under the Act, we are now empowered to undertake investigations on our own initiative. This means that, where we believe that there is maladministration resulting in personal injustice, we can start an investigation even if we have not received a complaint. More information about our work on the proposed first own initiative investigation can be found on page 55 of this Report.

We are also now empowered to set complaints standards for public bodies in Wales. This means that we can publish a statement of principles concerning complaints handling procedures for bodies in jurisdiction, as well as setting model complaints handling procedures for these bodies. We can also monitor the performance of public bodies in complaint handling, including by reviewing their complaint handling data. Page 52 of this Report details how we have taken forward this role to date.

The first UK ombudsman office equipped with full and operational powers to drive systemic improvement

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07/27/2020 10:33:33

Snapshot of the Year

2019/20

April

We delivered a TPAS Cymru seminar on effective complaints handling in social housing sector.

May

Public Services Ombudsman (Wales) Bill was given Royal Assent.

June

We hosted International Ombudsman Seminar at Aberystwyth University.

July

We met the Welsh Language Commissioner to discuss Welsh Language Standards.

August

We participated in a Youth Rights Panel at the National Eisteddfod in Llanrwst.

September

We gave evidence to the Assembly's Health Committee on the Health and Social Care (Quality and Engagement) (Wales) Bill.

McLellan,Holly
07/27/2020 10:33:33

Snapshot of the Year

2019/20

October

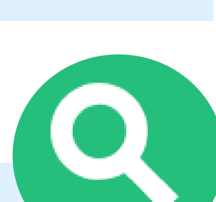
Sitemore 'State of the Nation' report named website ombudsman.wales in its top 10.

November

We published our first ever human rights-focused casebook.

December

We attended the International Ombudsman Institute seminar on the Venice Principles.



January

Our new powers of Complaints Standards and investigations on own initiative became operational.

February

We issued three public interest reports, two covering health matters and one regarding student loan finance.

March

We published thematic report entitled 'Justice Mislaid: Lost Records and Lost Opportunities'.

McLellan,Holly
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Our Key Performance Indicators

Like all public bodies, we measure our performance against a set of Key Performance Indicators (KPIs). The table below presents an overview of our KPIs. We discuss these figures in more detail throughout this Report. You can navigate easily to the relevant sections of the Report by clicking on the KPI title in the table below.

	2018/19	Target 2019/20	2019/20	Target 2020/21
KPI 1: Complaints about public bodies - decision times				
Decision that a complaint is not within jurisdiction < 3 weeks	83%	90%	95%	90%
Decision taken not to investigate a complaint (after making initial enquiries) < 6 weeks	84%	90%	92%	90%
Where we seek early resolution, decision within 9 weeks	85%	90%	94%	90%
Decision to investigate and start investigation within 6 weeks of the date sufficient information is received	55%	80%	67%	80%
KPI 2: Complaints about public bodies which are investigated - cases closed				
Cases closed within 12 months	82%	85%	81%	85%
KPI 3: Code of Conduct complaints - decision times				
Decision taken not to investigate within 6 weeks	92%	95%	93%	90%
Decision to investigate and start investigation within 6 weeks of the date sufficient information is received	76%	80%	86%	90%
KPI 4: Code of Conduct complaints which are investigated - cases closed				
Cases closed within 12 months	88%	90%	88%	90%
KPI 5: Customer satisfaction*				
Easy to find PSOW	84%	90%	91 / 98%	91 / 98%
Service received helpful	51%	70%	63 / 83%	63 / 83%
Clear explanation of process and decision	71%	80%	65 / 89%	65 / 89%

* In 2019/20 we changed the way we measure our customer satisfaction, which makes it difficult to assess our performance against the 2019/20 targets. The 2019/20 results are presented for all respondents as well as those satisfied with the outcome.

McLellan,Holly
07/27/2020 10:33:33

	2018/19	Target 2019/20	2019/20	Target 2020/21
KPI 6: Compliance				
% of recommendations made due and complied with by public service providers in the year	N/A	N/A	72%	N/A
Number of compliance visits	1	3	4	6
KPI 7: HR				
Completion of PRDP (appraisal) reviews	100%	100%	100%	100%
Employee response to staff survey	86%	85%	92%	N/A
KPI 8: Staff training				
% of staff achieving target number of days of continuing professional development	77%	90%	93%	95%
KPI 9: Staff attendance				
Average number of days lost through sickness per member of staff	3.3	< 6	9.0	6.5
% of working days lost through staff sickness	1.2%	2.0%	3.4%	2.5%
% of working days lost through short term sickness	N/A	N/A	1.0%	1%
% of working days lost through long term sickness	N/A	N/A	2.4%	1.5%
KPI 10: Financial				
Cash repaid to Welsh Consolidated Fund	0.5%	< 3%	1.0%	< 3%
Unit cost per case	£599	£700	£669	£700
Support costs as percentage of budget	3.5%	< 5%	4.3%	< 5%
External Audit Opinion on Accounts	Unqualified accounts	Unqualified accounts	Unqualified accounts	Unqualified accounts
Internal Audit Opinion on internal controls	Substantial Assurance	Substantial Assurance	Substantial Assurance	Substantial Assurance
KPI 11: Complaints about us				
Number of complaints received	30	N/A	36	N/A
Number of complaints upheld	9	N/A	7	N/A
KPI 12: Sustainability				
Waste (kg)	31,110	<30,000	26,996	26,000
Electricity (kWh)	106,701	<100,000	104,521	104,000

McLellan Holly
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Deliver Justice

Strategic aim 1

We strive to be a fair, independent, inclusive and responsive complaints service. We continue to deliver justice to the people of Wales by handling complaints about maladministration by public service providers and allegations of breaches of the Code of Conduct by elected members. When we intervene after considering a complaint, we want to ensure that we remedy injustice and drive systemic improvement.

McLellan,Holly
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A short guide to terminology

Caseload: all cases handled by the office.

Case: any engagement with our office by a member of the public.

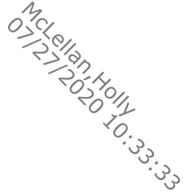
Enquiry: a case where a member of the public contacts us with a general query, does not have the required information to submit a complaint, or the matter in question clearly falls into the remit of another body. In such circumstances we offer advice or signpost people as necessary.

Complaint: a case that proceeds past the enquiry stage to assessment and/or investigation. Complaints can relate either to service providers or to alleged breaches of the Code of Conduct by elected members of local authorities.

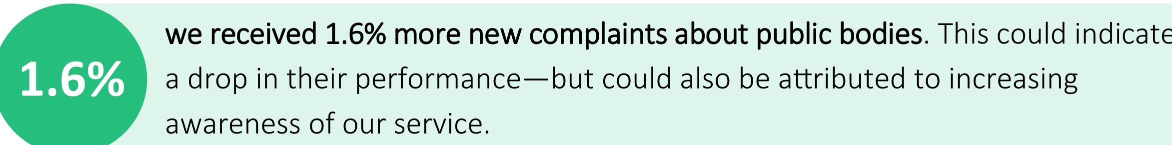
Outcome: our decision after we have considered a complaint.

Intervention: a complaint outcome when we decided that it is appropriate to take an action - uphold a complaint, or propose an alternative remedy or voluntary settlement.

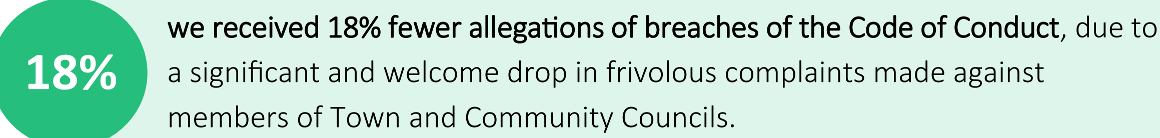
Referral: a type of intervention in the Code of Conduct cases where we refer a matter to a Standards Committee or the Adjudication Panel for Wales for consideration. This may be because the matter cannot be concluded in any other way or because it features serious breaches of the Code.



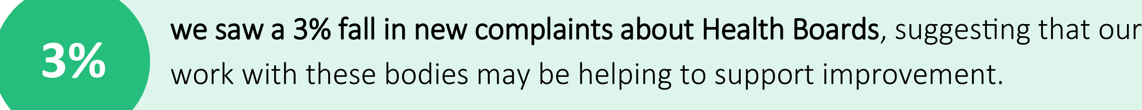
Our casework trends help to highlight some possible changes in performance of public bodies and conduct of elected members. Compared to 2018/19, this year:



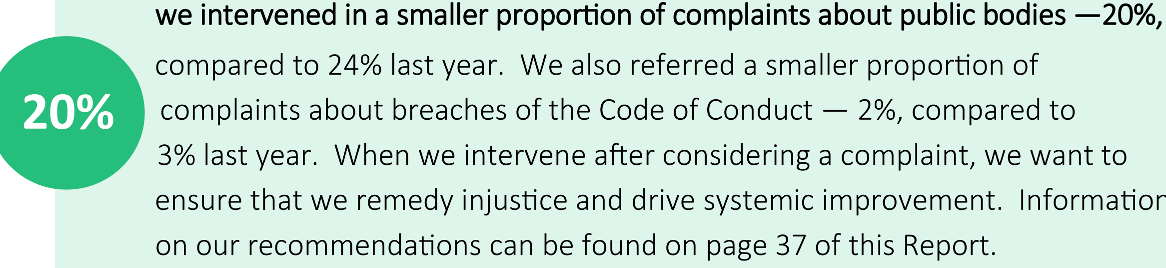
we received 1.6% more new complaints about public bodies. This could indicate a drop in their performance—but could also be attributed to increasing awareness of our service.



we received 18% fewer allegations of breaches of the Code of Conduct, due to a significant and welcome drop in frivolous complaints made against members of Town and Community Councils.

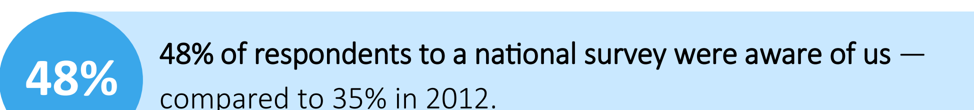


we saw a 3% fall in new complaints about Health Boards, suggesting that our work with these bodies may be helping to support improvement.

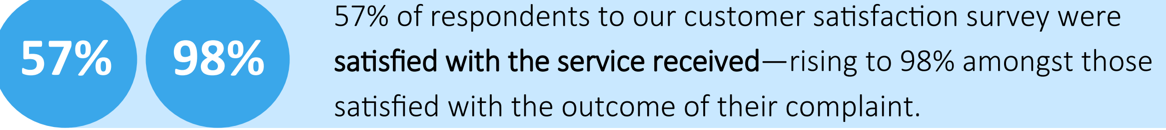


we intervened in a smaller proportion of complaints about public bodies —20%, compared to 24% last year. We also referred a smaller proportion of complaints about breaches of the Code of Conduct — 2%, compared to 3% last year. When we intervene after considering a complaint, we want to ensure that we remedy injustice and drive systemic improvement. Information on our recommendations can be found on page 37 of this Report.

We also work to ensure that we offer the best possible service and that we are accessible to all people who need us. In 2019/20:



48% of respondents to a national survey were aware of us — compared to 35% in 2012.



57% of respondents to our customer satisfaction survey were **satisfied with the service received**—rising to 98% amongst those satisfied with the outcome of their complaint.

2%

using our new powers, **we accepted 2% of all new complaints orally**, helping those with additional needs to access justice.

McLellan, Hayley
07/27/2020 10:33:33

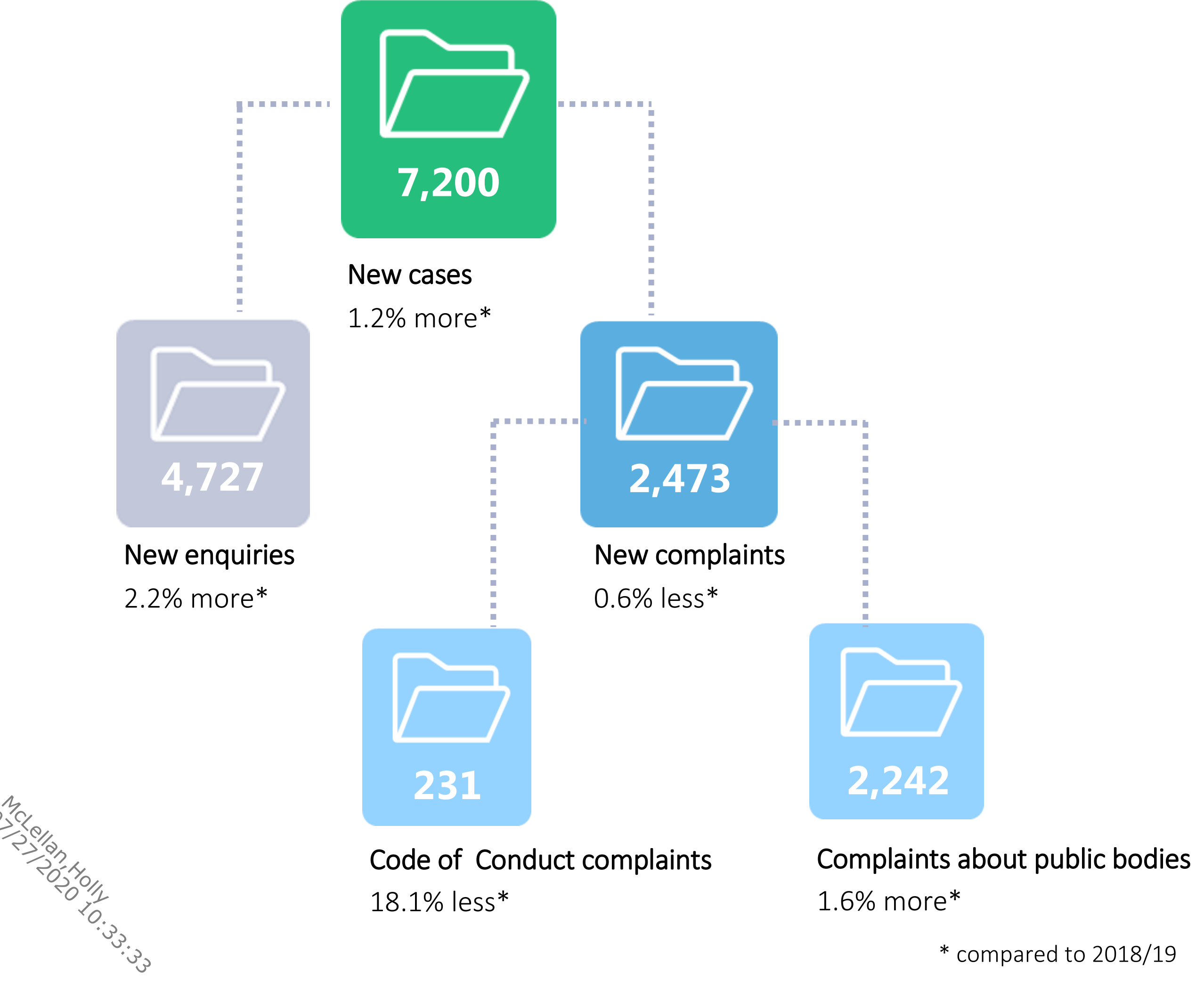
Our caseload volumes and trends

Caseload overview

(a) New caseload

Every year, we are contacted by thousands of individuals. Continuing the trend over recent years, in 2019/20 the number of contacts with our office increased by 1.2% to 7200—the highest since the establishment of the office.

As in previous years, around 65% of new cases involved enquiries rather than complaints. Whilst we welcome all contacts with our office, we continue to work to raise awareness of our role and powers to help people understand when and how we can help.



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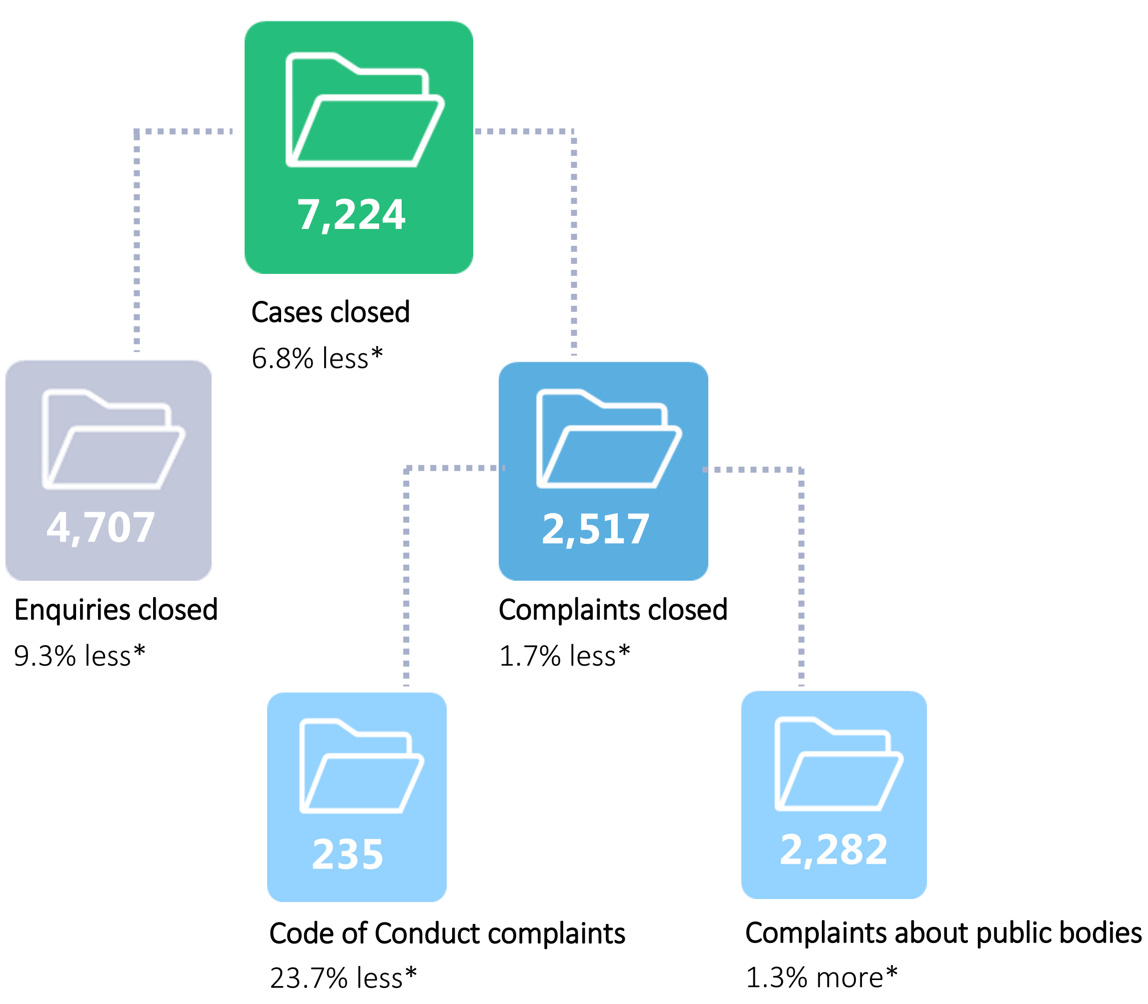
(b) Closed caseload

This year, we closed 6.8% fewer cases overall and 1.7% fewer complaints than in 2018/19. The number of closed complaints about public bodies increased slightly. However, we saw a drop in the number of closed complaints about breaches of the Code of Conduct—although we still closed more Code complaints than we received. **Overall, we still managed to reduce the number of cases open at year end,** from 489 in 2018/19 to 453 in 2019/20.



* compared to 2018/19

The number of cases that we close differs from the number of cases received. This is because some of the cases closed in 2019/20 were received in the previous year, and some cases received in 2019/20 will be closed in 2020/21.

McLellan, Holly
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Complaints about public bodies

(a) New complaints about public bodies

General trends

In 2019/20, we received 2242 new complaints about public bodies - 1.6% more than last year.

We categorise our complaints based on their primary subject. The chart shows the main subjects of new complaints about public bodies reaching our office and changes compared to 2018/19:

Subject	2019/20	2018/19
Health	41%	41%
Housing	15%	12%
Complaint handling	9%	11%
Social services	8%	9%
Planning and building control	7%	9%
Other	20%	18%

We also record our complaints by the type of public body complained about. Our new complaints related to the following groups of bodies:

Body	2019/20	2018/19	% change
NHS Bodies (including Health Boards, NHS Trusts, Dentist, GPs, Opticians and Pharmacists)	1020	1007	+1.3%
Local Authorities (including County/ County Borough Councils and School Appeal Panels)	890	912	-2.4%
Social Housing sector (housing associations)	202	168	+20.2%
Welsh Government and its sponsored bodies	68	68	-
Community Councils	27	23	+17.4%
Other	35	29	+20.7%
Total	**2242**	**2207**	**+1.6%**

McLellan,Holly
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This data points towards three main trends:

- Healthcare concerns continue to constitute the main subject of new complaints reaching our office with no significant change since 2018/19.
- The proportion of new complaints about housing matters in our new complaints overall has increased from 12% to 15%. This has contributed to a 20% increase in complaints about housing associations. This may reflect our efforts over the year to raise awareness of our role within the sector, but we will be monitoring these complaints in the year ahead. More details of this work can be found on page 64 of this Report.
- The proportion of new complaints about complaint handling has decreased from 11% to 9%. We welcome this trend, as we consider the volume of complaints about complaint handling as an important indicator of the overall standard of complaint handling in the public sector.

On its own, the number of new complaints reaching our office does not tell the whole story about the performance of public services.

This year, we have started to use our new power of Complaints Standards to begin to build a picture of the broader number of complaints handled by public service providers.

This work spells a step-change in our ability not only to promote systemic improvement in complaint handling in Wales, but also to contextualise the number of complaints reaching our office.

In due course, the information collected from public bodies will allow us to better understand how the numbers of complaints that we receive relate to the numbers considered through internal complaint handling procedures of the bodies in our jurisdiction.

More details about our Complaints Standards work can be found on page 52 of this Report.

McLellan,Holly
07/27/2020 10:33:33

The next sections discuss in more detail the trends in our new complaints by the main groups of bodies complained about - NHS bodies and Local Authorities.

New complaints: NHS bodies
Of all 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.

As in previous years, Health Boards accounted for the highest number of complaints about NHS bodies. The table below presents a detailed breakdown of new complaints about these bodies compared to 2018/19:

Health Board	2019/20	2018/19	% change
Aneurin Bevan University Health Board	140	134	+4.5%
Betsi Cadwaladr University Health Board	227	194	+17.0%
Cardiff and Vale University Health Board	100	102	-2.0%
Cwm Taf Morgannwg University Health Board*	80	75	+6.7%
Hywel Dda University Health Board	92	109	-15.6%
Powys Teaching Health Board	23	26	-11.5%
Swansea Bay University Health Board*	91	139	-34.5%
Total	753	779	-3.3%

* formerly Cwm Taf UHB and Abertawe Bro Morgannwg UHB— there were changes to names and boundaries on 1 April 2019.

During the year, we worked with all the Health Boards promoting improvements to their service delivery.

More details of this work with the Health Boards, as well as with other public service providers in our jurisdiction, can be found on pages 60-64 of this Report.

McLellan,Holly
07/27/2020 10:33:33

Overall, the number of new complaints about Health Boards has decreased by 3.3% compared to 2018/19. We saw a significant drop in new complaints received about the new Swansea Bay UHB (-34.5%), Hywel Dda UHB (-15.6%) and Powys Teaching Health Board (-11.5%).

On the other hand, as in previous years, Betsi Cadwaladr UHB continued to account for the highest number of complaints about Local Health Boards reaching our office. Betsi Cadwaladr UHB now accounts for 30% of all our new complaints against Health Boards. The second most complained about Health Board is now Aneurin Bevan UHB – showing a 4.5% increase on last year.

The overall increase in complaints about NHS bodies this year appears to be due to an increase in complaints about GPs. Compared to 2018/19, we saw a 24% increase in the number of new complaints about GPs. These complaints are widely spread, with no disproportionate focus on particular GPs or practices.

890

New complaints: Local Authorities

Of all new complaints about public bodies, 890 or 40% were about Local Authorities—a decrease of 2.4% compared to last year.

These complaints relate to a variety of subjects. The main subjects in 2019/20 were:

- Social services: 18%
- Housing: 16.9%
- Planning and building control: 15.4%
- Environment and environmental health: 10.6%
- Complaint handling: 9%

Complaint handling persists as one of the main subjects of our new complaints about Local Authorities. This year, we have engaged intensively with Local Authorities on this issue, starting to exercise our new Complaints Standards powers.

Our Complaints Standards work will allow us to report on all complaints handled by Local Authorities.

McLellan,Holly
07/27/2020 10:33:33

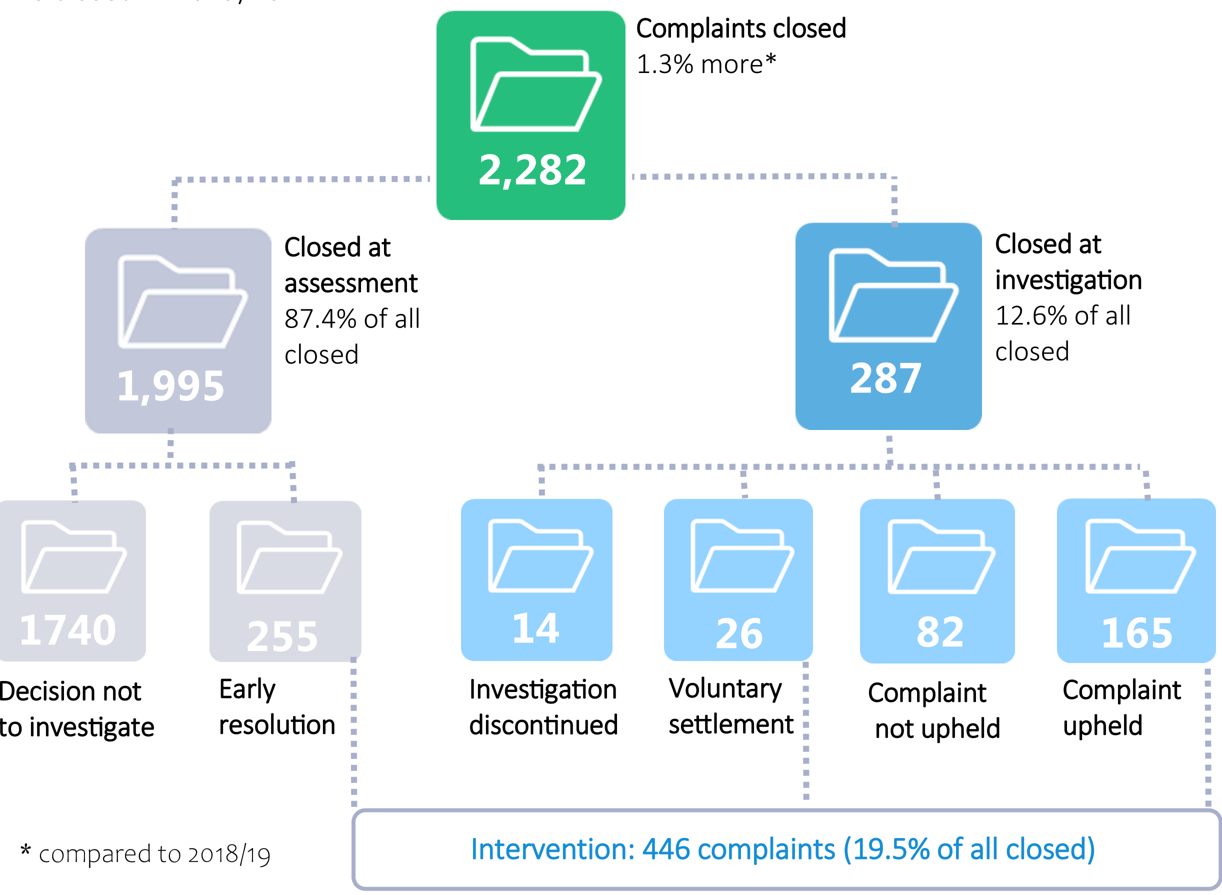
(b) Closed complaints about public bodies

General trends

2282

In 2019/20, we closed 2282 complaints about public bodies - 1.3% more compared to the previous year. This performance contributed to us reducing the number of complaints carried over at the end of the year.

The graphic below presents an overview of outcomes of complaints about public bodies that we closed in 2019/20:



When we receive a new complaint we undertake an initial assessment to determine whether we can and whether we should investigate.

The Public Services Ombudsman (Wales) Acts 2005 and 2019 set out key criteria that must be considered before we investigate. These include a requirement that the body complained about has had a reasonable opportunity to resolve the complaint and that the complaint is made to us within 12 months of the events complained about. If these criteria are not met, the complaint will generally be closed at assessment stage.

McLellan,Holly
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In 2019/20, we closed 87.4% complaints about public bodies at assessment stage - a slightly higher proportion than last year (84.7%). This increase reflects the number of complaints relating to matters outside our jurisdiction, and those made to us prematurely, generally, where the service provider had not had the opportunity to resolve the matter. This underlines the importance of good complaint handling by public bodies. Our Complaints Standards powers should support our work to address this. However, it also suggests that there is more work for us to do to make potential complainants aware of our role and our powers.

Compared to 2018/19, in 2019/20 we investigated a smaller proportion of complaints about public bodies - 12.6% compared to 15.3%. Almost identically to last year, most of our investigations - 82% - related to health. This trend reflects the complexity and seriousness of health cases.

A key measure of performance of public services is the proportion of cases where we intervened – that is, where we decided that there was evidence of maladministration or service failure which required action.

In 2019/20, we found grounds to intervene in 446 or 19.5% of our closed complaints—compared to 23.7% last year. We will monitor this trend in the coming years.

Also, our rate of interventions in health cases specifically dropped from 32% to 26%. This means that we found maladministration and service failure in a smaller proportion of health cases that we closed.

More information on the recommendations we make in cases that we intervene in can be found on page 37 of this Report.

Our interventions also include early resolution of a complaint at assessment stage. We continue to use early resolution where possible as this provides a timely and positive outcome for all parties. This year, early resolutions accounted for approximately 57% of our interventions overall—the same as last year.

1052

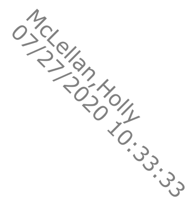
Closed complaints: NHS bodies

In 2019/20, we closed 1052 complaints against NHS bodies - 1.2% more compared to the previous year.

This is positive in terms of the output of the office, given that most of these complaints would have been complex and therefore take longer to investigate. In 2019/20, 97 out of 124 (78%) of our most challenging and complex cases related to NHS bodies.

Of the closed complaints about NHS bodies, 782 related to Health Boards. The table below presents our intervention rate in complaints about individual Health Boards compared to last year:

Health Board	2019/20	2018/19
Current Health Boards	Intervention rate	
Aneurin Bevan University Health Board	33%	38%
Betsi Cadwaladr University Health Board	31%	41%
Cardiff and Vale University Health Board	28%	35%
Cwm Taf Morgannwg University Health Board	15%	-
Hywel Dda University Health Board	32%	42%
Powys Teaching Health Board	54%	59%
Powys Teaching Health Board - All Wales Continuing Health Care cases	31%	44%
Swansea Bay University Health Board	11%	-
Former Health Boards		
Abertawe Bro Morgannwg University Health Board	72%	39%
Cwm Taf University Health Board	43%	33%
All Health Boards	**31%**	**39%**



This year we handled some complaints about two former Health Boards — Abertawe Bro Morgannwg UHB and Cwm Taf UHB. These Health Boards accounted for some of the highest intervention rates by us this year—72% and 43% respectively.

However, these intervention rates are skewed by the fact that the closed complaints against these Health Boards comprised predominantly cases carried over from the previous year that required investigation - with those not requiring investigation generally closed in 2018/19.

We recorded a high intervention rate for Powys Teaching Health Board (excluding All Wales Continuing Health Care cases)—54%. However, it is important to note that the overall number of complaints about this Health Board that we closed this year was very small (13).

In an overall positive trend, we saw that, compared to last year, our rate of intervention in complaints against all Health Boards decreased from 39% to 31%.

This decrease was the highest for:

- Powys Teaching Health Board - All Wales Continuing Health Care cases— reduced from 44% to 31%
- Betsi Cadwaladr UHB —reduced from 41% to 31%
- Hywel Dda UHB - reduced from 42% to 32%

Closed complaints: Local Authorities

In 2019/20, we closed 902 complaints against Local Authority bodies—2.9% fewer than last year. Of these, 879 related to County Councils and County Borough Councils.

Our intervention rate in complaints about the Councils decreased this year from 15% to 13%.

The Councils where we intervened in the highest proportion of cases were:

- Pembrokeshire County Council—24%
- Powys County Council—20%
- Torfaen County Borough Council—20%

Torfaen also saw a significant increase in the rate of our interventions—from 8% in 2018/19 to 20% in 2019/20. However, we saw the highest such increase for Merthyr Tydfil County Borough Council and Monmouthshire County Council. Both these Councils had 0% intervention rate last year, increasing to 13% in 2019/20.

The Councils for which we recorded the highest decrease in intervention rates were:

- Cardiff Council - Rent Smart Wales— reduced from 33% to 0%
- Blaenau Gwent County Borough Council - reduced from 29% to 6%
- Flintshire County Council— reduced from 29% to 14%

During the year we engaged intensely with Local Authorities as part of our new Complaints Standards role to drive improvement in public services. We will continue this work in 2020/21.

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Code of Conduct complaints

(a) New Code of Conduct complaints

This year we received 231 new Code of Conduct complaints - a decrease of 18% compared to 2018/19:

Body	2019/20	2018/19
Town and Community Councils	135	190
County and County Borough Councils	96	91
National Parks	0	1
Total	**231**	**282**

This decrease relates entirely to complaints made against members of Town and Community Councils. This is encouraging and suggests that standards of conduct of members of these bodies may be improving and/or that local resolution of issues may be taking place with good effect.

Nevertheless, within a small number of Town and Community Councils we are still seeing complaints which appear to border on frivolity or are motivated by political rivalry or clashes of personalities, rather than being true Code of Conduct issues.

In fact, 18% of the Town and Community Council complaints received related to members of just one body and were, in effect, 'tit for tat' complaints. In those cases, we were very grateful to the Monitoring Officer of the principal authority who agreed to visit the Council to remind its members of their obligations under the Code and their democratic responsibilities to the communities they serve.

We take a very dim view of complaints of this nature and have, where appropriate, advised members that making frivolous and/or vexatious complaints is a breach of the Code of Conduct in itself.

We categorise the subject of the Code of Conduct complaints based on the Nolan Principles, which are designed to promote high standards in public life.

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The table below shows the proportion of complaints received under each principle when compared to 2018/19:

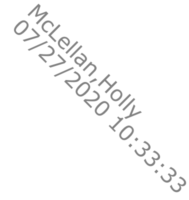
Subject	2019/20	2018/19
Accountability and openness	11%	7%
Disclosure and registration of interests	17%	17%
Duty to uphold the law	7%	9%
Integrity	10%	13%
Objectivity and propriety	2%	2%
Promotion of equality and respect	49%	51%
Selflessness and stewardship	3%	1%

As in previous years, the majority of the Code of Conduct complaints that we received during 2019/20 related to matters of 'promotion of equality and respect' (49%) and 'disclosure and registration of interests' (17%).

We are concerned that these themes continue to dominate. In fact, we have seen year on year an increase in the number of complaints where bullying behaviour is being alleged, particularly from Clerks or employees/contractors of Local Authorities or Town and Community Councils.

This suggests that members could benefit from training or refresher training on these subjects. However, our impression from investigations is that many members of Town and Community Councils often do not take up opportunities offered to them to receive training on the Code of Conduct.

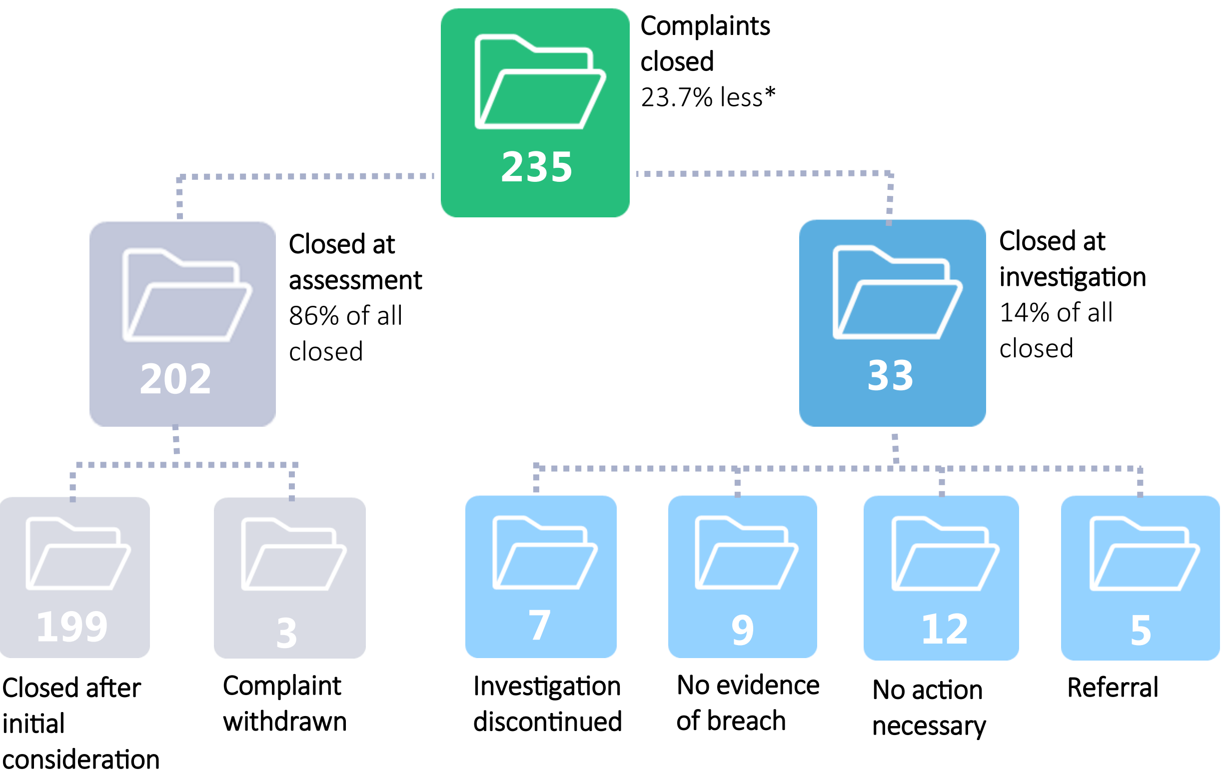
Our view is that Code of Conduct training is essential to becoming a 'good councillor'. We believe that members should embrace this training as soon as they become elected/co-opted and refresh themselves on the provisions regularly. Whilst there is no statutory obligation for members of Town and Community Councils to complete such training, we and the Monitoring Officers across Wales strongly advise them to do so.



(b) Closed Code of Conduct complaints

This year we closed 235 Code of Conduct complaints. This represented a 23.7% decrease compared to the previous year. The rate of closures was also inevitably affected by the number of new complaints received. However, we are glad that we still closed more complaints this year than we received.

The graphic below presents an overview of outcomes of the Code of Conduct complaints that we closed in 2019/20:



* compared to 2018/19

All the Code of Conduct complaints received by our office are assessed against our two-stage test. We consider whether:

- a complaint is supported by direct evidence that is suggestive that a breach has taken place
- it is in the public interest to investigate that matter.

Public interest can be described as "something which is of serious concern and benefit to the public"

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In 2019/20, we closed 202 or approximately 86% of all Code of Conduct complaints after assessment against our two-stage test or after a complaint was withdrawn at the assessment stage. This proportion is only marginally higher compared to the previous year (83%).

The remaining complaints taken forward to investigation represented the most serious of the complaints received.

During the life cycle of an investigation, we review the evidence gathered to assess whether it remains in the public interest to continue. Where it appears that investigating a matter is no longer in the public interest, we will make the decision to discontinue that investigation. Also, sometimes when we investigate we find no evidence of a breach. Finally, when an investigation is concluded, we can determine that 'no action needs to be taken' in respect of the matters investigated. This will often be the case if the member has acknowledged the behaviour (which may be suggestive of a breach of the Code) and has expressed remorse or taken corrective or reparatory action to minimise the impact of it on the individual, the public or the authority concerned.

We made one of these determinations in 85% of the Code of Conduct investigations this year.

In cases which cannot be concluded in this manner or feature serious breaches of the Code, it is necessary for us to refer these matters to a Standards Committee or the Adjudication Panel for Wales for consideration. In 2019/20 we made 5 referrals - that is, we referred 2% of all the Code complaints that we closed, compared to 8 or 3% last year.

The subjects of the Code of Conduct complaints that we closed this year largely mirrored the subjects of the new complaints received. The majority related to 'disclosure and registration of interests' and 'promotion of equality and respect'. We did, however, investigate a higher proportion of cases related to 'disclosure and registration of interests' than the proportion of this theme in the closed Code of Conduct complaints overall:

Subject	All closed	Closed at assessment	Closed at investigation
Disclosure and registration of interests	17%	15%	30%
Promotion of equality and respect	49%	50%	42%

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(c) Referrals

In 2019/20 we made:

- 4 referrals to the Standards Committees
- 1 referral to the Adjudication Panel for Wales

The Adjudication Panel for Wales and the Standards Committees consider the evidence we prepare, together with any defence put forward by the member concerned. They then determine whether a breach has occurred and if so, what penalty, if any, should be imposed.

The referrals to the Standards Committees this year featured behaviour which was considered to be disrespectful, capable of being perceived as bullying and/or disreputable behaviour. One of the cases referred involved conduct suggestive of bullying behaviour towards an employee of a contractor of the authority. At the time of writing, the Adjudication Panel for Wales was considering an appeal, on the issue of sanction only, in this case. Two of the referrals featured behaviour which suggested that the members had used their positions improperly to create an advantage or disadvantage for themselves or others. At the time of writing, these two referrals were awaiting determination.

The referral to the Adjudication Panel for Wales concerned the conduct and behaviour of a member in their private life and considered whether the behaviour complained about was capable of impacting on and bringing the authority into disrepute. It also concerned whether that member had used their position improperly for the advantage of another. In the case of this referral, the Panel determined there were serious breaches of the Code. As a result, a member of Flintshire County Council was suspended from holding office for 3 months.

Between 2016/17 and 2018/19, the Adjudication Panel for Wales and the Standards Committees upheld and found breaches in 88% of our referrals

This year Standards Committees and the Adjudication Panel for Wales also determined 5 cases referred by us in 2018/19. In all these cases, the Standards Committees and the Panel found serious breaches of the Code. Some of the breaches found included serious examples of disrespectful, disreputable and improper behaviour on the part of members towards other members and members of the public. In one case, the member was found to have been in breach of the Code for attempting to interfere with and prejudice our investigation of a complaint made about them. In all cases, the members, or former member, concerned were suspended for a period of 4 months.

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(d) Lessons

As is clear from the above, we make referrals only in a very small number of cases. We do not believe that the cases that we do refer are indicative of a wider decline in member conduct. Nevertheless, outcomes of these referrals demonstrate the importance of standards of conduct in public life and provide a helpful indication to members of all authorities as to the behaviours expected of them.

However, even when we do not refer a case, we try to use our investigation as an opportunity to promote good practice. We usually remind the members investigated of their obligations under the Code and, where possible include instruction on further training or engagement with the authority to prevent further possible breaches. We may also make the members aware that the matter could be taken into consideration in the event of any future complaints of a similar nature.

We think that it is important that we continue to look for innovative and pragmatic ways to resolve matters to ensure a timelier outcome for all concerned. Where appropriate, we also want to give members the opportunity to account for their own actions and for further development.

We plan to revise our Guidance to Members to include analysis of recent cases determined by Standards Committees and the Adjudication Panel for Wales.

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(e) Whistleblowing disclosure report

Since 1 April 2017, the Ombudsman is a 'prescribed person' under the Public Interest Disclosure Act 1998. The Act provides protection for employees who pass on information concerning wrongdoing in certain circumstances.

The protection only applies where the person who makes the disclosure reasonably believes:

1. that they are acting in the public interest, which means that protection is not normally given for personal grievances
2. that the disclosure is about one of the following:

- criminal offences (this includes financial improprieties, such as fraud)
- failure to comply with duties set out in law
- miscarriages of justice
- endangering someone's health and safety
- damage to the environment
- covering up wrongdoing in any of the above categories.

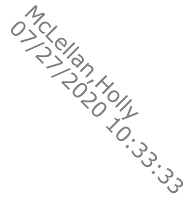
As a 'prescribed person' we are required to report annually on whistleblowing disclosures made in the context of Code of Conduct complaints only.

In 2019/20 we received 5 Code of Conduct complaints that would potentially meet the statutory definition of disclosure from employees or former employees of a council. The disclosures mostly related to allegations that the members concerned had 'failed to comply with duties set out in law'. Of these:

- we closed 2 after an investigation did not identify evidence of a breach of the Code
- we concluded in 1 case that no further action was required
- at the time of writing, investigation into 2 cases is continuing.

In addition, 3 cases which were ongoing in 2018/19 have now been concluded.

These cases have been referred to the Standards Committees of the respective councils for further consideration.



Timeliness

We are conscious of the need to consider complaints in a timely manner. The length of our process reflects the need to investigate thoroughly and diligently, to consider carefully the views and comments of complainants and public bodies and to draw on professional advice when needed. Whilst there is still more work for us to do, the timeliness of our service in 2019/20 has improved in most areas compared to the previous year.

The table below presents our performance this year against our Key Performance Indicators:

	Target	2019/20	2018/19
Complaints about public bodies - decision times			
Decision that a complaint is not within jurisdiction < 3 weeks	90%	95%	83%
Decision taken not to investigate a complaint (after making initial enquiries) < 6 weeks	90%	92%	84%
Where we seek early resolution, decision within 9 weeks	90%	94%	85%
Decision to investigate and start investigation within 6 weeks of the date sufficient information is received	80%	67%	55%
Complaints about public bodies which are investigated - cases closed			
Cases closed within 12 months	85%	81%	82%
Code of Conduct complaints - decision times			
Decision taken not to investigate within 6 weeks	95%	93%	92%
Decision to investigate and start investigation within 6 weeks of the date sufficient information is received	80%	86%	76%
Code of Conduct complaints which are investigated - cases closed			
Cases closed within 12 months	90%	88%	88%

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Whilst we have made progress in improving the proportion of investigated cases where the investigation is started within 6 weeks, we have not yet reached our target of 80%. However, we have been working on this aspect of our service and have been doing better as the year progressed.

We reported last year that an increased number of complex complaints about health services would affect our ability to complete investigations within 12 months. We also reported that performance was likely to be worse in 2019/20 as more older cases were closed. We actually completed investigations within 12 months in 81% of cases (82% in 2018/19). We continue to consider some cases against public bodies brought forward from 2018/19. These will unfortunately continue to affect our ability in 2020/21 to meet our target of 85% cases closed within 12 months.

We measure timeliness from the point at which we have sufficient information from the complainant to decide how to proceed. This is so that our reported performance reflects the experience of complainants. However it also means that our performance is affected by any delays on the part of public bodies, or our clinical advisers to respond to us, as well as the timeliness of our own work.
We are working hard to focus on completing investigations and issuing reports, but Covid-19 related pressures and restrictions are understandably limiting the ability of GPs, Health Boards and Local Authorities to engage with our investigations. We are avoiding putting additional pressures on these organisations during these challenging times.

Our performance regarding Code of Conduct complaints is broadly consistent with the previous year, with work ongoing to improve our performance against Key Performance Indicators.

Recommendations

When we find fault, we make recommendations to put any injustice right. In 2019/20:

1222 we issued 1222 recommendations to public bodies

£80k we recommended just under £80,000 of financial redress

This year, for the first time, we are publishing information about the recommendations that we make in cases concerning public bodies.

In 2019/20, we intervened in 446 cases. Across these cases, we made 1222 recommendations - an average of 2.7 recommendations per case.

The most common recommendation that we make is that a body should issue an apology to the person or persons who suffered injustice (23%). This reflects the importance to complainants of receiving an acknowledgement that things have gone wrong and an apology for the failings identified.

We also commonly recommend that a body fully explains its actions to the complainant (8%) or simply responds to their initial complaint (7%).

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This highlights the importance of good complaint handling by public bodies.

The next most common group of recommendations concerns procedure change or process review (10%) as well as feedback to staff (10%). These recommendations are particularly important: we aim not only to put right any injustice but also to help public bodies to learn from what went wrong and improve for the future.

Our key contribution is securing justice for individuals and broader improvement of public services. However, where appropriate we can recommend financial redress. In 2019/20, we recommended this in 15% of cases we intervened in.

The total amount of financial redress we recommended was £78,951.

Compliance

Our recommendations aim to put things right, secure justice and improve services for the benefit of the public - not just for those who complain. In 2019/20:

This year, we are also highlighting the impact our recommendations have made on public services.

Although we are aware of how important it is that an individual failing or injustice is put right, we are conscious that the greatest impact we can have is through ensuring that there is learning and improvement as a result of our recommendations.

We always seek the agreement of public bodies to our recommendations. Where public bodies do not agree with our recommendations or settlements, or do not implement the recommendations or settlements agreed, we are able to publish special reports. No such reports were needed in 2019/20.

However, in many cases public bodies implement our recommendations later than agreed with us.

This year, we received evidence of compliance with 72% of the recommendations due to be implemented during 2019/20. For the remaining 28%, evidence of compliance is outstanding and we will be pursuing this, subject to Covid-19 limitations, in the coming months.

In 2019/2020, we completed 4 compliance visits—compared to 1 last year. The purpose of these visits was to follow up on the recommendations made in public

20% of our recommendations highlighted retraining or process reviews. This can lead to significant improvement in public services.

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interest reports. The visits also allow us to see the changes that have been made and to share these with other public bodies who might benefit from the improvements made.

Below we refer to 3 cases which demonstrate how our interventions and recommendations can make a difference:

- In one example, we intervened this year in a complaint about a housing association that was trying to charge a group of elderly tenants for roof repairs—leading to the risk of financial hardship for many. Our involvement at an early stage of this complaint led the housing association to reconsider its approach and withdraw its demands for payment, as well as reimbursing those who had already paid.

- We also investigated this year a complaint brought to us by the family of someone who had sadly died. The family was concerned about the care given by the Health Board in question, including intravenous (IV) fluid management. We recommended that the Health Board review its procedures. As a result, the Health Board recognised that it did not have an up to date IV fluid management policy. The Health Board also appointed a clinical lead to co-ordinate new guidelines and, in December 2019, published new guidance on this issue.

- Our recommendations will not always have immediate effects. This year we saw the long-term effects of one of our investigations concluded in 2017. The investigation concerned a complaint about a Local Authority and savings for young people in care. We upheld the complaint and, as well as putting things right for the individual involved, we shared our findings with Welsh Government as we considered that national guidance should be improved. We were glad to see that our report was subsequently referenced in the Welsh Government consultation on changes to statutory guidance—including the addition of two new requirements under 'The Regulated Fostering Services (Service Providers and Responsible Individuals) (Wales) Regulations 2019'.

We will continue working with public bodies and reviewing the impact which our recommendations have on services, procedures and outcomes.

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Review and Quality Assurance

We have in place fair and transparent processes for handling review requests on casework-related decisions and for regularly assessing the quality of our casework to ensure it meets our service standards. We share any learning points from these reviews with staff to support organisational learning. In 2019/20:

11% we identified that we could do more in 11% of the cases reviewed, often where additional evidence was provided by the complainant

Case review requests

We have confidence in our investigation process. However, we may decide to re-open a case or carry out some further action where complainants either provide new evidence that was not previously available to us, or where we recognise that we may not have properly considered some aspect of their case or adequately explained our decision.

Case reviews are undertaken by staff who are independent of the previous decision-making process on the case.

The table below presents our review caseload in comparison with 2018/19:

Review cases	2019/20	2018/19
Cases carried over from previous year	16	20
New cases	216	209
Total	232	229
Completed	227	† 213
Carried over to next year	5	16

† In 2018/19, we mistakenly reported this figure as cases received.

In 2019/20, we completed 6.6% more reviews than in the previous year.

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We appreciate the need to consider reviews in a timely manner. We aim to complete all requested reviews of casework decisions and respond within 20 working days.

Response time	2019/20	2018/19
Response within 20 days	83%	89%
Average number of days taken to respond	15.5	13.9

We may decide to uphold or partially uphold a review for a range of reasons—for example, if the complainant provided additional evidence, information or clarification, or when we considered that we could have done more.

We decided that 23 cases reviewed in 2019/20 should be either re-opened or that some further action should be taken. This constituted 11% of the cases reviewed - the same as the previous year.

Whilst not all of our reviews this year would have related to cases closed during 2019/20, to put these 23 cases in context, they represent less than 1% of all cases closed this year.

Quality Assurance

In addition to undertaking the review of cases upon request, we also have in place a Quality Assurance (QA) process. This process is based on an audit of a random selection of 30 complaints closed per quarter, split equally between complaints closed at assessment and investigation stage. These cases are examined to see if the way we dealt with them was in line with our service standards, policies and procedures, and to identify examples of good or poor practice we can learn from.

We also undertake Quality Assurance reviews, involving health professionals, of a sample of the clinical advice we receive to help us in our casework.

During 2020/21 we intend to review and improve our Quality Assurance process, to make sure it provides timely and representative information, and assurance that we are meeting our Service Standards.

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Learning lessons

Whether based on reviews or the QA process, we aim to ensure that we consider what lessons can be learned and identify areas for improvement.

Our senior managers regularly consider samples of cases where we consider lessons can be learned. Our Review and Service Quality Officer also makes casework staff and managers aware of any issues that arise from reviews or quality assurance checks.

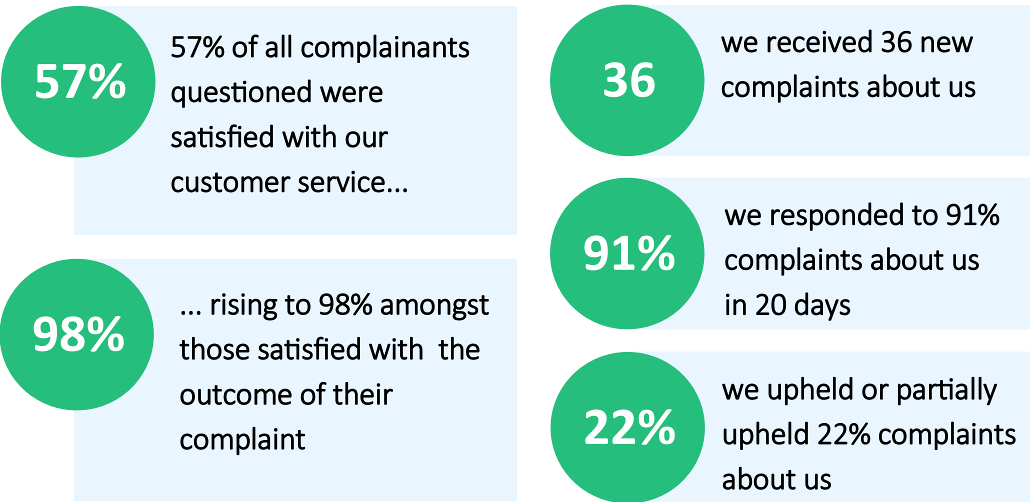
Any learning points identified are then cascaded to our staff through team meetings and a designated learning area on our Intranet. We also consider whether any individual or organisational training needs have been highlighted, and whether any changes to our policies and procedures are necessary.

An example of learning identified from these processes is where a complainant's request for communication in a specific format was not apparent to all staff, so correspondence was issued in the wrong format. We have now updated our case management system to record these requests clearly and ensure that this information is highlighted when new correspondence is prepared.

During 2020/21, we intend to develop the learning area on our Intranet to ensure that the lessons are shared more effectively and that they are clear to all casework staff.

Service user feedback

We are dedicated to delivering excellent service. We seek and welcome feedback from our service users and strive to learn from our mistakes. In 2019/20:



Customer satisfaction research

In previous years, we relied on the customer feedback submitted to us via an online satisfaction form, open to complainants at any stage of the process. However, the response rate was low and the sample of respondents was not representative. Therefore, during 2019/20 we commissioned a telephone survey of a representative sample of our complainants whose cases were closed during the year.

When analysing the findings, we saw that our handling of complaints about public bodies consistently received a higher positive score than our handling of complaints about breaches of the Code of Conduct. Also, positive scores were higher for cases that we closed at the investigation stage, rather than those we closed after assessment. However, the main theme was a very strong correlation between the positive perception of our service and complaint outcome. This is perhaps inevitable, given that many of our service users feel very strongly about their cases.

Some scores from the survey, including our score by 4 of our Service Standards, are presented in the table overleaf. In respect of our fifth Service Standard, “We will operate in a transparent way”, we will next year consider expanding the questionnaire to capture perceptions of transparency among our service users. For transparency and fairness, we are reporting the results for all respondents, and results for those respondents satisfied with the outcome.

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Positive scores from all respondents were highest in relation to our accessibility and communication, but lower in relation to our handling of their complaints and their perceptions of the fairness of our decisions.

This said, the accessibility score was low in respect of awareness of the option to request reasonable adjustments. This was probably because respondents not needing reasonable adjustments were less likely to remember being asked about this. Questions about reasonable adjustments are included in hard copy and online complaint forms and in letters acknowledging the receipt of new complaints.

When asked about how we could improve our service, respondents most commonly suggested improving personal contact (9%), improving timeliness of communication (8%) and of the service overall (5%), increasing our understanding of their cases (6%), and explaining clearly our role, process and decisions (5%).

5% of respondents stated that our service would be improved if their outcome was

Aspect of our service	All respondents	Respondents satisfied with the outcome
Overall satisfaction with the customer service received	57%	98%
It was easy to find us	91%	98%
Our service was helpful	63%	83%
We clearly explained our process and decision	65%	89%

Our Service Standards	All respondents	Respondents satisfied with the outcome
1. We will ensure that our service is accessible to all.	65%	77%
2. We will communicate effectively with you.	64%	82%
3. We will ensure that you receive a professional service from us.	57%	89%
4. We will be fair in our dealings with you.	49%	86%

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positive or if we investigated their case and 5% felt that we were biased or not impartial. This again, shows the very strong link made by our service users between the quality of our service and the complaint outcome.

In 2020/21, we will be investigating the reasons for some of the trends identified and looking to improve our service, based on the research findings.

Complaints about us

In 2019/20, we received 36 new complaints about our service. Together with 3 complaints carried over from the previous year, there were 39 complaints to be considered in total. However, 5 complaints were withdrawn or suspended during the year. These were cases where the complainant:

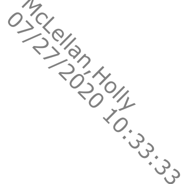
- had a change of heart (for example, when they understood that their complaint about our service would not change the outcome of their complaint about a public body that we handled)
- said they would submit a full complaint but did not
- did not provide any details of what they thought had gone wrong.

This means that the total number of complaints about us that we concluded in 2019/20 was 32—similar to the previous year.

In 91% of cases, we responded within the timescale we set – 20 days:

Response time	2019/20	2018/19
Within 20 days	29 (91%)	29 (94%)
Outside 20 days	3 (9%)	2 (6%)

However, we did not manage to do so in 3 cases. This was as a result of annual leave over the Christmas period, delays in securing Easy Read translations (i.e. versions using a



combination of words and pictures to aid understanding) and complaints that intertwined objections about our service with objections to casework decisions. This year, we changed our supplier of Easy Read translation and we trust that this action will eliminate those delays.

We upheld or partially upheld 7 (22%) complaints about our service. This is a reduction from 9 (28%) complaints last year. The complaints upheld this year related to matters such as:

- clarity and timeliness of our communication with service users (including insufficient updates)
- timeliness of our investigations overall
- incorrect method of contact despite agreeing reasonable adjustments
- delays in identifying and securing clinical advice required
- delays in Easy Read correspondence.

Complaints about us	2019/20	2018/19
Brought forward from the previous year	3	5
Received during the year	36	30
Total	**39**	**35**
Withdrawn / suspended	5	1
Closed	32	31
Open at year-end	2	3
Total	**39**	**35**
Fully or partially upheld	7	9
Not upheld	25	22
Total closed	**32**	**31**

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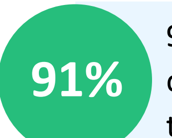
To ensure that we are open and accountable, if a service user is unhappy about how we responded to their complaint about our service, they may ask for their case to be considered by an external Independent Review Service for Customer Complaints (IRSCC). The IRSCC does not review our case decisions – it will only review complaints about the quality of service that we provided.

During 2019/20, 7 cases referred to the IRSCC were concluded. All concerned, to some extent, our decision-making, over which the IRSCC has no jurisdiction. One of the complaints that was externally reviewed was upheld in part. In that case, the IRSCC recommended that we consider providing guidelines for our staff about audio/video evidence obtained without the knowledge or consent of the people recorded. The IRSCC recommended that we review the way that decisions about the use of such evidence in investigations is communicated to people. This has been done.

During the year, the IRSCC commended our staff for their responsiveness to service complaints, in particular for their efforts to ensure that people with disabilities have full access to our services. Whilst we understand that there is always room for improvement, we are pleased to note the positive comments about the standard of our complaints handling and our efforts to provide reasonable adjustments. Learning points from cases reviewed by the IRSCC have been shared with staff.

Accessibility, awareness and outreach

We strive to provide an inclusive and responsive complaints service. We want to make sure that people are aware of and trust our service and that we are accessible to all who need us. In 2019/20:



91% of our customers questioned found it easy to contact us

48% of respondents to a national survey knew about us

we engaged with the Welsh Language Commissioner and received his draft standards Compliance Notice

we received 2% of complaints orally and planned for more outreach around this power in 2020/21

Equality profile of our service users

We invite all our complainants to share with us their equality information. This enables us to analyse the profile of our service users and identify under-represented groups. A full equality profile of our service users and our analysis can be found in our Annual Equality Report, published alongside this Report, as well as on our website.

Accessibility

We strive to be accessible to all those who contact us, and we offer a range of services to support accessibility.

The information we produce can be provided in a number of formats. Key documents can be provided in formats such as CD and Braille. Our website features a 'BrowseAloud' service, which assists the user by providing text-to-speech functionality on our website. A British Sign Language (BSL) video and a link to the 'SignVideo' (interpreting service for BSL users) are also available on the website. We ask complainants to identify any adjustments they need and we consider and respond to all requests.

This year, 91% of respondents to our telephone survey stated that they found it easy or very easy to contact us. This opinion was even higher among those respondents who were also satisfied with the outcome of their complaint (98%).

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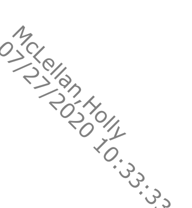
Welsh language

We are committed to ensuring that the Welsh language is welcomed and treated no less favourably than English in all aspects of our work and that we meet the needs of Welsh speakers. We currently operate in accordance with our Welsh Language Policy which was reviewed in 2018. Under the 2019 Act, we are required to comply with Welsh Language Standards, which will replace this policy in due course.

We already have arrangements in place to ensure that we can offer a comprehensive bilingual service to people who come into contact with the office.

During 2019/20, we engaged with the office of the Welsh Language Commissioner to discuss the extent of our envisaged Welsh language duties. In November 2019 we received our draft Compliance Notice. We were pleased to accept almost all the suggested standards, but made a few detailed suggestions about internal arrangements. However, given the ongoing public emergency related to the Covid-19 outbreak we have asked the Commissioner to delay the imposition of standards.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Awareness and outreach

We are conscious that a lack of awareness of our office or negative attitudes towards us might reduce access to our service. This year we commissioned research about awareness of our office and attitude towards it as part of a national survey run by Beaufort Research.

48% of respondents to the survey were aware of us. This result has improved since 2012 when we last commissioned similar research – with 35% of respondents stating at that time that they were aware of our office.

We also believe that it is important to capture public attitudes towards our work. We were glad to see a generally positive perception of our office:

However, it is important to maintain and increase public awareness and confidence in our office and better engage with groups under-represented among our complainants.

In one example of our outreach activities, in August 2019 we held a joint event with the Children's Commissioner for Wales at the National Eisteddfod to raise awareness of the difficulties faced by young people in accessing administrative justice.

Also, in February 2020 we were delighted to discuss awareness of our office and experience of submitting complaints with the Age Cymru Consultative Forum. We are grateful to Age Cymru for facilitating this opportunity and to the members of the Forum for a lively and insightful discussion.

We will be looking to organise similar events with other under-represented groups next year.

Oral complaints

Under the PSOW Act 2019, we can now accept complaints other than in writing, including oral complaints. We trust that in due course this new power will facilitate access to the service by individuals who, for a range of reasons, are unable to submit their complaint in writing.

The power to accept oral complaints came into force in July 2019, and during 2019/20 this option was used by about **2%** of our complainants.

We were pleased to see that **77%** of respondents to the national survey knew that they could submit a complaint to us orally.

Whilst we want this service to be used primarily by the individuals who cannot submit complaints in writing, we also want to make sure that all who need this service are aware of it.

During the next year we will finalise and launch an outreach campaign to promote our power to receive oral complaints.

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Promote Learning

Strategic aim 2

We aim to promote learning from complaints and stimulate improvements on a wider scale. This year, we are breaking new ground in this work. We are the first ombudsman in the UK to be equipped with full and operational powers to establish a Complaints Standards role and to undertake investigations on our own initiative.

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In 2019/20, we made large strides in launching our new powers to drive systemic improvement:

we engaged extensively about our new powers with stakeholders across Wales

we finalised our Complaint Handling Principles, Model Complaints Handling Policy and accompanying guidance

we started to gather data from Local Authorities on their complaint handling, finding much divergence in practices across Wales

we issued criteria and a process for undertaking own initiative investigations

we launched a consultation on our proposal to focus our first own initiative investigation on homelessness

We continued to inform the policy process in Wales by sharing insights from our work, responding to public consultations and participating in evidence sessions with the National Assembly for Wales.

We also continued to use a variety of traditional and new formats to communicate lessons from our casework. In 2019/20:

we issued 4 public interest reports

we published our first Equality and Human Rights Casebook

we issued 1 thematic report, 'Justice Mislaid'

we issued annual letters to bodies in our jurisdiction

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we continued to engage directly with the bodies in our jurisdiction and to share intelligence with other scrutiny and regulatory bodies

Complaints Standards

The 2019 Act equipped our office with new powers to drive systemic improvement of public services. The first of these powers is our new Complaints Standards role. It allows us to set model complaint handling procedures for bodies in our jurisdiction. It also allows us to monitor complaint handling by these bodies. In 2019/20:

we engaged extensively about this new power with stakeholders across Wales

we finalised our Complaint Handling Principles, Model Complaints Handling Policy and accompanying guidance

we began to build a better picture of complaint handling by Local Authorities, discovering much divergence in how they record and handle complaints

Background

Good complaint handling is an essential element of good administration.

Over the years, we have seen consistently that a noticeable proportion of complaints reaching our office relates to complaint handling by public bodies. In 2019/20, this subject accounted for 9% of all the new complaints about public bodies that we received.

Our Complaints Standards work aims to drive improvement throughout public services.

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In this year's Wales Omnibus Survey, we asked respondents about their experience of complaining to the main public service providers in our jurisdiction.

Of those who complained over the last 2 years:

found it very difficult or fairly difficult to complain

were not happy with how their complaint was resolved.

Improvement in public service complaint handling practice would be likely to reduce the number of complaints reaching our office. However, the main beneficiary would be the Welsh public—with less time, effort and frustration being expended on 'putting things right' directly with the bodies concerned.

This is why, as part of the reform of our office, we called for strengthening of our powers to drive improvement in complaint handling.

Engagement

Once the 2019 Act received Royal Assent in May 2019, we immediately worked to establish our Complaints Standards team, which was fully in place by August. We embarked on a widespread programme of engagement, meeting with 21 Local Authorities and 5 Health Boards—as well as various other stakeholders including the Healthcare Inspectorate Wales and the Wales Audit Office.

The purpose of this programme was to understand the challenges faced by different public bodies, to highlight and share existing good practice, and to identify any barriers to improving performance. During these visits, the Complaints Standards team also explored the appetite for bespoke complaint handling training.

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Following a public consultation, we were able to lay before the Senedd our proposed Complaint Handling Principles, Model Complaints Handling Policy and accompanying guidance. These documents were approved in January 2020.

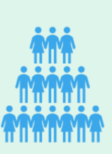
The Complaints Standards team planned to launch these documents formally in March 2020 and then deliver over 30 days of training to Local Authorities— free of charge. However, due to Covid-19 restrictions and pressures, it was decided to delay the launch and postpone the training. This means that, whilst the Complaint Handling Principles, Model Policy and guidance have been finalised, Local Authorities are not yet required to comply with them.

Complaints data

Although the activities planned for March could not go ahead as intended, we now have a better understanding of the complaints landscape in Wales. As soon as it became operational, the Complaints Standards team requested quarterly data on the complaints handled from Local Authorities.

Our work with Local Authorities suggests that the data received so far is not complete and that complaint handling practices in different authorities have developed independently from each other, diverging from complaint handling guidance issued by the Welsh Government in 2011.

However, the data we have* suggests that:



around 16,000 complaints were logged by Local Authorities in 2019/20 — amounting to 2.5 complaints per 1000 residents

40% of the complaints logged related to 'Environment and Environmental Health' (mostly waste)

nearly half of all complaints were upheld

80% were closed within 20 working days

6% were referred to us

The number of complaints about Local Authority services in Wales is considerably lower than those in Scotland, where the ombudsman has had Complaints Standards powers for 10 years. This appears to be the result of inconsistent and incomplete recording of complaints.

* Data was submitted quarterly by Local Authorities throughout 2019/20. However, some submissions in quarters 3 and 4 were incomplete or missing. The numbers displayed here are an approximation of a full year's results using information known.

Looking forward

In 2020/21 we will aim to secure more consistent complaint handling and drive service improvements for the benefit of the Welsh public.

Whilst uncertainty about the duration and extent of Covid-19 restrictions makes planning difficult, we intend to:

- formally issue the Complaints Standards documents
- publish information on complaint handling performance of public bodies via a new webpage, increasing transparency and allowing comparisons between different public bodies
- complete at least 26 visits to stakeholders
- deliver at least 50 days of training (with a notional value of approximately £150,000) free of charge to public bodies
- achieve a high level of satisfaction with this training.

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Own initiative investigations

The 2019 Act also equipped our office with another tool to drive systemic improvement of public services - the power to undertake own initiative investigations. This means that we can start an investigation even when we have not received a complaint. We are using the new power responsibly and engaging as broadly as possible to ensure that the work we do adds value. In 2019/20:

we engaged extensively about this power with stakeholders, including representatives from public bodies across Wales

we issued criteria and a process for selecting and undertaking own initiative investigations

we launched a consultation on our proposal to focus the first own initiative investigation on homelessness

Background

Equipping the Ombudsman with the power to undertake own initiative investigations is a new development in Wales. However, these powers have been widely and successfully used by ombudsmen throughout the world, for example, by the European Ombudsman and the Ontario Ombudsman. Using the power of an own initiative investigation, these ombudsmen have been able to respond to current issues and significantly affect service provision.

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With the 2019 Act, we have become only the second ombudsman's office in the UK to be granted this power (the Northern Ireland Public Services Ombudsman has had this power since 2016).

This power will help us provide a citizen-focused service. It will also aid us in the delivery of social justice and in the drive towards continued improvement in public services for the benefit of all citizens in Wales.

Doing the groundwork

Investigations undertaken on own initiative can be a powerful tool for improvement. However, for such investigations to lead to tangible benefits we must ensure that we are using them wisely, proportionately and based on solid evidence. We must also make sure that we add value to the work of other bodies overseeing or scrutinising service delivery in Wales. Finally, we must develop internal expertise to undertake such investigations, drawing on all good practice available.

Reflecting this, in April 2019 we created a small Own Initiative (OI) team. In preparation for the commencement of the 2019 Act, the OI team met with those responsible for similar work at other ombudsman offices to discuss good practice and to learn from their experiences.

The OI team also took steps to engage with broader stakeholders, providing a number of briefings in June 2019. These sessions provided an opportunity to raise awareness of the concept of own initiative investigations, to explain how such investigations could affect stakeholder organisations and to identify any potential barriers to the new process.

The 2019 Act requires that we consult Welsh Ministers, bodies in our jurisdiction and any other relevant bodies on criteria for undertaking own initiative investigations. In September 2019, we consulted on the draft criteria, along with a draft process for undertaking these investigations. Responses were largely positive, with many organisations welcoming this additional power.

In October 2019, we laid the proposed criteria and process before the Assembly. Our powers to investigate on own initiative were approved in January 2020. Details of the criteria and process, as approved, are available on our website.

Our first own initiative investigation

The OI team continued its engagement with various stakeholders and began research to draw up proposals for the first own initiative investigation. This work led to a proposal that our first such investigation should focus on homelessness in Wales.

Welsh Government statistics show that the number of Welsh households being assessed as homeless is increasing. Homelessness has a range of well-documented negative impacts.

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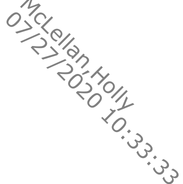
Amongst others, it can aggravate people's existing vulnerabilities (for example due to their age, race, sexuality or physical or mental health difficulties) and restrict their ability to access the support and assistance they require. Ensuring that vulnerable people are treated fairly by public service providers is central to the role of the Ombudsman.

Homelessness is a broad and multi-faceted problem. In order to better define the focus of the proposed investigation, the OI team met representatives of third sector and research organisations in Wales to discuss homelessness, and, in particular, the assessment process and the common difficulties experienced by homeless people. These discussions helped to narrow the focus of the proposed investigation to the administration of the homelessness assessment and review process by Local Authorities.

The initial consultation on this proposal was launched on 13 March 2020. However, as a result of the Covid-19 pandemic, the closing date for the consultation process and the forward work plan will be revised.

In 2019/20, the OI team met representatives of:

- **Northern Ireland Public Services Ombudsman**
- **European Ombudsman**
- **Wales Audit Office**
- **Future Generations Commissioner for Wales**
- **Older People's Commissioner for Wales**
- **Children's Commissioner for Wales**
- **Citizens Advice Wales**
- **Shelter Cymru**
- **Llamau**
- **Wales Institute of Social and Economic Research and Data (WISERD)**



Policy work

We continue to inform the policy process by sharing insights from our work. In 2019/20:

9 **we responded to 9 public consultations**

2 **we participated in 2 oral evidence sessions with the National Assembly for Wales on policy developments**

Focus of our policy work

We contribute to the development of public policy only when we feel we have the information and expertise to justify interventions.

Many of our contributions in 2019/20 related to health and social care – the focus of 49% of our complaints this year. For example, we responded to the inquiry by the Assembly's Health, Social Care and Sport Committee into provision of health and social care in the adult prison estate. We also contributed to a review of the national framework for continuing NHS healthcare, both as members of the working group convened for this purpose, and by responding to public consultation on the subject.

We were delighted to be invited by the Assembly's Public Accounts Committee to contribute to its inquiry into the effectiveness of local planning authorities in Wales.

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Planning and building control complaints represented 7% of our complaints this year and we valued the opportunity to share with the Committee some issues consistently raised by complainants, for example, in relation to information sharing and engagement by planning authorities and delays in planning enforcement action.

Another significant focus of our work is local government, including the investigation of allegations of breaches of the Code of Conduct by elected members. This year we commented on the Local Government and Elections (Wales) Bill. We welcomed the Bill, but also identified the potential to strengthen and clarify some provisions. In particular, we considered that the Bill should place more emphasis on the need to maintain clear lines of accountability in the event of collaborative working or joint service provision by principal councils.

We also sometimes comment on the organisation of complaint handling and administrative justice in Wales as well as on the broader frameworks that ensure effective public accountability. For example, in 2019/20 we submitted comments on the commencement, by the Welsh Government, of the Equality Act socio-economic duty, as well as on the proposals to strengthen the duties of certain public bodies to promote fair work and social partnerships. We also shared our comments on the recommendations of the Commission on Justice in Wales with the Welsh Government and other stakeholders, such as the President of the Welsh tribunals.

Most of our policy work is focused on Wales. However, we were delighted to contribute to the proposals for the establishment of the Jersey Ombudsman. Our comments received much attention in the summary of responses published by the Government of Jersey and we were glad to see that our suggestions were broadly reflected in the revised proposals.

All our policy responses can be found on our website.

Health and Social Care (Quality and Engagement) (Wales) Bill

Our main policy intervention in this area related to the progress of the Health and Social Care (Quality and Engagement) (Wales) Bill. We submitted a response to the inquiry on the subject by the Assembly's Health, Social Care and Sport Committee and also appeared before that Committee to share our comments.

Whilst we welcomed the aspirations of the Bill, we drew attention to a number of areas where it could be more detailed or more ambitious. Amongst others, we expressed concerns over provisions to ensure the independence of the proposed Citizen Voice Body, we underlined the need for it to be locally accessible, and we called for provision to strengthen its power to make representations. More generally, we were disappointed that the Bill does not address the need for better alignment of the NHS and Social Services complaints procedures.

We were glad to see some of our comments reflected in the report by the Committee at Stage 1 of the scrutiny of the Bill, and addressed through some amendments adopted since. Even if the lack of alignment between health and social care complaints procedures is not addressed as part of the Bill, we look forward to engaging with the Assembly and the Welsh Government on this subject in the months to come.

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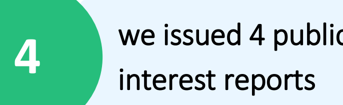
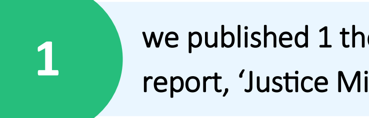
Sharing our findings

We use a variety of formats to communicate lessons from our casework and are constantly looking for new ways to share information more widely and make it more accessible. In 2019/20:



we issued 4 public interest reports



we published 1 thematic report, 'Justice Mislaid'

we published our first Equality and Human Rights Casebook

we continued to engage directly with the bodies in our jurisdiction, especially Health Boards

Public interest reports

Issuing a public interest report remains one of the key tools available to me to highlight systemic problems, promote learning from complaints and ensure that listed authorities are accountable for the services they provide.

This year, we issued 4 public interest reports - compared to 14 in 2018/19. However, the number of these reports in 2018/19 was unusually high—we would normally expect to issue up to 6 public interest reports each year. One possible explanation for the overall smaller number of these reports this year is the apparent reduction in the incidence of maladministration and service failure in the cases we investigated.

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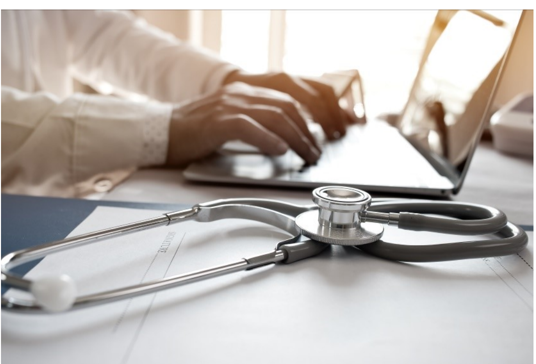
Two of our public interest reports this year related to healthcare.



The first report related to a package of care, funded jointly by Gwynedd Council and Betsi Cadwaladr UHB and provided by Cartrefi Cymru, a registered domiciliary care provider. In this case, Mr N sadly choked to death after a care provider failed to undertake an appropriate risk assessment and produce an acceptable plan for his care.

We were extremely concerned about the multiple failings in communication and in the proper commissioning and contracting of care for Mr N, on the part of the 3 bodies involved. We found maladministration on the part of the Council and the Health Board in relation to their management of contractual arrangements and failure on the part of Cartrefi Cymru to conduct a comprehensive risk assessment and keep appropriate documentation.

Our second report related to the case of Mrs T, an 87-year-old woman, who died after Swansea Bay UHB failed to take prompt and appropriate action to assess and treat her symptoms of a stroke. We found that the Health Board failed to undertake an appropriate assessment of Mrs T's risk of a stroke, even when her family raised concerns that she appeared to have left-sided weakness, facial droop and slurred speech. We also found that, when doctors were asked to review Mrs T's condition in light of her family's concerns, several clinicians failed to appropriately record their findings. Finally, we found that there were further shortcomings in record keeping throughout the period of care.

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Two further public interest reports issued by our office this year related to other services.

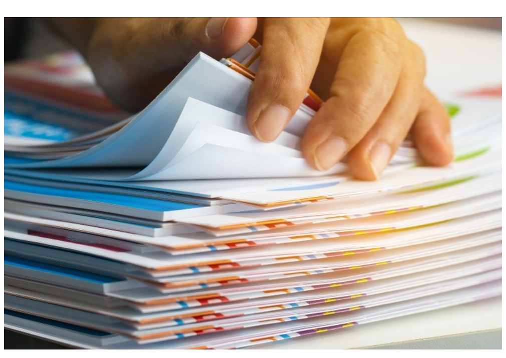
Our third report concerned maladministration on the part of Flintshire County Council which resulted in years of "persistent and intrusive" disruption to a resident from an unlicensed car wash. Mr R suffered "significant injustice" after being exposed to unacceptable levels of noise and water spray over a 5-year period. We also concluded that the Council failed to give due consideration to Mr R's right to the quiet and peaceful enjoyment of his home, as set out in the Human Rights Act 1998.

Our final public interest report concerned a complaint by Mr X about the Student Loans Company (the SLC). Our investigation found that the SLC failed to inform Mr X that he was not eligible for a tuition fee loan for 2014-15 in a reasonable way.

This was not properly communicated to Mr X until after he had incurred fees for the full academic year, leaving him in considerable debt. We also found that, even when the SLC knew that Mr X would never be entitled to additional funding due to his personal circumstances, it continued to ask for information about Mr X's personal circumstances and even (wrongly) granted his application for additional funding almost 18 months later. This, on top of the debt burden Mr X had already incurred, caused him considerable stress. We also found that the SLC and the Welsh Government's complaint handling process was confusing and had taken almost 2 years to complete.

Whilst in all these cases we recommended an apology and, in 2 cases, also financial redress, all these cases led us to issue detailed recommendations for wider action, including reviews of existing policies and procedures and improved training arrangements. We will be monitoring compliance with these recommendations and the impact of the changes instituted in the coming months.

Thematic report



Alongside our new powers to drive systemic improvement, we also intend to continue to publish thematic reports. These reports are based on the analysis of the cases investigated by our office and are a useful way of highlighting and emphasising the key issues being identified by us on a daily basis.

This year, we published Justice Mislaid: Lost Records and Lost Opportunities (also in Easy Read). The report highlighted a sample of cases considered where health and social care records have been mislaid or lost.

Lost or inadequate records held by bodies significantly affect the thoroughness of complaint investigations and the responses provided. The consequences of lost records can include a prolonged complaints process, a delay in justice, unreliable findings and a breakdown in the relationship between the service provider and the service user. Robust information governance and records management on the part of providers of public services in Wales would prevent these unnecessary and avoidable outcomes.

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The 'Justice Mislaid' report concludes with several recommendations in respect of effective and up to date records management policies and processes; training for staff; communication between service providers and complainants; and governance arrangements to ensure that lessons are learned from incidents of lost or misplaced records.

Casebook

We also continue to publish information about our casework in casebooks. The Ombudsman's Casebook, currently published on a quarterly basis, contains the summaries of all reports issued in cases relating to public service providers during the quarter, as well as a selection of summaries relating to 'quick fixes' and voluntary settlements. Next year, we intend to implement a new approach to producing closed case summaries. Instead of publishing the cases per quarter, we intend to move to 'live' case records, whereby we publish summaries of all cases closed on an ongoing basis.

This year we also published for the first time an Equality and Human Rights Casebook (also in Easy Read). It is not our function to make definitive findings about whether a public body has breached an individual's human rights. However, where we identify evidence of maladministration which has caused injustice, we consider whether a person's human rights may have been engaged and comment on a public body's regard for these rights. We work with all casework staff to develop and support the consideration of equality and human rights in our casework. The Equality and Human Rights Casebook assembles a selection of cases where human rights matters have either been expressly raised as part of the complaint or have been pivotal to our findings. It has been well received by our stakeholders and we intend to repeat this publication on an annual basis.

"The new Human Rights Casebook by the Public Services Ombudsman for Wales is an excellent resource for ensuring that public bodies remain committed to their equality and human rights obligations".
Equality and Human Rights Commission

We also produce a Code of Conduct Casebook. This is also published quarterly and contains the summaries of all reports issued.

Annual letters

We continue to send letters on an annual basis to Health Boards and Local Authorities concerning the complaints we have received and considered during the year. The annual letters aim to provide these bodies with information to help them improve both their complaint handling and the services that they provide. All annual letters are published on our website.
Given the developments in relation to the Covid-19 outbreak, in 2020/21 we intend to publish the letters in the second quarter of the year.

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Engagement

An important aspect of our improvement work is direct engagement with the bodies in our jurisdiction and liaison with other stakeholders operating in the sectors which account for most of our complaints.

In one example, we stepped up this year our efforts to engage with the housing sector. We hosted a visit from Pobl Housing Group complaints team. We also delivered 2 workshops in TPAS Cymru seminars 'Effective complaints in the housing sector' in April and May 2019. It is possible that this work helped to raise awareness of our role resulting in more complaints about social housing this year.

However, we continue to focus our main improvement efforts on Health Boards.

We have a small number of investigation officers who also have an improvement officer role. These staff spend a proportion of their time working to challenge and support Betsi Cadwaladr, Aneurin Bevan, Swansea Bay and Hywel Dda University Health Boards. As part of this work, during 2019/20, we:

- held quarterly meetings with Hywel Dda UHB complaints staff and attended its Improving Patient Experience Committee
- attended Cwm Taf Morgannwg UHB Complaints Scrutiny Panel
- held quarterly meetings with Aneurin Bevan UHB to discuss complaint handling and liaison issues, alongside regular telephone contact with the contact officer
- held 5 meetings with Betsi Cadwaladr UHB officers, including the former Chief Executive
- undertook an intense programme of engagement with Swansea Bay UHB, including quarterly meetings with the Health Board's Internal Audit team, a meeting with the Chief Executive and Director of Nursing & Patient Experience, delivery of training to newly qualified consultants and regular 'catch up' meetings with the Concerns Team.

We are delighted that some of this work appears to bear fruit. In particular, we were glad to see this year the decrease in new complaints about Swansea Bay and Hywel Dda UHBs. For all the Health Boards that we engaged with, we welcome the drop in the number of interventions that we had to make this year, which may be indicative of systemic improvements.

We also endeavour to share information and insights with other key stakeholders responsible for the scrutiny of the health sector.

We regularly exchange intelligence with Healthcare Inspectorate Wales, Care and Social Services Inspectorate Wales, General Medical Council, Community Health Councils and Audit Wales, as well as the Welsh Commissioners.

McLellan,Holly
07/27/2020 14:33:35

Use Resources Wisely

Strategic aim 3

We value and support our staff and are committed to creating an equal, diverse and inclusive workplace. We strive to ensure good governance which supports and challenges us and we benchmark our work against best practice in the UK and internationally. We also secure value for money and ensure that our services are fit for the future.

McLellan,Holly
07/27/2020 10:33:33

All staff completed their annual Performance Review and Development Process

93% of staff completed 28 or more hours of continuing professional development

We saw the average percentage of working days lost through staff sickness increase to 3.4%...

... but we launched our new Wellbeing Strategy and a number of actions to support staff wellbeing

We conducted a staff survey which found that:

99% of respondents were proud to work for PSOW

82% felt that training and development opportunities at PSOW are appropriate and relevant

87% felt that PSOW is committed to creating a diverse equal and inclusive workplace

We signed up as a Disability Confident Committed Employer

We achieved the silver FairPlay Employer level for gender equality

We reduced our waste by 13.2%

We attended two scrutiny sessions with the National Assembly for Wales

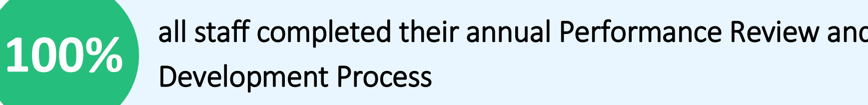
We reduced our median Gender Pay Gap from 21% to 11%, below the Welsh average for the public sector (14.2%)

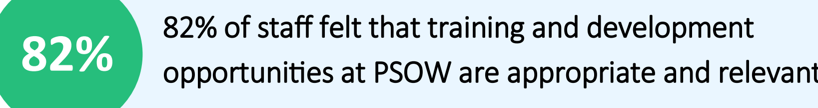
We maintained close links with colleagues in the UK, Europe and around the world

McLellan,Holly
07/27/2020 10:33:33

Training and development

We support our staff to develop the knowledge and skills essential for their work. In 2019/20:





Our staff are key to our service provision. That means that we actively encourage training and development and make sure that staff are clear about their objectives and priorities. We also work hard to involve staff in important decisions about our approaches and ways of working, for example, through workshop sessions at all-staff meetings.

We operate a Performance Review and Development Process for each member of staff, which involves:

- a review of the previous year's achievements and the setting of objectives at the start of the year
- a mid-year review of progress.

McLellan,Holly
07/27/2020 10:33:33

New staff, during their induction and probation periods, have a separate process for this, with more immediate objectives and priorities set. Staff returning from maternity/adoption leave or long-term sickness have objectives agreed at a point on their return. For all other staff, it is pleasing to note that both formal reviews were completed as planned.

Our emphasis on staff training and development is reflected in an annual assessment of training and development needs for each member of staff, a comprehensive induction programme for new staff, online training for key topics such as equality and in-house training and Good Practice Seminars on specific public services and legislative changes. We also provide skills training appropriate to staff roles.

Our focus on the importance of training and development of staff means that we have set a target that all staff achieve at least 28 hours of training and development each year. This year (excluding staff on maternity/adoption leave or long-term sickness) 93% of staff achieved this. We will continue to focus on this in 2020/21.

As part of our annual Performance Review and Development Process, we consider the effectiveness of the training and development activity completed and we are working to improve the ongoing assessment of training.

We were glad to see that 82% of staff who responded to our staff survey this year felt that training and development opportunities at PSOW are appropriate and relevant.

McLellan,Holly
07/27/2020 10:33:33

Health and wellbeing

We care for our staff and are pro-active in promoting wellbeing in the workplace. In 2019/20:

we saw the average percentage of working days lost through staff sickness increase to 3.4%...

... but we launched our new Wellbeing Strategy and a number of actions to support staff wellbeing

we trained and introduced Mental Health First Aiders

99% of staff responding to our staff survey said they were proud to work for PSOW

We recognise that our staff are key to the service we provide and indeed to supporting access to justice for complainants and prompting public service improvement. It is important, therefore, that as well as training and developing staff, we make sure that we support their health and well-being.

Our sickness absence figures for 2019/20 are disappointing, with staff absence averaging 3.4%, substantially more than in previous years. Most of this figure (70%) relates to long-term absence, with some staff receiving planned medical treatment requiring recuperation time. Short-term absences were similar to previous years, at 1%.

McLellan,Dolly
07/27/2020 10:33:33

Anxiety and stress accounted for 43% of days lost to sickness which emphasises the need to look after our staff's mental, as well as physical, wellbeing.

Recognising this, we have developed and launched a new Wellbeing Strategy. Under the Strategy, we have put in place a number of new actions, as well as continuing existing arrangements. Staff have access to counselling and can self-refer to our Occupational Health advisers. We offer subsidised yoga to staff during lunchbreaks, and we have responded to staff experiencing discomfort and musculoskeletal problems by providing standing desks, as needed.

We provide annual health checks to staff, to help them to stay healthy. We have also trained a number of staff as Mental Health First Aiders who can provide support to staff and signpost to other support services.

Our staff have been instrumental in the development of the Well-being Strategy and actions. An internal staff Wellbeing Group oversees the implementation of activities such as lunchtime mindfulness sessions for staff and lunchtime walks.

Roughly every 2 years, we undertake a detailed survey of staff to gather their views and to obtain feedback on how the organisation is doing. 92% of staff responded to this year's survey.

Responses to the survey were overwhelmingly positive. Amongst other highlights:

- 99% of staff stated that they were proud to work for PSOW
- 97% of staff considered that PSOW is a good place to work
- 94% of staff considered that their managers communicate effectively with them.

However, in some areas, we received less positive responses. These related to matters such as the amount of pressure on staff and the timescales staff are expected to work to.

We will be looking to address these and other aspects of the survey next year and improve some of the ways we work.

Staff equality, diversity and inclusion

This year, we stepped up our efforts to ensure that as an employer we promote equality and tackle any barriers to inclusion:

we signed up as a Disability Confident Committed Employer

we achieved the silver FairPlay Employer level for gender equality

87% of respondents to our staff survey felt that PSOW is committed to creating a diverse, equal and inclusive workplace

we reduced our median Gender Pay Gap from 21% to 11%, below the Welsh average for the public sector in 2019

Diversity of our workforce

We are proud to be an equal opportunities employer. We were glad to see that 87% of staff who responded to our staff survey this year felt that PSOW is committed to creating a diverse, equal and inclusive workplace — and 86% felt they were treated fairly at work.

We invite our staff and job applicants to participate in voluntary equality monitoring and, in 2019/20, extended our work on this to analyse the equality profile of our successful applicants.

During 2019/20, we acted to address the under-representation of disabled people within our workforce and amongst our job applicants. To help us in this work, we signed up as a Disability Confident Committed employer.

McLean,Holly
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The scheme supports employers to make the most of the talents disabled people can bring to the workplace. During the year, we revised the recruitment packs, confirming our commitment to offer interviews to disabled candidates if they meet essential criteria. We also reviewed our recruitment advertising strategy to ensure that our job offers reach disabled candidates.

This work has not yet affected the equality profile of our workforce and job applicants in 2019/20, which showed that disabled people remain an under-represented group. However, further actions to attempt to overturn this trend are planned for 2020/21.

This year, we also measured in more detail the Welsh language skills of our workforce.

Whilst 15.9% of people stated that Welsh was their main language (an increase of 3.9% since last year), the proportion of people with fairly good or fluent skills was higher:

- Speaking: 23.8%
- Reading: 27%
- Writing: 27%
- Understanding: 27%

Our work on gender equality

This year, our median Gender Pay Gap decreased from 21% at March 2019 to 11% at March 2020.

	2020	2019
% of staff female	75%	73%
Median Pay Gap	11%	21%
Mean Pay Gap	19%	23%

We are aware that, in a relatively small organisation, individual recruitment outcomes can make apparently large differences. Women among our job applicants consistently outnumber men by a significant margin. We also have in place a range of policies and training opportunities to remove barriers to employment or career progression by female staff.

McLellan, Holly
07/27/2020 11:33:53

However, the extent of our Gender Pay Gap at March 2019 prompted us to seek an external specialist opinion on our performance on gender equality.

As a result, we engaged with Chwarae Teg to work towards accreditation as a FairPlay Employer.

Chwarae Teg is a Welsh charity leading on gender equality, including in the workplace. Its FairPlay Employer scheme benchmarks organizations in terms of gender equality across 4 levels: bronze, silver, gold and platinum. We were delighted to achieve the FairPlay Employer Award at silver level, having scored above the Welsh public sector average across all the categories assessed.

We were also pleased that our median Pay Gap decreased by 10 percentage points and our mean Pay Gap decreased by 4 percentage points compared to the previous year. Our Median Gender Pay Gap is now below the Welsh average (13.5%) and below the Welsh average in the public sector (14.2%) (Chwarae Teg, 2019).

Whilst we are pleased with these results, there are clearly areas in which we can seek improvements. We have now received recommendations for actions from Chwarae Teg and will be working on the implementation of these actions in 2020/21.

Find more information about our work to promote equality in our Annual Equality Report 2019/20

Sustainability

We understand that we need to play our part in protecting the environment. We are continuing to develop sustainable practices throughout the organisation. In 2019/20:

we reduced our waste by 13.2%

we reduced our energy usage by 2%

0% 0% of our general waste was sent to landfill

41% we avoided 41% more commuting mileage per day

we published our report under the Biodiversity and Resilience of Ecosystems Duty (section 6 duty)

Where possible, we make changes to reduce the impact of the office on the environment and operate in a sustainable manner.

Waste management

In 2019/20, we reduced our waste by 13.2% compared to the previous year.

In the past 12 months we have removed all desk bins to encourage staff to recycle as much waste as possible and added recycling points throughout the office.

We also reduced by 40% the number of sub files (sent to our professional advisers for them to advise on cases) being produced in paper format.

McLellan, Holly
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This reduces printing and paper use but also reduces mileage covered by our courier company.

	2019/20	2018/19
Confidential waste (kg)	8,650	8,860
Mixed recycling (kg)	2,346	2,250
General waste (kg)	16,000	20,000
Total waste (kg)	**26,996**	**31,110**

Since April 2019, we have sent 0% of our general waste to landfill.

Lighting and energy

Total electricity usage has fallen by 2% from the previous year.

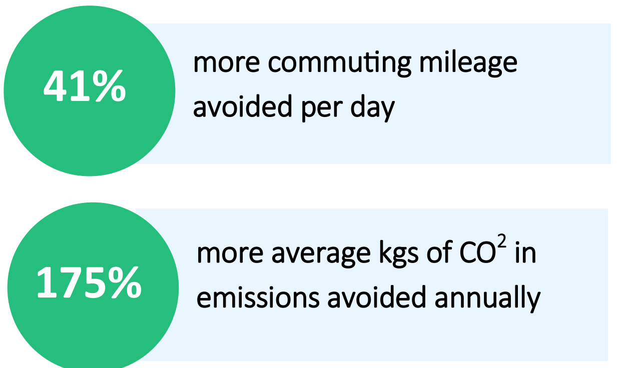
	2019/20	2018/19
Energy usage (KwH)	104,521	106,701

We achieved this by installing LED lighting and providing signage throughout the office to encourage staff and visitors to turn off lights and equipment when not in use.

Emissions

The number of staff who work at home as part of their normal working pattern, as well as those working compressed hours over fewer days, has increased this year by 175%.

We calculate that this increase has resulted this year in a reduction of our carbon footprint:



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These figures relate to the period before the COVID-19 lockdown. At the time of writing this Report, all our staff were working from home. Whilst this will clearly have a very strong effect on our emissions result in the short term, in the longer term it is also likely to increase working at home on a more regular and permanent basis.

Biodiversity and Resilience of Ecosystems Duty (section 6 duty) report

In December 2019 we published our report under biodiversity and resilience of ecosystems duty, in compliance with the Environment (Wales) Act 2016.

This report outlines our work to support sustainability since 2016 and contains detailed data on our actions and performance in this respect. It also contains an appendix with up to date detailed information on our performance on sustainability in 2019/20.

Formal accountability

We are accountable to the National Assembly for Wales for the work done and the office's use of resources.

The National Assembly for Wales

The Finance Committee has established a set of principles to guide the preparation of budget submissions and each year we make a formal submission, taking account of these principles, seeking funding for the following year. The submission is scrutinised by the Finance Committee, which makes a recommendation on the funding to be provided. The Committee also makes comments and recommendations on the submission and these are taken into account in subsequent years.

The Annual Report and Accounts document reports on the use of resources and on the work done during the year. It is laid before the National Assembly for Wales and published. The report is scrutinised by the Equality, Local Government & Communities Committee each year. In addition, the Public Accounts Committee periodically scrutinises our use of resources and makes observations and recommendations. We work to implement recommendations made by these Committees in our Estimates submission and our Annual Report and Accounts.

Judicial review

As a Corporation Sole, and to reflect the principles of ombudsman schemes internationally, the Ombudsman and his staff are fully responsible for casework decisions. Whilst complainants can request an internal review of a casework decision they are unhappy with (and this is undertaken by a senior member of staff who has not previously been involved in the case), the appropriate route to challenge our decision is through judicial review.

It is rare for our decisions to be challenged legally and very few cases are subject to judicial review proceedings. However, during 2019/20, we faced one legal challenge in the High Court. A complainant sought permission from the Court to judicially review our findings on his complaints about the relevant Health Board and Council's handling of his late mother's care. We had fully investigated the complaints, which we partially upheld.

On 19 March 2020, the Court refused the application for permission because no arguable grounds for judicial review that had a realistic prospect of success had been presented. An award of costs was made in our favour.

McLellan,Holly
07/27/2020 10:33:33

Benchmarking

We develop our work by benchmarking against best practice across the ombudsman sector. In 2019/20:

we maintained close links with colleagues in the UK, Europe and around the world

The ombudsman community

We continued to be closely involved in the work of the Ombudsman Association (OA). In 2019/20, we attended (and in some cases chaired) a number of the OA interest groups, considering legal matters, human resources, first contact, casework, communications and policy. We participated and assisted in the OA Annual Conference, 'Driving improvements: collaboration and peer learning' held in Belfast in May 2019. We also continue to meet members of the Public Services Ombudsman Group which this year convened on 3 occasions in Belfast, Edinburgh and Manchester.

We sustained relationships with European colleagues, attending the European Network of Ombudsmen, hosted by Emily O'Reilly, the European Ombudsman and addressed by the European Commission's chief negotiator, Michel Barnier.

We also participated in conferences and good practice seminars organised by the International Ombudsman Institute (IOI).

In one of the highlights of the year, in May 2019, the Committee of Ministers of the Council of Europe endorsed 25 'Principles on the Protection and Promotion of the Ombudsman Institution', subsequently also adopted by the Venice Commission. These so-called 'Venice Principles' represent a set of internationally accepted standards for the proper functioning and independence of public services ombudsman offices. We participated fully in the development of the Venice Principles and we view them as a new global standard of excellence for ombudsman schemes.

2019/20 has also been a year of change for our role in many of these networks. In May 2019, Nick Bennett, the PSOW, stood down as Chair of the OA, handing over the position to Anthony Arter, the Pensions Ombudsman.

McLellan,Holly
07/27/2020 10:33:33

2020 was also the final year for Nick Bennett to represent the UK on the IOI's world and European Boards. These roles have now passed to the Parliamentary and Health Service Ombudsman, Rob Behrens, and we wish him every success.

With the 2019 Act, we became the first ombudsman in the UK to hold active powers to undertake investigations on our own initiative and to set complaints standards for public bodies (our colleagues in Northern Ireland also expect to have the latter power in due course.) From the earliest day of calling for these powers, we were eager to avoid 'reinventing the wheel' and to draw on the good practice available.

In June 2019, we held a seminar on the new powers in Aberystwyth University, addressed by the leading ombudsmen from schemes in Ireland, Scotland and Northern Ireland, and the Catalan Ombudsman as well as the president of the European IOI.

Later in the year, our Complaints Standards team visited colleagues in Edinburgh to learn about the steps taken by the Scottish Public Services Ombudsman to establish a Complaints Standards service. The Own Initiative team liaised with the Northern Ireland Public Services Ombudsman and the European Ombudsman to discuss good practice in own initiative investigations.

McLellan,Holly
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We were also glad to support colleagues with our expertise. In January and February this year, we hosted visits from colleagues in Northern Ireland and England to discuss our progress in the implementation of the Complaints Standards role. We also participated in a peer review seminar in the UK Parliament where we shared our experiences with other UK and international offices.

The Welsh Commissioners and the Auditor General

Nick Bennett continued to meet the Welsh Commissioners and the Auditor General for Wales on a quarterly basis to discuss issues of mutual interest. On the back of these meetings, we were delighted to co-operate with the Children's Commissioner for Wales on a joint event in the Eisteddfod Genedlaethol 2019 in Llanrwst, as well as holding discussions during the year on the use of our new power to undertake investigations on our own initiative.

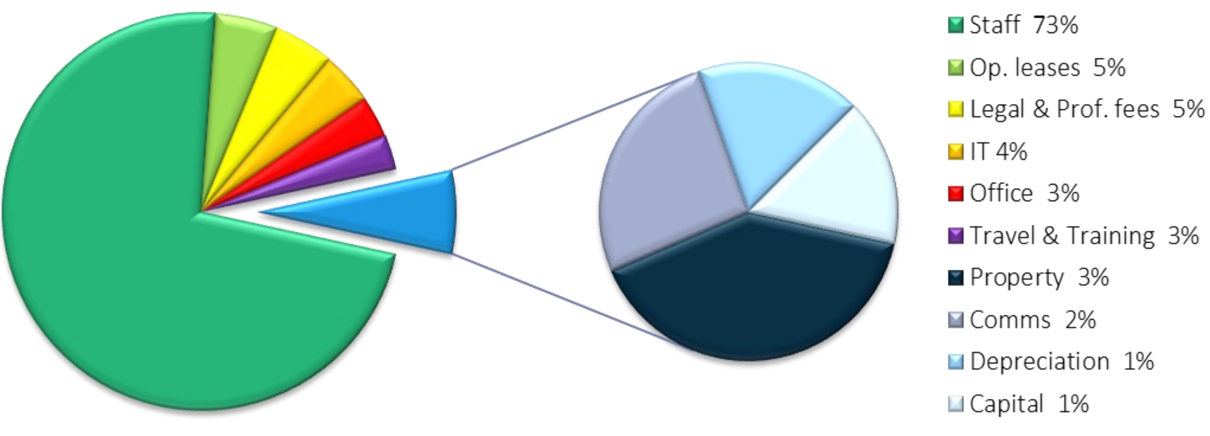
Our staff also met separately on several occasions representatives of these offices, as well as the Equality and Human Rights Commission, to discuss issues such as our approaches to casework, policy work and IT systems. We value these opportunities for sharing experiences, good practice and challenges with our colleagues. They are more important than ever in the context of the challenges that the Covid-19 outbreak is setting for public services in Wales.

Financial Management

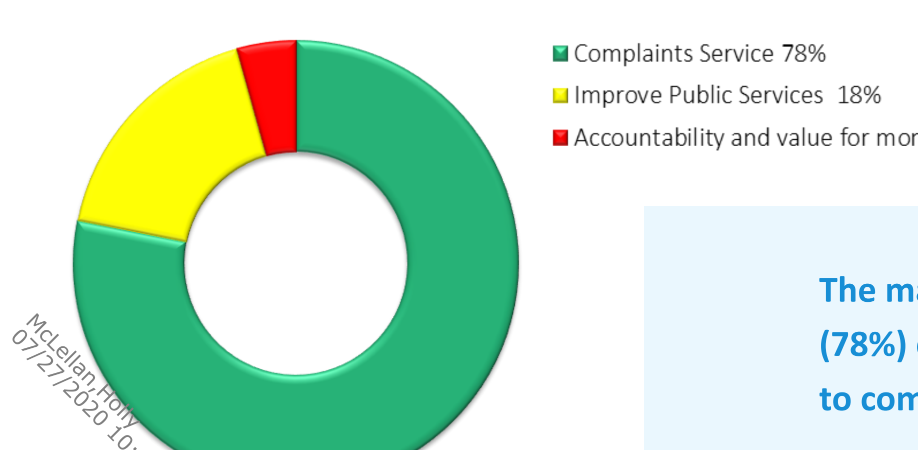
Overall resource and cash expenditure has increased compared to the same period last year. This is due to the commencement of the new Public Services Ombudsman (Wales) Act and a significant, national increase in employer pension contributions.

Resource Out-turn	**2019/20**	**2018/19**	**Change**
	£000s	£000s	£000s
Total Resource	4,871	4,445	+426
Cash Requirement	4,836	4,390	+446

Gross Resource Expenditure 2019/20



Analysis of spending by Strategic Aims



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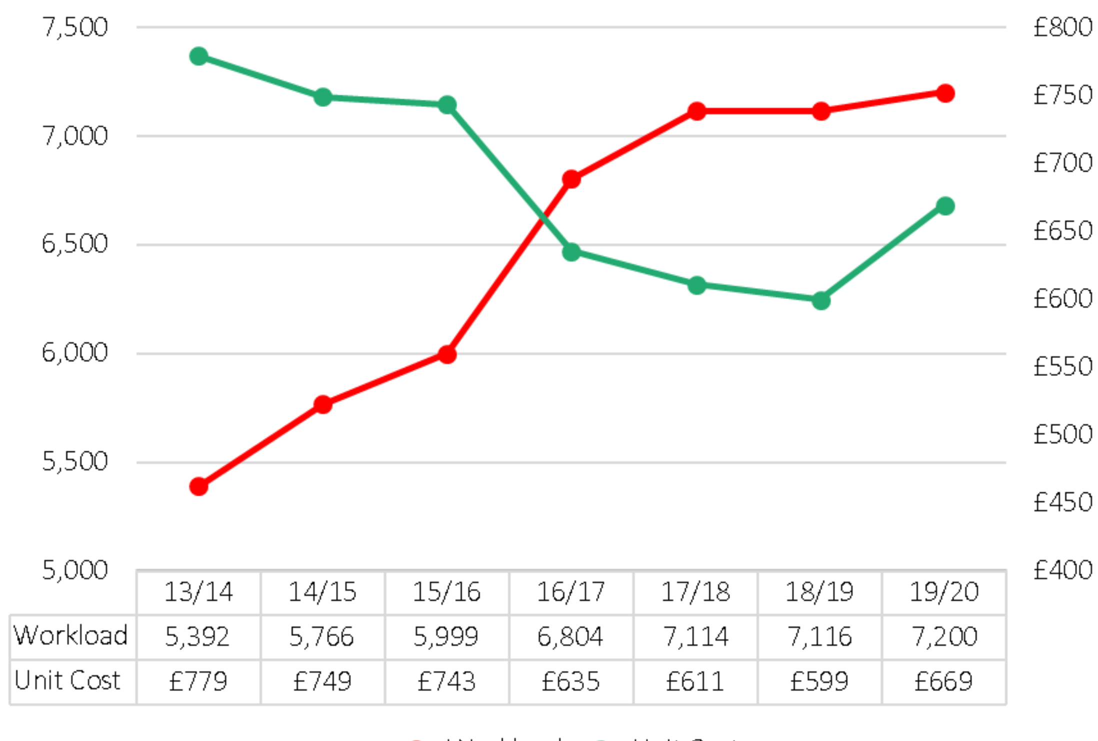
The majority of our resources (78%) continue to be applied to complaints handling

Workload Compared to Unit Cost

Prior year costs have been inflated by CPI.



	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Workload	5,392	5,766	5,999	6,804	7,114	7,116	7,200
Unit Cost	£779	£749	£743	£635	£611	£599	£669

We've seen a 34% rise in workload over the last 7 years and a 14% fall, in real terms, in unit cost

We spent 92% of our budgeted funding (£231k) on implementing the new PSOW Act

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PSOW Act 2019 expenditure

	£000s
Staff costs	171
Communications	25
Office costs	9
Capital	8
Training & Recruitment	5
Computer services	5
Premises	4
Travel & Subsistence	4
Total spent on New Powers	231
Budget	251
Variance	20

Expenditure to 31 March 2020 compared to previous year

	2019/20	2018/19	Reasons for significant changes
	£000	£000	
Salaries	2,582	2,389	Increase in staff numbers due to new PSOW Act
Social Security costs	252	221	
Pension costs	685	480	National increase in employer contributions
Pension fund charges	33	42	
Total Pay	**3,552**	**3,132**	
Rentals under operating leases	237	264	End of photocopier lease - December 2019
External Audit fee	15	18	Efficiencies in carrying out 2018/19 audit
Legal and professional fees	230	261	Improved management of professional advice
Other property costs	135	135	
Computer services	209	182	Full cloud back-up introduced in 2019/20
Office costs	169	103	Investment in Wellbeing & purchase of photocopiers
Travel and Subsistence	45	31	Costs to launch new PSOW Act
Training and Recruitment	93	55	Additional professional investigation training for staff
Communications	87	41	Outreach work to launch new PSOW Act
Depreciation	60	31	Large IT capital investment in 2018/19
Total other Administration Costs	**1,280**	**1,121**	
Gross Costs	**4,832**	**4,253**	
Income	(14)	(61)	End of staff secondment to HIW
Net Expenditure	**4,818**	**4,192**	
Capital	53	253	IT infrastructure investment in 2018/19
Net Resource	**4,871**	**4,445**	

More detailed financial information can be found in the financial statements and notes that support the accounts.

Nick Bennett N Bennett
Accounting Officer
Public Services Ombudsman for Wales 1 July 2020

McLellan,Holly
07/27/2020 10:53:33

Accountability Report

2019/20

McLellan,Holly
07/27/2020 10:33:33

Corporate Governance Report

Ombudsman's Report

Under the Government of Wales Act 2006, the office is financed through the Welsh Consolidated Fund (WCF) with any unspent cash balances repaid into the WCF after a certified copy of the accounts has been laid before the National Assembly for Wales. This creates a further control in that there is a need to effectively manage the budget on both a cash and a resource basis. The salary of the office holder of the Public Services Ombudsman for Wales and the related costs are a direct charge on the WCF and are administered through the National Assembly for Wales.

As at 31 March 2020, the Office comprised 73 full and part-time staff based in Pencoed, Bridgend including the Ombudsman, Chief Operating Officer & Director of Improvement, Chief Legal Adviser & Director of Investigations, as well as investigation and support staff.

The National Assembly for Wales provided cash of £4.9 million for the funding of the Office, with £251k being budgeted funding for the implementation of the new PSOW Act 2019. £48k of this overall funding is due to be returned to the WCF being the unused cash balance at the year end. The expenditure of the office was kept within the Estimate agreed in November 2018 and amended by Supplementary Budgets during 2019/20.

The table below shows that, over the past 7 years, the Office has seen an increase of over 34% in all contacts (that is, in enquiries, complaints about the conduct of members of local authorities and public body complaints), whilst unit costs have reduced by 14% when adjusted for CPI inflation, despite additional funding in 2019/20 for New Powers and the effect of a 6% increase in employer pension contributions.

Workload	Enquiries	Code	Public Body	Total Complaints	Unit cost
13/14	3,234	226	1,932	5,392	£779
14/15	3,470	231	2,065	5,766	£749
15/16	3,731	276	1,992	5,999	£743
16/17	4,512	236	2,056	6,804	£635
17/18	4,861	270	1,983	7,114	£611
18/19	4,627	282	2,207	7,116	£599
19/20	4,726	365	2,109	7,200	£669
Change	46%	62%	9%	34%	-14%

McLellan,Kathy
07/27/2020 13:33

Remuneration and Pension Liabilities

Details of the pay and related costs of the Ombudsman and the Office are shown in the Remuneration Report.

Pension obligations to present and past employees are discharged through the Principal Civil Service Pension Scheme (PCSPS), the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme and the pensions paid directly to former Commissioners or their dependants.

Further details are given in the Pensions Disclosures.

Corporate Governance

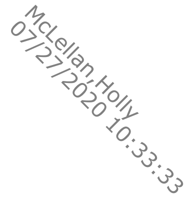
The office holder of the Public Services Ombudsman for Wales is a Corporation Sole. In addition, upon taking up my role as Ombudsman, I was appointed by the Treasury as the Accounting Officer for the public funds with which the National Assembly entrusts me to undertake my functions. The Audit & Risk Assurance Committee supports the Ombudsman by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and on the integrity of financial statements and the annual report. Further details are set out in the Annual Governance Statement.

Register of Interests

A register of interests is maintained for the Ombudsman, Directors and members of the Advisory Panel and Audit & Risk Assurance Committee.

Accounts Direction

Under the Accounts Direction issued by HM Treasury dated 21 December 2006, I was required to prepare accounts for the financial year ended 31 March 2020 in compliance with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (the FReM) issued by HM Treasury which was in force for 2019/20.



The accounts have been prepared to:

- give a true and fair view of the state of affairs at 31 March 2020 and of the net resource outturn, resources applied to objectives, recognised gains and losses and cash flows for the financial year then ended
- provide disclosure of any material expenditure or income that has not been applied for the purposes intended by the National Assembly for Wales or material transactions that have not conformed to the authorities that govern them.

Auditors

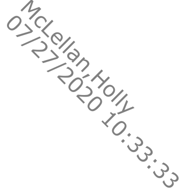
The Auditor General for Wales is the External Auditor of the accounts of the PSOW as laid down in paragraph 18 of Schedule 1 to the Public Services Ombudsman (Wales) Act 2019.

The cost of the audit for 2019/20 was £15k (2018-19: £18k).

As far as I am aware, I have taken all the steps necessary to make the auditors aware of any relevant audit information.

N Bennett

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales 1 July 2020



Statement of Accounting Officer's Responsibilities

Under the Public Services Ombudsman (Wales) Act 2019, as Public Services Ombudsman for Wales I am required to prepare, for each financial year, resource accounts detailing the resources acquired, held or disposed of during the year and the use of resources by the PSOW during the year.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the PSOW and its net resource outturn, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, as the Accounting Officer, I am required to comply with the requirements of the 'Government Financial Reporting Manual' and in particular to:

- observe the Accounts Direction issued by the Treasury including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable, and
- take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

My relevant responsibilities as Accounting Officer include the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PSOW's assets, as set out in Managing Welsh Public Money and the Public Services Ombudsman (Wales) Act 2019.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PSOW's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

McLellan,Holly
07/27/2020 10:33:33

Annual Governance Statement 2019/20

Status of the Public Services Ombudsman for Wales

As laid down in Schedule 1 paragraph 2 of the Public Services Ombudsman (Wales) Act 2019, the Ombudsman is a Corporation Sole holding office under Her Majesty and he discharges his function on behalf of the Crown. Schedule 1 paragraph 19 states that the Ombudsman is the Accounting Officer for the Office of the Ombudsman.

Scope of Responsibility

In undertaking the role of Accounting Officer, I ensure that the Office operates effectively and to a high standard of probity. In addition, I have responsibility for maintaining a sound system of internal control that supports the achievement of PSOW's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in 'Managing Welsh Public Money'.

I am independent of the National Assembly for Wales, but am accountable to its Public Accounts Committee for the use of resources made available to support my statutory functions. In determining the level of resources available to the Office, the PSOW's budget proposals are considered by the Finance Committee of the National Assembly for Wales in accordance with the process laid down in the Act. I produce a combined Annual Report and Accounts for consideration by the Equality, Local Government and Communities Committee and the Finance Committee.

I am required to include this Governance Statement with my annual report and accounts to explain how the governance of my Office works and to ensure it meets the requirements of the Corporate Governance Code and The Orange Book: Management of Risk. To enable me to satisfy these requirements, I have established appropriate structures, systems and procedures that are comprehensive and provide me with evidence that the governance arrangements are working as intended across the whole organisation and its activities. Such arrangements include my Governance Framework, a comprehensive internal control environment, effective internal and external audit arrangements and robust financial management, risk planning and monitoring procedures.

McLellan,Holly
07/27/2020 10:33:33

Strategic Planning and Performance Monitoring

In my Strategic Plan for the 3 years 2019/20 to 2021/22, I set the following for the Office:

Our Vision for public services in Wales:

Services that actively listen and learn from complaints.

Our Mission:

To uphold justice and improve public services.

Our Strategic Aims:

- Strategic Aim 1: Deliver Justice
  A fair, independent, inclusive and responsive complaints service.

- Strategic Aim 2: Promote Learning, Work to Improve Public Services
  Promote learning from complaints and stimulate improvements on a wider scale.

- Strategic Aim 3: Use Resources Wisely and Future-proof the Organisation
  Identify and adopt best practice. Secure value for money and services that are fit for the future. Support staff and ensure good governance which supports and challenges us.

McLellan,Holly
07/27/2020 10:33:33

Whilst individual teams within the Office are charged with implementing the actions identified, the Management Team monitors progress made against targets and the outcomes achieved via monthly reports.

System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable, and not absolute, assurance of effectiveness. It is based on an ongoing process designed to identify and prioritise the risks to the achievement of my policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system has been in place in the Office of the PSOW for the year ended 31 March 2020 and up to the date of approval of these accounts and accords with HM Treasury guidance. No significant areas of internal control weaknesses have been identified from audit work and steps to improve controls further are implemented promptly and monitored by the Audit & Risk Assurance Committee.

Corporate Governance arrangements: Audit & Risk Assurance Committee

Governance arrangements include an Audit & Risk Assurance Committee (ARAC). The Committee's responsibilities are:

(a) Terms of Reference

The Committee supports the Ombudsman by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

(b) Membership

Membership comprises up to 6 independent external members. The 2018/19 membership of Mr Jim Martin, former Scottish Public Services Ombudsman, Dr Tom Frawley CBE, former Assembly Ombudsman and Northern Ireland Commissioner for Complaints, Mr Jonathan Morgan, former Assembly Member and previously Chair of the National Assembly's Public Accounts Committee, Mrs Anne Jones, former Assistant Information Commissioner, Mr Trevor Coxon, former Monitoring Officer of Wrexham County Borough Council and Mr Ian Williams, former Group Chief Executive of Hendre Limited remained unchanged in 2019/2020. Mr Morgan's initial term of office was due to conclude in December 2019. However, for continuity particularly in light of the new PSOW Act 2019, the Ombudsman invited Mr Morgan to continue in his role as Independent Member and Chair of the ARAC for a further 12-month period.

McLellan,Harry
07/27/2020 10:33:33

(c) Training

Members of the Committee are invited to assess their training needs annually. An induction programme is provided for all new members of the ARAC.

(d) Meetings

The Committee sets itself an annual work programme. There are generally 4 meetings of the Committee during the year.

The Ombudsman attends ARAC Meetings and the Chief Operating Officer acts as Secretary to the Committee. The meetings were also regularly attended by internal and external auditors and appropriate members of the PSOW's Management Team.

At each meeting, the Committee received a number of standing agenda items. These include declarations of any identified fraud or losses, including any data losses. At each meeting, the Committee received a copy of the latest Budget Monitoring report considered by the Management Team. This is intended to provide the Committee with an assurance that there is regular scrutiny of the financial position within the Office.

During the year, the Committee also received reports on a number of other appropriate matters within its Terms of Reference. They included the 9 and 12-month accounts, internal audit plans, a review of the Whistleblowing Policy, a review of governance arrangements, updates on major IT developments, progress on the implementation of the Strategic ITC Plan and relevant financial and corporate governance matters issued by HM Treasury. The Committee reviewed the Office's counter-fraud arrangements, in the context of the Cabinet Office Counter-Fraud Framework, to satisfy itself that appropriate arrangements are in place.

The Committee provided advice to the Ombudsman to ensure that the 2019/20 Annual Governance Statement included appropriate information and complied with best practice.

A standing item is risk management. At each meeting the Committee considered a report on the greatest identified risks. The Committee explored and challenged the reported risks to satisfy itself that all key risks have been identified. Risk management and risk mitigation measures were also considered.

As a result of the Covid-19 pandemic, the March 2020 meeting of the Committee did not take place in the normal way. Papers were circulated as normal and all members commented and asked questions about the papers in writing. A small meeting was then held using video conferencing. This involved the Committee Chair, internal audit, external audit, the Ombudsman and a reduced number of staff. Other than for the Chair, full attendance for the year was therefore 3 meetings, and all members contributed to the fourth meeting.

McLellan, Haley
07/27/2020 10:33:33

Attendance at meetings by Committee members during the year was as follows:

Membership:	
Jonathan Morgan (Chair)	4
Ian Williams	3
Jim Martin	3
Anne Jones	3
Trevor Coxon	3
Tom Frawley	2

(e) Internal and External Audit

The Committee received regular reports from both the internal and external auditors. The work of Deloitte as Internal Auditors during the year was planned based on their overall needs assessment and carried out through their fourth annual programme. Their reports highlighted the satisfactory internal control framework within the organisation and made recommendations for improvement where necessary.

The internal audits undertaken in 2019/20 and overall assessments were as follows:

	Assurance level
Professional Advice	SUBSTANTIAL
Corporate Governance and Risk Management	SUBSTANTIAL
Information Security	MODERATE
Financial Systems:	
Fixed Assets	SUBSTANTIAL
General Ledger	SUBSTANTIAL
Purchasing and Payments	SUBSTANTIAL

In all but one audit, the level of assurance was considered 'Substantial', the highest assurance level. A number of low priority recommendations were made and these have either been completed or will be completed in accordance with agreed timescales. In addition, an advisory audit of Contract Management arrangements was carried out in August 2019.

The internal auditors' Annual Report for 2019/20 stated: 'Based on the work we have undertaken during the year we are able to conclude that the Ombudsman has a basically sound system of internal control, which should provide **substantial assurance** regarding the achievement of the Ombudsman's objectives.' These findings also provide assurance that the arrangements in place are reducing the Office's exposure to risk. The Committee noted the thoroughness of the audit work, practicality of recommendations and the open and positive response of management to the recommendations made.

McLellan,Harry
07/27/2020 10:33:33

The Committee considered the 2018/19 Annual Report and Accounts that included the Governance Statement of the Office for 2018/19, together with the External Audit of Financial Statements Report and Management Letter. An unqualified opinion was given, following external audit work undertaken by the Wales Audit Office, on the 2018/19 Accounts. There were no recommendations arising from the Audit. The external audit conclusions for the 2018/19 financial year were reviewed at the September 2019 meeting of the Committee.

Both Internal and External Auditors have the right to raise any matter through an open access policy to the Chair and, through that right, to bring any matter to the attention of the Committee. The Committee, by reviewing the programmes of both the External and the Internal Auditors, ensured that they were co-operating effectively with each other. The quality of the audit work has been evaluated during the year through consideration of the audit reports and recommendations and dialogue at meetings between Committee Members and the Auditors.

To ensure that appropriate matters can be raised in confidence, the Chair of the Committee generally holds an annual meeting with representatives of the External and Internal Auditors.

Arrangements this year were disrupted by Covid-19 restrictions. On 31 March 2020 the Chair of the Committee had a virtual meeting with the internal auditors. The external audit representative was unable to join this as planned but there was a subsequent discussion between the Chair of the Committee and the external audit lead, by telephone, on 21 April.

(f) Monitoring processes

At each meeting during 2019/20, the Committee received a report on progress made on the implementation of External and Internal Audit recommendations. Committee members were satisfied that all the recommendations made had been implemented or will be implemented by the first quarter of 2020/21.

(g) Annual Review and Assessment

This annual review is undertaken to evaluate the work of the Committee and to ensure that the work of the Audit & Risk Assurance Committee continues to comply with the Good Practice Principles set out in the HM Treasury Audit Committee Handbook. To assist the Committee in determining that it was complying with good practice, each member was invited to complete the National Audit Office's 'The Audit Committee self-assessment checklist'. Comments received from Committee members were considered in preparing the Annual Review for 2019/20.

McLellan,Holly
07/27/2020 10:28:33

The ARAC Annual Review concluded that it had received comprehensive assurances and information that was reliable and sufficient to enable it to carry out its responsibilities. Those assurances demonstrated a satisfactory overall internal control environment, financial reporting and the management of risk and of the quality of both the Internal and External Audit work undertaken.

The Committee was therefore able to provide assurances to support me effectively, as Public Services Ombudsman for Wales, to comply with my Accounting Officer responsibilities. The Committee provided evidence to assist in the preparation of this Annual Governance Statement.

Advisory Panel

The Advisory Panel is a non-statutory forum whose main role is to provide support and advice to the Ombudsman in providing leadership and setting the strategic objectives of the office of the Public Services Ombudsman for Wales. The Panel also brings an external perspective to assist in the development of policy and practice.

Panel meetings are chaired by one of the independent external members. In June 2019, following a recommendation from the Public Accounts Committee, Jonathan Morgan stepped down as a member of the Panel and therefore from the position of Chair, but remained Chair of the Audit & Risk Assurance Committee. On the recommendation of the Panel, Anne Jones was appointed to take over as Chair and took up the role with effect from September 2019.

Dr Jane Martin CBE joined the Panel in September 2019 as an independent member. She is not a member of the Audit & Risk Assurance Committee, so the membership arrangements for the Advisory Panel and Audit & Risk Assurance Committee take account of the recommendations of the Public Accounts Committee. Dr Martin was Local Government Ombudsman and Chair of the Commission for Local Administration in England until January 2017 and is now a member of the Committee on Standards in Public Life. The Advisory Panel is an advisory-only body to the Ombudsman and does not make decisions in its own right.

Reporting of Personal Data Related Incidents

All incidents involving personal data are reported to the Audit & Risk Assurance Committee. Guidance issued by the Information Commissioner's Office (ICO) is considered to establish whether it is necessary to report the incident to that office. Further improvements were made to the PSOW's process for handling such incidents to reflect current ICO guidance. During 2019/20, one incident required reporting to the ICO. The ICO was satisfied with the PSOW's approach to the incident and confirmed that no further action was required.

McLellan,Holly
07/27/2020 10:33:33

The Risk and Control Framework

As required by 'Managing Welsh Public Money', I am supported by a professionally qualified Financial Accountant who carries out the responsibilities of a Finance Director as set out in that document.

Risk management and the risk register are standing Agenda items for the Audit & Risk Assurance Committee, and the approach to risk management, together with risk appetite, is reviewed periodically.

I am continuing to enhance the robust internal control arrangements to ensure that the Office has the capacity to identify, assess and manage risk effectively. In undertaking this responsibility during the year ended 31 March 2020, I have been supported by a Chief Operating Officer to whom some of the Ombudsman's responsibilities have been delegated.

Key risks at the financial year-end were identified as follows:

Risk horizon	Risk affects:	Risk management and mitigation:	Residual risk:
Core function – Case volumes and meeting KPIs	Likely impact of Covid-19 on case volumes and ability to meet Key Performance Indicators (KPIs). Public bodies are unlikely to be able to engage with Ombudsman which will result in a growing number of open cases and growth in older cases. Cases cannot be concluded without public body input to investigation or agreement to findings and recommendations.	Work closely and supportively with public bodies.	The likely inability of public bodes to engage with us on our casework means that the residual risk is considered RED
Core function – Staffing levels	Likely impact of Covid-19 on maintaining productive casework staffing levels.	Make full use of IT systems to support effective and efficient homeworking.	The likely impact on casework staff and productivity means that the residual risk is considered RED
Support services – Staffing levels	Likely impact of Covid-19 on maintaining productive support (IT, Finance, HR, and Casework Support) staffing levels.	Make full use of IT systems to support effective and efficient homeworking.	The likely impact on support staff and productivity means that the residual risk is considered RED

I and my Management Team will continue to work to manage and minimise the risks in these key areas in the year ahead and the risks will be considered at each meeting of the Audit & Risk Assurance Committee.

McLellan, Holly
07/27/2020 10:33:33

Risk Assurance Framework Arrangements

PSOW Framework

- Strategic objectives from Business Plan
- Work programme
- Risk management
- Anti-fraud policy
- Governance framework
- Policies, procedures and code of conduct

Advisory Panel
Provides support and advice on vision, values and purposes as well as strategic direction and planning

Accounting Officer
Governance
Decision making
Financial management
Risk management

Audit & Risk Assurance Committee
Reviews and monitors governance, risks and internal controls.
Agrees annual governance statement

Management Team
3-year strategic plan
Operational plan
Performance monitoring
Corporate policies
Risk management
Value for money

Central Guidance
HM Treasury
FReM
Managing Welsh Public Money
Public Sector Internal Audit

PSOW policies, plans and risk register

Annual Governance Statement

Assurance Map Components

1st line of defence
Strategic and operational delivery reporting
KPI reporting
Financial controls / Budget monitoring

2nd line of defence
Risk register reviews
Quality assurance
Information security assurance

3rd line of defence
Internal audit reports
Financial accountant spot checks
Scrutiny by Finance Committee and PAC

Other assurances
External audit

McLellan,Holly
07/27/2020 10:33:33

I am satisfied that the systems in place identify potential risks at an early stage and enable, through active management, the appropriate action to be taken to minimise any adverse impact on the office.

The Audit & Risk Assurance Committee receives regular reports on the risks relating to this Office, explores the Office's approach to those risks and provides comments and suggestions on current and emerging risks.

Risks are considered across a number of key areas or risk horizons. These are:

- risks that could affect my ability to fulfil my core functions
- risks affecting data security
- financial risks
- governance risks
- risks affecting facilities & support arrangements (such as premises & IT services).

Budgeting Process

As Accounting Officer, I ensure that I have in place arrangements for tight control of the public money entrusted to me. The Management Team receives a monthly budget monitoring report setting out details of actual against budgeted expenditure. Any unexpected expenditure issues that may arise during the year are considered and any actions required to ensure that the office remains within its budgeted expenditure are agreed. No major issues arose in respect of the PSOW's budget for 2019/20.

As far as the process of producing the PSOW's financial estimate for 2020/21 is concerned, a paper setting out initial budget criteria was considered by the Advisory Panel in June 2019. The final estimate paper included full-year funding for New Powers as well as some inflationary increases. Overall, the resource and cash savings on a like-for-like basis in the proposed budget would be 1.3% and 1.1% respectively. The Finance Committee scrutinised the paper in October 2019 and the full amount sought was included in the Annual Budget Motion March 2020.

Conclusion

I can report that there were no significant weaknesses in the Office's system of internal controls in 2019/20 which would affect the achievement of the Office's policies, aims and objectives and that robust Corporate Governance is in operation with no breaches of the Corporate Governance Code.

N Bennett

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

1 July 2020

McLellan,Hoqy
07/27/2020 10:03:33

Remuneration Report

Public Services Ombudsman for Wales

The Government of Wales Act 2006 provides for my remuneration and associated national insurance and pension costs to be met from the Welsh Consolidated Fund, rather than being paid directly. These costs are included, for transparency, in the remuneration report.

Remuneration

The following sections provide details of the remuneration and pension interest of the most senior management of the Office: Nick Bennett - Ombudsman, Chris Vinestock - Chief Operating Officer & Director of Improvement and Katrin Shaw - Chief Legal Adviser & Director of Investigations.

Single Total Figure of Remuneration

2019/20					
Officials	Salary (£'000)	Bonus payments (£'000)	Benefits in Kind (to nearest £100)	Pension benefits (to nearest £1,000)	Total (£'000)
Nick Bennett	150-155	-	-	58,000	205-210
Chris Vinestock	100-105	-	-	75,000	175-180
Katrin Shaw	85-90	-	-	75,000	160-165

Single Total Figure of Remuneration

2018/19					
Officials	Salary (£'000)	Bonus payments (£'000)	Benefits in Kind (to nearest £100)	Pension benefits (to nearest £1,000)	Total (£'000)
Nick Bennett	145-150	-	-	58,000	205-210
Chris Vinestock	95-100	-	-	34,000	125-130
Katrin Shaw	75-80	-	-	29,000	105-110

Salary

Salary includes gross salary, overtime and any other allowances to the extent that they are subject to UK taxation.

Benefits in kind

The monetary value of benefits in kind, covers any expenditure paid by the PSOW and treated by HM Revenue and Customs as a taxable emolument. There was no such expenditure.

Bonuses

No bonus was paid during the year to me or to any staff within my office, as no bonus scheme is in operation.

Pay multiples

The banded remuneration of the highest-paid director in the financial year 2019/20 was £150-£155,000 (2018/19 = £145-£150,000). This was 3.6 times (2018/19 = 3.5) the median remuneration of the workforce, which was £42,684 (2018/19 = £41,847). In 2019/20, no employee received remuneration in excess of the highest-paid director (2018/19 = none).

Remuneration ranged from £20,000 to £155,000 (2018/19, £18,000-£150,000).
Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Pay awards

Staff pay is linked to the pay awards made to employees within Local Government in England and Wales. In line with that procedure, a 2% pay increase was awarded to staff in April 2019.

McLellan,Holly
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Pensions

Pension entitlements for the persons shown above are detailed below:

Pension Liabilities

The pension obligations to present and past employees are discharged through:

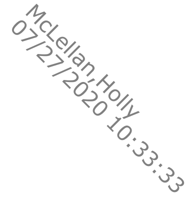
- the Principal Civil Service Pension Scheme (PCSPS)
- the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme (the Fund)
- the pensions paid directly to former Commissioners or their dependants.

	As at 31/03/20					As at 31/03/19
	Accrued pension at pension age and related lump sum	Real increase in pension and related lump sum at pension age	CETV	Real Increase in CETV	Employer contribution to partnership pension accounts	CETV
Name	£000	£000	£000	£000	Nearest £100	£000
Nick Bennett	45-50	2.5-5	559	30	-	495
Chris Vinestock	60-65	2.5-5	912	49	-	822
Katrin Shaw	35-40	2.5-5	553	51	-	476

CETV refers to the Cash Equivalent Transfer Value, and further information can be found in the Pensions Disclosures.

Sickness

During the year, an average of 9.0 days per employee were lost through sickness, compared with 3.3 days in 2018/19. This is the equivalent of 3.4% (1.2% in 2018/19) of total possible workdays. This reflects normal short-term absences, long-term sickness and several staff having planned major surgery. 70% of the total days lost to sickness were attributable to long-term absences.



Reporting of Civil Service and other compensation schemes

No exit packages were paid in 2019/20 (2018/19 Nil).

Advisory Panel and Audit & Risk Assurance Committee

The following non-pensionable payments, based on a daily rate, were made to members of the Advisory Panel and Audit & Risk Assurance Committee:

	2019/20	2018/19
	£	£
Jonathan Morgan	1,263	3,789
Anne Jones	1,263	2,488
Jim Martin	933	2,799
Ian Williams	933	1,866
Trevor Coxon	933	2,799
Tom Frawley	622	2,488
Jane Martin	564	-
Margaret Griffiths (left 2018/19)	-	282
John Williams (left 2018/19)	-	282

Due to the late timing of the March 2020 meeting only 3 payments were made to committee members in 2019/20, with the fourth payment for attending the remote meeting in March being made in April 2020. The 2018/19 figures include 5 payments for similar reasons.

For staff reporting issues see the Annual Equality Report.

N Bennett

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

1 July 2020

National Assembly for Wales Accountability and Audit Report

In addition to the primary statements prepared under **International Financial Reporting Standards (IFRS)**, the Government Financial Reporting Manual (FReM) requires the Ombudsman to prepare a statement and supporting notes to show resource outturn against the Supply Estimate presented to the Assembly, in respect of each request for resource.

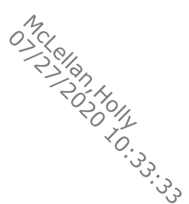
Summary of Net Resource Outturn

for the year ended 31 March 2020

	Revised Estimate			Outturn				2018/19
	Gross Expenditure	Income	Net Total	Gross Expenditure	Income	Net Total	Net total compared to estimate	Net Total
	£000	£000	£000	£000	£000	£000	£000	£000
Revenue	4,941	(14)	4,927	4,832	(14)	4,818	109	4,192
Capital	27	-	27	53	-	53	(26)	253
Net Resource	**4,968**	**(14)**	**4,954**	**4,885**	**(14)**	**4,871**	**83**	**4,445**
Net Cash Requirement	**4,898**	**(14)**	**4,884**	**4,850**	**(14)**	**4,836**	**48**	**4,390**

Positive totals reflect a resource or cash under-spend.

The Ombudsman's salary is paid directly from the Welsh Consolidated Fund with only the reimbursement of actual business expenses included in the PSOW accounts.



Reconciliation of Net Resource to Net Cash Requirements

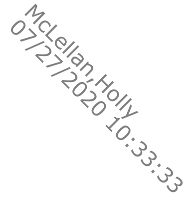
for the year ended 31 March 2020

		2019/20			2018/19
	Note	Revised Estimate	Net Total Outturn	Net total outturn compared to revised estimate	Outturn
		£000	£000	£000	£000
Net Revenue	2-4	4,927	4,818	109	4,192
Net Capital	6	27	53	(26)	253
Net Resource		**4,954**	**4,871**	**83**	**4,445**
Movement in provisions	10	(20)	(1)	(19)	12
Capital charges	6	(70)	(60)	(10)	(31)
Movements in working capital	7-9	20	26	(6)	(16)
Pension charges (LGPS)	Pension Disclosures	-	-	-	(20)
Net cash requirement		**4,884**	**4,836**	**48**	**4,390**

N Bennett

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

1 July 2020



The Certificate and Independent Auditor's Report of the Auditor General for Wales to the Senedd

Report on the audit of the financial statements

Opinion

I certify that I have audited the financial statements of the Public Services Ombudsman for Wales for the year ended 31 March 2020 under paragraph 18 (2) of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019. These comprise the Summary of Net Resource Outturn, Statement of Comprehensive Net Expenditure, Statement of Financial Position, Consolidated Statement of Cash Flows, Statement of Changes in Taxpayers Equity and related notes, including a summary of significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs) as adopted by the European Union/United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of the Public Services Ombudsman for Wales' affairs as at 31 March 2020 and of its net cash requirement, net resource outturn and net operating cost, for the year then ended; and
- have been properly prepared in accordance with HM Treasury directions issued under the Public Services Ombudsman (Wales) Act 2019.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

McLellan,Holly
07/27/2020 10:33:33

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accounting Officer is responsible for the other information in the annual report and financial statements. The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Legislation and directions issued to the Public Services Ombudsman for Wales do not specify the content and form of the other information to be presented with the financial statements.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

McLellan,Holly
07/27/2020 10:33:33

Report on other requirements

Opinion on other matters

As legislation and directions issued to the Public Services Ombudsman for Wales do not specify the content and form of the other information to be presented with the financial statements, I am not able to confirm that other information within the Annual Report (outside of the financial statements) has been properly prepared.

In my opinion, based on the work undertaken in the course of my audit, the information given in the Annual Report is consistent with the financial statements.

Although there are no legislative requirements for a Remuneration Report, the Public Services Ombudsman for Wales has prepared such a report, and in my opinion that part ordinarily required to be audited has been prepared in accordance with HM Treasury guidance.

In my opinion, based on the work undertaken in the course of my audit the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Governance Statement has been prepared in accordance with HM Treasury guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the body and its environment obtained in the course of the audit, I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- proper accounting records have not been kept;
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns;
- information specified by HM Treasury regarding the remuneration and other transactions is not disclosed; or
- I have not received all of the information and explanations I require for my audit.

Report

I have no observations to make on these financial statements.

McLellan,Holly
07/27/2020 10:33:33

Responsibilities

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for preparing the financial statements in accordance with the Public Ombudsman (Wales) Act 2019 and HM Treasury directions made there under, for being satisfied that they give a true and fair view and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the body's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Accounting Officer is responsible for ensuring the regularity of financial transactions.

I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the Senedd and the financial transactions conform to the authorities which govern them.

McLellan,Holly 07/27/2020 10:33:33

Adrian Crompton
Auditor General for Wales
2 July 2020

24 Cathedral Road
Cardiff
CF11 9LJ

Annual Accounts

2019/20

McLellan,Holly
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Statement of Comprehensive Net Expenditure

for the year ended 31 March 2020

		2019/20	2018/19
Administration costs	Note	£000	£000
Staff costs	2	3,552	3,132
Other non-staff administration costs	3	1,280	1,121
Gross Administration Costs		**4,832**	**4,253**
Operating Income	4	(14)	(61)
Net Administration Costs		**4,818**	**4,192**
Net Revenue Outturn		**4,818**	**4,192**

All activities commenced in the period are continuing.

Notes 1 to 18 form part of these statements.

Statement of Financial Position

for the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Non-current assets			
Property, Plant and Equipment	6a	202	185
Intangible assets	6b	148	172
Receivables due after more than 1 year	7	1	1
Pension fund surplus	Pension Disclosures	1,080	810
		1,431	**1,168**
Current Assets			
Trade and other receivables	7	207	175
Cash and cash equivalents	8	48	20
		255	**195**
Total assets		**1,686**	**1,363**
Current liabilities			
Trade and other payables	9	(210)	(172)
Provisions less than 1 year	10	(45)	(44)
		(255)	**(216)**
Total assets less current liabilities		**1,431**	**1,147**
Non-current liabilities			
Trade and other payables due after 1 year	9	(20)	(24)
Provisions greater than 1 year	10	(481)	(481)
		(501)	**(505)**
Total assets less liabilities		**930**	**642**
General Fund		**930**	**642**

Notes 1 to 18 and the Pension Disclosures form part of these statements.

The financial statements were approved by the Accounting Officer and authorised for issue on 1st July 2020 by:

N Bennett

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

1 July 2020

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Statement of Cash Flows

for the year ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Net cash outflow from operating activities	11	(4,783)	(4,137)
Net cash outflow from investing activities	12	(53)	(253)
Financing from National Assembly for Wales	13	4,884	4,410
Prior year cash balance repaid		(20)	(32)
Net increase (decrease) in cash equivalents after adjustments for payments to Welsh Consolidated Fund		28	(12)
Cash and cash equivalents at beginning of period		20	32
Cash and cash equivalents at end of period		48	20

Notes 1 to 18 form part of these statements.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2020

	General Fund	
	2019/20 £000	2018/19 £000
Balance as at 1 April	642	(356)
Net operating costs	(4,818)	(4,192)
Funding by National Assembly for Wales	4,884	4,410
Due back to Welsh Consolidated Fund:		
Cash	(48)	(20)
Non operating income	-	-
Actuarial re-measurement of LGPS pension fund	270	800
Total recognised income and expense for year	288	998
Balance as at 31 March	930	642

McLellan,Holly
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Notes 1 to 18 and the Pension Disclosures form part of these statements.

Notes to the Financial Statements

1. Statement of Accounting Policies

These financial statements have been prepared in accordance with the Government Financial Reporting Manual (the FReM) issued by HM Treasury which is in force for 2019/20. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adopted or interpreted for the public sector. Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be most appropriate to the particular circumstances of the PSOW for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the PSOW are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for any revaluation of fixed assets, where material to their value to the business, by reference to their current costs.

1.2 Property, Plant and Equipment

Expenditure on property, plant and equipment is capitalised where the purchases are expected to have a useful life extending over more than 1 year and the cost exceeds £5k. Assets costing less than £5k may be capitalised providing they are capital in nature and are part of a larger scheme that is, in total, more than £5k. Assets are shown at cost less an allowance for depreciation. On initial recognition, fixed assets are measured at cost, including such costs as installation, which are directly attributable to bringing them into working condition for their intended use. In reviewing the costs of fixed assets previously acquired and the prices paid for new acquisitions during the year there is no material difference between the historic net book value of the assets and their replacement cost less depreciation.

1.3 Depreciation

Assets are depreciated at rates calculated to write them down to zero or, if applicable, estimated residual value on a straight-line basis over their estimated useful life following an initial charge of a full month's depreciation in the month of purchase. Assets in the course of construction are depreciated from the month in which the asset is brought into use.

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Except where otherwise noted asset lives are assumed to be the following:

Plant	10 years or the lease term if shorter
Furniture and other fittings	10 years or in the case of fittings, the lease term
Computers and other equipment	3 to 10 years

1.4 Intangible assets

Purchased computer software licences and developed software are capitalised where expenditure of £5k or more is incurred, and the useful life is more than 1 year. Intangible assets costing less than £5k may be capitalised providing they are capital in nature and are part of a larger scheme that is, in total, more than £5k. Intangible assets are reviewed annually for impairment and are stated at amortised historic cost. Software licences are amortised over the shorter of the term of the licence and the useful economic life of the computer equipment on which they are installed. This would usually be from 3 to 5 years. Developed software is amortised over the estimated useful life. In the year of acquisition, amortisation charges commence when the asset is brought into use.

1.5 Value Added Tax

The PSOW is not registered for VAT. Expenditure is therefore disclosed gross of VAT.

1.6 Pensions

The pension obligations to present and past employees are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS), the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme (the Fund) and by direct payment to previous Commissioners for Local Administration in Wales or any surviving beneficiaries. Full details are disclosed in the Pension Disclosures at the end of the Financial Statements. The costs of providing these pensions are charged through the Statement of Comprehensive Net Expenditure, with actuarial gains and losses relating to the Cardiff and Vale of Glamorgan Pension Scheme being recognised in the year in which they occur.

1.7 Early departure costs

Where the PSOW is required to meet the additional cost of benefits beyond the normal benefits payable by the appropriate pension scheme in respect of employees who retire early, these costs are charged to the Statement of Comprehensive Net Expenditure in full when the liability arises.

McLellanHolly
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1.8 Leases

Expenditure on leased property and equipment is charged in the period to which it relates.

1.9 Staff Costs

In line with IAS 19, short-term employee benefits, such as wages, salaries and social security contributions, paid annual leave and paid sick leave, as well as non-monetary benefits for current employees, are recognised when an employee has rendered services in exchange for those benefits.

1.10 Provisions

These are sums which are of uncertain timing or amount at the balance sheet date and represent the best estimate of the expenditure required to settle the obligations. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the recommended HM Treasury discount rate.

1.11 Income

All income is recognised in the Statement of Comprehensive Net Expenditure in accordance with IAS 18 and IFRS 15.

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1.12 Impact of Standards Not Yet Effective

Standard	Effective date	Further details
IFRS 16 Leases	2021-22 Implementation delayed from 2020-21 due to Covid-19	IFRS 16 will replace the current leases standard IAS 17 and requires a lessee to recognise assets and liabilities for leases with a term of more than 12 months, unless the underlying asset is of low value. A lessee is required to recognise a right-of-use asset representing its right to use the underlying leased asset and a lease liability representing its obligation to make lease payments. As a consequence, a lessee also recognises depreciation of the right-of-use asset and interest on the lease liability and classifies cash repayments of the lease liability into a principal and interest portion. This is a significant change in lease accounting.
IFRS 17 Insurance Contracts	2021-22 at earliest	IFRS 17 replaces IFRS 4 Insurance Contracts, and requires a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so is not relevant only for insurance companies.

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2. Staff Costs and Numbers

The aggregate employment costs were as follows:

	2019/20	2018/19
	£000	£000
Permanent staff:		
Salaries	2,582	2,389
Social Security costs	252	221
Pension costs	685	480
Pension fund charges	33	42
Total	**3,552**	**3,132**

There were no temporary staff employed by the PSOW during 2019/20 and 2018/19.

The average number of whole-time equivalent persons employed (including senior management and fixed term appointments) during the year was as follows:

	2019/20	2018/19
	No.	No.
Directors	2	2
Communications and PA	3	3
Complaints and Investigations	50	49
Improvement Team	3	-
Corporate Services and ITC	7	8
Total	**65**	**62**

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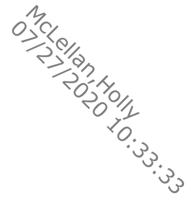
3. Non-Staff Administration Costs

	2019/20	2018/19
	£000	£000
Rentals under operating leases	237	264
External Audit fee	15	18
Legal and professional fees	230	261
Other property costs	135	135
Computer services	209	182
Office costs	169	103
Travel and subsistence	45	31
Training and Recruitment	93	55
Communications	87	41
Sub-total	**1,220**	**1,090**
Depreciation	36	24
Amortisation charge	24	7
Loss on disposal	-	-
Sub-total	**60**	**31**
Total Other Administration Costs	**1,280**	**1,121**

4. Operating Income

	2019/20	2018/19
	£000	£000
Seconded staff	(13)	(60)
Interest receivable	-	-
Other – Future Generations Commissioner	(1)	(1)
Total	**(14)**	**(61)**



5. Operating Costs by Strategic Aims

The costs of providing a first-class Ombudsman service to Wales are set out below. We have 3 strategic aims for delivering our mission and the allocation of costs to each of the aims has been based on the following:

(a) an estimate of the staff time spent on the objective
(b) direct allocation of expenditure where applicable
(c) apportionment of other costs pro rata to the estimate of staff time

	2019/20		2018/19	
	£000	%	£000	%
Strategic Aim 1:				
A fair, independent, inclusive and responsive complaints service.	3,764	78.1	3,356	80.0
Strategic Aim 2:				
Promote learning from complaints and stimulate improvements on a wider scale.	849	17.6	691	16.5
Strategic Aim 3:				
Identify and adopt best practice. Secure value for money and services that are fit for the future. Support staff and ensure good governance which supports and challenges us.	205	4.3	145	3.5
Net operating costs	**4,818**	**100.0**	**4,192**	**100.0**

Due to the implementation of our new Corporate Plan from April 2019 the strategic aims have changed, meaning that direct comparison to 2018/19 cannot be made. For this reason, the 2018/19 figures have been restated by combining strategic aims 2 and 3 from the previous plan.

The previous Strategic Aim of evolving and preparing for the implementation of the new Public Services Ombudsman (Wales) Act has been combined within the new Strategic Aim 2 as promoting learning and delivering improvement is a key aim of the new Act.

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6a. Property, Plant and Equipment

2019/20	Plant £000	Computers and other equipment £000	Furniture and other fittings £000	Total £000
Cost or valuation at 1 April 2019	156	216	428	800
Additions	-	29	24	53
Disposals	-	(22)	(14)	(36)
At 31 March 2020	156	223	438	817
Depreciation as at 1 April 2019	(156)	(139)	(320)	(615)
Charged in the year	-	(19)	(17)	(36)
Disposals	-	22	14	36
At 31 March 2020	(156)	(136)	(323)	(615)
Carrying amount as at 31 March 2020	-	87	115	202
Carrying amount as at 31 March 2019	-	77	108	185

2018/19	Plant £000	Computers and other equipment £000	Furniture and other fittings £000	Total £000
Cost or valuation at 1 April 2018	156	150	430	736
Additions	-	66	15	81
Disposals	-	-	(17)	(17)
At 31 March 2019	156	216	428	800
Depreciation as at 1 April 2018	(156)	(131)	(321)	(608)
Charged in the year	-	(8)	(16)	(24)
Disposals	-	-	17	17
At 31 March 2019	(156)	(139)	(320)	(615)
Carrying amount as at 31 March 2019	-	77	108	185
Carrying amount as at 31 March 2018	-	19	109	128

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6b. Intangible Assets

2019/20	Information Technology £000	Software Licences £000	Total £000
Cost or valuation at 1 April 2019	500	52	552
Additions	-	-	-
Disposals	(3)	-	(3)
At 31 March 2020	497	52	549
Amortisation as at 1 April 2019	(328)	(52)	(380)
Amortisation charged in the year	(24)	-	(24)
Disposals	3	-	3
At 31 March 2020	(349)	(52)	(401)
Carrying Value as at 31 March 2020	148	-	148
Carrying Value as at 31 March 2019	172	-	172

2018/19	Information Technology £000	Software Licences £000	Total £000
Cost or valuation at 1 April 2018	328	52	380
Additions	172	-	172
Disposals	-	-	-
At 31 March 2019	500	52	552
Amortisation as at 1 April 2018	(321)	(52)	(373)
Amortisation charged in the year	(7)	-	(7)
Disposals	-	-	-
At 31 March 2019	(328)	(52)	(380)
Carrying Value as at 31 March 2019	172	-	172
Carrying Value as at 31 March 2018	7	-	7

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In the opinion of the Public Services Ombudsman for Wales there is no material difference between the net book value of assets at current values and at their historic cost.

7. Trade and other Receivables

	2019/20	2018/19
	£000	£000
Amounts falling due within 1year		
Prepayments	207	175
Trade debtors	-	-
Amounts falling due after more than 1year		
Prepayments	1	1
Total	**208**	**176**

8. Cash and Cash Equivalents

Any bank balance held at the year-end must be returned to the Welsh Consolidated Fund. A figure of £48k (£20k in 2018/19) has been included within the accounts, being the net balance at the year end on all the bank accounts operated by the Public Services Ombudsman for Wales, irrespective of whether the individual account is in debit or credit. The year-end balance will be repaid to the Welsh Consolidated Fund in 2020/21 under the Government of Wales Act 2006.

9. Trade Payables and other Current Liabilities

	2019/20	2018/19
	£000	£000
Amounts falling due in 1 year		
Untaken annual leave	93	61
Deferred rent reduction	5	5
Welsh Consolidated Fund - unspent balances	48	20
Trade payables	6	15
Accruals	58	71
	210	**172**
Amounts falling due in more than 1 year		
Deferred rent reduction	20	24
Total	**230**	**196**

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10. Provisions for Liabilities and Charges

	2019/20				2018/19
	Pensions for Former Commissioners	Dilapidation Costs	Other Costs	Total	Total
	£000	£000	£000	£000	£000
Balance at 1 April	239	286	-	525	**537**
Additional provision	33	6	-	39	**33**
Discount rate movement	6	-	-	6	**(2)**
Provisions utilised in the	(44)	-	-	(44)	**(43)**
Balance at 31 March	234	292	-	526	525

Analysis of expected timings of payment of provisions:

	2019/20	2018/19
	£000	£000
Payable within 1 year	45	44
Payable within 2 to 5 years	157	157
Payable in more than 5 years	324	324
Balance at 31 March 2020	526	525

Pension provisions are calculated based on the National Life Tables for England and Wales issued by the Office of National Statistics. Later year pension increases are in line with GDP deflator information issued by HM Treasury. The discount factor has been amended to -0.50% for the financial year (0.29% in 2018/19) in line with the guidance issued by the Treasury. Two surviving spouses of former Commissioners remain as a pension liability.

Dilapidations were increased in 2019/20 in line with the Office for National Statistics latest all construction index.

11. Reconciliation of Operating Cost to Operating Cash Flows

	Notes	2019/20 £000	2018/19 £000
Net operating cost		(4,818)	(4,192)
Adjust for non-cash items	3	60	51
Decrease/(Increase) in trade and other receivables	7	(32)	13
Increase/(Decrease) in trade and other payables	9	34	(9)
Movement in provisions	10	1	(12)
Movement in cash repaid to Welsh Consolidated Fund	8	(28)	12
Net cash outflow from operating activities		(4,783)	(4,137)

12. Non-Current Asset Expenditure and Financial Investment

	2019/20 £000	2018/19 £000
Purchases of property, plant and equipment	(53)	(81)
Proceeds of disposals of property, plant and equipment	-	-
Purchases of intangible assets	-	(172)
Net cash outflow from investing activities	(53)	(253)

13. Reconciliation of Net Cash Requirement to Increase/(Decrease) in Cash

	2019/20 £000	2018/19 £000
Net Cash Requirement:		
Operating activities	(4,783)	(4,137)
Capital Expenditure	(53)	(253)
	(4,836)	(4,390)
Financing from National Assembly for Wales	4,884	4,410
Repayment to Welsh Consolidated Fund	(20)	(32)
Increase/(Decrease) in cash and cash equivalents	28	(12)

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14. Commitments under Operating Leases

	2019/20	2018/19
	£000	£000
Total future minimum operating lease payments on building:		
Payable within 1 year	198	198
Within 2 and 5 years	792	792
More than 5 years	72	270
	1,062	**1,260**
Other		
Payable within 1 year	-	12
Within 2 and 5 years	-	-
More than 5 years	-	-
	-	**12**
Total of all operating leases	**1,062**	**1,272**

The 2018/19 figures have been restated to reflect updated lease terms.

15. Contingent Liabilities

None.

16. Capital Commitments

There were no capital commitments at 31 March 2020 (2018/19 Nil).

17. Related Party Transactions

The PSOW is headed by the Public Services Ombudsman for Wales. The office was established under the Public Services Ombudsman (Wales) Act 2005 and is now governed by the Public Services Ombudsman (Wales) Act 2019. The Ombudsman is independent of Government and the funding arrangements of the Office are set up to ensure that the independence of the Office is secured. The PSOW has had a number of material transactions with the National Assembly for Wales, HM Revenue and Customs (Tax and National Insurance) and the Cabinet Office (payments in respect of the Principal Civil Service Pension Scheme). During the year, no directors, key members of staff or their close relatives have undertaken any material transactions.

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18. Events after the Reporting Period

None.

Pension Disclosures

Two pension schemes are operated on behalf of current staff – The Principal Civil Service Pension Scheme (PCSPS) and the Cardiff and Vale of Glamorgan Pension Fund (the Fund). There also remains an ongoing liability to meet the unfunded pensions of two dependant relatives of former Local Government Commissioners.

Civil Service Pensions

Pension benefits are provided through the Civil Service pension arrangements. From 1 April 2015, a new pension scheme for civil servants was introduced – the Civil Servants and Others Pension Scheme or **alpha**, which provides benefits on a career average basis with a normal pension age equal to the member's State Pension Age (or 65 if higher). From that date, all newly appointed civil servants and the majority of those already in service joined **alpha**. Prior to that date, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS). The PCSPS has 4 sections: 3 providing benefits on a final salary basis (**classic**, **premium** or **classic plus**) with a normal pension age of 60 and 1 providing benefits on a whole career basis (**nuvos**) with a normal pension age of 65.

These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under **classic**, **premium**, **classic plus**, **nuvos** and **alpha** are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within 10 years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between 10 years and 13 years and 5 months from their normal pension age on 1 April 2012 will switch into **alpha** sometime between 1 June 2015 and 1 February 2022. All members who switch to **alpha** have their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave **alpha**. (The pension figures quoted for officials show pension earned in PCSPS or **alpha** – as appropriate. Where the official has benefits in both the PCSPS and **alpha** the figure quoted is the combined value of their benefits in the two schemes.) Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a 'money purchase' stakeholder pension with an employer contribution (**partnership** pension account).

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Employee contributions are salary-related and range between 4.6% and 8.05% for members of **classic**, **premium**, **classic plus**, **nuvos** and **alpha**. Benefits in **classic** accrue at the rate of 1/80th of final pensionable earnings for each year of service. In addition, a lump sum equivalent to 3 years initial pension is payable on retirement. For **premium**, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike **classic**, there is no automatic lump sum. **Classic plus** is essentially a hybrid with benefits for service before 1 October 2002 calculated broadly as per **classic** and benefits for service from October 2002 worked out as in **premium**. In **nuvos**, a member builds up a pension based on their pensionable earnings during their period of scheme membership. At the end of the scheme year (31 March) the member's earned pension account is credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is uprated in line with Pensions Increase legislation. Benefits in **alpha** build up in a similar way to **nuvos**, except that the accrual rate in 2.32%. In all cases members may opt to give up (commute) pension for a lump sum up to the limits set by the Finance Act 2004.

The **partnership** pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 8% and 14.75% (depending on the age of the member) into a stakeholder pension product chosen by the employee from a panel of providers. The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.5% of pensionable salary to cover the cost of centrally-provided risk benefit cover (death in service and ill health retirement).

The accrued pension quoted is the pension the member is entitled to receive when they reach pension age, or immediately on ceasing to be an active member of the scheme, if they are already at or over pension age. Pension age is 60 for members of **classic**, **premium** and **classic plus**, 65 for members of **nuvos**, and the higher of 65 or State Pension Age for members of **alpha**. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes but note that part of that pension may be payable from different ages.)

Further details about the Civil Service pension arrangements can be found at the website www.civilservicepensionscheme.org.uk

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Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity, to which disclosure applies.

The figures include the value of any pension benefit in another scheme or arrangement which the member has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their buying additional pension benefits at their own cost. CETVs are worked out in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation for loss of office

No staff left under Voluntary Exit or Voluntary Redundancy terms during the financial year.

Cardiff and Vale Pension Fund - Local Government Pension Scheme

The disclosures below relate to the funded liabilities of the Cardiff and Vale of Glamorgan Pension Fund (the Fund) which is part of the Local Government Pension Scheme (the LGPS).

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The funded nature of the LGPS requires the PSOW and its employees who are members of the scheme to pay contributions into the Fund, calculated at a level intended to balance the pension's liabilities with investment assets.

The PSOW recognises gains and losses in full, immediately through the Statement of Comprehensive Net Expenditure. In accordance with International Financial Reporting Standards, disclosure of certain information concerning assets, liabilities, income and expenditure relating to pension schemes is required.

No further employer contributions are required to be paid to the Fund by the PSOW.

Disclosure under IAS19 (LGPS funded benefits)

Introduction

The figures below relate to the funded liabilities within the Fund which is part of the Local Government Pension Scheme (LGPS).

Results under IAS 19 (LGPS funded benefits)

Date of the last full actuarial valuation	31 March 2019
Expected employer contributions next year (£M)	0.00
Duration of liabilities	12.7 years

Key assumptions (% per annum)

	31 March 2020	31 March 2019	31 March 2018
	%	%	%
Discount rate	2.30	2.40	2.60
CPI Inflation	2.10	2.20	2.10
Pension increases	2.10	2.20	2.10
Pension accounts revaluation rate	2.10	2.20	2.10
Salary increases	3.10	3.20	3.10

Mortality assumptions

The mortality assumptions are based on actual mortality experience of members within the Fund based on analysis carried out as part of the 2019 valuation, and allow for expected future mortality improvements. Sample life expectancies are shown below:

Assumed life expectancy at age 65 (in years)	31 March 2020	31 March 2019
Males		
Member aged 65 at accounting date	22.2	22.4
Member aged 45 at accounting date	23.2	23.0
Females		
Member aged 65 at accounting date	24.6	24.8
Member aged 45 at accounting date	26.0	25.9

Asset allocation

	Value at			
	31 March 2020			31 March 2019
	Quoted %	Unquoted %	Total %	Total %
Equities	0.0	0.0	0.0	0.0
Property	0.0	0.0	0.0	0.0
Government bonds	100.0	0.0	100.0	100.0
Corporate bonds	0.0	0.0	0.0	0.0
Cash	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Total	**100.0**	**0.0**	**100.0**	**100.0**

Reconciliation of funded status to Statement of Financial Position

	Value at	
	31 March 2020	31 March 2019
	£M	£M
Fair value of assets	7.08	7.00
Present value of funded defined benefit obligation	5.04	5.26
Funded status	**2.04**	**1.74**
Unrecognised asset	(0.96)	(0.93)
Asset/(Liability) recognised on balance sheet	**1.08**	**0.81**

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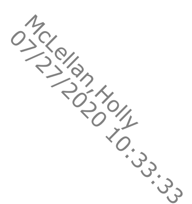
The split of the liabilities at the last valuation between the various categories of members is as follows:

Active Members	7%
Deferred Pensioners	13%
Pensioners	80%

Amounts recognised in Statement of Comprehensive Net Expenditure

	Period ending 31 March 2020	Period ending 31 March 2019
	£M	£M
Operating Cost		
Current service cost	0.02	0.02
Past service cost (incl. curtailments)	0.00	0.00
Settlement cost	0.00	0.00
Financing Cost		
Interest on net defined benefit liability / (asset)	(0.02)	0.00
Pension expense recognised in profit and loss	**0.00**	**0.02**
Remeasurements in Other Comprehensive Income		
Return on plan assets (in excess)/below that recognised in net interest	(0.16)	(0.21)
Actuarial (gains)/losses due to change in financial assumptions	0.00	0.19
Actuarial (gains)/losses due to changes in demographic assumptions	(0.10)	(0.20)
Actuarial (gains)/losses due to liability experience	(0.04)	0.01
Adjustments due to the limit in paragraph 64	0.03	(0.59)
Total amount recognised in other comprehensive income (OCI)	**(0.27)**	**(0.80)**
Total amount recognised in profit and loss and OCI	**(0.27)**	**(0.78)**
Allowance for administration expenses included in current service cost (£M)	0.00	0.00



Changes to the present value of the defined benefit obligation

	Period ending 31 March 2020	Period ending 31 March 2019
	£M	£M
Opening defined benefit obligation	**5.26**	**5.32**
Current service cost	0.02	0.02
Interest expense on defined benefit obligation	0.12	0.14
Contributions by participants	0.00	0.00
Actuarial (gains)/losses on liabilities – financial assumptions	0.00	0.19
Actuarial (gains)/losses on liabilities – demographic assumptions	(0.10)	(0.20)
Actuarial (gains)/losses on liabilities – experience	(0.04)	0.01
Net benefits paid out	(0.22)	(0.22)
Past service cost (incl. curtailments)	0.00	0.00
Net increase in liabilities from disposals/acquisitions	0.00	0.00
Settlements	0.00	0.00
Closing defined benefit obligation	**5.04**	**5.26**

Changes to the fair value of assets

	Period ending 31 March 2020	Period ending 31 March 2019
	£M	£M
Opening fair value of assets	**7.00**	**6.84**
Interest income on assets	0.14	0.17
Re measurement gains/(losses) on assets	0.16	0.21
Contributions by the employer	0.00	0.00
Contributions by participants	0.00	0.00
Net benefits paid out	(0.22)	(0.22)
Net increase in assets from the disposals/acquisitions	0.00	0.00
Settlements	0.00	0.00
Closing fair value of assets	**7.08**	**7.00**

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Actual return on assets

	Period ending 31 March 2020	Period ending 31 March 2019
	£M	£M
Interest income on assets	0.14	0.17
Remeasurement gain/(losses) on assets	0.16	0.21
Actual return on assets	0.30	0.38

Funded Benefits

The following data was provided by the Fund Administering Authority and/or the Employer and has been used to produce the IAS 19 results in this report. Details of the split of assets between the various asset classes were also provided by the Fund Administering Authority and are shown above. We have also shown some of the intermediate calculations used in evaluating the figures in this report.

Active Members as at 31 March 2019

	Number	Total Pay £(M)
Total	1	0.05

Pensioner and deferred pensioner members as at 31 March 2019

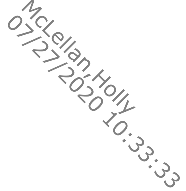
Type	Number	Total Pension £(M)
Deferred members	5	0.02
Pensioners and dependants	12	0.24

Funded cash-flow data provided

	Months Provided	Amount Provided	Amount Used
	£M	£M	£M
Employer – Normal contributions	12	0.00	
Employer – Additional capital contributions	12	0.00	
Employer – Early retirement strain on fund payments	12	0.00	
Total contributions by the Employer			**0.00**
Employee – Normal contributions	12	0.00	
Employee – Added years contributions	12	0.00	
Total contributions by participants			**0.00**
Transfers in	12	0.00	
Other income	12	0.00	
Transfers out	12	0.00	
Retirement lump sums	12	0.00	
Other outgoings	12	0.00	
Death in service lump sums *	12	0.00	
Benefits paid (i.e. pension paid)	12	0.22	
**Net benefits paid out ** **			**0.22**

* We have calculated the expected death in service lump sums over the year to be (£M) 0.00

** The 'Net benefits paid out' figure includes an allowance for expenses of (£M) 0.00



Annualised pensionable payroll over the accounting period

Type	(£M) *
Period ending 31 March 2020	0.05
Period ending 31 March 2019	0.05

* The annualised pensionable payroll has been derived from the contributions paid over the relevant accounting period

Fund return

The overall Fund return over the accounting period has been calculated as 2.4%.

The asset return over the accounting period for the Employer has been taken as the index return on the published FTSE Index Linked UK Gilts over 5 years total return index, to reflect the notional low risk investment strategy which has been put in place with effect from 1 December 2016, in respect of the Employer.

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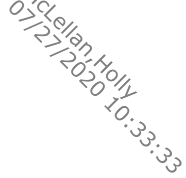
Pensions for former Ombudsmen

With the agreement of the Secretary of State for Wales in 1991 and subsequent confirmation by Statutory Instrument 1993 No. 1367, Local Government Commissioners became eligible to join the Local Government Pension Scheme. However, the pensions of the three previous Local Government Commissioners remained the responsibility of the Public Services Ombudsman for Wales and are met through the Statement of Comprehensive Net Expenditure. At 31 March 2020 two surviving spouses of former Commissioners continued to receive a pension.

Pensions are increased annually in line with other pension schemes within the Public Sector. The basis of calculations of the Annual Pensions Increase has been changed from using the annual movement based on the Retail Price Index (RPI) to the Consumer Price Index (CPI). The amount of the uplift applied is normally set out in the Statutory Instrument Pensions Increase (Review) Order. This uplift for 2019/20 was 2.4%.

The total payments during 2019/20 were £44k (£43k in 2018/19). The liabilities arising out of the obligation to finance these pensions together with any dependant pensions has been calculated to be £234k (£239k in 2018/19). The calculation to determine the overall liability has been carried out internally using life expectancy tables for males and females in Wales obtained from the website of the Government Actuary's Department. A discount rate, from PES (2019), of –0.50% (0.29% in 2018/19) has been applied in accordance with the Treasury guidance that all pension liabilities should be discounted.



Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Fax: 01656 641199
Email: ask@ombudsman.wales
Follow us on Twitter: @OmbudsmanWales

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Agenda item: 4.4

EXPERIENCE, QUALITY & SAFETY COMMITTEE	DATE OF MEETING: 30 July 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 July 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
✘	✘	✓

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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	✓

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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.

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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				✓	✓	✓

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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				✓		
Health and Safety Update	DWOD			✓			✓
Welsh Language Standards Update	DTHS						✓

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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			✓				

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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							

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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

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